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Natalie Douglas
Central Michigan University

Jacqueline Hinckley
Nova Southeastern University, jh988@nova.edu

Kate Grandbois
Grandbois Therapy and Consulting, LLC

Megan Schliep
MGH Institute of Health Professions

Amy Wonkka
Grandbois Therapy and Consulting, LLC

See next page for additional authors

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Authors

Natalie Douglas, Jacqueline Hinckley, Kate Grandbois, Megan Schliep, Amy Wonkka, Jennifer Oshita, and Julie Feuerstein

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Natalie Douglas,[a] [iD] Jacqueline Hinckley,[b] [iD] Kate Grandbois,[c] Megan Schliep,[d] [iD] Amy Wonkka,[c] Jennifer Oshita,[e] [iD] and Julie Feuerstein[f] [iD]

[a] Department of Communication Sciences and Disorders, Central Michigan University, Mt. Pleasant [b] Department of Speech-Language Pathology, Nova Southeastern University, Fort Lauderdale, FL [c] Grandbois Therapy and Consulting, LLC dba SLP Nerdcast, Concord, MA [d] Department of Communication Sciences and Disorders, MGH Institute of Health Professions, Boston, MA [e] Clinical and Translational Sciences Program, Larner College of Medicine, University of Vermont, Burlington [f] School of Communication Sciences and Disorders, University of Central Florida, Orlando

A R T I C L E   I N F O

A B S T R A C T

Purpose: The purpose of this article is to contend that there is a power differential between researchers and clinicians where researchers are the primary creators of knowledge and clinicians are the primary consumers of knowledge. Rooted in a sociological model illustrating interacting levels of power at macro-, meso-, and microlevels, we argue that authentic research–practice partnerships and clinician–researcher collaborations can mitigate this power differential.
Conclusions: Clinicians and researchers in our field have vastly different responsibilities and priorities that impact our ability to work collaboratively to solve the most pressing problems for the clients we serve. Although some current research practices may reinforce a power differential causing clinicians to feel less than and to only consume knowledge, there are examples of successful collaborations where this power differential is mitigated. These examples can contribute meaningfully to the dialogue on research–practice partnerships, with the goal of improving outcomes for the clients we serve.

Social, political, and economic systems shape research practices, and the way that research is traditionally conducted reinforces systems in which certain terminologies, skills, and expertise allow researchers to hold power around the production of knowledge (Green, 2016). Consider the traditional research pipeline, which moves from efficacy to effectiveness and ends with implementation. With this, researchers who may or may not have a clinical background ask a research question about the effectiveness of a particular treatment and study that treatment in the context of a controlled setting such as a laboratory (Balas & Boren, 2000). The researchers then follow a systematic path

so that the efficacy of that treatment can be established (Robey & Schultz, 1998). This path usually is followed without input from clinicians who will be implementing the treatment in routine clinical settings, perpetuating researchers holding more power in the relationship and a research to practice gap. Once treatment effectiveness has been documented, it is assumed that publications and continuing education on the topic will result in the transfer of evidence to routine practice (Olswang & Goldstein, 2017).

Embedded within this assumption is that clinicians have the tools, organizational support, time, and resources to appraise the rigor of the research; tailor it to their setting; and then implement the practice in their setting (Donohue et al., 2021, 2022). Furthermore, this assumes that the researcher's original research question is of value and importance to the end users of the research, both the clients who receive it and clinicians who provide it. The urgent needs of our clients with communication and

Correspondence to Natalie Douglas: natalie.douglas@cmich.edu. *Disclosure: Kate Grandbois is the owner of SLP Nerdcast, a platform for disseminating evidence-based practices in speech-language pathology mentioned in this article. The authors have declared that no competing financial or nonfinancial interests existed at the time of publication.*

related disorders, who each deserves best, evidence-based practices, compelled us to reflect deeply on the traditional research process, the production of knowledge, the consumption of evidence, and the gap between research and practice. Our hope is that this discussion will support efforts to increase the quantity and quality of research–practice partnerships and clinician–researcher collaborations, ultimately resulting in better services to our clients with communication and related disorders.

