

**A POINT OF VIEW  
ABOUT  
"COMPETENCY-BASED CERTIFICATION OR LICENSURE  
IN  
SPEECH PATHOLOGY AND AUDIOLOGY**

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In recent years a great deal of criticism has been levelled at licensure and/or certification requirements. Specifically criticized are those statements of the types and levels of academic degree, diploma or certificate required, fortified with an enumeration of the kinds and numbers and courses and supervised clinical hours to be taken during training. Generally speaking, the critics of such requirements point out the following weaknesses:

1. There is a great deal of "unevenness" between programmes with regard to the quality, quantity and content of the training. The result is that individuals from different institutions both possess the "same" degree and can demonstrate they had had the "same" courses and the "same" number of hours of supervised clinical practice, but that in no way insures equality of training.

2. Even if the above disparities could be "evened" out, this would only supply evidence of equal **academic** training which may or may not be correlated with clinical competence. In other words, while it is probably a more than reasonably safe assumption that clinically competent people will also be academically competent, it is unreasonable to assume the reverse.

The inevitable conclusion is that while licensure or certification requirements might be partially based on academic achievement ("... shall hold a degree, diploma, or certificate from a recognized training programme"), the preponderance of requirements should be based upon the candidate's successful demonstration of clinical competence. If this state of affairs could be brought about successfully, it would have the salutary side benefit of allowing training programmes to be more innovative and creative in the training process. In other words, the "proof of the pudding" of training programmes would **not** be the number of credit hours of "this or that" required of students, but rather whether or not the students could demonstrate their clinical competency upon completion of the programme and prior to being allowed to practice. Thus, each training programme's guiding philosophy could be followed to any limits desired with the possibility that eventually the programmes that consistently produced students with the highest degree of clinical competency would accrue a measure of validity to their philosophy. For example, assuming that 90% of university X's 3-year undergraduate diploma students consistently passed with high scores on a clinical competency examination, whereas, only 60% of university Y's 2-year Masters Degree candidates passed and had relatively low scores on the same examination, or **vice versa**, this information **should** constitute valuable data. Careful and objective analysis of various patterns would be valuable for all training programmes and for hiring agencies.

It should be obvious that the secret of success of "competency-based" certification or licensure is the ability to successfully develop the necessary measuring tools. Simply stated, the question to be answered is: How does one measure clinical competency in a **uniform** and **efficient** manner? This question, of course, raises

others. Can a "paper and pencil" test be devised which can reliably predict clinical performance? Will it be necessary for all candidates to demonstrate their capabilities *in vivo*? Since there are different philosophical "camps" with regard to appropriate clinical approaches and even as to what constitutes a successful clinical out-come for specific problems (eg., stuttering), the question of **who** will determine what is clinically acceptable becomes important. Is it possible to develop "tests of competency as you go" guidelines wherein training programmes could apply standardized tests of competency directly to their own students after the students complete uniformly agreed upon "content experiences" (not prescribed hours of credits of this or that)? Let us use this latter question as a suggestion. Suppose we could get all training programmes to agree that a competent clinician should know how to give, and adequately interpret, at least three "recognized" aphasia tests. Then, when the faculty of any training programme felt, by what ever training process is used, that their students should be competent in aphasia evaluations, a faculty member could administer a standardized examination, perhaps provided by CSHA or some other outside body, designed to determine if at least three tests were properly given and interpreted. Likewise, in some sequential manner (sequences to be determined by the training programme) students' competencies could be measured with a variety of evaluation and therapeutic tools for a variety of disorders. Ostensibly, upon graduation from a training programme, using this scheme, students could receive their diploma or degree in one hand and their certificate of clinical competence (or possibly a certificate allowing entry into an intership programme if that became an additional licensure requirement) in the other hand.

My own view is one that favours the pursuit of uniformly agreed upon curricular "content experiences" and competency-based certification and/or licensure regardless of the type and level of degree or diploma offered, such latter decisions being entirely within the province of the individual training programmes. However, if this state of affairs ever occurs, it will likely be many years down the road for obvious logistic reasons. In the meantime, it is likely that the minimum requirements for membership in CSHA (as stated in Article III, Section I; subsection D-ii of the by-laws) will continue to be thought of as the minimum **academic** requirements to be met before clinical practice. While most of the objections raised in the criticism paragraphs above are still valid, with regard to these requirements they, at least, do not specify the type and level of academic credential and are thus somewhat more liberal than the corresponding sections of the American Speech and Hearing Association by-laws. Also at least some degree of uniformity exists with regard to quantity, if not quality, of training. Finally is the matter of the alternatives which appear to be either no requirements at all, or scores of regionally different requirements. Potential reasons for rejecting these alternative revolve around whether or not our patients deserve the absence of **any** standards of practice at all and whether or not we feel that they do deserve at least a modicum of uniformity in the standards that **do** exist. There is also a more self serving, but never the less important, reason which relates to our professional image. Even if the uniformity in CSHA by-laws is more apparent that real, at the very least it provides **some sort** of definition of who we are as professionals. Actual definitions will only come about through uniform legislation at a national level and this eventuality is many years down the road.

