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Ethical Issues for Applying Linguistics to Clinical Contexts: The Case of Speech-Language Pathology

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In all applications of linguistics to clinical contexts, I understand the overriding ethical concern of the linguist to be "How can I make sure that patients are getting the best care possible whenever language is concerned?" This is, of course, not to say that linguists cannot themselves expect to benefit from professional relationships with clinicians, e.g., fascinating and illuminating data are often made available to the linguist in the process. But my experiences working with clinicians in several different settings have led me to believe that the linguist's perspective is critical to a more complete understanding of any clinical situation which involves language, such as history-taking in a doctor's office or bed-side talk in a hospital. Interactions between clinicians and patients can have potentially important consequences for the patient's well-being. These consequences can involve the more concrete, such as the relaying of necessary information to the doctor, as well as the more abstract, such as a patient's sense of identity and self-esteem. Whatever the level, the linguist's perspective is likely to offer insights different from those of the clinician which bear on the content and quality of service delivery.

Of course, without clinical expertise, the most sensible way for us as linguists to attempt to help patients is by helping the clinicians who are responsible for them to understand the role which language plays in their work. In this paper, I explore some of the more general issues of the application of linguistics to clinical contexts by focusing specifically on my experiences over the past two-and-one-half years in applying interactional sociolinguistics and discourse analysis to clinical investigations of language pathology at

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Walter Reed Army Medical Center in Washington, DC. The clinicians involved in this project all have advanced degrees in aphasiology or speech-language pathology. These clinicians, therefore, are somewhat different from the majority of clinicians with whom linguists might collaborate, in that they know a great deal about language in general, even though they may lack specific expertise regarding language variation, discourse-level structures and functions, and interactional concerns.

Aspects of speech-language pathology work to which linguistics has been applied in the project under discussion here include the following four areas: 1) the test battery; 2) the diagnostic interview in which the test battery is administered; 3) the evaluation tool, called the Modified Communication Performance Scale; and 4) the administration of this performance scale. Following a brief description of the project in which I am involved at the Walter Reed Army Medical Center, each of the four aspects is discussed in turn. The paper then concludes with some general guidelines which have been derived from my participation in this project.

WALTER REED DEFENSE HEAD INJURY PROJECT[1]

The ongoing project with which I am associated at Walter Reed Army Medical Center, called the Defense Head Injury Project, evaluates active duty military persons who have suffered a traumatic brain injury by, for example, hitting a metal pole while sledding off-duty or parachuting into a grove of trees, followed by a period of more than 24 hours of amnesia. The injury had to have occurred no more than three months prior to the patient's initial evaluation to be included in this project. Complete neurological evaluations and neuropsychological, speech-language, and occupational therapy test batteries are administered to the patients upon entry into the project, and then again at two, six, twelve, and twenty-four months after study entry. Similar to Finegan's (this volume) discussion of the limited role of linguists as expert witnesses in the overall determination of the guilt or innocence of a defendant, here too the role of the linguist is very limited and indirect in terms of a patient's diagnosis, as well it should be. The first patients were tested in early 1992; during the subsequent twelve months, more than thirty patients have been evaluated.

During early pilot tests before the speech-language pathology evaluation was designed, it became clear to the speech clinicians involved in the Defense Head Injury Project that the language and communication problems of these patients were different from those the clinicians had been trained to deal with, i.e., the more "classic" aphasias. After turning to work within the area of pragmatics in the speech-language pathology literature (Ehrlich & Sipes, 1985; Prutting & Kirchner, 1987; and Kennedy, 1991), the clinicians realized their need for assistance to better understand the issues involved from a linguistic perspective. They called the Department of Linguistics of Georgetown University and talked with me, since I was teaching a course in pragmatics at the time. Since I had just completed a four-and-one-half year longitudinal study of conversations I had had with one Alzheimer's patient (Hamilton, 1994) and had been consulting on an informal basis on discourse-level issues with the Language and the Aging Brain project at the Boston Veterans Administration Hospital, I was pleased to have an opportunity to be involved in an active way with an ongoing project of this type. Over the past two-and-one-half years, I have met approximately once a month—at times as frequently as once a week—with the clinicians at the hospital. In order to expose Georgetown graduate students to some of these issues, I offered a seminar entitled "Discourse in Clinical Populations" in Spring 1992, in which the students were able to analyze the audiotaped interviews and written narratives of the first six patients in the study. The students' seminar papers were shared with the Walter Reed clinicians, who found them highly informative and provocative.

