

# Integrating Speech-Language Pathology Services in Palliative End-of-Life Care

**Robin D. Pollens**

Clinical speech-language pathologists (SLPs) may receive referrals to consult with teams serving patients who have a severe and/or terminal disease. Palliative care focuses on the prevention or relief of suffering to maximize quality of life for these patients and their families. This article describes how the role of the SLP in palliative care services contrasts with more traditional impairment-based rehabilitation roles. Consultative services related to communication and swallowing should be informed by and align with overall palliative care goals of the patient, the family, and the team. Case examples illustrate how SLPs interact within an end-of-life care team, highlighting the importance of effective interprofessional communication. Speech-language pathologists are encouraged to consider how they might better integrate speech-language pathology into palliative care services in order to contribute to and learn from palliative care team members. Clinical practice in end-of-life care requires additional knowledge, self-awareness related to beliefs about dying, and level of comfort working with those who are facing severe illness/death and their families.

**Key words:** *communication, dysphagia, end of life, hospice, interdisciplinary team, palliative care, SLP, speech pathology, speech therapy, WHO-ICF*

## PALLIATIVE END-OF-LIFE MODEL OF CARE

Speech-language pathologists (SLPs) have to learn new roles and acquire new communication skills to integrate their services with others in addressing the palliative care needs of adults nearing the ends of their lives and their families. As described by Toner and Shadden (2012), some terms are used interchangeably to describe care for individuals

and families facing serious or life-threatening illnesses, although they have slightly different meanings. The most common terms are *palliative care*, *hospice care*, and *end-of-life care*. It would be helpful to consider the referential meanings of each of these terms before considering their deeper meanings for families facing end-of-life decisions.

*Palliative care* is defined by the World Health Organization (WHO) as targeting improved quality of life for patients and families confronting problems associated with life-threatening illness (European Association for Palliative Care, 2010; WHO, 1990). Emphasis is placed on identifying and managing symptoms and complications secondary to the precipitating illness. Although a common misunderstanding is that palliative care is focused primarily on symptom relief for people who are dying, this type of care can be elected by any individual with a serious, debilitating illness. For example, palliative care can be applicable in the early stages of an illness when the illness or associated treatments are causing significant physical or emotional

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distress to patient and loved ones but no immediate threat of death. Palliative care also can be provided for patients in many settings, including hospital inpatient units, outpatient clinics, family homes, and nursing homes (National Consensus Project for Quality Palliative Care, 2004).

*Hospice care* is considered a subset of palliative care. A person becomes eligible for hospice care under the Medicare benefit when it is determined that his or her life expectancy is 6 months or less if the disease follows the expected course. As with other forms of palliative care, emphasis is placed on management of symptoms and various forms of support, including social-emotional and spiritual support. The distinction in hospice care is that there is no longer an expectation of survival, and curative medical interventions are not pursued.

The term *end-of-life care* sometimes broadly applies to services provided in the last weeks of life. However, the term may also be referenced in a manner that is not defined by a particular time or duration of services. The National Institutes of Health Consensus Development Program (2004) conducted a conference on improving end-of-life care. In the consensus statement developed from this conference, end-of-life care was summarized as a time when symptoms or impairments resulting from an underlying irreversible disease require care and can lead to death.

Although distinctions can be made among the basic meanings of these three key terms, health care service providers must consider the deeper meanings and levels of personal significance they often evoke for patients and families facing end-of-life hospice and palliative care decisions. Professionals who assume roles in supporting families through end-of-life decisions must also conceptualize how their roles differ when engaging in palliative/hospice care service delivery from their roles when providing other forms of health care. The World Health Organization International Classification of Functioning, Disability and Health (WHO-ICF) model of health care

(WHO, 2012) is a useful framework for describing these distinctions.

Traditional health care is grounded primarily in the medical model, focusing on body function/impairment and targeting accurate diagnosis and “fixing” the problem. In contrast, palliative intervention is grounded in the social model, focusing on supporting the patient and family in meeting their goals for daily activities/participation and quality of life. Contextual environmental factors (e.g., effectiveness of communication partners) and personal factors (age, race/ethnicity, cultural preferences) as described by the WHO-ICF framework are important considerations in providing care within this model.

