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Speech-Language Pathologists' Experiences Diagnosing Swallowing Disorders

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Speech-Language Pathologists' Experiences Diagnosing Swallowing Disorders

by

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ABSTRACT

This study explores the factors that inform a Speech-Language Pathologist's (SLP's) process for diagnosing dysphagia (disordered swallowing) and seeks to determine what barriers they perceive to performing their standard of care. To achieve a qualitative data set, 10 SLPs were interviewed using a semi-structured format and their responses were analyzed using Reflexive Thematic Analysis to produce four themes. Theme one gave insight into the SLPs prerogative to provide patient-centered care. Theme two expounded upon this, emphasizing how the SLPs treat dysphagia as part of a collection of disorders, and not in isolation. Theme three explained a lack of understanding as the root cause of many barriers that SLPs face. Finally, theme four investigated the SLPs methods of advocacy, and suggested ways that clinicians can address challenges in their practice. These four themes also highlight the variation among SLPs in their practices, settings, and in meeting the needs of their patients. One desired outcome of this study is to empower SLPs, both new and experienced, to advocate for their patients, their methods, and themselves as they navigate challenges in their dysphagia careers. Another hope is that this research will add to the discussion of variability in diagnosing dysphagia and consider the factors that contribute to the field's natural variation.

Keywords: dysphagia/swallowing disorders, barriers, diagnosis, variability, instrumentation, patient-centered care

DEDICATION

I dedicate this thesis to my patients – both in the past and future – who struggle with dysphagia. As someone who loves to eat, my hope for you is that you will once again be able to enjoy your favorite foods! I also dedicate this thesis to all speech-language pathologists who care for individuals with these disorders despite the challenges they may face.

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This paper would not have been possible without the support of many individuals. First, I would like to acknowledge my husband, Gage Moran, for being my rock throughout this process. I could not have done this without you there to remind me to take care of myself, and celebrate my small victories, and to keep me grounded when I was overwhelmed. To my advisor, Dr. LeBert, thank you for taking time out of your busy schedule to advise me and assist me in completing this work. You have made me a better scholar, and I am so grateful for all you have taught me. I would also like to thank Dr. Koch for getting me started on my thesis journey as my previous advisor, and Dr. Cloud for assisting me throughout the process despite not being my official advisor. I am truly humbled by these three professionals for giving an undergraduate student their time and energy while expecting nothing in return. To my family, thank you for encouraging me and being so excited about my project. To the Honors College, thank you for funding my time as an honors scholar, and for the opportunity to engage in scholarship in my area of study. Finally, to the ten speech pathologists who participated in this study, I thank you for providing such invaluable insight into your experiences treating dysphagia, for the services you give your patients, and for inspiring me to be a better clinician.

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LIST OF ABBREVIATIONS

ASHA	American Speech-Language-Hearing Association
CEU	Continuing Education Unit
FEES	Fiberoptic Endoscopic Evaluation of Swallowing
MBS	Modified Barium Swallow Study
MBSimp	Modified Barium Swallow Impairment Profile
SLP	Speech-Language Pathologist
SNF	Skilled Nursing Facility

CHAPTER I: Literature Review

The Role of the Speech-Language Pathologist in Dysphagia Management

Dysphagia, or impaired swallowing, is a medical condition that affects 1 in 25 adults in the United States (Bhattacharyya, 2014). Difficulty swallowing, when left untreated, can lead to aspiration pneumonia, choking, and malnutrition (ASHA, Adult Dysphagia, n.d.). The disorder's complex nature requires a multidisciplinary approach to diagnosis and treatment, with the Speech-Language Pathologist (SLP) at the center of the intervention. SLPs are trained in identifying pathologies involving the upper gastrointestinal tract, making them the clinicians most qualified to diagnose and rehabilitate a disordered swallow (ASHA, Speech-Language Pathologists as the Preferred Providers for Dysphagia Services, n.d.). According to the American Speech-Language-Hearing Association (ASHA), SLPs, in consultation with other professionals, are responsible for diagnosing dysphagia using instrumentation including, but not limited to, endoscopy, videofluoroscopy, ultrasound, and biofeedback (ASHA, Scope of Practice in Speech-Language Pathology, 2016). ASHA's practice portal outlines the following processes under an SLP's role: selecting assessment procedures that are appropriate for a patient's needs based on the case history, identifying normal and abnormal physiology using imaging, and assimilating findings into practice alongside members of the patient's team (ASHA, Adult Dysphagia, n.d.).

Variability in Dysphagia Diagnosis

There is significant inconsistency among SLPs when diagnosing dysphagia. In 2013, a study by Carnaby and Harenberg compared the practice patterns of SLPs who treated dysphagia. They found that clinicians disagree on what they consider to be typical practices when managing the disorder and concluded that there is no standard of care in dysphagia management (Carnaby and Harenberg, 2013). A 2018 study that observed SLPs' ability to identify impaired swallowing on x-rays found that clinicians frequently made false positives by over identifying nonexistent swallowing impairments and their treatment recommendations were only in agreement up to 50% of the time (Vose et al., 2018).

There are multiple reasons why this lack of agreement can be problematic, and these consequences can affect both the patient and the clinician. First, SLPs cannot increase efficiency or improve outcome quality based on inconsistent methods (Carnaby & Harenberg et al., 2013). Misdiagnosed false positives can lead to unneeded treatment, which can be prohibitively expensive for the patient and risk teaching maladaptive behaviors. Moreover, unneeded treatment can injure or weaken otherwise healthy physiological functioning (Vose et al., 2018).

It can be argued, however, that variability in testing, when influenced by a clinician's decision-making, can be efficient on the part of the clinician. In a 2016 survey comparing SLPs' implementation of the Clinical Bedside Swallowing Assessment, clinicians reported which assessment components they consistently utilized. No clinician implemented every item on the assessment, and response variations were emphasized as an effective way for SLPs to personalize the tool based on clinical reasoning (McAllister et al., 2016). Clinical reasoning also plays a vital role in underserved communities, allowing healthcare providers to remain flexible and responsive to patient needs while working in environments that lack resources (Pillay & Pillay, 2021).

This variability may also be the result of clinicians' implementation of patient-centered care. Traditionally, healthcare providers have followed a medical model, an approach in which the provider focuses on the disease and makes decisions for the patient to either accept or refuse. In a patient-centered model, "Each individual is recognized as a unique person with distinct goals, needs, and preferences which is very important in providing the long-term services and supporting the medical care system" (Kumar & Chattu, 2018). Over the past decade, several studies have explored SLP's potential role in patient-centered care. Bellon-Harn et al. (2017) quantitatively determined that SLPs valued patient-centeredness while citing the need for more qualitative measures (Bellon-Harn et al., 2017). A study by Forsgren et al (2022) stated that research on clinicians' implementation was lacking in the literature (Forsgren et al., 2022).

Barriers to Practice

Plowman and Humbert (2018) hypothesized six barriers that may account for the lack of agreement in diagnosing dysphagia. Three of these barriers inspired questions that guided this research – a lack of education when preparing to view swallowing, the inability to directly visualize a swallow without proper instrumentation, and the high productivity requirements for SLPs in medical settings (Plowman & Humbert, 2018). The focus of this study relates to the practicing clinicians' individual experiences in their field. Therefore, the questions explored barriers that respondents can measure subjectively: the level of education offered to clinicians, challenges of clinical settings (particularly high caseloads and lack of materials), and members of a dysphagic patient's interdisciplinary team.

Education Barriers

ASHA maintains a list of education standards required for SLPs to hold their Certificate of Clinical Competency, a designation that allows them to practice in their field (2020). Standard IV-C, “Knowledge Outcomes,” lists the following criteria regarding an SLP’s knowledge of swallowing:

> The applicant must have demonstrated knowledge of communication and swallowing disorders and differences, including the appropriate etiologies, characteristics, and anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates in the following areas ... swallowing/feeding including (a) structure and function of orofacial myology and (b) oral, pharyngeal, laryngeal, pulmonary, esophageal, gastrointestinal, and related functions across the life span. (ASHA, Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology, 2020)

Despite ASHA’s high clinical standards, the swallowing education protocols provided to SLPs are minimal at best, with most colleges only offering one graduate-level course in dysphagia. The only other avenues for SLPs to learn more about swallowing are through Continuing Education Units (CEUs) or on-the-job training (Vose et al., 2018). CEU courses are the primary methods clinicians use to stay up to date with current evidence (Dumican et al., 2023), and most clinicians reportedly learned the majority of their therapy techniques from these courses (Carnaby & Harenberg, 2013). Moreover, even SLPs who receive dysphagia education at a graduate level often feel that the curriculum on swallowing is insufficient and suggest many SLPs may not learn to treat dysphagia until after they have entered the field. In a 2020 survey studying the perceptions of SLPs regarding their preparation to provide dysphagia services, most participants felt their graduate education was inadequate (Caesar & Kitila, 2020). In these scenarios, CEUs offer inexperienced clinicians additional evidence-based learning.

When comparing SLPs' educational level with their clinical decision-making, factors that did not predict clinician agreement included the number of years practicing in the field, the number of modified barium swallow studies (MBS) performed weekly, and certifications. However, those who reported frequent use of frame-by-frame analysis were 11 times more likely to correctly identify the primary impairment in a swallowing evaluation (Vose et al., 2018). Therefore, frame-by-frame analysis can be considered a vital need in dysphagia education.

Barriers of the Clinical Setting

According to a 2023 SLP Health Care Survey (ASHA, 2023), 90% of SLPs reported that swallowing was one of the top five adult diagnoses treated most frequently. The following settings reported the highest incidence of dysphagia: skilled nursing facilities (SNF), hospitals (general, VA, military, long-term acute care, and university), rehabilitation centers, and home health. These settings are associated with two factors that can potentially affect SLPs in their clinical practice. One is the level of productivity required of SLPs. When identifying the clinical practice patterns of SLPs treating dysphagia, 74% of clinicians reported having to meet productivity standards (Dumican et al., 2023). ASHA's 2023 SLP Health Care Survey for caseload characteristics showed that the caseload sizes of 45% of clinicians had remained the same, while 44% experienced an increase in their caseload size. Only 12% of clinicians saw a decrease in their caseload (ASHA, 2023). The second factor concerned the materials available to clinicians. A swallow cannot be directly visualized, and an SLP can only view a patient's swallow through instrumental evaluations. Without access to such materials, the SLP can only attempt to subjectively infer a patient's pathophysiologies, which can lead to high variability among findings.

