

Local and Selective Appropriation: Circulation of New Diagnostic Categories in Speech Therapy in Quebec's Clinical Practice, 1985-2002

Julien Prud'homme

This essay is about the development, transmission, and use of new categories of diagnosis among speech therapists in Quebec's hospitals and rehabilitation centres. From the viewpoint of the history of professions, the author emphasizes the driving role of clinicians' local initiatives and professional aspirations in this process. The author starts with a brief overview of speech therapists' professional situation in the early 1980s, then describes the emergence of a new category of neurological troubles, and, finally, analyzes the characteristics of its spread in clinical practice after 1986. By doing this, the author hopes to raise awareness about the study of the circulation of concepts in clinical settings.

Cet article traite de l'émergence et de la diffusion de nouvelles catégories diagnostiques parmi les orthophonistes québécoises. En s'appuyant sur les concepts propres à l'histoire des professions, je mettrai l'accent sur le rôle des initiatives locales et des aspirations professionnelles. Après un bref survol de la situation professionnelle des orthophonistes au début des années 1980, je décrirai l'émergence d'une nouvelle catégorie de troubles attribués à des causes neurologiques et je tâcherai d'analyser sa diffusion en clinique après 1986. Cette démarche devrait suggérer des pistes de réflexion sur l'étude de la circulation des concepts dans les milieux de santé.

The health-care network is crowded with a multitude of specialists, including medical, nursing, and allied health professionals, who define themselves by distinctive attributes and who seek to maintain or reinforce the specificities that identify them as fully recognized professionals. This essay analyzes the impact of those professional dynamics on the practices of health care by linking the transformations of clinical work, the constitution of patient bases, and the various and localized ways health care is delivered through health administration. This approach, based on the history and sociology of professions, suggests hints about a number of questions, including the constant growth of health occupations since 1970.

This article emphasizes the transformations in the clinical work of speech therapy. Unfortunately, large parts of the historiography still do not show much interest in the evolution of the concrete work of clinicians; indeed, many studies

seem to presume that each professional group fills a fixed and natural role that does not change much over the years, although recent work by Peter Twohig (2005) has demonstrated how much the duties and responsibilities of various health-care workers have changed over time. Also, following studies from other scholars such as Keith Wailoo (1997) and Sébastien Piché (1999),¹ I will use the case of Quebec's speech therapists in order to explain the development of new tasks in the field through the aspirations of clinicians themselves. Clinicians achieved their professional aspirations through the use of diagnostic concepts in their daily practice; in gaining recognition for new diagnostic categories specific to their profession, they gained new patients and thus improved their professional status.

By emphasizing the role of diagnosis and its use in winning new positions within the workplace, I will present two particular points. On the one hand, professionals use diagnostic categories that often tend to increase the scope of their practices, leading them either to compete among themselves for the same patients, or to extend their jurisdiction by medicalizing problems that previously did not fall under the domain of health-care expertise (such as failing school). On the other hand, not only have the diagnostic categories used in clinics changed over time, but the meaning and use of a diagnosis at a given time may vary considerably from clinician to clinician and from workplace to workplace, depending on the local conditions of interprofessional competition. The variety of delivery centres and their characteristics must be considered in order to explain the great diversity of practices hidden behind the apparent uniformity of diagnostic labels.

Those variations have already been discussed by historians and sociologists. It has been said that they are made possible by the gap existing between official formulations of diagnostic categories and their actual clinical use. For example, in researching Alzheimer's disease, Ad Prins (1998) noted how, despite the crucial importance of neurological etiology in the definition of the disease, Alzheimer's diagnoses were most often made without any of the neurological investigations used in scientific settings to assert the existence of the disease. For many observers, this gap between scientific definitions and clinical use is unavoidable: scientific categories are the fruit of specifically scientific settings focussed on knowledge production, and their transfer to clinical settings requires acts of interpretation and reformulation. Such transformations mean that diagnoses in clinics have a noticeably different meaning than they do in the academic writings that secure their legitimacy.² The gap may also be emphasized by the fact that health-care practitioners may appropriate diagnostic categories and techniques to help define and defend their positions, in selective ways that can change according to consumer and professional stakes within the local workplace (Abbott 1988). This

leads us to consider both how the general use of a particular diagnosis is locally determined, and how this localized use makes the place of a particular clinician in the health-care system an important determinant of its diagnostic practices.

This essay will examine the development, transmissions and use of new categories of diagnosis among speech therapists in Quebec's hospitals and rehabilitation centres from 1985 to 2002. By doing this, I will especially emphasize the driving role both of place and of clinicians' local initiatives and professional aspirations in this process. I will start with a brief overview of speech therapists' professional situation in the early 1980s, then describe the emergence of a new category of neurological troubles, and, finally, analyze the characteristics of its spread in clinical practice after 1986. In the end, I hope to raise awareness about the study of the circulation of concepts in clinical settings.