A general principle of palliative care is that it requires collaborative interactions of an interdisciplinary team (Gomez-Batiste, Portales, Paz, & Stjernsward, 2009; National Consensus Project for Quality Palliative Care, 2004). Palliative care teams usually include a core group of professionals in medicine, nursing, and social work. Other members of the team may include chaplains, counselors, physical therapists, occupational therapists, speech-language pathologists, pharmacists, art therapists, music therapists, and trained volunteers. Patients and family members are also considered to be active members of the team rather than passive recipients of services. The purpose of this article was to suggest ways the SLP can effectively contribute to and learn from the palliative care team to become more integrated members of this team.

#### **SPEECH-LANGUAGE PATHOLOGIST ROLES IN PALLIATIVE END-OF-LIFE CARE**

What roles might SLPs play as members of a palliative care team and how do those roles contrast with traditional roles? In traditional roles, SLPs are called upon to provide rehabilitation services for patients with neurological, oncological, or other disease processes that may impact the patient’s communication, cognition, or swallowing abilities.

Rehabilitative care calls for goals aimed at reducing impairments, increasing functional abilities, and maximizing opportunities for social participation (WHO, 2012).

In contrast, patients with a diagnosis of similar conditions but nearing the end of life would need a different type of speech-language services, which are guided by the context of the physical, social, and psychological status of the patient (Eckman & Roe, 2005) and modified as the patient's status declines. Patient and family preferences and collaborative problem solving may be valued in rehabilitation and palliative care, but the context of the care is different.

In the palliative care model, all interdisciplinary team members offer their expertise to develop strategies to add comfort and ease to the patients' quality of life, to support family members or other caregivers in providing care for the patient, and to consult in response to changes in patient status.

Specifically, Pollens (2004) outlined roles for the SLP in palliative, end-of-life, or hospice care as including the following:

1. Consultation with patients, families, and members of the hospice team regarding choices in the areas of communication, cognition, and swallowing function.
2. Consultation regarding strategies and tools in the area of communication to support the patient's active participation in decision making, to maintain social closeness, and to assist the patient in fulfillment of end-of-life goals.
3. Assistance in optimizing function related to dysphagia symptoms to improve patient comfort and eating satisfaction and to support positive mealtime interactions with family members.
4. Collaborative consultation with members of the interdisciplinary team to provide and receive input related to overall patient care.

To highlight some of these distinctions, Table 1 provides contrasts between traditional impairment-based speech-language pathology clinical outcomes and

participation-based outcomes that align with client-centered palliative care goals.

## **SPEECH-LANGUAGE PATHOLOGY CONSULTS**

The term *consult* is used here to reflect the referral process that occurs between health care professionals typically serving as core team members in the palliative end-of-life care model and SLPs, who are not routinely core members of the palliative care team. The use of this term also emphasizes the nature of the role as one of collaborative consultation, in contrast with a "referral for therapy services" within the rehabilitation model, in which the focus of care (therapy) is to facilitate a positive change in the function of the patient over a course of treatment. Actions involved in the initial SLP consult for palliative care might include (1) clarifying patient and family preferences and concerns in the areas of communication and swallowing; (2) assessing needs and providing assessment information to the patient, family, interdisciplinary team, and/or referring professionals in the relevant areas of communication and swallowing; (3) seeking relevant information from other members of the interdisciplinary team who can inform choices related to communication and swallowing; and (4) recommending follow-up SLP visits, as needed, to meet with patients and caregivers for strategy development and securing of resources. The actual extent of clinical involvement will depend on the needs and preferences of the individual client, the presenting communication or swallowing difficulties, the expected course of the life-threatening disease, and the palliative care setting.

When seeking collaborative consultation to address palliative care goals, professionals with diverse expertise share their expertise in a manner that addresses the patient's and family's comprehensive needs. In the case of speech-language pathology services, consults are requested primarily to address problems with communication and/or eating and

**Table 1.** Comparing Clinical Impairment-Based and Palliative Care Participation Outcomes

SLP clinical focus	Example of impairment-based outcome	Example of palliative care participation outcome
Voice	Patient able to increase voice volume using pushing technique for three- to four-word phrases	Using new strategy for increased volume, aides were able to understand patient's requests at mealtime
Hearing	Auditory acuity functional with use of amplification device in quiet setting	Patient was able to hear and engage in reminiscence session with social worker using the amplification device
Swallowing	Patient able to eat 5-10 small teaspoons of pureed food without signs/symptoms of aspiration	Patient can now comfortably eat small amounts of pureed food for pleasure during family meal
Reading	Patient able to point correctly to single words from array of 20 words on communication board	Communication board created for patient, and he pointed to "money" to indicate concern about finances