Power, Positionality, and the Research-to-Practice Gap

Power has been defined as the practices of communication, behavior, and relationships that position people in authority and justify that authority (Clegg, 1989). Ellis et al. (2021) describe power as "the authority to direct influence" (Ellis et al., 2021, p. 2033). Power differentials exist among groups along intersectional lines of ethnicity, race, class, gender, and ability, to name a few. Sometimes, these differences can be referred to as power imbalances where one person has more control over decision making in the relationship than the other potentially due to one's social position (Chan, 2009). One's social position in society based on class, education, occupation, income, gender, sexual orientation, ethnicity/race, religion, and residential segregation has even been found to negatively impact the health of vulnerable groups (Baah et al., 2019). Ellis et al. (2021) further notes that one's positionality, "offers the authority to determine the types of research questions asked, the population under study, how results are interpreted, where information is disseminated, and who has the opportunity to train in their laboratories" (Ellis et al., 2021, p. 2034). Indeed, barriers to research equity across race, gender, and class have been documented and are worthy of further study (Ellis et al., 2021), and while we do not believe that the relationship between clinicians and researchers is independent of these variables (e.g., gender and class), in this article, we explore the power dynamic between researchers and clinicians through the lens of researcher–practitioner partnerships and clinician–researcher collaborations.

If the long-term goal of clinical research in speech-language pathology is to benefit the client, we must reckon with the oft-cited statistic that it takes 17 years to implement 14% of research in routine clinical settings if left to traditional dissemination methods (Balas & Boren, 2000). Implementation science, or the study of how to increase the uptake of best practices into routine clinical settings (Bauer & Kirchner, 2020), provides tools to rigorously study the various factors that influence the uptake of evidence (e.g., client factors, organizational factors, and clinician factors) and has been receiving increased attention in the communication and related disorders literature

(Douglas, Feuerstein, et al., 2022). One approach to speed the transfer and increase the relevance of research purported by implementation science is establishing partnerships between researchers and clinicians (Alonzo et al., 2022; Curran et al., 2022; McCurtin & O'Connor, 2020). These partnerships arise out of research traditions like collaborative, community-engaged research (Warren, 2018) and participatory action research (Whyte, 1991). While differences exist in their methodologies, these collaborative approaches challenge the traditional roles and power dynamics among researchers, clinicians, community stakeholders, and clients within the evidence enterprise.

Although there are exemplars of successful research–practice partnerships, a recent premortem reflection over the past 15 years from top implementation science researchers in the United States revealed considerable challenges between researcher and clinician needs, priorities, timelines, ideologies, incentive structures, and perspectives (Beidas et al., 2022). We suggest that a power differential between researchers and clinicians is a contributor to these challenges. As displayed in Figure 1, researchers primarily need to ask research questions that secure extramural funding, whereas clinicians need to provide evidence-based practices to the clients in front of them. Researchers are often required to consume research in order to publish, present, and conduct their own research agendas. Clinicians are required to adhere to multiple layers of compliance such as licensing requirements at the state level and organizational policies and procedures at the local level. Researchers are often under the strict timeline of the tenure and promotion standards of their institution, and clinicians are often under the strict

