‘That doesn’t translate’: The role of evidence-based practice in disempowering speech pathologists in acute aphasia management

KEYWORDS: evidence-based practice; knowledge translation; clinical decision making; acute; aphasia; empowerment

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Abstract

Background: An evidence-practice gap has been identified in current acute aphasia management practice, with the provision of services to people with aphasia in the acute hospital widely considered in the literature to be inconsistent with best-practice recommendations. The reasons for this evidence-practice gap are unclear; however, speech pathologists practising in this setting have articulated a sense of dissonance regarding their limited service provision to this population. A clearer understanding of why this evidence-practice gap exists is essential in order to support and promote evidence-based approaches to the care of people with aphasia in acute care settings.

Aims: This study aimed to provide an understanding of speech pathologists’ conceptualisation of evidence-based practice for acute post-stroke aphasia, and its implementation.

Methods & Procedures: This study adopted a phenomenological approach, underpinned by a social constructivist paradigm. In-depth interviews were conducted with fourteen Australian speech pathologists, recruited using a purposive sampling technique. An inductive thematic analysis of the data was undertaken.

Outcomes & Results: A single, overarching theme emerged from the data. Speech pathologists demonstrated a sense of disempowerment as a result of their relationship with evidence-based practice for acute aphasia management. Three sub-themes contributed to this theme. The first described a restricted conceptualisation of evidence-based practice. The second revealed speech pathologists’ strained relationships with the research literature. The third elucidated a sense of professional unease over their perceived inability to enact evidence-based clinical recommendations, despite their desire to do so.
Conclusions & Implications:

Speech pathologists identified a current knowledge-practice gap in their management of aphasia in acute hospital settings. Speech pathologists place significant emphasis on the research evidence; however, their engagement with the research is limited, in part because it is perceived to lack clinical utility. A sense of professional dissonance arises from the conflict between a desire to provide best-practice and the perceived barriers to implementing evidence-based recommendations clinically, resulting in evidence-based practice becoming a disempowering concept for some.
**What this paper adds**

What is already known on this subject?

Evidence-based practice is reported in the literature to be an empowering construct for clinicians in the healthcare, however little research exploring speech pathologists’ understanding of evidence-based practice and its implementation in specific contexts exists.

What this study adds

This study provides in-depth information about speech pathologists’ conceptualisation of evidence-based practice and its application to acute post-stroke aphasia. It identifies that disempowerment has arisen from a restricted conceptualisation of evidence-based practice that focuses on the research literature, clinicians’ poor relationship with the research literature, and a conflict between the desire to provide evidence-based services to people with aphasia and the overwhelming perceived barriers to achieving this. Recommendations include revising how evidence-based practice is taught at a tertiary level, strengthening the relationships between researchers and clinicians, and empowering clinicians through organisational change in order to promote evidence-based approaches to acute aphasia management.
Introduction

Evidence-based practice (EBP) is a powerful principle in healthcare. In recent decades, a demand that interventions be evidence-based has emerged within the healthcare professions in response to calls from healthcare organisations, policy makers, and the public to demonstrate effectiveness and efficacy in clinical practice. The impetus for this move is the belief that EBP improves patients’ outcomes by providing the most effective care available.

From the beginning, EBP has garnered criticism from some regarding the potential for an overwhelming focus on experimental evidence. Opponents were concerned about a lack of clinical utility in the research findings, and the potential devaluing of clinical expertise (Bhogal et al. 2003). Conversely, proponents of the paradigm advocated for EBP’s capacity to ‘accommodate basic scientific principles, the subtleties of clinical judgement, and the patient’s clinical and personal idiosyncrasies’ (Greenhalgh, Howick & Maskrey 2014, p. 1). A return to the original definition of EBP highlights the importance of clinical decision making, defining EBP as ‘the conscientious, explicit, and judicious use of the current best evidence in making decisions about the care of individual patients’ (Sackett et al. 1996, p. 71). This definition clearly stipulates the need to incorporate research-based clinical evidence, clinical expertise, and patient preferences and values when making clinical decisions. Since then An additional stream of evidence – the practice context – has also been proposed given that the context of healthcare practice may have an important influence on the implementation of evidence (McCormack et al. 2002).

Recent research by Greenhalgh, Howick and Maskrey (2014) explored constraints to the uptake of EBP in the wider medical realm. They describe some of the unintended – and undesirable – consequences of this paradigm shift. These include the distortion of the evidence based ‘brand’, an unmanageable volume of research evidence, a lack of clinical significance in
research, and rule-based application of the research evidence. They advocate for a return to ‘real’ evidence-based care, in which clinicians exercise clinical judgement in order to deliver care which is individualised to the patient, suggesting a number of actions required in order for this to occur. These actions include: empowering and improving the health literacy of consumers; the honing of clinical reasoning and shared decision making in clinical training programs; the production of synthesised evidence which takes into account the consumers and contexts to which the evidence applies; and a broadening of the research agenda to encompass patient experiences, the process of evidence implementation, and the role of patients and healthcare workers in decision making. How, and indeed if, these challenges play out in the speech pathology profession is unknown.

Previous research into factors affecting the uptake of EBP in speech pathology has taken a profession-wide approach, irrespective of the client groups they serviced or workplace setting (O’Connor & Pettigrew 2009, Vallino-Napoli & Reilly 2004). The importance of examining the context specific influence of EBP on clinical practice in speech pathology has, however, been identified (Cheung et al. 2013). The specific context under focus here is the acute hospital setting. It is a focus because of an increased focus on dysphagia assessment and management (Rose et al. 2013), so that service provision to people with aphasia and their families in the acute hospital setting is now limited (Duffy, Fossett & Thomas 2011).

The value of providing evidence-based services to people with aphasia in the acute hospital setting is becoming clearer. Emerging research suggests that the amount of very early therapy provided to people with aphasia could significantly affect communication outcomes at 4 to 5 weeks post-stroke (Godecke et al. 2013). In addition, supporting people with aphasia to be able to communicate their healthcare needs and actively participate in their care increases their level of satisfaction with healthcare services (Tomkins, Siyambalapitiya & Worrall 2013) while also
potentially decreasing their risk of experiencing inappropriate or inadequate services within the hospital (Hemsley, Werninck & Worrall 2013). These arguments provide a strong rationale for the provision of evidence-based interventions.

Current therapeutic service provision to people with aphasia in the acute hospital setting is generally accepted to be inconsistent with best practice recommendations (Duffy, Fossett & Thomas 2011, Godecke et al. 2012, Verna, Davidson & Rose 2009). In addition to this, people with aphasia report being unable to consistently communicate their healthcare needs and actively participate in their care (Tomkins, Siyambalapitiya & Worrall 2013), and a lack of information regarding aphasia, stroke, and available services (Worrall et al. 2010). The reasons underlying this evidence-practice gap are unclear. What is clear, however, is the feeling of unease experienced by clinicians for whom the gap between current practice and literature recommendations is evident (Rose et al. 2013).

