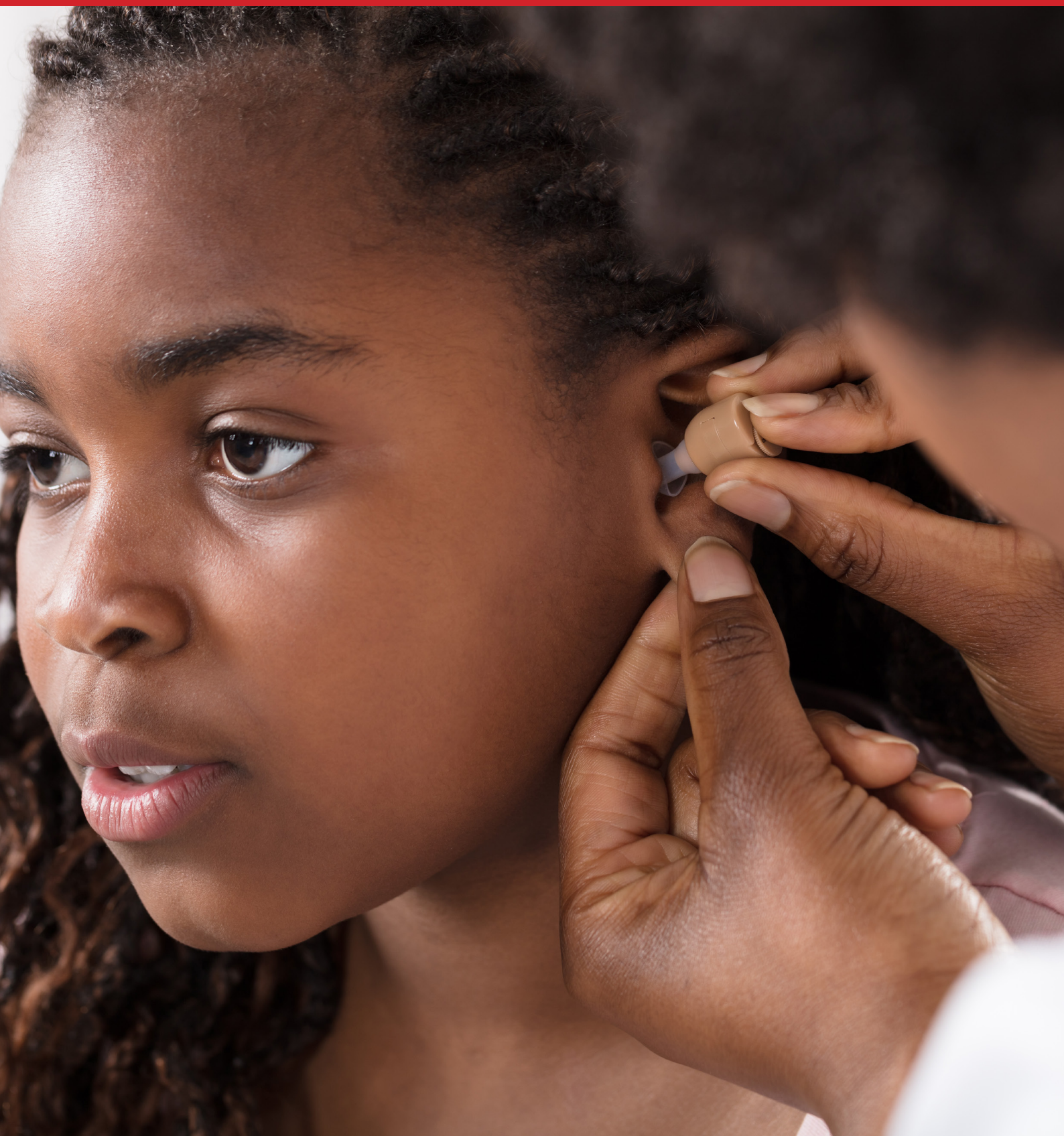
HPCSA
Health Professions Council of South Africa

Speech Language & Hearing Professions NEWS

Issue 01/07/2022

Newsletter for Speech Language and Hearing Profession (SLH) Board



CONTENTS

CHAIRPERSON'S NOTE

The Professional Board for Speech, Language and Hearing (SLH) is constituted in terms of the regulations relating to its constitution. The Professional Board exercise governance over Speech, Language, and Hearing practitioners inclusive of mid-level workers in the profession/industry. Current membership of the SLH Board includes ten (10) members representing a diverse range of stakeholders, professionals from Higher Education Institutions, private practice, community representatives etc.

Since the profession is in a constant process of learning skills and application of knowledge that allows therapists to establish and implement new processes, techniques, and methods of ensuring provision of high-quality speech, language and hearing healthcare for all individuals, various committees are constituted to guide regulations, professional practice, professional conduct etc. The SLH Board thus executes its work through various committees and has constituted the following committees: Executive Committee of the Board (EXCO), Education, Training and Registration Committee (ETRC), Committee of Preliminary Inquiry (Prelim), Professional Practice Committee (PPC), the Ad-hoc performance Assessment Committee and task teams as the need arises.

As a Board, we owe gratitude to our predecessors (the previous SLH Board: 2015-2020), who were exemplary in how they conducted the business of the Board to ensure that it (the Board) fulfils its mandate. As an incoming Board, we are therefore fortunate to be handed over a detailed plan from the previous Board to conclude outstanding matters , that could not be completed during the term of our predecessors. This has given us a firm foundation upon which we started our journey as a new Board.

As a new Board, we started our term under some exceptional circumstances, the country has just emerged from a protracted period of national lockdown following the advent of the COVID-19 pandemic. This essentially meant that the usual operational functions of the Board had to be modified. We had to quickly adapt to the new ways of working that complied with the national COVID-19 regulations. This led to very limited face-to-face engagement between Board members. Our journey as a Board therefore started in a virtual realm. However, despite these challenges, we have managed to carry on with the business of the Board to ensure that it fulfils its mandate.

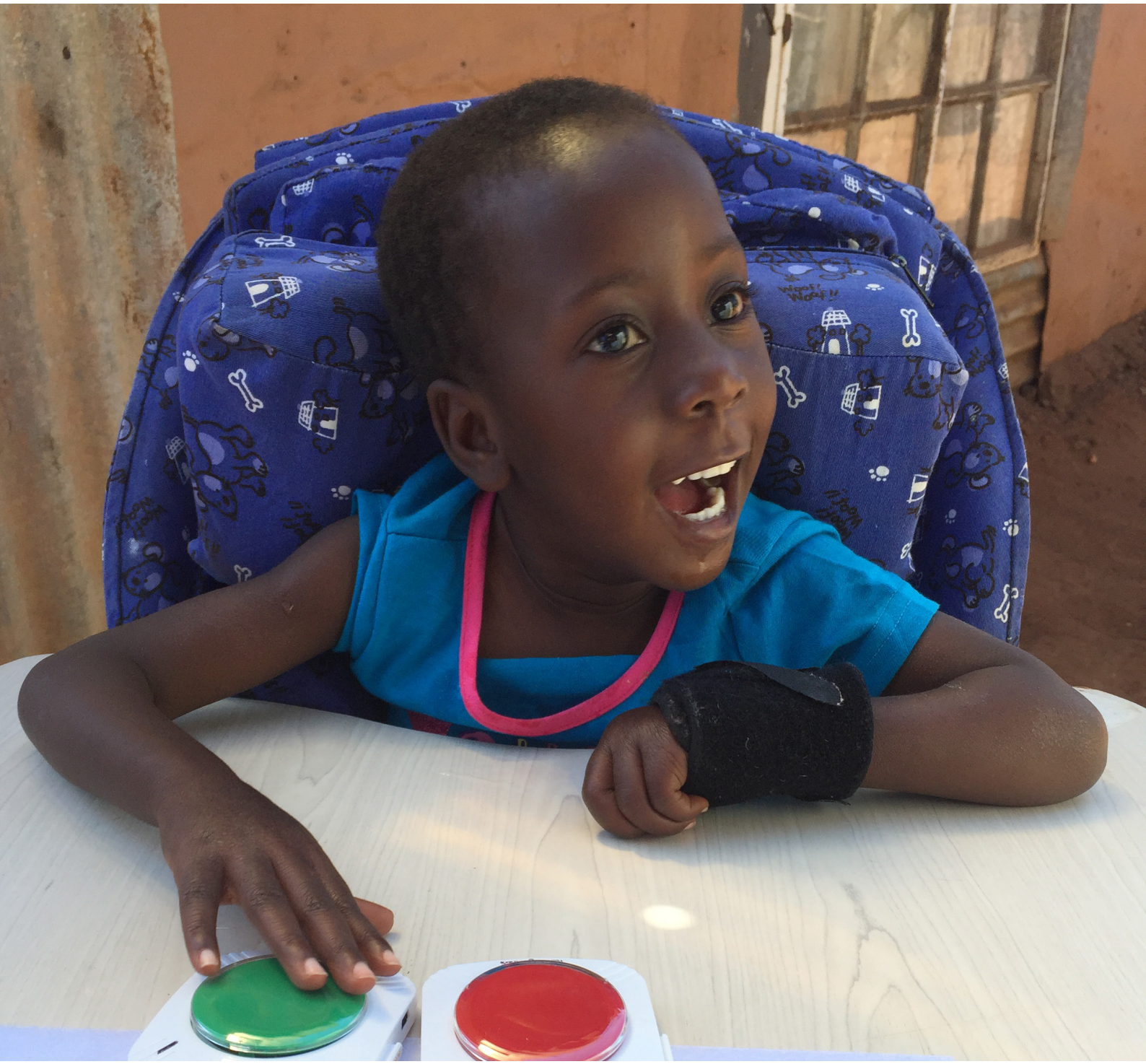
One of the biggest tasks that we embarked on was to craft a strategic plan that will guide our function as a Board during our term (2020-2025). In developing such a strategic plan, we were acutely mindful of our new reality. The rapidly changing landscape of our professions, partly due to the new pandemic that has forced the entire world into a state of collective reflection, and the advent of the fourth industrial revolution that has brought with it an urgent need for a digitally enabled Board, has resulted in us needing to be proactive and forward looking instead of just being reactionary and always playing catch up.