*Note.* SLP = speech-language pathologist.

swallowing. For example, in reference to palliative care in a hospital setting, Radtke, Baumann, Garrett, and Happ (2011) noted that the core members of interdisciplinary teams often are not trained in assessment and use of augmentative communication strategies; therefore, "SLP consultation may offer additional communication support, enhance communication outcomes, and add value to palliative care services. . . ." (p. 795). The other primary reason that palliative care teams seek consults with SLPs relates to concerns about the patient's eating and swallowing. These two areas of concern are addressed separately in the sections that follow, but they would need to be addressed in an integrated manner with an individual patient and family.

#### COMMUNICATION CONSULTS IN PALLIATIVE END-OF-LIFE CARE

Palliative end-of-life care incorporates goal setting with active involvement of the patient; for this to occur, communication is essential. Quality of life is also supported when a patient is able to communicate wishes, needs, and feelings, as well as to maintain relationships. For patients with impaired communication,

their ability to meet those needs and access the benefits of palliative care may be limited. Agitation and anxiety can be increased during critical illness by frustration and fear associated with not being able to communicate (Garrett, Happ, Costello, Fried-Oken, 2007). Other factors unrelated to a diagnosed communication disorder, such as fluctuations in fatigue, pain, and medication effects, might reduce the patient's communication ability (Salt & Robertson, 1998).

Speech-language pathology consults with a focus on communication can benefit the patient, the family, and the members of the interdisciplinary end-of-life team providing care in several ways. The speech-language pathology intervention can facilitate the patient's communicative access for providing input related to care choices and for participating in activities of choice. Speech-language pathologists can confer with family members about ways to maintain social connectivity with their loved ones and to advocate for communication services and supports based on the patient's wishes. The SLP may also assist the palliative or hospice care team in determining whether a patient with communication impairment has the

ability to participate in his or her own decision making through augmentative communication strategies (Wagner, 2008). Finally, a communication consult may assist the team to provide effective symptom management or to engage the patient in life review or other psychosocial support strategies (Rahman, 2000). The following case discussion highlights this interaction between palliative care goals and speech-language pathology communication goals:

Mr. A, a 62-year-old man with a terminal brain malignancy, was receiving care through hospice in his own home where he resided with his wife. The hospice nurse visited the family and found the patient to be angry and agitated and the wife tearful and confused. The patient's aphasia had advanced with the apparent growth of his tumor, and his wife could not understand what he wanted. In his frustration, the patient had become belligerent during care provision. The nurse requested a speech-language pathology consult.

When the SLP arrived at the home, the patient was angry and pounding his fist. His wife tearfully told the SLP that there was something he wanted but she did not know what it was. The SLP did a quick informal assessment of the patient's language skills and determined that his verbal output was limited to jargon, but he was following short conversational comments receptively. The SLP engaged the patient in conversation using supported conversation techniques (Aphasia Institute of Toronto, n.d.), such as (1) affirming to the patient that he knew what he wanted to say but it was hard to talk, (2) writing key words to guide the conversation using written choice, (3) establishing the main topic and then using questions to narrow the focus to the meaning he was intending to communicate, and (4) confirming with the patient what was understood. Mr. A's wife was present during this interaction and began contributing to the conversation. Using these strategies, she eventually understood that her husband wanted a specific type of soda pop that was meaningful to this couple from their past travels together.

The SLP was able to discuss with the couple that, although communication is difficult now, these strategies can help. The SLP contacted the nurse and described what had occurred so that the nurse would share the knowledge about the strategies. On a return visit, Mr. A's wife stated that, although communication was still a challenge, the couple

were working together to figure out his ideas. The nurse also contacted the SLP and stated that the patient was less agitated during care provision. This SLP communication consult supported the team's overall palliative care goals of providing psychosocial support for the wife, assisting the patient to communicate his care needs and preferences, and providing optimal medical care for the patient.

