An interview with John H. Gilbert

Vancouver — *From the highway, trees and a mist of rain almost hide the glassed and multi-colored walls that contain the Division of Audiology and Speech Pathology Services at the University of British Columbia. Once inside, in a sleeky modern but comfortable office, the Editor of* Human Communication *talked to* **John H. Gilbert** *about his personal and professional opinions. Dr. Gilbert is Chairman of the Division, and is (at once) speech pathologist, audiologist, teacher, researcher, and author. His views are often unorthodox, and are usually expressed with a forcefulness that masks his willingness to "sit down and reason together" with those he most gleefully scolds.*

Human Communication **Your program has been described as unorthodox; no practicum courses are offered, and yet you train students as clinical speech pathologists. Is that an accurate report?**

Gilbert That is a surface-structured question, and there are some deep-structured questions that the university program and the professional have to answer. What is the pattern of health care going to be in 1984? What are we going to do for the patient in 1984 that we can't do now?

Everything I am going to tell you has been fully discussed by everybody here, including the students. We have complete parity. We have no secrets about what the problems are in this program. Everybody knows the financial matters; they all know about promotion matters; they all know who is on top money and who is not. We have complete parity. Everything is hashed and re-hashed time after time. We eat together; we have parties. We have essentially done away with role playing. I don't see any reason to play some stupid game, just because I have a Ph.D. So we don't have my secretary sitting in the next office, because she is not my secretary. She is secretary for the whole division.

Now we are trying a new experiment. We are going to have two part-time people. We have this feeling that one of the ways of encouraging part-time work in the profession is for us to lead the way and offer part-time work here. So anything that I say here has been hashed out.

Does that mean there is no leader?

We try not to have any leader, except between myself and administration — myself and government. It is always a group decision. If our decision has to be changed when meeting on the university or provincial level, then I say that I would like time to discuss it first with the group. But, to get back to my original point, "What is going to be the pattern in 1984?" I think the majority of the profession in this country, if they know anything about the B.C. program, are not aware of the fact that I have clinical certification both in speech pathology and audiology, that I have an LCST, that I have a Diploma in Phonetics, that I worked in clinical situations for years, and I still do clinical work, in addition to research. In trying to answer this question, "What do we do in 1984?" we come to another question, and that is, if we are looking for a "how" answer, we must ask the question, "Why?" "Why" are we worried about people with communication disorders at all? And, if we are worried about them, "why" do these people have communication disorders?

One of my chief criticisms of most of the American schools is that they ask the question "how" before they ask "why?"

Is this true of the Canadian or English training institutions?

I don't think this is so true of the English training institutions. We were led through this question of "why" we are looking at these problems. I get angry with method-oriented programs; I don't believe in method that much. I believe in people. If it is the person we are interested in, then we are interested in the mechanics of the person. Speech pathology and audiology is three things as far as I am concered: speech, language, and hearing. It's speech as exemplified in phonetic chronological structure. It's concerned with language, syntax, and semantics; it's concerned with hearing as exemplified by applied acoustics, acoustic physiology. The various areas like cleft palate, for instance (which in the ultimate is an articulatory problem, but primar-

ily, it's a surgical problem), cerebral palsy, mental retardation ... these are very interesting areas, things about which one should know something.

But when students in this program write a report, I want them to tell the physician, the public health nurse, the teacher, about speech, language, and hearing. I don't want them to get bogged down in three pages of developmental history. I don't want them to tell about the psycho-social aspects, except as it relates directly to the speech functioning. I don't want some story about marriage counselling, which, I don't think, has anything to do with speech and hearing. I want them to know the phonetic structure of this kid's speech, how it relates to the normal. Does this kid have a problem because of some phonetic problem? some phonological problem? some syntactical problem? If so, describe it. Draw me a "tree" diagram in your case report. Show me where the breakdown is with the kid producing noun phrases, verb phrases. Is he doing it at the regular level? If it is a kid with an auditory problem, I want to know what kind of testing you are doing, why you are doing the testing in that way, what kind of observations do you make about the test results. Don't give me some notions that are rampant with medical terminology for a kid with a middle ear problem. You generally can't do anything about it anyway, except to demonstrate that the kid has a middle ear problem. The physician is ultimately going to have to do something about that.