In a 2022 survey studying the practice patterns of SLPs in stroke management, Chen et al. (2022) found that nearly 1 in 5 SLPs indicated limited resources as the reason for their inability to objectively test patients for dysphagia (Chen et al., 2022). Vose et al. (2018) compared this lack of resources to "a neurologist diagnosing and treating a stroke based on the 'signs and symptoms'" rather than using imaging to identify the disorder (Vose et al., 2018). Nevertheless, many SLPs are faced with limited access to instrumentation. Videofluoroscopy, for example, requires a radiologist to be present for the procedure. SLPs wishing to view a swallow frame-by-frame – a practice shown to increase diagnostic validity – require additional recording software. Additionally, some facilities may refuse an SLP's request for an instrumental evaluation due to funding. Dysphagia is an expensive disorder to treat, and the up-front cost of an instrumental can range anywhere from $400 to over $1000 per study (Barnes, 2023). Skilled nursing facilities are not typically equipped for imaging which necessitates referring the patient out for an instrumental evaluation, a cost that comes out of the funds the facility receives for the patient. In this situation, a SNF may consider treating the patient without instrumentation to be a more cost-effective option, despite the long-term costs associated with dysphagia (Patel et al., 2018). The most common approach to treating dysphagia is thickening a patient's liquids, a practice that comes with its own risks. A 2018 study found that thickened liquids have a higher prevalence of silent aspiration than thin liquids (Miles et al., 2018). Silent aspiration typically has no symptoms and can only be determined by viewing the patient's swallow on an instrumental. For this reason, it is safer to test a patient's response to thickened liquids on an instrumental, as trialing thickened at bedside may put the patient at risk for silent aspiration (Miles et al., 2018).

Interdisciplinary Team Barriers

While dysphagia is primarily addressed by the SLP, the disorder necessitates collaboration with providers from multiple disciplines to provide the best care for the patient. As stated on Asha.org's practice portal for adult dysphagia, "The causes and consequences of dysphagia cross traditional boundaries between professional disciplines. Therefore, management of dysphagia may require input of multiple specialists serving on an interprofessional team." (ASHA, Adult Dysphagia, n.d.). This team can include nurses, physicians, dieticians, other therapists, and family and caregivers of the patient. Although SLPs are acknowledged for the roles they have played in dysphagia evaluation and treatment since the 1980s, public perception of the SLP as a swallowing specialist is still in its infancy (Groher, 2016). This lack of understanding is clearly seen among interdisciplinary team members. The author of a 2007 survey reported that most nurses desire further education related to dysphagia management (McCullough et al., 2007). Researchers for two West Asian studies determined that most physicians do not understand the purpose that SLPs serve in dysphagia management (Bakhtiyari et al., 2019; Saleem et al., 2022). Neuroscientist, Dr. Campbell-Taylor (2008), suggested that

SLPs were inadequately trained in swallowing management, and she encouraged physicians to prevent the use of “inappropriate procedures,” such as MBS, that SLPs recommended for their patients (Campbell-Taylor, 2008). This may be one reason SLPs receive pushback from physicians when requesting an instrumental procedure to diagnose dysphagia, and a future study exploring what effect, if any, Dr. Campbell-Taylor's paper had on physicians who treat patients with dysphagia could provide invaluable insight regarding this barrier.

CHAPTER II: Methods

Research Design

This study followed a reflexive thematic analysis design that implemented semi-structured interviews to collect qualitative data from 10 SLPs. Thematic analysis is the process by which a data set is analyzed for meaningful patterns, or themes. The "meanings" evoked from these perceived patterns were captured and summarized using small labeling units which are referred to as "codes." These codes were then analyzed and used to generate themes (Braun & Clarke, 2022). This thematic method was selected to capture a qualitative look at the responses from the participants and gain a deeper understanding of their experiences diagnosing dysphagia.

A hybrid approach employing induction and deduction was also utilized as an approach to analysis. In an inductive approach, the researcher develops codes directly from the data, without relying on previous findings or theories. A deductive approach uses newfound data to attempt to validate preexisting theories, and items in the data are assigned codes that correlate with the author's analytic interest (Braun & Clarke, 2006).

There were two research questions at the heart of this study: "What factors make up an SLP's dysphagia diagnosis, and what barriers do they perceive to their practice?" The author of this study sought to explore the first question without following a theoretical orientation to reduce analytic bias and study the data without preconceptions. The second question built on findings in the literature, and the author analyzed these findings in greater detail.

Finally, this study featured a reflexive approach to analysis. Braun and Clarke described reflexivity as a "disciplined practice of critically interrogating what we do, how and why we do it, and the impacts and influences of this on our research" (Braun & Clarke, 2022, p. 5). The author kept track of each step of her methods, her analytical reasoning, and how her reasoning affected the scope of the research. These reflections were incorporated wherever she felt more information for her methodological reasoning was warranted.

Recruitment

Participants were recruited using the Find a Provider search engine on Asha.org, a public directory for contacting SLPs and Audiologists. Results were filtered to identify SLPs with dysphagia listed under their areas of expertise. Clinicians were contacted by phone using the numbers listed on their public profiles. This study focused on SLPs with three or more years of experience who lived in Mississippi and surrounding states. Snowballing was also utilized, and the SLPs were invited to pass the information on to others interested in the study. Interviews were scheduled with each SLP until 10 interviews were conducted.

Participants for the study included 10 SLPs (n=10) living in several southeastern U.S. states who are experienced in diagnosing dysphagia. Four SLPs currently reside in Mississippi, four in Alabama, one in South Carolina, and one in Louisiana. Four of the SLPs previously worked in more than one state, including North Carolina, Washington, and Florida. The work settings included both inpatient/acute and outpatient care in hospitals, skilled nursing facilities (SNFs), private practice, home health, and long-term care facilities. The number of years that each SLP had been certified ranged from 3 years to 38 years, with a mean of 19 years of practice.

Procedures

Each SLP was invited to review the list of nine research questions before being interviewed. To keep the interviews semi-structured, the questions were open-ended, allowing SLPs to take their responses in any desired direction. Depending on the clinician's answers, the interviewer skipped or rephrased some questions to fit the conversation more appropriately. The interviews ranged from 9 to 64 minutes with a mean length of 29 minutes.

Recording and Transcription

The interviews were conducted in person, over Microsoft Teams, or on the phone, depending on the preference of the clinician being interviewed. Microsoft Teams featured a built-in recording and transcription service that was used to collect and store data. Interviews completed in-person were recorded and transcribed via an offline recorder on a cellular phone. A separate phone number was set up using Google Voice to record incoming phone calls for those who chose to participate in the interview over the phone. The SLPs were instructed to call the Google Voice phone number and to provide both verbal and written consent to be recorded before the interviewer began recording the conversation. The recordings were then downloaded and uploaded to transcribe.wreally.com, where they were automatically machine-transcribed into text. Each method ensured that only the interviewer had access to the participant's personal information and data, which was protected on a password-secured device.

Instrument

Each participant was asked a series of questions (Appendix B). The semi-structured format of the questions allowed the interview to be easily adapted to meet the needs of the SLPs, creating a more conversational environment for the questions. The depth and structure of the questions varied depending on the interviewer's aims for the topics of interest. For example, questions related to the SLP's methods for diagnosing dysphagia were open-ended and attempted to probe without introducing bias or leading the SLP to give specific answers. Questions regarding an SLP's perceived barriers, however, were more direct, and often included suggestions or prompts based on either the participant's previous comments or the interviewer's perceptions of potential barriers.

Analysis

The author began the process of thematic analysis by listening to each audio recording. This required a minimum of three separate listens for each recording, although some of the longer interviews warranted additional listens to fully engage with the data. Once familiar with the data set, the author read the transcriptions while listening to the audio, making notes, and commenting on items of interest. This step was completed twice for all recordings. She then constructed a table with direct quotes and the items of interest to form meaning units. Finally, the quotes were compared with the meaning units to form codes. This process was repeated twice to fully "capture" the evoked meanings into identifiable codes.

Once all the items were coded, they were "clustered," or grouped with codes that shared a similar topic. These formed categories, which were then broken down into subcategories as needed. This was an ongoing process throughout the analysis, as the author continually added and removed codes in subsequent revisions. Finally, the categories were condensed into themes. Theme generation took multiple attempts and resulted in four themes. Any subcategories that the author believed supported the theme while retaining independent ideas were included under the themes to provide more depth to the topic.

CHAPTER III: Results

Responses from the interviews were generated into multiple codes. These codes were clustered into sixteen subcategories, further condensed into nine categories, and finally developed into four themes. All four themes highlighted the variability inherent in diagnosing dysphagia.

Theme I: Patient-Centered Practice

> Keep those patients, always, first. People come first, remember we're doing it for them and it's what's in their best interest. (SLP 5)

Patients are people before they become a name on a clinician's caseload. As SLP 5 explained above, the needs of the client come before all else. The theme of patient-centered care was significantly in the data set, other participants were quick to point out that it was the client's role to make decisions about their care, and the SLP's role to inform them of the risks and benefits.

Subcategory: A Patient's Right to Refuse

Client refusal was mentioned by many of the SLPs. Participants shared experiences of clients refusing to undergo instrumental evaluations or change their diets, despite clinicians recommending these options as best treatments for the clients' condition. SLP 1 and 4 concluded that such decisions were the patients' rights. SLP 4 went on to elaborate:

> I'm going to give them the information and I'm going to give them the opportunity for imaging and to modify their diet. But ultimately, it's their decision what they want to do. (SLP 4)

SLPs must remember that clients are the ones who make decisions about their care. While a clinician may be tempted to focus on treating the client's impairment, it is more important to first determine how the patient is affected. Many of the SLPs agreed that if a patient's health and quality of life were not affected, no immediate intervention was required. SLP 8 shared her experience of treating patients whose dysphagia did not serve as an impairment:

> Sometimes you have to get in that situation because we get black and white… Sometimes when we see someone having trouble like, oh my gosh, they're aspirating put them on NPO but it – you met him today! And then if you look at the big picture, it's like, you know what, he's not kind of having these symptoms, right? He's not had pneumonia congestion. He's gaining weight. His voice is strong. Sometimes they get those weak, low voices, you know when they're aspirating so you kind of look at the big picture. Look at the blood gases. Look at his blood work, you know, if everything looks good so good. … A lot of my patients are followed for sometimes 20 years, aspirating every time I see them, but they don't get pneumonia. And they're eating. So, I think that takes experience, and, you know, collaboration and constant monitoring and really knowing your patient. (SLP 8)

This experience highlighted another important concept: patients who choose not to undergo an instrumental exam or follow recommendations still need their SLP's support. In the case above, one can see that an SLP must establish a working relationship with patients to achieve the desired outcomes. Their clients may still have goals for therapy, and the SLP is responsible for helping them to achieve those goals.