The SLP in the aforementioned scenario might return for several more visits with this patient. If so, the focus of subsequent sessions would be derived from the patient and family's goals. For example, a picture guide of common meals could be created for the patient if the goal were to choose what he wanted to eat, or perhaps a basic schedule for the day could be created so that the patient could keep track of when another nurse was expected to come. In other words, the SLP would not be working on impairment-based goals (e.g., increasing the patient's ability to read longer passages or increasing his ability to repeat words) but rather would be working on language/communication tasks that are contextualized, personally meaningful, and supportive of this family's needs during their end-of-life time together.

In hospice care in particular, goals are immediate and may change frequently. In this case example, the following week Mr. A's SLP attended an interdisciplinary team meeting and learned that the patient's overall fatigue and alertness had greatly declined and he remained in bed. In the SLP's next visit to the patient, she noted that Mr. A's wife now was worried most about leaving his bedroom in case he needed something. Information and resources about appropriate alert systems were provided to ease the wife's concern.

Many complexities can develop within family systems during times of crisis (Farrelly, 2009). All members of the interdisciplinary team contribute cooperatively toward establishing and achieving mutual palliative care goals. The SLP may need to consult with the team social worker (master's level social worker [MSW]) to provide guidance and support to a family. Conversely, the MSW may

request a consult with the SLP for patients who may need to be supported communicatively so that they can participate with the MSW in engaging in psychosocial discussion, reminiscence, or other end-of-life goals (Pollens & Lynn, 2011). The following case discussion will highlight this interdisciplinary care for a patient receiving end-of-life care in his home setting:

The hospice social worker visited Mr. B, a patient with a progressive neurological disease. The patient tried mouthing words to the social worker in response to her questions, but his speech had become unintelligible. Mrs. B was concerned that he had become more despondent in the past week. The social worker asked Mr. and Mrs. B. whether they would like to have an SLP come to the home to determine whether any other communication strategies could be helpful, and they agreed.

With Mr. B's cooperation, the SLP offered several approaches for trial; Mr. and Mrs. B. were most satisfied with a laser-pointer light attached to a headband that he was able to direct to large letters taped to his bedroom wall. His wife confirmed the letters and words and sought to interpret the message. The SLP shared information with the social worker about this system of communication, and Mr. B and his wife modeled its use during the next social work visit. Mr. B was then able to inform the social worker about his personal concerns. He was worried about what would happen to his wife after he died, especially in the area of finances. The social worker was able to provide appropriate psychosocial support for the patient and enable the patient and his wife to discuss the matters of greatest concern to him.

One week later, the SLP contacted the wife to offer a return visit. The wife declined, stating that the communication system was working and more visits were not needed at this time. The palliative care goals of supporting the patient to communicate his needs and direct his care and providing psychosocial support for the patient and his wife were facilitated.

Awareness of topics that arise commonly in communicative interactions with people in hospice care can inform the development of augmentative and alternative communication systems and discussions of care goals. King and Lasker (2005) surveyed hospice workers and adult clients in hospice services to deter-

mine topics used frequently during end-of-life discussions. Topics included: *symptom management* (pain, fatigue, or anxiety), *reminiscence*, *quality of life* (how to live with the illness), *caregiver issues*, *relationships* (resolve conflicts, spend time with people, forgive), and *bereavement* (concern for how others will cope with the person's death).

#### **DYSPHAGIA CONSULTS IN PALLIATIVE END-OF-LIFE CARE**

Dysphagia is often a pivotal issue in palliative care. Groher and Groher (2012) describe the components and complexities of palliative dysphagia consults. In many settings, a palliative care referral to speech pathology services is initiated for an assessment of a patient's swallowing status. In response to such consult requests, the SLP assesses swallowing status and may also determine whether communication or cognitive concerns need to be addressed.

The following discussion focuses specifically on dysphagia consults in hospice as a patient's medical status declines. In this setting, frequent roles of the SLP in the area of dysphagia are to (1) optimize the patient's ability to eat or drink comfortably, with modifications as the patient's status declines; (2) promote positive feeding interactions for family members or caregivers; (3) support and educate family members regarding the patient's declining ability to eat due to the disease process; and (4) communicate about patient status with members of the interdisciplinary team.

