Episode 69: The Etiquette of Following Up on an SLP Position (A Day in the Life of a Medical SLP Series)

Meet Bret Stuckenschnieder and Michelle Lytle, two medical speech-language pathologists who work in the acute care and rehabilitation setting. These close colleagues walk us through what it's like working in such a facility, some of the challenges they face from day to day, and what new SLPs can do to break into the acute care setting.

Discussion & Reflection Questions

1. Tell us a little bit about who you are and where you work.
2. What do you look for when people interview for a medical SLP position? Any words of advice for the interview?
3. What's something you would not recommend putting on a resume for a medical SLP role?
4. What are some phone or email etiquette tips you have for applicants looking to follow up?
5. Can you share what a day in the life of a medical SLP working in a rehabilitation center looks like?
6. What are the challenges of working in an acute care setting?
7. Can each of you share with us a story of a patient you will never forget?
8. What words of advice would you give SLP grads, clinical fellows, or transitioning SLPs?

Quotes of the Conversation

"You always want to just put yourself out there, and if you get rejected, that's fine. That's going to happen. But you know, rejection is part of the process. You've got to keep going through it and pushing through it."

- *Bret Stuckenschneider, MS, CCC-SLP*

"My advice is always to just keep asking questions. Even in a new setting. Even if you've been here for almost 10 years, like I have. I'm always asking questions, and I always tell my students, 'You know, you're never not learning something.'"

- Michelle Lytle MS, CF-SLP

Bret Stuckenschneider, MS, CCC-SLP

Medical Speech-Language Pathologist

Bret Stuckenschneider is a 2018 graduate from Missouri State University who has spent the past three years working in the acute care setting. Bret currently works within the Baylor system in Irving, Texas where his main areas of interest include evaluating and treating communication and swallowing disorders in complex and critically ill patients.

Michelle Lytle MS, CCC-SLP

Medical Speech-Language Pathologist

Michelle Lytle is an acute care SLP who has worked for Baylor Scott and White Medical Center at Irving since 2012. She graduated from the University of Texas at Dallas in 2011 and completed her CFY at the University of Texas Medical Branch in Galveston, TX. Michelle is the lead SLP at her current facility and was promoted to acute care therapy supervisor in 2018. She has provided education to the Baylor Scott and White Health system on various topics including dysphagia in the oncology population and the role of the SLP in palliative care. Michelle recently served as the lead SLP for the system-wide implementation of the International Dysphagia Diet Standardization Initiative (IDDSI). She is currently certified as a Modified Barium Swallow Impairment Profile (MBSImP) clinician and a McNeill Dysphagia Therapy Program (MDTP) clinician. Michelle enjoys student mentorship and serving as a resource for local graduate SLP programs. Outside of work, Michelle loves to travel, read and spend time with her family.

Keep the Conversation Going

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Do you have a question you'd like answered on the show? Interested in sharing your experience as an SLP with our audience?
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The Missing Link for SLPs Podcast Show Notes

Mattie Murrey

So, if you like stories from an acute care rehabilitation speech pathologist, I have some great stories for you tonight, with Bret and Michelle both joining me. Both [are] acute care speech language pathologists, and they have amazing stories to share with us tonight. They are based in a larger acute care hospital in Texas, and they share with us all sorts of things that are happening during their day with their complex, medically fragile patients to those who survive and those who don't survive. So, get ready for a great podcast.

Mattie Murrey

Hello, and welcome to The Missing Link for SLPs podcast. I am so glad you are here. Today's episode is part of the medical SLP series, where we talk to some amazing speech paths who work in a variety of medical settings — all the way from intensive care through to home care, and everything else in between and beyond. You're going to hear some incredible medical SLP stories and lots of advice from these passionate medical SLPs.

Mattie Murrey

This really is just all about fun and storytelling, and even if mics and videos don't work, it's all just fun because we're talking about something that we love. So, today we are welcoming Bret and Michelle to our episode of The Missing Link for Fresh SLPs podcast. And we're excited you two are here. I don't think we've had two speech pathologists from the rehabilitation unit before. So, welcome.

Bret Stuckenschnieder

We're excited. This is our first podcast as well, so we've been slowly preparing and psyching ourselves up to, you know, "get famous." No, we're excited to talk about what we do and answer any questions you guys have or your students have.