Speech Therapy in Quebec in the Early 1980s

Speech therapy is an allied health profession that treats voice, language, and communication disorders; as a profession, it began in Canada in the 1950s. Because of its mostly female membership and its position in the health professional hierarchy, speech therapy is similar to professions like physical therapy or occupational therapy. Speech therapists are less numerous, though, having increased from 500 to approximately 1,000 in Quebec between 1990 and 2005.

Until the first half of the 1980s, speech therapists primarily dealt with articulation problems, like stuttering or lisping. They then only had what we could call a weak diagnostic initiative power, meaning they were rarely entitled to establish diagnoses of their own. For this reason, speech therapists were not able to build a practice or patient base of their own but instead relied on referrals from other professionals like physicians, psychiatrists, or psychologists, who selected and identified potential patients.

In psychiatric clinics, where speech therapists were most commonly found after 1975 (Prud'homme 2005; 2006), they rarely met children whose main problem was identified as language but rather children with already labelled psychological problems, like developmental delays or behavioural troubles, previously diagnosed as such by psychologists or psychiatrists with the terminology of psychology or educational psychology. Speech therapists' main task, then, was not to take the case as primary health-care provider but rather to facilitate or complement the psychiatrist's or psychologist's therapy. In those hospital settings where the "psys" could both refuse purely anatomic cases and keep for themselves those language cases that could be labelled intellectual or intercommunicative problems, it was particularly difficult for speech therapists to build a

practice. Some speech therapists attempted to circumvent psychologists' power to monopolize these cases, while others considered the pretense of psychiatrists to be an unacceptable infringement on speech therapy's territories. This situation caused much dissatisfaction among most speech therapists, a frustration tangible in many sources and in the discourses of their professional society. At the end of the 1980s, it was common for clinicians from Rivières-des-Prairies psychiatric hospital (near Montreal) to complain about how little recognition their experience and jurisdiction received from the other professionals they worked with (Morency and Chavy 1989, 39).

In the 1980s, however, the world of children's psychiatry was being changed by the rising spectre of so-called neurological troubles, like autism, that by their etiology were distinct from the traditional categories of developmental psychology. This was a North American process and, in the United States at the same time, neurology gave speech experts a basis from which to build new categories of classification and diagnosis, far removed from psychological categories. In American scientific writings, language ceased being a subdiscipline of general psychological models to become more of an object of its own, conceptualized in a neurological setting with its own models, a vocabulary of its own terms, and new and distinctive indicators³ linked to neurology and mostly developed through clinical research. This cocktail of clinical innovations and shifts to neurology characterized the emergence of a particular category of diagnosis that wore many names from 1985 to 2002. The new diagnosis enlarged speech therapy's jurisdiction, and led to an in-depth reshaping of categories that allowed speech therapists to reformulate their conception of language problems in ways that facilitated the appropriation of new kinds of cases. Through this process, speech therapists gained access to a part of the fast-growing psychiatric population of children who had, until then, been labelled with autism or other subcategories such as Asperger's syndrome.

This new constellation of diagnoses created categories that were distinct from the classic categories of developmental psychology, but, in the mid-1980s, these categories remained the preserve of psychiatric settings. Indeed, in Quebec during the 1980s, there were few research activities in speech therapy, and Quebec's speech therapists showed little interest in neurological problems. Perhaps for this reason, the diagnostic categories used in this domain remained at first numerous and scattered. Among those categories were "congenital aphasia" or "dysphasia," an American concept of the 1960s referring to comprehension problems linked to the central auditory system, and "audimutism," a French term from the 1950s referring to a severe delay in expressive abilities (AQEA 2001).

This last category, audimutism, would receive in Quebec political recognition because of the action of a parents' association, formerly known as the

Association québécoise pour les enfants audimuets (AQEA), Quebec's association for children with audimutism. Its current name is the Association Québécoise pour les enfants atteints d'audimutité. The AQEA was created in 1986 by parents of children served by the Audimutism Centre of Montréal (the CAM, a unit of the Sainte-Justine hospital); it aimed to win recognition for audmutism from the ministries of Health, Social Affairs, and Education (AQEA 2001, 1). Numbering 70 members in 1988, the AQEA remained at first a small group: indeed, the audimutism diagnosis that underpinned the membership of the group was only made by a small circle of speech therapists practising in the cities of Montreal, Sherbrooke, and Chicoutimi.⁴ Among this group of speech therapists was Professor John Dudley, from the school of speech therapy at the Université de Montréal, who collaborated with the members of the AQEA to strengthen the association's arguments. As early as 1987, the AQEA convinced the provincial departments of both Education and Health to form a joint task force, including representatives of the two ministries and speech therapists close to the AQEA. In 1988, the group released a report that included an official definition of the problem, a protocol for its diagnosis, and a recommendation for swift action. Immediately, the Department of Education recognized audimutism as a problem and created a program that provided substantial financial resources for each diagnosed case, while the Department of Health took a similar position in 1995 (Quebec 1988; AQEA 2001). Such formal recognition and the new funding prompted school boards and health centres to hire speech therapists to diagnose and treat audimutism, opening the door to a new kind of practice for speech therapists.