Applications of Linguistics to the Project

Although space constraints preclude an exhaustive discussion of the linguist's role in each of the four areas of the speech-language pathology diagnostic proceedings outlined above, I will try to characterize selected ethical issues which arise in various types of involvement, drawing on my own experiences, as well as on the findings of the graduate students participating in the seminar mentioned above.

1. Applications to the test battery: Here the driving question focuses on whether the test is designed in such as way as to uncover the patient's communicative strengths and weaknesses, which are of interest to the speech clinicians. Because the decision about whether

to place the patient in an in- or out-patient treatment program or to return the patient to some type of employment in the military is based in part on the patient's performance in the diagnostic interview (and the subsequent diagnostic label), it was the clinicians' goal in the project in question to ensure that the communicative strengths and weaknesses exhibited by the patient during the interview be as close as possible to those which would likely be exhibited in that individual's military workplace. Examples of these communicative behaviors include both being able to ask for clarification and to respond appropriately and fully to requests for clarification, and being able to convey information in a clear and concise way.

Since the clinicians at Walter Reed were primarily asking for my assistance in setting up tasks which would elicit extended periods of discourse from the patient (including both naturally occurring conversational discourse and elicited personal experience narratives),[2] I drew on basic methodological insights regarding the sociolinguistic interview (e.g., attention to speech, observer's paradox, and group vs. individual interviews), as well as investigations of vicarious and personal experience narratives, in both elicited and spontaneous situations.

Linguists can be of assistance to clinicians at this level during the actual construction of the test questions and tasks, or in the subsequent evaluation of pilot data to determine how well the questions and tasks are holding up in the actual interviews. Assistance can take various forms. For example, drawing on my experience with discourse features of everyday spoken narratives, I advised the clinicians early on that a particular black and white line drawing they had selected from a standardized aphasia battery would *not* function well in eliciting extended narratives from patients. Against my advice, they decided to go ahead and use the drawing, only to discover that it was eliciting primarily dry descriptions rather than the narratives they had expected. The task was subsequently changed. The fact that the clinicians did not initially take my advice in this particular case points to the importance of establishing an extended relationship with the clinicians which will engender greater trust over time. At the present point in our relationship, the clinicians are much more likely to accept on faith advice I offer them regarding discourse issues.

In another situation, I was asked to go into the clinical interview room, sit down at the table, read the piece of paper in front of me, and carry out the task requested of me. The task was to find

out how to get to a particular local office supply store whose name was given with no other information. On the table (apparently for my use in this task) were the following items: one pad of paper, a pen, a telephone, and various telephone books and street atlases. To make a long story short, I called up the store and found out what I needed to know, using the pen and pad to note only those directions which were unfamiliar to me. When the clinicians came into the room and saw my scribblings, it was clear to me that I had not performed as expected, which would have included a notation of every street en route to the store from the hospital. Needless to say, a discussion ensued regarding the full range of "normal" behaviors and how they might relate to issues of being an insider or outsider to Washington streets. This small example underscores the need for piloting all potential tasks and test questions on "normal" control subjects in an attempt to understand the range of acceptable behaviors possible in response to a given task or question.

As mentioned above, linguists can also be involved in pointing to possible problems in the test battery by analyzing pilot data. In her final paper for my seminar on clinical discourse, Robin (1992) argues that the personal experience narratives which are elicited as part of the test battery in response to the prompt "Tell me about what happened to you, about your injury" may in fact not be appropriate for assessing pragmatic competence on the part of the narrator. Robin claims that some of the organizational problems these narratives display, as well as the prevalence of what appear to be non-essential details, may stem from the fact that the patients are forced by their memory loss to shift at the critical point of the resolution of the story from recounting the events as a personal experience which they remember to reporting events as they were told them by witnesses after "everything went black." This unusual feature of the narrative task *may*, therefore, account for some of the pragmatic difficulties displayed by the patient at this point in the test battery.

