The Practice of Speech-Language Pathology in a Hospital Setting: Then and Now

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In 1960 when I came to Canada I applied for my first job at the Ottawa General Hospital in the Department of Child Psychiatry. When I contacted the psychiatrist who directed the department she told me she had considered it as likely to find a speech therapist as to find a "snowflake in hell." I was hired on the spot. The department had an audiometer although there were not as yet any audiologists in Ottawa, so, having a degree in both areas, I took on that job as well.

I was proud of the education I had just received in the United States to become a speech-language pathologist and, starting off in my first position, I felt I knew everything I needed to know. Only later did I realize that it might have been nice to have had a course in fluency disorders, to have learned about laryngectomies and voice disorders, to have learned about language (not to mention linguistics) rather than "delayed speech" and "severely delayed speech," and to have been supervised in my clinical practica by someone other than a student a year ahead of me with an infrequent interview with the university clinic director. Only later did I realize how much I didn't know.

Moving on to New Brunswick after two years in Ottawa, I became the third speech-language pathologist in that province. Beth Forbes and I travelled back and forth once a month between Fredericton and Saint John to have some contact with another person in the same profession. In my work as a speech-language pathologist I functioned as the learning specialist, the reading specialist, and the gross and fine motor therapist for my patients because people educated in those fields were also very rare. There was not an audiometer nor an audiologist to be found in New Brunswick, so children requiring audiological consultation were sent to Montreal or, by about 1965, to Halifax.

My experience is not unique—others were working in Canada under similar conditions but in different places, having begun years before to do the groundwork for the university education programs, the well established clinical programs, and the professional associations we now have.

I have worked for the past twenty-three years as a speech-language pathologist at The Montreal General Hospital, which was established in 1821 as one of the first major hospitals in Canada. The first speech-language pathologist to work at this hospital was employed part-time in 1941 in the Physiotherapy Department, and speech therapy treatments are listed in the hospital annual report for the next year alongside massage, quartz lamp, and diathermy.

I mention these historical anecdotes to illustrate the infancy of our profession and some of the issues which were before it twenty-five years ago and more: the insufficient numbers of speech-language pathologists and audiologists, the type of education required to produce qualified professionals, and the profession's independence from being a prescription service of the medical profession (Johnson, 1960). This latter issue is related to another, that of what to call ourselves—our "identity." A review of the journals twenty-five years later reveals that these issues continue to be matters for debate and resolution.

I was asked to write specifically about changes which have occurred over the past twenty-five years in the practice of speech-language pathology in a hospital setting. Being concerned about the possibility of a Quebec perspective being unique, I asked department heads from several other provinces to answer a brief, informal questionnaire. The answers indicate that our Quebec experience is reflected across Canada.

Changes in our work have occurred within the context of major upheavals in the hospitals which employ us: the introduction of medicare in 1970; drastically decreased availability of government funds to operate hospitals; closing of departments, particularly obstetrics, as a result of a declining birth rate; a less accommodating posture by hospital administrators who have realized that they can weather strikes by employees; cooperation rather than competition among hospitals as funds become scarcer; centralization of services in one major center with decreased duplication of services; computerization; expanding and astoundingly costly technology; increase in services required for the geriatric population and for native and immigrant populations; and crisis in the need for chronic care

beds, to name a few. Each one of these changes has had an impact on the delivery of speech-language pathology services in hospitals.

A notable development is the obligation, imposed upon hospitals within the last ten years, to formalize and document their quality assurance activities. The criteria established in a Quality Assurance Program are classified as pertaining either to structure (variables relating to the organization and resources of the department or institution), process (variables relating to the activities of providing service), or outcome (variables relating to the impact of the care provided to patients). It is, no doubt, an excessive preoccupation with quality assurance that has led me to organize the remainder of the ideas for this paper according to structure, process, and outcome!

Structure—Changes Related to Organization and Resources

My informal survey of selected hospitals across Canada indicated that departments have grown both in number of staff and in the scope of their mandate over the past ten years. A survey reported recently in *ASHA* showed that in the United States speech-language pathologists' and audiologists' full-time equivalent numbers increased 5.7% between 1982 and 1984, a percentage increase exceeded among hospital personnel only by that for physician's assistants (Shewan, 1987). Although this does not represent large numbers of people (235 in the U.S. survey), it suggests a heightened awareness among hospital administrators and medical staff of the importance of our professions to patient well-being.