EBP is reported in the literature to be an empowering construct for clinicians in the healthcare realm (Belden et al. 2012, Matter 2006, Patel et al. 2011). In addition, it has been reported that empowered clinicians are better able to implement evidence-based approaches to care (Melnyk & Fineout-Overholt 2011). Larkin and colleagues (2004) suggest that ‘empowerment is evidenced by organizational members who are inspired and motivated to make meaningful contributions and who have the confidence that their contributions will be recognized and valued’ (p.1). The notion of empowerment has been an important tenet in healthcare, with findings suggesting it is linked to job satisfaction, organisational commitment, a greater sense of autonomy, higher perceived quality of patient care, and the promotion of critical thinking (Bonias et al. 2010, DeVivo et al. 2013, Sabiston & Spence Laschinger 1995, Spence Laschinger 2008). Two important theories of empowerment are noted in the healthcare literature:
(a) *Psychological empowerment* (Spreitzer 1996) emerges from social psychology models and focuses on the degree to which a worker experiences a sense of impact, competence, meaningfulness and choice in their work (Thomas & Velthouse 1990).

(b) *Structural empowerment* (Kanter 1977), derived from management/organisational theory, explores the degree to which staff have access to resources, information, support, and learning opportunities in the work setting.

The majority of literature exploring empowerment in the healthcare setting has been conducted with nurses, with most studies focusing on the organisational rather than individual or social precursors of empowerment. While the selective definitional shaping of the construct has enabled healthcare disciplines to operationalise the concept, it has also been criticised for inadequately exploring the complex interactions that shape empowerment for professionals in the healthcare setting (Rao 2012). The exploration of workplace power for speech pathologists has been limited. While Beecham (2004) has described her perception of the inequity that exists in the power dynamic between speech pathologists and their clients created by EBP, this stance is not supported by others who feel this inequity is not present (Reilly 2004).

Some evidence has emerged relating to the implementation of EBP within the speech pathology profession. This research, which often favours questionnaire or survey methods of data collection, suggests that speech pathologists hold research and EBP in high regard and place value on its clinical importance (O'Connor & Pettigrew 2009, Vallino-Napoli & Reilly 2004). However, it has been noted by Skeat & Roddam (2010) that within the allied health professions, survey methodologies often yield ‘positive perceptions of the principles of EBP’ (p. 17), while ‘studies that use more in-depth evaluation of…perceptions about EBP…have reported that staff expressed considerable uncertainties and reservations about how they were expected to be implementing these principles’ (p. 17). The literature emerging from the field of speech
pathology places an emphasis on the research literature, rather than adopting a holistic understanding of EBP as the integration of different streams of evidence (e.g. Metcalfe et al. 2001, O’Connor & Pettigrew 2009, Vallino-Napoli & Reilly 2004), although exceptions to this rule are also noted (e.g. Cheung et al. 2013). In addition, this research often samples across the profession rather than targeting specific clinical settings or specialties. One concern with this is that it is based on the premise that speech pathologists hold a common understanding of EBP.

A relatively small amount of the published literature explores EBP within the context of speech pathologists’ management of aphasia. De Stefanis & Tomolo (2010) provide a case study of their experiences implementing evidence-based services to people with aphasia in the acute hospital setting, reporting on the challenges they experienced including: competing priorities, inaccessible therapy resources, and varying degrees of clinical expertise and experience in aphasia management. This is supported by a review of the literature which concluded that little is known about how speech pathologists understand, integrate, and implement the different streams of evidence in EBP in the management of acute aphasia (Foster et al. 2013). In addition, we have little knowledge of the barriers and facilitators to achieving EBP in specific clinical contexts.

**Methods**

**Research purpose**

This study is part of a larger project, in which the perspectives of speech pathologists, people with aphasia and the close others of people with aphasia have been explored in relation to acute aphasia care. This paper aims to provide an understanding of speech pathologists’ conceptualisation and implementation of EBP for acute post-stroke aphasia. Ethical approval
for the study was obtained from the Behavioural and Social Sciences Ethical Review Committee at The University of Queensland.

Research paradigm and strategy

Within a social constructivist paradigm, this study used interpretive phenomenology in order to obtain a deep and full understanding of acute aphasia management from multiple perspectives (Morse & Field 1995). Consistent with this approach, this study aimed to move beyond pure description in order to seek meaning embedded in the provision of acute aphasia services and to understand how these meanings influence the choices speech pathologists make (Lopez & Willis 2004).

Multiple arguments supported the selection of social constructivism as the most appropriate paradigm to underpin this research. A social constructivist paradigm was consistent with this research in that the research aimed to describe and understand current acute aphasia management practice by obtaining the perspectives of individuals within a naturalistic setting, rather than testing hypotheses and manipulating variables in an experimental setting (Denzin & Lincoln 2011). In addition, the complexity of acute aphasia management and the factors that influence it and the exploratory nature if the research supported the adoption of a social constructivist paradigm (Creswell 2013, Richards & Morse 2013).

Research method

Interpretive phenomenology stems from an underlying belief that reality is co-constructed through dynamic interaction between researcher and participants (Laverty 2003). The selection of interpretive phenomenology as the research strategy served the purpose of the research, in that it aims to develop a deep understanding from multiple perspectives about a particular phenomenon and allowed the researchers to go beyond description of the perceptions of speech pathologists to understand what might have contributed to shaping them. Secondly, interpretive
phenomenology is compatible with the underlying research paradigm, social constructivism, with both recognizing and acknowledging the co-construction of knowledge and the influence that personal experiences and socio-cultural factors have on this construction. Given the congruence with both the aims of the research, and the underlying social constructivist paradigm, interpretive phenomenology was considered an appropriate choice for this research. A basic principle of interpretative phenomenology is the emphasis on making sense of the human experience and engaging with the reflections people make about their lived world (Benner 1994). Consistent with this perspective, the research endeavoured to illuminate the participants’ experiences through the interaction inherent in single, semi-structured in-depth interviews. Interviews were selected as the method of data collection in this phase due to their ability to yield ‘detailed, richly textured, person-centred information’ (Kaufman 1994, p. 123), which is compatible with the aim of seeking to understand speech pathologists’ conceptualisations and perceptions in relation to acute aphasia management.

