

Role of speech-language therapists in palliative care

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ABSTRACT

Purpose: to describe the practice of speech-language therapy and identify the necessary competencies when working with people who require palliative care (PC), in Chile.

Methods: a study employing a qualitative methodology to collect data. Semi-structured interviews were conducted with 11 speech-language therapists experienced in PC. These interviews were transcribed and analyzed using content analysis.

Results: the primary areas of intervention that were identified include feeding and swallowing, communication, and emotional support. It was observed that PC is typically provided by interdisciplinary or, in some cases, transdisciplinary teams that may use various approaches. This research highlights the importance of training in public policy, ethics, and bioethics, as well as the need for effective listening and emotional management skills in PC settings.

Conclusion: there is a need for specific training in emotional management and therapeutic skills for palliative care patients, along with a consensus on approaches for working with this population. Additionally, it is crucial to establish the role of speech-language therapy in PC. Defining key concepts, such as therapeutic support, is essential for a better understanding and practice of this field.

Keywords: Speech, Language and Hearing Sciences; Palliative Care; Patient Care; Death

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INTRODUCTION

The Lancet Commission on Palliative Care and Pain Relief reported in 2018 that over 61 million people experience some form of suffering that requires palliative care (PC). Of this number, at least 80% lack access, even to the most basic PC interventions, such as pain management¹.

People may need palliative care due to various health conditions, including neurodegenerative diseases, chronic respiratory disorders, cardiac issues, renal failure, chronic liver damage, and others².

The care provided in PC focuses on 1) improving the quality of life of both patients requiring PC and their families, respecting their autonomy and dignity; 2) preventing and alleviating suffering; and 3) managing pain and addressing other needs, whether physical, psychosocial, and/or spiritual³.

Thus, PC is not limited to cases where curative treatment is no longer effective or needed solely during the terminal phase of an illness, but is introduced from the start of treatment and diagnosis confirmation, aiming at the highest possible level of comfort and well-being, until the moment of death⁴.

Palliative care seeks to address the various needs that arise from both the person requiring PC and their family⁵. In this context, professionals are expected to provide dignity and respect, helping patients cope with their health condition and accept death as a natural part of life⁶.

The guideline *Guía Clínica Alivio del dolor a personas con cáncer avanzado y CCPP* (Clinical Guide for Pain Relief in People with Advanced Cancer and Palliative Care) was implemented in Chile, in 2005⁷. This guide aims to provide PC to alleviate pain and other symptoms secondary to the person's health condition.

On the other hand, in March 2022, Chile enacted Law 21.375, which "Establishes palliative care and the rights of people suffering from terminal or serious illnesses" (*Consagra los cuidados paliativos y los derechos de las personas que padecen enfermedades terminales o graves*). This law ensures that all patients requiring PC have access to it, providing support to the person and their family, contributing to improved quality of life, well-being, and dignified death⁸. This guarantees people with non-oncological diseases, such as neurodegenerative or respiratory conditions, access to PC.

The Clinical Guide for Pain Relief in Individuals with Advanced Cancer and PC describes the professionals involved in care, including nurses, psychologists, midwives, physiotherapists, pharmacists, medical

technologists, and social workers, among others. However, the guide does not explicitly include speech-language therapists among the relevant professions in supporting these health situations. Nevertheless, interdisciplinary teams in other Latin American countries acknowledge the involvement of these professionals in care teams².

The role of speech-language therapists in PC includes prevention and rehabilitation, primarily in aspects related to swallowing and communication⁹. It is described that speech-language therapists are involved not only in the assessment, diagnosis, and treatment of individuals with swallowing and communication disorders but also provide support, offering guidance and education to people in PC and their families, as well as accompanying them throughout the process¹⁰.

