

How to Live in Harmony with a Neurologist:  
"I Want to Hold Your Hand"  
A Discussion Session

Robert T. Wertz, Moderator  
Veterans Administration Medical Center, Martinez, California

Eight of us gathered to discuss whether the relationship between speech pathologists and neurologists in the management of aphasic patients was harmonious or dissonant. In keeping with the musical theme of the evening, a few bars of popular tunes were offered, each offering was elaborated by a question or questions, and participants either sang along or improvised.

"Why Don't We Do This More Often": Dr. Frank Benson (1979) has suggested that a neurologist should remain involved with aphasic patients during the course of language therapy, and that he should participate in decisions to initiate, alter, or discontinue language therapy. What are the implications of this suggestion for speech pathologists and their traditional management of aphasic patients? Is this a step toward collaboration or prescription?

Discussion: While the potential danger of a neurological invasion of language therapy and ultimate treatment by prescription hovers in the background, most participants believed that the shadow cast was not ominous. In fact, most viewed Benson's suggestion as a positive one, designed to improve patient management. We reminded ourselves that late 19th and early 20th century treatment of aphasia began with neurology, not with speech pathology, and Benson is advocating neurologists return to participation in what they initiated. Several participants cited specific examples of collaborative treatment efforts with neurology. For example, stimulus modalities were selected based on information provided by a neurologist on a patient's sensory integrity; and, in another case, responsiveness was improved when a neurologist prescribed and monitored a medication program designed to increase the patient's ability to initiate responses. Further, Visual Action Therapy (Helm and Benson, 1978), a treatment program for severe aphasic patients, was a joint effort between speech pathology and neurology. Our experience has been that neurologists are not usually too much involved in a patient's language therapy. Typically, we find they are not involved enough. Thus, we welcome a neurologist's assistance and participation in language therapy, but we shun any effort to dictate or prescribe what that therapy should be, and we believe that Benson's suggestion to neurologists is a positive step toward improving patient care.

"Do, Do, Do What You Done, Done, Done Before, Baby": Do neurologists believe that language therapy for aphasia is efficacious?

Discussion: Response to this question ranged from, "Anyone who believes language therapy is not efficacious displays a gross ignorance of the literature," to "speech pathologists know that there are patients they have not helped with intensive language therapy." We agreed that the efficacy of language therapy must be qualified. Group studies, for example, Basso et al. (1979) demonstrate that language therapy is efficacious, but some treated patients in these studies did not improve. However, the data support the

position that language therapy for most patients will help; thus it should be provided, with qualifications and no guarantees, in certain individual cases. Further, a neurologist's belief in the efficacy of language therapy depends on his experience with speech pathologists. The extremes range from Benson's (1979) positive support for language treatment to Ruben's (1977) report that almost one-third of the neurologists he surveyed did not know what speech pathologists do. Thus, if a neurologist does not know what a speech pathologist does, one might infer he does not know what a speech pathologist can do. This position, our group believes, can be combatted through education and results. Systematic "in service" educational sessions presented by a speech pathologist to the Neurology staff and residents on the efficacy of treatment and well-documented reports of individual patients' responses to treatment through personal contacts and chart notes are possibilities. "He who does not toot his own horn does not get it tooted" (Source unknown, perhaps Ben Franklin or Darley or both.). The trend has been toward conversion. Participants reported that some neurologists are not only advocating language therapy, but also they are advocating it for severe, "global" patients, traditionally believed to be poor treatment candidates. Thus, our group concluded this topic with a rousing chorus of "The Times They Are A 'Changin'."

"Love Letters Straight From The Heart": Do you see every patient you believe you should see? How difficult is it to obtain consults?

