Specialty Recognition in Neurogenic Speech, Language and Cognitive Disorders: Introduction

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This paper and the three which follow were presented at the 1986 Clinical Aphasiology Conference as part of a panel entitled "Specialty Recognition in Neurogenic Speech, Language and Cognitive Disorders." The impetus for this panel came from two main sources, one internal to the discipline of speech and language pathology and the other external to the discipline.

The internal source derives from the rapid expansion of the scope of practice in neurogenic speech, language and communicative/cognitive disorders which has occurred in recent years. Not so many years ago, speech-language pathologists involved in the clinical management of persons with acquired neurogenic communicative disorders were concerned primarily with aphasia, apraxia of speech and the dysarthrias. In the last five to ten years, however, speech-language pathologists have played an ever increasing role in the evaluation and treatment of right hemisphere communicative disorders and communicative and cognitive impairments secondary to closed head injury and Alzheimer's and other dementing diseases. While patients presenting these disorders share with aphasic, apraxic and dysarthric patients a unifying impairment of communication, this expanded scope of practice, nevertheless, requires additional theoretical knowledge and clinical expertise. The issue arises as to how patients, their families and practitioners making referrals to speech-language pathologists can identify those clinicians with the requisite knowledge and expertise. Some form of specialty recognition or credentialing would greatly facilitate this identification.

The second source, one which is external to our discipline, is the manner in which other disciplines, seeking to expand their own scope of practice, have begun to include areas which have traditionally fallen within the purview of speech-language pathology. In particular, occupational therapists and clinical neuropsychologists have been claiming an ever-expanding role in the diagnosis and treatment of neurogenic speech, language and communicative/cognitive disorders. Numerous complaints have been made to state licensure boards regarding occupational therapists engaging in clinical activities which appear to be assigned by law to speech-language pathologists. At this time, however, it is the perception of many that the greater threat to our profession is posed by clinical neuropsychologists. Therefore, the remainder of this paper will be directed toward conflicts that have risen between speech-language pathologists and clinical neuropsychologists.

According to the American Psychological Association (APA), its Division 40, Clinical Neuropsychology, is one of its fastest growing specialty areas. Since June, 1981, when a steering committee for the formation of an American Board of Clinical Neuropsychology (ABCN) first met, clinical neuropsychologists have moved rapidly to establish credentialing procedures. At the inception of this credentialing movement, it was recognized that the rehabilitation of brain-injured individuals was a multidisciplinary endeavor, and it was anticipated that any practitioner, regardless of discipline, who met the established criteria would be eligible for credentialing. However, when in 1983 the ABCN affiliated with the American Board of Professional

Psychology (ABPP), the ABPP's requirements of a Ph.D. in psychology and membership in the APA or the Canadian Psychological Association were added to the credential criteria. These requirements effectively eliminated members of any discipline other than psychology from the credentialing process.

Our concerns arise not from psychology's efforts to identify members of that discipline who have particular expertise in clinical neuropsychology. Such efforts are of potentially great value to consumers and are to be applauded. Indeed, many speech-language pathologists feel that there is a need for some form of specialty recognition or credentialing within our own discipline. Rather, our concerns arise from clinical neuropsychologists' assertions of expertise in areas that are within our scope of practice, in particular (1) the assessment of neurogenic speech, language and communicative/cognitive disorders, including the differential diagnosis of aphasias and other language disorders, (2) the development of rehabilitation strategies and individualized treatment plans and (3) the monitoring of patients' recovery. Such assertions, when made to state legislators, publishers, health care administrators, third party payers and consumers, affect our discipline in two important ways.

The first area of influence is third party reimbursement. Leslie Gonzalez Rothi, a speech-language pathologist at the Veterans Administration Medical Center in Gaineville, Florida, has reported that Workmen's Compensation in Florida will provide reimbursement for language assessment and rehabilitation provided by a "certified" psychologist at a rate of $65.00 per hour, but will provide reimbursement for the same services provided by a speech-language pathologist at a rate of only $25.00 per hour. Furthermore, it has been reported that at the February, 1985 meeting of the International Neuropsychological Society (INS), the INS's Committee on Professional Affairs discussed its intention to develop a manual for third party payers defining the scope of practice of clinical neuropsychology.