This support has previously been mentioned within the practice of speech-language therapy, being described as "counseling" as proposed by the American Speech-Language-Hearing Association (ASHA)¹¹. This approach includes:

1. Advice: Education addressing emotional reactions, thoughts, feelings, and behaviors that result from living with communication, feeding, and swallowing disorders, or related conditions.
2. Prevention and well-being: Actions aimed at reducing the incidence of new disorders, detecting them at an early stage, and minimizing the severity or impact of associated disabilities.
3. Collaboration: Defined as shared decision-making among team members, including the person and their family, to achieve appropriate intervention.

Despite the literature supporting the importance of including speech-language therapists in palliative care teams, there are no studies in Chile specifying their role and function with individuals requiring PC.

Therefore, the question posed in this research is: What are the practices and competencies necessary for speech-language therapists working with people who require palliative care in Chile? The aim is to describe speech-language therapy practices and identify the competencies required for working with people who need palliative care (PC) in Chile.

METHODS

This research was approved by the Ethics Committee of the Faculty of Medicine at Universidad de Chile, Chile, under the number 038-2021. To safeguard the rights and responsibilities of all the participants,

informed consent was obtained from each interviewee. This is a formal document that explains and informs about the objectives, procedures, risks, costs, and benefits of this project.

The methodology employed in this study was qualitative, using a hermeneutic paradigm, which allows for the interpretation of information collected during the research process while considering the context in which it was obtained¹².

The study population was selected using non-probabilistic convenience sampling, which allows for the selection of an accessible population who are willing to participate¹³. The inclusion criteria were: being a speech-language therapist, with at least 1 year of experience, and working with people requiring PC. Exclusion criteria encompassed professionals without experience in PC or with less than 1 year of experience.

The sample consisted of 11 speech-language therapists, 8 females and 3 males. Nine participants worked in the Metropolitan Region (capital), 1 in the Antofagasta Region (northern part of the country), and 1 in the Los Lagos Region (southern part of the country). Regarding their work setting, 6 worked in the private sector and

5 in the public sector; 2 worked with pediatric populations and 9 with adult populations. The average number of years of experience in PC was 5.5 years.

Data collection was carried out through semi-structured interviews based on a script that was previously developed and piloted with other professionals in the field (Appendix 1). Each interview was conducted using Zoom (due to the health contingency) and lasted approximately 45 minutes to 1 hour. These interviews were recorded and later transcribed. Each speech-language therapist was assigned an identification code (E1, E2, E3, etc.) to protect their identity.

Data analysis was carried out using content analysis, which allows for the exploration of ideas expressed by the interviewees. The aim is "...to understand not only what is literally communicated, but also everything that might implicitly influence or condition the message"¹⁴.

RESULTS

The analysis of the information obtained from the interviews was organized into categories and subcategories, to group the data under relevant themes (Table 1).

Table 1. Summary of the categories and subcategories extracted from the interviews

Category	Subcategory
Common Roles of Speech-Language Therapists in PC	Functions Focused on the Person Requiring PC
	Functions Related to the Environment
Conceptual Aspects of Work in PC	Conceptual Tools
	Approaches to Work
	Team Dynamics
Participation of Speech-Language Therapists in the PC Team	Organization within Work Teams
	Understanding the Role of Speech-Language Therapists in PC

Caption: PC = Palliative Care

Common Roles of Speech-Language Therapists in PC

The interviewees agreed that during their interventions they act more as facilitators than rehabilitators, which is consistent across all areas. This is reflected in their efforts to facilitate food intake and/or communication with the surrounding environment by offering tools, strategies, and/or techniques to provide comfort to the person requiring PC.

Roles Focused on the Person Requiring PC

First, roles related to feeding/swallowing and communication are described, followed by practices related to supporting the patient through their end-of-life process.

Concerning feeding/swallowing, the respondents emphasized that their activities must have a different focus from rehabilitation (which aims to restore disrupted functions). Instead, they adopt an approach that prioritizes the wishes and needs of the person in their complex health context. According to the

interviewees, this aims at providing comfort, ensuring the person's safety while eating or hydrating, without neglecting the enjoyment of food throughout the process.