2. Applications to the administration of the test battery within the diagnostic interview: Regardless of whether the test battery has been constructed specifically for a particular clinical project, as is the case of the Walter Reed study, or whether a standardized aphasia battery is selected for use in a project, the test battery must be administered to particular patients at particular times. The initial assumption on the part of many clinicians (not just at Walter Reed), however, is that neither the test battery nor the

interviewer will significantly influence the language produced by the patient, i.e., that the test situation is, in a word, objective. But, despite the fact that a clinician may be asking questions from a script so as to make the evaluation as objective as possible (but see Rosenfeld (1992) for an analysis of the impact of the clinicians' deviations from the script), nothing can change the fact that the diagnostic interview is an interaction between *two* interlocutors. The fact that the patient is *not* reading a script allows for the interaction to go off in a direction unanticipated by the clinician. This situation alone may lend a slightly different meaning to the scripted questions when they do occur in an actual interview (see Rosenfeld (1992) for discussion).

Indeed, Shudo (1992) argues that the very attempts by the interviewer to remain strictly objective may create an unnatural situation for conversation. Shudo asks whether or not it is justified to evaluate a patient's use of language as inappropriate when the clinician's script did not allow the kinds of follow-up questions which might be expected to occur in an unscripted interaction, such as occurs outside the diagnostic interview. As an illustration she points to the following excerpt from one of the patient interviews:

Clinician: And tell me
[2 second pause]
what you've been doing..
since your injury.

[10.5 second pause]

Patient: Recovering.

[13 second pause]

Clinician: And tell me about your job in the military.

[7 second pause]

Patient: I'm a patient at Walter Reed Hospital.

[11 second pause]

Clinician: And tell me what happened to you..
about your injury.

Of course, the patient's abbreviated language behavior *does* seem to be marked within the context of the diagnostic interview. However, further investigation would be needed to determine whether this is an indication of a pragmatic difficulty of some kind or simply belligerence on the part of the patient. Shudo's point, however, is that, in the absence of a request for clarification or for elaboration (such as "What do you mean by that?" or "Well, besides that?"), an evaluation of the patient's abilities may be made on the basis of insufficient information.

Besides the possible unexpected influence of the interviewer's script, as discussed above, and the obvious influence that the interviewer's gender, age, ethnicity, and/or race may have on the language used by the patient, two additional questions seem to be central to the analysis of the administration of the test battery: 1) Does the clinician accommodate her language (see Coupland, Coupland, Giles & Henwood, 1988, for a discussion of communication accommodation theory) to some preconceived notion about the patient, based possibly on the patient's race, ethnicity, gender, age, socioeconomic status, educational background, etc.? And, if so, is there evidence that this accommodation influences the patient's language behavior?; and 2) Is there evidence of a mismatch between clinician and patient regarding the purpose of the interaction (i.e., is this an evaluation of memory, of intelligence, and/or of language?) which could result in different language use as the patient tries to exhibit the good memory, the high intelligence, or the intact language that he believes is being evaluated?

The issue of accommodation is illustrated by a clinician's deviation from a scripted prompt, "Tell me about what happened to you, about your injury," which she uses with all other patients, to ask "What was the precipitating event?" of one patient. Further examination uncovers that the patient who receives this higher register question is one who the clinician knows to have an advanced academic degree as opposed to the high school diplomas most of the other patients have as their highest academic achievement.

Evidence of mismatch regarding the purpose of the overall interview or of a component of it can be found in the patients' use of self-repair throughout the interaction. For example, in a written narrative elicited by viewing a copy of a Norman Rockwell painting, one patient scratched out lexical items he had used repeatedly in the narrative to replace them with synonyms, not realizing that his

purpose (which was apparently to write an aesthetically pleasing short story) would backfire, and that revisions of *all* types were actually counted against him according to the rating scale used by the clinicians.

The application of linguistics to the interaction in which the test battery is administered requires a good deal of microanalysis of transcriptions in order to be convincing to clinicians. In my experience, clinicians may be slow in the early stages of the working relationship to take a linguist's advice regarding specific tasks or interactional concerns (as was discussed above in the case of the narrative-eliciting illustration), not because of closed-mindedness on their part, but simply because the advice did not make sense within the clinicians' paradigm. Competent microanalysis which is carefully interpreted with an eye towards the clinicians' paradigm can go a long ways in working to establish both a common frame of reference and a higher degree of trust between clinicians and linguist. This frame of reference and trust can then be drawn upon in future discussions to facilitate quicker acceptance of the linguist's advice.