Figure 1. A visual depiction of researchers creating knowledge and clinicians consuming knowledge. Alt text: A triangle with a diagonal line above (with the left end higher than the right end) and two circles. One circle represents researchers creating knowledge and is on the upper end of the diagonal line, and one circle represents clinicians consuming knowledge and is on the lower end of the diagonal line.
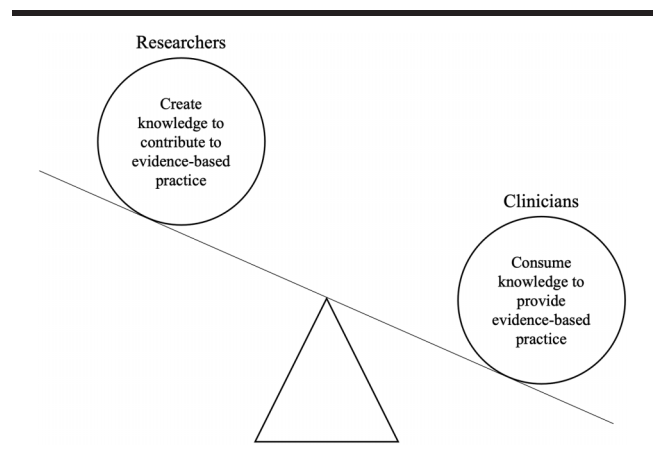
timeline of third-party payers such as insurance companies dictating the amount of time they have with a client. These differing requirements result in potentially opposing priorities that position the researcher as a primary creator of evidence and the clinicians as the primary consumer of evidence. The Social Ecology of Power in Participatory Research (Roura, 2021) is one tool to further unpack the influence of power between researchers and clinicians.

The Social Ecology of Power in Participatory Research

Participatory research focuses on actionable research informed by people directly impacted by the research, increasing its applicability (Cornwall & Jewkes, 1995). However, participatory research often relies on research–practice partnerships or clinician–researcher collaborations that may be difficult to construct. The Social Ecology of Power in Participatory Research (Roura, 2021) highlights macro-, meso-, and micro-influences of power that may influence researcher–clinician partnerships; see Figure 2.

Macro-Influences of Power

Macro-influences of power dynamics include societal, historical, and cultural factors and norms (Roura, 2021). The historical power imbalance between clinicians

Figure 2. Model of power dynamics in research at three levels adapted from the study of Roura, 2021. Alt text: One large circle with a small circle and a medium circle enclosed in it outlining three levels (i.e., macro, meso, and micro) of power that may influence researchers and clinicians. There is one vertical arrow pointing in both directions with the words power dynamics written in it.
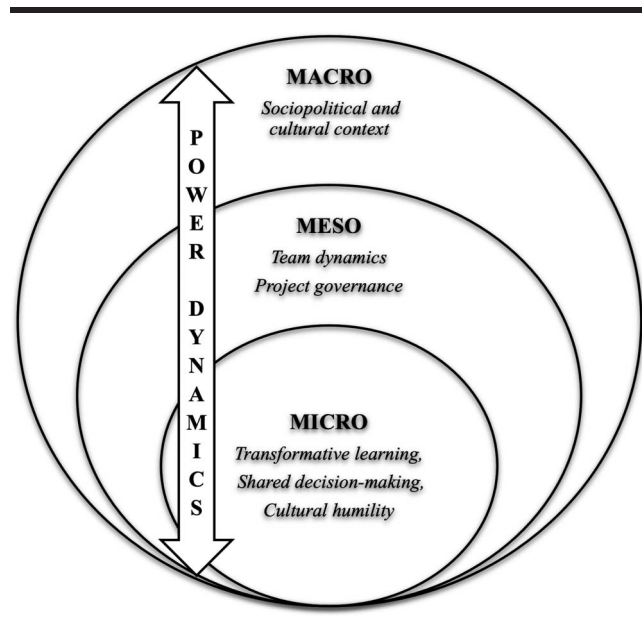
and researchers in evidence production and consumption has also been explored in the educational literature (Farrell et al., 2021; Finnigan et al., 2013; Tseng et al., 2017). Tseng et al. wrote, "...we invite readers into a dialogue on how we can collectively democratize the evidence movement in education...Many initiatives have been driven by top-down forces and imperatives, with too little attention provided to the perspectives, expertise, and diversity of people who are concerned with education. All too often, teachers have perceived evidence-based policies as something done to them rather than with them" (Tseng et al., 2017, p. 3). Anecdotal experience suggests a similar perception from clinicians in speech-language pathology, many of whom are also in educational settings.