Mattie Murrey

That's what this podcast is all about. And it started because students, because of COVID, weren't able to go into some of these settings and really see what was going on and shadow. So, when I put that call-out on Med SLP, a number of you guys responded back. And I'm so excited [that] you two responded and said, "Hey, we'd love to share our setting with you." Tell us a little bit about who you are and where you work.

Bret Stuckenschnieder

Okay. [Michelle], want to go first?

Michelle Lytle

Sure. So, my name is Michelle Lytle. And I graduated from the University of Texas at Dallas in 2011, and then I went to go on and do my CFY at the UT Medical Branch in Galveston. It's a big Level I trauma hospital, and I had the greatest time. It was very hard, but it was definitely what I needed to feel prepared to stay in the medical field. After I finished — it's a rotating position — I was looking for another acute care position. And I ended up finding, actually, where I am today: a position at Baylor Scott & White in Irving. And so, I've been here since 2012 and been kind of the lead [or] head SLP for pretty much that entire time. And I recently moved up into an acute care therapy supervisor position in 2018. And so, I'm splitting my work between still seeing patients and doing acute care and what I love, but also, now kind of moving toward more of a leadership/management side.

Mattie Murrey

So, you started in the medical setting, you moved around in that medical setting laterally, and now you're kind of moving up horizontally into supervision and everything like that. Yes?

Michelle Lytle

Yeah.

Mattie Murrey

That's great. It shows students — our listeners — that they have this ability to move within this care system. Excellent.

Bret Stuckenschnieder

So, my name is Brett Stuckenschnieder. I went to Missouri State University. That is in Springfield, Missouri. Most people don't really know where that's at. But I ended up... Throughout grad school, I knew from almost day one that I wanted to do medical. And that was all I wanted to do was medical — primarily, acute care was my ultimate goal. I did my externship at an acute care hospital that was actually about five miles down the road from my university. And from my externship, I was hired on, fortunately, to start a part-time job in their acute care setting. They only had a part-time job available. So, as I wanted to expand on my knowledge and learn more about the acute care side of speech pathology, I also joined in on a PRN job at the other big hospital down the street and worked there two days a week. So, I filled my weeks up with a full schedule. I just rotated from two different hospitals, both acute cares, both big hospitals — you know, probably around 500 to 800 beds. We saw everything. It was an incredible learning experience. I had some of the greatest speech therapists that a CFY could ask to learn under and kind of develop the skills necessary to branch out more independently in the future. So, shoutout to the Mercy Hospital speech therapists and also Cox Hospital [speech therapists].

And then, after my CFY, I knew I wanted to branch out of Missouri. You know, I just wanted to see other stuff. And so, wanting to get into the medical field, you have to open your eyes up and you have to open your ability to change locations for this setting, the setting you want. So, I applied for several jobs throughout the country. And I ended up landing this job and sweeping

these ladies off their feet. And so, that's 2019. I ended up moving down to Irving, which if people know, Irvinvg's about 20 minutes outside of Dallas. And I ended up moving to Texas and started this job. And it's a different change of pace, but I wouldn't change it for the world. And Michelle has been a great mentor for me. And our big boss is also a speech pathologist as well. So, we are surrounded by a lot of helpful hands. And it's a great learning environment.

Mattie Murrey

How many are on your team there?

Bret Stuckenschnieder

So, we have two full-time [speech pathologists] — so, myself and Michelle. And Michelle is technically counted as a half. So, like one and a half because of the fact that she is doing her supervisor role on top of that. But we also have... What is it, six?

Michelle Lytle

Six to seven PRNs that come and help us throughout the week as needed.

Mattie Murrey

I can think of a whole number of questions to ask each one of you. I would love to pick your brain a little bit, Michelle, about more of the administrative type things, like, what do you look for when people interview for a med SLP position? And particularly, any words of advice for the clinical fellow who might be moving in and really wanting that med SLP position? Or somebody transitioning in from the school system?

Michelle Lytle

Sure. So, having been here this long and transitioning into more of this leadership opportunity, you know, we really look for those who have experience or have kind of pushed themselves to get experience with modified barium swallow studies, but also, with FEES. And even if that's, you know, taking the basic class to get your passes, it shows your drive, your determination, [and] your passion for this field — even if you may not have all the experience or be signed off as competent yet. Having taken basically those steps to kind of show those interests is always great. Currently, we have a PRN that works for us who started off in a school. And she actually still works in the school, but she was able to get a job as a PRN and an L tech. And being able to have that experience with these medically complex patients, and basically seeking that type of experience but also a place where she was able to start getting her modified barium swallow study experience, that basically helped land her this position. She had experience in an L tech. She had experience at a SNF. And she already was mostly competent in her modified barium swallow study. And she was eager. We could tell that she loved medical SLP. I really admire her because she can kind of do it all. You know, she's still actually working in the schools, but she can come in and see adult patients. And she's eager to learn, and she's eager to ask questions.