From Audimutism to Dysphasia, 1988-2002

Since the mid-1980s, the concept of audimutism has expanded in ways that have blurred its diagnostic specificity. In fact, even among the 188 cases enumerated by speech therapists from the Université de Montréal for the joint task force of 1988, only 83 were truly and officially identified as audimute (Québec 1988); the other 105 were included even though they never received a formal diagnosis, on the basis that they had similar needs (Québec 1988, 14). In practice, it would seem that speech therapists gave the audimutism label to any child who was likely to benefit from the care linked to such a diagnosis, regardless of the etiological definition.⁵

This practical use of the concept allowed speech therapists interested in a larger vision of language to discover quickly "new" cases among populations of behavioural or learning problems being treated in psychiatry. The diagnostic category began to be reshaped in these settings, as it was in the pediatric psychiatry clinic

of the Quebec City Sacré-Coeur Hospital, where John Dudley became, in 1982, the first to diagnose audimutism cases among children classified in the autistic spectrum. In 1986, in the Rivière-des-Prairies psychiatric hospital, speech therapists started to classify some cases of behaviour problems as audimute, which allowed them to refer those children to speech therapists working at Sainte-Justine's Centre d'Audmutisme de Montréal rather than to local psychologists, implementing the new diagnosis category by this use of a new channel of reference (Québec 1988; AQEA 2001; Buttiens 1987; Morency and Chavy 1989).

Throughout this period since the 1950s, however, the word "audimutism" has officially designated only a very specific and quite rare problem with no more than 200 cases in all of Quebec, a small and uncompromising number that helped to explain the prompt answer of provincial government. The authors of the 1988 report insisted heavily on the narrowness of the category in two ways. First, the problem was very precisely defined as a congenital cerebral dysfunction in the hearing system (Québec 1998). Second, the report established a very strict diagnostic protocol. To be admissible to the financial program, the child had to demonstrate five specific problems⁶ that, like abstraction or time perception capacities, far exceeded the field of speech therapy alone: to be officially recognized, the diagnosis needed a positive identification by no less than four different specialists: the speech therapist, the audiologist, the psychologist, and the neurologist (Québec 1988).

What is remarkable is that, despite those explicit constraints, this apparently restrictive definition was never respected. Instead, two things happened in the following years: audimutism became the exclusive field of the speech therapist, and the clinical definition of the problem expanded, which allowed the clientele to grow dramatically.

First, speech therapists were the only professionals involved with the AQEA and with the task force that wrote the report. Moreover, no specialist except the speech therapist had the possibility of really fulfilling official demands. In the field, no one, including speech therapists, had the tools to detect a congenital cerebral dysfunction and, of the five specified symptoms, only language troubles could be effectively measured and demonstrated in the way required by the report; from the other specialists, the report asked for investigations but gave no precision about what should be expected. Only diagnosis in speech therapy could truly determine a child's admissibility, as was openly done at the Sainte-Justine Hospital. A similar situation prevailed in schools, where the other required professionals, like the neurologist, were simply non-existent (Québec 1998; Gauthier, Cossette, and Dubuc 1994, 92; Crête 2000, 10).

Second, the definition of the problem quickly expanded from its early narrow meaning and, in practice, began to include almost all of language problems

among children. In the United States, there was already such a trend towards combining numerous categories in a single new category of neurological troubles; researchers in speech therapy tended to reformulate language problems in neurological terms instead of psychological ones, and, in the process, eventually merged many once-distinct categories into one generic category called "speech language impairment." This progressive agglutination led to the diffusion of unique evaluation charts, like the Rapin-Allen chart published in 1989, that bring together all language problems, from the making of sounds to semantic or "pragmatic" deficiencies, in a unique spectrum of syndromes. In the early 1990s, Quebec's speech therapists followed that trend but, rather than creating a new generic category (and following American trends), instead transferred its meaning to an already existing word, "dysphasia," the original meaning of which was very near that of audimutism. Almost immediately, dysphasia became a synonym for audimutism. Dysphasia then replaced audimutism as the category that speech therapists used as the vehicle to invoke the financial privileges formerly attached to the category of audimutism. Through such shifts in meaning, speech therapists were able to expand the scope of their practice, and of the 1988 funding program, from the narrow category of audimutism to a new, generic and still expanding diagnostic category that attributed most language troubles to neurological causes (Samson 1993, 7-19; van Hout 1989, 11-15; Pothier, Pouliot and Allard 1996; Gadais et al., 2000).

