

Specialty Recognition in Neurogenic Speech, Language and Cognitive Disorders: Clinical Competence in Aphasia and Apraxia of Speech

Robert T. Wertz

Veterans Administration Medical Center, Martinez, California

The academicians in Plato's grove, after much debate, defined man as a featherless biped. This definition was thought sufficient until a citizen plucked a chicken and threw it over the wall into the grove. Those who make policy about Speech-language Pathology and Audiology in Washington, D.C. defined clinical competence as meeting the requirements for ASHA's Certificate of Clinical Competence. This definition was thought sufficient until Neuropsychology established a telephone number one could call and be informed that a speech-language pathologist could do "cognitive retraining" with traumatically brain damaged patients if the speech-language pathologist worked under the direction of a neuropsychologist. Other incidents such as a publisher refusing to sell the Minnesota Test for Differential Diagnosis of Aphasia (Schuell, 1965) to a speech-language pathologist because the speech-language pathologist was not a neuropsychologist began to get ASHA's attention.

Nothing seems to generate position papers and statements about who is and who is not competent more than a turf war. It also makes us realize we are no longer the youngest profession. Chick LaPointe has observed that speech-language pathology has its roots in the time of Herbert Hoover and Al Capone. Using his political-criminal criteria one can place Neuropsychology's roots in the time of Lyndon Johnson and Charles Manson. But, as Dogberry in Much Ado About Nothing observed, "Comparisons are odorous." This, of course, was a blunder for, "Comparisons are odious." Then, again, it may not have been a blunder at all, but who cares.

Perhaps there are better reasons for considering competence than who has rights to which patients and who should work for whom. And, in all fairness to the ASHA, concern about the competence of its members is not recent or only reactionary. There is a history of ASHA's concern about determining, certifying, and maintaining competence that dates from at least the Highland Park conference in 1963 (ASHA, 1963) and runs through the 1983 National Conference on Undergraduate, Graduate, and Continuing Education (Reese and Snape, 1983). Reading that history, one gets the impression that words can never express what words can never express. Nevertheless, one can try, and I will.

Specifically, I will try to cull a definition of competence, explore what one might want to know and what one might want to be able to do in competently managing aphasic patients and those with apraxia of speech, and discuss the means for determining whether one is or is not competent. Please remember when I say nothing, I don't necessarily mean nothing.

#### A DEFINITION

The word competence seems to have entered English by several roots. One began in Latin, "competentia," and wandered through French, "competence," and meant "agreement." Because there will be little of that in our discussion today, that will be enough etymology. "Competent" in middle English meant "suitable and appropriate" and, for our purposes, seems more suitable and appropriate.

Contemporary definitions must be considered carefully. For example, "competence" meaning a "property or means sufficient for the necessities and conveniences of life" pales when we consider salaries paid to competent aphasiologists. Further, "competence" meaning the "ability of a stream to transport detritus as measured by the size of the largest particle, pebble, or boulder it can move forward" seems more appropriate for discussing competence in Urology than in Aphasiology, unless one considered the ASHA Certificate of Clinical Competence as a catheter for incompetence.

More appropriate for aphasiologists is the definition of "competence" meaning the "state of being functionally adequate." This certainly applies to our more pragmatic peers such as Audrey Holland, Martha Taylor Sarno, Albyn Davis, Jeanne Wilcox, and Marilyn Newhoff. To pacify the more traditionally oriented among us, I would add, "having sufficient knowledge, judgment, skill, or strength," and throw in a "range of ability or capability." I particularly like the "range of ability" part, because while I may not be totally perfect, parts of me are excellent.

So, competence, for the purposes of this paper, becomes "being functionally adequate; having sufficient knowledge, judgment, skill, or strength; and a range of ability or capability to manage patients displaying aphasia or apraxia of speech or both." How does one get this way?