I don't know what it is like in Alberta, but it is really bad here, or was. I think that in 1984, we will need the clinician who has excellent background in speech, language, and hearing. There is not time anymore to get concerned with external problems that are not directly related to the communication functioning of that individual. My observation is that when you get into other areas about which you are uncertain, that's when you talk in generalities.

Can you give us some examples of those areas? Are you implying that an audiologist using an impedance bridge shouldn't suggest the source of the problem?

I think that he should. We have to get over this idea that the audiologist doesn't tell the physician about the site of the lesion. I am quite prepared to go in and look at a kid who has a dysarthria, and say where

the site of the lesion is for speech. I have no qualms about doing that. That's my job. Otherwise, following the diagnosis, how can I say what kind of a program this child should have. I've got to be able to say, "It's no use working on a cerebral palsied child. I think we would be wasting time, because it involves dysarthria, and dysarthria affects both sides of the tongue." But there are a lot of speech pathologists who spend their time feeding, giving breathing exercises. That's a physiotherapist's job. Get where the action is. There would be half as many problems if we could honestly say it does not work with these types of patients. Or if we say, the kid fits into normal development right here, but you can only say this if you know what is coming out of the language acquisition and acoustical work.

So the misconceptions about our program being research oriented are the misconceptions that I suppose I led people to when I have said we are interested in research. We believe that the link between good health care is what we find in the lab today. We've got to get the answer tomorrow, not in twenty years' time, not fifteen years' time, not even next year.

Your students do see patients?

They have the longest internship of anybody in this country. We send them out in April, and we don't see them until August. Four and a half months straight. If you read the Quirk report of speech therapy services in England, the recommendation is that England is going on the block method of clinical training. When this program started four years ago, we said that's the way we are going to train the students.

Who are their supervisors?

People who usually have master's degrees. They are in various community agencies.

Do the students have any clinical practicum under the University staff before they go out?

No. Let me qualify that. Everything has to be based on the normal. So, the first term we introduce the normal child. We send them into the Day Care Centre on campus. For their second term, they start observing in my clinic downstairs; then they go to another clinic in the community and observe. Maybe towards the end of the second term, they get to work. We try not to get them working until the summer, then, hope-

fully, they've got all the basics from their courses.

Is it up to the clinical supervisors to teach the students how to do treatment?

To demonstrate the methodology. We hope there will be a kind of cross-verbalization, that the students can demonstrate to the therapists some new things, and the therapists by the dint of their experience, can do the same thing back. Over that four and a half month period the methodology comes by practicing it, not by sitting in the classroom and having someone go through step one, step two, step three on the board. That is a useless way of teaching.

Are these supervisors paid?

It is the University's responsibility to pay clinical supervisors, and pay more than a token honorarium, because it does require a lot of work.

Are the students paid?

No. Practically all of our students have grants. Of the 12 students here at the moment, eight have 12-month Medical Research Council studentships.

You implied that not all supervisors hold their master's.

They all do at the moment. We are considering using other kinds; we may have to.

Do you think it is preferable that the supervisor has a master's degree?

Oh, I don't know. I have had a lot a late nights thinking about this master's and bachelor's. I don't know whether it is realistic anymore to say that everybody should have a master's degree. There are so many kids not coming to university to begin with, and we give our kids 25 hours in class in their first term and 24 class hours in their second term. Then they go out for four and a half months work, and by their second year they are pretty tired. I don't know how realistic it is to try to do it in two years post-bachelor's. The profession is going to have to think about this. I think, at the moment, that it is the preferable way because, as Dan Ling at McGill University says, it allows us to get the really good people. McGill gets excellent students; and we get excellent students. We can take the best people, and if you take good people, you have a much easier job training them. If you take students who have a B+ average, and we couldn't take them in this program anyway, because they'd be too low, they are going to look for method, they are going to

look for "how" all the time; they've got to be led. I don't want to lead people by the nose.

You think that the master's alone is preferable to a combined bachelor's and master's?

I think that the master's degree is the way to do it. All of us feel that the students should come with a good solid academic background, but with no preset ideas about what speech pathology and audiology is.

Your calendar suggests a psychology background.

Psychology or linguistics.

If they have a speech pathology bachelor's?

We don't take students who have already been through a program. If you take four years of a student's life and spend that time training him to be a professional, why the hell does he need another two years? What the hell is he going to do in a master's program?

