Chapter 1

The geography of professional practice: swamps and icebergs

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This book differs from many texts written for speech and language therapists, in that it is not about a specific client group, communication disability or area of practice. It explores the common ground in professional practice and crosses clinical boundaries in order to understand the nature of speech and language therapy in practice more fully.

Schön (1987) first described professional practice in terms of the contrasting geography of high, solid ground and 'swampy lowlands'. He imagined that practitioners on the high ground approached the challenges of professional practice by applying theory supported by research and by using technical skills. However, he argued that this approach was unable to address the complex and messy challenges common in the 'lowlands'. The challenges on solid ground were much less pertinent to practice, whereas the 'swamp' was populated by issues most meaningful to clients and to the wider world. This analogy provides a useful starting point for many of the topics explored in this book. There are many areas of speech and language therapy practice that remain relatively uncharted in the literature, and many of them would probably be found in Schön's lowlands. This book provides new material in the search for better understanding of these territories.

The nature of professional competence

The question of what makes a 'competent' professional has always been a challenging one for practitioners. More recently, the nature of competence has come under the spotlight of the regulators whose role is to safeguard patients and clients, and to protect the public from incompetent practitioners (Health Professions Council, 2002; Nursing and Midwifery Council, 2002). This form of external scrutiny has created a new imperative to articulate what is meant by 'competence'.

One of the difficulties in defining the competence of a healthcare practitioner is that competence depends on more than technical knowledge and expertise. Jackie Stengelhofen, a pioneer of speech and language therapy education, was among the first to address this issue, describing healthcare practice as having three levels (Stengelhofen, 1993). The techniques clinicians use and the relationships they have with clients are at the surface level of this model. These features may be observed in interactions and are learned and developed as skills. The knowledge and understanding that healthcare professionals are aware of is at a deeper level, as it underpins decisions, although it is not always stated explicitly. At a deeper level still are personal attitudes and belief systems, which have unconscious effects on choices at the upper levels. Davies and van der Gaag's study of professional competence in speech and language therapy reached similar conclusions. They looked at competence across a range of clinical specialisms, and described competence in terms of three elements – knowledge, skills, and attitudes and attributes – and all were of equal importance to the 'competence' of professionals (Davies and van der Gaag, 1992; van der Gaag and Davies, 1992a, b). Fish and Coles (1998) used the model of an iceberg to demonstrate the relationship between observable skills and the much larger and more influential aspects of competence that lie 'below the waterline'.

Influences on professional practice

Models of care

Kath Williamson's work further refined the concept of competence in professional practice and included reflection on practice as essential in evidencing competence (Williamson, 2001). Reflection, in turn, is dependent on which model of care a practitioner works within, as this influences thinking both on practice and about the definition of competence. These models of care have been construed by authors from a variety of backgrounds (O'Brien and Tyne, 1981; Leahy, 1995; Oliver, 1996; Byng et al., 2000). In some senses, they lie along a continuum, from the medical model at one end to the social model at the other. A medical model of care is based on the premise that illness or disability is a deviation from the 'norm', either a developmental norm, or a physical or behavioural norm. The role of the professional is to effect a change in the individual's physical, cognitive, linguistic, emotional or sensory state that brings them closer to the 'norm'. In contrast, the social model of care is based on understanding a client's experience of disability or impairment within a broader societal context. Disability arises from the societal

context as much as from the individual, and it is society's barriers that restrict the individual, rather than the intrinsic characteristics of their condition. The practitioner is not there to 'fix' what is broken, but to work with the individual to understand the impact of the disability and to address context-driven issues of importance to that individual's everyday life.

The medical–social dimension is only one among many contrasting 'dimensions' that exist for the practitioner and which can have a profound influence on the nature of reflection and practice. There is the 'technical fix' versus 'quality of life' continuum, which mirrors the medical–social continuum. These contrasting viewpoints are evident when the professional construes her role as one of delivering a technical 'fix' to the client, of applying expertise to a particular clinical situation and bringing about change as a result. In contrast, at the quality-of-life end of the spectrum, the practitioner is concerned with enhancing quality of life, and reducing environmental, attitudinal and other barriers within the individual's life. There is also the profession-led perspective versus the client/user-led perspective. At one end of this continuum, the professional sees herself as an expert on a particular condition, and at the other, the client is the expert on his lived experience of that illness or disability.

Technical rational approach versus professional artistry

Fish and Coles (1998) discussed this continuum in terms of the conflicting demands of the technical rational and professional artistry types of practice. These approaches are seen as polarising healthcare decision making for professionals. The technical rational approach breaks professional practice down into parts. Professional autonomy is reduced, as 'delivery' of care packages becomes the overriding concern. These packages are discussed as if they can be designed separately from the client and administered by the clinician. The technical rational approach is underpinned by audit and quality standards, which in themselves are laudable in their aims for client care. However, Fish and Coles argue that we may begin to be bound by rules and application of procedures if fear of not following these guidelines begins to hem in our decisions, often in unconscious ways. It is easy to lose confidence in personal judgement and rely instead on just 'sticking to the rules'. But treatment is about judgement and decisions. Clinicians must not lose sight of the professional ability to make choices through applying principles and frameworks to decisions. Professional artistry recognizes the messy uniqueness of decision making in individual cases. Professional autonomy is increased through greater understanding of the decision-making process. In this way, therapists and clients can jointly explore individual routes along pathways of care through Schön's 'swampy lowlands' of practice to a moral 'good'. This

thinking represents a complex view of professional practice with a holistic appreciation of the interconnectedness of parts. It celebrates the fact that interpretation is needed to do this piecing together effectively. This type of professional practice requires that we make thinking and decision making explicit to ourselves and others so that it can be examined through reflective practice. In this way, experience becomes a recurring source of data for 'reflection in action' and 'reflection on action', leading to continuous professional development (Schön, 1987).

