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CASLPO TODAY

Communicating By the Book:

Adults with Aphasia and the Life History Book Program

When Truth is Stranger than Fiction:

Using Memoirs to Guide Patient/Client Centred Care

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MESSAGE FROM THE PRESIDENT

Tough Decisions

> "Again and again, the impossible problem is solved when we see that the problem is only a tough decision waiting to be made."
>
> – Robert Schuller

Everyone faces tough decisions. From buying a house, to deciding on a mortgage, to allowing a teenage daughter to go out on a date, we all have to make difficult decisions in our personal lives on a regular basis. As professionals, we face a whole set of tough decisions daily. What is the best course of intervention for each and every client? How do we manage our time in order to respond to our clients' needs, while ensuring we do not burn ourselves out? How do we go about breaking bad news?

The dilemma inherent in many of the decision-making challenges we face is to make the choice between taking the quick and easy route or the long and hard road, seeing the process through to the end. Do we trust the bank advisor's suggestion as to the most suitable mortgage rate or do we conduct our own research? Do we hope for the best as we watch our daughter cross the threshold on her way to a movie with the young man wearing the tattoo or do we enter into an extensive negotiation with her? (My solution would be to develop a guideline, which I would refer to as the "Rule of Sixes" – more than six piercings, six tattoos, and/or six days without a shower, and he's out!) Do we make the recommendation that is in the child's best interests despite the parents' preferences? Do we wait the extra hour to get the doctor's order prior to initiating the swallowing assessment? Do we contact the university's clinical coordinator to indicate we have a concern with a student? In the end, do we stick to our professional guns in the face of potentially harsh criticism, and perhaps even threats?

CASLPO Council and staff have to make tough decisions on a regular basis as well. Rarely does a committee meeting conclude without members having asked if we are taking appropriate action on a number of issues. Further, we constantly ask ourselves if we have dealt with a matter with sufficient depth. Are we overzealous in our efforts or are we taking necessary steps? How do we make a ruling that provides protection to the consumer, but allows the practitioner to sustain his/her practice? What do you do with a complaint? Is it real? Is it frivolous? Who is telling the truth? What is a fair penalty? Do you punish or remediate? When is someone deemed incompetent or incapacitated?

CASLPO has the mandate to protect the public, but we also must be fair and sensitive to the member. In the previous issue of *CASLPO Today*, you will have read the decisions and reasons relating to two discipline hearings held in November 2007. I was interested to learn that the decisions made in both cases caused some controversy within the membership. Having been aware of the process at the complaint and investigation levels, I was certainly confident that the referral to discipline and the ultimate outcomes were fair and well thought-out. Not everyone would appear to agree, however.

So how do the Complaints Committee and/or the Discipline panel come to a decision? The scope of this article is simply too limited to address this question in any great depth. I would, however, like to take this opportunity to highlight a few key points, which I feel are necessary in understanding any decision that is rendered by the College in disciplinary matters. In making their decision, a panel must consider the following:

- **All** of the evidence that is produced by the both the complainant(s) and the member;
- The seriousness of the breach of standards;
- The pros and cons of the decision versus other alternatives available;
- Information relating to previous investigations and/or findings relating to the member;
- Any mitigating factors (this refers to any information regarding the member or his/her circumstances that might result in a lesser penalty);
- The consistency of the panel's decisions with previous College decisions;
- Its responsibility to the people of Ontario to ensure that services are provided by competent professionals.

If the panel of the Discipline Committee decides that the member is guilty, it has a responsibility to determine a penalty which addresses the principles of specific and general deterrence. **Specific deterrence** focuses on the individual's past behaviours. The aim of the penalty is to discourage the member from similar future acts by instilling an understanding of the consequences. At this stage, the panel determines that the member may not have clearly understood the potential consequences of his/her actions or that he/she may have acted negligently regardless of an awareness of the potential harm the actions may have caused. **General deterrence** focuses on future behaviours, preventing the membership as a whole from engaging in similar acts by impacting their rational decision-making process.

Decisions are put through a number of tests to determine if all of the above factors have been considered. Legal counsel is sought. What you see on the pages of *CASLPO Today* is a very brief summary of the culmination of months, if not years, of investigation, negotiation, consultation, and consideration. What allows us, as a Council, to recognize the fairness of the outcome, is our knowledge of all of the efforts that have been expended to reach the determination, as well as the fact that all decisions, no matter how small, have been made not by any one person, but by a group of trained individuals who represent the member's peers and the public.

As I said at the outset, everyone must make tough decisions. At CASLPO we do our best based on the facts, information, input, and feedback we get from our members, the public and other stakeholders. We welcome comments and questions in any form. If you would like to talk about a CASLPO decision, I encourage you to get in touch with David Hodgson, Registrar, or myself.

Karen Luker, MHSc, Reg. CASLPO,
Speech-Language Pathologist – Orthophoniste
President CASLPO

March 2008 Council Highlights

Council held its regular Council meeting on March 7, 2008. The following are the highlights.

- Council approved a draft regulation for Advertising and directed that the draft regulation be sent out for members' comments.
- Council approved a draft regulation for Conflict of Interest and directed that the draft regulation be sent out for members' comments.
- Council approved a draft Practice Standard and Guideline (PSG) on Dispensing with revisions so that the Dispensing PSG has the same requirements regarding real ear measurement as both the Child and Adult Hearing Assessment PSGs. Council directed that it be circulated to the members for comment.
- Council approved the PSG on Hearing Assessment of Children for publication and circulation to members.
- Council approved the PSG on Hearing Assessment of Adults for publication and circulation to members.
- Council approved the Draft Position Statement on Equipment Servicing Requirements and directed that it be circulated to members for comments.
- Council approved the Practice Standards and Guidelines for the Process of Screening and Assessment of Children's Communication and Swallowing by Speech-Language Pathologists for publication and circulation to the members.
- Council reviewed the report from the QA committee on its review of the PSG format and process and directed that the College must continue to articulate standards of practice and there is a need for preferred practice guidelines. An author/project leader who is a content expert should be selected to work with an expert panel to develop the document. There needs to be member feedback and external stakeholder consultation as well as a sound methodology for determining consensus. The content should include practice area specific standards and preferred practice guidelines. The format would incorporate Resource Requirements, Collaboration Requirements, Health and Safety Requirements, Competencies, Components of Service Delivery, and Documentation. Standards and guidelines should be included in one document although clearly differentiated and be called Practice Standards and Guidelines. PSGs must be clear and readily understandable.
- Council approved a public awareness program described elsewhere in this issue of *CASLPO Today*.
- Council set May 26, 2008 as the election date for Districts 1 and 3.

For more information on any of these topics please contact David Hodgson, Registrar at 416 975 5347 ext. 215 or by email at dhodgson@ caslpo.com.

Fee-Based Service Settings

By Lynne Latulippe, Manager of Professional Conduct

Many CASLPO members practice in settings where the services are not publicly funded, and the audiology or speech-language pathology services are provided on a fee-for-service basis. Members employed in fee-based settings and those considering this model of service delivery contact the College with questions concerning fees and billing issues. When fees are charged for service, challenging situations that may not occur in other practice and employment contexts can arise.

Scenario 1

I have encountered a difficult situation in my employment in a private practice. Parents accompanied their child to the first appointment with me, and I am told it is the parents who have provided payment for my services. The patient/client has now stated that she does not want any information shared with her parents about the services received, and I have determined that the patient/client does have the capacity to make this decision. However, the parents insist that because they are paying for my services, they are entitled to receive any information they request. I disagree but am feeling uncomfortable in this situation.