The second area of influence is our professional autonomy. Two areas of activity involving neuropsychologists illustrate what can only be viewed as a "clear and present danger" to our profession. The first is the development of a "Code of Fair Testing in Education" which would be made available to test publishers. This code would delineate the minimum qualifications for those using particular test instruments and would require publishers to ensure that tests are disseminated only to qualified users. The code is being developed by the Joint Committee on Testing Practices (JCTP) which is composed of three representatives each from the APA, the American Educational Research Association (AERA) and the National Council on Measurement in Education. The JCTP reportedly had asked fifty organizations with a direct interest in testing to name a representative who could provide input to the Committee. However, ASHA was not inclouded among the original fifty organizations. It was only after ASHA had been informed of the JCTP's activities by a publisher and had approached the Committee about representation that in December, 1985, ASHA was invited to name a representative. Arlene Kasprisin, Chief, Audiology and Speech Pathology, Palo Alto Veterans Administration Medical Center attended an "open" session entitled "Report of the Joint Committee on Testing Practices" held at the AERA convention in April, 1986. However, Dr. Kasprisin was denied attendance as a representative of ASHA at a "working group" meeting. Already several instances of speech-language pathologists being denied access to widely used test instruments (e.g., Minnesota Test for the Differential Diagnosis of Aphasia, The Word Test) have been reported. It seems clear that if the Code being developed by the JCTP is adopted without appropriate weight having been given

to input from our discipline, our access to instruments will be further restricted.

The second activity which threatens our professional autonomy is that of statements made in articles, textbooks and public information announcements regarding the supervision of speech-language pathology services by neuropsychologists. Two examples follow:

In an article by Gloag entitled "Rehabilitation After Head Injury: 1: Cognitive Problems" (British Medical Journal, 1985, 290, 834-837) it is asserted that

> ... there are not enough clinical psychologists to give training to the many head injured people who need some help and the relatively few who need intensive help. But much of the actual training can be given by other staff, notably occupational and speech therapists; this happens even where a full time psychologist is available. Thus, the need is for psychologists to work out in detail the approaches and techniques to be used for each person and study the response, with changes of strategy as needed.

A telephone information service provided by Neuro Rehab Associates (716 248-9409) includes a message on cognitive rehabilitation (menu item #6). This message includes the following statement:

> Cognitive rehabilitation is so new that no specific licensure requirements for professional practitioners exist. Most often a competent provider should have doctoral level training in clinical and neuropsychology. In some settings a licensed speech pathologist or occupational therapist acts as the cognitive retrainer under the neuropsychologist's supervision.

Such statements clearly undermine our professional autonomy and the confidence our patients or clients have in our services. A strong public information campaign is needed to combat the efforts of members of any discipline who would seek to usurp our autonomy.

The time to act, and act forcefully, to protect our profession and those whom we serve, is now. The report of ASHA's Ad Hoc Committee on Specialty Recognition will be forthcoming in Fall, 1986. Also, thanks in large measure to the efforts of Steve White, Director of the Reimbursement Policy Division of ASHA, and his colleagues, an April, 1986, report from the Consumer and Professional Relations Division of the Health Insurance Association of America (HIAA) asserts that "Speech-language pathology and audiology services are important rehabilitation and habilitation programs." and that "There is no requirement for medical prescription or supervision since the profession is autonomous." This report was disseminated to the HIAA's 340 member companies. ASHA is also continuing its efforts to gain a greater voice with the JCTP. These efforts on the part of ASHA are most welcome. Anyone who can document specific instances of restricted access to test instruments or instances of encroachment on our scope of practice or our professional autonomy is urged to communicate this information to Carol Kamara at the ASHA national office.

There is, however, much more which needs to be done. In particular, we as a profession need to look at the qualifications of our own membership regarding the provision of clinical services to particular populations. This