

Brief Report

Hearing Loss in Hospice and Palliative Care: A National Survey of Providers



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Abstract

Context. Age-related hearing loss can impair patient-provider communication about symptom management, goals of care, and end-of-life decision-making.

Objectives. To determine whether hospice and palliative care providers screen for or received training about hearing loss, believe it impacts patient care, and use strategies to optimize communication.

Methods. This was a national survey of hospice and palliative care providers conducted via email and social media. Survey questions were pilot tested with multidisciplinary providers in San Francisco.

Results. Of 510 responses (55% age 50+ years, 65% female, 64% in practice 5+ years, 57% practiced hospital-based palliative care, 45% hospice), 315 were physicians, 50 nurses, 48 nurse practitioners, 58 social workers, and 39 chaplains. Ninety-one percent reported that hearing loss has some or great impact on the quality of care for older adults. Eighty-eight percent recalled a situation where hearing loss created a communication problem with a patient and 56% a communication problem with a caregiver. Eighty-seven percent of physicians, nurses, and nurse practitioners reported not screening for hearing loss. Although 61% felt comfortable with their communication skills for patients with hearing loss, only 21% reported having received formal training in its management, 31% were unfamiliar with resources for patients with hearing loss, and 38% had never heard of a pocket talker amplification device.

Conclusion. Hospice and palliative medicine providers believe age-related hearing loss impacts care yet most do not screen. Although they feel they are managing well, few have formal training. Knowledge about management approaches and resources is suboptimal. *J Pain Symptom Manage* 2016;52:254–258. Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.

Key Words

Hearing loss, aging, hospice, palliative care, communication

Introduction

Sixty-three percent of adults older than 70 years and 80% of persons older than 80 years have hearing loss.^{1,2} Despite this high prevalence, denial of hearing loss is widespread, partly because there are strong social reasons to avoid the labels hearing impaired or deaf, and its onset is insidious. Consequently, only 20% of adults older than 65 years consider themselves hearing impaired,^{3–5} and hearing aids are widely underused.⁶

Age-related hearing loss adversely impacts quality of life and quality of communication, two factors considered vital to patients near the end of life.⁷ The capacity to hear allows individuals to access essential information, including treatment plans, goals-of-care discussions, prognosis, and social or spiritual support.⁸ Hearing loss disrupts the transmission and receipt of such data, often leading to isolation, depression, and misunderstandings. To fail to communicate near the

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end of life because of hearing loss seems tragic when potentially effective methods of communication are available.

Unfortunately, age-related hearing loss is overlooked in most health care settings, with screening rates found to be around 20% in primary care.^{9,10} However, almost nothing has been written about the impact of hearing loss on care for seriously ill older persons and those nearing the end of life,⁸ so that although anecdotal reports suggest that hearing loss is also overlooked in hospice and palliative care, no data are available to document whether this is true. As an initial step in addressing this gap, we conducted a study to assess hospice and palliative care providers' perspectives, experiences, and responses to hearing loss in the clinical care of older adults.

Methods

Participants

Our goal was to survey a large convenience sample of hospice and palliative care providers from multiple disciplines, including physicians, nurses, nurse practitioners, social workers, and chaplains. We recruited participants using emails to professional contacts, members of the American Academy of Hospice and Palliative Medicine (including 3672 physicians, 196 nurse practitioners, 91 nurses, 27 social workers, and 15 chaplains), the GeriPal blog, Twitter, and Facebook. Data were collected using SurveyMonkey (www.surveymonkey.com [SurveyMonkey, Inc, Palo Alto, CA]). On the welcome page of the survey, we asked respondents to proceed only if palliative care is a primary component of their practice. We specified that they focus on hearing loss among the older persons in their practice. As no potentially identifying information was collected, the institutional review board at the University of California, San Francisco considered this proposal exempt from review.