Are you saying that a four year undergraduate program could accomplish the same as your two years master's?

If it is a well-structured program. The problem is that the majority of undergraduate programs are not well structured.

If they follow the ASHA certification requirements?

Oh bull! Who's ever shown that 350 clock hours of supervised clinical practicum is any better than 100 hours? Those are arbitrarily drawn figures. Nobody has demonstrated conclusively that hours bear any resemblance to clinical proficiency. Teachers are what are necessary. Good clinical teachers. A good clinical teacher can teach more in four hours than a poor clinical teacher can teach in 32.

Do you have good clinical teachers?

We do now. We have people who are really "on the ball." I enjoy teaching. I like going downstairs to the clinic to work with a child, with a parent, with a student sitting around me. A very close situation. And then getting up, going to a blackboard and saying to the student, "What about this? ... What about this?" Going through a logical evaluative procedure. Let the parents sit there and listen to what goes on.

You do have a functioning clinic?

Yes, a half-day clinic once a week. We can't afford to staff any more time.

Is this an audiology clinic as well?

Just speech pathology.

Do you offer audiology training?

Sure. Audiology is done at the General Hospital and at the Western Institute for the Deaf. We would like to have a demonstration audiology clinic, and I'm sure we will, but since we are working with children, and any kind of puretone testing with children is useless until about four and one half years of age, we don't really have that problem. Our kids come in quite young. We can demonstrate whether a kid is hard of hearing or deaf in a free-field situation.

What happens to your students? Do they all go on for their PhD?

No, none of our students have gone on for a PhD. All of our students are working in clinics. They are all clinical people, and they're bloody good clinical people.

You have English and American training in your background. Is that combination reflected in your programs?

My clinical bias comes from the tremendous amount of clinical exposure I had as an LCST student. There is no doubt that whatever is wrong with the LCST, there are some very good things about it. One of them is that you get good clinical exposure. It is often boasted abroad that the LCST is a much better clinician than the American. I don't think that is necessarily true. But they do get a lot more clinical exposure. They see a lot more different kinds of cases or patients than do North American trained people. I saw cleft palate operations, worked with adult aphasics, worked with voice cases. I worked with the cerebral palsied, and I worked with multiple language problems, all in my undergraduate years. We try to get that kind of thing for our students. Give them maximal exposure to everything.

You are talking about quantity now?

No, I'm talking about quality. Also, we have very good courses in neuro-anatomy, in psychiatry, and in phonetics. I think my North American training demonstrated to me, by default rather than by action, the necessity for very closely integrated courses. There were just so many "Mickey Mouse" courses. Incredibly Mickey Mouse.

Do all of your people take the same courses rather than emphasizing a special area of study?

They all take the same eight courses.

So a graduate from UBC can function as a speech pathologist or audiologist?

Yes.

Or language pathologist?

Well, I don't know what you mean by language pathologist, but I don't know what you mean by speech pathologist anyway. It is hard to define. What is a speech pathologist? An applied linguist. Speech pathology is applied linguistics, plus a very important component, something called client-patient relationship. I don't look at our graduate as a teacher in the sense of a public school speech therapist. I don't buy that notion. I think that there is a mutual respect, a growth together of the patient and the therapist during a course of treatment, and I don't think that it is just a teaching process. I think there is a clinical art. It is an art that is a bit like painting or writing poetry. A good painter learns method; he learns about colors; how to mix them. He learns about brush strokes. He practices until he produces, but he never produces a perfect painting. That is what I am trying to get across to my clinical section; we keep practicing. We'll read something, and we'll want to put it into use. It's like finding new color. You just keep practicing, and that develops the refined art, the clinical seal for putting these things together. I don't think that's teaching per se. That's a special relationship that exists.

You don't think it is para-education?

No, I don't think it is para-anything. Christ, I get so sick of people asking, "are we para-?" Is this the educational model, whatever the hell that is? Is it the medical model? Is it the research model? Why can't we forget about models? Why can't we just remember about people? If we forget people, then this profession is lost. We'll get rampant professionalism. And that's what happens with professions that erect this little theory, and that little theory and this little model and that little model, and then they ask, "What do I have to do to fit things into the model? X hours of this and X hours of that?" And once you start the numbers game, you forget about people. I get pretty mad about it sometimes when people say, "All you do is research." What I do is try to make things better for the person with a problem which interferes with the most important thing that man has — speech and language.

