OBSERVATIONS

From the Far Side of Retirement

Dick Barrett

This is not a scientific report. It is a "Special Feature," a device by which to maintain some contact with a cherished group: the IAOM membership.

As I meander about this Ozark farm, spending far too much time recuperating from repeated surgeries and unexpected illnesses, I find that my brain no longer obeys with any decent degree of respect. It does not create when I tell it to, which slows down the fiction output. It refuses to remember on command, producing requested information only by disgruntled caprice. It fatigues easily. And yet, I do have lucid moments when random thoughts intersect, coalesce, and presto: an idea. I will share some of these crotchety ruminations, in their original random form, for what they are worth.

First, some perceptions of retirement itself. I highly recommend it. I come to report that there is life after therapy.

In orofacial myology and most of the related fields--dentistry, dental hygiene, private-practice speech pathology, etc.--there is no mandatory retirement age, no law that automatically revokes our license to practice, and usually no reliable source to tell us when enough is enough. An unfortunate number of individuals find excuses to cling to their work: the attractive lure of a few more dollars, a misguided notion of being indispensable, the honest desire to continue "helping," the horror of having nothing to do, the insecurity of adapting to an untested lifestyle.

Those impulses notwithstanding, there are moral and ethical strictures that should be observed. We must not overstay our welcome--or our efficacy. It is tragic to watch the palsied hand of a still-practicing dentist attempting an intricate procedure, the futility of an unretired speech pathologist who no longer relates easily to younger clients, the frustration of the over-ripe myologist grown testy and impatient with a patient's rate of progress. Each of them would deny the charge, but they (and many less-obvious cases) are no longer serving the best interests of their patients. At that point, they are duty bound to turn loose.

I loved my work so devotedly that I wanted never to stop. I frequently stated the hope that, when my time came, I might simply drop dead at my office--between appointments, of course. Still, the realization struck me one day that, at some unknown moment along the way, I had lost my zest for therapy. I was only going through well-practiced motions. I will be forever grateful for that insight, and wish the same for you at the opportune time. When a wee voice calls "Time's up," may you recognize its implication and admit that we do not really take our practice till death do us part. Do NOT dream up some ridiculous substitute approach to do therapy simply as a means of relieving boredom. Let it go!

I am still discovering the benefits, large and small, to be found in retirement. One boon, a special prize, bubbled up to the surface of my awareness only a short way back: in retirement, I am **safe.** While in active practice, there was always the threat that one might antagonize a referral source, that a patient might sue, that one might be slandered or persecuted by another professional,

criticized by a professional agency at the whim of some idiot. I used to worry a lot. Now, I am beyond reach. No one can hurt me. I snuggle into my haven.

Plenty has already been written on the advisability of preparing for retirement, and methods by which to do so. It is nonetheless an issue that few of us want to face at the propitious time.

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Enough of that. I must express my delight with the forthcoming issue of SEMINARS edited by Dr. Robert Mason (and how humbly grateful the dedication made me feel.) My joy was increased immeasurably by the aspect of orofacial myology that is stressed therein.

For so many years it has been my conviction, along with that of Marv Hanson and a few others, that the most valuable service which we provide involves resting position: rendering a beneficial posture myologically effortless, then assembling, establishing and perpetuating that function. Otherwise, we fight too many illogical, unnecessary and unwinnable battles. Remediation of any interfering swallowing or "tongue thrust" problems is merely incidental to achieving an acceptable resting posture, and in many cases such added attention may prove needless.

The key phrase in the preceding paragraph may well be "myologically effortless." My experience continually verified the need for **thorough-going** retraining of the component musculature. Assigning a few superficial tongue and lip exercises, then trying to motivate the patient to "hold" the desired posture, can yield frustrating results. As long as an inappropriate posture is easier or more comfortable, regression is almost inevitable. In order to achieve total modification, it is just as essential to weaken some **non-closure** tendencies in lips as it is to augment others. I have deplored the penchant for focusing on "strengthening lips" in the presence of associated muscles crying out for lowered tonicity. While it may require a bit more time and effort, success is more likely when the patient finds the sought-for posture to be no more strain than his previous configuration. The habituation process will still remain to be done, but the prognosis is brighter. I am not sure why I felt that it was important to include this paragraph at this time.