A topic guide was utilised (see table 1). Semi-structured, in-depth qualitative interviews – in which a variety of question forms were utilised, with a focus on the dynamics of interaction and a critical attention what was, and was not, said (Kvale 1996) – were conducted by the primary researcher, herself an acute speech pathologist, in a quiet room at the participants’ workplaces over a thirteen month period from May 2012. All interviews lasted between 66 and 111 minutes, and were audio-recorded and transcribed verbatim for analysis by either the primary researcher or outsourced to a transcription company. Assessment of the transcript accuracy was undertaken by the second author for ten percent of the transcripts. In addition, the transcripts were sent to participants for checking of accuracy and amendment as required. Minor amendments were requested by one participant only, who expressed concerns that her views may identify her. Member checking of analysis was not undertaken, as the researchers contended that member checking can lead to confusion rather than confirmation, as it relies on
the assumption of a ‘fixed truth’ (Liamputtong 2009, Sandelowski 1993). The verbatim transcripts were augmented by field notes and notes from a reflective journal kept by the primary researcher.

### Table 1. Topic guide

<table>
<thead>
<tr>
<th>Topic</th>
<th>Example questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience working in acute aphasia management</td>
<td>‘Tell me about your experience working with people with aphasia and their families in the acute hospital setting’</td>
</tr>
<tr>
<td>Management pathway for people with acute post-stroke aphasia</td>
<td>‘Can you describe your experience of the typical management of people with acute post-stroke aphasia and their families in your workplace?’</td>
</tr>
</tbody>
</table>
| Influences on decision making in acute post-stroke aphasia           | ‘In your experience, is the management of people with aphasia pretty much the same for everyone or is it different for some people with aphasia compared with others?’
|                                                                      | - ‘Can you give me an example?’                                                    |
|                                                                      | - ‘In your experience, what factors might influence your decision making?’         |
| Barriers and facilitators to evidence-based acute post-stroke aphasia management | ‘In recent times, there has been discussion regarding evidence-based practice in speech pathology. Has this influenced your acute aphasia management at all? If so, how?’ |

*Note:* The topic guide provides a list of topics to discuss, with example questions. No fixed wording or ordering of questions was utilised. The topic guide was not provided to the participants prior to the interview.

### Participants

Expression of interest forms were distributed through professional development events, online speech pathology forums, special interest groups, and a direct mail out to the speech pathology departments of hospitals listed by the National Stroke Foundation as having a stroke care unit or ≥100 stroke admissions a year. Expressions of interest were sought from speech pathologists
who were working, or had within the last 12 months worked, in an Australian acute hospital setting with a caseload including people with acute post-stroke aphasia. Participants were restricted to those working in the Australian acute hospital setting for two reasons. Firstly, because a review of the literature found that context – represented in both the country and the clinical setting in this research – is an important variable in the implementation of EBP (see Background section). Secondly, because research has revealed an evidence-practice gap in the provision of aphasia services in the acute hospital setting (Foster et al. 2013). In addition, participants with recent clinical experience were required given the nature of enquiry which required reflection upon and analysis of personal experiences. Together, these reasons provide a strong rationale for the inclusion criteria, which allow for a context-specific understanding of the factors that influence speech pathology practice. Of the thirty-six speech pathologists who expressed interest in participating in this research, fifteen speech pathologists were selected using a purposive maximum variation sampling technique (Creswell 2013). This sampling technique allowed for the selection of speech pathologists with varying levels of clinical experience, from metropolitan and non-metropolitan clinical settings, public and private sector hospitals, with and without acute stroke units. Participant characteristics are summarised in table 2. One participant was excluded after recruitment as although she was based at a hospital site, her work was not in the immediate acute post-stroke phase.
Table 2. Participant characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of participants (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration of clinical experience as a speech pathologist</strong>&lt;br&gt;<em>(Range = 1.25 – 20 years; mean = 7.95 years)</em></td>
<td></td>
</tr>
<tr>
<td>&gt; 5 years</td>
<td>6</td>
</tr>
<tr>
<td>5 – 15 years</td>
<td>5</td>
</tr>
<tr>
<td>&lt; 15 years</td>
<td>3</td>
</tr>
<tr>
<td><strong>Setting of clinical role</strong></td>
<td></td>
</tr>
<tr>
<td>Metropolitan</td>
<td>10</td>
</tr>
<tr>
<td>Non-metropolitan</td>
<td>4</td>
</tr>
<tr>
<td><strong>Presence of acute stroke unit in hospital of employment</strong></td>
<td></td>
</tr>
<tr>
<td>Acute stroke unit present</td>
<td>11*</td>
</tr>
<tr>
<td>No acute stroke unit</td>
<td>4*</td>
</tr>
<tr>
<td><strong>Sector of employment</strong></td>
<td></td>
</tr>
<tr>
<td>Private sector</td>
<td>4*</td>
</tr>
<tr>
<td>Public sector</td>
<td>11*</td>
</tr>
</tbody>
</table>

* A single participant worked across multiple work environments

Data analysis

Transcript data was entered into NVivo 9 (QSR International Pty Ltd 2010). In a process consistent with the phases of thematic analysis outlined by Braun & Clarke (2006), a process of data familiarisation was undertaken, with the primary researcher keeping a record of her initial thoughts and ideas in relation to the data. Initial codes were generated, as the researcher systematically identified and collated interesting features across the entire data set. Codes were then grouped together into tentative themes. Regular meetings between members of the research team – all speech pathologists and clinical researchers – were held to discuss themes merging from the data analysis. Where differences in interpretation occurred, interview transcripts, memos and field notes were re-examined, and the theme under review was discussed until a point where agreement about the interpretation was reached. Modifications were made to the topic guide in order to further explore emerging themes, consistent with the
iterative nature of qualitative research. These themes were then revised to ascertain fit with the data extracts, after which these preliminary themes were refined, labelled and defined.

**Rigour**

Throughout the research process, a range of strategies were implemented in order to ensure the credibility, transferability, dependability and confirmability of the results (Lincoln & Guba 1985). Strategies used to establish rigour, included: (1) member checking of transcript accuracy; (2) peer checking through joint coding and regular research team discussions (all authors); (3) the use of field notes, memos, and a reflective journal to establish an audit trail of analysis; and (4) seeking feedback regarding the resonance and usefulness of the findings from researchers and clinicians following the presentation of preliminary findings at international conferences. Furthermore, the researchers employed reflexivity by actively and regularly engaging in discourse regarding their expectations and experiences, with careful attention paid to ensure that these did not unduly influence the processes of data generation and analysis. A number of additional strategies for rigour are used as part of the reporting process, including the use of illustrative verbatim quotations, comparison of the findings with existing literature (Richards & Morse 2013), and thick description (Liamputtong 2009).

**Results**

It is important to state that an analysis of the participants’ understanding of and relationship to EBP in relation to acute aphasia management was not pre-determined by the research team, but rather emerged organically from the data. Overall, the interviews took a relaxed, conversational manner, supported by the primary researcher’s shared clinical background with the participants. However, a noticeable shift in the dynamic of the interviews was observed when questions pertaining to EBP were raised. The primary researcher’s reflective journals are littered with references to changes in pragmatics and syntax associated with this line of enquiry, including altered tone of voice, closed body language, defensive posture, reduction in the use
of personal pronouns, and ‘clipped’ responses requiring additional probing. It was felt that this warranted further exploration.