This evolution was never ratified by the public departments involved in treating audimutism. In fact, speech therapists made almost no use of the administrative definition of 1988, and instead referred to the scientific reformulations proposed by Quebec's speech therapy researchers. Moreover, they highlighted such reformulations, which were normal for scientific concepts, as acceptable. The enlargement of the diagnostic category far beyond the limits of 1988 appeared, then, to be positive: in 1994, a researcher from the Saint-Justine Hospital linked to the AQEA said she preferred the word "dysphasia" over "audimutism" precisely because dysphasia included all linguistic neurological problems, even those not included in the category of audimutism, such as apraxia or semantic-pragmatic problems (Larose 1994b, 22). The same year, a group of speech therapists working in schools offered another enlarged definition of audimutism: once congenital cerebral dysfunction in the hearing system, the category was now described as a severe language problem specifically affecting comprehension and expression (Gauthier, Cossette, and Dubuc 1994, 91). In 2000, the Institut Raymond-Dewar, a Montreal rehabilitation centre, defined the dysphasic child in an even more inclusive way, as a person who demonstrates great difficulties expressing himself or understanding others (1999-2000, 29).

This powerful reshaping of diagnostic categories, especially by extending the concept of “dysphasic trouble” to semantic and pragmatic problems, allowed speech therapists to diagnose as audimute, or dysphasic, children who were once identified as autistic, making possible the appropriation of a large population that were beyond the scope of speech therapy until then.⁸ Finally, in addition to enlarging it, the transformation of the category reinforced the centrality of language and the speech therapist’s role in the definition and diagnosis of the problem despite the definition of 1988; the non-linguistic aspects of the diagnosis, once mandatory, were more and more often described as facultative or associated (Déziel 1996). By emphasizing the primacy of verbal troubles in the definition of the problem, the new formulations strengthened the centrality of the speech therapist in diagnosis and treatment.

Very quickly, the extension of the category caused a dramatic increase in the number of diagnoses. In 1991, the departments of Health and of Education noticed that the prevalence was four times that predicted by the speech therapists of the joint task force of 1988. In 1992, the suddenness of still more numerous demands from school boards incited a cut in funding, and the Department of Education declared itself astonished at finding audimutism sufferers more and more numerous and diversified (Picard and Clermont 1993, 1). While the 1988 data predicted a prevalence of cases of 0.04%, in 1995 hospital researchers in speech therapy suggested instead a prevalence up to 5% among school children, taking public authorities by surprise (Pouliot 2002, 16-17; Samson 1993, 37-39; Larose 1994b, 22; Crête 2000, 10).

Clinical Diffusion, Neurological Etiology, and Differential Testing

The spectacular case of the reformulation of audimutism, which made the application of the 1988 treatment program totally unpredictable, showed two characteristics, both linked to the question of place. First, the transformation of the category, although it happened quickly, did not happen in a massive or uniform way, as it might have through important articles, new university courses, or other formal channels. The new category was established in very localized ways, clinic by clinic, mostly through interpersonal exchanges. Indeed, exposed to the activities of the AQEA and to changes in the American literature, many speech therapists consulted with researchers from the Université de Montréal (like Dudley) and compared their ideas with colleagues or interns. All of this led to very different interpretations and practices, depending on the various clinical settings. The use by some of a unique taxonomy like the Rapin-Allen chart did not help to unify diagnostic practices; in the 1990s, widely differing diagnostic strategies led to important variations in

labels among clinics: nothing, at this time, prevented a child's receiving very different diagnoses from one speech therapist to another, with respect to the kind of problem ("morpho-syntactic" or "semantic-pragmatic") and its gravity, while testing tools and the very comprehension of the category might vary from one clinician to another. According to observers from the Department of Health, the wide variety of diagnostic approaches used (Lessard 1999, 15) made it difficult to establish the portrait of speech therapy practice in this domain as late as 1999.⁹

Second, this variety suggests that it is the professional dynamic specific to each clinic that constitutes the main driving force of the new categories' diffusion. These variations, however, reveal trends heavily marked by local professional competition: the proportion of new diagnoses, in comparison with the old developmental psychological categories, was higher in the clinics where professional stakes were high, where the struggle for autonomy against psychologists or educational psychologists was the strongest, and where the population met offered the greatest promises of diagnosis in terms of a widely understood concept of communication. New diagnoses were, then, more frequently made in some settings than others: in the language services rather than the hearing ones, in multidisciplinary teams rather than services divided by discipline, and in schools rather than hospitals.¹⁰

Those variations suppose that what we are studying is less the spread of theoretical categories than the action of clinicians who were selecting particular parts of these categories in accordance with the particularities of their workplaces, and mostly to compete with psychologists. By understanding how this selection occurred, we can understand how new diagnostic categories made their appearance in clinics. Systematically, the selected aspects were those that gave clinicians the means to establish distinctive diagnosis aspects, like etiological taxonomies and differential tests.