#### ATTAINING COMPETENCE

Bess (1983) suggests that competence requires the synthesis of skill, knowledge, and performance, and competent clinicians have the ability to transform learning into effective and appropriate actions that demonstrate they are competent. This implies that competent clinicians know some stuff and can use what they know to do some things competently. The traditional approach used to know some stuff in Speech-language Pathology is to get a master's degree in Speech-language Pathology. And, the typical approach to using the stuff you know to do something is to spend some time in clinical practice.

The ASHA has prescribed, generally, the stuff one needs to know and how one learns to use it. Meet these requirements and you are certified clinically competent.

How does the ASHA suggest the competent clinician should be built? The requirements for the Certificate of Clinical Competence (CCC) (ASHA, 1982a) specify 60 semester hours, 12 in normal development and use of speech, language, and hearing, and 30 in communication disorders--24 of these in the major professional area, Audiology or Speech Pathology, and six in the minor area; 300 clock hours of supervised clinical practice with individuals who present a variety of communication disorders; nine months of full-time professional experience in the major professional area; passing the National Examination in Speech Pathology or Audiology; and becoming a member of the ASHA.

Do these requirements produce competent clinicians? I don't know, but the evidence suggests they may not. The ASHA Self-Study Project Master Report of Surveys and Discrepancies (1982b) suggests that a lot of clinicians who hold the CCC do not judge themselves competent. To them, I suggest--try to be the best of what you are, even if what you are is no good.

More specifically, do the ASHA CCC requirements produce clinicians competent in managing patients who suffer aphasia or apraxia of speech? There is nothing in the requirements stating that a course in aphasia or apraxia of speech, or clinical experience, supervised clock hours with

aphasic or apraxic patients during the Clinical Fellowship Year is required. The ASHA Self-Study report indicates that less than 50 percent of 597 CCC speech-language pathologists believed they were competent in evaluating motor speech disorders.

Now, there must be several routes that will lead to being competent in managing patients who suffer aphasia or apraxia of speech. Specifying specific course work, clinical practice, etc., as is done in CCC requirements is only one. I know competent clinicians who did not take a course in neuroanatomy in a medical school. I know other competent clinicians who survived a course in neuroanatomy in a medical school. This may indicate that a course in neuroanatomy has nothing to do with achieving competence, and the real measure of competence is being smart enough to avoid a course in neuroanatomy or strong enough to survive a course in neuroanatomy.

Some are competent, perhaps, because they survived their incompetent, prescribed education. Chick LaPointe, Jay Rosenbek, and Peg Lemme are competent in spite of, or perhaps because of, the inadequacy of the early University of Colorado doctoral program. Much of their competence results, I believe, from the necessity of being self-taught. This demonstrates that good people will become competent even when immersed in an academic program designed to meet CCC requirements.

Lisa Graham, a wise Stanford graduate--which is redundant--did not find her way into aphasiology through the typical door. She took a double undergraduate major in Linguistics and French and did a master's degree in Speech-language Pathology. Her course work in aphasia and apraxia of speech, such as it was, occurred before Chick La Pointe arrived at Arizona State University. Yet, Lisa Graham is competent in managing patients who suffer aphasia or apraxia of speech. How do I know? Not because she has a CCC in Speech-Language Pathology. I know because Pat Holtzapple told me Lisa is competent, and Pat is both competent and capable of judging competence in others.

Hildred Schuell was competent in aphasia but not necessarily because of what she studied in graduate school. Her dissertation was on sex differences in stuttering. I suspect she became competent in aphasia by taking 15 years to develop the Minnesota test and spending thousands of hours with aphasic patients. What I really suspect is that Hildred Schuell would have been competent at anything she elected to do.

I guess I am challenging the assumption that the CCC guarantees competence. Certainly, it does not keep someone from being competent, but I wonder whether it is more a statement of what we say we are rather than what we are. There are some things competent clinicians should know and some things they should be able to do, but I am not certain either is required for or measured by the CCC.

#### ASSESSING COMPETENCE

How do you know that someone is competent to manage aphasic and apraxic patients? The traditional yardsticks for measuring competence are the CCC, continuing education, peer review, performance audits, supervisory assessments, and reexamination. And, a new means, specialty certification, is being discussed. Let's consider whether any of these measure competence.