Consistent with the underlying research strategy and paradigm, themes were derived through a process of co-construction in which the experiences and socio-cultural backgrounds of the researcher and the participants are valued. Themes emerged based on perceptions of the relative strength of the theme across the data set, rather than the frequency of information. It should be noted that where alternate perspectives were expressed by participants, these have been explored within the theme.

Analysis of the interview transcripts, with a focus on EBP, resulted in the emergence of three sub-themes:

(1) ‘To me EBP means...’: Speech pathologists’ restricted conceptualisation of EBP;
(2) ‘That doesn’t translate’: Speech pathologists’ relationship with the research literature and other streams of evidence; and,
(3) ‘[EBP] is in the back of your mind but there’s nothing I can do about it’: Conflict between a desire to provide optimal service to people with aphasia and the perceived barriers to implementing EBP recommendations clinically.

Each of these sub-themes contributes to the single overarching theme: The disempowering influence of EBP on acute aphasia management. The theme, its sub-themes, and supportive quotes to illustrate these themes are presented in table 3. Throughout the results sections, the participant’s pseudonym and the letter ‘s’ followed by a number in parentheses following a quotation provides information regarding the section, or turn, from the transcript from which this quotation is taken.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Illustrative quotes</th>
<th>Sub-themes</th>
<th>Illustrative quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The disempowering influence of EBP on acute aphasia management</td>
<td>‘…Everyone’s jumping up and down saying…”You better make sure you’re applying evidence base!”’ [Stella, s162]</td>
<td>‘To me EBP means…’: Speech pathologists’ restricted conceptualisation of EBP</td>
<td>‘When I think of evidence-based, I do think of that…double blinded, controlled thing, and I think of the literature. That’s what I think of and I automatically think evidence based, but it is, probably is a lot wider than that’ [Viv, s112]</td>
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<td></td>
<td>‘How are we supposed to help our patients if we know this is what we really should be doing and we can’t get there? …I have a very love-hate relationship [laughs] with evidence-base because of that’ [Viv, s108]</td>
<td></td>
<td>‘I think it means…giving your patients the best opportunity for success, um, based on…things that have been proven or therapies that have been proven.’ [Amy, s196]</td>
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<td></td>
<td>‘We all know what needs to happen, it’s just can we get it done? And I think that was a really hard thing, um, first rotating into…this role…I know what all the evidence says and I, you know…but does it happen?’ [Josie, s132]</td>
<td></td>
<td>‘Okay, it means using the best evidence that’s available in the literature to guide your practice.’ [Leah, s137]</td>
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<td>‘…I see evidence as a really broad thing…but I think you’re probably talking more about evidence that is research, um, evidence, you know, with, with s…um…you know, good, strong, ah robust, um research’ [Rachael, s94]</td>
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<td></td>
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<td></td>
<td>‘[My manager] said, “I think that people forget that they are doing it all the time”. You know, it’s not like you’re going up to see someone with aphasia and doing, like, star jumps. She said, “You’re all, you know, everything you’re doing is on some kind of evidence. It may not be...&quot;’ [My manager, s94]</td>
</tr>
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</table>
the evidence in the book, but it’s the evidence that you’ve learnt over time that works for that patient”. So I think that that was a really nice way to do it, to talk about it” [Stella, s162]

‘I haven’t been a researcher, that’s not really my nature. I’ve never been one that’s super, super, you know, loves reading journal articles and picking out bits and pieces. That’s not in my nature. Um, I’d rather just be told [laughs]. So in terms of getting new evidence all the time, that’s probably why I prefer to go to PDs and get that knowledge and information from others’ [Viv, s108]

‘It can be really hard to find the evidence. So whether that be actually trawling through everything to find what you’re looking for, versus it’s not actually there, those two are both obviously completely different things but, but still fall under that…sometimes you’re looking for something in particular and you just, you just can’t find it’ [Ada, s122]

‘I think evidence-base is great…but…they don’t have the patient in front of them’ [Josie, s122]

‘I think, um…I’ve spoken a lot about it with, with
but there’s nothing I can do about it’: Conflict between a desire to provide optimal service to people with aphasia and the perceived barriers to implementing EBP recommendations clinically

the other clinicians, um, in the department and, you know, “I think this needs to happen,” or, “I’d love to do this,” and everyone says, “That’s great Josie, you know, that you…we all would love to do that, but it just isn’t the reality” [Josie, s92]

‘…I guess it's just an individual thing…I didn't find it very hard to make change because it was all things that I knew, so it was really just making sure I was doing them’ [Celeste, s56]

‘…So I do think there is a big gap, and I think that that gap will probably always be there. I think we can minimise it, but I think that in reality there probably will always be a gap because we can never be perfect. I don’t think we can ever be perfect and I don’t think that any one service can ever be perfect because of funding, and skills’ [Viv, s76]

Note: Pseudonyms are used in the above table in order to preserve the confidentiality of participants.

The disempowering influence of EBP on acute aphasia management

Speech pathologists in this study showed a clear awareness of EBP and in some sense an attraction or desire to practise in this manner. For example, Josie said, ‘it’s the best practice that we should be doing’ (s42; authors’ emphasis) and Viv said, ‘I know that I need to think
about what’s evidence-based’ (s100; authors’ emphasis). These participants, and others, suggest that EBP is an aspirational goal rather than a reality in their practice.

Despite identifying a motivation to provide EBP for people with aphasia, many of the participants expressed a sense of disempowerment in relation to their acute aphasia management. This disempowerment resulted from a perceived inability to meet the requirements of EBP, and therefore the perceived personal, organisational, and professional expectations of them. The sense of a lack of power is palpable in the following illustrative quotation:

‘We all know what needs to happen; it’s just can we get it done? And I think that was a really hard thing ...I know what all the evidence says and I, you know...but does it happen?’ [Josie, s132]

While this sense of disempowerment was not experienced by all participants and was experienced by each clinician in differing degrees, for those who did experience it the notion of disempowerment carried significant weight. Disempowerment was most strongly felt by clinicians with a restricted concept of EBP, poor relationships with the research literature, and a perceived inability to act as an agent for change in their own acute aphasia management practice. Demographically, disempowerment was more strongly felt by less experienced clinicians, and those working either in private hospitals and/or outside of acute stroke units. Each of these sub-themes, and their contribution to the key theme, are discussed below. Figure 1 provides a diagrammatic representation of the interrelationships between the overarching key theme, and the sub-themes.