Subcategory: Informed Consent

A key factor in empowering patients to make their own decisions regarding their healthcare is ensuring they understand the risks and benefits so they can make an informed choice. This concept of informed consent is, according to SLP 1, more than a patient's right:

> It's actually a federal law – informed consent is an ethical and legal obligation that speech pathologists have. So, patients need to know that these tests we do, whether it's the bedside, the instrumental, and the therapy, if there's gonna be recommendations for altered diets made, they need to know that ahead of time because they absolutely have the right to decline. (SLP 1)

Participants reported pushback and challenges from a patient's family members and other providers in response to recommendations (A concept explored further in the third theme). Most SLPs, however, did not report pushback from patients. The few who treated uncooperative patients did not force their patients to comply and instead found other ways to help them. SLP 2 shared an experience where her patient with intellectual disabilities needed to perform a head turn to swallow safely. The clinician had the person's dinner chair turned to the side so they would naturally perform the maneuver while swallowing. When asked if she ever received pushback from the patients, SLP 1 explicitly stated that she has not, and then went on to explain how she lets the patients choose how they wish to conduct their therapy.

Theme II: Variability in Clinical Rationale

The participants' responses showed a variety of clinical reasoning. Their overall methods followed a standard approach that began with a chart review, bedside evaluation including an oral examination, and a trial of thin liquids. However, their clinical reasoning demonstrated varied objectives in their use of methods. Their objectives reflected the settings in which they worked, ranging from stabilizing their patients in critical care, discharge from hospitals, managing risk in skilled nursing facilities, to maintaining patients' safety, and achieving the patient's goals in home health. The patients' unique cases and treatment aims also influenced the SLPs' clinical decision-making processes.

Subcategory: The Use of Instrumentation

Although all participants in the study advocated for the use of instrumentation for diagnosis, their rationale reflected the needs of their varied settings. SLP 5, who works with critically ill patients, believed that her patients warranted an instrumental study 99% of the time, and they typically received several swallowing studies over a very brief time period. Comparatively, SLP 7, who works with home-bound patients, felt that it was not always reasonable to send those people out for a swallow study and instead relied on clinical methods to treat her patients.

Nine out of the ten participants agreed that some circumstances do not warrant an instrumental evaluation. The most significant determinant noted throughout the data set was the level of the patient's cooperation, with half of the participants choosing not to push for a study if the patient refused to either participate in the study or comply with any recommendations that might follow, a concept highlighted in Theme I above. Another determining factor included specific cases where the patient's presentation precluded them from the study. SLP 3 provided one example of how patients recovering from a stroke need 24 hours to improve or decline:

> I would take into consideration if they had just had a stroke. I wouldn't want to do an instrumental too soon, you know, just because they can improve significantly within, you know, or decline… they're still kind of in process the first 24 hours. (SLP 3)

Instrumental exams can be a challenge for clinicians to access. They are expensive for patients without insurance, and those who are insured may only be able to afford one per year, according to SLP 10. They can be difficult to schedule, as an MBS requires a radiologist or technician to perform the study. Therefore, when a patient is being evaluated instrumentally, the SLP wants to make an efficient use of time and resources, typically by trying out diet modifications, postural maneuvers, and other compensatory strategies. If a patient appeared unable to effectively participate, SLP 6 would delay a swallow study so the patient could get the most "bang for their buck."

> A lot of times, too, if the patient maybe doesn't seem like they can participate well for the exam like that. Say, give them some ice chips and they do fair, you know I suspect that something's going on, but I don't have X-ray vision, so, I can't really tell. We can always postpone an instrumental for another day, the next day or something like that, to make sure that they are able to successfully complete the exam right. (SLP 6)

Subcategory: Dysphagia Is a Sequela

The concept of looking at the whole picture also applies here. When SLPs assess a patient for dysphagia, they are not diagnosing the swallow in isolation. Dysphagia is a sequela to many different disorders – and not only those related to the head and neck. SLPs must be cognizant of the multiple factors surrounding their patients to not only identify the cause of dysphagia, but to also notice any signs and symptoms of other potential disorders so they can make referrals to the appropriate providers. For example, when SLP 8's patients showed signs of a reflux disorder alongside potential dysphagia, she would first refer them to a physician to treat that condition. Another example was SLP 10's use of her cranial nerve assessment to make appropriate referrals where she felt they were warranted.

Theme III: Misunderstanding and a Lack of Education Regarding an SLP's Role

The barriers to practice perceived by SLPs were highly variable. Responses from participants highlighted six areas that they felt obstructed their practices: Working in teams with multiple disciplines, collaborating with families, disagreements with other SLPs, navigating the lack of resources in specific settings, learning the fundamentals of dysphagia care, and addressing fear-based recommendations from other SLPs and providers. A common narrative among these areas was a lack of understanding that others – even fellow SLPs – had of an SLP's role in the medical field. This lack of understanding is explored in more depth in the subcategories below.

Subcategory: Interdisciplinary Challenges

SLPs do not singularly treat dysphagia. Each member of a patient's care team has a unique role to play in assessing and treating dysphagia. Many participants reported working alongside other providers and shared the benefits and challenges associated with interdisciplinary collaboration. A recurring theme among SLPs' responses was that challenges to care were often a symptom of misunderstanding an SLP's responsibilities in dysphagia management.

A key member of the patient's interprofessional team is the physician, who is typically responsible for approving requests for instrumental studies and signing off on the SLP's Care Plan. Results showed cases in which physicians did not understand an SLP's need for certain resources, such as instrumental exams, and denied their requests. SLP 2 shared the following example of a doctor refusing her request for a fiberoptic endoscopic evaluation of swallowing (FEES):

> I had a doctor at the nursing home, that was denying my request for swallow studies for FEES because we had a person on our team that traveled around and did FEES. And he thought I was just drumming up business for our company and so he would say, "No." (SLP 2)

Other SLPs shared experiences of physicians who neglected to collaborate further with them after making a referral for a speech consult. For SLP 6, this often took extra time out of her day:

> In outpatient I'll say the barriers would be obviously insurance, getting the physician to sign the order, because a lot of times the physician will refer the patient to us and then they think their job is done. And, but in outpatient we write the plan of care and then we need the physician to sign it so the insurance will pay

> for their treatments… So, a lot of times it's the SLP having to be the squeaky wheel when you don't really have that free time to do that. (SLP 6)

Even after obtaining a swallowing study, SLPs may continue to face collaborative challenges. A typical modified barium swallow study offers a lateral (side) view of the patient. However, an anterior and posterior (AP) view, which shows the front and back swallows of a patient, also falls within the scope of practice for an SLP and radiologist (American College of Radiology, ACR–SPR Practice Parameter for the Performance of the Modified Barium Swallow, 2023) While a lateral view may be sufficient for a simple view of a swallow, again, SLPs rarely assess the swallow in isolation. Therefore, if clinicians want to assess multiple factors surrounding their patients, they may need more than one view of the swallow to do so. SLP 8 shared her frustrations in convincing her radiologists to provide these views:

> Sometimes… the radiologist is reluctant to do an AP view... they didn't know that they have the freedom to do it, sometimes, so we kind of had to have a big discussion. That's where the speech pathologist has to be a huge advocate for themselves, for the doctors they work for, and for the patients to get those views because I can't tell you how many times, but a lot of times, we would catch stuff that you normally wouldn't catch if you stopped at the shoulders... It doesn't mean that you're assessing the esophagus, and I think that was the biggest barrier that radiologist had they felt like well, this is a modified barium swallow test if you want to look at that, then you have to come back tomorrow, or whatever, you know, and do an esophageal test. (SLP 8)

Situations may arise when an SLP must recommend modifications to other departments to align with standards. Oftentimes, the recommendations are not received in a positive manner, as SLP 2 illustrated:

> I've got a nursing staff when I told them, um, let's look at having the tube feeders head-of-bed elevated. They said straight up, we'll handle nursing care. You just handle the speech stuff… the nurses are going to think you don't know anything about medical. (SLP 2)

Though clinicians may consider interdisciplinary challenges frustrating and time-consuming, they must remember that other team members bring valuable skills to the table, and that the patient cannot improve without interprofessional practices (ASHA, Adult Dysphagia, n.d.).

Subcategory: Family Challenges

Another challenge participants faced was telling families that their loved ones could no longer tolerate food in the same way they once did. For example, one of SLP 2's clients had a mother who would regularly bring her shrimp and french fries during visits. When the client's diet was changed to puree, and she could only tolerate items that had been blended into a pudding consistency, that was no longer a safe option. SLPs discussed the impact of eating on a family's culture, and the struggle to change that aspect of their life.

> Families want their loved ones to eat usually regardless of the risk. (SLP 3)

> I feel like in our culture the one thing you did for someone who’s sick is let me bring you something to eat. They might not believe that the tube in the nose is giving the person the nutrition that they need. (SLP 6)

Family is crucial to a patient’s therapy, and they are often responsible for carrying out a clinician’s recommendations. However, if they do not understand or agree with these recommendations, the patient’s care can be compromised. Several of the SLPs noted that families were often resistant to changes in their loved ones’ diets and additional education was necessary to help the family understand treatment outcomes. SLP 2 shared one horrifying account of a family’s active refusal to follow recommendations:

> Also had a family here threatening to take me to court... Staff over the years had misinterpreted directions on this person, to the point where, when I came here, they were having his feet above his head, his leads straight out because his hips don't bend. So, instead of having him up, they had him down and then they would pour liquid into his mouth, until he swallowed... The parents were like, "No, every time one of you speech therapists comes in here, you want to change things on him, and he gets sick and we're not doing it...” They were cramming it in, holding his mouth shut and everything. He gets to the hospital, "surprisingly" with pneumonia. They lavage him. They took so much food out of his lungs! (SLP 2)

While not all cases of family collaboration are as dramatic, according to the data, family pushback and trust remains a significant hurdle for SLPs to overcome. As SLP 2 mentioned, the family in question claimed that previous clinicians had changed the client’s care plan multiple times, and they came to associate these changes with causing their son’s illnesses. By the time SLP 2 began working with the patient, the family did not trust SLPs to work with their loved one. The concept of SLPs causing barriers for others in their field is discussed in more depth below.