Another way that I've seen people kind of get their foot in the door is sometimes taking an outpatient adult placement. Working with adult outpatients, especially if that adult clinic is part of a hospital system, a lot of times those outpatient SLPs are performing outpatient modified

barium swallow studies. And so, if they are able to come on, usually they can get training in that as well. And then that can help them transition into an acute care setting, if that's what they want to do. There are all different ways to approach it. But you know, we definitely look for those who are passionate — those who are looking for more learning opportunities, and those who kind of take the extra step to kind of get some experience under their belt.

Mattie Murrey

How does that show on a resume or a letter of intent?

Michelle Lytle

So, usually, we're looking at... Especially if, let's say, we're looking for a CFY, we're looking at what were their placements as far as externships, internships, whatever you may call them in school? I knew I wanted medical, and I kind of knew that if that was the route I wanted to go, that I needed as much experience as I could get in grad school. And so, I actually was able to get two full-time placements at two different hospitals over my last year in school. And that experience itself, knowing that I had worked as an intern at a VA hospital and also at an acute care hospital in Dallas, helped me land the CFY that I had in Galveston. And I've told students a lot, you know, it's one of those things that, if medical is something that you're really thinking about and you're really wanting, that's kind of the first thing you should push for in your CF if you can. Because it's really hard to kind of grow the other way. Like, if I decided one day that I wanted to go to a school, a school would probably hire me. I'd need a lot of training, but a school would probably hire me. But it's really hard the other way, to come from the schools and try to get your foot in the door. And so, my advice is always, if that's what you're pushing for, really talk to your advisors at school, your professors, [and] see what opportunities there are. And yeah, just kind of do what you can to [get experience]. And I also say, sometimes you have to move for the experience. So, it's kind of tough, too. I know there are certain life situations where you may not be able to, but that was the advice that somebody had given me, to be willing to move for the job and the experience. Because even if it's a year away from home, if you get that CFY, you're kind of invincible after that. You can take your experience to a lot of places.

Mattie Murrey

What is something that you would recommend not putting on a resume? Or something you've seen on a resume that you're just like, "ugh"?

Michelle Lytle

That's a good question. I think it's really, especially kind of first coming into the field, if you are loading up your resume with kind of everything you've done, a lot of that is going to be blurred over by who's looking at it, because really, they want to know what is relevant to this job that you're seeking. So, it may be that you had all this experience in school or at a pediatric outpatient clinic or something, but if you're really pushing for adult, you really want to highlight

what you've done for adults — maybe what CEUs or courses that you've taken, or the classes that kind of highlight that knowledge that you have.

Mattie Murrey

And that preparation, possibly. Getting ready for this position.

Michelle Lytle

Yes, definitely.

Mattie Murrey

Any words of advice for the interview?

Michelle Lytle

Well, our goal is always to be as laid back as possible if we can. I mean, I think it's always different wherever you go for an interview, but I think just, as stressful as you may feel, just know that we're really trying to just feel you out as a person, too. And it may be that you don't have all the experience in the world that you want. But sometimes, we're also looking for just a great fit to our team. And I can say that, when Bret interviewed, that was something that I noticed right away. One, I noticed that he kind of pushed to get an interview, even though we were looking for people who had two years of experience or more. And he was like right under two years, so the recruiter wasn't sending us his resume. And so...

Bret Stuckenschnieder

I bombarded them with phone calls.

Michelle Lytle

Yes. He just kept calling, and I said, "How did you get this number? And he keeps calling!" But, you know, I took that as such a good sign — like, here's somebody who's passionate and wants it, and he's willing to push to get it. And so, we also look for somebody who's going to fit with our team. When you come into a new job and a new setting, the biggest thing is, you may love the patient population you work with, but you also want to love who you're working with, too. And so, not only are we interviewing you, but you're interviewing us. We want to know, is this a good fit? Are we going to be a good family?