[INSERT FIGURE 1 HERE]
Subtheme 1 – ‘To me EBP means...’: Speech pathologists’ restricted conceptualisation of EBP

Throughout the interviews, a broad notion of the factors underpinning their acute aphasia management practice was conveyed by the participants. It is clearly evident from the interviews that the speech pathologists who participated in this study sought evidence from a range of sources – including clinical expertise, patient views and values, and the clinical context – but they do not, for the most part, perceive them as constituting EBP due to their conceptual restriction. When the notion of EBP was introduced by the interviewer, a noticeable shift in focus away from these broader sources of evidence and honing in on the research literature was observed.

‘When I think of evidence-based, I do think of that...double blinded, controlled thing, and I think of the literature. That’s what I think of and I automatically think evidence based, but it is, probably is a lot wider than that’ [Viv, s112].

This illustrates a limitation in the way that the notion of EBP is represented and understood conceptually by these speech pathologists, characterised by an emphasis on the research literature rather than a broader definition which includes other streams of evidence.

One clinician identified the potential negative implications of a demarcated characterisation of EBP, saying that ‘it’s a little bit easy for us to think, well, unless we’ve read ...a clinical practice guideline or a RCT study on something, then we’re not confident that what we’re doing is correct’ [Rachael, s96]. This was the driver of a more inclusive definition of ‘evidence’ for this participant.

This definitional restriction did not exist for all of the speech pathologists interviewed. Some reported a broader interpretation of the evidence, although there was a sense that they felt the need to defend this choice. ‘I see evidence as a really broad thing...but I think you’re probably
talking more about evidence that is research, um, evidence, you know, with, with s...um...you know, good, strong, ah robust, um research’ [Rachael, s94]. These extended constructs by participants were reported to be in response to the expressed views of managers or respected colleagues.

Given the centrality of the research literature to these speech pathologists’ perception of EBP for acute aphasia management, it is important to explore in-depth their relationships with the research literature, and other streams of evidence.

**Subtheme 2 – ‘That doesn’t translate’: Speech pathologists’ relationship with the research literature**

For many of the speech pathologists interviewed, an evidence-practice gap in relation to their acute aphasia management was reported. This theme emerges from the perception of some speech pathologists that research into acute aphasia management lacks utility, is not practical, and is not grounded in the reality of clinical practice. Even for those participants who perceived the concept of EBP to be central to their practice, there was hesitancy in investing too heavily in the research literature as demonstrated in one speech pathologist’s statement that she ‘take[s] some of [the research literature] with a grain of salt. I know that sometimes research is done for research purposes and the results cannot always be translated into clinical practice’ [Danielle, s95].

The speech pathologists who spoke about the evidence-practice gap reported a number of different reasons for the breakdown. These included: (a) a perceived paucity of literature on acute aphasia management; (b) challenges seeking, appraising and implementing recommendations from the research literature; (c) a perceived lack of clinical utility within the
acute aphasia research; and, (d) personal and departmental attitudes to seeking the research literature.

(a) Perceived paucity of relevant literature

Participants reported a perceived relative paucity of research literature related to acute aphasia management. Amy reports that ‘we found it really hard to find papers [laughs] um, talking about acute aphasia management’ [Amy, 160]. The perception of the equivocal nature of the research findings into acute aphasia management meant that speech pathologists lacked confidence that the research alone was sufficient to drive their practice.

‘Even now there, you know, is not enough strong evidence to say either way whether our intervention in that acute setting, um, is...you know, can, can guide our practice, um, with any real certainty’ [Rachael, s96].

(b) Challenges seeking, appraising and implementing recommendations from the research literature

Poor information literacy stood in the way of some participants accessing the research literature. Some of the participants felt they lacked the required research seeking skills, and once research literature was identified, comprehending the recommendations of the research literature was also considered to be difficult by some, as ‘sometimes I find the actual written literature stuff confusing’ [Ada, s122].

Perhaps in response to this, many clinicians reported a preference for collated, pre-appraised sources of research evidence, with much weight given to the Australian National Stroke Foundation guidelines (National Stroke Foundation 2010) and Cochrane reviews (Brady et al. 2012, Kelly, Brady & Enderby 2010).
(c) Perceived lack of clinical utility within the research

A striking feature of the interviews was the participants’ perception that the research literature appeared to lack clinical relevance and utility. The assumption that research evidence should always be directly applicable and useful to clinical practice clearly underpinned this belief. A clear distinction was drawn by the participants between those in the research world and those in the clinical realm, and a sense that research was ineffective in capturing the ‘real world’ components of clinical practice in the acute hospital setting was conveyed.

‘Sometimes my view on evidence-base is...that's okay for you in a research way, where you've got all the time in the world to spend with your patient, but that's not how it, like that doesn’t translate’ [Viv, s108]

(d) Personal and departmental attitudes to seeking the research literature

Speech pathologist’s motivation to seek the literature was also noted to be variable. While some reported that they ‘like to read the evidence, I like to read the literature and I like, I certainly seek it out and I, I look for it’ [Rachael, s96], others did not feel the same imperative. For some this is because they feel that their current practice does not require modification: ‘We do, we do what works and what we can do in the time, but it's not as if I've - I read something - I seek it out to read and then want to apply that’ [Karen, s176]. For others, the expectation that any consultation of the literature be undertaken outside of work hours results in this not being pursued. This variability lacks a clear explanation, but may be attributable to individuals’ perceptions of utility of the research literature.

Interestingly, some clinicians sought to create a distinction between their relationship with aphasia research literature and dysphagia research literature. The research literature for dysphagia was reported to be more concrete and prescriptive, ‘because...it's neuromuscular or it's physiology. It's, it's straightforward. Whereas aphasia is, has so many variables for so
many, for each individual...maybe that's why there's no...good [evidence based] case for, um, aphasia...or why I can't quote it’ [Karen, s194].

Subtheme 3 – ‘[EBP] is in the back of your mind, but there’s nothing I can do about it’: Conflict between a desire to provide optimal service to people with aphasia and the perceived barriers to implementing EBP recommendations clinically

The participants each articulated a desire to provide optimal service to the people with aphasia under their care. They suggested that the obligation to provide evidence-based approaches to care was (a) personal; (b) organisational; and (c) ethical.

(a) Personal imperative

The speech pathologists who participated in this study all presented as passionate clinicians, committed to their roles and optimising service provision to their patients. For many, it was important for them to re-iterate that they were doing the best that they could clinically, with repetitive use of statements such as ‘I’m doing...the best that I possibly can do with those patients’ [Stella, s106], ‘we tried to do our best’ [Rachael, s36], and ‘we all do the best we can’ [Josie, s132] throughout the interview transcripts.