Measures

As there are no established questionnaires or instruments to assess perspectives and knowledge of hearing loss in palliative care, we created measures based on our review of the literature and perceived areas of concern.⁸ Survey questions addressed the following domains: perceived impact of hearing loss on quality of care, screening and audiology referral practices, comfort with and training in caring for patients with hearing loss, treatment strategies, perceived prevalence, and demographic data about respondents. Survey questions on communication strategies queried regarding the use of communication strategies, including both recommended (e.g., facing the patient) and nonrecommended (e.g., speaking in the persons ear).¹¹ Most response options were either

dichotomous (yes/no) or Likert scales. Chaplains and social workers were not asked questions about screening and audiology referral. Measures were developed by study authors and then pilot tested with multidisciplinary hospice and palliative medicine providers at the San Francisco VA Medical Center. The full survey can be accessed at <https://www.surveymonkey.com/r/TXMqw55>.

Statistical Analysis

We received 616 responses. We excluded 106 who responded to all questions but did not respond to the questions on demographics. This left a final analytic sample size of 510. Likert scale categories were dichotomized for ease of interpretation. We present descriptive findings for all respondents followed by statistically significant differences when the sample was separated into professions. For the purposes of this analysis, nurse practitioners/advanced practice nurses were combined and analyzed separately from nonadvanced practice nurses because of their different roles in the management of palliative care. *P*-values were calculated using the chi-square test. The critical value for determining significance (*P*) was set at <0.05. All analyses were conducted using Stata (version 13; StataCorp. LP, College Station, TX).

Results

Of the 510 respondents, a majority were older than 50 years, female, and had been in practice for more than five years (Table 1). Physicians were the largest group of respondents ($n = 315$), followed by social workers ($n = 58$), nurses ($n = 50$), nurse practitioners ($n = 48$), and chaplains ($n = 39$). Fifty-seven percent practiced hospital-based inpatient palliative care, 45% hospice, and 26% outpatient palliative care (nonexclusive categories).

Ninety-one percent of respondents felt that hearing loss had some or a great impact on the quality of care provided to older patients in their palliative care practice. Eighty-eight percent recalled a situation where hearing loss created a communication problem with a patient. Fifty-six percent recalled a communication problem with a caregiver. We asked respondents to think back on the patients who have died and estimate how many had hearing loss before death (i.e., prevalence). Thirty-one percent responded "one in three," 26% responded "every other patient," 25% responded "one in five," with the remaining 18% responding with lower proportions.

When asked how comfortable they felt with their communication skills for older patients with hearing loss, 61% reported feeling either comfortable or very comfortable (Fig. 1). However, only 21% had received

Table 1
Characteristics of Participants (n = 510^a)

Characteristic	%
Age group, yrs	
21–29	2
30–39	21
40–49	18
50–59	31
≥60	24
Female	65
Provider type	
Physician	62
Nurse practitioner	9
Nurse	10
Social worker	11
Chaplain	8
Practice duration, yrs	
<5	33
5–10	28
>10	36
Practice type	
Hospice	45
Hospital-based palliative care	57
Outpatient palliative care	26
Nursing home-based palliative care	16
Home-based palliative care	22
Practice location	
Midwest	22
Northeast	18
South	23
West	30

^aFour percentage missing for all characteristics.

formal training in how to care for patients with hearing loss, 31% were either unfamiliar or very unfamiliar with resources available to patients with hearing loss, and 38% had never heard of a pocket talker amplification device. Table 2 lists approaches to hearing loss used by physicians in our sample. Although many of these are recommended strategies, 70% of respondents reported “speaking in the hearing-impaired patient’s ear,” and 42% reported “speaking to the caregiver instead,” both of which are nonrecommended strategies.

Eighty-seven percent of the 412 physicians, nurses, and nurse practitioners in our sample do not formally screen for hearing loss in their palliative care practice. The most common reasons for not screening were as follows: “I don’t know how to formally screen” (39%); “Other issues were higher priorities than screening” (34%); “I can detect hearing loss when I’m talking to people” (33%); “People will tell me if they can’t hear what I’m saying” (15%); and “Screening for hearing loss takes too much of my time” (12%). Among the 13% ($n = 54$) who do screen, 56% said they screen all patients in their practice. The most common method of screening was asking the patient if they have hearing problems (89%), followed by asking friends or family if the patient has hearing problems (78%), the whisper test (59%), the finger rub test (35%), and using a handheld audiometer (9%). We could not ascertain

whether standardized approaches to the whisper test and finger rub test were used.