Although the parents are paying for the services, the member is indeed correct that they are not entitled to access the patient/client's information. The fact that a person is paying for the member's services is not relevant to whether that person has access to the patient/client information. With limited exceptions, only the patient/client or a substitute decision-maker has access to the information in the patient/client record.

The Personal Health Information Protection Act (PHIPA) establishes the following criteria to determine if the person is capable regarding consent to collection, use, and disclosure of personal health information.

> Capacity to consent
>
> 21. (1) An individual is capable of consenting to the collection, use, or disclosure of personal health information if the individual is able,
>
> (a) to understand the information that is relevant to deciding whether to consent to the collection, use, or disclosure, as the case may be; and
>
> (b) to appreciate the reasonably foreseeable consequences of giving, not giving, withholding, or withdrawing the consent.

Given that the member has determined that the patient/client is capable, the parents are not considered to be substitute decision-makers and therefore they do not have access to the information they are seeking from the member.

In this situation, the member might attempt to further discuss the situation with the patient/client and the parents to determine if the issue can be resolved to the satisfaction of all parties. For example, the patient/client may agree to the disclosure of some of the information, and the parents may also accept their child's desire for privacy.

Such difficult situations may be avoided if, during the initial appointment or communication regarding services, the member were to review with the patient/client and family members the circumstances under which patient/client information can be disclosed. Even if, at that time, the patient/client consents to disclosure to their parents, for example, that consent does not bind the patient/client indefinitely. Once a patient/client consents to the disclosure of information to a third party, whether verbally or in written form, the patient/client can also choose to withdraw that consent at any time.

Scenario 2

I am providing fee-based services to a child. The parents observe the sessions and I also meet with them briefly at the end of each session, to inform them of their child's progress and to discuss recommendations and home programming with them. One of the parents has private insurance coverage for my services. In order to take full advantage of the coverage available, the parent has requested that I invoice in the child's name until the coverage for the child has reached the maximum available, and that I then invoice in the parent's name as the person to whom the service was provided. Is this allowed?

CASLPO's Code of Ethics states that members "will be honourable and truthful in all their professional relations" (item 1.3). The Professional Misconduct Regulation also states that the following is considered to be an act of professional misconduct: "(23) Submitting an account or charge for services that the member knows is false or misleading."

Members in this situation have been advised to provide billing information that is accurate and truthfully represents the services rendered. In this situation, the member could indicate that a parent received consultation or training services regarding their child, who has a communication difficulty. Thus, the member has made it clear that the child is the person with the communication difficulty, not the parent, while indicating that the parent did indeed receive the service. The invoice or receipt should also accurately reflect the time spent providing the consultation or training (or other parent activity). Thus, for time spent entirely in therapy with the child, with no parent training component (and thus in effect the parent did not receive any service), the member should not provide any billing or invoicing information stating that the parent received the service.

And of course, there should be no "double billing" i.e., any time period should only be billed once, for example, in this situation, in the child name or the parent's name, not both.

Scenario 3

I am just setting up my private practice and I am wondering what fees CASLPO has established for member services.

CASLPO does not provide a specific fee structure for member services. However, given its mandate to protect the public interest, it has passed regulations in regard to maximum fees charged to the public.

CASLPO's Professional Misconduct Regulation sets out a number of acts that have been determined to be professional misconduct. In the public interest, CASLPO, like other colleges, has passed regulations to protect the public in regard to the maximum allowable fees charged.

> The following are acts of professional misconduct for the purposes of clause 51(1) (c) of the Health Professions Procedural Code:
>
> (24) Charging a fee that is excessive in relation to the services charged for.
>
> (25) Charging a fee that exceeds the fee for services set out in the schedule of fees published by the Ontario Association of Speech-Language Pathologists and Audiologists, without the prior informed consent of the patient or client.

From time to time, CASLPO receives calls from members or the public asking about the OSLA fee guidelines and how the fees are established. The College has published an article regarding the establishment of the OSLA fee guidelines, in the August 2004 issue of *CASLPO Today*, available at www.caslpo.com.

Do you have any questions regarding fee for service issues? We would like to hear from you. Please contact Lynne Latulippe, Manager of Professional Conduct at llatulippe@caslpo.com or at 416-975-5347 or 1-800-993-9459, at ext. 221.

Hearing Aid Concerns

By Lynne Latulippe, Manager of Professional Conduct

Complaints received by the College regarding audiologists' services frequently have as their principal focus concerns over hearing aids prescribed and/or dispensed by the audiologist and the patient/client's unhappiness with the member's response to these concerns. The following complaint can serve as an example of this type of matter, as the complainant alleged that:

a. The hearing aids malfunctioned numerous times and the member did not provide satisfactory service regarding the malfunctions, and

b. Staff at the facility were unresponsive, and the member bears responsibility for her staff's lack of responsiveness.

As in the case with all complaints, the issues for the Complaints Committee to decide in this matter were whether:

1. the nature of the allegations, if true, warrant a discipline hearing in all of the circumstances;
2. if the allegations do warrant a discipline hearing, is the information in support of the allegations of a sufficient quantity and quality to require a hearing; and
3. if the allegations are not referred to a hearing, is some other action by the Complaints Committee appropriate?

Decision and Reasons

The panel of the Complaints Committee carefully reviewed the submissions of the parties and the information and materials referred to above. The panel also discussed the matter of potential conflicts of interest and determined that no panel members were in a position of conflict of interest regarding this complaint.

Consistent with the College's policy on the Use of Prior Investigations and Decisions in College Complaints and Investigations, the Committee determined that there were no previous complaint(s) against the member that could assist the Committee with its consideration of this matter.

The panel first considered the complainant's concerns regarding the numerous hearing aid malfunctions she experienced and the services provided in response to the malfunctions. The panel recognizes the unfortunate situation in which the complainant found herself due to the hearing aid malfunctions and the frustrations she experienced due to those malfunctions. The panel also notes that the member, in her reply to the complaint, acknowledges the complainant's "significant hearing aid repair history." The panel carefully reviewed services provided by the member and staff in response to the hearing aid malfunctions and determined that the complainant was provided with appropriate services in response to the malfunctions. The panel noted for example the numerous attempts by the member and office staff to address the concerns raised regarding the hearing aid, the services (in-office cleaning, shipping, and programming) provided at no charge to the complainant, and that a courtesy repair for the hearing aid was successfully requested from the manufacturer, after the warranty had expired.

The panel then considered the complainant's concerns regarding responsiveness from the staff and the member's responsibility in that regard. The panel carefully reviewed the information obtained from both the complainant and the member and determined that the member and staff appeared to be responsive to the complainant's concerns and as indicated above, made numerous attempts to address them.

Having regard to all the circumstances, the panel is of the opinion that the allegations do not warrant referral to a discipline hearing, and that no further action is required.

Public Awareness: New Goals, New Strategies

David Hodgson, Registrar

For the past several years, public awareness has been a high priority of the College. There is a clear need to inform the public about audiologists and speech-language pathologists and the valuable services they provide. The public also needs to know about the College and the protection that is provided in choosing services from a regulated health professional.