That is why, despite major disparities on every other aspect, speech therapists in all places unanimously and heavily insisted on the neurological etiology of dysphasia even though, according to many academic papers, the location of the cerebral dysfunction often remains unknown and in 80% of cases it is impossible to identify a precise cause (Lessard 1999, 9). More stipulated than observed, the presence of a neurological lesion was agreed on as soon as it was indirectly diagnosed by the speech therapist on the basis of observed symptoms (Larose 1994b, 23). The shift and the clinical choice of the speech therapist that led to this labelling becomes obvious when we note that the symptoms used to confirm the diagnosis were most often the very same (slowness, inconsistencies, weak variety of sounds or vocabulary) that once led to a psychological diagnosis of delay (Larose 1994a; AQEA 1993).

Associating the symptoms with a neurological cause (or etiology) helped clinicians to sustain a diagnosis and to create a vocabulary and description that removed the diagnosis—and the patient—from the authority of psychologists or other specialists. In the case of audimutism/dysphasia, the diagnosis was formulated in such a way that it distinguished the language problem from other categories that would have justified the involvement of other professionals, categories like hearing problems, low IQ, most psychopathologies, and even the category of neurological deficit as it is used by neurologists themselves. Even when speech therapists assert a generic neurological source, they are excluded once a neurological lesion is diagnosed by a neurologist, who then takes the case for himself. Clinicians used the numerous tests produced by researchers in the same way. Some speech therapists linked to the AQEA used a variety of psychometric tools that allowed them to separate organic (neurological) disorders from psychological ones (behavioural, socio-affective) (Lussier 1994, 31). Other clinicians used the DSM-IV, a well-known classification grid for identification of mental health problems, to isolate what they called associated autistic traits to distinguish better the linguistic aspects.

Most clinicians selected the products of scientific research that best suited their goal of distinctive diagnosis. For example, we see clinicians using the difference between verbal and non-verbal IQ as a differential measure, many years after Quebec's academic community in speech therapy had rejected it as a means of diagnosis. One speech therapist, using a severity chart to make a diagnosis, indicated that the chart's user's guide itself warned against using the chart to make a dysphasia diagnosis; she defended herself by observing that there were no other tools for confirming the diagnosis (Crête 2000, 12, 14; Lessard 1999, 16, 18-24, 40; Lussier 1994, 31-34; Gauthier, Cossette, and Dubuc 1994, 93).

Putting New Categories in Place(s)

This new trajectory for speech therapy took place in the specific context of Quebec's health system during the 1990s, the most salient feature of which was the vigorous reform launched by the provincial state after 1991, which combined both strong cutbacks in financing and pressures for greater complementarity between health-care settings. Required to give themselves distinctive vocations and threatened by budget cuts, health-care centres became very aware of the demands of clinicians able to target new problems and start new services.¹¹ In this context, the renewed capacity of speech therapists to identify cases through the use of new diagnoses was of great value for health-care centres in their quest to refresh their mandates and increase their clientele.

The impact of the new practices of speech therapists were indeed decisive. At the Institut Raymond-Dewar, a spectacular increase in patients after 1995 was almost entirely the result of a new program for dysphasic children. Other rehabilitation centres experienced a similar evolution, like the Centre montréalais de réadaptation, which welcomed during the 1990s a massive number of children with language problems (Institut Raymond-Dewar 1993-2001; Moquin 2002). As their new client base emerged, speech therapists gained a new status in interprofessional relationships. They automatically took charge of numerous patients: in 2001 at the Institut Raymond-Dewar, young children were assigned in a larger proportion to the speech therapists than the psychologists.¹² Less dependent on the side effects of problems diagnosed by others, speech therapists became a source of new references for their clinical settings: more children than ever were being introduced in the health-care network for language problems diagnosed in speech therapy, and were eventually also referred to psychologists or occupational therapists for side motor or developmental problems "associated" with dysphasia; it was now up to other professionals to complement the work of and wait references from speech therapists (Institut Raymond-Dewar 1988-2001; Desruisseaux 1992; Picard and Clermont 1993).

The creation of new and better work positions was also of some importance for the future of the profession. The number of speech therapists in Quebec had more than doubled since 1989, from 495 in 1988 to 1,150 in 2001, with the effect that the newcomers met, until 1995, with an employment crisis, while hiring in psychiatric settings and schools stagnated and part-time jobs were more frequent in speech therapy than in most of other allied health professions. The scarcity of jobs was such that many speech therapists started to lament their poor career prospects: in 1994, after a rough fight against the closure of positions in schools near Montreal, a group of speech therapists criticized their own professional association for a shortage, not of therapists, but of decent positions (Fréquences 1994, 8-9).