In a technical rational approach, professional practice requires the acquisition of competencies which can be improved by skills training. Performance measures of quality assurance and control can demotivate the professional by reducing autonomy in decision making. Theories are seen as explicit and external to practitioners as in this view, theory is something learned and applied to practice. All is known or knowable, and risks need to be assessed and reduced. In contrast, professional artistry in practice is about increasing competence through a variety of methods, not just acquiring more competencies. Competence is more than skills, as therapists need to be prepared to handle new and unexpected situations. Competency involves improvement in ability to adapt and improvise during the 'hot action', in therapy sessions where decisions are made on the spot (Eraut, 1994). This requires an understanding and thinking about the complexity of a client's condition and underlying theories. The professional continues to refine theories through reflective practice. Fish and Coles argue that action and theory develop and are created in practice to be transformed by reflection into the clinician's personal constructs and values.

Choosing directions

All these contrasting perspectives in some form or another have a profound effect on everyday professional practice. They are not incidental to practice. Moreover, it is no coincidence that the majority of newly qualified therapists find that they are more comfortable at the medical/expert/profession-led end of this continuum, as they seek to establish their identity and to build their self-confidence as practitioners. The technical–rational end of the continuum is more easily defined and measurable, and one which fits well with the emphasis on evidence-based healthcare, clinical guidelines and national standards of service delivery.

Professional practice is therefore more than its surface features and skills. This is a more uncomfortable place to work in the absence of certainties and the necessity of continually re-evaluating practice. Quality in this approach is about making appropriate moral judgements, which comes through examining our own interactions, attitudes and beliefs.

Accepting that we do not know all the answers ensures that we keep looking for best possible solutions. Minimizing risks will be part of planning, but professional artistry often produces creative and flexible client care and is therefore seen as a positive force.

This move towards recognizing artistry in professional practice is not exclusive to speech and language therapy. Nursing, social work and of course medicine have all developed along similar lines (Balint, 1957; Toon, 1994). Nursing has perhaps taken the lead among these professions in terms of researching and promoting the notion of the reflective practitioner (Burns and Bulman, 2000). Nurses have recognized the importance of reflecting not only on technical skills but also on interpersonal skills and the ability to critically evaluate such key components as communicative style, empathy and understanding of the client's perspective (Loughran, 1996; Bolton, 2001). However, medicine and social work have made similar journeys (Everitt and Hardiker, 1996; Greenhalgh, 1998).

The notion that therapy, and therefore the outcome of therapy, is not just about the application of a technical skill is gathering momentum among many healthcare professions. In recent times, medical educators and academics have asked whether medicine has been focused for too long on the technical end of the continuum. In most instances, technical skills are both easier to define and more susceptible to external scrutiny and analysis. Professional artistry is much more challenging, and lends itself to qualitative evaluation rather than quantitative approaches.

Involving consumers

There is another dimension that is changing the landscape of professional practice and which is equally challenging. Involving consumers of healthcare in decision making, and recognizing that clients are 'experts' on their own condition and are equal partners in the therapeutic encounter may not be new ideas and constructs, but they are now becoming part of mainstream policy (Lorig and Holman, 1989; DoH, 2002). If consumers are to be genuinely involved in decision making, then the imperative to understand and articulate professional artistry and its relationship with an individual's practice will become stronger. This is not to suggest that consumers are not concerned with the technical skills of professionals. However, what is emerging from the small amounts of research in this area is that consumers are as concerned with the relationship as they are with the technical skill of the therapist. In short, from the consumer's viewpoint, it is not enough to be technically 'expert'. Therapy that is technically driven may be sufficient for the more straightforward, short-term encounters. Such encounters are part of mainstream practice, and they are not inconsequential. However, the majority of encounters

are with clients who live with communication disability long term. This model of working will not provide the client with a lasting and transformational type of therapy. This can only come through therapy that puts the client at the heart of decision making, and engages in a dialogue about the everyday barriers to successful communication and how they can be dismantled.

Mapping the routes

The rationale for compiling this book lies within these complex and challenging issues. We have brought together a series of essays from a wide range of speech and language therapists, all of whom have provided theoretical frameworks and practical suggestions on how to address these issues in relation to their area. The first eight chapters may be read in any order, but it is recommended that you read Chapter 5 after having read Chapter 4 as it assumes understanding of the Care Aims model. Chapter 9 is designed to be read after the other chapters, as it aims to extend the reader's reflection on points raised in the previous chapters. Although the term 'patient' is used in some cases, 'client' is preferred where possible in this text. This term is used to convey the reality that many of the people therapists work with are not ill, and to reflect our thinking about biopsychosocial models of care.