An additional consideration at the macrolevel is distribution of power and resources. Roura (2021) encourages researchers to consider if certain population groups are disadvantaged or excluded from the research process. We contend that clinicians are typically excluded from resources designated to conduct research as most funding announcements require a PhD and/or an affiliation with an academic institution. Furthermore, clinicians are not usually incentivized or compensated for their participation in research should they enter into a collaboration. Clinicians in typical settings require the majority of their time to be in direct clinical care and any participation in research would be outside of their normal job responsibilities.

A further macrolevel consideration, potentially specific to systems in the United States, occurs from the beginning of a clinician's career when knowledge is disseminated to graduate students almost exclusively by tenured or tenure-earning faculty with PhDs and researchers. If knowledge is disseminated by faculty with clinical doctorates or by seasoned clinicians, they often are paid less and not offered tenure. This establishes a norm that knowledge production and dissemination is unidirectional, from researchers to clinicians, for the purpose of clinicians consuming and implementing that research without the input of clinician-initiated needs or questions.

The cultural norm at the macrolevel that researchers produce knowledge for clinicians to consume can also be highlighted by a disclaimer published as part of a clinician-hosted podcast aiming to disseminate evidence-based practices to clinicians. The hosts state, "We are not PhDs, but we do research our material" (Grandbois, 2020), as a means of informing the audience that clinicians are disseminating the knowledge through the podcast publication. This disclaimer is, presumably, meant to deflect any criticism for clinicians generating knowledge and implies that knowledge generated by clinicians is perceived as having less value than knowledge generated by a researcher. We purport that authentic researcher–clinician collaborations would equally value the strengths of the researcher (e.g., research design and statistical analysis)

with the strengths of the clinician (e.g., relevant research questions) without assigning hierarchical value to either.

Meso-Influences of Power

Meso-influences of power in participatory research include the workings of research teams. Factors related to joint decision making, consensus building, who benefits from participating in the research, and how they benefit are considered at this level. We do not believe that it is typical practice to consult with clinicians about decisions regarding the conduct of clinical research. Clinicians also often report that research that is published does not apply to the clients they are serving (O'Connor & Pettigrew, 2009). It is a logical assumption then that consensus was not built with clinicians prior to most research studies being carried out. Overlapping with macro-influences of power, at current, clinicians do not directly benefit from participating in research. Researchers are required to publish in peer-reviewed journals about their research topics; however, clinicians usually do not have such a publishing requirement in their jobs. As such, it is less motivating for a clinician to put the labor into writing an article when there is no direct benefit to them for doing so.

Another barrier at the mesolevel is the structure of workplaces where most speech-language pathologists work. After graduate school, speech-language pathologists seek employment in nonuniversity educational facilities (50.9%), health care facilities (39.4%), and private practices or other facilities (7.1%) where research–practice partnership opportunities rarely exist (American Speech-Language-Hearing Association [ASHA], n.d.). When those opportunities do arise, clinicians are often without the time, resources, or administrative support to participate effectively. Even in writing this article, the clinician authors had difficulty accessing research articles and finding references, as many of these resources were behind paywalls.

Micro-Influences of Power

Microlevel influences of power dynamics highlight the actions, attitudes, and values of the individual. According to Roura (2021), a key aspect to influence the individual level of power is reflecting upon any preconceived assumptions, including one's privilege. Interestingly, both clinicians and researchers in speech-language pathology have the privilege of a graduate degree; however, the PhD is considered a terminal, or the highest, degree possible. Although clinical expertise is valued by the definition of evidence-based practice adopted by the ASHA (e.g., scientific evidence, clinical expertise, and patient preferences; ASHA, 2005; Sackett et al., 1996), it is difficult to operationalize and, thus, compare to a terminal degree.

Individual choices can influence research–practice partnerships, perpetuating the distance that occurs when one's perceived social status is related to an assessment of their competence as described by Belone et al. (2016). These choices at the microlevel can influence the power differential and shift a workplace culture to inhibit or facilitate research–practice partnerships. For example, in a workplace setting where a PhD is referred to by their honorific (i.e., "Dr. _____") yet clinicians go by a first name, social distance may be experienced by the two professionals who, with more equal footing, could be successful collaborative partners.