(b) Organisational imperative

EBP was presented by the participants as being an organisational construct, a ‘buzz word’ lacking relevance to the ‘worker bee[s]’ [Ada, s114]. An organisational pressure to demonstrate evidence-based clinical practice was noted, with a perception that ‘everyone’s jumping up and down saying...”You better make sure you’re applying evidence base”’ [Stella, s162]. As such, there was a sense of this concept being imposed, rather than being of direct value to clinicians, patients and their families. The lack of a sense of ownership may be a contributing factor in the disconnection that speech pathologists feel with the notion of EBP.
(c) Ethical imperative

In addition to this, one clinician identified an ethical imperative to provide evidence-based approaches to her clients.

‘...All of us want to be evidence-based practice...practitioners...We’ve all got that, um, ethical sort of background, um, and, you know, we know that that’s what we should be doing.’ [Rachael, s98]

Despite this multifaceted motivation to provide EBP, speech pathologists identified a gap in their current aphasia practice and barriers which they perceived as preventing them from achieving this goal.

'I don't feel like it's...best practice' – Perception of an evidence-practice gap in acute aphasia management and the associated dissonance for clinicians: Many of the clinicians identified the presence of an evidence-practice gap in their acute aphasia management practice. Identification of an evidence-practice gap may be considered to be an essential step in improving acute aphasia management services. However, for those speech pathologists experiencing a sense of not being able to meet their perception of the requirements of EBP, a professional tension is evident.

‘How are we supposed to help our patients if we know this is what we really should be doing and we can’t get there? We need to sort of find a...a middle ground. So, um, I have a very love-hate relationship [laughs] with evidence-base because of that.’ [Viv, s108]

This sense of dissonance is loud and powerful, especially when considering the potential implications on workplace satisfaction, the potential for burnout, and attrition for acute speech pathologists.
Perceived barriers to achieving evidence-based acute aphasia management: A number of barriers were perceived to be preventing clinicians from being able to attain evidence-based practice. The majority of these were organisational barriers, related to the resources, staffing, and time these speech pathologists perceived to be required to achieve EBP when working with people with aphasia in the acute hospital setting.

‘I think it, it means if we had the resources, if we had the staff and if we had the time, we could provide evidence-based. I think we aim to, um…we, we aim to, but I don’t think we always get there.’ [Josie, s122]

In addition, the application of EBP for people with aphasia was reported to at times be hampered by the organisational requirement to prioritise other patients, including new admissions and those with dysphagia, meaning that ‘[people with aphasia] are pretty much always de-prioritised’ [Amy, s50].

One less experienced clinician also suggested that she would feel more able to implement EBP if she had easier access to clinical supervision and mentoring, ‘...even just, um, somebody that you can, um, talk to about it...discussing a, a patient, um, you know. [But] it’s just me’ [Josie, s126]. This desire is consistent with speech pathologists expressed focus on the clinical expertise stream of evidence, and their preference for social learning environments.

Perceived facilitators to achieving evidence-based acute aphasia management: Despite reported difficulties enacting change, speech pathologists were able to identify potential facilitators to achieving EBP. Potential facilitators fell into the categories of: organisational support for EBP; strengthening relationships between researchers and clinicians; standardising
the pathway for aphasia management in the acute care setting; and, methods of evaluating performance.

(a) Organisational support for EBP

The speech pathologists interviewed suggested that a number of these barriers could be overcome through the provision of organisational support for EBP. There was a strong sense amongst the speech pathologists interviewed that EBP is time consuming, both in its planning and implementation. As such, a lack of time was perceived to have the potential to act as a significant barrier to EBP implementation. This links to both the limited length of stay of the acute hospital setting, competing demands for the speech pathologists’ time, and the lack of protected time to seek and appraise the literature.

Speech pathologists spoke about organisational support for EBP through education. Support for speech pathologists to attend groups, either internal or external to the organisation, which provide support for and promotion of the notion of EBP were reported to be beneficial. They provided attendees with ‘a lot of experience in collecting the evidence, and then trying to interpret it and implement it’ [Leah, s139]. One speech pathologist reported that ‘evidence-based champion for the department’ [Stella, s158] was appointed within their local practice environment, but the importance of this role was downplayed by this participant as ‘just a fancy title really’ and ‘a pretty cruisy job’.

The responsibility for driving EBP within the department was attributed to the manager (‘I think ‘cause she’s heavily involved then [EBP]’s driven by her’ [Stella, s162]). In addition, speech pathologists who perceived their managers to be supportive and trusting of the management felt empowered to make changes towards EBP within their own practice.
(b) Strengthening relationships between research organisations and clinicians

One participant reported that aphasia-specific research organisations were important to refocus the profession on aphasia management, raising awareness of aphasia management within the profession by ‘bringing [acute aphasia management] back to the fore’ [Leah, s157]. Research organisations also provided the opportunity for clinicians ‘to be guided on what we should be doing’ [Karen, s196], as they were perceived to be ‘doing the reading for us, um, and passing it on, communicating with us, letting us know what’s going on - so that we’re not reinventing the wheel as clinicians on the coalface’ [Rachael, s98]. An implicit trust in these organisations and their recommendations was evident. This trust was reported to be strengthened when specific measures were taken by the research organisation to strengthen the mutual relationship, such as regular email communication, site visits, and involving the speech pathologists in research activities.

(c) Standardising the pathway for aphasia management in the acute care setting

Given speech pathologists lack of direct interaction with the source research literature, as discussed above, it is perhaps not surprising that they expressed within these interviews a preference for compiled sources of literature, and the provision of clear, concise recommendations. Some participants spoke of their belief that as a result of being so time-poor, a standardised pathway would be beneficial in making speech pathologists use of time more efficient.

‘Because we are so time-poor – and that’s not gonna improve much in the current climate – we do need something that’s structured and helps us guide through managing the patient optimally. Because we’re trying to do that anyway, but with all these competing demands on our time, it’s difficult.’ [Leah, s167]
(d) '[Auditing] is a good way to check what people have been doing and work out what we could do better' – Auditing as a tool for change in acute stroke and aphasia management

Speech pathologists recognised the need to evaluate performance as a means to improving the service provided to people with aphasia and their families in the acute hospital setting. A familiarity with the National Stroke Foundation (NSF) audit program was reported, and as such the concept of audit and feedback as a mechanism for service improvement in stroke care was not novel. Auditing was reported to be a successful facilitator of change management when it was interactive (‘[Staff member from the NSF] came in, um, and talked to us about our, um, recent, our last stroke audit, um, results here at the [name of hospital]’ [Stella, s54]), and identified specific goals regarding the improvement of service delivery by allowing organisations to ‘check what people have been doing and work out what we could do better’ [Amy, s154]. In addition to creating service delivery goals, other potential outcomes of an audit-feedback cycle in acute aphasia management were identified by these participants as influencing the content of local guidelines for management and minimum documentation standards, while also improving the consistency, and therefore equity, of service provided to people with aphasia.