As expected, there were many matters that we wanted to take up as strategic initiatives. However, following a careful process of SWOT analysis, we were forced to be selective and ended prioritising strategic goals and objectives that will enable us to stay relevant as a regulatory Board amidst a rapidly changing professional landscape (both in education and training and professional practice). We therefore identified eight goals that we eventually adopted as our strategic

objectives. The strategic objectives included a plan to ensure standardisation of exit competency levels of new graduates, improving relationships between the Board and all our relevant stakeholders, ensuring that our current rules, regulations and guidelines are relevant and just, creating an enabling environment for CPDs for professionals registered with the Board, timeous conclusion of all professional conduct matters as well as ensuring that the Board is digitally enabled to function optimally.

Our first year as a Board has been off to a great start. The current Board is constituted with amazing individuals who bring along with them a wealth of expertise and experience. I am therefore confident that we will fulfil our mandate and competently execute our strategic goals to ensure that we move our professions forward.

Thank you.
Lebogang Ramma
Chairperson of the Professional Board for Speech, Language and Hearing



LEBOGANG RAMMA

Professor Ramma is the current Chairperson of the HPCSA's Professional Board for Speech-Language and Hearing (SLH) . He is also the Head of the Department of Health and Rehabilitation Sciences at University of Cape Town (UCT). He holds a Doctor of Audiology degree (AuD) from the University of Florida-Gainesville, USA; Master of Public Health (MPH) from the Witwatersrand University (Wits) and Post Graduate Diploma in Health Economics from UCT. He started his clinical audiology career in the US, first working for the Department of Veterans Affairs (Veteran's Administration Hospital, La Jolla, San Diego, California and later worked for Riverside Medical Clinic (in Riverside California). His academic career started at Wits as a lecturer (2004 until 2006) and later moved to UCT in 2007. His general area of research is population-based interventions in Audiology; specifically, prevention of acquired hearing loss from recreational noise exposure and therapeutic agents. He has published several peer-reviewed research articles in this area. He also presents regularly at conferences (both national and international). Prior to being appointed as the Chairperson of the SLH Board, he served on several HPCSA task teams and he has also chaired the National Advisory Committee on the Prevention of Ototoxicity in patients undergoing DR-TB treatment (2018-2021).

JOSIAS NAIDOO

Josias Naidoo is an Audiologist with 15 years of clinical experience. He is a well-respected public health activist and contributes to a range of media publications and discussions. Josias is currently a member of the SLH Board and is the present Chairperson of the Board's Practice Committee. Mr Naidoo serves as the National Vice Chairperson of the National Health Care Professionals Association as well as founder and Chairperson of a health focused NPO – Hope4Health. He has also pursued further education and holds an International MBA as well as training and certification in NLP, Medical law & Ethics, Humanitarian Law and is currently pursuing his PhD in Public Health. He is very involved in the private health sector and assists in various conduct issues affecting practitioners in private practice. Mr Naidoo is a firm believer in equitable healthcare and is a strong advocate for universal health coverage.

PHILEMON RATSHULUMELA

Philemon Ratshulumela holds a diploma as a HAA from University of Pretoria, and a diploma in Community Sp & H from Wits University. He worked at Tshilidzini Hospital and Siloam Hospital as a middle manager for both the Speech and Hearing services. He also worked at the then 2010 hotel service management responsible for the upgrading and services improvement at a hospital level. He was a director at Riakona Community Based Rehabilitation for the Physically challenged and the blind responsible for Orientation and Mobility services . He later moved to independent private practice in the Vhembe District in Limpopo. Mr Ratshulumela agreed to serve on the HPCSA Board to positively contribute both experience and community development skills to the SLH Board in its judiciary mandate to guide the profession and to protect the public.

SHILUVANA SYDNEY MASHELE

Shiluvana Sydney Mashele is the Founder and Managing Director of Nkuhlwana Trainers and Projects. He leads a company that believes in a world-class service and offers learning and performance-related solutions for government sectors, consulting engineers, government departments and the community for the enablement of effective and efficient stakeholder engagement, training and skills development. The company is accredited with various Sector Education and Training Authority (SETA) organisations such as the Service SETA, the Local Government Sector Education and Training Authority (LGSETA) and the Safety and Security Sector Education and Training Authority (SASSETA). He is a seasoned Skills Development Facilitator and a trainer with vast experience. Mr Mashele currently serves as the Chairperson of the Preliminary Inquiries Committee on the Professional Board for the Speech, Language and Hearing Professions (SLH).

He holds a diploma in Community Sp & H from the University of the Witwatersrand (Wits) and a Certificate in Primary Health Care Management Services from the Public and Development School (Wits). In addition, he holds a Postgraduate Diploma in Health Management from Wits University and a Certificate in Project Management from the University of South Africa (UNISA). He has completed several certificates related to training, including the Certificate in Training for Trainers and the Assessor Course. He worked at Letaba Provincial Hospital for seventeen years as a Community Speech and Hearing Therapist.

Mr Mashele has always been passionate about success. Unlike skill, knowledge or abilities, passion is innate: it can't be learned or acquired but it is always present. It has been this passion that powered his hard-work, determination and creativity which

made great accomplishments possible. He attended his schooling in Bordeaux in Limpopo , where he was born and bred. When he was a young lad, his mother was a domestic worker and during school holidays he used to work in nearby farms to help her make ends meet. He also worked in Phalaborwa residences as a garden boy and earned fifty cents (50c) per day. After obtaining his matric he worked for an NGO, Gazankulu Society in Alcoholism and Drug Dependency as an Information Officer. He was also sent to African countries to do observation in community primary Health Care after obtaining his certificate in Primary Health Care Management.Through it all, his passion was the powerful force that made him accomplish all his successes. It is life stories such as his that makes one realise that, indeed, where there is a will, surely there is a way!

DAVID MJ MASEMINE

David MJ Masemine holds a BA (Hons) from the University of Limpopo, and certificates and diplomas from various learning institutions. Mr Masemine is a teacher by profession and has taught at various schools holding different positions. He started teaching at Siloe School for the Blind in Chuenespoort, Polokwane and spent fifteen years at this school. While at Siloe he obtained a diploma in Special Education (DSE).

Mr Masemine later obtained the post of Principal at Matanta Secondary School and held various leadership positions in the Mapela Circuit. As Chairperson of the South African Principals Association (SAPA) at both District and Regional level, he then obtained a certificate in Value Based Educational Leadership in South Africa (The Catholic Institute of Education in Association with Wits.) He was appointed as Circuit Manager in the Naboomspruit Circuit (Mookgophong) and was elected as Deputy President of the Circuit Managers' Forum in Limpopo.

Mr Masemine as a SLH Professional Board member serves on two committees; namely, the Education, Training and Registration Committee and the Committee of Preliminary Inquiry.