Subcategory: Intradisciplinary Challenges

Clinicians who fail to keep up with the best practices in their field may use outdated and potentially dangerous practices. One older practice is the use of thickened liquids at bedside. Recent findings have revealed that thickening liquids leads to a higher incidence of “silent aspiration,” wherein the patient aspirates with no visible symptoms (Miles et al., 2018). Nevertheless, the practice is still sometimes used by clinicians without instrumentation, as SLP 6 noted:

> I’ve worked in a facility before where a clinician did not feel that instrumentals were important because this person that I’m thinking of specifically they had probably 30 to 40 years’ experience… and this person would put people on thickened liquid and, and that without an instrumental …and then I would see them the next day to follow up and I would say, "Well, I don’t know that you really need this". So, then it would get kind of awkward because then the family or the patient are like, well, that person was just in here yesterday and they said this is what we need. Now, you’re saying that we might not need that and that we might need another test. And so then ... it’s like a little bit of distrust because then it’s not consistent on all fronts. And so, they need to go to the doctor to get

> requests for the order, and they say, "Why? They're eating fine, they're on nectar thick, or mildly thick..." I would say that that's another barrier. (SLP 6)

SLP practices require specialized skills, which must often be defended to physicians, patients, and family members. When clinicians are not in agreement regarding treatment strategies, it creates disharmony in the field. This inconsistency causes distrust among team members and the families of those on an SLP's caseload.

Another factor concerning collaboration within the discipline is the communication between SLPs. When SLP 10's patients were referred out to a hospital for a swallowing study, the clinician relied on information she received from the SLP who performed the swallow study to treat her patient. She, as well as other participants, felt that these reports were often lackluster.

> For those patients that I continue to treat that I send out for a, a swallow study, sometimes, oftentimes, I get the information from their test, and it's still limited... I've had some reports that indicate the presence or absence of aspiration, but not the, the whole picture of their swallowing mechanism… the more information that could be provided during that time and then also reported to, to us... the better. (SLP 10)

SLP 10 included other considerations she wanted to know about a study, such as how the patient responded to any postural modifications during the study, or if any structural abnormalities were present. This desire reflected the concept of patient-centered care and showed the role a lack of communication plays in this aspect of an SLP's practice. A clinician performing a swallow study in a hospital may not know what needs a clinician in home health or long-term care needs for their patient and may unintentionally complicate that SLP’s therapy.

Subcategory: Insufficient Resources and Finances

One pattern among responses was the difficulty many SLPs experienced in obtaining an instrumental exam. This was often the result of inaccessible equipment. Other times the facilities did not want to cover the costs of sending the patient out for an instrumental. In some cases, SLPs had access to an MBS without the software needed to record the study, which placed an unrealistic expectation on the clinician to evaluate a one-second swallow in real time.

> In skilled nursing facilities, they don’t want to pay for an instrumental because it comes out of their money that they get for the patient. They want you to go ahead and treat them anyway. They want you to change diets at bedside, thickened liquids, that sort of thing. (SLP 1)
>
> A local hospital here where they did not have the ability to record those and so you have to make a decision very quickly in real time on what is safest and best for those clients. (SLP 4)
>
> We don’t have the equipment to provide FEES, which I really wish that we, we did have the training and the equipment… (SLP 10)

Instrumental testing is very costly upfront. Facilities that historically observed dysphagic patients treated without instrumentation may not see a need for additional expenses. In these situations, the SLP must educate the administrators on updated practices in their field so they can provide ethical care.

Subcategory: Education Needs

According to the demographic data, nearly half of the participants graduated during the 80s and 90s, which was a time when dysphagia care was not taught traditionally in schools. These clinicians cited continuing education, the support of fellow clinicians, and on-the-job training as their primary modes of learning to become adept at diagnosing dysphagia. As SLP 1 explained:

> Swallowing is new to the field of speech pathology, and it had really just come into being… when I graduated. So, we really didn't know what we didn't know... We have to stay up with the evidence. We have to follow it. (SLP 1)

The lack of education on swallowing can lead to many SLPs misdiagnosing dysphagia and providing care that lacks an evidence base or, worse, has proven to be harmful. As demonstrated in the intradisciplinary subsection above, these SLPs can also make it difficult for SLPs who use evidence-based practices to effectively advocate for their methods, breed distrust among collaborators, and even put the patient at risk.

Even SLPs who graduated more recently felt that the education offered to them was lacking. While SLP 4 praised her Modified Barium Swallow Impairment Profile (MBSimp) course, she believed some aspects of it were limited,

> So, when we were in graduate school, we had to do the MBSimp course... You can learn a lot of really good information from that course, but it can be a little too nit-picky. You know, this is the real world, and we can't sit around and spend 30

> minutes evaluating a swallow study... And so, I learned how to diagnose dysphagia in the field. There was some coursework on it. But I'm sure you'll see as you go through your programs that book work... doesn't hold a candle to real life experience. (SLP 4)

SLP 10 mentioned that new graduates might not know what to look for in an oral assessment, which she attributed to the education in schools.

> For those who are new, like if they've just graduated, they're not really sure what to look at, cause at school they kind of teach a whole bunch of different things, or it could be quite limited... after you've been practicing for so long, you kind of know what to go in and look for. (SLP 10)

Another barrier involved the cost of continuing education. Several SLPs reported that their work provider does not cover the cost of CEUs.

> Also, a lot of companies no longer pay for continuing education. So, I have to pay for my own education to stay up to date, umm, with changes in our field. And so, if someone’s a new grad or a new therapist not making a lot of money, it’s very expensive to pay for your own courses. (SLP 1)

To hold the Certification of Clinical Competence and to stay up to date with evidence in the field, all clinicians must complete a set number of continuing education units each year. As these units are quite expensive, companies have historically reimbursed SLPs for the fees. Paying for CEUs out of pocket is not only a financial burden, but it can also affect the learning of new SLPs, who rely on such education to effectively learn dysphagia care.

Subcategory: Fear-Based Treatment and Scare Tactics

A customary practice among providers is to focus on treating the signs of the patient’s dysphagia, the most visible of which is typically a cough. A cough can be beneficial, as it serves as the body’s defense mechanism to clear the airways and keep unwanted substances from entering the lungs. However, many providers seek to eliminate it, and incorrectly correlate the absence of a cough with an absence of dysphagia.

> Unfortunately, sometimes a lot of clinicians and especially nursing will push for is just, "Well, have you tried thickening, like, you know what about, maybe they just need to be on puree, or maybe they just need mechanical soft,” … A lot of times now, people tend to assess and treat in this mode of fear, or what can I do to eliminate a cough, without understanding that just because a cough might be “eliminated,” quote unquote, doesn’t mean that, you know that person is not potentially aspirating. (SLP 10)

Other responses indicated that participants have seen other SLPs attempt to “scare” the patient into following recommendations.

> I’ve seen some therapists tell patients, you know, this is what you’re going to have to do. You have to do this or you’re going to choke and just like, oh my gosh, let’s just, let’s scare the sick person! So... I’m not a scare-person. I’m not going to do that to my patients. I’m going to present them with the information. Let them know, you know, these are your deficits. This is what this looks like for you. This is probably not going to improve because of X Y & Z, and these are your options and if you choose this option this is what will happen… You are an

> adult it is your opportunity to make choices for yourself. I think sometimes we forget our patients are adults. (SLP 4)

The fear-based strategies described above can both undermine patients' autonomy and put them at risk for complications. Treating the symptoms without knowledge of the impairment can worsen the pathophysiology, weaken healthy functioning, and increase the patient's chance of aspirating silently, leading to aspiration pneumonia (Miles et al., 2018; Steele et al., 2021). Moreover, patients who are compelled to follow recommendations may not be compliant after being discharged from the SLP's care. Therefore, the need for SLPs to use evidence-based methods for assessment and considering the unique factors surrounding the patient, rather than treating in a mode of fear, is warranted.

Theme IV: Advocacy and Education: An SLP's Resources to Overcoming Barriers

If barriers in dysphagia care stem from a lack of information, then an SLP must respond by educating whenever misunderstanding arises. Most of the SLPs described how they spend much of their time advocating for their patients, their methods, and themselves. SLP 5 considered advocating a necessary skill to be practiced daily:

> I would say we as speech-language pathologists always have to advocate for our patients' care and means and we just have to remind ourselves that teaching and training staff and family and caregivers is a skill that's necessary on a daily basis. (SLP 5)

Subcategory: Educating Oneself

Advocacy takes many forms for clinicians. SLP 1 recommended clinicians stay up to date with the research evidence so they can be effective advocates for their patients.

> I suggest to all my students that I get, new grads – follow the evidence. Stay up with the evidence if there's any way possible. Get continuing education because you can't advocate for your patients adequately if you don't know what you need to know. (SLP 1)

SLP 7 recognized the limitations of her setting and continually educates herself to provide better patient care:

> Because I'm not in a medical field, I do a lot of continuing education in that area and especially a lot of continuing education in like, like swallowing with my ALS patient … I want to be sure that I'm keeping up with the medical research because I'm not in a medical setting by making sure that I target that as part of my education. (SLP 7)

SLPs can also find success in interprofessional teams by familiarizing themselves with the practices of other professionals. When SLP 8's request for an anterior/posterior (AP) view of a swallow was met with resistance from her radiologist, she researched radiology guidelines so she could more accurately advocate for her patient's needs.

> You know, if you look at the Academy of Radiologists guidelines for doing modified barium swallow, it is kind of vague, but it does allow for a cursory view of AP… if you take it as swallowing a barium tablet or some liquid you can

> actually go from the mouth all the way down to the stomach and back up and be within your realm… it took a long time, and years, and, every time you get a new radiologist, kind of encouraging them and asking for that part of the test, which we might call, you know, a dynamic modified barium swallow where I'm going to want different views and so a lateral and an AP view … I had to actually show the radiologist the guidelines and their own manual and pull it up and say can we come to an agreement on this. (SLP 8)

By acquiring information from other disciplines, clinicians can understand the barriers that other providers may face – or, as the case above demonstrates, believe they face – when assisting SLPs.

Subcategory: Educating Others

Clinician 5 believed that an SLP's skills warrant regular education of other providers, families, and patients. She further explained that those educated require different approaches to learning.

> What we do is a skilled service, and they don't have the same level of understanding and you have to put yourself in a different place as far as helping them understand and showing them different ways to understand whether it's verbally showing them, visually showing them with pictures and videos. And, and I've tried to learn that, you know, you have to do it over and over and over again in different ways because they all have different learning styles. And I educate about it and I, even to this day, try to find new ways to make it easier for staff, easier for families, easier for my patients. (SLP 5)

SLP 9 pointed out how advocacy looks different in each setting:

> (Advocacy) depends on the setting you're in. So, if you're in a setting where you know, you have others around you that are also advocating for the same thing, you know, like if we you know, are presenting research that you know will back whatever you're asking for funding. Typically, they're pretty receptive of that but definitely in like a rural setting… it took a while… (SLP 9)

Her perspective highlights the impact that multiple clinicians have when they come together to advocate. This also reinforces SLP 1's assertion that clinicians must keep up with their continuing education, as SLPs cannot effectively advocate for others if they do not agree on best practices.