Working with families may entail assisting them to understand and expect declines in swallowing ability in their loved ones in end-of-life care. When patients decline in their ability to eat, even with assistance, compassionate and specific conversations with family members may provide support and relieve the family members' concerns that they are not competent at feeding their loved one. Reframing feeding as a time of loving interaction and diminishing the focus on the quantity of food that the patient is able to consume

may comfort the family. This includes helping family members understand that the patient's inability to eat is due to the illness and not to the family member's inability to prompt oral intake. Suggesting other ways to "nourish" loved ones, such as by brushing their hair or applying lotion to their hands or feet, may also be helpful. A significant decline in swallowing may also signify that the patient is nearing the time of active dying, and the SLP should notify members of the interdisciplinary team.

The following case describes a referral to an SLP for assessment of swallowing, in which communication support was also addressed; the important role of interdisciplinary communication is highlighted as well:

Mrs. C was an 86-year-old woman receiving hospice care at home. Her family was concerned about her limited food intake, and the hospice nurse responded by initiating a referral to the SLP. The SLP observed Mrs. C's daughter feeding her mother and provided guidance for optimal strategies to enable Mrs. C to continue eating small amounts of food as long as it was pleasurable. The SLP also informed the family that Mrs. C's communication ability could decline and encouraged the family to engage in meaningful conversation prior to further decline. Mrs. C's husband was unable to hear his wife due to her weak vocal volume coupled with his hearing loss. The SLP loaned an assistive listening device to enable Mrs. C's husband to better hear his wife's occasional responses.

During the last SLP visit, Mrs. C said repeatedly, "I have to reach the next level." The daughter tearfully told her mother that it was okay if she had to go and that she loved her. The SLP informed the nurse, social worker, and chaplain of this exchange as it had implications for their provision of psychological and spiritual support to the patient and family. Two days later, the nurse informed the SLP that the patient had a further decline in physical and mental status. She was bedbound, had lost her interest in and ability to eat, and had increased sleepiness and mental confusion. She was demonstrating the early stage of "actively dying." (Weisman, 2005)

End-of-life services require cultural sensitivity, as do all professional practices, but with particular sensitivity to cultural, religious, or social factors that influence a pa-

tient's or family member's beliefs in end-of-life care and attitudes toward the dying process (Borgmeyer, 2011). Palliative care guidelines (National Consensus Project for Quality Palliative Care, 2004) include the importance of assessing cultural preferences of patients and families and accommodating differences in language, dietary options, and habitual practices.

Listening to families and supporting their ability to participate in care for their loved ones in ways that are meaningful to them are important components in end-of-life care. For example, a family of Hmong background caring for their elderly mother at home wanted to give traditionally prepared rice milk to support her well-being. The SLP instructed the family on strategies for offering small spoonfuls and observing for a completed swallow before offering her the next taste. This facilitated the patient's overall comfort in swallowing and enabled the family to provide their cultural nourishment.

In another example, a farmer who had lovingly provided fresh squeezed juice from his orchard grove was dismayed when his wife had severe coughing when sipping his juice. The SLP showed the farmer how to thicken his special juice with pureed banana to ease his wife's ability to swallow so that the husband could continue to share his juice with his wife each morning.

In all palliative care settings, the SLP seeks input from team care providers when assessing and developing recommendations regarding dysphagia or feeding strategies. Groher and Groher (2012) further describe the importance of this communication. Nurses, home health aides, dietitians, family, and patients all have valuable contributions toward creating appropriate recommendations.

#### **RECOMMENDATIONS FOR PARTICIPATING ACTIVELY ON A PALLIATIVE CARE TEAM**

In many palliative care settings, the SLP is not a core member of the hospice team but rather is called on to provide services on an

on-call basis (referred to as PRN for *pro re nata*, which means “as needed”). In such circumstances, the services may be perceived as ancillary rather than as an integrated part of the team’s work. Although communication, cognition, and swallowing challenges affect the quality of life for patients in palliative care, there may also be some uncertainty about referrals to speech-language pathology or lack of clarity about the role of the SLP in palliative end-of-life care. The SLP may also wish to access education from other disciplines and knowledge of palliative care approaches in order to be a more effective member of the palliative care team.

The following recommendations are proposed as three broad actions SLPs might take to integrate their contributions more fully into the work of the palliative care team. Recommendations for the three broad *actions* are followed by specific suggestions for implementation.