As the implementation of new diagnoses by speech therapists resulted in the growth of the diagnosed population, however, many agents in the health-care system began to evoke the fear of a real shortage of speech therapists. The number of cases, essentially in dysphasia, increased fast, and the first waiting lists began to appear, some reaching from three to six months in rehabilitation centres by 1999, and up to a year at Sainte-Justine Hospital (Leduc 2000). A sudden shortage of speech therapists appeared as the direct consequence of the therapists' new activities: through the use of new categories like dysphasia, they diagnosed many more cases than they could take. The longer waiting lists came from the centres like Sainte-Justine and the Institut Raymond-Dewar, which were well staffed with speech therapists, since that is where the diagnostic activity was the most

intense. The increase in actual cases was only real in speech therapists' new fields of activity: more traditional conditions, like motor problems, occurred at historical levels. Waiting lists included more than 92% of 0-to-11-year-old children in hospitals, and more than 72% of 0-to-4-year-olds in rehabilitation centres, which was precisely the population targeted by speech therapists' new diagnostic categories, and among those the main needs were for speech therapy services (Leduc 2000, 39; Bédard, Couture, and Delisle 1991, 1; Picard and Clermont 1993, 16).

What is more interesting is that the changes had to do with a variety of localized initiatives issued from workplaces themselves, rather than from global changes in the field, and, in those localized initiatives, the convergence of clinicians' aspirations and the interests of health-care institutions appeared to be the driving force. Most often, the sudden shortages of therapists emerged because of the new diagnoses that were made out of existing programs. This was the case, for example, with the Institut Raymond-Dewar. Perceiving recent political changes and therapists' aspirations, the managers of the Institut Raymond-Dewar decided, in 1993, to widen their interests in severe communication problems. In 1996, a year after the official recognition of dysphasia by the Department of Health and months after the beginning of heavy budget cuts, the institute embraced a new mandate, inaugurating the DYS/TAC program (Dysphasie/Troubles auditifs centraux) for dysphasia and central auditory diseases.¹³ At its beginnings, the program employed a quarter of the institute's speech therapists; in three months, the team opened up 181 files, mostly for children aged three to six, and created new relationships with speech therapists from the Sainte-Justine Hospital and with school boards in Montreal and its Laval neighbourhood, for testing and screening purposes. Created solely on the institute's initiative, the program received no federal or provincial funding, and soon lacked resources. In 1998, representatives of the program established a partnership with their counterpart at the Sainte-Justine Hospital, which was dealing with a similar problem; other agreements with this hospital as well as with the Jewish Convalescent Hospital (in Laval) permitted them to admit new cases and to join forces and, with help of the AQEA, address demands for development funding to the provincial government (Institut Raymond-Dewar 1995-2000).

It is the mechanics of those local initiatives that produced the unprecedented increase in the number of available speech therapists and an unprecedented shortage of personnel. The situation allowed the professional association to state in 1997, that even if the situation of services has not deteriorated globally, the needs of the population and waiting lists are increasing (Ordre des orthophonistes et des audiologistes du Québec 1997-1998, 9). The pressures caused by the lack of therapists gave the association the opportunity, in collaboration with patients'

associations, to launch a 1995 campaign to heighten public awareness of the problem and the potentially harmful delays caused by waiting lists (1996-1997, 7). The long waiting lists for dysphasia services became of political importance to the point that, during the provincial election campaign of 2003, liberal candidate Jean Charest raised this specific issue as an additional proof of the failure of the government (Chouinard 2003, A4).

Conclusion

In this essay I emphasized the impact of clinicians' local initiatives and professional aspirations in the diffusion of new categories of diagnosis at the local level in health-care centres. I also showed how this depended upon professionals' ability to use diagnoses that made possible the appropriation of cases otherwise treated by other specialists. In this, we saw the role of scientifically produced new categories, but also the autonomous and localized ways they were received and used by clinicians, thereby explicating the great variety of practices that lay behind the apparent uniformity of labels. Clinicians tended to appropriate the categories and the scientific production linked to them in a very selective way, selecting etiologies and tests that helped implement their diagnoses, but not elements that would have constrained their professional autonomy. The determinants of those particular selections were in good part local, to the point that informal fragmentation might give way to very different and sometimes even contradictory practices and interpretations of the categories from one place to another, depending especially on local professional trends.

To the historian, this approach may suggest some considerations about how knowledge circulates from one place to another, and also how clinicians select and make interpretations, depending mainly on local and professional imperatives. This approach demonstrates how political decisions aimed at rationalization, based on the idea of complementarity between health-care centres, in fact supported a strong pressure for more differentiation and the unprogrammed multiplication of health activities.