That's what separates the man from the ape. The rest is only incidental. Being here, doing research; that's incidental but terribly important, because I can't help that person unless I know that information.

Is the fact that you are located in a medical school good, bad, or immaterial?

It doesn't matter where the hell you work; it's who you've got working with you that's important. We could be in a grocery store. If you've got the group together, and they know their goals and can articulate them, that's what is important. It's the spirit of the group, the philosophy of the group, not where you are. A lot of people think we should be in an education department. But we would have to think about getting certified. It's important, sure I want to protect the public, but not for some rinky dink piece of paper to hang on the wall that says I'm certified as a speech pathologist.

Do you think certification is important to speech pathology?

Registration and licensing is a critical issue. I have no way of demonstrating that my students are any better than anybody else's. There is no way of demonstrating that they are any good, period.

Do you see this coming through the Canadian Speech and Hearing Association?

No, I think it will come at the provincial level. We could have a national set of criteria, but we are not going to get any criteria until we define what is speech pathology. What is audiology. In any university program, we have two problems. We are responsible to the academic community and to the community at large for maintaining a standard of excellence. We are also responsible to our professional colleagues to make sure that our students are well trained. We've had our problems, and we will always have problems. We, as professionals, have to define ourselves in our role and set up a curriculum, a syllabus, that describes us as a speech pathologist and audiologist, which can be taken to some examining body established outside the university, and our students can be examined on that curriculum. The professional associations then, are not telling me how to run the university program; they are allowing me flexibility. The way we proposed it in this province was to have a licensing act which would establish a board of seven people, four of whom would be nominated and elected by the professional

association, and three would be selected by the Lieutenant-Governor in Council. The chairman would be one of the four elected by the membership, and the board would have an examining committee. The committee would establish an examination in conjunction with, and in cooperation with, the association. It would draw up a curriculum; it would draw up the outline and how the examination should be administered.

Would everyone who wanted to practice in British Columbia be required to pass the examination?

They could have a temporary license for a year, and at the end of the year, take the examination. It wouldn't be some pencil and paper examination entirely. We'd try to use such things as video-tape examinations; maybe some kind of practical. The profession has to say what level is to be reached. It can't by saying that you have to have 22 hours of this and 33 hours of that, because you immediately lock me into some system that I or the University may not agree with. My criticism of the American association is that flexibility is not built into their requirements. You have to have a bit of this and a bit of that in terms of hours. You can't specify hours.

Will licensing pass in the form you've outlined?

Oh, I don't know. I am chairman of a government committee that has just been established, in fact, and I'm going to report to CSHA on this. The government committee is to examine, report, and make recommendations by August on services for the communicatively impaired in British Columbia. We are going to come up with a report which will make recommendations about licensing.

Is the committee going to recommend a specific degree?

That's up to the association.

Are you going to suggest that they do so?

Well, we're into the same problems as everybody else, including the sub-professional, and I don't know what the association will propose. I certainly believe that we need a reasonable number of highly-trained people. Our province needs 350 or 400 master's level people to cover the population.

There are two million or so people living here. If we go on the estimate of one speech pathologist to ten thousand population, and one

to ten thousand for audiology, we end up with 350 to 400 people. At the present time, our population is growing at about four and one half per cent; it'll tail off a bit in the next couple of years. We are talking ultimately about 500 people, and what these people should be, of course, is going to depend on what the committee recommends.

I'd like to see the committee recommend that they are trained at the master's level. I think they will have to be examined and certified by the board. They may be able to do that without any training at all, although there will have to be a minimal requirement for taking the examination, I suspect.

Do you think there is a place for a sub-professional?