An effort to start taking steps down the road referred to above is provided below and is an attempt to somewhat codify what might constitute a measure of "clinical

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competency" in the area of diagnosis. It should be noted that many other tools will have to be developed in order to sample a wide variety of therapeutic competencies. Please also note that this initial effort, directed only at general diagnosis, is one which should be conceived of as merely something to respond to. Undoubtedly, this tool will require additions, subtractions and other forms of honing before being considered adequate.

### Clinical Competency In General Diagnosis

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Examiners are to use this tool to measure a student clinician's performance on diagnostic evaluations. Each sub-item would be scored on a 1 to 5 scale where: 1 = totally inadequate, 2 = basely adequate, 3 = adequate, 4 = superior, and 5 = excellent. All scores totalled and divided by the total number of items would have to produce a value of 3.0 in order to define the lower limits of clinical competency. It should be noted that if any item was scored N/A (not applicable), this item should not be included in the denominator of the formula above. For example, in item C under Evaluation Plan, N/A would be marked if there were no pre-diagnostic data available.

#### I. Evaluation Plan:

Circle One

- A) Did plan specify measuring tools of processes and equipment to be used? ..... 1 2 3 4 5 N/A
- B) Did plan take into account the age of the client and the category (fluency, articulation, language, etc.) of the presenting complaint? ..... 1 2 3 4 5 N/A
- C) Did the plan reflect knowledge of any pre-diagnostic data (reports from prior evaluations, reports of other specialists, intake forms, pre-filled out history or information forms, etc)? ..... 1 2 3 4 5 N/A
- D) Did plan have contingency statements, ie., specification of alternate tools and methods if the ones selected were inappropriate, the client was uncooperative, etc.? ..... 1 2 3 4 5 N/A
- E) Was the plan realistic in terms of time allocated? ..... 1 2 3 4 5 N/A

#### II. Evaluation Performance:

- A) Did clinician follow plan? ..... 1 2 3 4 5 N/A
- B) If contingency plans were needed, were they properly anticipated? 1 2 3 4 5 N/A
- C) Were standardized tools administered in appropriate or prescribed manners? ..... 1 2 3 4 5 N/A
- D) Was the evaluation done in a manner consonant with the patient's age, sex, intellectual capacity, and motor abilities? ..... 1 2 3 4 5 N/A
- E) Were accurate records kept of diagnostic results? ..... 1 2 3 4 5 N/A
- F) Was the evaluation conducted in a logical, sequential manner with equipment and tools readily available? ..... 1 2 3 4 5 N/A

III. Interpretation and Report:

- A) Did clinician organize results in a manner of which would allow for recognition of differential diagnostic patterns? ..... 1 2 3 4 5 N/A
- B) Where norms and standards were provided for tools, did clinician use them (even if only for broad guidelines)? ..... 1 2 3 4 5 N/A
- C) Did clinician report facts rather than conclusions in the body of the report ("the patient exhibited constant extraneous movements versus "the patient was very nervous")? ..... 1 2 3 4 5 N/A
- D) Were diagnostic impressions or statements consonant with the pattern of results **and** with what is known about the nature of the diagnosed disorder? ..... 1 2 3 4 5 N/A
- E) When more than one explanation for a pattern of responses was possible, did the clinician recognize them and state the differential possibilities (eg., "while auditory discrimination scores are currently within normal limits, it should be noted that John's history reveals that he suffered from chronic bilateral middle ear disease from about 18 months through 30 months and, moreover, his auditory memory span for digits is severely retarded")? ..... 1 2 3 4 5 N/A
- F) If necessary, did the clinician recognize the need for further examination by other specialists and so recommend? ..... 1 2 3 4 5 N/A
- G) If the clinician did recommend examination by other specialists, did she or he also defer diagnosis or make only a tentative diagnosis pending the additional desired information? ..... 1 2 3 4 5 N/A
- H) Were therapeutic recommendations not only consonant with the diagnostic impressions, but also consonant with the patient's capabilities from an intellectual, motivational, and physiological point of view? ..... 1 2 3 4 5 N/A
- I) Were reasonable and realistic constraints on the patient's or the patient's parent's time and economic situation taken into account in the recommendations? ..... 1 2 3 4 5 N/A
- J) Did recommendations include specific suggestions for treatment, with a rationale, rather than generalities (eg., "because Susan's error patterns are easily self-recognized and few in number, and in view of her above average intellectual and motivational level, it is recommended that she might best benefit from a paired-associates approach to her problem")? ..... 1 2 3 4 5 N/A
- K) Did the clinician provide a prognostic statement with a rationale? ..... 1 2 3 4 5 N/A

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