What The Speech Pathologist Expects
From The Neurologist

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First of all I want to say that I appreciate the opportunity to be here, and in some way, to serve as a representative voice of speech pathology on this issue. Those of you who disagree with me can feel free to disclaim my views of being representative, but I <u>have</u> in fact discussed the matter with several of my professional colleagues and have taken a somewhat less than formal survey and have woven some of that input into these thoughts.

But I must say that those of you who are here for the same reasons that you go to bullfights or watch the Wallendas are likely to be disappointed by the lack of bloodletting. Though Dr. Rubens and I have some different opinions on some issues and can be very candid about it, we agree and share similar philosophies on many things.

We've worked together on some committees and programs and panels, and I believe have developed a good deal of mutual professional respect. Though the topic is emotion-laden and potentially inflammatory, I am sure we can prevent it from degenerating into name-calling and have the capacity to deal with it in a rational, intelligent fashion. Right, dummy?

In addressing "what the speech pathologist expects from the neurologist", I think it is wise to begin by trying to put the whole area of interprofessional responsibility and relationship into perspective. The real or imagined problems between neurology and speech pathology are certainly not unique. It may provide some comfort to know we're not alone.

The same problem exists between and among many other professions or even between specialities within professions. The most obvious example is the continuing storm (currently with small craft warnings) between audiology and otology. But some of these same nagging questions also exist between psychology and psychiatry; between psychiatry and all other medical specialities; between neurology and neurosurgery; between physiatrists and rehabilitation specialists; between proctology and civil engineering; and even between general practitioners and specialists.
(<u>A General Practitioner</u> - One who learns less and less about more and more until ultimately he knows nothing about everything. <u>A Specialist</u> - One who leans more and more about less and less until finally he knows everything about nothing.)

But even though the problems are shared by a number of others, they're not going to go away without addressing them and this forum is a good way to gain some insight. So let me summarize the most frequently recurring answers by my professional colleagues to the question"What do you expect from a neurologist?" I feel compelled to add that some of the comments which might be interpreted in a critical light, probably do not apply to our previous speaker. But let us air them with the request to, "Pass it on".

<u>Referral - Consults</u>

First, some obvious things. In most settings, we need consults and referrals. We expect neurologists to refer brain-injured patients to us for decision-

making about their communication. Certainly we are mindful of the fact that many patients are too sick to engage in our treatment or even to tolerate evaluation or testing, and that the physician has legal responsibility for the patient, and the responsibility to judge that point at which referral will not jeopardize the patient's overall medical well-being. But we expect the neurologist to be liberal in his referral and not go through some pre-sorting triage of "He won't get better", "He doesn't need it", "He's too involved", "He's too mild". Refer liberally. We'll make the judgment of whether or not a patient can benefit from our services, and we certainly welcome input in helping us make that decision.

Information

The next thing we expect from the neurologist is information. We need to know the results of neurodiagnostics, medical background, factors affecting prognosis, and changes in medication. Sometimes information about the patient which is not found anywhere in the chart is very helpful to our decision-making; so we need to have a mutual, not a one-way flow of information. We need to have our questions in the chart answered. We need to have our calls returned.

Disposition Input

The next thing and perhaps the most frequently mentioned item, is related to discharge planning. Speech Pathologists expect to be able to provide input on discharge planning. Perhaps in some settings this is no problem but in many places it recurs, particularly in teaching hospitals and so-called "acute care centers". It is annoying and counterproductive to evaluate a patient, determine a favorable prognosis, outline a treatment plan, begin instituting therapy and see some progress, and return to work on Monday and find the patient was discharged.

This happens far too often; and is particularly unfortunate when not enough notification was received to do pre-discharge testing, recording, or institute an appropriate follow-up program.

Some will agree that rehabilitation of the so-called "chronic" patient is not the domain of the acute care center and that other facilities are available for long term rehabilitation, including speech therapy. But I submit that all too often adequate follow-up from acute care centers is not achieved, and maximal rehabilitation remains an unfulfilled goal. Too often patients are sent home, or sent to facilities for chronic patients with less than adequate rehabilitation emphasis. If this is the case, someone ought to re-think and attempt to modify this philosophy. Some semblance of compromise is certainly possible without diluting the purpose of an acute care center.