The basic flaw in all of these measures is that they lack validity. Few validation data exist, and those that do are not very good. One way of obtaining validity is to compare a measure with other measures that are known

to be valid. But, when no valid measures exist, it is difficult to make comparisons. Another way to obtain validity is to appeal to authority. In the case of clinical competence, one would observe competent clinicians, list those things that make them competent, and use these to measure competence in others. The problem here, of course, is defining authority--deciding who is, indeed, competent--and being certain the traits listed are, in fact, those things that indicate these folks are competent.

I have suggested that the CCC may be a myth--certified means competent at the time of certification. We may be perpetuating this myth if we assume that continuing education is a means for maintaining competence. The data on the effects of continuing education, most of it from disciplines other than our own, show negative results (Bess, 1983). Voluntary or mandatory continuing education has done very little to right wrongs, change practice, or increase competence. Developing specialty certification seems to be no solution, because most of the questionable means for determining competence in the CCC and through continuing education appear in the proposals to determine competency in specialty areas.

Peer review, performance audits, and supervisory assessments are more appealing measures, especially to the peers who are doing the reviewing, the auditors, and the supervisors. The problems with peer review and supervisory assessment are that the peers and the supervisors must be competent in judging competence. Both of these approaches frequently result in disagreements among the peers and the supervisors doing the reviewing and assessing, and, unfortunately, the methods are sometimes a means for cutting costs disguised as attempts to determine competence.

Reexamination as a means for determining competence assumes that the original examination and the reexamination are valid measures. There are no data that I know of to support this assumption.

So, how does one determine competence? I don't have a solution, but I do have a suggestion. Ray Kent (1983) reminded us that a profession that provides its own research base is more in charge of its own destiny than a profession that doesn't. Much of what we do is designed to determine communicative competence or the lack of it in our patients. Perhaps we should turn a portion of our research efforts on ourselves and develop valid, reliable methods to determine clinical competence. If we cannot, perhaps we should question what we are doing with our patients. But I suspect we can, and I know we must, because the only way we are going to have any influence is to provide data-based answers that refute the answers other groups make up.

#### COMPETENCE IN APHASIA AND APRAXIA OF SPEECH

Everyone here is clinically competent to manage patients who suffer aphasia or apraxia. We demonstrate that by being here. In the time that remains, I will list some traits that I believe certify one is competent to manage aphasic and apraxic patients. Little is original. Some comes from Ken Moll's presentation to the ASHA National Conference (Moll, 1983); some from Alan Rubens' presentation to this conference in 1977 (Rubens, 1977); some from Jeff Metter's letter in Asha and his presentation to this conference last year (Metter, 1985a; Metter, 1985b); some from Jay Rosenbek's challenges for clinical aphasiologists presented to the ASHA language intervention conference in 1983 (Rosenbek, 1983), and a lot from what I have heard many of you say and from what I have seen you do. So, let's unmask some

competent clinicians and see if we can specify about ten things that they know and can do.

First, a competent clinician knows the coherent and current body of knowledge about aphasia and apraxia of speech. If he or she lives in Boston or attends New York University, he or she does not know about apraxia of speech, because it does not exist, and not knowing indicates competence.

Second, a competent clinician has developed the ability and skill needed to add continuously to his or her knowledge of aphasia and apraxia of speech--to learn new things, to evaluate them, and to integrate the useful within existing knowledge.

Third, a competent clinician has developed the ability and skill to apply knowledge in doing something or to refrain from doing something in his or her appraisal, diagnosis, and treatment of aphasia and apraxia of speech.

Fourth, a competent clinician has the ability and skill needed to develop new and variant applications of knowledge when confronted with change in the knowledge or situations that transcend his or her knowledge or experience with aphasia and apraxia of speech.

Fifth, competent clinicians never insult the alligators until they have crossed the river. They know that no principle or technique is true or false until it has been tried. And, the test of truth is a patient's performance. These clinicians have stood in the stream of clinical change long enough to develop Rosenbek's (1979) "wrinkled feet."

