

APPENDIX: Review of "In Pursuit of Quality: Evaluating Clinical Outcomes"

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Reprinted, with permission, from (Hooper, C. (1991). In pursuit of quality: Evaluating Clinical outcomes. NSSLHA Journal, 18, 15-16). This material was originally developed and copyrighted by the National Student Speech Language Hearing Association, Rockville, MD, U.S.A., www.nsslha.org.

Abstract:

A review of the article "In pursuit of quality: Evaluating Clinical outcomes," by Dr. Frattali.

Article:

Dr. Frattali's paper is full of pearls. While reading her thoughts about clinical outcome I found myself stopping, staring into space and having clinical memories. Sometimes I became enraged, sometimes enthusiastic. Much of the time I wondered why I, and we in clinics and academia, do not do things differently as we know we should. At first reading this paper is interesting and full of important facts for beginning clinicians. At a second reading I was ready to re-design our hospital and university. I will leave the school systems alone for now.

I would like to give some general reactions to the paper, not on a point-by-point basis, but in reaction to Frattali's general themes.

The Need for Clinical Outcomes

Frattali uses a term that scares the CCC off my wall, "clinical truth." I agree that we need empirical evidence. We need carefully, thoughtfully designed clinical outcome data to support our "is therapy working" question. Clinical assumption needs to move toward something else, but let's not call it Clinical Truth. How about Good Clinical Certainty or Clinical Effectiveness? Who among us is ready for a search for Truth? Leave it to Kent and Siegel.

Where does this search for clinical outcome information begin—or at least the seeds for this search? Where do most clinicians and researchers (assuming they may sometimes be the same person) alike get a fire in the gut—or have the fire put out—to find out if clinical intuition is correct? You guessed it—in that first clinical experience. And where does that first clinical experience take place? Right again—the university clinic. And do we who work in those settings make beginning clinical research appealing? An exciting lifetime endeavor? Fun? Do we encourage all of our graduate students to engage in some form of clinical research? Or do we make it an elitist activity for the chosen few? Does research experience have to take the form of a thesis, with the accompanying forms, procedures, and committees, or can the experience be a different one? Can a student assist a faculty researcher in a more "hang out and learn" fashion? Frattali mentions that speech-language pathologists and audiologists do not feel prepared to evaluate clinical outcome when they leave graduate programs. Should we expect any different result when we make students suffer to do research? Of course I have never worked at such a university, but I have friends. . .

Frattali discusses the cost issue in regard to the need for clinical outcome data. The readership of this journal, students in our profession, provide supervised clinical service in a setting that can often afford to engage clinical outcome research, Student training is already costly with the accompanying supervision meetings, observations, and planning. The requirements for state-of-the-art materials and instrumentation send the costs even higher. So with just a little more planning and thinking, clinical outcome research can take place in a setting that assumes research as its mission. But thanks to Frattali I began to ask who is responsible for the gathering of this outcome data? Right now "they are responsible, Not you, not me. When was the last time you asked your supervisor, "Why are we doing this procedure or this type of therapy?" "How do we know it works?" What can you do to find out if it works? What if you do not like your supervisor's answer?

National Initiatives

Let us assume for now that the search for clinical outcome data really is shifting to the private sector, as Frattali suggests, and to the public sector in health care settings. While reading this section I wondered if the funds and support for this endeavor on a national level would filter (trickle?) down to the front-line clinician in those settings. I hope that the focus on health care also applies to educational care for those children not treated in a health care setting. Our colleagues in the Veterans Administration Medical Centers across the country find support for large cooperative studies. Even our students in VAMC practica are familiar with their research protocols. These carefully designed investigations could take different formats in different settings, such as a regional school district(s) for similar national outcome data.

But I worry about my own profession. Leija McReynolds is optimistic (It's easy to become optimistic when you retire, Leija.) about clinical research by members of our own profession, I think Frattali is correct. If we do not engage in clinical outcome research, someone else will do it for us. I fear a day when all of our clinical data (number of sessions, type of therapy or procedure, final results, client identification data) will have to be turned in to a school administrator or a health insurance administrator. After some number crunching we will be told what works and what we can do to receive financial support.