JANE HERBERT

Jane Herbert comes from Port Elizabeth, now Gqeberha, in the Eastern Cape. She holds a BA (Logopaedics) from the University of the Witwatersrand and an MA (Linguistics) from the University of Stellenbosch. Her lifetime clinical career as a Speech Therapist has included experience in state healthcare, special needs education, private healthcare, and private practice. Later in her clinical career she found her passion was working with adult patients who had suffered severe neurological disease or trauma and this led her to study further in the field of clinical linguistics and dysphagia theory and therapy. She worked as a Speech Therapist at Aurora Hospital soon after its opening as the first private acute rehabilitation hospital in the Eastern Cape and later became the hospital's first Director of Physical Rehabilitation Therapy. She attended and presented papers at both national and international conferences. Immediately prior to serving her first term on the Board, she was President of SASLHA for three years, as well as being on the Board of the Southern African Neurorehabilitation Association. After retirement from Aurora Hospital, she was involved in the monthly assessment clinics and family and carer education and training at the Eastern Cape Alzheimer and Dementia Society. This is her second term on the SLH Board, serving on the Committee of Preliminary Inquiry and the Professional Practice Committee.

NOMFUNDO MOROE

Nomfundo Moroe, is the current Chairperson of the Education, Training and Registration (ETR) Committee of the HPCSA's Speech-Language and Hearing (SLH) Professional Board. She is a senior lecturer and current Head of Discipline (Audiology) at the University of the Witwatersrand. She is part of the Department of Higher Education and Training's New Generation of Academics Programme (NGap) – a programme that involves the recruitment of highly capable scholars as new academics, against carefully designed and balanced equity considerations and in light of the disciplinary areas of greatest need. She is a passionate researcher, with an interest in Occupational Audiology, Complex Interventions, Deaf culture and Deafblindness. She is a CARTA Fellow (Consortium for Advanced Research Training in Africa), a highly competitive programme that trains young and emerging researchers in Africa. She is currently conducting post-doctoral research which is funded by this consortium. She has published several peer-reviewed articles,and has presented at both national and international conferences. She has co-edited a Special Issue Journal for the South African Journal of Communication Disorders (2020) titled Occupational Hearing Loss in Africa: An interdisciplinary view of the current status. Her upcoming outputs include a co-edited book Occupational Noise Induced Hearing Loss: An African Perspective by AOSIS Press.

DR CARMEN MILTON

Dr Carmen Milton is the deputy chairperson of the Speech- language and Hearing Professional Board of the HPCSA. She has working experience in a variety of sectors including the semi-private sector (NGO), health sector, education sector as well as in higher education. She has however spent the majority of her career in academia, starting at the Medical University of Southern Africa (MEDUNSA) currently known as

Sefako Makgatho Health Sciences University (SMU) but joined the University of Pretoria at the beginning of August 2021.

Her career highlights in the various sectors include the establishment of community outreach programmes in various historically disadvantaged areas, developing and implemented disability and rehabilitation programmes as well as policies around disability, assistance in setting up the speech-language therapy department at learners with special educational needs (LSEN) schools and establishing therapy protocols and policies within the schools. She was a key role player in founding the Department of Speech Language Pathology and Audiology at MEDUNSA currently known as SMU. As an academic she had the opportunity to present at a number of conferences and workshops.

Dr Milton served on the editorial board of the South African Journal of Communication Disorders during 2006/7 and served as a co-opted member of the ETR Committee of the HPCSA since 2018. She is currently a member of the EXCO and ETR Committee of the SLH Board as well as the Inter-board Health Committee of the HPCSA. She is very conscious of current issues in transformation and the role it plays in shaping the future of our profession as well as our country. She looks forward to contributing in shaping the profession to meet the unique needs of the people we are serving. Coming from a previously disadvantaged community where her primary and secondary education took place, and being an alumnus of the University of Pretoria, the University of Stellenbosch as well as Sefako Makgatho Health Sciences University combined with her experience in higher education and her passion for the profession and the people we serve, places her in a unique position to serve the profession in an ethical, professional manner whilst persistently fostering compliance with healthcare standards as prescribed by the SLH Board of the HPCSA.

KGWITI MICHAEL MAHLAKO

Kgwiti Michael Mahlako is an employee of the National Department of Health as a Director: Primary Health Care. He had acquired the following academic qualifications: Diploma in Nursing (General, Community, Psychiatry) and Midwifery; Bachelor of Nursing Science (Nursing Education and Nursing Management) and Master's Degree in Health Service Management.

He started his career as a professional nurse at the Elizabeth Ross District hospital in 1990, progressed to QwaQwa Nursing College as a junior nurse educator in 1994 and moved to the Free State School of Nursing in 1997 at Welkom campus a senior nurse educator. In 1999 during the rationalisation process in the Free State Provincial Health Department, he was transferred to Thabo Mofutsanyana District to be part of District Health Management Team. In 2001, he worked as Nursing Services Manager responsible for nursing services in Phekolong and Reitz District hospitals complex. In 2002 he moved to the National Department of Health responsible for health promotion programme. During the period; 2009 - 2011 he moved and worked in Development Cooperation Directorate and was responsible for monitoring Official Development Assistance (Donor Funding) from Canada, United States of America, Italy and Germany. From 2011 to date he is working in Primary Health Care Directorate responsible for providing leadership and technical support to provinces on the Primary Health Care Service Package through District Health Systems and national health programmes integration. He has passion on restoring the health service delivery platform for quality care.

Key achievements:

In 2004 he facilitated the development of Health Promotion Training standards (NQF, level 3 - 6) with the universities of the Witwatersrand, Walter Sisulu and Limpopo. In December 2006, (as an Acting Director: Health Promotion) he successfully led the Local Organising Committee for the 19th World Diabetes Congress - an international event, held in Western Cape province, approximately 12 600 people from 130 countries attended including politicians. He led the drafting of the amendments to the Tobacco Products Control Act (Principal Act, Act 83 of 1973); and the processes that led to two amendments on the principal legislation being promulgated which are Tobacco Products Control Amendment Act 23 of 2007, Tobacco Products Control Amendment Act 63 of 2008. He led the team that represented South African at the Conference of the Parties to the World Health Organisations' Framework Convention on Tobacco Control that adopted two Articles: Guidelines for Packaging and Labelling of tobacco products and Prevention of illicit trade on Tobacco products. He conducted a research project on "monitoring adherence to physical exercises and eating healthy diet by chronic diseases support groups in some primary healthcare clinics". He conducted a Qualitative Research study, entitled "The study on registered midwives' responses to women in labour/ childbirth in selected Government hospitals (under the supervision by University of South Africa). He actively participated during all the stages of the development of a formal curriculum for community health workers who serves in the Ward Based Primary Health Care Outreach Teams – the curriculum was approved by the South African Qualification Authority in 2014. He actively participated in Action Research of the Ideal Clinic Realisation and Maintenance for 10 clinics in 4

National Health Insurance Pilot sites. The Ideal Clinic Realisation and Maintenance report was used during the Operation Phakisa Health Laboratory session that took place during 13 October – 21 November 2014 facilitated by the Department of Performance Monitoring and Evaluation. The Ideal Clinic Realisation and Maintenance programme is adopted as a key basic health service delivery platform reform programme in preparation of the implementation of the National Health Insurance.

FRASER MATHETI RAMPHISA: MSC (PGDED) EDINBURGH, B.A, B.A(HONS) UNISA; STD (NORTH)

Fraser Matheti Ramphisa is an educationalist with vast experience in the field of teaching and learning. He served the Limpopo Department of Education as a Teacher, Deputy Principal, Principal and Chief Education Planner.

He is serving a second term as an Ordinary member of the SLH Board in his capacity as community representative.

MESSAGE OF SUPPORT:

As a family of professionals with vast experience in our fields of specialisation, I urge you all to join hands in reviving and accelerating service delivery which was, to an extent, slowed down due to COVID-19. The past waves affected our professional practice negatively with lives being lost. This is the time to rebuild and to re-unite.

Let us, however, remain hopeful that the fourth wave will be less destructive, and that professional life and livelihood will gradually return to normality.

Let us remind ourselves as practitioners and as members of the SLH Board that our core functions are two-fold; viz

- to protect the communities, we are serving and servicing, and
- to guide and promote the profession through implementation of regulations and legislation relevant to the course.
- May we have a fruitful 2020/21- 2025/26 term of office.

UNDESIRABLE BUSINESS PRACTICES FROM NON-REGISTERED INDIVIDUALS OFFERING SERVICES IN SPEECH THERAPY/AUDIOLOGY

In its duty to guide the professions and protect the public, the HPCSA often find cases that are of concern. These include the prevalence of fake practitioners and individuals providing services that are specific to the practice of health professionals registered under Council.

Recently several members of the public as well as practitioners raised concerns about a hearing aid business in Johannesburg that was brazenly offering very cheap hearing aids to the public. On investigation it was noted that the individual behind this business was not a registered practitioner and had no adequate training in the field of Audiology or Hearing Aid Acoustics. He was reported to be using rudimentary techniques to guess a patient's hearing threshold and was then fitting unsuspecting individuals with cheap hearing amplifiers which he retailed for thousands of rands. Such products are not regulated and when fitted, can lead to further hearing damage.