"...environmental aspects that enhance the comfort of people in palliative care and everything related to comfortable feeding, comfortable hydration, and the appropriate times to do it" (E2).

"...As speech-language therapists, it is our duty to... do everything within our power to help them enjoy their food or an alternative to it. And not follow the protocol, but rather be guided by the patient's wishes and needs" (E3).

The participants agreed that communication is the second most frequently addressed area when working with people in PC. They believe it is essential to act as facilitators, aiming to establish or maintain effective/functional communication channels between the person in PC, their family members, and healthcare staff. To achieve this, they assess the individual's health condition and needs. Based on this information, they look for strategies and adaptations to maintain communication activities. These interventions can include implementing augmentative/alternative communication systems, such as the use of boards, cards, or pictograms, to help the person improve communication and be understood by their family and others around them.

"...and establish functional communication channels between the patient and their family... training with augmentative/alternative communication systems, always in a functional context ...creating a board...for basic needs like hunger, going to the bathroom, or indicating any discomfort or pain" (E3).

"...the main thing is to maintain the communicative connection between the patients and their close circle...and we have to identify whether they are understanding something, how much they are understanding, and based on that, teach the family how to speak to them" (E6).

The interviews revealed that a key aspect is accompanying patients throughout their health situation.

"...so sometimes the last sessions were just accompanying them during feeding when their food passed through the gastrostomy...so they could also feel something, that they were being fed, and we tried some flavors" (E1).

"...providing care that was more about accompaniment and not curative intervention...offering support according to their beliefs...their wishes, giving them the information to make informed decisions, uh... accompanying them in that context" (E7).

Functions Related to the Environment

The interviewees indicated that the usual functions of speech-language therapists in PC concerning the person's environment primarily involve education and accompaniment for families and/or caregivers.

They propose that the education provided should consist of counseling or guidance. Moreover, they emphasized that speech-language therapists should actively participate in this process, aiming to comprehensively educate the family about the individual's health situation to support decision-making.

"...they must participate, for example, in the comprehensive education of the family and the affected person or their surroundings" (E1).

"...specifically, the intervention involves a lot of family education from our point of view, uh...and trying to implement measures that increase the comfort of people in PC" (E2).

Regarding the role of accompanying the close environment of the person in PC, the interviewees mentioned that this involves being physically present so that the family feels they are not alone and that they are being heard and understood. However, there were different perspectives among participants regarding how and when this accompaniment should occur. Some mentioned that this accompaniment should begin at the onset of the health situation, while others believe it is necessary when the person is in a more advanced stage of the illness.

"...but in my speech therapy role, I feel that it is more about... a final accompaniment, uh... providing comfort strategies, communicative strategies with the family, and support for the caregivers" (E10).

"...there's a whole approach for pain management, physical pain management, and also an approach associated with family accompaniment, managing expectations, and handling prognosis" (E2).

The participants expressed that this accompaniment towards the family should focus on psychological and emotional aspects, particularly supporting them in making decisions.

“...what I can do, rather, in palliative care is to help accompany the family in decision-making so that they feel empowered as active participants in their healthcare role” (E7).

“...in the end-of-life stage, the patient no longer wants to eat, no longer feels hungry, and doesn’t want to eat, so in that stage, what we do is accompany the family” (E8).

Conceptual Aspects of Working in PC

This section discusses the key conceptual tools that professionals working with this population should develop, followed by the working approaches they use.

Conceptual Tools

Most of the interviewees mentioned the need for specific knowledge in the areas of swallowing and communication, which should be tailored to the particular health situations they are facing. Some also indicated the importance of skills in education, counseling, and accompaniment, as previously mentioned. Furthermore, they emphasized the relevance of ethical and bioethical training to ensure interventions are conducted with the person’s best interest at heart.

“...you need to have a solid understanding of swallowing... not to be overly strict, like ‘oh, the pharyngeal phase isn’t functioning efficiently, so they can’t eat,’ but rather, ‘it’s not optimal, but it wouldn’t be appropriate to resort to an artificial feeding method, so how can we compensate?’... you also need to have knowledge of ethics and bioethics” (E2).