I have great qualms about health care costs. There are two areas that the profession has not seriously looked at. We have to seriously examine man and machine interactions, because that might be very cost-saving in terms of people. We need to develop behavior mod programs that you can turn on and let the patient go at it, a self-correcting kind of thing. The other area we neglect is the training of elementary education teachers to teach normal voice, speech, language skills, and just do articulation skills with the first, second, and third grades. I think that would eradicate perhaps 90 percent of the problems that appear in public schools. What I would like to see come out of my recommendations on the health committee is that during a two-month period in elementary school training, the teachers get to learn normal voice and speech skills so that when they get into the classroom, it becomes a mandatory part of the day like reading the Bible, or "show and tell." Christ, most kids with speech problems never get that in a speech clinic. If they got it every day in the classroom with all the rest of the kids, they wouldn't be "different." That is the second alternative we should look at before starting to jump in and train another 250 people, because the implications of training sub-professionals at a time when our profession is very small in this province — only 79 people — are enormous. You could have a community college program which enrolls 20 people in each of two years, and in no time flat, there will be 200 people with two years training out there in the field doing what? Supervised by whom?

What is the major weakness in your program?

Money.

The money comes from the federal government?

From many different sources, and we hope that the majority will come from the provincial government. That's the real bug all the time. We have no problems with students. We get excellent students. Our research is well known, and we have very good contacts all over the place; no problem there. The most difficult area in any program can be the clinical problem. Some programs have to send kids here to get clinical training and that's crazy. How can you supervise? How do you know what they're doing? Like I can have a beer session every two weeks with the students just to talk about what they're doing. No, the money is the weakness. It leaves us in a very tenuous position all the time.

Is most of the program on "soft" money?

One hundred and twenty thousand dollars on the budget last year; fourteen thousand comes from the University; the rest had to be raised from other sources.

What is the reason that the University doesn't support the program to a greater extent?

Budget. There's not enough money. Like, we are in the Faculty of Medicine, and we don't train medical students; so our priority in Medicine has been pretty low until this year. This year, we got top priority because I have to go on the budget, so what they do is give half the increase to my salaries. This year the Faculty of Medicine got $30,000 for new programs to bring in new people. Chicken feed! You can't do anything with $30,000. They will give everybody an increase; over and above that, we only have $30,000. So this year we have that much priority, but we can't expect that next year. We couldn't expect it wherever we worked.

Is your faculty involved in clinical work?

Joyce Edwards is our clinical co-ordinator. She's at the hospital, and she is not directly involved in patient contact, although we are hoping that we will have an audiology clinic. The rest, no. The academic faculty are not clinicians because we are all different, you see. John De Lac is a linguist, Gregg Pierre Vengrell is a communication scientist, Don Greenwood is a psychologist, Joyce is an audiologist, and I'm a phoneticist more than anything now, but I still reckon to be a clinician.

You don't hire staff on the basis of someone who is "knowledgeable" in aphasia, in stuttering, and so on?

Why would you do that?

Don't most universities?

Yes, but why? I teach a course called "Neurology and Language." Now that is more of an aphasia, and I wouldn't hire somebody just to teach a course in aphasia. They've got to know about speech; they've got to know linguistics. My specialty is speech perception, particularly language acquisition, and so I teach perception, speech perception. I wouldn't hire someone just for stuttering. What can you teach about stuttering? I'm a heretic on this.

But do you get into stuttering in any of the courses?

Yes, I have a speech pathology course, and we go through the routine so-called clinical problems. We start with voice, because it locks in with discussions we are having in speech perception and laryngeal mechanisms, so things begin to tie in much easier. We talk about voice and I tell them there's not much you can do about it. Most of them have physiological problems that the physician has to cure.

You don't teach syndromes per se, then? You teach aspects?

I teach the theory of production. I suppose I teach syndromes. I mention them in passing but, if I were talking about voice, I talk about "why is it like it is?" A physician can see down the tube if he is any good, you know; looking in a laryngeal mirror he can see if there are polyps. What he wants to know, and what the patient wants to know, is what difference does that make to the acoustical characteristics in the vocal tract? Why the hell does his voice sound funny? If you take them off, what will happen? If you are going to change the acoustic output, what is output going to be like? That's all you can tell him. You can't tell him anymore. Now, you can do some fancy relaxation exercises. Bull! If the guy has polyps on his vocal folds for hypertension or whatever, he shouldn't be seeing a speech pathologist. He should be talking to a psychotherapeutic counsellor about his worries. That's not what I'm teaching. I can't teach psychiatry.

Would your students work with a contact ulcer case?

I don't know. Probably they would, but I hope they'll ask what are the practical reasons for not doing speech pathology with this kind of

problem.

You work in a clinic, you recently published a book, and you're writing another one. Do you have any time for teaching?

