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Allied health professionals’ perspectives of working with dysphagia in a rural paediatric team

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Rural healthcare practice is influenced by social, economic, political and cultural factors particular to its geographical location. However, studies typically report that accessibility, isolation, team-working, professional development, being ‘specialist generalists’, and human resources are key issues for services.1

We report on research involving semi-structured, face-to-face interviews with a paediatric allied health team in rural New Zealand. The focus was paediatric dysphagia as an example of a complex health condition requiring team-working and education for professionals.2,3,4 Rural allied health professionals (AHPs) report a lack of support and confidence in working with children and complex conditions, such as feeding disorders.5 All six team members (all female, New Zealand European; 3 physiotherapists, an occupational therapist, a speech-language therapist, and a social worker) participated. Analysis of interviews using a general inductive approach identified four themes: attitudes, knowledge and skills, scheduling, and support.

Participants commented on client and community attitudes of resilience as a positive aspect of rural work.

“...people from...a really strong farming community, families' attitudes to getting on with things are really different. And that kind of Kiwi do-it-yourself attitude which is different from say some of the families in [small town]...”

There was an overall sense of resignation, especially about self-managing and funding their time, resources, professional development, and supervision. The use of Skype or video links for meetings, therapy and supervision was supported by most participants, but they raised doubts about the effectiveness of interactions over the internet.

“I'd love to have more knowledge [about dysphagia] but it's just really hard...if I was doing full time paediatrics, then I'd definitely put more effort into it but it's such a small window of my working week that I can't really justify it.”

“I haven't got the energy to do it for myself...one day a week you don't have a lot of time...to come up with ideas and do stuff like this.”

Participants described difficulties, but appeared to accept these rather than actively seek solutions. Recent research suggests that rural professionals, especially females, may be more agreeable and cooperative than urban professionals.6 In international comparisons, people from New Zealand are often described as easy-going, ‘she'll be right’, and agreeable.7 Research is needed to determine whether this ‘national personality’ is relevant to rural AHPs’ abilities to manage complex cases such as paediatric dysphagia.

Except for the speech-language therapist, participants reported limited dysphagia knowledge and skills, and felt uncomfortable and unskilled:

“I’m nervous actually...I don't always feel like I know the advice...if people ask me...I just say 'look it's not my specialty, I'll have to find out for you'...Which isn't ideal, 'cause we need to be a bit generalist...”
Most participants recognised their upskilling needs, but without practical experience or easy access to expertise, noted it was hard to maintain competency with complex conditions.

“...you’re not seeing the same numbers through in a place like this, but you’re still expected to see the same severity or acuteness of some of those children.”

“...we can’t just pop down the hallway and have a chat with the paediatrician or the neurologist or whoever else the specialist might be.”

Participants’ discomfort around their knowledge and skills working with children with dysphagia reflects previous findings. Challenges with accessing advice and education in rural settings are known, and were a factor for the AHPs interviewed here. Despite reported barriers, most participants were positive about the team and none attributed blame to the team or management.

A consistent theme was difficulty scheduling meetings and liaison with colleagues. A major barrier to discussing clients was differences in employment hours. Lack of opportunity for relationship building and upskilling added to the frustrations. Family-centred practice was difficult due to distance, time, prioritisation and family availability, which seemed out of the professionals’ control.

“Travelling an hour and a half to two hours to see four children in one region who all feed at the same time or at very similar times...that is a constant difficulty for me.”

Limited accessibility to and for clients, and limited team-working opportunities, are associated with poorer health outcomes for clients, increased cost for health providers, and reduced job satisfaction. Similar to AHPs in Australia, participants found scheduling a barrier. Dysphagia posed additional scheduling difficulties in terms of children’s sleeping and feeding patterns.

All participants commented on the support of the team and employer, as well as feeling isolated. Those based away from the main healthcare centre felt more isolated and less supported than those in the main centre. A lack of shared clinical notes, resources and opportunities for liaison enhanced feelings of isolation. Past experience and networks played a large role in mitigating feelings of isolation.

We interviewed a team of rural AHPs who felt under-skilled and lacking in resources for working with complex paediatric cases, highlighting a need to further examine the state of rural allied health practices in New Zealand with a view to reducing barriers to effective healthcare in complex cases.

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