Another aspect relates to teaching hospitals. With the rotation of interns and residents, frequently we experience the "clear the wards" phenomenon. Apparently nobody likes to work-up patients who've already been worked-up, and so many times patients who need further speech treatment, but have lost their "teachability", mysteriously disappear at the end of an academic quarter.

Certainly, good cross-disciplinary communication and input by all members of the rehabilition team can alleviate some of these problems. Speech patholo-

gists expect an avenue of input regarding discharge planning and expect their views to be seriously considered against the backdrop of the broader goals of overall patient management.

Open-Mindedness - Perspective

And now some less tangible aspects of our aspirations. We expect a degree of open-mindedness and perspective in our dealings with neurologist. This is applicable to a number of issues and it certainly relates as much to speech pathologists as it does to neurologists. I guess one aspect is the problem we have of "slipping into camps"; or becoming permanently entrussed with the sometimes stultifying opinions or biases of our training. This glares through the history of aphasiology and certainly is, at the very least, still flickering brightly today. We have the "Boston School" and the "Minnesota School" and the "Iron Mountain School" and perhaps one of these days the twain ought to be meeting. This is not to suggest that everyone should take a totally eclectic approach and abandon what they believe in, but we expect sincerity and openness and receptivity to the possibility that maybe the other person has something there, after all. Though debate and vigorous exchange of ideas is healthy, cross-pollinization does not always result in weird hybrids, and cynicism and narrow-mindedness have no place when the welfare of patients is involved; whether it be related to the efficacy of therapy or to the existence of "trans-Atlantic cable aphasia".

Another thing that speech pathologists would expect from neurologists, in as great a degree as is exemplified by Dr. Rubens, is some tempering of the "diagnostic attitude" with some of the flavor and philosophy of rehabilitative medicine. We would hope that the influence of the great neurological diagnosticians such as DeJong and Wechsler and Grinker are tempered by a smattering of influence from Howard Rusk.

Because we've got to do more than "label and relax". We've got to do more than become pre-occupied with "lesion, lesion, where is the lesion?" These are important concerns, but after the very necessary life-prolonging diagnostic riddles have been answered someone has got to be around to address the question "Now what?" Improving the quality of life extends beyond, well beyond, making a diagnosis. Everyone knows this, but not everyone practices it. The speech pathologist expects some assurance that the rehabilitative and follow-up efforts are approached with equal vigor as the high quality diagnostic efforts we have come to expect.

Tolerance

Another factor which is also somewhat less tangible, relates to tolerance and understanding. This touches several issues, not the least of which is related to the "efficacy of therapy" matter. We recognize, and are constantly reminded, of the problem involved in documenting the effect of language rehabilitation in aphasia. This is a pervasive problem and keeps intruding in one's late night private thoughts.

We have not been as efficient as we would like in generating data on the course or the ultimate usefulness of language training. Good language clinicians will argue convincingly that they see enough progress in their patients to be assured that aphasia therapy is not functionally antonomous. Active and conscientious clinicians hold very strongly to the view that therapy has a significant and positive effect on language recovery beyond

what can be expected from spontaneous recovery. Most of us believe this. But as Audrey Holland (1969) has suggested, the scientific community has a right to demand our data instead of our word.

What do we expect from the neurologist? Some tolerance. Give us some time. We are a young profession and as all new kids on the block we have been eyed with some skepticism. But because we are a young field, we can afford to reappraise our work without losing face.

At a recent cross-disciplinary conference in Florida, the question was posed, "If there's little evidence on the efficacy of therapy, then how do you justify your existence?" Well, we are well aware that no perfectly controlled definitive study exists proving the effectiveness of therapy, but I submit that anyone who persists in suggesting that no controlled studies exist that demonstrate communicative skills can be manipulated, even in patients well past the spontaneous recovery period, is presenting a rather restricted appreciation of the literature.

The evidence of case studies and time-series designs and a few between group studies is accumulating, and I'm confident we are on the threshold of laying to rest the granite hard prejudices against therapy.

We are more than dispensers of socialization therapy and emotional salve and we're not about to lower our heads and do the slow-foot shuffle off into the sunset.

