Doors, Mole Crickets, and Life after Puberty
Welcome and Opening Remarks

Leonard L. LaPointe, Ph.D.
Veterans Administration Medical Center, Gainesville, Florida

Thank you. As conference chairman and on behalf of the committees responsible for this year's meeting, I want to extend to you a hearty welcome to the Eleventh Clinical Aphasiology Conference. The program looks stimulating and relevant, and the locale is ideally suited to our long tradition of revelry and hedonism.

Bruce Porch conceived us, so to speak, eleven years and nine months ago, and gave birth in the basement of the Albuquerque VA Hospital. As happens so often, we swept through the developmental stages, and here we are as a robust and thriving eleven-year old, face to face with puberty.

In The Power and the Glory (1940), Graham Greene, suggested that "there is always one moment in childhood when the door opens and lets the future in." I'd like to suggest that, as an organization, we may be at that metaphorical transition point. And I'd like to suggest as well, that as the door opens to let the future in, we exercise some caution as to what we allow in with it. Don't get the wrong idea. We have enough prophets of doom around constantly mouthing warnings of impending nuclear holocaust, economic collapse, and crucial shortages of dental floss. I'm not suggesting that we face the future with wolves at our door, but I do think we have a rich variety of rodents, mole crickets and a few other problems that may prove to be more than just a nuisance.

As clinical aphasiologists we face some challenges that we will have no choice but to address. Some of them are external and may slip in the door around our feet, and some of them are internal and have been around under the furniture and in our darkened closets for awhile. Without too much elaboration, I'd like to outline a few of the issues that we must carefully consider as we mature from an equivocally assertive, giggling pubescent to a self-actualized adult. Perhaps it's time to consider some of these as a group. No doubt any opinion or any stand we take would have greater impact if it were to come from a cohesive group of clinical aphasiologists, than if it trickled from a number of individuals.

1. First of all, we must be sure that we do not abdicate our professional independence in dealing with the communication needs of our patients. We must struggle to make sure that third party payment sources, larger and richer professional associations, and the hued-cross insurance megalopolies don't relegate us to a position of subservience; dependent for our handout on the rubber stamp of some other profession. We are independent professionals and must retain the right to decide, as long as there is no medical contraindication, on the initiation, type, and duration of communication treatment.

We welcome D.F. Benson's plea (1979) for neurologists to assume "a greater role in the rehabilitation of aphasic people," but we blanch at prescription or dictation of what we should do by people untrained in our field. This is definitely a mole cricket of the future, and we must gird up our ankles, if not our loins, and protect what we have.

2. A related issue is that of encroachment and the rewriting of privileges by some professions. We do not want to get into arguments of territorial imperatives or suggest that we have staked out the sole claim to rehabilitation rights to the brain. But recent advances in neurodiagnostics have left some of our colleagues in related fields tapping their fingers with fewer things to do, and we are seeing a resurrection of interest in rehabilitation and a promulgation of programs of "cognitive retraining," "cognito-linguisto reorganization," and "higher cortico-cognitive reprogramming." This is probably good. I doubt if we'll run out of patients. But this is an area that is going to take a good deal of interprofessional dialogue, cooperation, and compromise if we are to avoid squabbles, duplication of services, and ensure that we work to the best interests of our patients.

3. Other issues are more internal and they are many. Particularly in aphasiology, we must continue to foster the upgrading of the delivery of our services. By continuing-education programs such as this one (and by the way, participants should get continuing education credit for it, and in the future will), and by a variety of other means, we must ensure that only the highest standards of service delivery are maintained. At the risk of sounding sacreligious, perhaps not everyone in private practice should be doing aphasia treatment. It seems as though there are a few out there winging it without benefit of a data base. It should be more than just a sideline; and perhaps we as a group ought to at least address this issue and if an opinion or recommendation ensues, we could pass it on to our national associations.

Other challenges include the continued documentation and accumulation of evidence on the worth of our efforts in aphasia. As Dr. Rosenbek reminded us in his address on dessicated podiatry, we must continue to question and reevaluate cherished beliefs and old saws. Not everything should be accepted at face value and without the luxury of evidence. Related to this is the challenge and responsibility to publicize what we do well and how well we do it. We need to tell other professionals and institutions, and various levels of government, and the public. It's a shame that the public knows a lot more about the heartbreak of psoriasis and onion breath than it does about the heartbreak of aphasia.

Finally, as a Clinical Aphasiology Conference, as a group of active, dedicated professionals who are just as interested in the <u>person</u> who has aphasia as we are in the fascinating <u>condition</u> of aphasia, we must meet the challenge of purity of purpose. This group was founded and continued to grow because of the need to exchange information on <u>clinical</u> issues (it's part of our name); that is, the evaluation, treatment, and overall management of communication of people subjected to the barriers created by aphasia. There was a great need for this group 11 years ago and it continues. We don't have to be a group of clinicians adrift without benefit of theory, but at the same time let us not evolve into the Brain-Language Theoretical Model Builders Society to the point where our meetings become exercises in intellectual self-abuse.

I hope that the next four days prove to be as stimulating and relevant as past conferences. In this group everyone participates, so if we have a good conference we have ourselves to thank. Enjoy yourselves, and may you find something that will make you a better teacher, and a better scholar, but most of all a better clinician.