Because the linguist's involvement at this level is very demanding, this kind of analysis would probably appeal only to linguists who had a primary research interest in the field of communication disorders or who had student assistants who could carry out much of the transcription and analysis. Bringing these interactional issues to the awareness of the clinicians is useful, but without microanalysis, the issues themselves would probably not result in a change of behavior or attitude on the part of the clinicians. Since speech clinicians are not in the business of evaluating their own language use, there is a great need for work of this type by linguists to try to stave off the great potential for skewed data based solely on patients' use of language.

3. Applications to the performance scale: Here, as at the previous levels, it is possible for the linguist to be involved during the construction of the rating scale or in subsequent revisions following some pilot testing of the scale. The involvement of the linguist during construction of the scale is similar to the linguist's involvement during the construction of the test battery: that is, to listen to the clinicians' needs regarding the communicative behaviors of the patients and to assist in devising appropriate categories and descriptions of a range of appropriate and inappropriate behaviors.

In the case of the project under discussion, the rating scale called the "Modified Communication Performance Scale," based on the work of Prutting and Kirchner (1987), Ehrlich and Sipes (1985), and Kennedy (1991) had been constructed in January, 1991, without my input. The fourteen communicative behaviors[3] which are evaluated as either 3 "consistent and persistent behavior that is clearly abnormal," 2 "behavior similar to that observed in the previous category but that is inconsistently present," 1 "behavior that falls within the normal range," or 0 "no instances of this behavior could be observed for evaluation" proved to be somewhat problematic to apply. Sample problems include the following: 1) how to define normal behavior when we know that normal behavior is extremely variable within the "normal" population; 2) how to differentiate between behavior rated as a 2 (inconsistently inappropriate) and that rated as a 3 (consistently inappropriate), i.e., what constitutes "consistent" behavior within the interview?; 3) how to handle constraints by the formal interview context on the exhibition of many of the fourteen behaviors, including the variety of speech acts and initiation of conversation; 4) how to approach the conflation of different behaviors within the same category (cohesion and coherence in category G, topic maintenance and topic content in category I, and conversational initiation and response in category J); and 5) how to provide a clear place to mark behavior regarding assumed shared knowledge, which seems to be a significant difficulty for many of these head-injured patients. These problems are currently being addressed and the performance scale is being revised accordingly.

4. Applications to the administration of the performance scale: This has proven to be the most important and time-consuming area for my own involvement as a linguist in the Defense Head Injury Project. Often I sit with the clinicians and listen to an audiotaped interview or watch a videotape and fill out the performance scale with them. At various points throughout the recording and then again at the end of the recording, we discuss all fourteen behaviors in detail, plus any behaviors which we feel were significant in the interview but which have no clear place in the scale.

This is the level at which on-site informal training in linguistics takes place. I see this training in linguistics to be a critical piece in the ethics of the sustained relationship which exists between the clinicians and me. In other words, I believe it more ethically

sound for me to *teach* the clinicians to approach their data like linguists, so that they have experience which they can build on from session to session, rather than for me to provide them with a finished analysis of their data. In this way, our discussions can become increasingly sophisticated over time and the division of labor involved in such analyses can shift over time from the linguist to the clinicians.

Such training sessions typically begin with discussions in response to a clinician's statement to the effect that "Something strange is going on here, but I can't quite put my finger on it." Communicative phenomena identified as contributing to the 'strangeness' in the interaction seem to fall into two categories: those which could plausibly be difficulties related in some way to the patient's head injury and those which seem to be related to dialectal differences or attitudinal considerations. Illustrations of the first type (possible relationship to head injury) include the following: topic shifts which are unmarked as such for the listener; insufficient expansion of a previous response following a specific request by the clinician for the patient to do so; consistent overestimation on the part of the patient regarding knowledge shared with the clinician; and disorganized narrative accounts. Illustrations of the second type (possible relationship to dialectal difference or attitude), which I have difficulty imagining being the result of a head injury include: use of nonstandard English syntax, such as "He don't come around here much anymore;" difficulties in overall intelligibility of the patient (which sometimes seem to be due to dialectal differences between the patient and the clinician); somewhat flat intonational contours which sometimes seem to be due to mild depression or lack of interest in the interview on the part of the patient; and greatly reduced participation by the patient which sometimes seems to be due to belligerence. Because the clinicians do not have samples of these patients' speech and writing prior to their head injury, however, it is difficult (if not impossible) to know for sure if a particular communicative problem is due to the head injury or if the patient communicated that way before the injury.