We are fortunate that through the swift intervention of our investigators from the HPCSA's Inspectorate Office , this illegal business was stopped. This is a great victory for both the public and the profession as it safeguards our communities from potential harm and protects the autonomy and reputation of the profession.

The public is advised to always ensure that it seek advice and healthcare services from registered practitioners who are licensed and qualified to provide healthcare. If you are not sure if an individual is registered, you can make use of a free verification tool on the HPCSA's official website. This will provide information confirming the practitioner's status and qualification. All practitioners should operate from a clean and professional environment and their qualifications and registration certificate should be available to view in the practice.

In a troubled economy, people are always looking for ways to create an income, however the public is warned to avoid trying to provide health services that are regulated under the Health Professions Act, 56 of 1974. These undesirable practices can lead to serious harm and in some cases even death. Those found guilty of misrepresenting themselves as health professionals or those found to be providing services that are solely under the scope of practice of health professionals will find themselves in breach of Section 39 of the Health Professions Act and can face serious charges and even imprisonment.
If you know of any illegal activity related to the above, please report it to the HPCSA.

ABSTRACT

As the awareness of and requirements for evidence-based practice (EBP) increase, there is a justifiable call for the application of EBP into clinical practice. Speech-language pathologists and audiologists in clinical practice, scientists in related research settings, and students in clinical training are required to abide by the American Speech-Language Hearing Association's Code of Ethics, which mandates members use "evidence-based clinical judgement" (ASHA, 2016, p. 5). This paper proposes that it is a violation of ethical standards to engage in clinical practices that do not have any evidence of efficacy, understanding that there are different levels of evidence. An EBP model and applicable parts of the Code of Ethics will be discussed in addition to the levels of evidence commonly used. Finally, the application of ethics and EBP will be discussed.

Robin L. Edge, Ph.D. is employed at Jacksonville University in Jacksonville, FL.
Financial – Associate Professor and clinical supervisor in the Brooks Rehabilitation Department of Communication Sciences & Disorders at Jacksonville University in Jacksonville, FL.
Nonfinancial – Has published numerous articles. Conducts research in ethics education, fluency disorders and the scholarship of teaching and learning in communication sciences disorders.
Bess Sirmon-Taylor, Ph.D. is employed at the University of Texas at El Paso, TX
Financial – Associate Professor of Speech-Language Pathology, Chair of the Rehabilitation Sciences Department and Associate Dean for Academic Affairs in the College of Health Sciences at the University of Texas at El Paso, TX
Nonfinancial – Conducted research in concussion prevention & recovery, professional regulatory policy & legislation and ethics/models of ethics education.

LEARNING OBJECTIVES

1. List the 5 levels of evidence
2. Identify 3 potential ethical implications of evidence-based practice (EBP)
3. Identify the ASHA Code of Ethics rules addressing EBP

Speech-language pathology (SLP) and audiology professionals who serve clinical populations, conduct research, and engage in the supervision of students and other personnel are required to adhere to the principles of ethical conduct as dictated by the American Speech- Language- Hearing Association (ASHA, 2016). One of the primary tenets of ethics involves providing services or engaging in practices that are proven to be efficacious and effective. As the awareness of and requirements for evidence-based practice (EBP) increase, there is a justifiable call for the application of EBP into clinical practice. The Speech-Language Pathologists' Scope of Practice (ASHA, 2007) calls for the delivery of high quality, evidence-based services, noting that, "services are provided based on applying the best available research evidence, using expert clinical judgments, and considering clients' individual preferences and values" (p. 5). The Scope describes ethics as the critical underpinning of all clinical practice. The most recent revision of the ASHA Code of Ethics (2016) "… establishes expectations for our scientific and clinical practice based on principles of duty, accountability, fairness, and responsibility" (p. 2), and specifically addresses evidence-based practice, delineating principles and rules which are certainly applicable in spirit and purpose. For example, Principle I, Rule K requires holders of the Certificate of Clinical Competence (CCC) to evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected (ASHA, 2016). In this context, there is a risk that evidence for therapeutic methodologies may not always rise to the highest level of scientific rigor. This paper defines concepts of ethics and evidence-based practice and we argue that it is a violation of ethical standards to engage in clinical practices that do not have demonstrable evidence of scientific merit.

Ethics is typically defined as a set of principles or guidelines that are based in morality, cultural norms, or acceptable behavior, with a polar dichotomy of what is good or bad, right or wrong (Sirmon-Taylor & Edge, 2017). Ethics is not a fixed construct, but can vary according to cultural norms and practices, and is influenced by a community of practice or professional

standards. Ethical behavior may be contextually bound and is learned through observation, as well as by direct instruction. Carrese and colleagues (2015) proposed that ethical principles guide how an individual determines a right course of action or morally acceptable choice from the available options. ASHA (2016) describes ethics as the standards for professional conduct that are applicable to all individuals.

A code of ethics is a document that outlines the acceptable norms and behavioral expectations within a professional organization. A code will reflect the agreed-upon core values of the group, and is designed to inspire a higher level of critical thinking, decision-making, problem-solving, and collegial engagement in all interactions. Most codes are written in a way that provides an aspirational ambition for those who are held to the outlined standards, providing a mechanism by which members of the organization can make decisions about what is acceptable or unacceptable.
ASHA (2016) defines the Code of Ethics as a, "... focused guide for professionals in support of day-to-day decision making related to professional conduct" (p. 2). The ASHA Code of Ethics defines the role of the professional, with obligations and descriptions, serving as the standard to which all speech-language pathologists and audiologists should aspire (ASHA, 2016). Codes of ethics may also include language that addresses sanctions involved for violations of the principles as defined.

The ASHA Code of Ethics has been through a number of iterations across the decades, with the most recent revision published in 2016. The current version includes 4 principles and 55 rules, which provide standards that govern the practice of speech-language pathology, including research and administration in the discipline. The Code serves as a means of educating individuals within the profession, as well as policy makers and consumers of the services provided. A more thorough review of the current ASHA Code of Ethics is provided elsewhere (see Edge, Sirmon-Taylor, & Prezas, 2016).

Principle of Ethics I, Rule M within the Code states that "Individuals... shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served" (ASHA, 2016, p. 5).

Before addressing what "evidence-based" involves, one must first understand clinical judgment, which has been defined in speech pathology as a clinician's ability to consider data from all available sources to recommend interventions and treatment outcomes for patients (Records & Weiss, 1993). Treatment outcomes are designed to evaluate the efficacy, effectiveness, and practicability of interventions being used with a patient or student. Although the effectiveness of treatment is a vital part of the clinical process, treatment outcomes should also be evaluated during the initial stages of therapy when the therapist is using treatment procedures and modalities on a trial basis to address patients' needs. In other words, how does a clinician choose the outcomes he/she targets in therapy? This selection of treatment targets and associated outcomes is a prerequisite step in the EBP method, as treatment outcomes should be hypothesized using patient input with the clinician's experience, before initiating the first step of intervention. When planning the treatment outcomes for a patient, the therapist should focus on the patient and family's personal goals, as well as the empirical evidence that a treatment can achieve these goals by using EBP methodology (Sackett, Straus, Richardson, Rosenburg, & Hayes, 2000).

Clinicians might assert that all of their assessment and treatment decisions are evidence- based, and indeed, all treatment assessment and management decisions are evidence-based, when "evidence" is broadly defined (Bothe, 2004). Evidence used in the decision making process for treatment outcomes includes empirical research, textbooks, guidance from a trusted supervisor/teacher or colleague, their own clinical expertise, publicity, information from the web, social media, presentations, and/or testimonials (see Dollaghan, 2007). Although these mechanisms are frequently used by practicing clinicians, only empirical research is considered "evidence" as described in the EBP 5-step model.

EBP, or evidence-based medicine as it was originally known, "is the integration of best research evidence with clinical expertise and patient values" (Sackett et al., 2000, p1). EBP is not a new concept, with its beginnings cited in mid-19th century Paris and ancient Chinese medicine (Sackett et al., 2000). Many authors have used phrases like "evidence-based" or "research- based" in speech-language pathology and audiology and other disciplines (Bothe, 2004). Clinicians may question

the advantage of EBP when compared to using textbooks, relying on what they learned from professors, or personal experience when making clinical decisions. The EBP methodology allows clinicians to be accountable, ethical, and responsible professionals.
Speech-language pathologists and audiologists are accountable to their patients, patient families, their profession, payers, their boss, their coworkers, students in training, and themselves. Reimbursement for services is a complex process and there is

significant importance on justifying treatment methods and outcomes for funding and productivity demands. Ethically, ASHA's Code of Ethics requires that members use EBP, as Principal of Ethics I, Rule A states "Individuals shall use every resource…to ensure that high-quality service is provided" (ASHA, 2016, p4). . As clinicians, it is our responsibility to make sound and appropriate treatment decisions that will not reflect negatively on ourselves, our workplace, or our profession. As the Code of Ethics mandates that all ASHA members must use EBP, a discussion of the implementation of EBP is warranted.