It is worth noting that educating is more than telling team members ways that they can improve. The purpose of educating is to ensure that all providers understand the needs of both the patients and the other members of their interdisciplinary team. When all members of a team reach a consensus, they can more effectively work together in meeting the patients' needs. As SLP 6 demonstrated:

> So then that that's where our job is to educate the physician and it's usually a slow process as usually not something that you can do in five minutes so usually, building a relationship with them and getting them to see that what you have to add is valuable and that your, that your clinical expertise is critical to the patient progressing….Kind of go the extra mile a little bit for them. Then you'll notice that there is a relationship shift and then they'll be more apt to help, well to kind of rely on you some. (SLP 6)

Specialists from other disciplines can also advocate for the patient alongside the SLP. SLP 2 shared an experience when she and an occupational therapist (OT) collaborated to raise the head of bed for patients who used a feeding tube. She also refers to the concept of street credibility, which she has developed after years of working in the field.

> …So, he would say no. And his two nurse practitioners, who I worked much more closely with went to him and said, if she's asking for it, she needs it. It's not about business. So, they have backed me up at times… we got a different director of nursing and I brought (raising the head of beds for tube feeding) up again, we got an OT, who is really good and so the two of us collaborated and pushed it. But you do, when you get out in the field, you have to develop your street credibility because the nurses are going to think you don't know anything about medical. (SLP 2)

SLP 2 also offered advice for communicating with families regarding changing patients' diets:

> I had an Italian woman, tell me a long time ago, in our culture, it's, I love you, I feed you, you love me, you eat. Okay, so that is something you have to watch out for and in a treatment situation or anytime you're going to take away, you got to give something back… So just try and find an alternative and if it's not an alternative food, it's got to be an alternative activity and explain it to them like that. (SLP 2)

In response to intradisciplinary miscommunication regarding swallow studies, SLP 10 recommended communicating early with other clinicians:

> I've been trying to push, advocate for my patients to get more information. I've even gone as far as far as to send off like written things that I'm hoping that they'll do, like an esophageal screen… a cup and straw…consider compensatory strategies or postural changes, facilitation techniques before just recommending, say, a modified diet."

When it comes to advocacy, patient care is always the primary desired outcome. SLPs who work side-by-side with other professionals to put the patient first, educate to correct misinformation, and advocate daily may begin to see their barriers disappear. Though she has worked in the field for a shorter duration of time compared to the other participants, SLP 10 has already observed the benefits of consistent advocacy.

> So, there's a whole, there's a whole lot of stuff that we have to, on a day-to-day basis, try to advocate for, but it really does make a difference. And I think it's important, as a provider, to never stop considering and actively doing those things for the patients. (SLP 10)

CHAPTER IV: Discussion

The purpose of this study was to explore the SLPs' rationale for diagnosing dysphagia, the barriers they perceive to their practice, and their methods for overcoming those barriers. Semi-structured interviews and reflexive thematic analyses were implemented to provide a deeper understanding of these concepts. Participants shared their processes for diagnosing dysphagia, which considered variable factors such as the patient's therapeutic wishes, the goals of their clinical setting, and their own clinical judgement. The barriers to the clinician's practice were regarded as an effect of the general misunderstanding of an SLP's role and the resources they need to provide effective care. The clinicians shared their response to these challenges, which included seeking additional education for themselves, educating staff and families, and advocating for their patients, their clinical methods, and themselves.

Clinical Rationale

Variation in Practice

Findings from this study were consistent with claims in the literature of the varied practice patterns among SLPs who diagnose dysphagia (Carnaby et al., 2013, Plowman & Humbert, 2018, Vose et al., 2018). The author identified several variables that influenced a clinician's rationale for assessment, which included the goals of the clinical setting, the resources available to the clinician, and the needs of the client. These factors concurred with those of Pillay and Pillay (2021), where the discrepancy between SLPs clinical reasoning in acute care settings and community hospitals was determined to be a result of the context in which clinicians practiced. Moreover, the variation in clinical reasoning is crucial, as an SLP must adapt to meet the demands of the setting and those of the patient (Pillay & Pillay, 2021).

Another factor that affected clinicians' diagnostic decisions was the availability of instrumentation. Although all clinicians recognized the importance of instrumental evaluation for diagnosing dysphagia, not all had access to these resources. Participants who worked in home health, skilled nursing facilities, or other long-term residential facilities practiced without access to instrumentation. When their patients' symptoms warranted an instrumental study, they were required to travel to other facilities for an MBS or FEES procedure. SLPs who worked in inpatient hospitals and acute care settings typically had more access to instrumentation. However, even participants for whom instrumentation was easily accessible still used it on a case-by-case basis. In addition to honoring a patient’s refusal of an instrumental, many of the participants chose not to use an instrumental study based on their patient’s presentation.

A Patient-Centered Approach

All SLPs in this study demonstrated a person-centered approach to therapy, which may account for the high variation in clinicians’ practices. This provided a qualitative look into the experiences of SLPs practicing patient-centered care in dysphagia assessment. A patient-centered approach may also explain the lack of pushback from clients, as the patients were primarily responsible for the direction of their care. Other key characteristics of patient-centered practices noted among the participants included a patient’s right to refuse an SLP’s recommendation, an SLP’s responsibility to listen to and to collaborate with the patient, and a patient’s decision to terminate therapy. A significant finding in this study was the recurring perspective among participants that clinicians needed to cease black-and-white thinking about dysphagia and consider all the factors related to the evaluation and treatment of their patients. Many SLPs shared experiences where they did not treat their patient's dysphagia. This was on a case-by-case basis, and it was only reported in instances where the patient or family refused treatment. When the family refused treatment, it was typically in scenarios involving patients who were dependent on their families to make decisions concerning their medical treatments. The SLP's responsibility was to inform the family regarding the risk of oral intake. The clinician then collaborated with the family, the patient's physician, and other appropriate professionals to determine the best course of action for the patient. In the case of patients refusing treatment, SLPs would inform them of the risks of untreated dysphagia and the symptoms they needed to watch. The participants noted that these patients were otherwise healthy, did not have a history of aspiration pneumonia, and were eating without visible complications. They continued to monitor these patients, sometimes for years, to watch for indications that their dysphagia had become problematic. While supporting patients in refusing treatment is not unusual for patient-centered care, it has been given little attention in research. Future studies are needed to explore in greater depth the concept of patients choosing to live with untreated dysphagia.

Barriers

Collaborative Challenges

A major theme in this study regarded the challenges associated with an SLP's collaborative efforts. SLPs relied on the efforts of physicians, nurses, respiratory therapists, other rehabilitation specialists, dieticians, and family members to provide their patients with best care practices. However, many of these relationships created challenges that impeded an SLP's ability to practice. A lack of education, misunderstanding of an SLP's role, and poor communication often accounted for these challenges. These challenges were divided into the subcategories of interdisciplinary, family, and intradisciplinary challenges.

Interdisciplinary Collaboration. SLPs collaborated with practitioners from multiple disciplines. Most participants reported challenges related to these working relationships. It was common for clinicians to request an instrumental on a patient only to be refused by the physician or the facility. Several clinicians shared experiences of being pressured to change diets, often without an instrumental exam, despite evidence that such changes can negatively impact a patient's health. Although part of an SLP's scope of practice includes "assimilating findings into practice alongside members of the patient's team" (ASHA, n.d.), when SLPs make suggestions to providers from other disciplines, they are often told something to the effect of, "We'll handle (this department), you just handle the speech stuff," (SLP 2). Other SLPs wanted to be involved in a patient's care earlier before the patient began to show symptoms of dysphagia.

Family Collaboration. Families can provide a powerful support system for patients. They are typically the ones who help the patient comply with therapeutic recommendations, particularly if the patient is dependent on the family members to provide care. Many families have a culture of feeding to show love, and one of the first responses most people have to an illness is to feed their sick loved ones. Participants shared their struggles to help the families understand and comply with their patients' new diets.

Intradisciplinary Collaboration. Another finding from the study was that an SLP can be a barrier to others in the field. One of the most significant challenges was the result of clinicians using outdated practices. When participants recommended evidence-based practices that contradicted outdated information provided by previous SLPs, they frequently caused the patient, family, and other members of the team to question their validity.

Another challenge occurred during communication among SLPs who provided an instrumental exam for a patient and SLPs who provided therapy for the same patient in a different setting, such as home health or a SNF. SLPs who oversaw the patient’s therapy would use the information from the assessment to create a treatment plan. Several participants mentioned scenarios in which the report they were given did not provide information about the patient’s physiological function, reporting only the presence of dysphagia and recommending a dietary modification. Considering the difficulty of obtaining an instrumental exam, SLPs who perform the exams would do well to provide a more in-depth report of the patient’s swallowing function. This way, the SLP who receives the report would have more information to develop effective treatment goals.

It is crucial to understand that members of the interdisciplinary team are not the cause of barriers. Nor are they an impediment that the SLP must overcome to provide patient care. Instead, they play a vital role in helping an SLP assess for and treat dysphagia. Regarding interdisciplinary collaboration in dysphagia treatment, ASHA maintains, “The causes and consequences of dysphagia cross traditional boundaries between professional disciplines. Therefore, management of dysphagia may require the input of multiple specialists serving on an interprofessional team” (ASHA, Adult Dysphagia, n.d.). Challenges arise when team members misunderstand the knowledge and skills that SLPs contribute to healthcare. When SLPs themselves do not keep up with new evidence, they risk hindering the practices of other clinicians in their field.

Education Needs/CEUs

Disordered swallowing is arguably the most critical disorder that an SLP can directly treat. A clinician must understand and have extensive experience with dysphagia, as improper care can cause injury or even death. Despite the depth of knowledge needed for the management of dysphagia, some have challenged the level of education offered to clinicians (Campbell-Taylor, 2008, Plowman & Humbert, 2018).

Many participants in this study did not receive formal training in dysphagia management while in school and learned to diagnose dysphagia on their own. For these clinicians, CEUs are the primary educational modality for dysphagia. Even today, SLP students' resources to learn dysphagia in school are limited, with most universities offering one course on swallowing disorders (Plowman & Humbert, 2018). This leaves many graduates feeling unprepared to treat dysphagia (Caesar & Kitila, 2020).