Uncertainty as to possible explanations was at the heart of one difficult discussion regarding our different rating of the communicative performance of two patients during their interviews. I had been very reluctant to rate a patient's nonstandard English syntax or a patient's somewhat flat intonational contours with a 2 (inconsistently abnormal behavior), if that syntax seemed to co-

occur with lexical and phonological features of a particular nonstandard English variety, or if the intonational contour seemed to co-occur with conversational topics which suggested depression or lack of interest in the interview.

I was told at the time, however, that it was not our responsibility as raters of the patients' performance to think about possible causes of the patient behavior, but rather to try to describe that behavior as completely and accurately as possible. I, of course, could understand on a theoretical level the desire on the part of the clinicians to separate description from interpretation or explanation, but I needed to be reassured that my rating a patient's behavior as somehow abnormal would not necessarily contribute to a diagnosis which would result in him being enrolled in a treatment program when the behavior could have been consistent with his pre-injury behavior. The clinicians assured me that the rating scale is just one piece of the overall evaluation of the patient and that, if the behavior in question were due to a dialectal difference or an attitudinal consideration, this would be discovered as the data from the various tests and interviews were being correlated.

Although I have agreed (for now) to try to separate out description from interpretation as I rate patients' behavior, I am still somewhat uneasy with this situation, as it calls to mind the atrocities of the 1960s (and later) in which nonstandard English speaking children were required to meet with speech-language pathologists in schools. This ethical dilemma seems to me to be similar to a possible dilemma of the linguist as expert witness in a court case. Just as a linguist cannot be concerned with the guilt or innocence of a defendant, as that is the duty of the jury or judge (see Finegan, this volume; and Shuy, 1993), in clinical cases, the linguist cannot be concerned with the final diagnosis of a patient. In both cases, it seems to be the linguist's ethical responsibility to carry out the best possible analysis using the available data. In the specific situation regarding nonstandard syntax just discussed, it could be argued that I conceded too much to the clinicians in our ideological tug-of-war and that I am no longer carrying out what I believe the best analysis to be. The current nature of our compromise (which includes a notation at the top of the patient's evaluation form in cases where it seems that dialect or attitude are at work), however, allows me to continue to work with the clinicians towards improving their paradigm. This continued working relationship, albeit not perfect, leaves the door open to a possible paradigm shift down the road; a

breakdown in our working relationship, on the other hand, as a possible result of my being too insistent too early on certain changes could close that door.

Given the situation just described, however, the problem still remains as to how to talk about "normal" behavior, when the variety of such "normal" behavior within the "normal" population is so great for many of the categories included in the performance scale (see Lesser & Milroy, 1993, for an excellent discussion of this problem). Depending on the patient's language use, our discussions have included issues of style shifting, bilingual interference, cross-cultural pragmatics, gender differences in language use, regional variation, and social variation with regard to the categories of prosody/rate, body posture/proxemics, facial expression/affect, lexical selection, syntax, organization, variety of language uses, interruption/turn-taking, listener responses, and sociolinguistic sensitivity. In short, clinicians are faced with having to determine what "normal" turn-taking behavior is, what "normal" topical development is, what "normal" storytelling is, what "normal" eye gaze is, and so forth which, as we know, is a very complicated task. One of the clinicians told me in a conversation which took place two years after I became involved in the project, "This is all very complex. You've been telling us this and we're finally beginning to understand it."