ASHA (2005) states that "the term evidence-based practice refers to an approach in which current, high- quality research evidence is integrated with practitioner expertise and client preferences and values into the process of making clinical decisions" (p. 1). Critics have argued that EBP uses only research to make clinical decisions (see Bernstein-Ratner, 2006; Cohen, Stavri, & Hersh, 2004), but as noted, ASHA defines EBP as a triad of high-quality research evidence plus patient input and the practitioner's clinical experience. Just because the EBP methodology only considers research evidence when critically appraising treatment methods, it does not discount the use of clinical experience and patient/family preferences in the decision-making process.

RESEARCH EVIDENCE

When reading external scientific evidence, the quality of the research must be scrutinized, or critically appraised, as all research is not created equal. The goal is to find research conducted with high levels of control that demonstrates efficiency and effectiveness, and that is relevant to the individual patient (Bouffard & Reid, 2012). External research evidence has been classified by levels, with lower numbers indicating traditionally stronger research methods than higher numbers, as shown in Table 1. A detailed discussion of the intricacies of the evidence levels can be found elsewhere (see Agency for Healthcare Research and Quality, 2002; Lohr, 2004; Robey, 2004). Levels Ia and Ib are often hard to find in speech-language pathology (e.g., Wood, McIlraith, & Fitton, 2016), as researchers may have a difficult time recruiting enough patients with a specific diagnosis to randomly assign them to groups -- a necessary component of a randomized control trial. Although not the "top tier" of research evidence due to fewer controls, clinicians may instead depend on levels IIa to IV as the basis of clinical decisions. EBP practitioners look for research demonstrating the highest level of evidence available to them which can be combine with the patient's preferences, their clinical experience, and their hypothesized treatment outcomes.

Table 1. ASHA's Levels of Evidence

LEVEL	DESCRIPTION
Ia	Well-designed meta-analysis of >1 randomizedcontrolled trial
Ib	Well-designed randomized controlled study
IIa	Well-designed controlled study without randomization
IIb	Well-designed quasi-experimental study
III	Well-designed non-experimental studies (i.e., correlational and case studies)
IV	Expert committee report, consensus conference, clinical experience of respected authorities

Note. Adapted from the Scottish Intercollegiate Guidelines
Network as seen on https://www.asha.org/Research/EBP/Assessing- the-Evidence/

CLINICAL EXPERTISE

The second piece of the EBP triad is clinical expertise or expert opinion. Clinical experience is invaluable in the therapeutic process, but should not stagnate as the field evolves (see Bernstein-Ratner, 2006; Kahmi, 2006). In the ASHA Code of Ethics, Principle of Ethics II addresses the responsibility to meet and maintain the requirements for clinical practice, noting, "Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance" (ASHA, 2016, p. 6). Rule A addresses ethical practice with consideration of clinical experience, education, and training.

PATIENT/CAREGIVER PERSPECTIVE

The third mandatory piece of the EBP method is to include the patient and/or caregiver perspectives when making treatment decisions. This is given priority as the first directive in the Code of Ethics, Principle I, states "Individuals shall honor their responsibility to hold paramount the welfare of the persons they serve professionally" (ASHA, 2016, p. 4). There are a number of strategies that may be used to ensure patient and family perspectives are included in treatment outcome decisions. These include practicing patient-centered care, considering the patient's and family's values, priorities, and preferences, and considering the effect of environment and culture on their perspective on health and well-being (ASHA, 2005). As discussed above, all three of these tenets are vital to being a successful evidence-based clinician, though the identification and assessment of research evidence may present a challenge.

EVIDENCE-BASED PRACTICE

David Sackett (1997), whom many believe was responsible for popularizing EBP, wrote:

Without clinical experience, practice risks becoming tyrannized by evidence, because even excellent external evidence may be inapplicable or inappropriate for an individual patient. Without current best external evidence, practice risks becoming rapidly out of date, to the detriment of the patients (p. 3).

EBP is designed to direct clinicians in their search and evaluation of information related to patient care. Additionally, it serves as a guideline for the evaluation process and for searching for additional treatments if the initially chosen treatment was not as effective as expected. According to Sackett and colleagues (2000), EBP involves a 5-step process designed to assist in decision-making so that clinicians will have a framework for ethical and responsible behavior. The process of determining the quality of evidence for implementation in practice is complex and thorough (see Sackett et al., 2000 for an in-depth review of EBP and Yampolsky & Matthies, 2002 for a description and application of the EBP steps in speech-language pathology). A description of the EBP steps, adapted from Sackett et al., (2000) are presented below.

STEP 1

The first step in the EBP model is to develop a patient-specific question. A commonly used method to develop this clinical question is the PICO Framework (Centre for Evidence-Based Medicine, 2017; Hutcheson, 2017).

PICO includes the Patient or problem in which the clinician describes the patient population similar to the person receiving treatment. For example, "In preschool children who stutter…" defines a group similar to the patient assuming one is working with a child who stutters, five years of age or younger. This wording is specific enough to not receive an overwhelming number of articles during the literature search in step two, but is broader than, "In 5-year-old girls who stutter…" which may not produce a sufficient list of articles to review due to its specificity. The challenge is to find a balance between having a patient or problem that is too broad versus one that is too specific as part of your PICO question.

The Intervention and a possible Comparison intervention are next. For example, "...how effective is the Lidcombe Program when compared to the GILCU Program…" A comparison intervention does not have to be included, but having two interventions in the question typically makes the literature search more efficient (Greenhalgh, 2014). The final piece of the PICO Framework is the treatment Outcome such as, "...leads to lower stuttering frequency." A generic PICO question is "For a patient like this, what is the best way (or ways) to achieve a certain specific treatment outcome?".

Having a clearly defined PICO question is important for efficiency in completing the next steps of the EBP process.

STEP 2

After determining your clinical question, the second step in EBP is to find the current best evidence in an effective and efficient way. The first important component of this step is to identify what type of information is needed to answer your question. There are three categories of research traditionally used, the first of which is quantitative, in which the results are numerical, such as measuring the percentage of syllables stuttered or mean length of utterance. An example of a research study presenting quantitative data is Stuttering Frequency, Speech Rate, Speech Naturalness, and Speech Effort During the Production of Stuttering (Davidow, Grossman, & Edge, in press). The second type is qualitative research, which typically reports results as non-numerical (narrative) data. An example of a qualitative research study is Communication in Young Children With Fragile X Syndrome: A Qualitative Study of Mothers' Perspectives (Brady, Skinner, Roberts, & Hennon, 2006). The final type is research presents both numerical and non-numerical data and uses both quantitative and qualitative methods. This is known as mixed-methods research and an example is Quantitative and Qualitative Documentation of Early Literacy Instruction (Cullata, Kovarsky, Theadore, Franklin, & Timler, 2002).

Once you have determined the type of research that is needed, the final task of step 2 is to search for research using the PICO question. This requires a search for evidence that is balanced with sensitivity and specificity, that yields a sufficient amount of research to evaluate for an informed decision, but not so much research that the clinician must sort through many irrelevant articles. There are numerous databases to search, including PubMed, Web of Science, and Google Scholar. Although some of the search databases are free to access, many articles have to be purchased. ASHA members have free access to ASHA journals, ASHA practice portal and evidence maps as well as other resources at www.asha.org.

STEP 3

In the third step of the process, the clinician performs a critical appraisal of the evidence found in Step 2 and assesses the validity and usefulness/applicability of the research to their patient. First, while reading article abstracts only, the clinician should ask two questions: (1) is the article peer reviewed? (2) Does the treatment, as described, seem to be feasible for my patient, my work environment, or would it make me change my standard intervention plan? After using these questions to determine if the research is appropriate for the patient and the resources available at the work facility, the final piece of Step 3 is to evaluate the research found. Evaluating or critically appraising research can be accomplished by determining the results of the study and if these are reliable and meaningful. Determining reliability requires the assessment of each study's design to determine if the research is strong enough to guide clinical decisions. Greenhalgh (2014) and Davidow, Bothe, and Edge-Bramlett (2006) provide assistance in determining the quality of research studies.

STEP 4

The fourth EBP step is to determine which treatment to implement with a particular emphasis on how relevant the evidence is to the current patient, and discussion with the patient and/or family if they believe this approach will address the hoped-for treatment outcomes. Afterward, the clinician should make an informed clinical decision based on the valid and reliable evidence, its relevance to the patient, personal clinical expertise, and the patient's preferences. This step is "integrating the critical appraisal with our clinical expertise and with our patient's unique biology, values, and circumstances" (Straus, Glasziou, Richardson, & Haynes, 2011, p. 3).