Mattie Murrey

I keep one day a week at my clinic because I absolutely love what we do. I love my patients, and I love my colleagues. And I recently moved, and people are like, "Well, why don't you apply at the hospital where you moved?" And I'm like, "No." Because if you find a good team, and in your case, a good supervisor, it just makes work so much better.

Michelle Lytle

And that's one of the reasons I haven't left. I got here, and I had put my foot in so many other doors and kind of saw so many other teams. And when I got here, I realized, wow, this is different. And it would be crazy of me to think to leave this.

Mattie Murrey

And you've moved up, which is great. And Bret, you moved sideways. You kept some PRN positions and kind of teeter-tottered here and there. Tell us how you were so brave and so consistent with, "this is the job I want, please meet with me," and how you opened up the doorways that you have.

Bret Stuckenschnieder

So, yeah. Even in grad school, knowing this is what I wanted, knowing my supervisors told me this is what I needed to do — just because they saw how I was with kids and were like, "Yeah, you probably shouldn't work with kids all the time" — but it's what I wanted, and I honestly treated my externship as a prolonged interview. It was a big hospital, and so, I treated it as the fact that I'm fighting to maybe get a job here if they have an opening. Because they were a teaching hospital, and they had a history of recruiting CFYs, especially CFYs that had their externships there, depending on what availability they had. So, I worked. And I worked hard. And I did a lot of research. And I did a lot of studying for this placement. And I was always, you know, the first one with my hand up to get in there with new experiences, and learning how to document correctly, and all the things that I knew mattered to the team that I wanted to be a part of. So, I did that, to the point [where] I actually had some really good friends of mine from grad school that were doing the same thing. We had an externship together. We all wanted that one job. And unfortunately, they only had one part-time job at that moment. And my really good friend and I were both fighting for that one part-time job. And both of us were just as qualified. There was no change. There were just a couple factors, and I ended up getting that job. And I'm very, very lucky for it because I know it's a very hard thing to do to get a CFY acute care position.

And like Michelle said, it might not be conducive with your ultimate living situation. Because, leaving grad school, I didn't really want to stay in Missouri. I always wanted to branch out. But I got that opportunity, and I wasn't going to leave it. Because I wanted to get the experience so I could branch out. So, I stayed there. And I stayed there for another year, and I opened the door up to where I got another PRN position, luckily, in the same setting. And those two positions together, I learned a lot. I worked a lot. I built up my resume as much as I could. I took my FEES course in Boston. I did modifies several times a week. I did everything that I thought would matter for a major hospital wanting to hire someone new. And so, after my CFY was over and I was looking to branch out, then I looked at a couple different hospitals in different areas of the country as a list of top five places I would potentially want to move to versus just moving wherever. And so, I looked at the top five places, Dallas being one of them, because it isn't terribly far from home — about a six and a half hour drive or so — and so, my mom wouldn't freak out too much.

Bret Stuckenschnieder

So, I looked at different jobs around here. There are a couple hospitals I applied to and didn't get anything. Nothing came of it. And it was kind of a stagnant situation for a while. Then this job became available along with some other jobs, and I applied for them. And in movies and things, you always see that the person who always calls and asks about their application — you know, gets their name recognized. So, I went, "I will try that." So, I ended up actually calling the hospital. I asked to be transferred to their rehab department. And now, this hospital has an inpatient rehab department and an acute care department as well. So, I got transferred to the acute care department and asked to speak to the rehab director, which is our big boss right now. And that's who I called. And I left messages on her work phone. And I did that a couple times without a response. I just basically said, "I applied for this job. I just wanted to talk to you briefly [about] what the job entails, what you guys are looking for, make sure you got my application, see if there are any questions you had about my application, and if there's anything I could do moving forward to promote myself, that kind of thing.

So, I was actually at work, and our boss called me. And I talked him through it. And the first thing I told him was, "I know I don't fit the criteria of your application or your job listing, which I think Michelle said was two years experience, and I'd just got done with my CFY." But I said, "But this is what I've been doing: I've been doing modifieds five to 10 times a week. I've been working with these populations, this kind of setting, and these two big major hospitals in this area of Missouri, where I'm from. I have experience with X, Y, and Z. I also have letters of recommendation from my current CFY supervisors and my other colleagues that I work with if you are interested in those." You know, I basically just promoted myself as much as possible, which I hate doing. I hate talking about myself. Most people do. It's just something that's necessary if you want to put yourself above it.