In any event, I have high hopes that the upcoming volume of SEMINARS will point the way toward some definitive research into this subject, and there are indications that may be so. But then, in 1960, I naively assumed that basic research would be quickly ready to report. In 1970, I bitterly assumed that it would **never** be done. In 1980, I philosophically assumed that necessary research would come, but not in my lifetime. Every assumption was wrong, so beware of placing too much faith in my present anticipation.

Since I may live forever (I am well on the way) I may never have a tombstone. Had I such a marker, I would prefer, when it is carved, to have "Rest in Peace" replaced by "Resting Posture."

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Addressing the long and middle-time members of IAOM for a moment (newcomers are welcome to watch): didn't you swell with pride at scanning the caliber of the candidates on the slate for us last election? I would have been happy to accept any combination of electees. Remember when the Nominating Committee was required to scramble to put one worthy name in each slot, and hope that nominations from the floor would provide some semblance of a contest? Our progress is both obvious and gratifying as we continue to add quality to our quantity.

Perhaps even more fulfilling are the notes occasionally attached to correspondence that Nita receives from newer members, to the effect that "You have the nicest people in IAOM," or "What a great group!" By including such comments herewith they can be passed along to you, the people who inspired them. You really are an exceptional lot.

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It may be this perverse memory again, more likely my previously-noted proclivity to worry, but, in retrospect, I recall my failures more readily than successes. I must live with that. For you others, a few more of my negative opinions, subject to challenge and revision.

1. The biggest mistake of the novice clinician: assuming that it is possible to provide adequate service with an inadequate background of training. I was taught by hundreds of instructors, some of them "authorities" but many of them patients, during several years when I made no pretense of knowing what I was

doing. The desired knowledge had not then been assembled. Now it has been developed, in large part, so that we can no longer afford the bumbling efforts that characterized therapy in earlier days. When do more institutions of higher learning wake up, accept their responsibility, and start to offer meaningful courses.?

2. The biggest error of the experienced clinician: exchanging tested procedures for something new simply for its novelty value. Never stop improving your therapy, but change only after you have reasoned out how the new technique will further your ultimate goal. Unless you fully understand the purpose of a procedure, you cannot explain that purpose to a patient. Unless the patient understands that purpose, he/she (it?) cannot fully incorporate the desired benefit into the patient's neuromuscular system.
3. The biggest mistake of any clinician: making any sort of claim that cannot be backed up in therapy. These still surface occasionally. At this stage of our evolution, what we need are not promises but results, true verifiable results. Patients and referral sources may forgive the limitations of a sincere clinician; they react poorly to betrayal.
4. The biggest mistake of a single clinician: the fellow from the New York area who attended one of our meetings in Chicago. He declined to apply for membership because of our competency exam. "Who would be able to grade my test?" he asked me soberly. "I know more about this work than anyone else in the world." No one has ever heard of him since. Such a waste of that vast knowledge!"

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On a more positive closing note, I can report that Anita, your Executive Secretary, continues to drive the 25-mile round trip to the Post Office, through rain and snow, and spends a considerable amount of her time on the humdrum nitty-gritty of Association details. I still do not understand why she does it. She says that, in the summer, it provides respite from the canning, cooking, freezing, jelly-making tasks when it seems that every day brings something else just ready to harvest. In the winter, it helps to fill the long cold evenings that she never knew existed during her life in Arizona. During the pursuit of these chores, she seldom snarls at me, and she does so much for so little reward that she is certainly the best bargain that I, or IAOM, ever got.

And I know that it is important for a professional organization to maintain a stable permanent address, but in **Green Forest, Arkansas?** Just kidding, Nita!