Termination and Follow-Up
Round Table Discussion

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Terminating the treatment of an aphasic patient is a complex issue. Occasionally, extenuating circumstances simplify the matter, e.g., death of the patient or withdrawal of the patient from treatment by his family. Typically, the aphasiologist must determine the efficacy of continued treatment. The literature in aphasia is abundant with strategies for diagnosis and treatment, but few criteria are cited which help the aphasiologist decide when to stop treatment. From our discussion emerged several basic issues: (1) What are the essential criteria for making a proper decision about termination? and (2) How can these criteria be best implemented?

Termination of treatment can have different meanings for a group of aphasiologists. Concepts of termination included: (1) the end of clinician-directed treatment, (2) the end of a phase in the patient's treatment program, e.g., individual to group treatment or to home program, or (3) the termination of the patient-clinician relationship. For the sake of discussion it was agreed that termination of treatment occurred when the patient no longer received clinician-directed treatment.

CRITERIA

The majority of remarks concerned those criteria considered essential to making appropriate decisions about termination. In this synopsis these criteria will be presented in five categories: (1) patient factors, (2) treatment goals, (3) test and treatment data, (4) logistics of continued treatment and (5) system pressures and professional/ethical issues.

Patient Factors

The etiology of aphasia and related disorders has implications for the course and duration of recovery. For example, traumatic and surgical cases have different recovery patterns than thrombo-embolic cases. The length of the post-morbid period and the presence of acquired sensory deficits should also be considered.

The most frequently discussed "patient factor" was the patient's own attitude about his language problem. The influence of behavioral intervention in aphasia is somewhat dependent upon the patient's cooperation. If the patient is not cooperative, his attitude becomes a highly weighted factor in the termination decision. In cases where the patient has strong personal goals, the termination process may elicit psychiatric reactions (e.g., depression). The group voiced concern that, in clinics where services are provided on a non-fee basis, the opinion of the patient is not given the same consideration as it would receive in the delivery of fee-basis treatment.

Treatment Goals

Decisions to terminate a patient's treatment interact with the goals of treatment. Treatment goals are determined by our expectations of patient performance. Our expectations are influenced by the patient's need for language in his extra-clinic or home environment, his vocational objectives and his pre-morbid language behaviors. Admittedly, treatment goals are directed to purposes other than improvement in specific speech and language behaviors: psycho-social support, use of the patient as a model for other patients in group treatment, student training on interesting cases, etc.

Test and Treatment Data

The group concurred that the productivity of treatment is best determined by improvement in the patient's communicative behavior. Test data, representing behavioral change from baseline to various time-points,are necessary to assess the productivity of treatment. The issue was raised that a static test score represents a variety of behaviors which are the product of an information processing system, and the potential of the system is not totally represented by a score. Therefore, test performance should be correlated with more frequently acquired treatment data. Caution should be exercised in using similar test criteria across patients. For example, using PICA data to predict a 15% increase in response level may not have the same functional significance for a patient at the 20% as it does for a patient at the 45%.

Test scores should be used to assess the patient's learning potential. Does the patient utilize stimulus cues, can he maintain a response over increased levels of time, across competing stimuli? Some discussants used the term "stimulability," another used "modifiable circuitry," but all agreed that the termination decision requires the aphasiologist to make a judgment concerning the patient's potential to improve his language performance.

The patient's performance in structured treatment programs should be compared to observation of his language behavior in other situations. Feedback from other disciplines, ward personnel, and family provide important estimates of the functional success of the patient's language. The termination decision should also consider whether all appropriate strategies have been considered in the patient's treatment. Finally, the clinician's judgment, based on experience, is an integral part of the decision process. The development of more reliable and sensitive measurement scales enables us to be more objective in the termination decision, but the significance of this objectivity remains a value judgment made by the aphasiologist.

