Ruminations

From time to time, articles on the topic of the elderly have appeared in Human Communication Canada. This one has a somewhat different focus as it is related specifically to a palliative care facility. I have learned much about this topic in my dealings with the author, Patricia Sloan, and am pleased she was willing to share her experience.

Submissions or topics for "Ruminations" can be sent to me directly or to Human Communication Canada.

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THE ROLE OF SPEECH/LANGUAGE PATHOLOGY IN GERIATRICS AND PALLIATIVE CARE

It is well known that our older population is growing rapidly, relative to the rest of the population. It is also known that disorders of speech, language and hearing are more common among older adults than in any other age group. These facts represent a real challenge to the professions of Speech/Language Pathology and Audiology in the areas of training, clinical practice and research. What do we know about the aging process as it affects communication skills? What characteristics of the geriatric population require special consideration in assessment and treatment? What changes in our approaches to assessment and treatment need to be made for more effective involvement with this population? While these questions are yet to be addressed formally, there is a beginning recognition of this population's special needs regarding communication. As a member of a large team of professionals in the Geriatric Rehabilitation Wing of the Edmonton General Hospital, I have learned a great deal about working with older and sometimes dying adults which I would like to share with you. In the near future, it is likely that more and more of you will also be involved with the geriatric and palliative care population.

Briefly outlined here are the most commonly seen communication disorders of the aging. Hearing problems are by far the most frequent disorder affecting the older population. An estimated fifty percent of persons over the age of 65 suffer some degree of hearing impairment. Undiagnosed and untreated, hearing problems contribute to the social withdrawal and generalized anxiety thought by some to be a natural effect of the aging process. A full scale hearing screening program is as necessary in the older population as in the young if we are to abide by a philosophy of equal health care for all. A coordinated effort on the part of doctors, audiologists, hearing aid dispensers and aural rehabilitationists is also necessary to ensure appropriate amplification, education and counselling, and regular follow-up.

Stroke is the leading cause of speech and language disorders in older

people, resulting in aphasias, apraxias, and/or dysarthrias of varying degrees of severity. Other neurological conditions or diseases can precipitate speech/language problems such as Parkinson's Disease, multiple sclerosis, bulbar palsy, brain tumors, Amyotrophic Lateral Sclerosis, etc. Voice problems secondary to cancer, stroke or other neurological conditions form another body of disorders frequently treated in the elderly.

First and foremost, the geriatric patient/client is part of a family and community, and the focus of rehabilitation must involve this larger unit from admission and assessment through treatment to discharge. There is a large role to be played by all team members in family counselling and community education, particularly in denuding the general public of popular myths about aging - eg. all old people are a little "senile", older folks are resistant to change, older people are unproductive, old age is an emotionally tranquil period. Further, our role extends to patient advocacy in exploring alternatives to traditional institutionalization of the disabled elderly person.

Not less important is the need for all team members to take an holistic approach to the patient and his/her presenting problems. This means that each professional must put together a whole picture of the person - past social and medical history, daily routines, activity level, recreational pursuits, spiritual leanings, uses of medications, and the attitudes and perceptions of the person about his/her problem and its solutions. Part of this undertaking is accomplished through the completion by designated team members of a data base on each new patient. It also involves the letting down of professional defences and a greater sharing in the grey areas where professions overlap and meld. The speech/language pathologist delves into aspects of visual-motor perceptions and ADL (Activities of Daily Living) when assessing reading, writing and calculation skills, traditionally under the auspice of the occupational therapist. She/he may be the one to unearth a leisure pursuit possibility during therapy and to pass this along to the recreation therapist. Diet restrictions may be questioned; medication side-effects observed. Personal crises often require the combined efforts of the social worker and speech/language pathologist for interpretation and resolution. On the other hand, nursing reports on communication behavior; O.T.'s and P.T's may trouble shoot a hearing aid problem; the pharmacist may discover the person can manage a self medication program through a symbol system. In this way of knowing the person and cooperating with a functioning team, the patient is respected as a whole person and not fragmented along professional boundaries. Regular team conferences to discuss a patient's progress and to develop concerted treatment plans are also a crucial part of this process. It has been necessary for most teams to go through a team building process whereby the different roles are developed and understood, lines of communication are drawn out, and unified objectives are clear.

The necessity of developing good rapport with patients is inherent in this approach. It is a gradual process, perhaps further slowed by the individual's physical tolerance, sociability and previous experience with illness or disability. It is the patient who sets the pace. Such practices as a pre-assessment introduction and informal visit are not mere niceties but are reflected in the person's motivation in assessment and subsequent treatment. Participation in patient activities and events apart from therapy also provide valuable observation opportunities and treatment ideas. Selecting and designing treatment materials and activities that are personally relevant to the patient and imminently functional further aids in the demonstration of respect for the person. In a milieu of positive expectations, with honest explanation of the therapy program, the patient can accept his/her responsibility in the rehabilitation process.

These principles hold true when working with the terminally ill, as well. However, there is a perceived lack of compatibility between the needs of the dying patient and the traditional goals of treatment, and certainly palliative care is not a commonly viewed role for the speech/language pathologist. We are undertrained and inexperienced, for the most part, in matters of death and dying and may not have come to grips with our own feelings regarding death. Yet good communication is necessary in order to carry out the philosophy of palliative care that patients and their families come to terms with and prepare for death. Our role with the terminally ill appears to be fourfold: to determine and provide an ongoing means for the patient to communicate, not only basic needs but feelings also; to consult with the medical team, family and volunteers on how to facilitate and enhance communication; to monitor for changes required in the communication system as the patient's abilities and needs change over time; and to be part of the team of people providing for the psychosocial needs of the dying patient.

The need for palliative care is expected to grow as our population grows older and as the number of patients in the terminal stages of debilitating diseases continues to grow. Therefore the profession should be developing a response, a philosophy of treatment which prepares clinicians for the different responsibilities and roles required of them in a palliative milieu.

Hopefully, these remarks have sparked an interest in and concern for the kind of care we afford the older people of our country and those approaching death. The need for research with these populations is glaring as is the need to train emerging clinicians about the normal processes of aging and dying and the communication problems associated with these periods in life. By careful observation and reflection on the response of our patients to treatment, a body of ideas, techniques, and procedures adapted to the geriatric and palliative patient will start to take form and be submitted to the scrutiny of practical application and clinical research.

Editor's Note: *The purpose of "Ruminations" is to provide a philosophical forum in which to discuss fundamental issues in speech, language and learning. Such issues might be related to theory, clinical practice or to the growth and development of the profession. The ideas represented do not necessarily reflect the official position of CSHA, the members of the National Council, or of the Editorial Staff.*

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CSHA has new address

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