I think a lessening of the "clinician-researcher gap" will help alleviate my fears. I think the statistics Frattali quoted from *Asha*, 1990, are not as bleak as they seem, Agreeably, less than 1% of ASHA members report research as a *primary* research activity, but what about the rest of us? I am a *Clinical* Assistant professor with 25% of my work time allocated to research. I never know how to fill out those ASHA forms each year. My work is equally divided into administration, research, clinical practice, teaching, and professional/community service. So what is my primary employment activity? I think many ASHA members have a small amount of research or administration time they might carve out for clinical research planning. The rest might ask. Some of my colleagues have never asked. But be prepared, if you plan that for your clinical future, to take your show on the road to Sertoma, American Speech-Language-Hearing Foundation, local community foundations, philanthropic clients (with good outcomes). Pop into the ASHA professional exhibits and poster sessions. Notice how many clinician-researchers are showcasing their clinical outcome research when research is not listed as a primary activity. These professionals have not accepted a two-tiered system of those who do research and those who provide service.

Quality of Care and Quality of Life

All I can say after reading this section is, read everything Rosemary Lubinski ever wrote about nursing home intervention and environmental language intervention. Those of us who are middle-aged clinicians (Frattali and Hooper included) have heard, since we were in graduate school, of the "old timers" in our profession. I remember the wonderful 50th anniversary 1975 ASHA convention in Washington, DC (my first convention—who can ever forget that?) where these men and women were honored. They were men and women of science who had quality of life in the forefront of their thoughts. Many of them did not start out as speech-language pathologists or audiologists, but brought information from other disciplines to ours. I remember much talk about the alleviation of human suffering at that convention. Frattali reminded me that we need to use that phrase a little more often. Perhaps the determinants of quality of life can be identified, as she suggested from the National Institute on Disability and Rehabilitation Research, by clients and their families. Even the very move in our profession back to functional measurements and back to a families focus is a sign that we are, once again, thinking about the alleviation of human suffering.

Cost

Frattali said it all when she addressed cost complaint as a "reaction—not a conclusion," in the "absence of scientific data." How can we afford not to do outcome research? I am so glad to see Frattali's reference to the Garret (1973) and the Boone (1970) articulation lower dismissal rate research. These studies influenced me greatly as I changed from a graduate student to a school clinician. I had been keeping those clients much longer in therapy, as had most everyone then. It took some courage to dismiss my first client before he was 100% accurate in conversation. When I rechecked him later in the school year, I was amazed that the research was

correct—he was fine without those last sessions. I saved a school, a school system, and a state a little money while still alleviating human suffering. I think similar studies that Frattali referenced in clinical aphasiology research are achieving the same goals with those clients. Group therapy—something not covered by Medicare in the 1970s—is now covered for some clients, thanks to some good clinical outcome data by speech-language pathologists.

Outcome and Competency

Frattali's excellent review of research possibilities should strike fear in the heart of every graduate student. Have you heard of all of these types of research, even on a cursory level? If not, why? Ask before it is too late to learn the easy way—in graduate school! Did your research design book or course leave out single-subject design or meta analysis? What kind of research designs are your instructors using in their own research? Ever ask them? I will bet the farm that they would love to talk about it.

Once again, university training programs were highlighted as neglecting the research focus for a more clinical focus. As a consumer of graduate school education, what are you demanding? I worry when some of my students want form over content, or procedure over thinking. They are tired of me telling them that graduate school is an appetizer; the main course comes later in clinical work. I teach first and second year medical students in a course called Problem Based Learning. I notice that they are not sweating the small stuff. They are not memorizing blood pressure values and laboratory measures – they carry little books around in their pockets with this information in them. They are focusing on the Big Picture of patient care. I am sure that in a few years they will not need the little books. Repetition has a way of doing that. These students are panic stricken (well, concerned) that they may not treat their first patients with the very best cost-efficient care. They are thinking life, death, malpractice, and insurance. I think we worry only about life insurance. Perhaps it is time to add a little death and malpractice to our worries.

Thanks to Frattali for allowing me to have a talk with myself. I believe that this paper is one of the most important papers that beginning graduate students and almost-new clinicians can read. Frattali did a wonderful job of pointing out that the evaluation of clinical outcomes benefits not just some national data pool or policy-making body, but it benefits each and every clinician in his or her daily work. She reminds us that we got in this field to alleviate suffering. How do we know we are?