This perceived inadequacy of education highlights SLPs’ need for CEU courses to learn evidence-based practices for their patients. Indeed, Carnaby and Harenberg (2013) found that most respondents’ therapy techniques were most commonly acquired from CEU courses (Carnaby & Harenberg, 2013). Moreover, the field of speech-language pathology is constantly evolving, and CEUs allow clinicians to stay up to date with these changes, as demonstrated by a 2023 study (Dumican et al., 2023). However, a small number of SLPs reported that they were not reimbursed for CEUs. This could further impede clinician's ability to develop their knowledge of dysphagia management, as new graduates may struggle to afford to further their education.

Lack of Resources

Many SLPs experienced facilities denying their requests for instrumentation. This was thought to be due to the high costs associated with such testing. While instrumental exams can incur significant expenses upfront, they can also save facilities money over time. For example, the average cost of providing care to a patient with dysphagia was over $6,000 more per year than the cost of a patient without dysphagia. As the average cost for an instrumental evaluation is approximately $1,000, a facility would do well to consider the benefits of evaluation in the long-term (Barnes, 2023).

Scare Tactics/Fear-Based Approaches

Fear-based treatment among other clinicians and providers was reported by several participants. These practices typically included attempting to treat the visible symptoms of dysphagia, such as a cough, by thickening patients' liquids. This was often recommended without an instrumental study, a practice that places patients at risk for silent aspiration (Miles et al., 2018). Another practice related to fear was "scaring" the patient. SLP 4 recalled times when she saw other SLPs telling patients that if they did not follow recommendations, they would choke or aspirate. This appeared to be a tactic used after the patient had been educated on the risks and benefits and while the patient was attempting to make an informed choice.

These fear-based approaches to dysphagia management are problematic because they focus on the symptoms, rather than the cause of the issue. To elaborate on the stroke analogy quoted in the literature review by Vose et al. (2018), treating a cough and expecting dysphagia to be cured is comparable to having a person showing signs of a stroke sit down to "cure" the dizziness and imbalance that often accompanies a cerebrovascular accident (Vose et al., 2018). Focusing only on visible symptoms may distract the providers from the true disorder that requires treatment. Furthermore, when SLPs attempt to scare patients into compliance, they are taking away the patient's right to make informed decisions. This reduces patient autonomy and reflects the outdated, medical model of healthcare. Moreover, patients are the ones who are left alone to follow a clinician's recommendations. Patients who choose their own treatment strategies are more likely to follow protocols than those who have been "scared" into compliance. The concept of treating dysphagia in a mode of fear has not been researched in depth and is a topic worth exploring in future studies.

Addressing Barriers

Advocacy and Education

A major finding of this study was the role advocacy and education played in an SLP's practice. All participants showed a desire to provide their patients with best practices and defended them whenever they felt their efforts were challenged. Advocacy and education were used interchangeably by the clinicians to describe their responses to these challenges.

Education for advocacy was a pattern found among SLPs, and all participants reportedly prioritized their continuing education and regarded it as a lifelong process. They learned to ask questions of others with more experience and stayed up-to-date with changes in the field. They also familiarized themselves with other disciplines' scopes of practice so they were on the same page when misunderstanding arose. Finally, SLPs who maintained their educational status could advocate for other clinicians in their field, a process that participants indicated was more effective than advocating alone.

Regarding a lack of knowledge inherent in most new graduates, participants never recommended that a new clinician feign competence. They recommended SLPs ask questions, be open to learning, and seek guidance from other experienced SLPs. One resource shared by SLP 1 was Student to Empowered Professional (STEP), an online mentoring program through ASHA. Through STEP, new clinicians connect with an experienced mentor who guides them through the beginning of their careers (ASHA, n.d.).

SLPs have a responsibility to educate other members of the interdisciplinary team. Participants felt this was accomplished most effectively when an SLP put in the effort to build a working relationship with other providers. Several SLPs who shared experiences of going the extra mile to help those professionals often saw it positively impact the relationship. Participants were also prepared to discuss the pros and cons of treatment options with other providers. Again, the long-term cost of some recommendations may be worth the steep upfront costs for some facilities. SLPs who advocate for expensive equipment will do well to familiarize themselves with the cost-to-benefit ratio of such treatments.

When working with the patients’ families, keeping a clear channel of communication and allowing the family to be part of the decision-making process appeared to result in less family pushback. SLPs can also support family members who desired to feed their dysphagic loved ones by offering additional options. Providing the family with a solution, which might be a different type of food or an alternative activity, can be therapeutic for everyone. When a patient cannot eat what they used to eat, it can be a loss for all involved.

In cases of intradisciplinary collaboration, SLPs took extra steps to communicate their needs early in the process. One SLP provided a list of options that she wanted the SLP instrumentally evaluating her patients to attempt during the exam. She found that the other clinicians were typically happy to comply with these requests.

CHAPTER V: Limitations

One limitation of this experiment was giving participants a copy of the questions to be asked before the interview. Doing so allowed them time to read the prompts, which had the potential to lead their responses. As this study's purpose was to give SLPs an opportunity to share their challenges, the element of spontaneity was sacrificed to give them more time to consider their own experiences before answering. Moreover, at least two interviews were conducted on the spot, giving the participants less time to familiarize themselves with the questions than others. While this allowed their responses to be more impromptu, it also gave them less time to fully construct their responses. Notwithstanding the amount of time each participant prepared, all SLPs provided a rich, heartfelt look into their careers.

Another limitation of using a semi-structured interview was the flexible nature of the questions. Although there was a set list of questions and prompts, they were not always given in the same order, and different prompts were given to different clinicians as deemed appropriate by their previous responses. Some questions were eliminated due to time constraints and the nature of the conversation. Semi-structured interviews require a significant level of sophistication and expertise on the part of the investigator, and the author's inexperience could have resulted in a loss of opportunity to collect information. Human error could also account for the limitations of the analysis. There is no endpoint for coding, and the author could have potentially generated countless other codes.

One factor that was not represented in this study was SLPs' consideration of their workload, as the participants did not share their opinions on their caseload size. One clinician mentioned that productivity standards are still a problem, but that she does not have them at her facility. This is a limitation of the study, as the SLPs were not directly asked if they considered their caseload sizes to be problematic. Future studies may be needed to explore SLPs' feelings regarding their caseloads, and what effects they perceive productivity standards have on their practices.

Finally, a limitation of the study was due to the selection of the participants. All participants of the study were female and living in a small geographic area. A broader selection of participants would have made for a more representative study.

CHAPTER VI: Conclusion

The aim of this study was to gain deeper insight into an SLP's perspective throughout the dysphagia diagnostic process. This revealed a significant variability in SLP's clinical rationales. Several factors that could account for this variation included the clinicians' patient-centered methodology. Other factors included the unique purpose of each clinical setting, and the resources available to SLP. Barriers to the SLP's practice were considered the result of a lack of understanding of the SLP's role and the resources needed to provide evidence-based care. Insufficient education could also account for intradisciplinary challenges and further the misunderstanding SLPs faced by others. Lastly, participants shared how they addressed these barriers by educating themselves and others and advocating for their methods.

This study offered a subjective look at SLP's diagnostic processes for dysphagia, a topic that is rarely given qualitative treatment in research. Additionally, it posed several ideas that are not reflected in the literature, and which have the potential for future areas of study. These included the clinician's rationale for not treating dysphagia in otherwise healthy individuals, a decision typically implemented to support patient-centered care. In contrast, the concept of a fear-based mode of treatment was introduced, which was a problem among both SLPs and other providers.

Finally, this study suggested ways that SLP clinicians can overcome the barriers in their field. It is crucial that SLPs know they are not alone in their challenges, that others have had similar experiences, and that they can rise to these challenges. Thus, this study highlighted both problems and solutions in the assessment and treatment of swallowing disorders.

APPENDIX A: Interview Questions

1. Can you tell me about your background as a speech-language pathologist (SLP)?

Prompts: years practicing, university obtained degree, states practiced in

2. Can you tell me about your clinical experience as an SLP?

Prompts: caseloads, client populations, private practice/hospital/SNF

3. Can you describe your method of diagnosing dysphagia?

Prompts: Where did you learn to diagnose dysphagia? What are the criteria you use for the diagnoses? What caseloads/populations do you typically treat? How many clients do you treat in a typical day? What do you consider to be the gold standard of care in dysphagia diagnoses? What other professionals do you collaborate with?

4. How often do you use instrumental evaluation in your therapy? Where and/or when do you not think instrumentation is necessary? Why?

Prompts: VFSS, FEES, signs and symptoms that prompt the use of instrumentation, old age.

5. What is your method for assessing a patient after therapy?

Prompts: Do you consider instrumental evaluation necessary post-therapy?

6. Have you ever experienced barriers to providing your standard of care when diagnosing dysphagia?

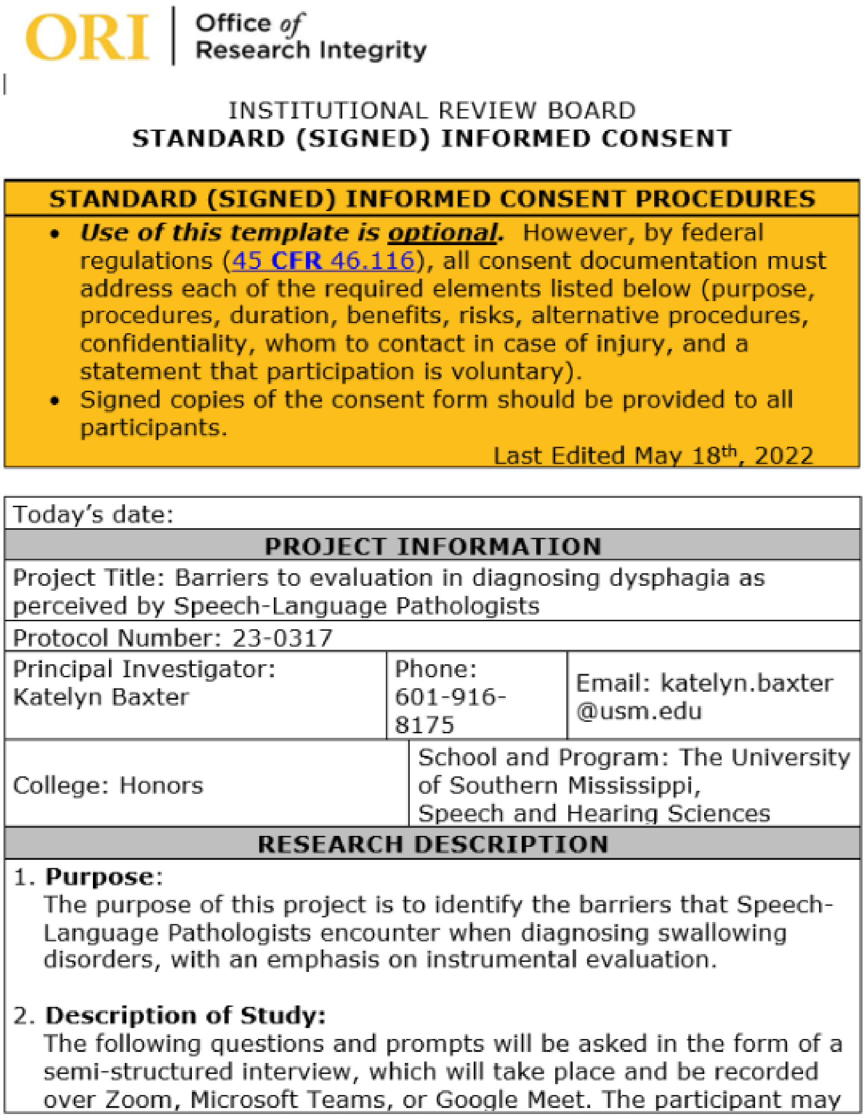
Prompts: fellow clinicians, financial limitations, inaccessible equipment, patient refusal, need to advocate for self or patient