At a recent seminar for hospital management staff we were asked to list the problems in our departments which caused us stress. Everyone had the same three things on the list: not enough money, not enough time, not enough space. How different from twenty-five years ago—a time described by Mary Cardozo as "a glorious period when if we needed it we got it." The pace of the daily practice of speech-language pathology has become quite demanding compared to my recollection of twenty years ago, even though waiting lists may have been even longer then than they are now. Clinical speech-language pathologists describe a "hustle-bustle" of non-stop activity with an increase in the number and variety of demands on their time as compared to years ago. In my department today we juggle patients, staff members, students, volunteers, visitors/observers, and self-help groups within an area long outgrown. I recall a time when there was unused space in the hospital; now rooms are divided into more rooms, people share offices and work in corridors.

As they grapple with the problems mentioned above and fight for their hospital's existence and independence, hospital senior administrators have become increasingly remote from the day-by-day functioning of the hospital and demand more and more from the management staff, resulting in a dramatic increase over the last ten years in the management component of a speech-language pathology department head's position. One of my speech-language pathology colleagues spends ten hours each week in administrative committee meetings discussing such things as cost management, information management, and administrative issues related to rehabilitation services. As costs have risen and consumers have become more vocal, governing and professional bodies have reacted by imposing or making available ways of demonstrating our accountability to them. Governments now collect cost and work unit statistics for each department so as to compare the productivity of departments in similar hospitals; the Canadian Council for Health Facility Accreditation now examines speech-language pathology and audiology departments during its accreditation visits; hospitals now require departments to have policy and procedure manuals and quality assurance programs. Our own national association has instituted voluntary accreditation of service programs and has cooperated with the federal government in the development of a workload measurement system. These types of documentation of our activities have added a new, positive dimension to the clinician's and administrator's work, but translate into many hours of paperwork.

Material benefits of our jobs have also increased. In 1966 my salary after five years prior experience was $4,600.00 a year. I loved my job, and when my salary grew to $17,000 in 1973, I wondered why I was paid so much to do something that was so much fun. Today the starting salary at the Master's level in my province is $32,288.00. (I suppose it's important to put these things in perspective: twenty-five years ago the "Gourmet Guide" for the 1964 ASHA convention in San Francisco informed prospective attendees that "an inexpensive dinner is $2.75 or less, a moderate priced dinner is $2.75 to $4.25, an expensive dinner is $4.25 and up" (*ASHA*, 1964). Despite this growth, our starting and maximum salaries no longer compare as favorably as they did eight or ten years ago with other professions with which we must compete for the highest level students.

Benefits such as paid maternity leave, increased vacation time, and the opportunity for sabbaticals and part-time employment represent a significant change in the past twenty-five years, as does the opportunity for members of our professions to become unionized—unheard of in 1964!

Process—Changes Related to the Activities of Providing Services

A phrase commonly used to describe the most significant change in our professions in the last twenty-five years is "information explosion." Our expanding knowledge and that

of related disciplines has changed the types of patients we treat and the types of treatment we provide. Improved obstetrical techniques, pre- and post-natal care, and genetic networking mean that we now see fewer children with severe neurological disorders such as severe cerebral palsy. The saving of high risk babies has added to our patient population more children with subtle neurological disorders affecting language and learning. Improved medical and surgical techniques with cleft palate and laryngeal cancer have reduced or changed the involvement required of the speech-language pathologist. Our knowledge has grown to include areas such as dementia, degenerative neurological diseases, head injury, glossectomy, swallowing disorders, and augmentative communication within our domain.

Twenty-five years ago the only piece of equipment in most speech-language pathology departments, including my own, was a tape recorder. Except for one or two published aphasia and articulation tests, we constructed our own tests and made, or adapted from educational supplies, most of our therapy material. The technological advances of the past fifteen years have meant that we have had to learn how to compete for hospital funds, raise money from private sources, and use expensive and sophisticated equipment such as sound analyzers, stroboscopes, and computers if we are to maintain a leading edge. We are able to obtain more and better information about our patients with this equipment and with the many published tests now available. We use computer-mediated therapy programs in our patient treatment, along with expensive therapy materials ordered from the many catalogues which arrive at our offices.