Another issue on which we would expect some tolerance relates to the qualifications and capabilities of members of our profession. Again, we expect some understanding because we are a fledgling discipline, born of the mixed parentage of the medical and educational models. We have not had the benefit of centuries of introspection and professional honing because we don't trace our roots to the age of Hippocrates and Galen, but rather to the age of Herbert Hoover and Al Capone. This does not excuse the existence of less than qualified professionals, but it does suggest that our upgrading efforts, in the immortal words of Karen Carpenter, "have only just begun".

It has been stated that there is nothing worse than a poor speech pathologist. I can think of a couple of things. We cannot condone shabby professionalism or mediocrity in speech pathology, but by the same token we have the right to be proud of the considerable efforts to elevate our standards, and we have the responsibility to call this to the attention of our professional colleagues. We do not condemn unions because of some lazy workers, or universities because of some incompetent professors, or orchestras because of some poor musicians (Goldstein, 1973). And we can't allow the luxury of hasty generalization about our profession because of a few bad experiences.

Independence

Another issue concerns the independence of our profession. Speech pathologists are too often viewed as the "hands of the physician" along with other non-medical personnel such as x-ray technicians, physical and occupational therapists and nurses. We expect to be viewed as independent, decision making equals. The old misconception that we work under prescription is gradually becoming eroded. We expect to work on consultation with all its inherent privileges and responsibilities. We are trained, certified, and capable of evaluating communicative disorders and want to make the decisions regarding type, frequency and duration of therapy for referred patients.

Another point which is even less measureable but certainly related to the independent status of our profession and to all allied health fields is

the connotatively-laden concept of "respect". This is a common gripe of non-medical people who work in a medical setting. Certainly we're not as paranoid as Rodney Dangerfield and don't go around continually muttering "We don't get no respect", but some people view it as a problem. Much of this is related to the well-deserved esteem that the general public has for the medical profession generally and neurology more specifically. A few years ago someone did a study using the semantic differential to rank laymen's feelings about certain professions. With this strategy, as you know, several bi-polar adjectives are used such as "good-bad", "powerful-impotent", "strong-weak", etc. The results of the study were interesting in that a large group of laymen ranked "physicians" quite a bit ahead of "mother" and "monarch", and in fact, it nearly nosed-out "God" for first place.

What does the speech pathologist expect? Don't take the study to seriously. Relate to us with courtesy and professional respect; and we shall try to always be mindful that respect is earned, not demanded, and usually results from willingness to share, interact, and offer advice and assistance; and further, that respect is earned through daily demonstration of competence and commitment.

To avoid misinterpretation and prevent a totally negative flavor to all of this, I think it is time to turn to some very real reasons for optimism. Things are changing. Inter-disciplinary groups such as the Academy of Aphasia, inter-diciplinary courses such as the one sponsored by the Florida Neurology Society, cross-disciplinary journals and the steady increase of collaborative research are all healthy trends. There appears to be less and less of a chasm between clinical aphasiology and neurological aphasiology and some of the credit for narrowing the gap can be attributed to our guest speaker today.

It's obvious that speech pathology and neurology must retain their clear identities, but the point is, our ideas and philosophies are merging somewhat. Certainly we don't expect a Clairol commercial of slowmotion running through a grassy meadow, hair waving, arms outstretched, to meet in a tender embrace and sink slowly to our knees. That's probably too much to ask, and may not be desirable. I can visualize some neurologists with whom it might even border on the ludicrous.

So let me summarize. What does the speech pathologist expect from the neurologist?

We expect referral, consults, a mutual flow of information, some input in discharge planning, appreciation of our independence, some tolerance for the problems inherent in being a young profession; and finally some appreciation of the intensity of our dedication. Our profession is dedicated to support the beauty and efficiency and restoration of communication. The thunderous effect of the loss of speech is that, without it, life becomes lonely, frustrating, morbid --- a living death (West, 1961).

Please convey that we recognize some of our problems, and we're facing them head on and making progress; but most of all convey our excitement about this profession, and the intensity of our commitment to lessen the communicative suffering of our patients.

Thank you very much.

References

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