In fact this last quotation reveals the long-term, sustained training efforts which I believe to be fundamental to a linguist's ethical concerns regarding clinical contexts. As I stated at the beginning of this paper, it seems to me that the most sensible way for linguists to attempt to help patients is by helping the clinicians who are responsible for them to understand the role which language, in all its complexities, plays in their work. It is important in this enterprise, however, to keep a keen focus on educating the client. If fascinating research projects are sparked by an attempt to understand some aspect of this complexity, it is crucial for the linguist not to lose sight of the patient. Because, for us as linguists and for the clinicians as well, such complexity can be intriguing and provoke us to undertake more and more sophisticated research; for the patients who are currently being diagnosed and treated for language problems, however, it is a much more immediate and pressing concern. As one patient back for his 12-month evaluation in the Defense Head Injury Project said, "This has ruined my life," referring to the fact that his diagnosis prevented him from returning

to the tank-driving job he had held before his injury and had placed him instead in a much less satisfying (to him) desk job.

Of course, the patient's diagnosis may have been—and probably was—correct. But, knowing what we know about the many problematic points at each of the levels I discuss in this paper—at the levels of the construction of the test battery and its administration in interaction, as well as at the levels of the construction of the performance scale and its administration in the analysis of the patient's discourse—I believe that linguists who know and care about this kind of research owe it to the patient population to get involved with and stay involved with clinicians.

Some guidelines for applying linguistics to the speech-language pathology context

In order for the linguist to be allowed to stay involved with clinicians, of course, it is important for all participants to work towards establishing a healthy working relationship. Based on my experiences, I offer the following modest, common-sense guidelines.

1. Discuss basic assumptions: Early in the professional relationship, exchange basic literature from your respective fields as it relates to the project at hand. Be prepared to discuss this literature and elaborate upon it by avoiding jargon and using real-life examples. Identify the assumptions (explicit or implicit) in the articles about the nature of language, interaction, methodology, and whatever else might be relevant. Discuss these assumptions, identifying related apparent assumptions on the part of the clinicians and being careful to point out similarities and differences between what you assume and what they assume. Try hard not to be judgmental; at this point both sides are learning. If something seems suspicious, odd, or just plain wrong, try to find out more about it by probing in a relatively neutral way.

2. Continue to build up mutual frames of reference and shared knowledge: Both sides should begin in the early meetings by defining terms and concepts in as simple a way as possible, without, of course, being misleading. Build on these simple definitions in subsequent meetings, bringing in more and more sophistication as the data and discussion warrant it. Be persistent in stressing factors which you believe to be of the utmost importance. In my experience, this persistence (if done in a low-key

way) does eventually pay off. Approximately two years after my first meeting with the Walter Reed clinicians, and after relentless emphasis on the importance of context in the analysis of patients' language use in the diagnostic interview, the clinicians decided to initiate a small study using the data from the Defense Head Injury Project. This study will investigate the validity of the assessment of patients' communicative abilities during the diagnostic interview by comparing the ratings made by the diagnosing clinician with those made independently in more informal contexts during the first week of treatment by the therapist. It seems that my point about context had finally been accepted as relevant and potentially important for the clinicians' work.

3. Offer assistance in any area of the project which involves language: Be alert to any opportunity to get in your linguistic "two-cents-worth." As should be clear from the above discussion, such opportunities may occur at the level of choosing or creating a test battery or performance scale (or specific portions of these) or at the levels of the administration of the test battery or the performance scale. Be ready to act as a guinea pig in pilot tests of specific tasks (even of non-linguistic ones, such as the telephone task discussed above) and, importantly, don't be reluctant to discuss the pros and cons of the tasks you just undertook. If you would like your involvement to extend beyond on-site advice, discussion, and analysis to the microanalysis of the data for your own research purposes, be sure to discuss this with the clinicians so that they can begin to work out an agreement with the research staff regarding access to data and the necessary permission by the patients.

4. Suggest ways in which your students may become involved in the project: Setting up a seminar in which students can work with the data in the ongoing project has the potential to benefit all involved. Students have an opportunity to apply what they have been learning about language to a real-life project and to discuss the ups and downs of working in a cross-disciplinary endeavor without having individually to seek access to such a project. You, as the link between the students and the clinicians, have a chance to discuss relevant issues and concerns with other linguists. And, finally, the clinicians have the opportunity to gain new perspectives and insights, including some valuable constructive criticism, into their project.