### **Action 1: Communicate effectively with the interdisciplinary team**

#### ***Describe SLP communication consults in relation to improved palliative care outcomes***

Documentation ideally reflects how the consultative services support the tenets of palliative or hospice care (Marrelli, 1999). As described in Table 1, context-specific or participation-based speech-language pathology outcomes support palliative care goals. For example, “Using the communication notebook, patient was able to choose her preferred care schedule” responds to the palliative care goal of obtaining the patient’s input in care provision. Stating this same outcome in an impairment-based paradigm (e.g., “Patient able to read phrase level information accurately”) does not reflect the SLP’s role as a participant in the team’s palliative care goals.

#### ***Share information across discipline boundaries to support mutually established patient care goals***

In an ideal interdisciplinary team, “There is mutual awareness of roles and clinical red

flags” (Roe & Leslie, 2010, p. 307). According to Byock (2009), all members of a clinical team must be prepared to note physical problems or listen to spiritual concerns. In a well-functioning team, sharing roles and observations related to mutual goals established by the team supports the collaborative process. At the same time, the reason for bringing in professionals with diverse expertise is to take advantage of the special knowledge and skills each brings to the process.

This recommendation also implies that SLPs should become familiar with the expertise and scope of practice of other professionals on the interdisciplinary team. It implies as well that professionals on the team must recognize that family members and the patient on a particular team are the final experts regarding the family’s priorities and values. In sessions with patients, professionals, including the SLP, must listen and respond to patient or family concerns and communicate these concerns to the other team members. For example, the family of a patient with end-stage dementia told the SLP that the patient seemed to have pain on urination. The SLP communicated this physical status update to the nurse and the physician.

### **Action 2: Offer quality care to patients and their families**

#### ***Focus on both communication and swallowing needs of the patients***

Particularly, in agencies or facilities in which referrals to the SLP are primarily initiated by the observation of swallowing difficulties in patients under palliative care, the SLP should help others understand the equal importance of communication status and provide appropriate observations and recommendations in that domain as well. Schleinich, Warren, Nekolaichuk, Kaasa, and Watanabe (2008) developed a questionnaire for identifying patient priorities for rehabilitation in palliative care. Of 36 parameters included in the questionnaire, communication and swallowing goals were rated in the top-10 items of importance. Speech-language pathologists

can offer expertise to support patients in both of these areas and may help other members of the team understand the nature of both roles.

***Remain informed about the holistic clinical status of the patient***

A characteristic of teams providing effective palliative care is the use of “multidimensional approach using interdisciplinary teamwork” (Gomez-Batiste et al., 2009). Understanding patient status from the perspective of the other interdisciplinary team members can inform modifications in the SLP’s approach. For example, an SLP working on development of a communication board with a patient noted that the patient had a markedly reduced level of alertness during the third visit and did not attend to the visual stimuli as she had in the prior visits. The SLP contacted the nurse who explained that the patient’s pain and agitation increased as the day progressed and a new medication was now being administered at lunchtime. This informed the plan of care for the SLP who changed scheduling plans to incorporate morning visits for this patient. The patient was then able to choose topics to include on this communication board, including the phrase “I’m ready to be with God.” During the next visit, the chaplain saw this communication and was able to engage the patient in prayer and reflections most meaningful for this patient as she faced her impending death.

***Be present in literal and figurative ways***

Providing care for a dying patient or a grieving spouse draws upon the facet of the speech-language pathology profession that is grounded in compassion and sincerity. A caring, engaged approach and presence is valuable for SLPs during palliative end-of-life care. This skill involves deep listening and responding to social-emotional messages, in addition to offering the technical expertise needed to consult in the areas of communication or swallowing. Goldberg (2006) offered suggestions—talk gently, listen compassionately, sit close by, and treat each person as if

he or she were your family member—for the SLP working specifically with dying patients.

Professionals working in palliative care are at risk for entering a state of “compassion fatigue” or psychological exhaustion (Figley, 1995). This implies that to be fully present for others in need, one must arrange time for self-care practices to maintain one’s own mental and physical health. Strategies for self-care include developing a support system in one’s work setting and advocating for continuing education about end-of-life care (Clark, 2011). This leads directly to Action 3.