If they felt the patient had hearing loss, whether they screened for it formally or not, 52% of physicians, nurses, and nurse practitioners in our sample reported they would recommend referral to audiology for further assessment and management, including hearing aids. Among the 48% ($n = 198$) who would not refer, the major reasons were as follows: “Patients don’t live long enough to benefit from hearing aids” (39%) and “Hearing aids are too expensive” (31%).

When we checked for differences by profession, we found few. Differences were not present for impact of hearing loss on quality of care ($P = 0.30$), comfort caring for a patient with hearing loss ($P = 0.78$), receipt of formal training in care of persons with hearing loss ($P = 0.15$), or screening for hearing loss ($P = 0.69$). Differences were noted in three areas. Physicians were more likely to refer to an audiologist if they felt a patient had hearing loss (likely to refer: physicians 58%, nurse practitioners 34%, nurses 30%, $P < 0.0001$; social workers and chaplains not asked about referral). Nurses expressed the least familiarity with resources for patients with hearing loss (unfamiliar with resources: nurses 48%, chaplains 39%, nurse practitioners 33%, physicians 29%, social workers 21%, $P = 0.024$). Finally, nurses, social workers, and chaplains were least likely to be familiar with the pocket talker amplification device (unfamiliar with pocket talker: nurses 56%, social workers 48%, chaplains 46%, nurse practitioners 33%, physicians 29%, $P = 0.007$).

Discussion

To our knowledge, this is the first study on how hearing loss is perceived and managed in palliative care and hospice settings. Findings support the fact that hospice and palliative medicine providers believe age-related hearing loss impacts care for many of the patients they care for. However, only 13% reported screening for hearing loss. These findings are consistent with rates identified in primary care.^{9,10} Thus, hearing loss may be unaddressed even during the sensitive conversations that are a major component of palliative care. And, in fact, 88% of the respondents recalled a situation where hearing loss created a communication problem with a patient.

Lack of screening is also interesting in the context of the perceived prevalence of hearing loss in hospice and palliative care. More than 75% of providers in our study believed the prevalence of hearing loss among adults they cared for was one in five or greater. In a recent national study, we documented a prevalence of 33% of older adults who self-report poor hearing

