

Clinicians face many challenges when implementing evidence-based practice (EBP) in the fields of speech-language pathology and audiology. Clinicians must find time—despite high caseloads and responsibilities—to ask meaningful questions, search the literature for external evidence, read relevant articles, and conscientiously consider professional and client factors to arrive at a decision. Even then, the external evidence is rarely conclusive nor does the evidence always perfectly align to a particular population. As evidence-based practice has become more of a mainstream topic, more resources have become available to clinicians to facilitate this process. ASHA has created the Practice Portal, where clinicians can look for evidence on particular disorders (ASHA, 2016); *EBP Briefs* offer clinicians answers to clinically relevant questions (as well as a model for conducting their own searches); and an increasing number of continuing education events are available to empower clinicians to access and consume external evidence. However, continuing to add resources and training may be fruitless without addressing an underlying hindrance to EBP: namely, clinician bias. Bias, according to Merriam-Webster (2016), is defined as a tendency to believe that some ideas are better than others. From a practical perspective, bias in the evidence-based practice world is any belief or opinion regarding clinical service provision that prevents a clinician from being open to new ideas or approaches. In this Editor's Note, we explore the role of clinician bias and offer a charge to clinicians vested in implementing evidence-based practice to pay attention to their individual biases.

In a general sense, bias carries negative connotations; it is something to be avoided and guarded against whether you are biased for or against a particular idea (Lickerman, 2013). The challenge, however, is that we *all* have biases. Everyone. Specific to speech-language pathology and audiology, we carry biases for/against patients with a particular disorder. We hold biases for/against particular treatment protocols. We even hold biases for/against aspects of our scope of practice. Don't believe me? Let's try some examples. Consider these PICO questions:

Do children with autism make stronger gains in language using ABA or PECS treatment approaches?

Are oral motor exercises (OMEs) effective in remediating speech sound disorders for young children?

Is it more effective to treat children with language impairment in a classroom setting or pullout therapy?

As you read each PICO question, what was your internal response? Be honest—you had one. Maybe you read the first question and thought, “Why do you need to ask? The answer is obviously ABA.” Or maybe you thought, “I am not interested in this answer because PECS is the only treatment approach I feel comfortable with.” Maybe you read PICO question #2 and thought, “My professors told me OMEs were obsolete,” but you don't have a strong rationale as to why. Or maybe your internal response was, “I've used OMEs for 20 years now. It doesn't matter what the research says; I know they work for my kids.” For PICO question #3, maybe your response was one of discomfort: “I got into speech pathology so I didn't have to be in front of a classroom. I really hope our profession doesn't change.” Or maybe you instead have already tried classroom therapy and, regardless of the research, plan to continue because this type of therapy just “feels right to you.” The challenge with biases is not that we have them, but rather that we aren't always *aware* of them. Any of the responses above are natural. The problem with bias comes when those opinions and beliefs prevent us from (a) being open to new ideas, (b) receiving evidence contradictory to our bias, and (c) changing our current treatment approaches in light of high-quality evidence.

The discipline of speech-language pathology and audiology is growing, and the external evidence guiding our practice is ever-expanding. Ratner (2006) indicated that the number of peer-reviewed articles increased by over 20,000 in less than 30 years (1977–2006), arguably presenting new evidence for effective treatment approaches. If we allow our biases to guide our clinical decisions—and limit the extent to which we allow our practice to be shaped by new evidence—then we risk violating the principles of beneficence (conducting treatment that is maximally beneficial to patients) and nonmaleficence (conducting treatment in a manner that does not harm patients; see Dollaghan, 2007).

Clinicians cannot accurately implement evidence-based practice without awareness of their own bias on any given issue. In many regards, identification of bias may be one of the first steps in implementing EBP. Dollaghan (2007) frames identification of bias—the awareness of one’s bias and willingness to change one’s perspective/opinions when faced with new facts—as a part of professional integrity. As the editor of *EBP Briefs*, I charge clinicians, in their pursuit of improving implementation of evidence-based practice, to bring bias to a higher level of consciousness. Be aware of internal biases specific to clinical service delivery, and be willing to set them aside to give full consideration to external evidence.

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