So, I have an interview here. I actually was on vacation when they interviewed me. We did it through a Skype call, kind of like this. And I had my first interview with the ocean in the background. And so, I was very relaxed. And I think that kind of helped a little bit. Then, after that, we had a second interview. And I was kind of just patiently waiting in Missouri to see what the next step was because, you know, that was kind of the decider: Am I going to continue my job in the same spot, or am I going to put in my two weeks notice and move states and, you know, change my whole life? So, that's kind of where it was. And I was in a position, I'm lucky enough, that I had that opportunity. I didn't have anything tying me to that spot, that area. I had the ability to move around, which I know is not always the case with most people. They might have to only get a job in this one city, and that always makes it a lot harder to get those jobs. But my main focus was just, "I need the experience. This is a coveted role in my eyes. I need to put myself above. I'm going to take the experience wherever I get it. And I'm going to work hard for it, and I'm going to basically get to the point where, in the future. If somebody says, 'Can you do this?,' I'm going to answer, 'Yes,' for every question — you know, so they have no reservations about my abilities, regardless of how long I've been in the field." That's kind of just

my mentality about the whole situation — you know, getting into this environment and staying in this environment and moving laterally, if needed.

Mattie Murrey

So, you really looked for, cultivated, focused on finding those opportunities, where you wanted to go. And you were okay with rejection. You would rather put it out there, "This is who I am," than not put it out there. I mean, if you kept calling and saying, you know, "These are my strengths," that's excellent.

Bret Stuckenschnieder

Most definitely. I mean, I had several rejections. I went through several hospitals I applied to. Most [of the time] I didn't call. You know, they look at your... Like Michelle said, HR looks at your resume and they see you didn't meet their qualifications, so they don't even consider you a candidate. They don't even send you to the next level. So, that's why I knew that I needed to change something. I needed to change my process. So, that's kind of just what my mantra was the whole way. I was going to put myself into every job application because you just never know. If you're going to apply for it, you just never know if it's going to be something that they are, you know, agreeable to amend their terms a little bit. You always want to just put yourself out there, and if you get rejected, that's fine. That's going to happen. But you know, rejection is part of the process. You've got to keep going through it and pushing through it.

Mattie Murrey

It is. And it's a very normal part of the process sometimes.

Bret Stuckenschnieder

Especially as a young SLP, it's going to happen.

Mattie Murrey

It's going to happen. So Michelle, question for you: Students listening to this — your new SLPs or transitioning SLPs — may think, "Okay, now I'm going to call." What are some phone etiquette or email etiquette things that you could give them? I mean, how many times do they call? How many days do they wait? What is the point where they cross over into being annoying? Or where they don't call enough and they're not noticed?

Michelle Lytle

Well, I think if you know that you are in contact with the right person... This is kind of a tough one because it's hard to know, really, when you send out your resume, now what's the next step? Who do I talk to? So, knowing that Bret kind of put himself out there to call the hospital and figure out who may be the rehab manager or the rehab director, he was calling the right person. I would say, the intention is always for us to call back. Even when I've sent out emails to my grad school when we've had open positions, just to help kind of get the word out there, if somebody emails, most likely you should get a response back, whether that's yes or no. If you don't, I think it's still appropriate to email at least after a week or so. If you still don't get a

response, I think the third time is probably the last time. If you don't get anything, then it may be that you don't fit the criteria. And unfortunately, maybe that place is not where you would want to work anyway because it kind of shows something that they're not responding to you. Because, at least here, if someone's reaching out, whether that's through email or through phone, we're going to reach back out saying, "At this time, we either don't have a position," or, "These are the qualifications and maybe you don't have them at the moment, but that's okay." We've even had opportunities where people, maybe they've applied and had almost enough experience, and we said, "Hey, if you are able to, finish up that modified competency, because right now we really need someone who's competent in modifieds, reach back out to us in the future." We always leave the door open like that. And that's something that I would encourage students to think about: that if it's a place that you applied to, and maybe it wasn't the right time and it wasn't the right fit, but then you're able to go get the experience somewhere else, and then you realize, "You know what, I feel ready and I have the experience they're looking for and this is a certain hospital or rehab system I want to be in," it also doesn't hurt to reach back out to those people that you have previously spoken to or interviewed with.