5. Keep an open mind: It is my experience that, by keeping an open mind and listening critically to what the clinicians say, you will

learn a good deal about why their assumptions and methodologies are as they are. Real-world considerations which enter the discussion may necessitate the revision of a task or instrument, or demand a compromise in order to allow the project to proceed. Demanding that things be carried out in the most linguistically sound way may actually result in your influence being cut off entirely (as was discussed above in the example of nonstandard syntax). In my view, if we are indeed trying to use our linguistic knowledge to help patients (albeit indirectly), keeping communication and influence lines open vis-à-vis the patients' clinicians, even in the face of having to make some concessions, is the ethical choice to make.

6. Voice any ethical concerns you might have: Do not be reluctant to speak up immediately if some aspect of the project strikes you as being potentially unethical from your point of view. If this is done in an non-accusatory way, it is my experience that the clinicians will be more than willing to make sure that the issue is discussed and resolved to everyone's satisfaction. Clinicians have their own code of ethics to guide their work, and will not be willfully acting in disservice of the patients. Of course, should you find yourself in a situation where an ethical issue was not resolved to your satisfaction, it would seem to be an ethical duty to remove yourself from the project, explicitly stating the reasons for doing so. In extreme cases, it would seem warranted to discuss the relevant issues with the clinicians' supervisors and, failing satisfactory resolution there, to bring the issues to the attention of a more neutral body.

7. Be patient: Changing assumptions and learning new definitions, theories, and methodologies takes time. Do not expect others to be convinced immediately that your approach is the one that should be adopted.

8. Retain your outsider status/perspective: Of course, it is important to attempt to learn as much as you can about the assumptions and methodologies subscribed to by the clinicians with whom you are working. But experience has led me to believe that you will continue to be most beneficial to the professional relationship if you keep your linguist identity firmly intact. Your knowledge about the other discipline will help you to design more convincing arguments and fend off additional potential criticism; it will also help you to focus in on the most crucial areas of application. But it is only by continuing to provide information as yet unknown to the clinicians and by continuing to play devil's

advocate that you can help to move the project in the direction in which you believe it should go. It was in this sense that I asked the students in my graduate seminar on discourse in clinical populations to address their final papers to the clinicians, grounding any criticism in and basing any recommendations on sound linguistic/discourse analytical theory and methodology. This instruction allowed the students to make significant, provocative contributions to the Defense Head Injury Project based on what the students knew (discourse analysis, pragmatics, and interactional sociolinguistics) without the students having to pretend that they knew enough about speech-language pathology to criticize the overall framework of the project.

Such cross-disciplinary encounters, which are necessarily part of the application of linguistics, can range from the highly frustrating to the highly gratifying. Whether one finds herself batting her head up against the wall of indifference to linguists' perspectives on language or whether one finds himself in a pleasant learning environment seems to have very much to do with open-mindedness on all sides and a sense of common purpose among all concerned. But, whether frustrating or gratifying, these encounters are characterized by divergent—and sometimes opposing—viewpoints on almost all conceivable levels. This need not be bad. During a recent meeting, after I had offered yet another piece of constructive criticism followed by an apologetic remark, "That's just from my perspective, of course," one of the clinicians commented, "Oh, that's okay, Heidi. We *need* you to be different!"

NOTES

[1] My deepest appreciation and respect go to Ms. Marcia Bond and Dr. Bonnie Podraza of the Walter Reed Army Medical Center for their open minds and collegial spirit which have resulted in a wonderful learning experience for me.

[2] The portion of the overall test battery which focuses on extended discourse comprises approximately 10-15 minutes of the first of two partial days of testing. The discourse section is followed by tests of oral paragraph comprehension, repetition of lexical items and sentences, object naming, animal naming fluency, delayed recall of the oral paragraph, and writing dictated sentences.

[3] The fourteen categories in the January 1991 version of the scale include the following: A) intelligibility, B) prosody/rate, C) body posture/proxemics, D) facial expression/affect, E) lexical selection, F) syntax, G) cohesiveness/organization, H) variety of language uses, I) topic, J) initiation of

conversation, K) repair, L) interruption/turn-taking, M) listening, and N) sociolinguistic sensitivity.

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