In the first three years, posters were sent to 15,000 doctors and all MPPs, as well as libraries, public health units, and schools across the province. Packages of brochures were sent to nearly 1,000 pharmacies for a total of 165,000 pieces. The CASLPO corporate brochure was sent to more than 15,000 human resource professionals, unions, nurses, and others. Packages were also sent to our 2,750 members for use in their communities.

Doctors, MPPs and others put the posters on their walls, CCACs put them on their front doors, and schools sent the brochures home with students. Members distributed the information throughout their communities.

Based on the requests for additional brochures and posters and judging on the number of calls from members as well as numerous public mentions, Phase One of the public awareness campaign was a great success.

In the second phase, we took out ads in consumer magazines. These ads talked about taking speech and hearing for granted, and about the problems students with hearing, speech and language difficulties encounter in keeping up with their peers. Many members adapted these ads to promote their own practices. They are available on our website.

This year CASLPO's Council wishes to do something dramatically different from past public awareness efforts. Council wants to generate greater public and governmental awareness of the audiology and speech-language pathology professions: the assessments, treatments, and prevention modalities they perform, the public's need for the professional services they offer, the disorders they address and the existence and role of the College itself.

The strategy identified by the College is to select two research projects, one of relevance to audiology, the other of relevance to speech-language pathology. These research projects would, inter alia, quantify a public need and identify the economic impacts for Ontario of particular dysfunctions or disorders. They would identify the need and provide compelling evidence for effective policy and financial responses from the government to support the more extensive and effective utilization of audiologists and speech-language pathologists to address that need.

The College plans to create a "state of the union" report on communication and hearing disorders in Ontario, and use this report to raise public awareness about:

- Communication and hearing disorders and their impact on society
- Services needed by Ontarians to deal with these disorders
- The services being provided by audiologists, speech-language pathologists and others
- The need for additional services with some specific recommendations
- The role of audiologists in the health care system and the education system
- The shortage of audiologists and speech-language pathologists to meet the need
- The role of the College in ensuring quality services

This report would be released publicly and used to engage in discussions with government ministers and civil servants, consumer stakeholder groups, other health care professionals, teachers and professionals in other fields as well as employers and other stakeholders.

It is hoped that these activities will over time result in:

- New programs to meet the needs of Ontarians with communication and hearing disorders
- Increased opportunities for audiologists and speech-language pathologists to provide services
- Increased opportunities for the

public to directly access publicly funded services provided by audiologists and speech-language pathologists
- Greater awareness of the professions and the College

The first step in our strategy is to undertake research in order to develop our papers. We will also be engaging in discussions with a variety of government and non–government agencies and consumer groups about our research projects and our ultimate goals. As we proceed with the project we will keep our members informed and be requesting member input from time to time.

If you have any thoughts on how we might achieve our public awareness goals and more specifically the project outlined above please email me at dhodgson@caslpo.com.

Interprofessional Collaboration: Challenges and Opportunities

David Hodgson, Registrar

As members may be aware, the College has been given an opportunity and a challenge to provide advice to the Minister of Health and Long-Term Care through the Health Professions Regulatory Advisory (HPRAC) on the subject of interprofessional collaboration.

The minister has asked HPRAC to “recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession.”

The minister has also asked that HPRAC “take into account, when controlled acts are shared, of public expectations for high quality services no matter which health profession is responsible for delivering care or treatment.”

HPRAC has developed a Discussion Guide posing questions concerning interprofessional collaboration. Documents are posted on the HPRAC website www.hprac.org and are being shared with organizations and individuals with an interest in the matter for their comment and additional information.

HPRAC is reviewing the role of the Colleges that regulate the health professions in Ontario in order to recommend mechanisms to facilitate and support interprofessional collaboration among health Colleges that in turn will promote interprofessional care at the clinical level. This comes at a time of unprecedented change and transformation within the health care system, including a strong desire among patients and providers to move towards a patient-centered approach to health care delivery.

For clarity and discussion, HPRAC adopted the definition that was framed by HealthForceOntario:

> “Interprofessional care is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.”

HPRAC has stated that its view is that any initiatives should be directed to finding ways to assist health regulatory colleges and their members to work collaboratively, rather than competitively, and to learn from and about each other through a process of mutual respect and shared knowledge to:

- Improve patient care and facilitate better results for patients;

- Protect the public interest; and ensure the highest standards of professional conduct and patient safety;
- Regulate health professions in a manner that maximized collective resources effectively and efficiently, while protecting the public interest;
- Optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services;
- Ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment, and
- Enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability

HPRAC is seeking ways for the Colleges to progress by removing or minimizing any unnecessary barriers that exist and to consider new means for the Colleges to support and enable interprofessional care by their members at the clinical level.

To assist CASLPO to draft its submission we asked our members for examples of barriers and enablers to interprofessional care. Here are some of the comments we received:

"Professionals lack knowledge of each other's expertise and services. Physicians lack knowledge of SLPs and yet they are supposed to be a gatekeeper or referral source to our services. In 22 years of practice I can count on one hand the number of referrals I've had from a physician. Similarly, some teachers have minimal knowledge of SLPs. I'm often contacted by teachers in training who are asked to conduct a project on SLP services for children in classrooms. The three areas they are told to research are: articulation, voice, and fluency. There's no mention of SLP services in language, reading, written expression, or social communication. And yet, teachers are to be the referral sources for SLP services for children across the province."

"Suctioning of swallowing, tracheotomy and/or communication patients would be a good area to work with RT and RNs. I strongly feel that SLPs understand the anatomy, physiology, and medical issues involved in this process at least as well as other professions that suction. Suctioning is an area I feel SLPs should be competent in and should feel free to do when necessary in their clinical environment (or be delegated to do if necessary)."

"I think we could work closer with OTs regarding cognitive assessments and therapies. SLPs could develop separate cognitive communication goals while the OTs continue to target ADL related cognitive goals. We often get left out of the picture regarding cognition and cognitive therapies."

"The profession of audiology is not that well known by the other professionals. They think we are the 'hearing aid guys' so if the client does not have or need a hearing aid, the audiologist can't do anything with that client. So, my role within the team is, most of the time to explain what we can do with people who have a hearing related problem. I often feel in a constant battle, that I have to fight to 'save' audiology in the team."

"One area of professional collaboration that has been a concern to me from time to time is the sharing of written reports. The process starts with a referral or recommendation to another service provider. I require and get parent consent (normally to receive and send information) to make the referral and support the student's educational needs. Often I do not receive a written report from the professional who sees the student at my request/recommendation. Rather than having to specifically get consent to receive a specific report that I don't know has been written, I believe it would be appropriate for the consulting/concurrent service professional to take any appropriate steps to ensure that the required consent is obtained to share the report with appropriate professionals."

"One thing I see is barriers in the educational system. Students will need to learn to work in an interprofessional manner while they are still in school."

"I am a private practice audiologist. If I believe that a referral is necessary to an ENT, I cannot do this directly. I must contact the family physician, and the patient usually has to make an appointment with them, and then the family physician makes the referral. This step not only takes time but also costs the health care system more money. It would be wonderful if we could directly refer to an ENT."

We want to thank all of the members who took the time to send us their comments. In addition to these issues, the College will raise again the difference between the standards of practice of the College of Physician and Surgeons of Ontario with respect to prescribing hearing aids by doctors and those of this College as they apply to prescribing hearing aids by audiologists. We will also restate our belief that our members should be able to communicate a diagnosis and use the title "doctor" if they hold a doctoral degree. We will also point out that many of our members work outside the "traditional" health care settings. For example, our members work in private practice, school boards, and retail settings. There are no doubt many opportunities for interprofessional collaboration in these environments.