STEP 5

The final step in the EBP method is to implement the treatment chosen in Step 4. This involves evaluating each treatment outcome chosen by collecting strong data on each goal, and completing the 5-step EBP process again if a treatment change is warranted. Step 5 is contingent on the quality of clinical record keeping, for both treatment outcome data and reassessment data throughout the intervention period. New questions may need to be formulated and treatment changed based on the patient's progress and observations made throughout therapy. If the chosen treatment plan does not result in the desired outcome, the EBP process can be recycled to find an alternative treatment method.

The Intersection of Ethics and Evidence-Based Practice The ASHA Code of Ethics (2016) undergirds all professional practice for speech-language pathologists and audiologists, specifically addressing evidence-based practice by delineating principles and rules which are clearly applicable in spirit and purpose. These principles and rules commit ASHA members and certificate holders to preserve the highest standards of integrity, professional excellence, and honesty while encouraging autonomy and self-regulation (Davidson & Denton, 2010). The Code speaks to the obligations of the scientific, educational, and clinical community in the profession to practice in a manner, "…based on principles of duty, accountability, fairness, and responsibility" (p. 2). Although the Code is inspirational and aspirational in nature, it has stringent ethics enforcement policies (Davidson & Denton, 2010) as it is a credentialing and membership organization. To avoid ASHA sanctions for unethical conduct, it is important for members and certificate holders to abide by all of the Code's principles and rules including those related to EBP.

The first principle of ethics states that "Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner" (ASHA, 2016, p. 4). The rules within this principle that are relevant to evidence-based practice speak of the need to provide informed consent related to the risks and effects of services and products provided, including accurate representation of the purpose and effectiveness of such services and products (Rules H, J). Services provided, including technology used and products dispensed, can only be implemented when a favorable outcome is projected, but no implicit or explicit guarantee of results can be made (Rules K, L). In order to keep the welfare of the clients, patients, or students served at the center of all decision-making, evidence-based judgment about treatment efficacy is required, with no misrepresentation of the services provided or treatment modalities engaged (Rules M, Q).

The second principle of ethics states, "Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance" (ASHA, 2016, p. 6). The rules that speak to EBP in this principle discuss the requirement for practicing within the scope of professional competence and scope of practice, which is related to the fundamental tenet of EBP regarding the best use of clinician's clinical judgment (Rule A). EBP provides

a structure to investigate treatments to enhance one's professional competence and assist in broadening one's personal scope of practice. This competence-based principle also includes a rule requiring individuals in professional practice to use technology in a manner for which it is intended (Rule G).

The third principle of ethics says, "Individuals shall honor their responsibility to the public when advocating for the unmet communication and swallowing needs of the public and shall provide accurate information involving any aspect of the professions" (ASHA, 2016, p. 7). The rules included herein mandate that individuals will not misrepresent their skills or competence, fabricate, dissimulate, or contrive any results or effectiveness of services provided or products used, and require all information to be accurate and complete (Rules A, C, E). Falsification in advertising, promotion of services or products, and in reporting of research is prohibited by the Code and financial disclosures must be accurate and complete (Rules F, G). Further, individuals must avoid potential conflicts of interest that may influence the ability to engage in unbiased and objective clinical decision-making (Rule B).

The fourth and final principle of ethics states, "Individuals shall uphold the dignity and autonomy of the professions, maintain collaborative and harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards" (ASHA, 2016, p. 7). In dealing with professional colleagues, ASHA members are required to be truthful in all interactions, with no dishonesty, fraud, or maleficence when discussing clinical outcomes, research findings, and product endorsements (Rules C, E).

The Application of Ethics and Evidence-Based Practice Speech-language pathology has changed over time with the addition of treatment areas not included in the early years of the field. The SLP Scope of Practice has evolved with the addition of dysphagia in the 1980s (Veis & Logemann, 1985), literacy in 2001 (ASHA, 2001), and telepractice within the last two decades. SLPs who completed degrees before the addition of these treatment areas may not have received training in these areas during their graduate program and therefore may need a method to investigate treatment options for patients with swallowing or literacy disorders. EBP provides that method. Over time, seasoned clinicians and researchers have observed waves of innovation in treatment methodology that seemed marginal or questionable when first presented, but were eventually proven to be efficacious and appropriate. EBP provides methodology to support clinicians' investigation of novel or new methodologies to treat patients. For dysphagia, literacy, and telepractice, a sufficient evidence base was eventually established to demonstrate efficacy of interventions in these areas, and evaluation and treatment modalities are included in the SLP scope of practice and competence. There are examples of interventions for which the evidence did not show positive results over time. For example, facilitated communication is a treatment which made an initially positive impression but never materialized into efficacy, with treatment claims based on anecdotal evidence and unsubstantiated outcomes. The method has fallen out of favor, and although it appears in the literature and clinical practice every few years (typically under a new name), it quickly disappears again because of the lack of scientific evidence to support those claims, and the potential for harm to patients (ASHA, 2018).

Clinicians and researchers who are in the process of engaging in ethical EBP may use the tools presented here to make decisions about treatment methodologies and outcomes. This includes working through the five steps of EBP as outlined, and a self-examination using the appropriate rules from the Code of Ethics (ASHA, 2016), to determine if the intervention, modality, or methodology under consideration meets the criteria for ethical behavior and practice. If after using the EBP model to search for available research, no treatment studies are found that can be implemented to meet the current need, then a clinician is within ethical boundaries to implement the treatment regime, by applying clinical judgment (tempered by patient and family preferences), based on evidentiary data at hand regarding the effect of the treatment.

CONCLUSION

For practicing clinicians, the ability to access and understand EBP is an ethical responsibility. The ASHA Code of Ethics (2016) clearly speaks to the need to provide services which are efficacious, and it is incumbent on service providers to be good consumers, avoiding unsubstantiated pseudoscience, and seeking evidence-based intervention. Researchers are likewise obligated to generate evidence to support or disprove methodologies, and those providing supervision hold the responsibility for teaching the next generation to engage in ethical and evidence-based practice. Simply stated, professionals must be skeptical of success rate claims that are not supported by acceptable levels of scientific research

or evidence. Professionals should also resist adopting treatment approaches that are presented first to the public, especially through mass media, rather than through established scientific channels. In addition, professionals should be wary about trusting their own clinical experience as the sole basis for determining the validity of a treatment claim, and must remember their ethical responsibilities to clients, other professionals, and the public.

On the other hand, new methodologies should not automatically be ruled out, even if there is not sufficient evidence to warrant adoption or establish efficacy within a population. Clinicians must become good end users of the available literature, and make judgment calls about claims that have not yet been substantiated with appropriate evidence. The bottom line is that discussion of efficacy and ethics in EBP should focus on whether a treatment claim is a valid and scientifically- based. Clients, professionals, and the general public are all best served when there is a solid scientific basis to support the discipline and the profession.

HPCSA ETHICS ARTICLE QUESTIONS

1. What is the highest level of research evidence according to ASHA:
   a. Ia
   b. Ib
   c. IIa
   d. III

2. Which of the following is not part of the evidence-based practice definition?
   a. Patient testimonials
   b. Empirical research
   c. Patient and family preferences
   d. Clinical experience and judgment

3. Which of the following is related EBP as described by the ASHA Code of Ethics?
   a. Novel application of treatment methodologies
   b. Truth in advertising
   c. Reporting only favourable results
   d. Guaranteed outcomes

4. Which of the following is not included in PICO?
   a. Problem
   b. Investigation
   c. Comparison
   d. Outcome

5. The levels of evidence in the correct order includes
   a. (i)developing a patient specific question, (ii) finding the current best evidence in an effective and efficient way (iii) performing a critical appraisal of the evidence found and assessing its validity and usefulness/applicability to the patient (iv) determining which treatment to implement, emphasising the relevance of the evidence to the current patient, and discussing it with the patient and/or family (v)implementing the treatment whilst evaluating each treatment outcome chosen by collecting strong data on each goal, and completing the process again if a treatment change is warranted
   b. (i), finding the current best evidence in an effective and efficient way (ii) performing a critical appraisal of the evidence found and assessing its validity and usefulness/ applicability to the patient (iii) developing a patient specific question (iv) determining which treatment to implement, emphasising the relevance of the evidence to the current patient, discussing it with the patient and/or family and implementing it (v) evaluating each treatment outcome chosen by collecting strong data on each goal, and completing the process again if a treatment change is warranted
   c. (i) finding the current best evidence in an effective and efficient way (ii) performing a critical appraisal of the evidence found and assessing its validity and usefulness/ applicability to the patient (iii) developing a patient specific question and discussing it with the patient and/or family, (iv) determining which treatment to implement, emphasising the relevance of the evidence to the current patient, (v) implementing the treatment whilst evaluating each treatment outcome chosen by collecting strong data on each goal, and completing the process again if a treatment change is warranted
   d. (i) developing a patient specific question and discussing it with the patient and/or family, (ii) finding the current best evidence in an effective and efficient way (iii) performing a critical appraisal of the evidence found and assessing its validity and usefulness/ applicability to the patient (iv) determining which treatment to implement, emphasising the relevance of the evidence to the current patient, (v) implementing the treatment whilst evaluating each treatment outcome chosen by collecting strong data on each goal, and completing the process again if a treatment change is warranted