“...the idea of person-centered care, bioethical aspects, and being there for them near death... accompaniment and counseling, validation therapies, all those oriented toward the psychology of accompaniment in the final stages of life” (E7).

Additionally, the participants highlighted the need for training in public policies and patients’ rights in PC, as this knowledge helps professionals provide information relevant to the person’s rights, duties, access to healthcare, and benefits under current health coverage.

“...it’s essential to know a lot about public policies for people, like what rights a person in palliative care has today. What support should the state provide,

what should be given to help them through the end-of-life process in palliative care” (E11).

Another important issue mentioned was the need for training in delivering bad news since certain speech-language therapy practices involve difficult conversations with families. Knowing how to handle these discussions appropriately is crucial.

“...there should be training on... there have been courses on how to break bad news in speech-language therapy... right? So, for example, how to tell the family that the patient can no longer eat by mouth. When you tell the family that, it’s devastating, it’s terrible” (E9).

Approaches to Work

This subcategory presents different approaches to the work of speech-language therapists in end-of-life processes, defining their actions within their functions and roles in PC.

Some interviewees emphasized aspects of their practice where they clearly distinguish between traditional interventions and those guided by a palliative care perspective. Topics related to quality of life, family peace, and enjoyment emerged.

“...accompanying in the final moments of life should prevent pain, provide quality of life, ensure the safety and peace of the family and the child, but for me, enjoyment is also important. And enjoyment in the last period, ideally allowing them to carry out the activities they love, maintaining their identity, their activity, their participation in the final moments... at that moment, the family and the child are the protagonists” (E4).

“...providing care that’s more about accompaniment and not about curative intervention, but offering support based on their beliefs, the context, and their wishes, and providing information for informed decision-making” (E7).

Other interviewees focused on how to approach the concept of a “good death” and emphasized the importance of broadening the scope of interventions. Several comments pointed out that PC extends beyond just managing pain, and it must primarily aim to respect the individual’s wishes, identity, and autonomy while addressing the multiple needs that arise in the course of complex health situations nearing the end of life.

“...Receiving these services primarily focused on softening, reducing the pain—that’s what most

people know as the definition of palliative care—but we know it's much more than that, not necessarily just about pain itself" (E1).

"...the final objectives are about what is a good death, what rights those people have, what policies support them... the speech therapist's work goes far beyond just focusing on swallowing or communication, but also understanding what other needs the person will have in their context" (E11).

Participation of Speech-Language Therapists in PC Teams

Palliative Care teams vary in their composition and may include occupational therapists, physiotherapists, physicians, dentists, psychologists, social workers, and others.

The variability of working contexts for the interviewees is notable, as some report being part of a team, while others do not. Among those who are part of a team, two groups emerge: those participating in specific transdisciplinary palliative care units and those who belong to rehabilitation groups that support palliative care units. The participants who are not part of any team report that their services are provided through referrals from other professionals within the system, though direct communication with these professionals is not always consistent. It is noteworthy that some interviewees mention that their inclusion in work teams is often conditioned by the requirements of the healthcare center. For instance, when care is provided at home, it must be approached by a team, whereas in-center care is often handled individually by the professional through medical interconsultations.

Dynamics within the Palliative Care Team

Participants who work within PC teams describe two types of hierarchical relationships: horizontal and vertical. In teams with horizontal structures, there is no internal hierarchy, allowing for equal participation among team members in addressing patient needs. Decision-making is typically achieved through consensus. In contrast, teams with vertical structures are characterized by a clear leader, who is responsible for defining the treatment plan for the person in palliative care. This leader also delegates tasks and establishes guidelines for successful interventions.