What do you mean, do I have any time for teaching? I taught 16 hours this week. On an average, I'm in the classroom nine hours a term. That's not to say how much time I spend sitting here shooting the breeze with the students.

And you're Chairman of the department?

I'm Chairman of the department. And I cook, and I take photographs, and I walk on the beach.

You teach more hours than a person generally would, even without being chairman?

People do what they want to do. It's the kind of life I want to lead. I'm an academic, really, and I love teaching. I love doing. I go home at 11:15 at night, and I'm exhausted, but I'm happy. I'm happy because I think finally I'm getting some of the answers. I have a picture of the children I had when I was at Moorhouse School. I had a group of ten children, and that sticks with me, that and some aphasics I had when I was an undergraduate in the Medical Rehabilitation Centre in London with Edna Butfield. She was my supervisor. Remarkable woman! And I think we are getting there. It's a long road, and hopefully, things are changing.

What problems do you see facing the profession in Canada?

The problem of definition. Who are we, and what are we, and why are we? We've got to answer those questions, and until we do, talking about licensing and how many more programs should we have is so much whistling in the wind. I don't think this country needs any more programs. God forbid! If we all started producing at maximum in two years time, which we'll be doing, we'll be turning people out at the rate of over 200 a year.

Seven and one half thousand graduates are being produced this year in the United States. With about one-tenth the population here, Canada will graduate about 94 people. Does that mean the United States is over producing or Canada is underproducing?

Over producing. That's my definition. It may not be yours; it may not be the rest of the profession's, and so we have to come to some

agreement on what the definition is. And I think we have to do that before I could honestly say to any province, set up a program. Manitoba came here some months ago; we were talking about it. I can't see how economically they could set up a program in Manitoba. I don't think it would be justified at the present time, until we get some clear cut consensus on what it is we are asking. We can only do this on a provincial level though, at the moment.

You are suggesting that what one person may feel is within the realm of the speech pathologist to work with, you may not; consequently, they may feel many more professionals are needed than you would.

Yes. And we have to reach that middle ground. At one time I was very rigid. But now, as I'm getting older, hopefully I'm learning that people have different views, and they should have different views. That's what makes life a rich experience. The thing is getting a consensus, coming towards the center and saying, "Okay, we can't make this extreme happy, and we can't make that extreme happy, but we can accommodate the majority." Definition is important, because it leads to everything else; the economic wherewithall of the field, the number of students that need to be trained, the kind of service which is given, how it should be given, where it should be given. All those things are dependent on saying who we are, what we are, why we are. We talk about it in our association. We have some horrendous meetings that bring on a lot of argument. If we can get the definition of what the field is going to be, rather than what it was, or is actually today, then I think we are halfway towards solving some of the other problems. The word "vocation" was once upon a time very respectable, but then we got into the era of relativism, and so the respectability of vocation became tarnished, and nobody ever spoke about it anymore. I think we lost sight of that because of professionalism, rampant professionalism. Fiddling around with people's emotions is kind of a real danger in graduate and undergraduate programs.

What do you mean by "fiddling around with people's emotions?"

Teaching a little bit of this and a little bit of that. Churning someone out and saying, "Now you're qualified to work with ... whatever." That's tinkering; that's not really getting down to the problems. And the reason that I circumscribe speech, language, and hearing is that I

recognize, and I think that the majority recognize, that we are never ever going to be able to do psychotherapy. We don't have time for that. We don't give the background for that, so we should not "monkey around." Let's not play the tune on somebody's emotional xylophone imagining that we are doing something. Dishonesty that prevails in the professionals is apparent to a lot of people. When we don't say, "Well, I can't help it," but rather, "Well, I may be able to help it." And that worries me. It worries me that this idea of professionalism has really killed vocation as an idea, as an ideal, and we've got bound up with salary scales which are important. I would never disagree that the helping professions have to gear up to fight medicine, and so on and so forth, for a better piece of being alive. But I think in doing so, we lost a little bit of magic and we should try to get that back; that little bit of something that has to do with that Moorhouse kid and me.

If you don't have that, if you don't work with children, if you don't work with adults, if you're not in that thing, you can't talk about it, so that you fire up other students. Instead, you only teach them, or educate them. I don't like teaching in that sense of the word. I like to feel that you are being educated and I'm part of the catalyst in the educational program.