Members will be notified when CASLPO's submission is available for review. Developing interprofessional collaboration will be an ongoing process in the years to come. If you have any comments or suggestions on how to improve interprofessional collaboration please send them to dhodgson@caslpo.com.

Advocating for Speech-Language Pathologists and Audiologists in Ontario

By Beth Ann Kenny, Executive Director, OSLA

Sharon McWhirter, president of the Ontario Association of Speech-Language Pathologists and Audiologists (OSLA), reported in the spring edition of *OSLA Connection* that "This has been an exciting year for OSLA. We are presently in the process of developing a resource guide for teachers and speech-language pathologists on the Oral Language Foundations for Academic Success, funded by the Ministry of Education. This ground-breaking project would not have been possible without the years of working through the OSLA School Services committee to build relationships, respond to requests for information and ensure that speech-language pathologists are represented at the Ministry's Advisory Council for Special Education."

Consistent advocacy is necessary for a strong profession. In Ontario, OSLA fulfills this role.

OSLA is actively advocating on behalf of Ontario's speech-language pathologists and audiologists on key issues that will directly affect practitioners' practices, including the following:

- Responding to the most recent Health Professions Regulatory Advisory Council (HPRAC) consultation on interprofessional collaboration among health colleges and professionals (with a deadline extension of May 31, 2008)
- Assuring that the process to create the controlled act of psychotherapy does not exclude our members who work in cognitive communication
- Ensuring that the implementation of Bill 171 does not infringe on the rights of speech-language pathologists and audiologists, including the requirement to inform the public about any "offense" and what exactly an "offense" is defined to be
- Continuing participation in the Allied Health Professionals Development Fund, allowing members the possibility of accessing up to $1,500 for professional development a year
- Sharing members' views on CASLPO initiatives, such as consent to treatment guidelines
- Providing a voice for members at the Workplace Safety and Insurance Board (WSIB) on issues relating to the Noise-Induced Hearing Loss and Mild Traumatic Brain Injury Programs of Care as well as the recent fee review
- Advising the minister of finance in annual consultation processes as the Ontario government's budget is prepared
- Participating in Assistive Devices Program (ADP) reviews, such as the most recent Operational Review
- Sitting on committees and the Alliance of Professional Associations of Community-Based Therapy Services (APACTS) with the Ontario Association of Community Care Access Centres (CCAC) and Service Provider Associations to ensure our members in home care are represented
- Educating insurance companies and other payers about the value of our members and the need for fair reimbursement

How do we advocate? We ask questions of people in positions of power. We are at the table at meetings where decisions are being made or information is shared to influence those decisions. We write letters and responses to government and key stakeholder initiatives. We ensure your voice is heard.

In her presidential message, Sharon also wrote, “OSLA is able to achieve these benefits for our members because we have the unique ability to represent Ontario speech-language pathologists and audiologists at the provincial table where issues of interest to you are decided. As an association, we are invited to meet with the Ministries of Health and Long-Term Care, Education, Child and Youth Services, Community and Social Services, Finance, and Labour. We work hard to build relationships with Ministry staff so that our services are respected and valued and we continue to be included at tables where funding and service delivery issues are decided.

“Speech-language pathologists and audiologists in Ontario continue to be concerned about ongoing issues of insufficient funding and poor service delivery models as well as new issues as they arise. We need OSLA at the table! And we need all speech-language pathologists and audiologists in Ontario as members!”

In addition to our many advocacy efforts, OSLA continues to be a resource for our members. We provide support and seek member input through our committees, regional chapters and interest groups. We have restructured our website to be more accessible and provide easy access to the information you need and to provide a forum for communication with other speech-language pathologists and audiologists across the province.

Sharon concluded, “We know that OSLA members are a dedicated group of professionals who value the strength of a resource-rich association; you recognize that a strong voice in Ontario is necessary for you as a speech-language pathologist or audiologist practicing in this province. However, as our Membership Committee Chair, Jacques Soucie likes to say: ‘All of the audiologists and speech-language pathologists working in Ontario are in the same professional boat. Some are rowing. Some are not. It is that simple.’ We need the support of all speech-language pathologists and audiologists in Ontario.

Guidelines, Standards, Position Statements – What Do They Mean?

David Hodgson, Registrar

There was a considerable amount of discussion at the 2007 Moncton meeting on Interorganizational Collaboration amongst the representatives of associations, regulatory bodies, and universities who were present on the mandates and roles of organizations and groups. Areas of existing and potential overlap and conflict were identified and suggestions to clarify mandates and roles were put forward.

One of the items discussed was the role of associations, regulatory bodies, and universities in setting standards for the professions. It was generally recognized that the colleges in Alberta, Ontario, and Quebec and provincial professional associations in Manitoba, New Brunswick, and Saskatchewan that regulate the practice of audiology and speech-language pathology have been given the mandate by provincial acts to set standards and engage in other activities. Well over 80% of audiologists and speech-language pathologists in Canada are regulated and practice in a regulated jurisdiction.

These regulatory bodies have been given specific authority by law to:

- Regulate the professions and govern members
- Develop, establish, and maintain standards of qualification for persons to be issued certificates of registration
- Develop, establish, and maintain standards of knowledge, skill, and programs to promote continuing competence among members
- Establish standards of practice
- Establish standards of professional ethics

Members of the professions, in these provinces, must comply with these standards.

However, there was also recognition that non-regulatory associations have a role in developing standards, codes of ethics, and guidelines. Members of the profession who voluntarily join these associations are obligated to follow these standards. In addition, universities have expertise and research which can and should be utilized in the development of standards. This will not only add to the quality of the standards but also will help to ensure that standards can be integrated into university curricula.

In addition to standards it was noted that associations and regulatory bodies develop many other types of documents. Sometimes these documents have the same name but a different meaning.

For example, some regulatory bodies produce “Position Statements” that set out mandatory non-clinical practice standards. At the same time, associations set out their “Positions” on various matters relating to the professions, legislation, and other matters. It was acknowledged that, at times, members of the profession are confused as to which standard or other document applies to their practice.

At the end of the meeting there was strong consensus that collaboration among associations, regulatory bodies, and universities offered many advantages and opportunities. As a start, it was suggested that the development of common terminology for the various documents promulgated by associations, regulatory bodies, and universities would be of value. This would then inform a discussion on the roles of various bodies in their formulation.

In dealing with standards and guidelines, it could be stated that guideline is a recommendation, more like “You should, if your situation warrants,” while a standard is “Thou shall … ”

Guidelines

Guidelines are suggestions of voluntary behaviour or recommended procedures that might assist prudent practitioners in providing their clients with specific, well-defined outcomes. They are not intended to be mandatory. Guidelines are written using words such as: "may," "should," "suggest," and "recommend."

For example:

Alberta College of Speech-Language Pathologists and Audiologists (ACSLPA) Preferred Practice Guideline:

A Preferred Practice Guideline (PPG) provides suggestions of voluntary behaviour that might *assist* speech-language pathologists and audiologists in their practice. A PPG is not intended to be mandatory, but by definition outlines "preferred" methods of practice. Preferred practice guidelines may *assist* members in assessing their competence under the competence program and may assist the College in developing cautions for members in the assessment of professional conduct issues.