This leadership role within PC teams is usually undertaken by physicians and/or nurses, who carry out

a comprehensive evaluation to make decisions about the person's health situation and relevant interventions. Moreover, participants noted two types of leadership within these vertical teams. The first is a dominant leader, who is more rigid with their guidelines and communicates minimally with the team. The second is a communicative leader, who effectively delegates responsibilities and fosters open communication with the team.

"There's very marked leadership from the treating physician, and if the physician has a vision that they don't want to share or review, it's difficult to proceed" (E2).

"The doctor takes charge, does their evaluation, and decides on the work plan for the patient, whether they need support, and of what type. Both the nurse and the doctor are like the heads of the team. They are constantly assessing the situation... seeing what professionals are needed to support, as they recognize they can't handle everything on their own because the pain is so multidimensional" (E6).

Organization within Work Teams

The organization of work teams in palliative care varies significantly, particularly in how strategies are employed to define approaches for patients and their environments.

Some participants describe regular meetings of professional committees where they discuss the health status of patients in palliative care to determine the appropriate course of action. Others mention these meetings serve as a platform for exploring options that will be presented to the patient and their family, who will ultimately make the final treatment decision. On the other hand, some interviewees state they work without a team and interact with other professionals through interconsultations. In such cases, there may not be a coordinated approach to patient care.

"The patient is presented to a committee that ultimately decides what treatment to pursue. Once the committee decides, the patient is informed about alternatives A and B, and they choose which treatment to follow" (E5).

"In the oncology unit, we are consultants; we belong to the rehabilitation unit...the oncology team consists of doctors, nurses, and technicians, and we only attend when we receive a referral. We're not permanently based in that unit...we respond to

requests when the doctor believes the child requires assistance” (E4).

“...the patient is either referred or I see them in a speech therapy assessment, because speech therapy is new here. This is why I have taken in individual cases during the assessment” (E9).

Other interviewees emphasize that therapeutic options are determined by each professional based on their expertise, and these decisions are accepted by the team and the patient:

“...but obviously each professional is important, and each makes their own decisions, right? In our area, I decide when to place a feeding tube, when to remove it, or when to refer the patient for a G-tube. While referrals to gastrostomy must go through a physician, we are the ones who make these decisions” (E9).

Understanding the Role of Speech-Language Therapists in Palliative Care

Participants express that understanding the role of speech-language therapists in PC is complex, primarily due to a general lack of awareness regarding the full range of tasks they can perform throughout a patient’s life, especially in the evolving field of palliative care.

Several interviewees noted that this lack of understanding about the role of speech therapists is particularly evident in palliative care settings, which they attribute to insufficient dissemination and visibility of their functions within this specialty.

“There is a lack of awareness... regarding the work of speech-language therapists in general, so when we take it to a more specific area like palliative care, it becomes even less known” (E3).

“I think palliative care in speech-language therapy is not very visible... it’s not highlighted at all... because there’s no training, and few people are working with palliative patients” (E11).

This lack of awareness also extends to other health disciplines. However, interviewees mentioned that the involvement of speech therapists in inter- or transdisciplinary teams within the palliative care context has made their practice more visible. This increased visibility has led to greater understanding among healthcare staff and has subsequently increased referrals to the speech-language therapy area.

“I believe the role of the speech-language therapists is validated in some areas... but it is not recognized in geriatrics or oncology unless it involves the larynx. For example, if it’s lung cancer, they won’t refer to a speech-language therapist... and in palliative care, it’s zero recognition. At first, they would ask me, ‘Why are you here if the patient is dying?’ and I would say, ‘I know the patient is dying, but I still want to accompany them; I want to review this and that, and maybe I will communicate with the family’” (E2).

“The girls find it essential for children to eat. They tell me, ‘It’s super important for you to go because if not, they won’t let him eat.’ So, it’s important to have someone by your side who sees your work as important, who helps and supports you, making your work more effective” (E4).

*The word “girls” (*chiquillas* in Spanish) used here, refers to teammates who work with the interviewee, their professions being physiotherapy and occupational therapy.