6. Identify 3 potential ethical implications of evidence-based practice (EBP)
   a. allows clinicians to keep paramount the best interests of those being served
   b. allows clinicians to evaluate the effectiveness of services provided, technology employed and products dispensed, and providing services or dispensing products only when benefit can reasonably be expected
   c. allows clinicians to be accountable, ethical and responsible professionals
   d. All of the above

7. A code of ethics will:

   a. reflect the agreed-upon core values of the group, and is designed to inspire a higher level of critical thinking, decision-making, problem-solving, and collegial engagement in all interactions

   b. provide an aspirational ambition for those who are held to the outlined standards and provides a mechanism by which members of the organization can make decisions about what is acceptable or unacceptable.

   c. include language that addresses sanctions involved for violations of the principles as defined.

   d. A and B above

   e. A, B and C above

8. Clinical judgment is defined as:

   a. a clinician's ability to consider data from all available sources to recommend interventions and treatment outcomes for patients

   b. a clinician's ability to consider data from all available sources and implement interventions and treatment outcomes for patients

   c. a clinician's ability to consider data from selected sources to recommend interventions and treatment outcomes for patients

   d. a clinician's ability to combine data from all available sources to recommend interventions and treatment outcomes for patients

9. Treatment outcomes are designed to evaluate:

   a. the efficacy, the effectiveness, and the practicability of interventions being used with a patient or student

   b. the benefits, the effectiveness, and the practicability of interventions being used with a patient or student

   c. efficacy, the reasonableness, and the practicability of interventions being used with a patient or student

   d. efficacy, the effectiveness, and the risks of interventions being used with a patient or student

10. When planning the treatment outcomes for a patient, the therapist should focus on:

    a. the patient and family's personal goals, as well as the clinicians experience

    b. the empirical evidence that a treatment can achieve these goals; by using EBP methodology

    c. the effectiveness, and the risks of the interventions

    d. A & B above

    e. A, B and C above

11. Evidence used in the decision-making process for treatment outcomes as described in the EBP 5-step model includes:

    a. empirical research, textbooks, guidance from a trusted supervisor/teacher or colleague, their own clinical expertise, publicity, information from the web, social media, presentations, and/or testimonials

    b. Only empirical research

    c. All of the above

    d. None of the above

12. Speech-language pathologists and audiologists are accountable to:

    a. their patients & patient families,

    b. their profession, their co-workers, students in training

    c. payers, their boss, and themselves

    d. all of the above

13. EBP methodology only considers research evidence when critically appraising treatment methods, it discounts the use of clinical experience and patient/family preferences in the decision-making process.

    a. True
    b. False

14. Speech-language clinicians may depend on research evidence _____ as the basis of clinical decisions as researchers may have a difficult time recruiting enough patients with a specific diagnosis to randomly assign them to groups

    a. levels Ib to IV
    b. levels IIIa to IV
    c. levels Ia to IV

d. none of the above

15. Strategies that may be used to ensure patient and family perspectives are included in treatment outcome decisions include:
    a. building a solid rapport with the patient and their family and considering the patient's and family's values, priorities, and preferences, and considering the effect of environment and culture on their perspective on health and well-being
    b. the clinician doing an in-depth investigation of the cultural perspectives of the client, practicing patient-centered care, and considering the patient's and family's values, priorities, and preferences
    c. practicing patient-centered care, considering the patient's and family's values, priorities, and preferences, and considering the effect of environment and culture on their perspective on health and well-being
    d. considering the patient's and family's religion, values, priorities, and preferences, and considering the effect of environment and culture on their perspective on health and well-being

16. The principle of ethics which states that "Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner". The rules within this principle that are relevant to evidence-based practice speak of:
    a. The need to provide informed consent related to the risks and effects of services and products provided, including accurate representation of the purpose and effectiveness
    b. the requirement for practicing within the scope of professional competence and scope of practice, which is related to the fundamental tenet of EBP regarding the best use of clinician's clinical judgment
    c. the fact that individuals will not misrepresent their skills or competence, fabricate, dissimulate, or contrive any results or effectiveness of services provided or products used, and require all information to be accurate and complete
    d. when dealing with professional colleagues, members are required to be truthful in all interactions, with no dishonesty, fraud, or maleficence when discussing clinical outcomes, research findings, and product endorsements

17. The rules that speak to EBP in the principle of ethics stating "Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance" is
    a. The need to provide informed consent related to the risks and effects of services and products provided, including accurate representation of the purpose and effectiveness
    b. the requirement for practicing within the scope of professional competence and scope of practice, which is related to the fundamental tenet of EBP regarding the best use of clinician's clinical judgment
    c. the fact that individuals will not misrepresent their skills or competence, fabricate, dissimulate, or contrive any results or effectiveness of services provided or products used, and require all information to be accurate and complete
    d. when dealing with professional colleagues, members are required to be truthful in all interactions, with no dishonesty, fraud, or maleficence when discussing clinical outcomes, research findings, and product endorsements

18. The third principle of ethics says, "Individuals shall honor their responsibility to the public when advocating for the unmet communication and swallowing needs of the public and shall provide accurate information involving any aspect of the professions". The rules included herein mandate:
    a. that individuals will not misrepresent their skills or competence, fabricate, dissimulate, or contrive any results or effectiveness of services provided or products used, and require all information to be accurate and complete
    b. Falsification in advertising, promotion of services or products, and in reporting of research, is prohibited and financial disclosures must be accurate and complete

c. individuals must avoid potential conflicts of interest that may influence the ability to engage in unbiased and objective clinical decision-making

d. All of the above

19. The SLP Scope of Practice has evolved with the addition of dysphagia, literacy, and telepractice. SLPs who completed degrees before the addition of these treatment areas may not have received training in these areas during their graduate program and therefore may need a method to investigate treatment options for patients with swallowing or literacy disorders. EBP provides that method.

a. True

b. False

20. If after using the EBP model to search for available research, no treatment studies are found that can be implemented to meet the current need, then a clinician is within ethical boundaries to implement the treatment regime, by:

a. applying novel treatment methodologies supported by patient testimonials

b. discontinuing their services and continuing to seek evidence-based interventions

c. applying clinical judgment (tempered by patient and family preferences), based on evidentiary data at hand regarding the effect of the treatment

d. avoiding unsubstantiated pseudoscience, but trusting their own clinical experience as the sole basis for determining the validity of a treatment

SLH CPD ACTIVITY

You can obtain three (3) CEUs ethics credits for reading the article and answering the included questions. Please submit your answer sheet to **SLHBoardCPDPractitionersAnswers@hpcsa.co.za** by due date as indicated.

How to Earn your CEUs

1. Complete your personal details below
2. Read the article.
3. Indicate the answers to the questions by marking an “x” in the appropriate block at the end.
4. You will earn 3 CEUs (Level 1 - Ethics) if you answer 70% or more of the questions correctly.
5. A score of less than 70% will unfortunately not earn you any CEUs.
6. Make a photocopy for your own records in case your answers do not reach us.
7. Scan and email or post your answers to:

Please note: The answers should not reach us later than **30 September 2022.** Answer sheets received

after this date will not be processed.