Examples of guidelines might include suggestions on how to avoid complaints through good communication practices, a proposed process for obtaining informed client consent or how to work with interprofessional teams. Guidelines are a "word to the wise."

Standards of Practice

Every profession has standards of practice expected of members. These are the generally accepted consensus of right thinking members of the profession and based on scientific evidence and research. Such standards are communicated through university programs, continuing education programs, professional literature, and the informal "shop talk" that accompanies almost any meeting of members of the same profession. Regulatory bodies are given specific legislative authority to set practice standards. However, often regulators will adopt standards and guidelines that have been developed by professional associations or standards writing agencies. As professions become larger, more complex, and dynamic, regulators try to assist their members in maintaining currency in these standards of practice.

One way of doing so, besides putting them in a regulation or law, is to publish documents that describe the existing generally accepted standard on recurring or significant issues. The standards of practice address clinical practice in that they set out a minimum level of training or skill that is required to perform clinical activities and procedures in speech-language pathology and audiology. Standards of practice outline the basic, minimum practice patterns for the professions. Standards are intended to be the rules of the profession in respect to particular practice issues. They are written using words such as: "shall," "expect," "must," "require," and "oblige." In order to ensure that the document accurately describes the relevant standard, regulators usually engage in an extensive consultation process. In fact, in some provinces, consultation with the government and various stakeholders is mandatory before standards can be adopted or revised.

For example:

In Ontario, Practice Standards and Guidelines inform members of both mandatory (standards) and best practices (guidelines) and would be used by the regulatory body to determine if members were practicing in compliance with the standards of the profession if a member of the public brought a complaint forward.

CASLPO Practice Standards and Guidelines incorporate both "must" and "should" statements. "Must" statements establish standards that members must always follow. In some cases, "must" statements have been established in legislation and/or CASLPO documents. In other cases, the "must" statements describe standards that are established for the first time in a PSG. "Should" statements incorporated into this PSG describe best practices. To the greatest extent possible, members should follow these best practice guidelines. The inclusion of a particular recommendation in these standards and guidelines does not necessarily indicate that the practice is supported by high level research evidence (i.e., evidence from randomized clinical trials), but rather that the guideline is grounded in current best evidence derived from a broad review of the research literature (ranging from single case reports to larger trials) and/or expert opinion. SLPs and audiologists should exercise professional judgment, taking into account the environment(s) and the individual patient's/client's needs when considering deviating from guidelines. SLPs and audiologists must document and be prepared to fully explain departures from a PSG.

Practice Standards, whether they are standards on managing dysphagia, or prescribing hearing aids, or regulations on records, or telehealth, are regulatory matters. Regulated professionals must practice in conformity with the standards of the profession set by the regulatory bodies. These standards should be developed in consultation with the professional associations and the universities.

Other Regulatory Standards

In addition to Standards of Practice, regulatory bodies have the mandate to set many other standards and requirements for their members that are mandatory. For example, regulatory bodies are able by law to set entry to practice standards and enforce them through legislation. Similarly, regulatory bodies have the mandate to set requirements for members to participate in Quality Assurance Programs.

The Canadian Alliance of Regulators has been created to coordinate the discussion of regulatory issues, the development of regulatory standards such as Preferred Practice Guidelines, and the development and harmonization of registration standards.

Another area that deals with standards is the accreditation of university programs.

Provincial regulatory bodies have the legislated mandate to set education and other entry to practice standards for their applicants. It is essential therefore that the regulatory bodies are involved in setting the standards for course content for university programs because without the approval/acceptance of the regulatory bodies, future graduates will be at risk of not being accepted for registration. Associations may set membership standards or requirements for individuals who wish to become members of the association.

However, even though regulators have the legislative mandate to set educational standards for the professions, the regulators, associations, and universities have agreed to share this responsibility and have created the Council for the Accreditation of Canadian University Programs – Audiology and Speech-Language Pathology (CACUP-ASLP). It has been recognized that collaboration of all three parties will produce a better system.

Advisory Statements

Many regulators believe that they can provide a valuable service of not only alerting their members of the new legislation, but also trying to explain its most significant implications. Some regulators even go so far as to make suggestions as to strategies for complying with the legislation (without giving legal advice). Advisory statements serve as notice or warning to the profession of already existing legal requirements. For example, many regulators have issued advisory statements about privacy legislation and directed members to resources that might help them know what is expected. Advisory statements normally relate to legal obligations imposed by other authorities upon the practitioner.

For example:

ACSLPA Advisory Statement:

An Advisory Statement relates to legal obligations imposed by other legislation or authorities on the speech-language pathologist or audiologist. College advisory statements might *warn* members about legislation, make suggestions as to strategies for complying with legislation, and direct members to resources that might help them know what is expected.

Position or Policy Statements

A position or policy statement sets out how the regulator or association will approach various situations. It clarifies ambiguities for members. Position or policy statements provide an official position or stand on an issue or matter that is significant not only to the profession, but also to other outside agencies or groups. They are written using words such as “ordinarily,” “typically,” “must,” “usually,” and “normally.”

For example, many registration or licensing requirements authorize the regulator to accept an educational program that is equivalent to a Canadian program. A position statement could set out the criteria used by the regulator to assess educational programs for equivalency (or even list educational programs that have already been found to be equivalent).

Another example relates to the discipline context. Many regulators can discipline a member for having been found guilty of a criminal or other offence that reflects on the member’s suitability to be a member of the profession. A position statement could identify the regulator’s interpretation of the types of offences that will likely result in disciplinary action.

For example:

ACSLPA Position Statement:

An ACSLPA Position Statement sets out how the College will *interpret* or *clarify* legal provisions governing the College and its regulated members. The purpose of a position statement is to *clarify* ambiguities for members and guide the College’s exercise of discretion. Position statements may be used to challenge the College or the regulated member if they are not adhered to. Position statements will be of interest to outside agencies and organizations in addition to College members.

CASLPO Position Statements

deal with non-clinical matters. Compliance with Position Statements is mandatory for CASLPO members. Position Statements deal with matters such as use of the title "doctor," procedures when providing concurrent therapy, telepractice, etc.

For associations, position statements frequently are used to put forward an association's opinion or position on a given matter. For example an association could have a position on whether or not the AuD should be required as a minimum entry to practice requirement. However, the association does not have the authority to make it mandatory except for those persons who voluntarily wish to become members of their association.

The determination of whether or not a doctoral degree will become the minimum requirement for registration as an audiologist is a regulatory matter. It is an education standard that would be set by the regulatory bodies in consultation with the professional associations and the universities with ultimate approval by the government of that particular province

Regulations

Only regulatory bodies have been given specific authority under provincial legislation (acts) to make regulations to govern and regulate the professions. These regulations must, in most provinces, be approved by the lieutenant governor-in-council. This for most purposes means the minister of health and the provincial cabinet.

Compliance with regulations is mandatory. Examples of regulations include entry to practice/registration requirements, professional misconduct, advertising, conflict of interest, restricted acts, etc.

Codes of Ethics

The code of ethics addresses clinical practice in terms of duties and responsibilities to clients and the public.

Conclusion

While the many examples of standards and other documents outlined above may be confusing at the outset, it should be relatively straightforward to determine which are mandatory and which are advisory.

Only the standards set by the six regulatory bodies are mandatory by legislation. Standards and guidelines set by associations in the other provinces and territories affect only the professionals who choose to be members of those associations.