DISCUSSION

Speechlanguage therapists have gradually begun to integrate into the work of PC teams^{15,16}, encompassing outpatient, inpatient, and home care settings, and serving both pediatric and adult populations throughout their lifespan.

Traditionally, the practice of speech-language therapy has focused on the rehabilitation and reactivation of functions from a biomedical perspective. However, the biopsychosocial approach has gained importance, and in certain cases, the social or community perspective has become the primary focus of speech-language therapy practice¹⁶. In this context, PC represents a significant turning point, as the target population often lacks opportunities for “improvement” from a purely biomedical approach, thus requiring specific competencies to carry out a comprehensive and contextualized intervention. The results of this study indicate a need for specific skills and competencies to work with individuals requiring PC. Among the highlighted aspects are concepts such as “accompaniment,” “counseling,” and “comprehensive approach,” underscoring the relevance of skills such as adaptability, emotional management, mental flexibility, and the ability to listen and pay attention, among other therapeutic skills relevant to speech-language therapists¹⁷. These competencies are not always explicitly

considered in professional training, often being left to self-teaching or assumed as innate abilities.

The interviewees emphasized the importance of training in therapeutic skills and continuous accompaniment, especially in the final stages of life, aligning with various proposals in the field of PC⁵. However, there are no specific definitions for this term within the discipline of speech-language therapy, suggesting the need to investigate and create collective reflection spaces that facilitate professional preparation and the development of a common language that enhances the quality of care.

In terms of communication, speech-language therapists play a crucial role as mediators, facilitating effective communication between the patient in PC and their environment, thereby enabling the expression of emotions and reducing the burden on caregivers¹⁸. These findings are consistent with current research emphasizing the pursuit of comfort and the improvement of social and personal relationships, contributing to a better quality of life in the final stage of illness¹¹. Regarding feeding, the importance of maintaining hydration and nutrition, as well as the pleasure and comfort associated with food, is highlighted as essential elements for the quality of life and death of patients¹⁶. Furthermore, the participants pointed out the relevance of knowledge beyond communication and swallowing, which are considered fundamental in end-of-life contexts and PC. These include aspects of ethics and bioethics, public policies, rights and responsibilities in health, as well as training in transversal skills for healthcare professionals, such as delivering bad news. However, this knowledge and skills are not always central to the practice of speech-language therapists, and various studies indicate deficiencies in training in ethics and bioethics among healthcare staff, highlighting the need to evaluate graduation profiles and the training received by speech-language therapy professionals¹⁹.

Teamwork was identified as a fundamental pillar in the practice with people requiring PC. Although speech-language therapists are not always considered essential within PC teams²⁰, their inclusion in Chile has been gradual, with different degrees of participation according to the healthcare service they work in. Participants in this study mentioned hierarchical dynamics, where physicians typically lead and decide on approaches, as well as more horizontal dynamics where decisions are made collectively²⁰. These different

dynamics pose a challenge for professionals regarding the adaptation and configuration of roles within teams.

The results also revealed several barriers and facilitators to the effective implementation of PC by speech-language therapists. Some barriers mentioned by the participants include a lack of specific training, a scarcity of resources and institutional support, the absence of internal protocols, and the limited visibility and recognition of the role of speech-language therapists in the field of PC. On the other hand, facilitators include support from interdisciplinary teams, ongoing training, and prior experience in the area²¹.

Finally, the interviewees emphasized the need for timely referrals and the delivery of PC to those who require it, avoiding postponement solely for the final stages of life¹⁵. They also suggested the need to develop specific training and skill-building programs in PC for speech-language therapists, which should include both theoretical and practical aspects, focusing on the development of transversal and emotional skills, as well as ethics and bioethics.

This study shows that the practice of speech-language therapy focuses on improving quality of life by addressing communication and swallowing needs²² through personalized assessments and interventions tailored to the individual needs of each person and their environment. Additionally, significant challenges were identified for speech-language therapy practice with this population, including the lack of standardized protocols and low awareness of the role of these professionals in the field²³.

