Stroke is a major cause of disability worldwide and it is a leading cause of acquired communication disorders, such as aphasia, dysarthria and apraxia of speech. Nearly 14 million new strokes are estimated to occur annually, and 80 million people are considered to be stroke survivors worldwide. Globally, 1 in 4 people over the age of 25 is at risk of having a stroke at some point in life (World Stroke Organisation, 2020). Prevention of stroke is considered to be the primary goal to reduce the numbers. Yet, health care professionals are faced with new people acquiring strokes every day and we have a huge responsibility to attend to them. Here, I will focus on the responsibility we have to attend to and protect the basic human right to communication.

International studies have exposed staggering figures – up to 88% of stroke patients will have one type of communication disorder (O’Halloran et al., 2009), and one third of them will have a language disorder called aphasia, affecting the ability to use and/or understand spoken and/or written language (Brady et al., 2016). This means that right now 27 million people worldwide have aphasia.

Imagine having aphasia ... you are unable to speak to your closest friend or partner, you cannot write a simple text message, call your mother, order a cup of coffee, read a good book, listen to the news, or use your computer to order a home delivery. Aphasia can affect other domains of life, such as access to education, return to premorbid employment, ability to vote, and to participate in other areas of community life. Communication disorders are hidden disorders – they are not obvious unless the person attempts to speak. Yet, the impact of acquired communication disorders is widely recognised. A reduced quality of life, reduced social participation, emotional distress, depression and isolation, are among the consequences that are reported as a result of communication disorders post-stroke. Even when provided with optimal therapy and rehabilitation in hospital and clinical settings, it is possible for people with communication disorders following a stroke to have residual impairments affecting communication with family members and with people in the wider community.

It is not enough to provide intensive therapy to improve the production of words or to enhance comprehension of sentences when the affected person sits at home waiting for the days to go by. What we should be focusing on is true participation, true involvement and engagement in life situations which are meaningful and satisfying. A biopsychosocial approach to intervention and a focus on life participation (LPAA project group, 2000; Kagan, 2020) can enable health care professionals to target these objectives.

Every person has a basic right to communicate, to be heard, to express needs, thoughts, ideas and desires, to seek and receive information and to understand it. Every person has a right to make decisions that affect him/her independently, irrespective of the severity of the communication impairment. Every person has his/her own individual preferences, interests and skills which need to be taken into account during therapy. But, it is not just Speech Language Pathologists (SLPs)
who have a role in improving the quality of life of the communication impaired person after a stroke. Health care professionals, family members and friends, employers and other people providing services in the community can address the issues which are relevant to the person with the communication impairment to limit the risk of isolation.

Providing the person with access to communication is key in every phase after the stroke occurs, from the moment of admission into hospital where nursing and medical staff communicate with the person and obtain informed consent for medical intervention, during medical imaging procedures by radiographers, during occupational therapy, physiotherapy sessions and more. Access to communication is essential when making choices about the food menu during the hospital stay or about discharge destination, and to make decisions about later involvement in meaningful life activities. Using aphasia-friendly documents with simplified text and pictorial symbols, giving additional time to respond, and using slower, shorter sentences when communicating with persons with aphasia are just a few strategies that can be used by health care professionals.

Reengagement in activities that are chosen by the person rather than for the person is a major concern for the aphasia stroke patient who is discharged to community life. Local coffee shops can adapt menus to make them aphasia-friendly by simply adding pictures of the items on offer. This allows the person to choose the desired hot latte as opposed to the ice, cold frappé. Signage in the form of pictures/symbols, as opposed to written text, in shops and elsewhere in the community, can further provide access to communication, allowing the person to independently locate the ladies and the gents room. Access in this context is not about physical structures, like ramps and lifts; it is about access to information. This will benefit persons with any type of communication impairment and people who are not able to use/understand spoken/written language for different reasons.

Given the necessary human resources, SLPs can be involved in training fellow health care professionals to understand the needs of the person with aphasia and to make the environment communication accessible. We, as health care professionals, need to be highly sensitive to the physical, social and attitudinal environments that we create. Reducing background noise and distractions, and providing the necessary signage can enhance the physical environment. By adopting positive communication strategies, such as facing the person, slowing down the rate of speech, being patient, allowing more time to respond, and using pictorial resources on smart phones, we can improve the social environment. Medical and health science students can be trained to modify their modes of communication to communicate more effectively with patients/clients who have communication impairments. Health information leaflets should be accessible, using aphasia-friendly, easy to read and understand text and symbols. The attitudinal environment is a hidden, but powerful element having the potential of facilitating or hindering communication. More information about the Life Participation Approach to Aphasia can be found here: https://www.aphasiaaccess.org/.

Participation in research is another area of concern. Researchers intending to collect data from persons who have acquired a stroke, or from other people who may have some form of communication impairment, must make use of resources that are aphasia-friendly. Our Faculty of Health Sciences Research Ethics Committee has collaborated with the National Institute for Health Research (NIHR, UK) and we have included templates of aphasia-friendly information letters and consent forms on our website: (https://www.um.edu.mt/healthsciences/students/researchethics). Availability of both Maltese and English versions ensures access to communication in the local context.

In Malta, we are also currently engaged in an international project that is focusing on outcomes for persons with aphasia. The International Population Registry for Aphasia after Stroke (I-PRAISE) is underway locally, with myself as principal investigator, and with the contribution of a postgraduate student, Francesca Vella, who is exploring outcomes one-year post-stroke.

Are we really communication aware? Are we really focusing on the real-life meaningful issues as health care professionals? Are we really making the environment accessible?

Open your eyes to the world around you; communication disability can be invisible ... but what you say, how you say it, and what you do can impact the communication impaired person’s potential to understand, to decide, to make choices and to feel involved. We can all contribute ... we can all support people to have meaningful participation in LIFE.

https://www.um.edu.mt/healthsciences/mjhs/
References