Having said this, it has been generally recognized that standards affecting the profession should be as uniform as possible across Canada in the interests of the public and the members. In this vein, collaboration on the development of standards amongst associations, regulatory bodies and universities is essential.

All of CASLPO's Practice Standards and Guidelines, Regulations, By-laws and Position Statements can be found on our website at www.caslpo.com.

Suspended Members

The following members were suspended as of February 4, 2008 for failure to pay their fees for 2007–2008 in accordance with section 24 of the Health Professions Procedural Code:

BAIN, Donna Lynne Hoelle (4756)

CHELLADURAI, Sally Jane (1229)

KUHN, Kathryn Helen (2534)

LAUER, Therese (1749)

LEVASSEUR, Josée Lucie (3024)

MICHAUD, Jocelyne Monique (1929)

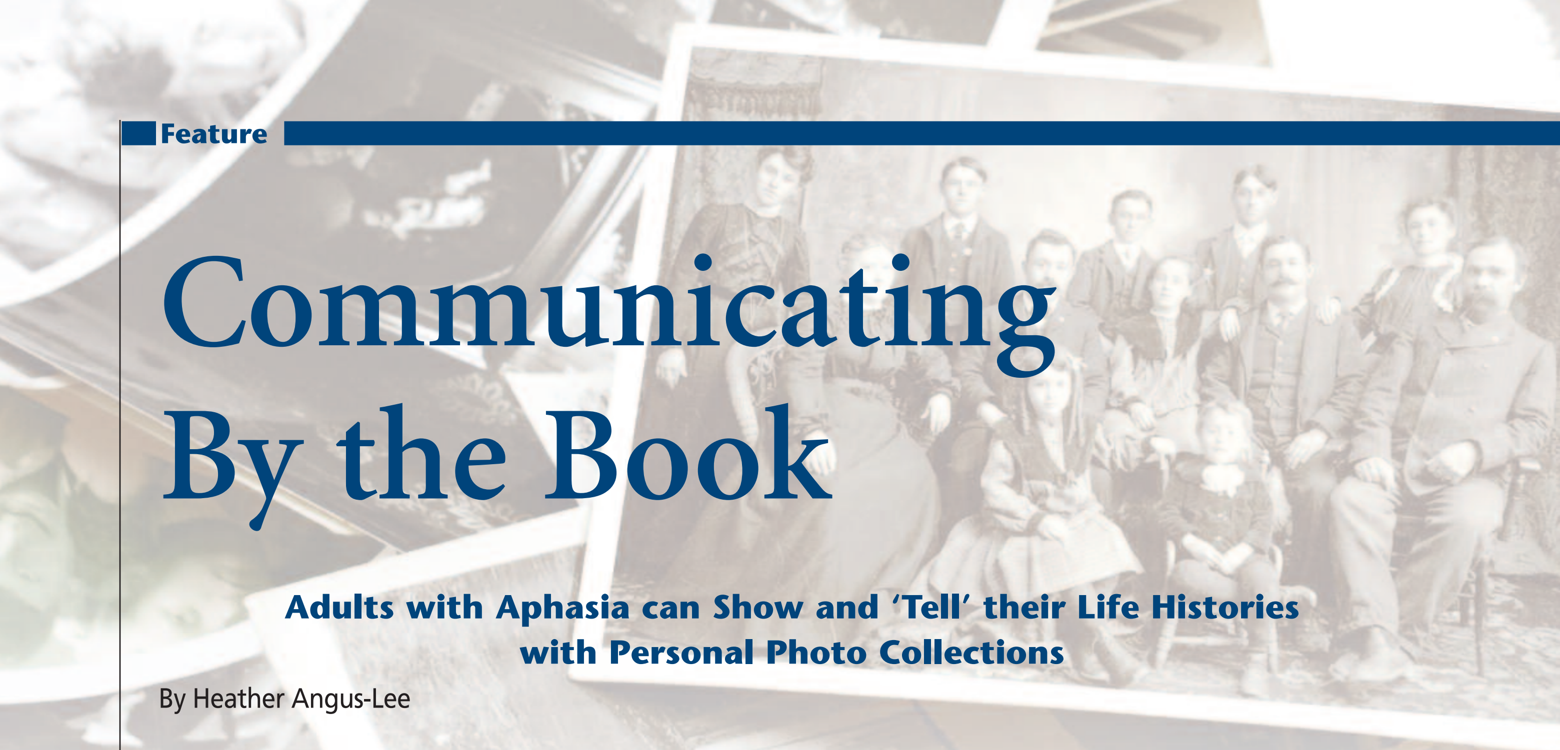
MILLER, Janet E. (4558)

MYERS, Karen Renée (1989)

ROTELLA, Teresa (2747)

SALEH, Shirin (4820)

SMITH, Marilyn Alice (2622)



Communicating By the Book

Adults with Aphasia can Show and 'Tell' their Life Histories with Personal Photo Collections

By Heather Angus-Lee

We're familiar with the sight of teenagers holding out their cell phones to snap pictures of virtually everything, then immediately sharing the images with each other. No doubt most of them go home to post their photos on blogs and Facebook; it's how youth today tell stories about their lives.

There's another group of people – much older and less tech-savvy – who also rely on photos to tell their life stories. Adults with aphasia aren't uploading their pictures onto websites, though; they're pasting them into "life history books" to share with peers, family, and caregivers.

Indeed, this very personal, ongoing visual form of communication is making a dramatic difference in both the efficacy of care and clients' quality of life, according to speech-language pathologists in Ontario who participate in what are known as "life history book" programs.

The development and use of life history books was pioneered by Ruth Patterson, SLP, communications program coordinator of the York-Durham Aphasia Centre. Soon after co-founding the centre with a social worker colleague in 1989, she started noticing that clients were arriving with some visual communication aids developed at hospitals or rehabilitation facilities.

A client and volunteer at the Stouffville site using her "life history" communication book to communicate.

"But those aids tended to be focused only on daily activities – eating, toilets, and such," Patterson says. "Once clients get home, they don't need that anymore; they need a useful basis for conversation. We started looking for a way to personalize the [pictorial aids]… We found that people always want to talk about themselves."

And what better way to do that than show off snapshots taken by and of yourself, your loved ones, and colleagues over the decades. "We see the books as a blend between the practice of SLP and social work," notes Patterson. "It's a therapeutic process; by reviewing someone's life, you identify their strengths and experiences, and that helps them accept the life they are living now. That's especially important for people with aphasia who are competent – their intelligence is intact and that's not always acknowledged," or other people may not know how to bring that intelligence out.

Patterson remembers one client with unintelligible speech who was a community leader prior to his stroke and ensuing aphasia. "We asked the mayor of the town he lived in, and members of the many groups he belonged to, to give testimonials of the work he'd done to put in his life history book," she says. "His daughter and granddaughter were also very involved in the book."

And, since that client lived in a long-term care facility, assisting him with his life history book "changed the perception that caregivers in the home felt about him as a person," adds Patterson, who co-authored the handbook, *Aphasia: A New Life.*

Ruth Patterson

Professionals who can benefit from the use of history books include occupational therapists, communication disorders assistants (CDAs), nurses, recreation therapists, and activation managers, as well as SLPs and social workers. "The books help us know the person behind the disability," says Patterson.