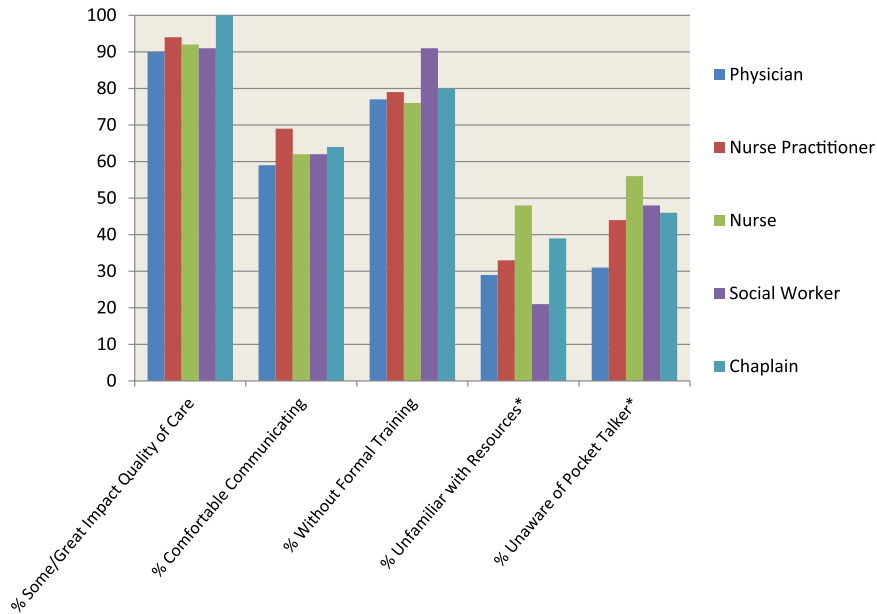


Fig. 1. Palliative care providers' perceptions, comfort, training, and familiarity with resources for older adults with hearing loss. *Denotes significant values ($P < 0.05$). Some/great impact quality of care includes responses of "some impact" or "great impact" to the question, "How much do you think hearing loss impacts the quality of care you provide to older patients in your palliative care practice?" Comfortable communicating includes responses of "very comfortable" or "comfortable" to the question, "When you have an older adult with hearing loss, how comfortable do you feel with your skills in communicating with that patient?" Without formal training includes "no" responses to the question, "Have you received any formal training in how to care for patients with hearing loss?" Unfamiliar with resources includes responses "very unfamiliar" and "unfamiliar" to the question, "How familiar are you with resources available to patients with hearing loss?" Unaware of pocket talker is a response of "I don't know what a pocket talker is" to the question, "Do you use a pocket talker for palliative care patients you have identified with hearing loss?"

in the two years before they die.¹² Although similar to the prevalence reported by clinicians in the present study, these reports are likely underestimates given problems with self-identification and lack of screening. Nonetheless, both national survey data of patients and the present survey of providers support a high prevalence of hearing loss near the end of life among older adults.¹²

Although our respondents reported feeling comfortable with their communicating skills, few reported having had formal training, and knowledge about management approaches and resources is sub-optimal. A substantial proportion of hospice and palliative care providers reported speaking in a person's ear or talking to a caregiver instead, both nonrecommended methods of communication. Although it may seem appropriate to speak into an individual's ear when he or she has difficulty hearing, such strategies prevent the individual from speechreading (lip-reading) and obtaining visual cues from facial expressions. Talking to the caregiver further isolates the individual and limits his or her ability to participate fully in conversations that have significant importance for the care they receive.

These findings suggest that hearing loss is not a doctor issue or a nurse issue or a social worker issue—more striking than variation was congruence in these findings across professions. This suggests that hearing loss is underaddressed in most educational programs for health professionals. Yet, hearing loss cuts across and impacts all aspects of care and communication for older adults with serious illness. All health professionals who deal with older adults during times of serious illness and at the end of life should have

Table 2
Strategies Used by Hospice and Palliative Care Providers Caring for Older Patients With Hearing Loss (n = 510)

Strategy	% Endorsing Strategy
Recommended strategies	
Ensuring you are enunciating your words clearly	84
Speaking slowly	82
Speaking in a low pitched tone of voice	52
Writing information	90
Reducing extraneous sounds	90
Closing the door to the room	75
Facing the patient	94
Making sure the patient is wearing hearing aids	90
Nonrecommended strategies	
Shouting	7
Raising my voice	65
Speaking in the patient's ear	70
Speaking to the caregiver instead	42

training and be familiar with resources for persons with hearing loss.

Results must be considered within the context of the study's limitations. We used a convenience sample; only those involved in the American Academy of Hospice and Palliative Medicine distribution lists and those involved in social media or contacted via email could respond. It is possible that those who are not connected to these sources would respond differently or that those who replied were more likely to believe hearing loss was an issue. However, recruitment materials emphasized participating if they believed hearing loss is not an issue, and we attempted to reach as broad an audience as possible. We were unable to compare the 106 who did not respond to the demographic questions to the 510 who completed the full survey because the demographic questions were asked at the end of the survey. Finally, no validated survey tools exist on this topic. Although we believe our survey questions have face validity, future research should focus on creating a validated tool for use in this relatively new field.

Conclusions

Hearing loss is a significant issue for providers in palliative care and hospice settings, yet it remains largely a silent and underappreciated problem. Our data suggest that there is a need both for more research and greater clinical attention to this issue. Reasonable management strategies exist to facilitate communication in persons with hearing loss,⁸ and these need to be communicated to those providers who are using strategies that are not recommended and potentially make communication even more difficult. Increasing awareness of effective strategies could be relatively straightforward. A distribution of information sheets to providers, patients, and caregivers might be an easy first step. At the same time, more advanced research to investigate the role of more robust interventions, such as pocket talkers, caregiver training, and ongoing support from providers, and their impact on decision-making and quality of life.

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