Challenges relating to the process of auditing were identified, however. These included that speech pathologists may change their clinical behaviours during an audit period in order to demonstrate the requirements of the guideline (‘I guess when people know that there’s an audit…people might change the way they’re doing things to meet the guidelines’ [Amy, s174]). In addition, it was recognised that for long-term, sustainable change in clinical behaviours to be achieved, the aims of the audit need to be compatible with the speech pathologist’s perceived worthiness of the clinical activity. A sense of separation between the clinicians and the auditing body, and the alignment of their goals, may also limit the effectiveness of auditing as a mechanism to promote clinical change.
‘I guess it depends on, yeah, what you think of what they’re trying to get out of it. So, um, if you don’t care too much about it, then people will just change it for the audit period…you’ll just change it for a short amount of time then go back to what you prefer to do.’ [Amy, s176-178]

‘There’s nothing I can do about it’ - Attitudes to change in aphasia service provision: In order to enact change in response to the premise of EBP, an understanding of acute speech pathologists’ attitudes to change in aphasia service provision requires exploration. Within this study, a range of attitudes to change were reported. Some speech pathologists felt disempowered to enact change on behalf of people with aphasia, and externalised the locus of control for change. ‘I don’t feel like it’s, it’s the best practice that we should be doing, um…and I think we’re all aware of it but there’s, you know, told nothing we can do about it’ [Josie, s42].

In order for a change in practice to be deemed appropriate, the goal of the change had to be consistent with the priorities of the acute hospital setting. When discussing the intensity of aphasia intervention in the acute hospital setting, Stella suggested that ‘practicality, in that the hospital’s always talking about risk and, you know, how to reduce the risks, and it’s the way the hospital works – that’s not, I don’t think that that’s gonna change’ [Stella, s136].

For more junior clinicians, attitudes to change may have been shaped by the reaction they received from their colleagues when a desire to create change was voiced. Josie reported disengaging with the notion of creating change when she was told by senior staff ‘…we all would love to do that, but it just isn’t the reality’ [Josie, s92], which she reported has ‘been a bit hard, ‘cause you know, we wanna help people. It’s why we do the job! [laughs]’ [Josie, s132].
Those who felt a sense of mastery, control and confidence in their workplace, however, were more able to seek opportunities and avenues for change towards evidence-based approaches. This sense of control appears to be linked to the speech pathologist’s years of clinical experience, and also the role in which they were working.

‘…Because I guess it's just an individual thing I didn't find it very hard to make change because it was all things that I knew, so it was really just making sure I was doing them.’ [Celeste, s56]

Discussion

Why is the experience of disempowerment important in relation to EBP for acute aphasia management?

The findings from this research do not support the notion of EBP as an empowering concept for speech pathologists working in acute aphasia management. The use of a qualitative methodology and context-specific exploration lend strength to this finding. The notion of disempowerment is a powerful one for speech pathologists working with people with aphasia, and it is perhaps not drawing too long a bow to note the parallels between the experiences of people with aphasia as being voiceless in the acute hospital setting and some speech pathologists’ experience in being powerless in their capacity to effect change for this population.

Understanding the relationship between EBP and empowerment for clinicians working in acute aphasia management is important. This is particularly true in a healthcare environment which is ostensibly values staff health and well-being, and is focused on the provision of patient-centred services. The notion of EBP as a disempowering concept with speech pathology is one that, while raised theoretically in the literature (Beecham 2004), has to date had no evidentiary
support. Staff empowerment has been linked to job satisfaction, organisational commitment, and a greater sense of autonomy for healthcare workers (Sabiston & Spence Laschinger 1995, Spence Laschinger 2008, Spence Laschinger, Almost & Tuer-Hodes 2003), and has been correlated with both a higher perceived quality of patient care (Bonias et al. 2010, Spence Laschinger 2008) and a facilitation of empowerment (Kuokkanen & Leino-Kilpi 2000, Spence Laschinger et al. 2010) for patients. The potential implications that these influences have on professional identity, staff well-being, and workplace recruitment and retention cannot be ignored. Additionally, the importance of this when working with people with aphasia may be considered to be heightened given this is a patient population who may already feel disengaged and excluded from their own healthcare decision making (Worrall et al. 2010). But rather than simply making the assumption that EBP is by its very nature disempowering, it is important to further explore why this concept is perceived to have a potentially disempowering effect for some speech pathologists in this context.

Why do speech pathologists feel disempowered in relation to EBP for acute aphasia management?

Much of the previous speech pathology research into EBP assumes an underlying and consistent knowledge of what constitutes EBP among the participants. It is evident in this research, however, that many of the speech pathology participants have a narrow understanding of EBP with a strong focus on the research literature. Additionally, they appear to give little, if any, weight to other streams of evidence. This definitional dilemma is not new, with debates surrounding the definition of EBP occurring since its inception as a concept in healthcare. However, the definitional dilemma carries a powerful message as participants’ relationships with and reactions to EBP are likely to be based on this restricted conceptualisation. It is, therefore, not surprising that speech pathologists feel disengaged with EBP for acute aphasia
management if their belief is that in order to be considered an evidence-based practitioner, they must replicate the research literature in the clinical setting.

The participants in this study suggested some possible interventions across both psychological and structural domains which may promote speech pathologists’ empowerment in the management of acute aphasia. These suggested solutions warrant further investigation. Through this exploration, the profession has the potential to enhance acute speech pathologists’ perceptions of their self-efficacy and self-determination in relation to aphasia management, while also boosting the perceived meaningfulness and impact of their role in acute aphasia management for people with aphasia, their families, and the healthcare system alike.

How can the empowerment of speech pathologists for EBP in acute aphasia management be supported?

The clinicians in this study who experienced disempowerment in response to EBP for acute aphasia management experienced this at both a psychological and a structural empowerment level. As such, suggested interventions to promote empowerment are across both domains.

The participants in this study most readily identified the influence that increased resources – time and staffing – would have on their capacity to implement evidence-based approaches to aphasia management. However, it remains unclear to what extent these additional resources would be of benefit. As it is unlikely that intervention targeting this area alone is likely to be successful, a range of additional potential interventions are required.

Firstly, the cultures of the hospital and of the profession need to be considered. While healthcare settings promote the uptake of EBP, some practitioners regard EBP as a regulatory mandate, rather than an opportunity to advance clinical practice (Belden et al. 2012, Olade
2004). This belief was supported by the opinions of some participants in this research project. Any interventions to improve acute aphasia management must, therefore, be undertaken with the determination to support speech pathologists in addressing service challenges rather than imposing solutions on them (Ham 2014). This may be achieved by leaders actively devolving decision-making and accountability to frontline clinicians (Ham 2014), lending credence to the notion that strong leadership plays a significant role in creating a context which supports EBP in healthcare.