Book Must be in the Hands of the Client

Patterson notes that "the [life history book] process can be a very positive experience for the family who are really struggling to find something meaningful to do to communicate with their loved ones." She recalls cases where siblings were busy emailing each other to gather information and photos for their mom or dad's life history books. But, Patterson stresses, "the book has to be in the hands of the client. Sometimes the caregiver can hijack the process…maybe the family wants to tell a different story" than the client does.

Jan Roadhouse, SLP at the Adult Recreation Therapy Centre's aphasia program in Brantford, who uses the communication books, sees the need for "more education for family members as to the value of the life history book. I'm asking them to bring in personal things, and they may not understand how their loved one is going to use it."

Clients with aphasia are either limited verbally, or completely non-verbal, sometimes cannot write or draw or even in some cases, cannot gesture. To accommodate all these needs, the life history books are mostly image-based, including standard pictorial aids from the Aphasia Institute in Toronto as well as personal photos, with no more than a couple of sentences per page, in very large, bold print.

In the case of the York-Durham Aphasia Centre, the four SLPs who work there – one at each of the centre's locations – conduct a home visit "communication assessment that asks people questions about their lives and families," says Patterson. "We ask permission to use this information to start a basic life history book so it's already in place when the client comes to our centre for the first time." After that, much of the book's development is moved forward by the CDA and team leaders of the program, she adds, not to mention the participation of the client's family. (See the sidebar article for the step-by-step process of creating a communication book.)

Business

We have a family business in San Nicola.

We make excellent olive oil.

Work

I ran my own business in heating and air conditioning. It was called "Rizzo Heating and Air Conditioning". I worked with my brother Paolo and my sons Vince and Maurice.

Stock Car Racing

This is a stock car that I supervised in building. My friend **Dennis** raced it in a stock car **race** in 2003.

It was totally **destroyed**.

"The basic form of organizing the book is chronological order," says Patterson, "then we look at themes that emerge." However, "the product is not as important as the process" – the teaching of "communication strategies layered on top of the life history book." The books never get perfected, though, she adds, laughing. "They're not always pretty… and it can take many years to build up a sizeable life history book!"

"You stop building [the book] when your life story ends," says Roadhouse, whose Brantford program is one of the few other places in Ontario – or anywhere else –

using the life history books. “I have to give a lot of credit to Ruth [Patterson] and the York-Durham Aphasia Centre; I took her workshop and it inspired me.”

Patterson continues to offer workshops to identified clients and their families as well as to SLPs, CDAs, and volunteers, on how to begin developing a life history book. She says her centre has been visited by a Quebec association of people with aphasia, as well as some professional groups from France and Switzerland, to learn more about the life history books.

Seeking Funds and Recognition

Roadhouse started the Brantford aphasia program in 2001, and she’s used life history books since the beginning. She works half-time there and half-time providing outpatient therapy at a local hospital, helping clients start their history books at the hospital, then apply the book as a tool for one-on-one therapy once they transition to the Adult Recreation Therapy Centre. The book program is limited by size; Roadhouse is the only SLP, with seven volunteers, and no CDA on staff. The Brantford program is 60% funded by the Ministry of Health, the rest comes from United Way, the Rotary Club, and other community support.

Although the York-Durham Centre for Aphasia has more staff (and its significantly bigger volunteer base is well trained in supportive communication techniques), Patterson says there is definitely room for improvement in her own book program. “We have no specific funding for it one-on-one, just group-based work,” she says. And the one-time funding by the IBM Community Grants Program has not been followed by any further source of grants.

“Funding depends on results, and that can be hard to show in the book program,” notes Patterson, adding she wants to find a way to measure its success, such as increases in the self-esteem of clients who use the life history books. She also wishes to develop the books as a separate part of the aphasia program, and have it recognized as important therapeutic treatment.

Ideally, more than one copy of the life history book exists, says Patterson: one in the centre for caregivers to access, another book resides with the family, etc. But a book that’s upwards of 50 pages in a three-ring, two-inch binder requires a lot of photocopying, and the burden of that cost falls to the client or family. When they have enough volunteers to help out, the centre will create an abbreviated version known as the “communication wallet” that clients can take out with them into the community to help with conversations.

Fostering Intercultural Understanding

Using life history books could be even more important when it comes to immigrants with aphasia. “Aphasia affects all of a client’s languages,” notes Patterson, “so if their English wasn’t that strong before, it may be rendered almost non-functional” after the onset of aphasia, reverting the client back to comprehension of his/her native tongue only. The York-Durham centre provides a basic life history book outline in Cantonese/English and Italian/English. (The books must be in English too since the centre’s other programs are only offered in English.)

Roadhouse notes that the Brantford area is becoming increasingly mul-

ticultural – especially with Eastern European immigrants and more recently, Asians – and her aphasia program reflects that change. She'll use the clients' family members as much as possible to help write in their native tongue. "The immigrant experience is central…We find the books very helpful for intercultural understanding."

A client's native land and immigration story often appears as a theme throughout his/her life book, along with career, family, world travel, pets, friendships, competitive sports, and hobbies. Roadhouse recalls one completely non-verbal client who was an "amazing gardener." He didn't have any family close by, so she went to his home and took photos of his garden. "He just had to have it in his book," Roadhouse says. "Another client, now in his 70s, brought in a photo of himself as a young, accomplished bodybuilder…you can imagine the reaction this got" within the group!

Some clients, when they start at the centre, don't want to do a life history book; they say they're too sad looking back at who they were," notes Patterson. "But every single client develops one ultimately; they see how others use the book, how proud they are, how they grow and change" with the use of the books.

Roadhouse sees the books as change agents, too. She recalls how the family of one client who passed away made his life history book part of a photo display at the funeral. "It was very touching, it reflected their acceptance that his stroke – and his aphasia – was part of his life journey."

Heather Angus-Lee is an award-winning journalist; she can be reached at anguslee@cogeco.ca

Building a Life History Book

The York-Durham Centre for Aphasia has developed the following structured process:

- SLP identifies need, writes "prescription" for the life history book.
- SLP contacts (in person or by phone) the client/family/caregivers and explains purpose of the book.
- CDA arranges home or facility visit to gather information and to help family or caregivers fill out outline:
  - ☐ what does person need to communicate?
  - ☐ who does he communicate with?
  - ☐ where does he need this communication book?
- Meeting between CDA/SLP to jointly design communication book (reading level, size of print, etc.)
- CDA begins process of collecting information:
  - ☐ develops "skeleton" outline from information in client file/family outline
  - ☐ assigns volunteer and supervises regularly
  - ☐ meets with assigned volunteer and client, provides materials, forms, and outlines
  - ☐ introduces volunteer to family in person or by phone
- Meeting between CDA/SLP – first "draft" of the life history book
- CDA maintains weekly or bimonthly contact with family and/or volunteer/client (in person or by phone)
  - ☐ provides support to volunteer
  - ☐ keeps track of number of hours spent by volunteer
  - ☐ keeps progress record for each client book in progress
  - ☐ in consultation with SLP monitors and provides feedback
- SLP meets with CDA/volunteer and client/family to go over "final draft" of communication book before it is printed/photocopied.
- CDA assists volunteer to make final copy of book; asks for written permission from client/family to keep copy to use for educational purposes.
- SLP/CDA assist client and volunteer to use communication book in group.
- CDA conducts final home or facility visit to assist client, family, caregivers in using communication book; determines need for further support/training.

