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Evidence based speech-language pathology intervention

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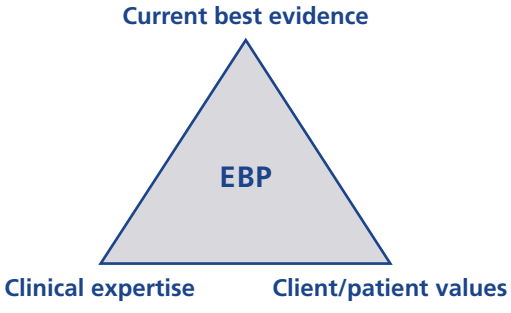
Henri-Frédéric Amiel was the name and **pathography**[1] was his game. Not much is heard about the issue of pathographesis, or the writing out of illness, but it is clear from Amiel's *opus magnum* that writing "out" illness was a complex, melancholy business – part poison, part antidote and part therapy – that makes writing "about" it seem very straightforward.

Scarcely acknowledged in his lifetime, international fame and acclaim came posthumously to this Swiss philosopher and diarist who lived from 1821 to 1881, when his *Journal intime* was published and translated into English. He was outwardly successful as professor of aesthetics, and then as professor of moral philosophy in Geneva, but because his were political appointments he struggled with isolation from the city's rich cultural life. Left with his own ideas in pursuing a lonely quest for truth and values through scrupulous self-observation, his writing both defined and created his ills (Rousseau & Warman, 2002), never exorcising his demons.

Sad to say, this introspective man, intent upon knowing himself, thought of himself as a failure: deficient personally and professionally. Nonetheless, a century and a quarter after his genius was revealed, the oft-quoted Amiel's reflections on the urge to intervene and the need to analyse our motives for, and methods of, doing so resonate in helpful ways with contemporary thought on evidence-based clinical practice.

Truth and values

The processes and responsibilities of clinicians who adopt evidence-based practice are commonly represented diagrammatically as points on an equilateral triangle (ASHA, 2004) in the **Euclidian plane geometry**[2] tradition. Echoing Amiel, two points of the triangle represent our constant quest for truth: theoretically, empirically and in practice, and the other point, our regard for our clients' values.



At the topmost tip of the triangle is the *clinician's* dynamic engagement with science via refereed and non-juried articles, chapters, proceedings, books and continuing professional development activity. On the left-hand point is the *clinician's* expertise: that blend of knowledge, skill and experience, and the capacity for constructive professional engagement with clients and their worlds. On the right is the *clinician's* respect for clients' beliefs, values, responsibilities and priorities, and an appreciation of the *assets* (Kretzmann & McKnight, 1993) that the people we serve bring to therapeutic encounters. In the middle of the plane is the now-familiar abbreviation, EBP representing the clinician's conduct. Yes, this little triangle is *all* about clinicians.

Best evidence

Unlucky Amiel lived in an age of scepticism. By contrast, we exist in a professional milieu that welcomes accountability, best evidence and exemplary care. In embracing the "three Es" of quality assurance – effectiveness, efficiency and effects (Olswang, 1998) – we understand that "it works for me", or "I don't know why it works but it does" approaches to justifying why we implement particular interventions simply won't wash! Why? Because "professionals should be wary about trusting their own clinical experience as the sole basis for determining the validity of a treatment claim" (Finn, Bothe & Bramlett, 2005, p. 182).

The onus for adopting EBP rests with individual clinicians. It cannot be imposed by professional associations, employers, legislators or policy-makers. It is up to us to constantly gather and objectively view clinical data, reflect, and ask hard questions about our interventions. Are they theoretically sound? Are they supported by evidence? Are they effective and valid? Do they work? Are they efficient? Do they work as well as, or better than other therapies? Can their efficiency be improved? And their effects: what changes do our therapies evoke?

Bernstein Ratner (2006) explains why she believes that EBP is a valuable construct, but cautions that along with those reflections and hard questions come potentially difficult issues. These require us establish robust communication at all points, from laboratory and clinic– that is, between the funding bodies and researchers who develop the evidence, the academics who spread the word, the administrators who regulate change, the employers charged with maintaining conducive workplaces, the practitioners who implement the evidence, and the client, who, in egalitarian practice, may have the last say.