A greater cultural understanding of the value of communication needs to be established. The current role diffusion for speech pathologists results in the majority of time and resources being allocated to dysphagia management (Lawrie 1996, Rose et al. 2013). With a growing body of literature suggesting the potential importance of speech pathology intervention for people with communication impairments in terms of impairment (Godecke et al. 2013), patient satisfaction and involvement in healthcare decision-making (Tomkins, Siyambalapitiya & Worrall 2013), and risk management (Hemsley, Werninck & Worrall 2013), an opportunity presents itself for the profession to reassert itself as the communication experts.

In order for the profession to regain this notion of expertise, however, self-efficacy must first be established. It may be argued that the focus on swallowing has resulted in de-skilling of some speech pathologists in aphasia management. The cyclic nature of low self-efficacy (Thomas & Velthouse 1990) may be reinforced in this context by organisational guidelines which promote the de-prioritisation of aphasia management. Encouraging a building of competence in acute aphasia management through clinical exposure, mentoring and supervision, reflective practice, and ongoing professional development all have the potential to improve self-efficacy. This may result in speech pathologists initiating behaviours,
increasing effort, and demonstrating persistence in the face of obstacles to acute aphasia management (Thomas & Velthouse 1990).

A clinician’s perception of both the impact and meaningfulness of acute aphasia management may be supported by a greater awareness of consumer perspectives and experiences. Integration of patient needs and values is central to the notion of EBP (Pearson 2010). While research is beginning to explore the experiences of people with aphasia (e.g., Tomkins, Siyambalapitiya & Worrall 2013, Worrall et al. 2010), this may be supported by encouraging experience with people with aphasia across the continuum of care or by strengthening relationships between clinicians in the acute, sub-acute and community sectors.

Finally, the mechanisms for knowledge transfer and exchange require revision. The speech pathologists in this study clearly articulated a preference for social, interactive learning styles. Where written research literature was sought, it was most often in the form of compiled literature sources, such as systematic reviews or, more commonly, clinical practice guidelines. This is consistent with previous research exploring relationships with the research literature for speech pathologists (Guo, Bain & Willer 2008, Nail-Chiwetalu & Bernstein Ratner 2007, Vallino-Napoli & Reilly 2004). Participants in this study keenly supported the notion of a standardised, evidence-supported care pathway for acute aphasia management. Consistent with knowledge transfer and exchange models (Graham et al. 2006), each stage of the knowledge creation process - design, implementation, and evaluation – should be tailored to the needs of the potential users (Hadely, Power & O'Halloran 2014, Miao, Power & O'Halloran 2014). Consistent with previous studies, participants in this study also expressed that any pathway designed should include the capacity to audit performance (Hadely, Power & O'Halloran 2014, Miao, Power & O'Halloran 2014), however given the desire to devolve
accountability to clinicians it is perhaps prudent to ensure that ownership of the audit-feedback cycle lies with clinicians.

Further research examining the relative importance of structural and psychological empowerment in influencing speech pathologists’ uptake of evidence-based acute aphasia management would be beneficial. In addition, context-specific intervention studies may strengthen the profession’s understanding of the relative benefit of different strategies to increase empowerment and EBP uptake within this setting.

By providing interventions such as those discussed above, the profession has the potential to enhance acute speech pathologists’ perceptions of their self-efficacy and self-determination in relation to aphasia management, while also boosting the perceived meaningfulness and impact of their role in acute aphasia management for people with aphasia, their families, and the healthcare system alike.

**Study strengths and limitations**

The strength of this study lies in its context-specific, qualitative design. The use of an interpretive phenomenological research strategy granted the researchers an opportunity to develop an in-depth understanding of these speech pathologists’ perceptions of evidence-based practice and its influence on acute aphasia management. Methodologically, strategies were implemented during data collection, analysis, and reporting which enhanced the rigour of the research. The transferability of results was supported by the use of a maximum variation sampling across multiple parameters.

One potential limitation of this research is that it was undertaken exclusively with Australian speech pathologists. While the preliminary findings presented at international conferences have resonated with clinicians practicing in other regions (e.g. Canada, USA, and UK), differing
In contrast to traditional scientific methods which seek research that is ‘unbiased’ and value-free (Klenke 2008), the axiology underlying social constructivism requires that individual values are honoured (Creswell 2013). Putting aside pre-understandings (or ‘bracketing’) is not consistent with the chosen research paradigm and strategy, which rely on a co-construction of meaning (Laverty 2003). As such, it is entirely conceivable that other researchers may have generated alternative findings in response to the data. Specifically, the authors’ backgrounds as both clinical and research speech pathologists – and in particular the primary researcher’s experience as an acute clinician – engendered certain expectations regarding the experiences of acute aphasia management and the influence of EBP on practice. In recognition of this, the researchers explicitly identified their background and assumptions within the research team, engaging in the reflexive process of self-questioning and self-understanding and remaining cognisant of the ‘cultural, political, social, linguistic, and ideological origins of one’s own perspective and voice as well as the perspective and voices of those one interviews’ (Patton 2002, p. 65). As a means of offsetting the expectations held by the research team, a thorough review of the literature from multiple perspectives – including those from outside the profession of speech pathology – was undertaken. In addition, the researchers ensured that findings were grounded in the data through the use of verbatim quotations and in vivo coding. Of note, while the research team held the expectation that the influence of EBP on aphasia management in the hospital setting would be somewhat restricted, the extent to which the
participants felt disengaged from EBP surpassed assumptions. It is possible that, rather than being a bias, the primary researcher’s professional background may be perceived to hold value in terms of trust and relationship building, achieved through a perception of ‘sameness’, within the interview process.

Conclusion
The findings of this study demonstrate that speech pathologists hold a restricted conceptualisation of EBP, with a strong focus on the research literature and a lack of emphasis on other streams of evidence. This focus is made more concerning by their disengagement with the acute aphasia management research literature. Given the current knowledge-practice gap perceived by these clinicians in acute aphasia management combined with the experience of organisational emphasis on EBP, EBP has become a disempowering notion for some speech pathologists.

However, structural and psychological empowerment for speech pathologists both have the potential to be increased by interventions targeting the pressing challenges in acute aphasia management. Through this, the profession has the opportunity to meet the aims of decreasing the sense of dissonance experienced by speech pathologists, improving the experience for people with aphasia, and improving patient outcomes through evidence-based acute aphasia management.

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Figure 1. EBP as a disempowering construct in acute aphasia management

Organisational imperative

Ethical imperative

Personal beliefs

Speech pathologists’ desire to provide EBP for aphasia in the acute hospital setting

Restricted conceptualisation of EBP
Focus limited to the research literature

Poor relationship with the aphasia research literature
Preference for other streams of evidence & roles with stronger research evidence

Perception of evidence-practice gap for acute aphasia management
Perceived lack of organisational support for acute aphasia management

Perceived inability to affect change in acute aphasia management
Sense of professional dissonance

Disempowerment