Chapter 7
Deconstructing the Three Pillars of Evidence-Based Practice to Facilitate Social Justice Work in Speech Language and Hearing Sciences

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ABSTRACT

This chapter reviews the limitations of the evidence-based practice (EBP) framework adopted by American Speech Language Hearing Association for the field of speech, language, and hearing sciences (SLHS) in addressing systemic racism. The authors argue that a shift from a medically-based EBP model to a pluralistic EBP model would better serve the needs of black, indigenous, people of color (BIPOC) with communication impairments in the current sociopolitical landscape. The authors examine the three pillars of EBP through the lens of social justice work. They describe how the current EBP model limits the development of social justice work in SLHS. They describe the need to refine the EBP model by validating the contribution of qualitative research as scientific evidence, reevaluating the basis of clinical expertise in client-clinician cultural mismatch, and address the importance of integrating policy and culture in consideration of client and family preferences. These transformations are critical in light of the under-representation of BIPOC clinicians in the field of SLHS profession.

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INTRODUCTION

Evidence-Based Practice (EBP) in Speech, Language, and Hearing Sciences (SLHS) refers to a clinical decision making perspective, adopted from evidence-based medicine, which has been endorsed as a primary guiding principle to enhance the quality of clinical services (ASHA, 2004). This three pillar model is described as "…the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients…[by] integrating the best available evidence, clinical expertise, and patients' values and preferences" (Sackett, et al. 1996, as cited in *ASHA*, 2004, p. 1). In order to meet the demands of insurance companies and government agencies to ensure treatment efficacy and reduce reliance on "intuition" in practice, this three-pillar EBP model was adopted for financial and political reasons (Hazel, et al., 2019). This model sought to address the tendency of certified clinicians to rely on their own opinions in clinical decision-making (ASHA, 2004). Following the adoption of this model of EBP, several critiques came to light. Some of these critiques pointed to the model's inability to evaluate the effects of therapies, therapists, or some combination of both on treatment outcomes (e.g. Ratner, 2006). Challenges were noted in integrating the scientific evidence with clinical practice (e.g. McCabe & Usher, 2018; Olswang & Prelock, 2015; Plante, 2004). Although there was a focus on evaluating external scientific evidence according to levels of evidence (Dollaghan, 2007), the model did not address the varying quality of work within the same level of evidence (e.g. Nelson & Gilbett, 2020).

The focus on the three-pillar model of EBP occurred ten years following an institutionalized emphasis on cultural competence in the academic training of speech language pathologists (SLPs) and audiologists. ASHA's 1994 national standards for professional certification added a requirement for academic institutions to include culturally and linguistically diverse (CLD) topics in their curriculum. However, more recent events catalyzed larger conversations about racism in the field, along with demands for action from our professional organizations. Following the worldwide and national sociopolitical events of the summer of 2020, including the murders of George Floyd and Brianna Taylor, along with the rise of the Black Lives Matter movement, the field of SLHS was forced to analyze their role in systemic racism and maintaining white supremacy in the field, while addressing the lack of diversity in the profession. The Council on Academic Programs in Communication Sciences and Disorders (CAPCSD, 2020) put out a report on September 9, 2020 announcing the establishment of a Diversity, Equity, and Inclusion Task Force (CAPCSD, 2020). In turn, ASHA began offering free continuing education courses on microaggressions (ASHA, 2020a). With this emphasis on diversity, equity, and inclusion, there is a focus on culturally responsive practices, both in training the next generation of clinicians, and in service to our clients. In culturally responsive practice, clinicians apply their knowledge and skills effectively to integrate the client's culture, beliefs, and values into service provision (Hyter & Salas-Provance, 2018). To fully engage with culturally responsive practices, clinicians must become knowledgeable of and engaged with social justice work. Social justice work is defined as "scholarship and professional action designed to change societal values, structure, policies, and practices" (Goodman et al., 2014, p.795). Culturally responsive practice is also based on partnership with clients and families and dismantled power relationship between clinician and client (see Bellon-Harn & Garrett, 2008; Hyter & Salas-Provance, 2019 ; Rose, 2013). The main challenge in training healthcare professionals to achieve competency in social justice work is not instilling in them the importance of social justice and diversity, but rather how to apply it to clinical practice (Hage et al., 2020).

This chapter will describe and deconstruct the medically-based three pillar framework of EBP in the context of social justice work and culturally-responsive practice. We describe the barriers to authentic