Notes

I wish to thank Robert Gagnon, Yves Gingras, Peter Twohig, and the anonymous evaluators of the *Journal of Canadian Studies* for their helpful suggestions and kind help. The research was financially supported by the Social Sciences and Humanities Research Council of Canada.

1. These authors analyze the emergence of hematology in the United States and in Quebec.
2. This gap leads sociologist of professions Eliot Freidson to state that "the actual substance of the knowledge that is ultimately involved in influencing human activities is different from the formal knowledge that is asserted by academics and other authorities" (1986, xi). For examples of this kind of analysis applied to medical work, see Barbara Sicherman (1977) and Christopher Crenner (2002).
3. Like morphological markers, length of utterances, or specific language units labelled "speech acts."
4. There is virtually no identified case in areas like Quebec City or Ottawa, where there are no centres dealing with audimutism (Quebec 1988, 6-9, 13, 25).
5. This was consistent with functional principles emphasizing handicap instead of etiology; about those functional principles, see Prud'homme (2006, 260-61).
6. The five symptoms were problems with language, auditory perception, abstraction, generalization, and time perception.
7. Pragmatics refer to the broad, often non-verbal, rules of personal interaction, like respecting turns to speak or maintaining eye contact.
8. A population in which psychologists, and some psychiatrists, keep diagnosing autism or other related categories is schizophrenia. The overlap is also due to the extension of the fields of psychology and neuropsychology to the communicative use of language (Mottron 1996).
9. In order to rectify this confused situation, the professional association of speech therapists in 2003 began a process of consultation to determine an official definition of dysphasia, resulting in the 2005 definition of dysphasia as a primary language impairment.
10. In the schools, the fields of speech therapy also extend to reading and writing, learning problems that were until then under the jurisdiction of educational psychologists (Leduc 2000, 37; Dudley 2001; Noreau et Tousignant 1993; Gadais et al. 2000; Lessard 1999, 15, 18, 40).
11. For a more developed discussion about the administrative context in Quebec, see Prud'homme (2006), Bergeron (1990), and White (1994).
12. The speech therapist met twice as many children as the psychologist, including all children aged 0-4 and 58% of the 4-12-year-olds; speech therapists also spent, on average, twice as much time with every child. The presence of speech and hearing therapy at the Institut Raymond-Dewar has increased steadily, the financial weight of the service increasing from 17% to 40% of the centre's budget from 1983 to 1993, and the proportion of speech and hearing therapists among the clinic personnel rising from 40% to 50% between 1993 and 2001 (Institut Raymond-Dewar 1992-2001).
13. The original amalgam of those two problems comes from the early attribution of dysphasia to an impairment of the auditory function. The latter problem is diagnosed differently and dysphasia cases will always represent most of the new patients.

References

- Abbott, Andrew. 1988. *The System of Professions: An Essay on the Division of Expert Labor*. Chicago: University of Chicago Press.
- Anonymous. 1994. "Tribune libre." *Fréquences* 7, 1: 8-9.
- AQEA. See *Association québécoise pour les enfants audimutets*. 1993. [Untitled]. Montréal : AQEA.
- . 2001. *Les besoins de la clientèle dysphasique*. Montréal : AQEA.
- Bédard, Danielle, Francine Couture, and Hubert Delisle. 1991. *Expérimentation et évaluation du Programme Hanen en milieu communautaire*. Sherbrooke: Centre hospitalier universitaire de Sherbrooke.
- Bergeron, Pierre. 1990. "La Commission Rochon reproduit les solutions de Castonguay-Nepveu." *Recherches sociographiques* 31 (3): 359-80
- Buttiens, Bernadette. 1987. *L'aphasie congénitale*. Amos: AQEA.
- Chouinard, Tommy. "Autistes et dysphasiques en attente de services—Landry a abandonné les jeunes, accuse le chef libéral." *Le Devoir*, 19 March, A4.
- Crenner, Christopher. 2002. "Diagnosis and Authority in the Early Twentieth-Century Medical Practice of Richard C. Cabot." *Bulletin of the History of Medicine* 76: 30-55.
- Crête, Françoise. 2000. "Les critères d'identification de la dysphasie sévère, un outil fort intéressant !" *Fréquences* 12 (2): 10-15.
- Desruisseaux, Doris. 1992. *L'enfant présentant un syndrome dysphasique et l'ergothérapie*. Sherbrooke: AQEA-Estrie.
- Déziel, Joane. 1996. "Éditorial." *Fréquences* 8, (2): 3-4.
- Dudley, John. "Philosophie: 200 cas d'audimutité." In *Actes du colloque sur l'audimutité*, ed. AQEA, 129-31. Montréal: AQEA.
- Freidson, Eliot. 1986. *Professional Powers: A Study of the Institutionalization of Formal Knowledge*. Chicago: University of Chicago Press.
- Gadais, Patrick, et al. 2000. "Taxonomie des dysphasies." *Fréquences* 12, 2: 17-21.
- Gauthier, Mireille, Céline Cossette and Christine Dubuc. 1994. "Modèle de service du CAM." In *Actes du colloque sur l'audimutité*, ed. AQEA, 91-96. Montréal: AQEA.
- Institut Raymond-Dewar, *Annual Report, 1988-2001*.
- Larose, Mireille. 1994a. "Indices d'anomalies du développement du langage chez l'enfant de 0 à 5 ans." In *Actes du colloque sur l'audimutité*, ed. AQEA, 1-6. Montréal: AQEA.
- . 1994b. "Syndromes dysphasiques." In *Actes du colloque sur l'audimutité*, ed. AQEA, 18-26. Montréal: AQEA.
- Leduc, Murielle. 2000. *Description des services d'orthophonie et d'audiologie offerts par les CHSGS, CHR, CR en déficience physique, URFI et hôpitaux de jour de la région de Montréal-Centre*. Montréal: Régie régionale de la santé et des services sociaux de Montréal Centre.
- Lessard, Nicole. 1999. *Le devenir des enfants ayant fréquenté le CAM*. Montréal: Régie régionale de la santé et des services sociaux de Montréal Centre.
- Lussier, Francine. "Neuropsychologie et audimutité." In *Actes du colloque sur l'audimutité*, ed. AQEA, 28-32. Montréal: AQEA.