Mattie Murrey

Good advice. So, we've spent some wonderful time talking about things I didn't intend to talk about. You just came here, and I'm like, "Oh, I have all these questions." But I would love to hear more from you — Bret, specifically — about what your day in the life of a medical SLP working in a rehabilitation center looks like.

Bret Stuckenschnieder

So, acute care is very different from most other settings. You don't operate on a fixed schedule. Everything is kind of come as you go. There are so many complexities to your patients that you never know what your day is going to look like when you first start. You might think your day starts one way, and it's going to be completely derailed within the first couple hours and completely changed. And some people hate that. Some people love that. And for me, I like that. I like the fact that every day is different. For the most part, you never know what you're walking into. Even if you have a recurring patient, you still never know what you're walking into. These are very medically complex patients. So sometimes, you walk in and they're a whole different person that day. And that's when our expertise comes in to talk about, "Hey doctor, this person, they were doing this, this, and this yesterday. Now they can't even do this, this, and this. Maybe we should order some sort of new imaging because there's something going on here that's not quite right." Everything is so medically fragile, and it requires a lot of critical thinking. I think that's my main thing that I love about this setting.

But you know, as far as going back to your original question — I keep going off on tangents — I walk in for the day... Every hospital is different, but for our sake, I will walk in and open up our operating system. We operate with Epic, and we look to see, you know, what does our caseload look like today? How many new evals did we get overnight? They're looking at our caseload as a whole. And we have little comments next to each patient to see. You know, who's the highest priority today? Who are patients that are NPO or not eating? Who are the people that we

absolutely need to see today, or they're having a change of status and we need to reevaluate them? When there's a new valve that was brought in yesterday night and is still there, we need to cover that. And then, from there, depending on what coverage we have that day — whether it just be me, Michelle, some PRNs, you know, who's going to be here that day — I work on creating our lists, as we call it. So, divvying up our caseload by person, and basically saying, "Okay, you're going to see this person, this person, and this person today. I'm going to see this group of people. You're going to see this group of people." And then, from that, looking at my list... And we try to keep this consistent. So, if you've seen somebody a couple days before or you've been seeing them routinely, you try to keep that same person, ideally.

Bret Stuckenschnieder

So, looking through my list. Then I go through my chart review. I go through all my new evals first to see, you know, why are they here? What's going on with them? Look at their history. Look to see if they've seen us before. What's their dysphagia history? What's their swallowing history? What's their medical complexity, and why are they in the hospital? Is there anything on their chest x-ray that looks suspicious? Is there anything in the lab values that look suspicious? Are they on any medications that might be inhibiting their participation today? Do they have any procedures today? Are they on a diet now? Are they not on a diet now? If they're not on a diet now, what's the reason? Is it a GI issue? Is it an issue with swallowing? There are a lot of things you've got to go through to kind of see how to prioritize your patients that day. And so, once I get my whole list figured out and I see who I'm going to see first and who's the top priority, I just hit the floors. And our hospital is small enough that we tend to float to all the floors. There's no specific floor that one speech therapist is assigned to, which bigger hospitals do have. You know, you might have a speech therapist assigned to neuro. You might have a speech therapist on oncology or hospice or trauma. There are a lot of different things that, you know... People could be separated into those specific units. But in our case, we float everywhere.

So, going through, then looking to see who you want to see first. I go to their room, talk to their nurse, [and] see what they look like today — you know, see what's going on with them today. If I started them on a diet yesterday, I want to make sure they're doing okay still. Are they still taking their meds? Are they having any issues with the aspiration signs when they're eating? What's their options status? Has it gone down [or] up? Do they look more lethargic today? You know, just kind of seeing what their status is. And then, going and seeing the patients. For me, I typically see one or two patients [and] then document it. I see one or two patients, then document. And that is kind of how I do it. Some people like to see all their patients in the morning and document all afternoon. It just depends on what works for you. For me, I forget too many details. I need to see them. I need to document. And I kind of just need a mental break, a breather, just to kind of sit down and focus on something else for a second versus just constant stimulation, which is the nice part about this setting too. It's more flexible in what you can do. You can kind of schedule your day how you want it. And then throughout the day, I have my pager. And then I'll get paged for people I wasn't expecting to see today. New evals start

rolling in. And so, you might have to change your whole list up. You know, if several new valves come in, they want you to see this person [or] this person. They need to be seen right away. You change your whole day up, and that's kind of where the inconsistency comes. But that keeps it exciting, too, and it keeps you on your toes. That's for sure.