> "EBP is a valuable construct in ensuring quality of care. However, bridging between research evidence and clinical *practice* may require us to confront potentially difficult issues and establish thoughtful dialogue about *best practices* in fostering EBP itself (Bernstein Ratner, 2006, p. 257)."

Plane figures

A triangle has three sides and three angles, but it is a plane, and a plane has no depth. The points on a plane have no parts, no width, no length and no breadth. But each point has an indivisible location. Do we accept that EBP is all about truth and values and that it is located at the junctures between clinical SLPs' engagement with scientific theory and research, their clinical expertise and their respectful engagement with their clients and their worlds? Or is it deeper and more complex than that, and is adopting EBP *all* about clinicians and their responsibilities?

Bridges

Bridges have three necessary parts: substructure, superstructure and deck. The substructure is the foundation of a bridge comprising the piers and abutments that carry the superimposed load of the superstructure to the underlying

soil or rock. The superstructure is that portion of a bridge lying above the piers and abutments. The deck is supported on the bridge's superstructure; it carries and is in direct contact with the traffic for which passage is provided.

As a framework for representing EBP, a bridge is as incomplete as a triangle. Sure it is multidimensional and not completely static, but like a triangle it is going nowhere (we hope). But what of the components of the bridge: the activity going on around, near, over, under, on and *because* of the bridge; and the people who construct, are affected by, care about, rely upon, jealously guard and constantly upgrade it? What of the careful multidisciplinary science that conquers difficult construction issues and engenders sound theory and evidence that the bridge, and others like it, will work if it is properly maintained? And the application of that science by competent, committed, self-aware practitioners sensitive to the values, capabilities and vulnerabilities of those who will need the bridge? And the end-users of the bridge, trusting that they, or their parent, sibling, spouse, child or friend are in good hands?

Freedoms

Maintaining, upgrading and modernising a working bridge that has been standing for many decades involves challenges, setbacks, stalemates, triumphs and satisfactions. So too does developing a construct like evidence based practice in a manner consistent with best practice. Amiel said, "conquering any difficulty always gives one a secret joy, for it means pushing back a boundary-line and adding to one's liberty". Then, typically for him, he offset this uncharacteristic flirtation with personal pleasure with wise advice.

> "Mutual respect implies discretion and reserve even in love itself; it means preserving as much liberty as possible to those whose life we share. We must distrust our instinct of intervention, for the desire to make one's own will prevail is often disguised under the mask of solicitude. (Amiel, 1892, entry of 7 Nov.)"

Speaking for the moment clinician-to-clinician, where does our *furor therapeuticus* fit? In our enthusiasm for EBP, in our fervour to intervene, in our knowing what to do, why it works, and how to do it, do we give sufficient thought to clients' individual freedoms? Their right to find their own way to conquer difficulties? To choose their own bridges?

Interconnections

Perhaps every one of us – administrators, clinicians, employers, researchers, students, teachers and thinking consumers – would do well to ask, "Do I have a place on the bridge?" "What should my role be in the conversion of speech-language pathology into an evidence based discipline?" "What is the nature of the gap between research and practice?" "How can I help in closing it?"

Given a choice between a mono-cultural triangle with no depth inhabited only by clinicians, and a cavernous, complex, dynamic well-maintained working bridge that links professional research, academic and clinical cultures, people and ideas, the bridge wins hands down.

We don't need a bridge *between* research evidence and clinical practice. We need interconnected research and practice riveted into the substructure, superstructure and deck of our multidimensional bridge, allowing direct contact with the traffic – in research and practice; theory and therapy – for which passage is provided.

References

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Links

1. http://www.mja.com.au/public/issues/178_06_170303/letters_170303-9.html
2. http://www.dform.com/projects/euclid/glossary.html

Webwords 31 is at http://speech-language-therapy.com/webwords31.htm with live links to featured and additional resources.