7. Have you ever had to advocate for your methods of care or for yourself as a clinician? What was that like?

8. Is there anything about your experience diagnosing dysphagia that you wish you could change?

9. Are there any other comments you would like to make regarding your experience diagnosing dysphagia?

APPENDIX B: CONSENT FORM



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INSTITUTIONAL REVIEW BOARD
STANDARD (SIGNED) INFORMED CONSENT

STANDARD (SIGNED) INFORMED CONSENT PROCEDURES

- ***Use of this template is optional.*** However, by federal regulations (45 CFR 46.116), all consent documentation must address each of the required elements listed below (purpose, procedures, duration, benefits, risks, alternative procedures, confidentiality, whom to contact in case of injury, and a statement that participation is voluntary).
- Signed copies of the consent form should be provided to all participants.

Last Edited May 18th, 2022

Today's date:

PROJECT INFORMATION

Project Title: Barriers to evaluation in diagnosing dysphagia as perceived by Speech-Language Pathologists

Protocol Number: 23-0317

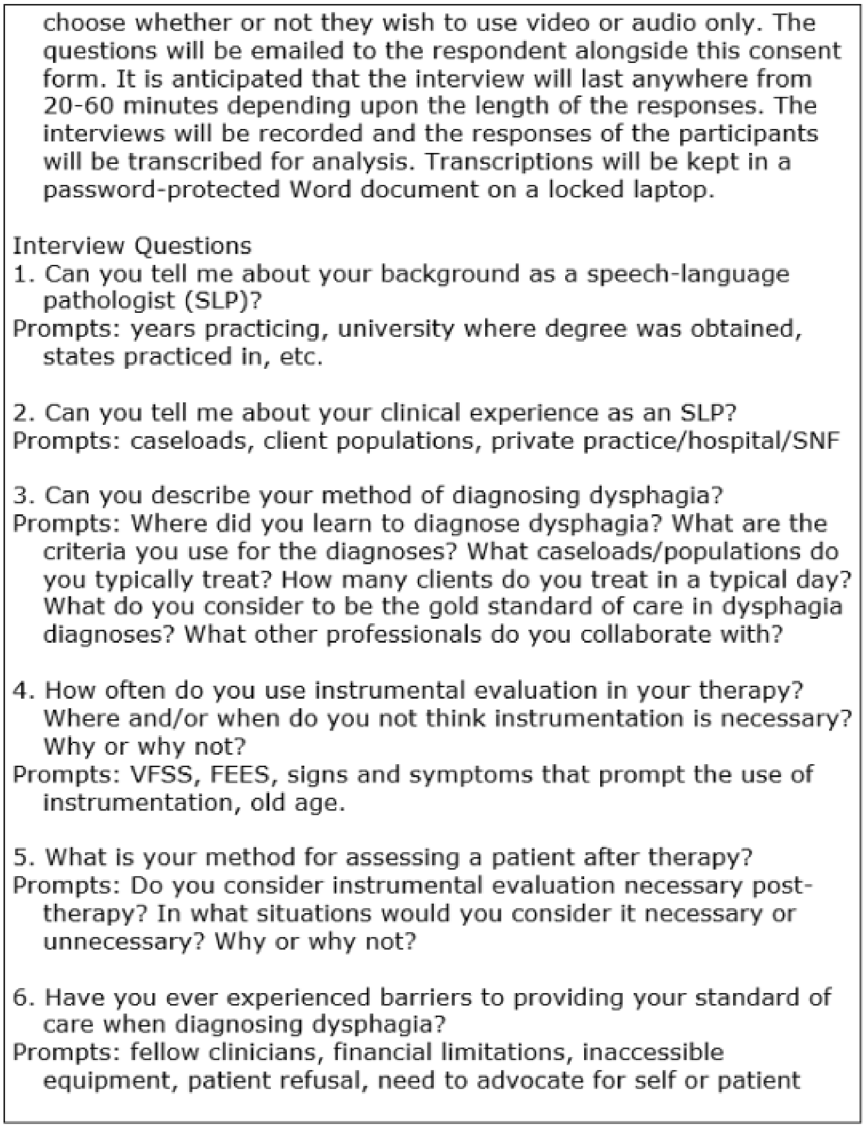
Principal Investigator: Katelyn Baxter	Phone: 601-916-8175	Email: katelyn.baxter @usm.edu

College: Honors	School and Program: The University of Southern Mississippi, Speech and Hearing Sciences

RESEARCH DESCRIPTION

1. **Purpose**:
   The purpose of this project is to identify the barriers that Speech-Language Pathologists encounter when diagnosing swallowing disorders, with an emphasis on instrumental evaluation.

2. **Description of Study:**
   The following questions and prompts will be asked in the form of a semi-structured interview, which will take place and be recorded over Zoom, Microsoft Teams, or Google Meet. The participant may



choose whether or not they wish to use video or audio only. The questions will be emailed to the respondent alongside this consent form. It is anticipated that the interview will last anywhere from 20-60 minutes depending upon the length of the responses. The interviews will be recorded and the responses of the participants will be transcribed for analysis. Transcriptions will be kept in a password-protected Word document on a locked laptop.

Interview Questions

1. Can you tell me about your background as a speech-language pathologist (SLP)?

Prompts: years practicing, university where degree was obtained, states practiced in, etc.

2. Can you tell me about your clinical experience as an SLP?

Prompts: caseloads, client populations, private practice/hospital/SNF

3. Can you describe your method of diagnosing dysphagia?

Prompts: Where did you learn to diagnose dysphagia? What are the criteria you use for the diagnoses? What caseloads/populations do you typically treat? How many clients do you treat in a typical day? What do you consider to be the gold standard of care in dysphagia diagnoses? What other professionals do you collaborate with?

4. How often do you use instrumental evaluation in your therapy? Where and/or when do you not think instrumentation is necessary? Why or why not?

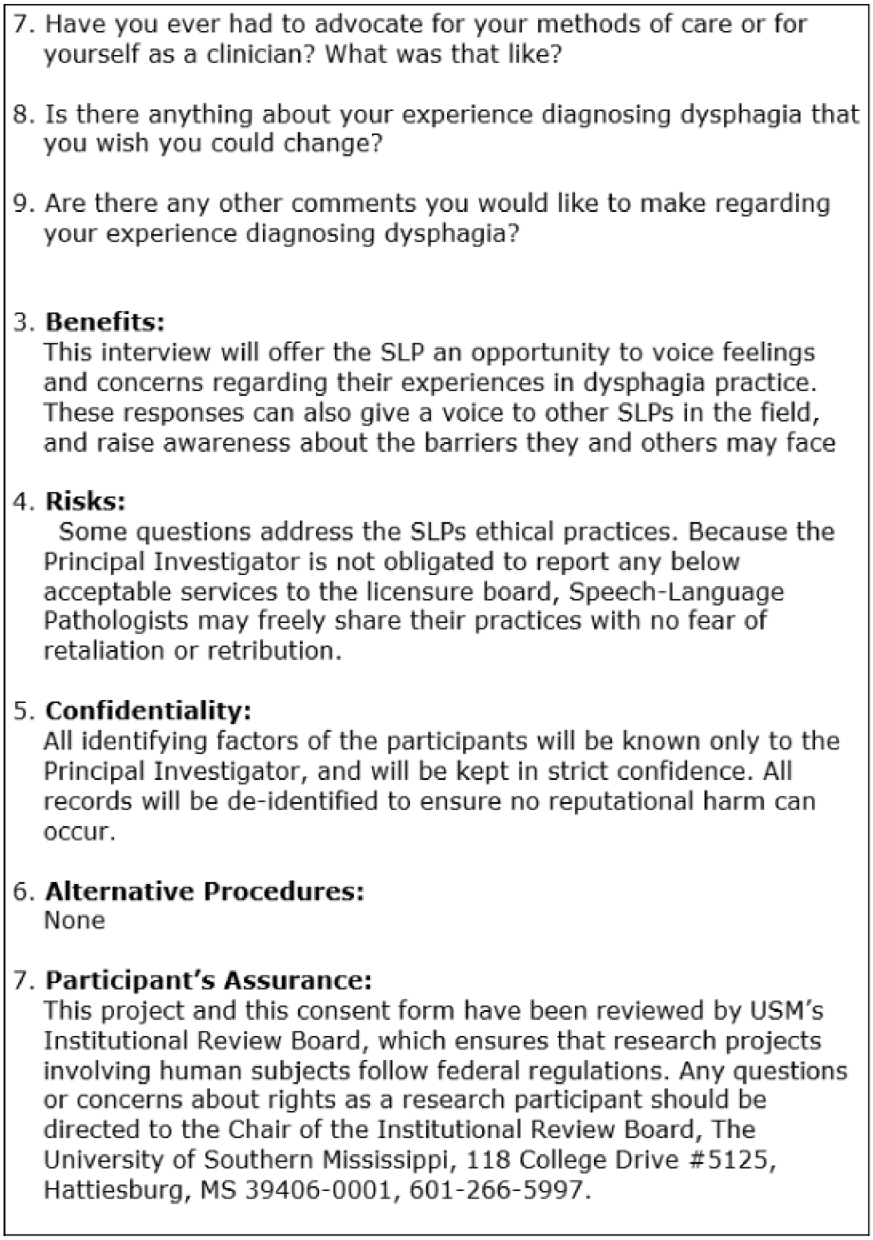
Prompts: VFSS, FEES, signs and symptoms that prompt the use of instrumentation, old age.