**Action 3: Learn more about palliative care services and educate others about the contribution of the SLP on the palliative care team**

Speech-language pathologists can benefit from learning more about palliative care and about provision of services at end-of-life when they enter clinical practice. It has been documented that more education in the area of palliative end-of-life care may be needed for SLP students (Mathisen, Yates, & Crofts, 2011; Rivers, Perkins, & Carson, 2009; Roe & Leslie, 2010). In the study of Mathisen et al. (2011), students were introduced to clinical training in palliative care thinking. Content was provided by social workers and speech-language pathology staff, and the nature of care supporting quality of life as well as reflective practices was emphasized. Social and cultural differences were highlighted, as they affect individual choices for comfort in palliative care. Speech-language pathologists in practice also can seek to obtain and provide relevant palliative care information.

***Attend palliative care educational sessions provided by your facility***

Involvement in these sessions may increase SLPs’ knowledge about palliative care and can broaden professionals’ sensitivity to the needs of those living with serious, sometimes life-threatening illnesses. Specific opportunities to learn more about how the contributions of other potential team members and about best practices in palliative care should

be sought. The presence of an SLP at in-service sessions also serves as an indicator of interest in participating as an active member of the palliative care team and attending agency-sponsored workshops provides an opportunity to be with peers in discussing and reflecting on aspects of end-of-life care.

***Provide a presentation for your interdisciplinary team on the role of the SLP in communication and dysphagia***

Many agencies need to document that they provide continuing education opportunities to their palliative care team, and administrators may welcome the offer of a presentation. Briefly describing scenarios in which palliative care goals were facilitated through the SLP intervention may assist the team members to recognize when a referral for an SLP consult may be beneficial. In addition, providing a discussion component to the presentation is an educational opportunity for the SLP to understand the other palliative care team members' concerns and perspectives.

The value of in-service training was supported by a study in Britain (Biddle & Mitchell, 2008), in which a pair of SLPs presented to community and hospital hospice teams to provide referral guidelines and to increase awareness of the role of the SLP. Referrals of patients to speech-language pathology services increased significantly.

***Provide an educational session to local chapters of relevant organizations or academic institutions***

The local chapters of Amyotrophic Lateral Sclerosis (ALS) Association or Alzheimer's Association may appreciate a presentation for family members on anticipated changes in communication and swallowing skills during the disease progression. Clients and families as consumers may then be better aware of how and when to request the services of SLPs. This may include seeking early assessment and ongoing monitoring, described as critical by Brownlee and Bruening (2012).

Collaborating with local agencies may also benefit patients in other ways. For example,

exploring community resources for loaner communication devices for people with ALS may result in lending a device to serve individuals during their end-of-life care. Presenting a guest lecture or facilitating an interdisciplinary panel discussion on palliative care to students in a number of disciplines (e.g., social work, speech-language pathology, nursing, psychology) also can enhance the ability of future health care providers to integrate into palliative care teams.

***Attend and participate in regional or national palliative care conferences***

Attending a professional interdisciplinary conference offers the opportunity to highlight the role of the SLP in palliative end-of-life care. This author presented at a national palliative care conference and was the only SLP present. During the day following the presentation, several health care professionals initiated a conversation with the author by recalling a patient for whom an SLP communication consult might have been appropriate. In addition, palliative care education from experts outside the field of speech-language pathology can provide a more holistic and inclusive knowledge base and perspective for the clinical SLP.

***Review continuing education materials within the field of speech-language pathology***

The American Speech-Language-Hearing Association (2012) Web site includes a page on end-of-life issues in speech-language pathology. It contains resource information and links related to many important topics in the area of palliative care. This information can augment the SLP's knowledge and serve as a reference for palliative care practice.

**CONCLUSION**

Speech-language pathologists can play important roles in integrative service delivery for patients and families receiving palliative and end-of-life care. Communication and dysphagia consults should reflect the goals and

principles of palliative care in that they are aimed at improving quality of life as defined by the patient and family rather than at curing a disorder or fixing a problem. Integrating speech-language pathology services and collaborating with other health care professionals on palliative care teams address goals to optimize quality of life for the patients, improve symptom management for the team, and sup-

port families in caring for their loved ones. Strategies to educate clinical team members about the role of the SLP in palliative care may result in improved access to this care for patients and their families. Speech-language pathologists may also benefit from palliative care educational opportunities to gain knowledge of and share perspectives about effective quality care for patients and their families.

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