Regarding the essential competencies for working in the context of PC, technical skills for assessing and managing communication and swallowing, as well as crucial interpersonal competencies such as empathy and the ability to manage emotionally complex situations, were included²⁴. Furthermore, the need for specialized training that prepares professionals to face the specific challenges of PC was identified, including the ability to work in interdisciplinary teams and effectively communicate with individuals, families, and other healthcare team members²⁵. This research leads to recommendations regarding the necessity for these professionals to develop and standardize specific practice protocols for speech-language therapy in PC²⁶. Additionally, it is suggested to implement ongoing training programs that encompass clinical, psychosocial, emotional, and spiritual aspects, in order to enhance the quality of their interventions and preparedness in this field²⁷.

CONCLUSIONS

This study highlights the important role that speech-language therapists play in improving the quality of life of patients requiring palliative care. This is achieved through bespoke interventions that address both communication and swallowing needs. Significant challenges were identified, such as the lack of standardized protocols and the low visibility of the role of speech-language therapists in this area, which hinders their full integration into interdisciplinary healthcare teams.

Additionally, a need for specific competencies, both technical and interpersonal, was observed. These include empathy and the ability to manage emotionally complex situations. Training in these areas is insufficient, which underscores the importance of implementing specialized training programs that encompass clinical, psychosocial, emotional, and spiritual aspects. This would better prepare speech-language therapists to face the unique challenges of palliative care, promoting more collaborative and effective work within interdisciplinary teams.

This research also emphasizes the relevance of timely referrals to palliative care, enabling early and more comprehensive intervention. However, one of the main limitations of the study was the small sample size, which may restrict the generalization of the results. Future research should consider a larger sample and explore variability in practices and competencies across different regions and contexts, both in Chile and in other Latin American countries.

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Authors' Contributions:

STS: Conceptualization; Formal analysis; Methodology; Project administration; Supervision; Writing - Original draft; Writing - Review and editing.

PMR: Conceptualization; Formal analysis; Methodology; Supervision; Writing - Original draft; Writing - Review and editing.

JSB, NTF, ATC, VVN: Data curation; Formal analysis; Writing - Original draft; Writing - Review and editing.

Data Sharing Statement:

The data from this research will not be shared due to the sensitive nature of the information collected and the associated ethical restrictions. The data include confidential information about the health and well-being of the participants, which prevents public disclosure. However, aggregated results are available in the published article. For additional inquiries, the researchers may provide anonymized data summaries upon formal request.

In cases where access to the data is required to replicate the study results, interested parties must submit a formal request to the corresponding author, describing the purpose of the data use and compliance with applicable ethical standards. All requests will be evaluated to ensure the protection of participants' privacy.

Appendix 1. Semi-Structured Interview Guide

Training and Motivation:

What training have you received in palliative care?

What is your main motivation for working in palliative care?

Experience and Professional Role:

What has your experience been like when working in palliative care?

What has been your role as a speech-language therapist in palliative care?

Objectives and Activities:

What is your personal objective when accompanying a person and their family in palliative care?

What activities do you carry out in palliative care accompaniment?

What does it mean for you to accompany a person requiring palliative care?

Knowledge and Skills:

What knowledge should a speech-language therapist have when working with people in palliative care?

What skills do you believe a speech-language therapist should possess to accompany a person in palliative care?

What psycho-emotional and affective tools should a speech-language therapist have? Why?

Interdisciplinary Work:

What has interdisciplinary work been like when accompanying a person and their family in palliative care?

What has teamwork been like in an interdisciplinary setting? Do you consider it important? Why?

Perspectives and Needs:

From a speech-language therapy perspective, what have been the needs of people in palliative care and their families?

Do you consider the participation of speech-language therapists important in the accompaniment of people requiring palliative care?

Do you think that the participation of speech-language therapists contributes to improving the quality of life for individuals requiring palliative care?

Final Reflection:

Why do you think the role of speech-language therapists in palliative care is not well-known in Chile?