5. What is your method for assessing a patient after therapy?

Prompts: Do you consider instrumental evaluation necessary post-therapy? In what situations would you consider it necessary or unnecessary? Why or why not?

6. Have you ever experienced barriers to providing your standard of care when diagnosing dysphagia?

Prompts: fellow clinicians, financial limitations, inaccessible equipment, patient refusal, need to advocate for self or patient



7. Have you ever had to advocate for your methods of care or for yourself as a clinician? What was that like?

8. Is there anything about your experience diagnosing dysphagia that you wish you could change?

9. Are there any other comments you would like to make regarding your experience diagnosing dysphagia?

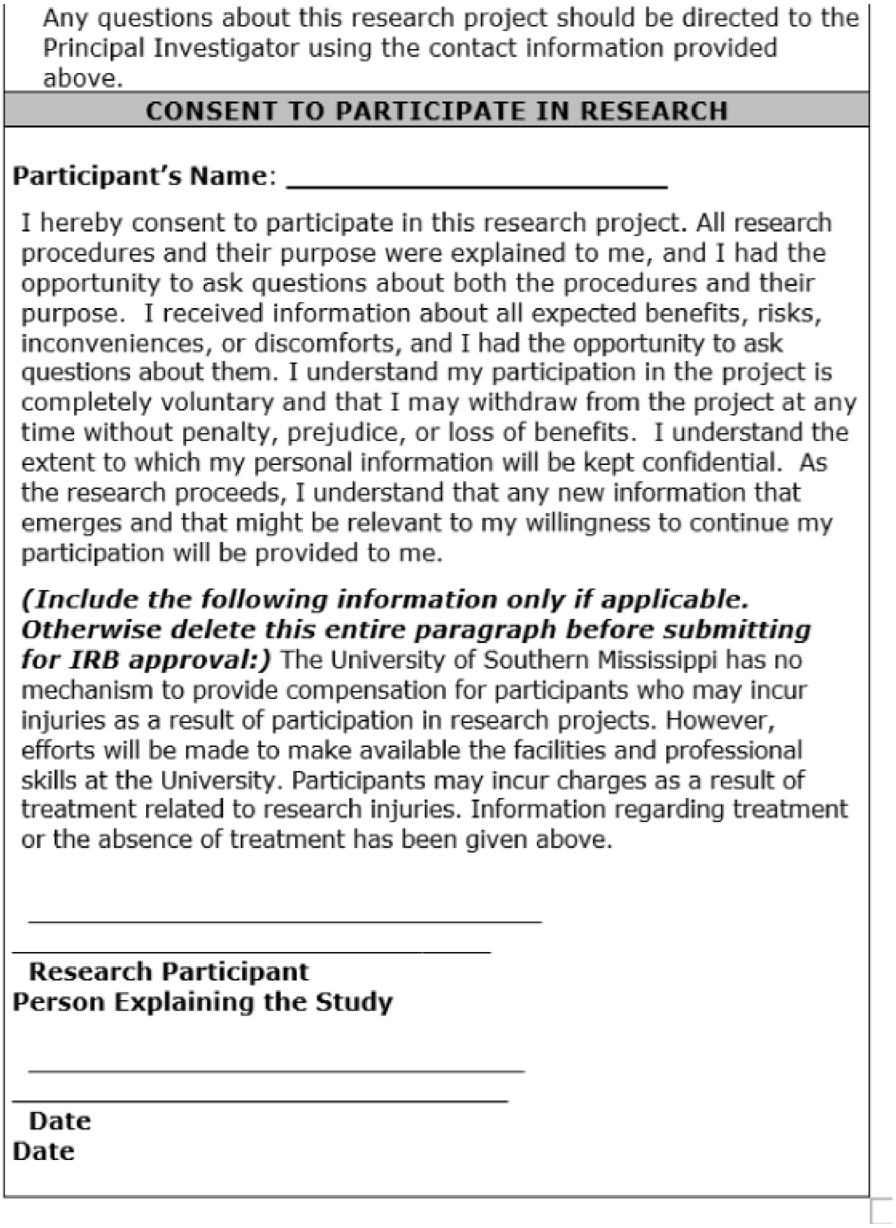
3. **Benefits:**
   This interview will offer the SLP an opportunity to voice feelings and concerns regarding their experiences in dysphagia practice. These responses can also give a voice to other SLPs in the field, and raise awareness about the barriers they and others may face

4. **Risks:**
   Some questions address the SLPs ethical practices. Because the Principal Investigator is not obligated to report any below acceptable services to the licensure board, Speech-Language Pathologists may freely share their practices with no fear of retaliation or retribution.

5. **Confidentiality:**
   All identifying factors of the participants will be known only to the Principal Investigator, and will be kept in strict confidence. All records will be de-identified to ensure no reputational harm can occur.

6. **Alternative Procedures:**
   None

7. **Participant's Assurance:**
   This project and this consent form have been reviewed by USM's Institutional Review Board, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research participant should be directed to the Chair of the Institutional Review Board, The University of Southern Mississippi, 118 College Drive #5125, Hattiesburg, MS 39406-0001, 601-266-5997.



Any questions about this research project should be directed to the Principal Investigator using the contact information provided above.

CONSENT TO PARTICIPATE IN RESEARCH

Participant's Name: ________________________

I hereby consent to participate in this research project. All research procedures and their purpose were explained to me, and I had the opportunity to ask questions about both the procedures and their purpose. I received information about all expected benefits, risks, inconveniences, or discomforts, and I had the opportunity to ask questions about them. I understand my participation in the project is completely voluntary and that I may withdraw from the project at any time without penalty, prejudice, or loss of benefits. I understand the extent to which my personal information will be kept confidential. As the research proceeds, I understand that any new information that emerges and that might be relevant to my willingness to continue my participation will be provided to me.

(Include the following information only if applicable. Otherwise delete this entire paragraph before submitting for IRB approval:) The University of Southern Mississippi has no mechanism to provide compensation for participants who may incur injuries as a result of participation in research projects. However, efforts will be made to make available the facilities and professional skills at the University. Participants may incur charges as a result of treatment related to research injuries. Information regarding treatment or the absence of treatment has been given above.

____

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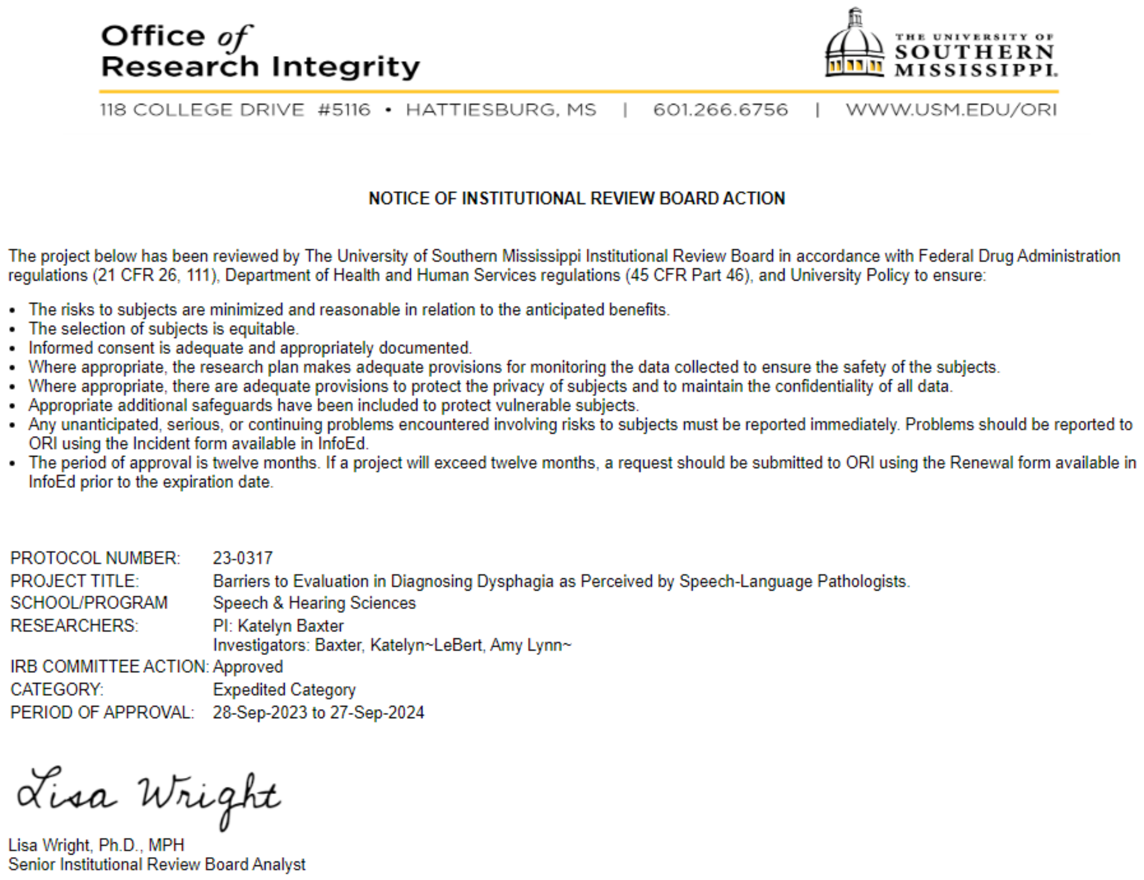
Research Participant
Person Explaining the Study

____

____

Date
Date

APPENDIX C: IRB Approval Letter



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NOTICE OF INSTITUTIONAL REVIEW BOARD ACTION

The project below has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy to ensure:

- The risks to subjects are minimized and reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered involving risks to subjects must be reported immediately. Problems should be reported to ORI using the Incident form available in InfoEd.
- The period of approval is twelve months. If a project will exceed twelve months, a request should be submitted to ORI using the Renewal form available in InfoEd prior to the expiration date.

PROTOCOL NUMBER: 23-0317
PROJECT TITLE: Barriers to Evaluation in Diagnosing Dysphagia as Perceived by Speech-Language Pathologists.
SCHOOL/PROGRAM Speech & Hearing Sciences
RESEARCHERS: PI: Katelyn Baxter
Investigators: Baxter, Katelyn~LeBert, Amy Lynn~
IRB COMMITTEE ACTION: Approved
CATEGORY: Expedited Category
PERIOD OF APPROVAL: 28-Sep-2023 to 27-Sep-2024

Lisa Wright

Lisa Wright, Ph.D., MPH
Senior Institutional Review Board Analyst

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