Our work demands continuous learning, changing, adapting, growing. Some of the treatment issues of concern to us presently include how to solve the problem of long waiting lists; specialization by speech-language pathologists; boundaries of treatment responsibilities with other professions such as education, psychology, occupational therapy, and medicine; and learning to work with native people and immigrants from third world countries with different languages, child rearing practices, and expectations.

Outcome—Changes Related to the Impact of our Care

How have these changes influenced the impact we have upon our patients? Has the burgeoning bureaucracy, information, technology, and supply of materials made us better clinicians, better able to improve our patients' communication skills and quality of life? Should we be described as Charles Van Riper did: "...smothered by an overload of information and administration, we deal with behaviors and not human beings"? (Van Riper, 1989) These are important questions we need to ask to determine whether all of the structure and process has been worthwhile. How can we answer them? A hospital administration colleague of mine counselled: "Don't measure indirectly what you can measure directly;" that is to say, if you want to know whether your profession is doing a good job, measure treatment outcome, not units of work, productivity, amount of available knowledge, treatment procedures, number of tests, or pieces of equipment.

This is good advice. Can we measure directly? Certainly we have tests which measure change in communication more thoroughly and reliably than was possible twenty-five years ago; but knowing, documenting, and explaining whether and how change in communication is related to treatment is a continuing challenge to us, as is documenting concomitant changes in attitude and quality of life. In 1964, the four issues of the *Journal of Speech and Hearing Disorders* and the *Journal of Speech and Hearing Research* contained no articles describing research in treatment outcome. In subsequent years excellent articles have appeared from time to time, particularly in the areas of aphasia and fluency, reporting the efficacy of speech-language therapy. Although each of us evaluates and documents treatment outcome for every patient we treat, we are not as advanced as our colleagues in medicine, for example, in developing generally accepted disorder classifications, replicable treatment procedures, and outcome descriptions and ratings, and in disseminating outcome information. Yes, we can and should measure directly, but we are neophytes in standardizing this complicated process and sharing its results.

Time has passed quickly! It's amazing to me to reflect that during the time I've been working as a speech-language pathologist, my profession has progressed from one with a small body of scientific and professional knowledge, a few academic texts, almost no published test and therapy material, whose practitioners worked in an independent, unmonitored, often isolated environment, to the burgeoning profession - and business - it has become today.

The Future

The government of my province has committed itself to the education of a larger number of future speech-language pathologists. What will be their experience in the next twenty-five years - by the time the Canadian Association of Speech-Language Pathologists and Audiologists is fifty years old? Those graduates who choose to work in hospitals should expect to be better educated in the pathophysiology of the disorders they encounter than has been the case in the past, so that they are better able to work in concert with the physician in determining the diagnosis and plan of treatment for their shared patients. In an excellent article about the future of our profession, Arnold Aronson wrote: "...the adequacy of our professional education is now dangerously behind the demands of clinical practice, especially in the context of speech-language pathology as

practised in a health care setting" (Aronson, 1987). He wrote further of the necessity to "restructure the graduate curriculum so that it will provide a solid foundation in the health sciences and human illnesses relevant to communicative disorders" (Aronson, 1987).

In order to cope with our expanding knowledge base and with the need of future students to acquire this knowledge, a reorganization of university training programs and increased specialization within the clinical setting seem inevitable. Continuing education after graduation will assume an even greater importance in the eyes of those who set our regulatory standards. It may be possible for future clinicians to obtain the clinical PhD now being debated and to have a greater option to work in private practice.

The speech-language pathology departments in which these new professionals work will be more productive, as will hospitals generally. I believe it's likely that more of these graduates than in the past twenty-five years will go on at some point in their careers to obtain degrees in business administration if they wish to advance in the hospital administrative hierarchy to the position of department head or beyond. Of course it may be that in the next twenty-five years rehabilitation services will have pretty much moved out of acute care hospitals into rehabilitation centers.

The increase in number of research papers submitted to convention organizers suggests that future Canadian clinicians will be working in environments where clinical research is encouraged and assisted. They will work in an exciting world of high-tech and will be finding new areas of usefulness. It is to be hoped that, amidst the inevitable struggle in the future for finances and increased productivity, the students who graduate in the next twenty-five years never lose sight of their original purpose in selecting their profession: to have the opportunity to help human beings.

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