- Moquin, Danielle. 2002. Interview with author. 8 November.
- Morency, Michèle and Cécile Chavy. 1989. *Troubles de langage et de communication versus troubles psychiâtriques*. Rivière-des-Prairies : Hôpital Rivière-des-Prairies.
- Mottron, L. 1996. "La place du trouble de langage dans l'autisme." *Fréquences* 8, 2: 16-18.
- Noreau, Danielle, J.-L. Tousignant et al. 1993. *Audimutité: Pédagogie adaptée aux élèves*. Saint-Hubert: Sous-comité régional d'adaptation scolaire de la Montérégie.
- Ordre des orthophonistes et des audiologistes du Québec, *Annual Reports, 1991-1995*.
- Picard, Liette and Michel Clermont. 1993. *L'organisation des services aux personnes présentant des problèmes de langage, d'audition et de communication*. Québec: Department of Education and Departement of Health and Social Services.
- Piché, Sébastien. 1999. "Histoire de la spécialisation médicale au Québec: Le cas de la naissance de l'hématologie à l'hôpital Notre-Dame de Montréal, 1920-1960." MA thesis, Université du Québec à Montréal.
- Pothier, Josée, Caroline Pouliot, and M.-H. Allard. 1996. *La dysphasie: Portraits d'enfants*. Québec: Centre Cardinal-Villeneuve.
- Prins, Ad. 1998. "Aging and Expertise: Alzheimer's Disease and the Medical Professions, 1930-1990." PhD thesis, Universiteit der Amsterdam.
- Prud'homme, Julien. 2005. *Histoire des orthophonistes et des audiologistes au Québec, 1940-2005: Pratiques cliniques, aspirations professionnelles et politiques de la santé*. Québec: Presses de l'Université du Québec.
- . 2006. "Diagnostics, promotion professionnelle et politiques de la santé: les orthophonistes québécoises depuis 1970." *Recherches sociographiques* 48, 2: 253-275.
- Quebec. Joint task force on audimutism. 1988. *Rapport du comité sur l'audimutité (ou aphasie congénitale)*. Quebec: Department of Education and Department of Health and Social Services.
- Samson, Madeleine. 1993. *Mise au point sur l'audimutité*. Montréal: Commission des écoles catholiques de Montréal.
- Sicherman, Barbara. 1997. "The Uses of a Diagnosis: Doctors, Patients, and Neurasthenia." *Journal of the History of Medicine and Allied Sciences* 32 (1): 33-54.
- Twohig, Peter. 2005. *Labour in the Laboratory: Medical Laboratory Workers in the Maritimes, 1900-1950*. Montreal: McGill-Queen's University Press.
- van Hout, Anne. 1989. "Aspects du diagnostic des dysphasies." *Approche neuro-psychologique des apprentissages chez l'enfant* 1 (1): 11-15.
- Wailoo, Keith. 1997. *Drawing Blood: Technology and Disease Identity in Twentieth-Century America*. Baltimore: Johns Hopkins University Press.
- White, Deena. 1994. "The Rationalization of Health and Social-Service Delivery in Quebec." In *Health, Illness and Health Care in Canada*, ed. B. Singh Bolaria and Harley Dickinson, 83-105. Toronto: Harcourt Brace.