Logistics of Continued Treatment

The termination decision is influenced by the practical, financial, and physical aspects of providing treatment. Fluctuation in patient load and staff must be considered. In clinics where students are providing patient treatment, training versus treatment priorities must be managed. Financial considerations are often a determinant of the termination decision. In hospital settings, the discharged patient and/or the hospital service often face prohibitive travel costs for outpatient treatment. In the experience of the discussants, the cost of treatment *per se* is not a financial concern of the patient himself; more often it is a concern of the institution providing the service. Obviously this conclusion may be a function of the

working environment of the discussants. However, those employed in private practice indicated that few patients actually paid for treatment themselves; usually they were funded by community programs, charitable organizations, etc.

System Pressures and Professional/Ethical Issues

Every large medical care delivery system has, or soon will have, stringent controls. Like it or not, administrative decisions concerning staff-patient ratios, outpatient load limitations and patient-visit quotas are having a growing influence on the termination decision. Privately funded organizations experience similar pressures from contributing sources. This is not unique to the delivery of treatment for aphasia. However, due to the long-term nature of our rehabilitative strategies, controls, accountability, and requests for estimates of the duration and cost of treatment programs are inevitable.

Some discussants contended that the aphasiologist has a moral obligation to maintain a supportive relationship with the patient as long as the patient desires. In cases where the patient is paying for the treatment himself, this may be an adequate guideline. In large clinic programs where treatment is provided on a non-fee basis or sliding-fee basis, moral obligation must be matched with productivity. Programs such as PSRO (Professional Services Review Organization), for example, will soon require objective criteria demonstrating that treatment is producing continued improvement in the patient's communicative behavior. The issue of controls and accountability can be challenged, but that is beyond the scope of this discussion.

IMPLEMENTATION OF CRITERIA

Most discussants agreed that criteria used in the termination decision are implemented appropriately and stringently. Others stated that the termination decision was sometimes avoided, or criteria were unintentionally rearranged by other professional commitments. Several suggestions to improve implementation of termination criteria were presented.

At the start of a treatment program, goals and prognostic statements should be framed in a time base. For example, the treatment strategy should be developed for a specific period with a commitment to re-assess the purpose and goals of treatment. Discussants concurred that most clinicians monitor progress of the patient, but sometimes the use of an "open-ended" approach at the beginning of treatment does not provide the needed commitment to re-evaluate the patient's disposition. From a psychological standpoint, the patient is better prepared for termination if he knows that his disposition will be evaluated at regular intervals.

At times, careful analyses of data, opinion, and logistics does not result in a clear-cut termination decision. The salient cause of action is to seek another opinion.

For many patients, the end of their treatment program is a negative, demoralizing experience. The discussants strongly expressed that: (1) prior to his departure, the patient be prepared for termination with counseling as part of his final phase of treatment, and (2) termination should be presented as a positive event, e.g., the patient has successfully completed his planned treatment. Not all patients dread termination; some are relieved to know their treatment is completed.

OTHER ISSUES

Although follow-up strategies were an intended topic for discussion, it received little attention from group participants. The purpose of home programs, telecommunicology and group treatment is to provide a supplement to treatment or an alternative to individual, clinician-directed programs. The issue was raised that these strategies have valid use as treatment supplements, but should not be used to avoid the termination decision. Another interesting question was raised, but not discussed: When new treatment techniques are developed, e.g., Melodic Intonation Therapy or Amerind Sign, should terminated patients be re-called?

SUMMARY

The termination decision is based on the aphasiologist's opinion of the efficacy of continued treatment, the logistics of providing continued treatment, and the aphasiologist's concern about the patient. These develop from the interaction of patient characteristics, test and treatment data, treatment goals, clinical and financial arrangements, system pressures operating on the environment in which the treatment is provided, and the ethical and moral viewpoints of the aphasiologist.

Our ability to predict and measure the recovery of language skills is improving. The discussants concurred that we are experiencing a similar increase in our ability to make appropriate judgments in the termination decision.

Our discussion on termination produced the inevitable struggle between the viewpoint stressing human concern and moral obligation, and the viewpoint emphasizing objectivity and realism. Ideally, one bias should not exclude the other: on one hand the patient's aphasia cannot be reduced to test scores, and on the other, the aphasiologist cannot base his judgment on visceral feeling. The key to understanding the termination decision is to examine the aphasiologist's use of concern and objectivity, his selection of criteria, and the consistency of his method.