As Roura (2021) explains, these macro-, meso-, and microlevels often influence each other in bidirectional ways meaning that action taken at the individual level may influence change at the meso- and macrolevels. We argue that participatory research can mitigate power differentials when specific attention is paid to macro-, meso-, and micro-influences of power. As such, we offer some examples.

Participatory Research Can Mitigate Power Differentials Between Clinicians and Researchers

Example 1: The Evolving Early Intervention Landscape

In their work on exploring the effectiveness of an early intervention to address social communication and engagement in young children with complex communication and motor needs, Pinder, Olswang et al. adopted the traditional approach of conducting research studies along the efficacy–effectiveness–implementation pipeline (Olswang et al., 2013, 2014; Olswang & Pinder, 1995; Pinder & Olswang, 1995; Pinder et al., 1993). This approach yielded necessary evidence to support the efficacy of the intervention for young children and their families but was not designed to integrate clinicians' practice realities until the end of the pipeline. As a result, the research did not fully address societal and cultural changes that were occurring at a macrolevel, specifically the evolving landscape of early intervention service delivery in the United States, of which clinicians were acutely aware. These large, structural, and macrolevel changes included a transition from center-based services for children and families to the now predominant model of early intervention delivered within families' natural environments (e.g., home, childcare, and community settings). As the researchers began to appreciate these macrolevel changes, the research necessarily turned toward more directly engaging and partnering with practitioners working in natural environments. Studies that directly explored and prioritized clinician's attitudes,

perceptions, and their real-world practice demands were conducted to better understand barriers and facilitators to implementation of the evidence (Feuerstein et al., 2017, 2018). Meaningful and productive researcher–clinician partnerships were developed that ultimately enhanced both research and practice. The clinicians were able to voice their needs, priorities, knowledge, and perspectives related to real-world practice demands (Feuerstein et al., 2018). The researchers, in turn, were able to apply methodological approaches that integrated clinician perspectives. Ultimately, information and experiences communicated between clinician and research partners have the power to advance and better tailor interventions to support real-world practice environments through mitigating macrolevel power differentials such as these.

Example 2: Assessment Practices for People Poststroke

A lack of consistency of assessment practices for people following stroke led clinicians and researchers to question the status quo (Schliep et al., 2020; Vallila-Rohter et al., 2018). Prior to researchers and clinicians collaborating, clinicians were limited in their ability to measure patient progress as patients moved from one level of care to another, and researchers were unable to consistently examine patterns of change in the initial days to weeks following stroke. Through researcher–clinician collaboration, clinicians at Brigham and Women's Hospital (BWH) and Spaulding Rehabilitation Hospital (SRH), both within the Mass General Brigham Integrated Healthcare System, identified opportunities to streamline practice for the evaluation of language skills following stroke. As standardized assessment tools were selected and protocols were integrated into practice, an iterative process of surveying clinicians to evaluate the utility of the protocol and making changes based on their needs was employed. In this way, a meaningful partnership at the mesolevel was developed that, similar to the example of research involving children with complex communication needs described previously, enhanced both research and practice.

Beyond the primary objective of streamlining practices within and between settings, each team's work toward a common goal supported ongoing partnerships between clinicians and clinician-researchers to address other priorities identified by full-time clinical staff. Alonzo et al. (2022) highlight this type of longer term, ongoing collaboration as a foundational component of successful and mutually beneficial research–practice partnerships. For example, at BWH, the team of clinicians and clinical researchers now meets monthly to identify areas for evaluating practices and measuring outcomes within the acute care setting. Questions are driven by clinician's observations, interests, and needs and projects have spanned from