Discussion: Like a chorus, the refrain was repeated, "It all depends on the speech pathologist's relationship with the Neurology Service and how much time is spent educating the staff and residents through "in service" sessions. With the exception of mild aphasic patients, participants believed that all aphasic patients were referred to Speech Pathology. For speech and language disorders other than aphasia, the experience in our group was mixed. Most of us believe that many demented patients are not referred, and the situation is similar for patients who sustain a right hemisphere lesion. Conversely, several participants reported receiving consults on patients who were comatose or in the Intensive Care Unit. While these patients are not ready for Speech Pathology to intervene, the group encouraged their referral for identification, following, and intervention at the appropriate time. Other participants noted an increase in the number of patients with progressive disorders being referred. Some neurologists are appreciating the need to document progression of speech and language deficits, to combat progression with compensatory techniques, and to provide alternative modes of communication as speech and language deteriorates. Current concerns about "cost effectiveness," audits, and the like may negate the referral of patients demonstrating certain disorders. For example, a neurologist who is convinced of the value of language therapy for aphasia may hesitate to refer patients with dementia, or a right hemisphere lesion, or a progressive disorder, because he believes he cannot justify the value of a referral. In these situations, it appears necessary for speech pathologists to provide sufficient justification for their involvement. This may range from the need to document current performance as a baseline for measuring change or the lack of it, to providing a "clean bill" of speech and language health, much the same as the normal individual's annual physical. Finally, all participants agreed that neurologists referred much more often than neurosurgeons. Frequently, the neurosurgical patient in need of speech and language services arrives in our clinic only after the intervention of a knowledgeable and cooperative neurologist.

"Can't We Talk It Over": How much influence do you have on rehabilitation and discharge planning?

Discussion: La Pointe (1977) identified the "clear the wards" phenomenon, and all participants could offer empirical evidence of its existence. Sometimes, typically before holidays or every time residents rotate, inpatients receiving language therapy may disappear. While there are several theories to explain the source of this mystery, the most popular is that patients with chronic communication deficits are, usually, no longer medically interesting. Thus, space is created for patients who are. We agreed, again, that the situation could be avoided through constant contact and education of staff and residents. Language treatment typically transcends a patient's hospitalization. What begins as an inpatient will continue as an outpatient. Speech Pathology must insist on an active role in this transition from in to out; whether to continue treatment on an outpatient basis; to refer to another speech pathologist nearer a patient's residence; or, simply, to schedule a language reevaluation.

"You Say Tomato and I Say Tomaato": Is language a barrier in working with a neurologist? Is there a difference between the "medical model" of aphasia and the "nonmedical model"?

Discussion: Rubens (1977) suggested that speech pathologists become familiar with the "medical model" of brain damage and be willing to translate their jargon into language that is understood by neurologists. The initial response of our group, "two models do not exist," was modified, eventually, to "perhaps different ways of talking about aphasia exist, but most speech pathologists are bilingual, and, unless it influences treatment, it is not necessary to insist on preference." Consultation requests stating, "please fix this man's motor aphasia," do not dictate that a speech pathologist reach for a wrench before conducting an appropriate appraisal, making a diagnosis, and focusing treatment. We agreed that perhaps there are medical diagnoses and there are speech diagnoses. One discipline's pseudobulbar speech is another's spastic dysarthria. Even speech pathologists differ in their terminology. One clinician's aphasic articulation deficits are another's apraxia of speech. Most of us, in this group, had no objection. We recognize that our patients usually are not our patients. They are referred by the primary care person, the physician. There is no need to "turn him off" for the wrong reasons. Objecting to another discipline's terminology is a matter to be debated in an educational arena, not an exercise in linguistic petulance to be acted out in ward rounds. More importantly, we paraphrased Holland (1975)--speech pathologists will dazzle neurologists more with their data than with their words.

"Speak To Me Only With Thine Eyes" or "I Only Have Eyes For You": How many akinetic mute patients have you seen lately?

Discussion: In the interest of time and good taste, this topic was avoided.

#### REFERENCES

- Basso, A., Capitani, E., and Vignolo, L.A. Influence of rehabilitation on language skills in aphasic patients. Archives of Neurology, 36, 190-196, 1979.
- Benson, D.F. Aphasia rehabilitation. Archives of Neurology, 36, 187-189, 1979.
- Helm, N. and Benson, D.F. Visual action therapy for global aphasia. Paper presented at the 16th Annual Meeting of the Academy of Aphasia, Chicago, 1978.

- Holland, A.L. The effectiveness of treatment in aphasia. In R.H. Brookshire (Ed.), Clinical Aphasiology: Conference Proceedings, 1975. Minneapolis, MN: BRK Publishers, 1975.
- La Pointe, L.L. What the speech pathologist expects from the neurologist. In R.H. Brookshire (Ed.), Clinical Aphasiology: Conference Proceedings, 1977. Minneapolis, MN: BRK Publishers, 1977.
- Rubens, A.B. What neurologists expect of clinical aphasiologists. In R.H. Brookshire (Ed.), Clinical Aphasiology: Conference Proceedings, 1977. Minneapolis, MN: BRK Publishers, 1977.