When Truth is Stranger than Fiction:

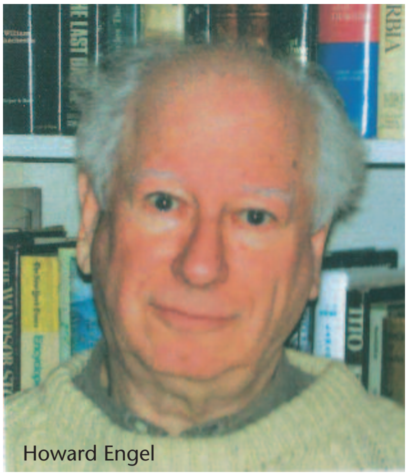
Using Memoirs to Guide Patient/Client Centred Care

By Barbara Meissner Fishbein

Fans of Benny Cooperman the shy, unimposing small town Canadian detective will be happy to hear that he is doing well having resolved two more cases since his *Memory Book* was published in 2005.

Fans of Howard Engel, Benny's creator will be happy to hear that he is also doing well having sufficiently recovered from his 2001 stroke that left him an author who could not read. Engel's newest book is not a fictional detective story for which he is well known but a memoir entitled *The Man Who Forgot How to Read*. The mystery in this real life account is what makes Engel tick.

Engel says that long before his stroke, he had toyed with the idea of writing his memoirs. He had written some first sketches of his life that he thought would eventually become a book. He wanted his memoir to capture the various twists and turns of his life. He wanted to talk about being born with an unfinished left hand and becoming a puppeteer as a young boy. He wanted to describe his experiences on the stage from public school through his university days at McMaster. He wanted to talk about his career in broadcasting at the CBC and his travels in Europe as a foreign correspondent.



Howard Engel

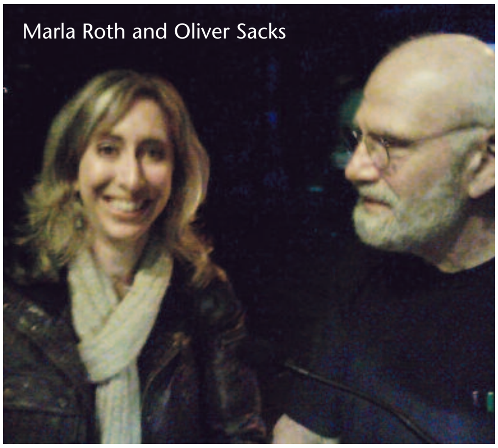
The Man Who Forgot How to Read is not the book Engel had intended. In his initial discussions with the publisher there was a difference of opinion on how the book would develop. The publisher wanted a book that focused primarily on Engel's stroke and his recovery. He wanted "the whole stroke and nothing but the stroke," Engel recounts. The publisher had envisioned a book about a stroke that befell a writer. On the other hand, Engel wanted the book to be about his life as he had been planning, a story that that had a broader scope in which the events surrounding his condition and rehabilitation would be but one part. Engel wanted to write a book about a writer who had a stroke.

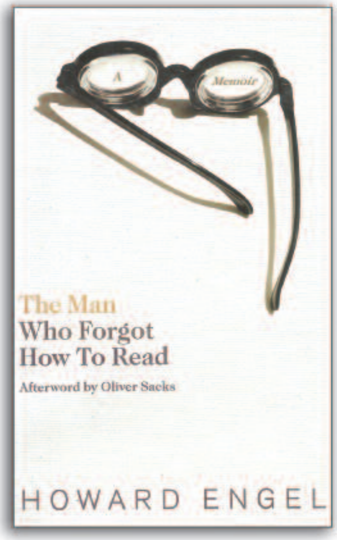
Engel's description of his struggles with his publisher highlight how it is that people look upon those with impairments or any type of differences in terms of those differences, yet the people want to be seen as people first and their differences as one part of them. Health care providers tend to see their patients/clients in terms of their diagnoses. Audiologists may refer to their patients/clients as that gentleman with the severe to profound hearing loss or the woman with the BTE, (behind-the-ear hearing aid). Speech-language pathologists refer to their strokes or stutterers or voice patients.

In the end, *The Man Who Forgot How to Read* served both masters. The book describes Engel's love of reading dating back to his childhood in St. Catharines, his career which took him from broadcasting to crime writing and his journey from stroke patient to published author. This story is set against a background of family and friends which paints a picture of Engel's personal life and provides a context with which the reader can identify. Engel is happy with the end result. As he wrote the book he realized that it had to demonstrate the effects of a stroke on a writer. "That" Engel states "is its chief success."

Oliver Sacks the famous New York City neurologist and author would agree. Engel came to Sacks' attention following a letter he sent at the recommendation of one of his speech-language pathologists, Marla Roth. Sacks appreciated Engel's unique situation and a few weeks later wrote to Engel asking if he could use quotes in an article to appear in the *New Yorker* magazine. This was the start of a correspondence which resulted in Sacks writing the afterword in both *Memory Book* and *The Man Who Forgot How to Read*.

One of Engel's goals in writing *The Man Who Forgot How to Read* was to illustrate the personal side to his story. "I really wanted to communicate this special knowledge that I had gained. I wanted to tell it the way it is from the inside," he says. In the book, Engel gives a first-hand account of what it was to wake up one morning to find he is unable to read his *Globe and Mail*. "*The letters, I could tell, were the familiar 26 I had grown up with. Only now, when I brought them into focus, they looked like Cyrillic one moment and Korean the next*," he wrote. His first reaction was that he was the victim of a practical joke but when he realized that that the letters seemed to change before his eyes "like astigmatism on a drunken weekend" he determined that he had suffered a stroke and with his 12-year-old son, hailed a cab to the hospital.


Marla Roth and Oliver Sacks



> *"The letters, I could tell, were the familiar 26 I had grown up with. Only now, when I brought them into focus, they looked like Cyrillic one moment and Korean the next."*

Engel goes on to chronicle his hospital stay describing the sketchy memories, the frustrating word-finding difficulty and the slow and depressing realization of the impact of his alexia. "*The idea of being cut off from Shakespeare and company left me weak. My life had been built on reading everything in sight. My jokes were based on reading; my take on current events was informed by reading. I was a one trick pony, and reading was my trick*."

The contribution of Engel's speech-language pathologists Roth, Lea Auuyao, and Michelle Cohen is described with respectful admiration. Engel references the August 2005 *CASLPO Today* article "*Private Eye Tackles the Mystery of Language Processing*," to fill in his memory gaps and use his therapist's perspective as a backdrop for his own. In all cases the speech-language pathologists took their cue from Engel. They encouraged him to pursue his interests and supported him to regain the skills he needed to resume his vocation. Their sensitivity to Engel's particular situation coupled with their professional expertise was not lost on Engel.

"*I was impressed by the skill, dedication and inventiveness of all the therapists I worked with both in the Rehab and, later, when I was back on the street. What I learned from them I quickly absorbed and made use of and I used much of it again to buttress the authenticity of the novel I had started working on. They had dropped the coloured stones that I followed to discover the way out of the forest. For this alone, I am forever in their debt*."

Part of the appeal of a memoir such as *The Man Who Forgot How to Read* is that Engel points out that a memoir that describes a devastating turn of fate and the challenges faced in overcoming the resulting impairments has the same appeal to a reader as a true crime story. One has the opportunity to view a life that one would not normally have known about with all its unique features and strange twists. Were it not for the catastrophe, these lives would be unknown. "It's like lifting up a stone and finding interesting creatures crawling underneath living unexpected, unpredictable, and random lives," he says.