HPCSA number: _____

Initials: _____

Surname as registered with the HPCSA: _____

Contact number: _____

E-mail address: _____

PLEASE ANSWER ALL THE QUESTIONS AND MARK THE APPROPRIATE BLOCK WITH AN “X “

1. A □ B □ C □ D □

2. A □ B □ C □ D □

3. A □ B □ C □ D □

4. A □ B □ C □ D □

5. A □ B □ C □ D □

6. A □ B □ C □ D □

7. A □ B □ C □ D □ E □

8. A □ B □ C □ D □

9. A □ B □ C □ D □

10. A □ B □ C □ D □ E □

11. A □ B □ C □ D □

12. A □ B □ C □ D □

13. A □ B □

14. A □ B □ C □ D □

15. A □ B □ C □ D □

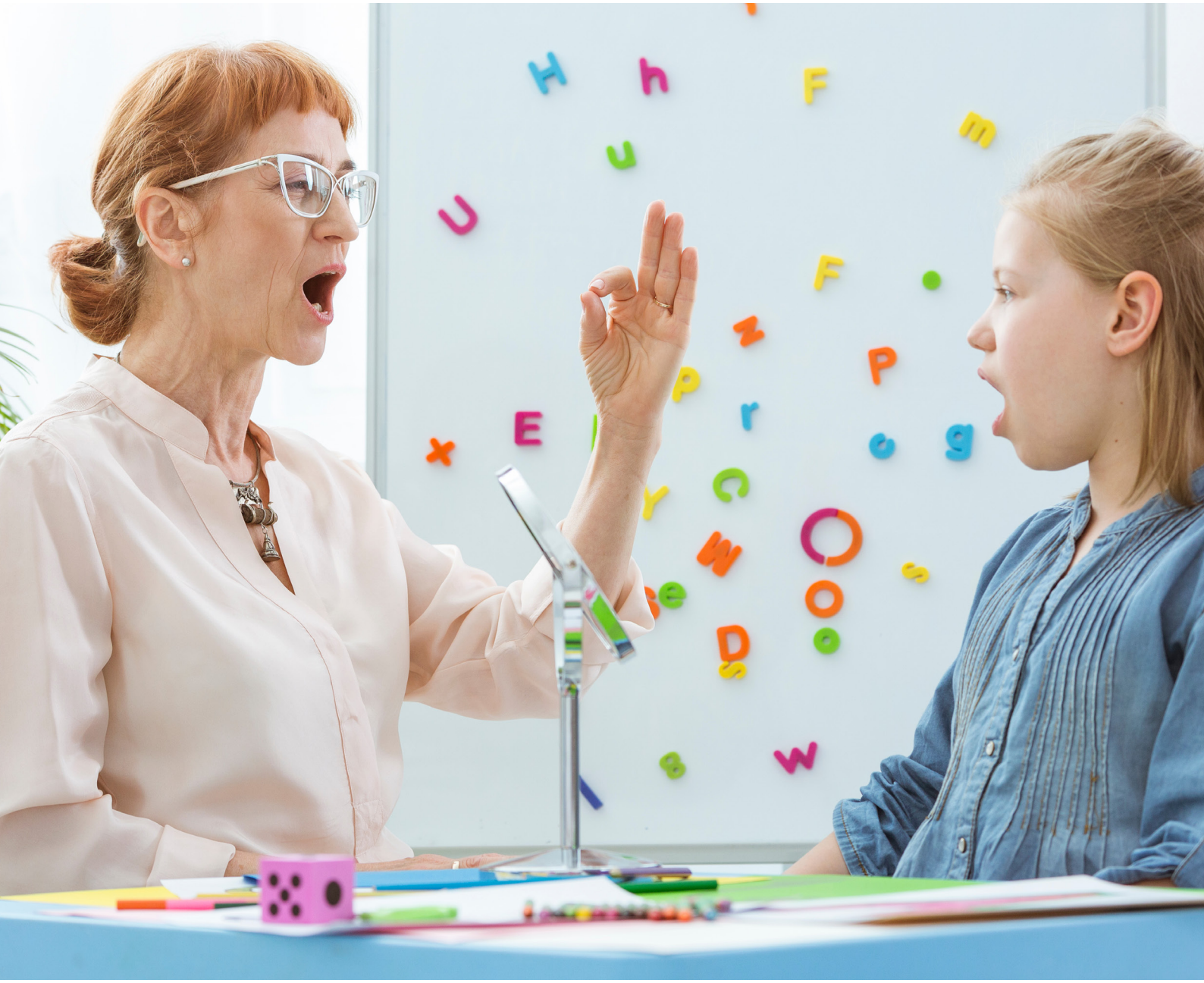
16. A □ B □ C □ D □

17. A □ B □ C □ D □

18. A □ B □ C □ D □

19. A □ B □

20. A □ B □ C □ D □



The mandate of the Health Professions Council of South Africa (HPCSA) in protecting the public and guiding the professions includes ensuring that healthcare practitioners are fit to practise their profession. As such, the Health Committee of the Boards is established in terms of Section 15(5) of the Health Professions Act, 56 of 1974 (The Act) to regulate and/or advise healthcare practitioners who may be impaired. Impairment means a mental or physical condition or the abuse of or dependence on chemical substances, which affects the competence, attitude, judgment or performance of a person registered in terms of the Act.

Allegations of impairment of healthcare practitioner may be reported to the HPCSA by anyone, including members of the public as well as own or fellow healthcare practitioner. Healthcare practitioners includes registered students and interns. Any reported case is referred to the Health Committee for assessments (formal or informal), mostly based on medical reports in order to make considered findings. The healthcare practitioner is, of course, always notified of the complaint and is requested to undergo relevant assessments to ensure that the committee is empowered to make resolution on the case. The assessments are only conducted by the qualified specialist as appointed by the Health Committee or self-appointed healthcare practitioner.

After all the processes and assessments are conducted, then the Health Committee makes a determination if impairment exists or not. The healthcare practitioner can only be declared impaired in terms of Section 51 of the Act. Note that such declaration may be followed by conditions of practice, such as limitation of practice, registration restrictions etc, depending on the specific case.

The committee recommends and provides oversight of the implementation of a treatment and/or rehabilitation programme and frequently reviews the status of the healthcare practitioner over a duration of time, typically for at least three (3) years. The healthcare practitioner who is under the management of the committee provides frequent reports to ensure that the committee can evaluate progress. Typically the reporting frequency start with quarterly, then followed by bi-annual progress reports , annual reports, followed by an exit interview depending on the progress made in achieving rehabilitation.

It is in the best interest of the affected healthcare practitioner to co-operate with the process and instructions of the Health Committee, not only for their rehabilitation, but in ensuring that the public is protected from potentially harmful practice. In the absence of cooperation from the healthcare practitioners the Health Committee may appoint an investigation committee on an ad hoc basis to undertake formal investigations and, if required, may impose conditions of registration or practice.

The committee also considers applications by impaired healthcare practitioners to have their conditions of registration or practice amended or revoked.

What is important is that the Health Committee is a non-punitive structure established to manage treatment compliance by the healthcare practitioner. Declaration of impairment does not necessarily means suspension, the healthcare practitioner can still practise after being declared an impaired practitioner. The decision to suspend a healthcare practitioner is solely based on evidence available, mostly from medical reports as provided by the treating practitioner.

The current Health Committee of the Professional Boards consist of eleven (11) members representing each Professional Board. The committee also co-opt one (1) Psychiatrist from Medical and Dental Board. When fully constituted, is always composed of the following professions:

- One Clinical Psychologist;
- One Occupational Therapist;
- One Psychiatrist

Chairperson is elected amongst the Professional Boards represented.

To contact the Health Committee or to report an alleged impairment kindly contact us at: email healthcommittee@hpcsa.co.za or telephone 012 3383963.

GENERAL INFORMATION

FOR ANY INFORMATION OR ASSISTANCE FROM THE COUNCIL

Direct your enquiries to the Call Centre
Tel: 012 338 9300/01
Fax: 012 328 5120
Email: info@hpcsa.co.za

Where to find us:
553 Madiba Street
Corner Hamilton and Madiba Streets
Arcadia, Pretoria
P.O Box 205
Pretoria 0001

Working Hours:
Monday – Friday : 08:00 – 16:30
Weekends and public holidays – Closed

Certificate of Good Standing/ Status, certified extracts verification of licensure
Email: hpcsacgs@hpcsa.co.za
Continuing Professional Development (CPD)

Susan Ndwalane
Tel: 012 338 3995
Email: hpcsacgs@hpcsa.co.za

Continuing Professional Development (CDP)
Helena da Silva
Tel: 012 338 9413
Email: raylenes@hpcsa.co.za

Change of contact details
Email: cpd@hpcsa.co.za

Raylene Symons
Tel: 012 338 9443
Email: raylenes@hpcsa.co.za

Change of contact details
Email: records@hpcsa.co.za

Ethics and professional practice, undesirable business practice and human rights of Council:
Ntsikelelo Sipeka
Tel: 012 338 9304
Email: NtsikeleloS@hpcsa.co.za
Service Delivery
Email: servicedelivery@hpcsa.co.za
Tel: 012 3389301
Complaints against practitioners Legal Services
Fax: 012 328 4895
Email: legalmed@hpcsa.co.za

Statistical Information and Registers:
Yvette Daffue
Tel: 012 338 9354
Email: yvetted@hpcsa.co.za

Professional Board Speech Language and Hearing
Tel: 012 338 3964/3904/9497
Email: SLHboard@hpcsa.co.za

COPYRIGHT DISCLAIMER

Health Professions Council of South Africa