Sixth, competent clinicians know that tests do not diagnose; clinicians do.

Seventh, competent clinicians have a purpose, and a purpose can be written down. If it cannot, it is not a purpose.

Eighth, competent clinicians consider context and content. They encourage all efforts that convey, but they seek balance. While pointing to one's ear is seldom requested during a phone call and /p -t -k / is difficult to work into a conversation, responding "mondorf" doesn't work if your name is Harold.

Ninth, competent clinicians know that all patients do not need treatment, want it, or should have it. When they elect to treat, they realize that treatment has an end, and this should be considered before treatment begins.

Tenth, a competent clinician is his or her own inventory. He or she does not need the latest test or treatment program. He or she may evaluate these and then elect to use them. But, they are not needed. Competent clinicians know that if you are constantly changing the outside, you mess up the inside.

Enough! The list could go on, and I am sure it will during the discussion session. Wendell Johnson observed that one can talk and talk and one will never say more than he or she knows. And, I have talked and talked and said all I know, except, maybe, one thing. It's a guess. Perhaps the best measure of a competent clinician is that he or she seeks competence as much for what it demands as for what it promises.

#### REFERENCES

- American Speech-Language-Hearing Association Requirements for the Certificates of Clinical Competence. Rockville, MD: ASHA, 1982a.
- American Speech-Language-Hearing Association Professional Self-Study Project Master Report of Surveys and Discrepancies. Rockville, MD: ASHA, 1982b.

- American Speech-Language-Hearing Association Graduate Education in Speech Pathology and Audiology (Report of a National Conference). Washington, DC: ASHA, 1963.
- Bess, J.C. Issue VIII: Continuing education. In N.S. Reese and T.L. Snape (Eds.), Proceedings of the 1983 National Conference on Undergraduate, Graduate, and Continuing Education, ASHA Reports, Number 13. Rockville, MD: ASHA, 66-75, 1983.
- Kent, R.D. Issue IX: Role of research. In N.S. Reese and T.L. Snape (Eds.), Proceedings of the 1983 National Conference on Undergraduate, Graduate, and Continuing Education, ASHA Reports, Number 13. Rockville, MD: ASHA, 76-86, 1983.
- Metter, E.J. Feature. Asha, 27, 43, 1985a.
- Metter, E.J. Speech Pathology--The physician's perspective. In R.H. Brookshire (Ed.), Clinical Aphasiology, Volume 15, 1985. Minneapolis, MN: BRK Publishers, 22-28, 1985b.
- Moll, K. Issue II: Graduate education. In N.W. Reese and T.L. Snape (Eds.), Proceedings of the 1983 National Conference on Undergraduate, Graduate, and Continuing Education, ASHA Reports, Number 13. Rockville, MD: ASHA, 25-37, 1983.
- Reese, N.S. and Snape, T.L. (Eds.), Proceedings of the 1983 National Conference on Undergraduate, Graduate, and Continuing Education, ASHA Reports, Number 13. Rockville, MD: ASHA, 1983.
- Rosenbek, J.C. Some challenges for clinical aphasiologists. In J. Miller, D.E. Yoder and R. Schiefelbusch (Eds.), Contemporary Issues in Language Intervention, ASHA Reports, Number 12. Rockville, MD: ASHA, 317-325, 1983.
- Rosenbek, J.C. Wrinkled feet. In R.H. Brookshire (Ed.), Clinical Aphasiology: Conference Proceedings, 1979. Minneapolis, MN: BRK Publishers, 163-176, 1979.
- Rubens, A.B. What the neurologist expects from the clinical aphasiologist. In R.H. Brookshire (Ed.), Clinical Aphasiology: Conference Proceedings, 1977. Minneapolis, MN: BRK Publishers, 1-4, 1977.
- Schuell, H. The Minnesota Test for Differential Diagnosis of Aphasia. Minneapolis, MN: University of Minnesota Press, 1965.