In Chapter 2, Anna van der Gaag and Chris Mowles discuss values in professional practice and how values can be realized. Some theoretical differences in management approaches are contrasted to highlight their impact on values in organizations. The authors provide an example of good practice in the field of adult aphasia to demonstrate how ongoing conversations around values can contribute to the ethos of a workplace. The implications for staff and service users are discussed in relation to the challenges of addressing complex, long-term communication needs in supportive and creative ways.

In the next chapter, Margaret Glogowska looks at the importance of understanding expectations based on the drive in the health service towards finding out what clients think and want. The insights into expectations were gained from a randomized controlled trial of community-based therapy for pre-school children with early speech/language delay. A number of areas are highlighted in relation to practical points surrounding information about service delivery, as well as recognizing the potential for conflicting expectations of parents and therapists in diagnosis and intervention. The research suggests that it is necessary to change practice to take much fuller account of client/carer expectations, which will impact on uptake of service and, potentially, therapy outcomes.

In Chapter 4, Kate Malcomess outlines the Care Aims model, including the concepts of duty of care, clinical risk and clinical need. The model is then described as enabling the clinician to reflect on these core building blocks of clinical reasoning and effectiveness. As this is a model of thinking about care at a meta-level rather than a model of clinical care delivery, it is designed to focus on the reasons for care rather than the type of care delivered, and can therefore incorporate any number of clinical approaches. This is a powerful framework for reflective practice in clinical decision making. As Malcomess points out, this may present challenges for clinicians as it requires a shift in thinking from decisions based on diagnosis, to reflecting on impact and change for individual clients. The clinician's risk assessment is recorded by identifying the care aim, the main reason for care at each stage of intervention. The eight care aims are defined, with examples demonstrating the importance of predicted outcome rather than therapy input. Case examples of care pathways show how reflective practice can be evidenced through successive episodes of care. The chapter concludes with a section on evidence for clinical governance.

In the following chapter, Pauline Beirne focuses on the management issues that must be addressed for successful implementation of the Care Aims model. She provides a detailed and carefully crafted account of how the model works within a large children's service. This chapter covers issues including case management, prioritization, audit, reflective practice and user involvement. The decision making around these areas is discussed in relation to the model. While it is accepted that there is a radical shift in thinking required for a service to implement this model, the benefits to clients, clinicians and health services are proving to be worth the effort.

In Chapter 6, Karen Bunning discusses the commonalities of therapy and produces a model for describing therapeutic intervention using context, content and process. The author presents the definition and application of a conceptual framework for looking at speech and language therapy intervention across a range of client groups. To begin the process, the therapist and client build an individual profile, which considers strengths and difficulties in communication in the context of the person's needs and environment. Intervention is then based on specific aspects of function that are relevant to identified goals, with key decisions made explicit to all participants. Bunning proposes a universal framework for intervention, as the commonalities of this procedure are applicable to all client groups. The interrelated components of the conceptual framework are outlined: content (what will be done), process (how it will be done) and context (the setting conditions). Two case examples show how the framework can be applied. This framework is based on client-centred, transparent decision making. Bunning suggests that using the framework

will also enable students to problem solve with any client, as it is based on principles, not pathology.

In Chapter 7, Kate Swinburn reflects on her personal journey as a therapist in working with adults with aphasia, and the insights gained from a career in this field. She discusses three constructs – health-related quality of life, user involvement and the social model of disability – and explores how they have influenced her outlook and practice. This chapter provides valuable insights into the way in which evolving policy can contribute to radical changes in practice.

In Chapter 8 Karen Krawczyk makes the case for the biopsychosocial model in dysphagia management, challenging the dominance of the medical model in this area of practice. Thinking about management of dysphagia has changed recently as a result of increasing understanding of swallowing and aspiration. As more is understood about the complex interrelationship between risk factors such as oral hygiene, adherence and dependence for eating, clinicians are reassessing their recommendations regarding clients at risk of aspiration. Research is raising questions about what constitutes a 'normal' swallow and whether clinicians can identify the range of 'normal' swallowing from pathology with confidence, using current techniques. Against this background of uncertainty, clinicians are considering how to manage dysphagia more effectively by looking at service delivery. The model described in this chapter outlines pathways of care in an interdisciplinary team context, based on principles of user involvement and training nurses and carers to manage dysphagia.

The concluding chapter by Carolyn Anderson contains practical suggestions to enable clinicians to reflect on the concepts explored in the preceding chapters. These reflection points are designed to assist in the application of the concepts to practice. They lend themselves well to the kind of reflective processes that are now an integral part of continuing professional development.

Bringing together constructs and challenges from differing areas of practice has proven to be a stimulating endeavour. Speech and language therapy education and practice have often remained in quite separate clinical areas, and yet these chapters illuminate significant areas of overlap. We hope that the collection will stimulate readers to think about their work in new ways, and to learn from experts outside their own scope of practice.

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