monitoring patterns and trends to quality improvement projects to ongoing implementation science initiatives. In some cases, measurement has led the team to discover that no structured practice patterns need to be put in place, whereas in other cases, the team has worked to develop processes to improve practice and measure the results of changes. Similarly, at SRH, the standardized assessment initiative led to the cocreation of Spaulding Aphasia Rehabilitation Working Group (recently renamed the Aphasia Rehabilitation Implementation Science Exchange; Juckett et al., 2022; Storkel et al., 2022). The group, coordinated by two clinician researchers, also meets monthly to identify and discuss priority areas in clinical practice and implementation. Core objectives identified by the group members include (a) establishing clinician–researcher partnerships to promote and accelerate evidence-based practices; (b) developing clinical resources and educational materials; (c) supporting the implementation of evidence-informed assessment and treatment approaches to meet client needs; and (d) disseminating knowledge and resources. Considering the mesolevel, success within the group has been facilitated by the team-based dynamic and bidirectional exchange of ideas. While there are lead coordinators, the group's initiatives have been identified by clinicians' practice needs, which are then prioritized by group consensus. This commitment to shared decision making and the focus on patient outcomes has helped to advance the work of both groups described previously. Given that all members (clinicians and clinician researchers) work together to provide patient care, potential power imbalances are likely minimized, further advancing the effectiveness of the group collaboration. Ovretveit et al. (2014) also outline guidance for research–practice partnerships where project roles and responsibilities are specified among partners prior to the project. In this way, researchers and clinicians can specify who will lead and who might play a more supportive role across identified research priorities and questions.

In a collaborative approach such as this, knowledge that is obtained during clinical practice would be valued equally, and ideally, knowledge from research and knowledge from clinical experience would inform one another (Douglas, Oshita, et al., 2022; Feuerstein et al., 2017). Beidas et al. (2022) recommend embedded approaches wherein researchers work within settings where knowledge is to be implemented. By increasing the researcher's proximity to clinical practice, experiential knowledge could inform the research process, indicating value to that form of knowledge.

Example 3: Project BRIDGE

Project BRIDGE (Building Research Initiatives by Developing Group Effort) is a research incubator that provides individuals and research teams the tools and techniques needed to engage in collaborative research

where the viewpoints of various stakeholders, including clinicians, people living with aphasia and other communication disabilities, their family members, and others, are valued equally, beginning with the selection of a research priority and carrying through all research phases to its dissemination. At the beginning of the project, we noticed that researchers were often unsure about how to effectively collaborate with others. For example, some researchers initially bowed to the ideas of the patient partners who were in the groups, as though the researcher were in a clinician mode and the collaboration were a therapy setting (Hinckley & El-Khouri, 2021; Malendowski et al., 2021). It took time and expertise to support researchers to recognize that they had an expertise but that their knowledge had limits. Other groups offered their own expertise, with its own boundaries. Researchers, clinicians, patient partners, and others who enter a collaboration must go through a learning process (or possibly, an "unlearning" process) during which they learn that they are not completely in control nor are they completely without value. Everyone brings a particular value regardless of role, personal experience, or research expertise, and the navigation of these individual roles can be supported by intellectual humility.

Intellectual humility has been defined as being transparent about and owning the limitations of our own work (Hoekstra & Vazire, 2021). Intellectual humility was found to be of high value to clinicians, but it is not incentivized in current research practice (Hoekstra & Vazire, 2021; Wadhwa & Mahant, 2022). However, de la Peña and Koch (2021) argue that intellectual humility might be critical for effective collaboration across groups. Appreciating the differing priorities of researchers, clinicians, and people with aphasia helped all groups acknowledge limitations and the need for one another to help solve the complex problems of communication disorders.

Conclusions

Clinicians and researchers in our field have vastly different responsibilities and priorities that impact our ability to work collaboratively to solve the most pressing problems for the clients we serve. We believe that current research practices reinforce a power differential causing clinicians to feel less than and to only consume knowledge while researchers solely produce knowledge. We outlined examples to illustrate how it is possible to leverage research–practice partnerships to mitigate power differentials that are present between researchers and clinicians across varying levels of power. With positive intent and in efforts to embrace intellectual humility ourselves, we sincerely hope this article contributes to the conversation on research–practice partnerships with the ultimate eye on better outcomes for the clients we serve.

Acknowledgments

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