Mattie Murrey

I love that setting. Go ahead.

Bret Stuckenschnieder

But then, after that, that's pretty much how the whole day rolls. And just knowing, when you come to a hospital, you know, documentation is a big part of it. So, you have to be well versed in your documentation, knowing that it does take time. When you're dealing with these medically complex patients, you want to document like you know what you're talking about. And that sometimes gets wordy if you are trying to relay some complex information for people who might not understand as well.

Mattie Murrey

Do you work weekends at all? Holidays?

Bret Stuckenschnieder

We will pick up weekends as needed, but typically, we have PRNs that work our weekend schedule. That's actually a lucky thing that we have here, I think because we're smaller. Most bigger hospitals don't have that luxury. I know, during my CFY, we had to work at least one weekend per month. So, at both hospitals, I had to work at least one weekend per month. So, two weekends per month, I was working. And then I'd have comp days during the week. But we try to schedule here where we don't have to work weekends if we don't want to.

Michelle Lytle

But I do think it's important... I've had to talk to students to say, "If you really want acute care, even an inpatient rehab setting... You know, when we think about the hospital, the hospital's open seven days a week, which means we're here seven days a week." So, even if we have some coverage, if that coverage falls through, then it's up to the full-time staff to cover that. And so, as nice as it can be to know, "Okay, well, we have some extra help," you always in the back of your brain have to know and plan that can fall through. And, you know, Bret and I have to be in close communication. And you have to be with your team to know, "Hey, if this doesn't work out, are you here in town? Are you okay to pick up this weekend if it doesn't work out?" And kind of scheduling holidays around that as well. So, I think that's important to know for new clinicians. Sometimes, it's even a weekend phone call. We've had to talk about patients. I've had to call therapists. If I'm following up on a patient and I have a question, sometimes I have to call that therapist on the weekend. And you have to be open to, if this is the job that you want, then you have to be available in some aspect or another.

Mattie Murrey

I'm glad you really highlight that because, as we're working our way through "A Day in the Life of a Medical SLP," those are some of the questions I'm asking. And it's really beneficial for somebody stepping into the acute care/rehab setting to know that they are going to be part of the team and working on weekends and holidays and what happens when they fall through. Then, who picks up the slack? And that impact and ripple effect on the team is important to know.

Bret Stuckenschnieder

Michelle and I have definitely had our weekends where we'll have a PRN call in and we're at home enjoying some breakfast, and then, you know, "Oh, I have work today." It's not like we're going to be there for you know, a whole eight hours, hopefully, but you know, we've got to go see those people — the patients who need to be seen. It is a good point that Michelle highlights, that you always have to be kind of "on call," whether that be actually on call to come in or on call for somebody to come ask you a question if they need to.

Mattie Murrey

We're almost out of time, and I think I need to start asking these two questions at the very beginning because they're my very favorite questions. Actually, I just thought of a third one. Each of you, briefly, what are the challenges of working in that setting?

Michelle Lytle

I think we touched on it. A challenge can be that it sometimes feels like a seven-day job. I think another challenge we saw this past year: working through a pandemic. I would say that this past year was probably the hardest year of my career. And it was adjusting to figuring out what to do. We're all kind of flying blind, and knowing that if you stay in the medical field, this could happen again. Something else could come up that kind of shakes us to the core. And having that team that we did, I think, really helped us get through working through COVID and navigating the new road of that and what that looks like. So, definitely being aware of that coming into this setting. You know, you think one thing, and then your whole world can change — your patient population and kind of how you meet. How you've always evaluated and treated a patient, you kind of have to throw that out the window and figure out something else. And so, yeah. I would say those are kind of the biggest challenges I can speak of right now.

Bret Stuckenschnieder

So, I think, definitely that. I think that's a huge portion. This whole year has been kind of a whirlwind for all of us. But I think a couple other things, kind of including that, is that you're working with such medically fragile patients that you develop these bonds [with]. And you do, unfortunately, see, the repercussions of the fragility of their medical status. So, you see patients who pass away. You see them decline after you get close to their family. There's always that risk of somebody not doing so great, like you thought they were going to do.

But also, you're working in this environment with so many different disciplines, and everybody has their own specialty. And everybody has all these fancy letters after their name. And [you're]

trying to promote yourself. So, you become part of the discussion. I think that's always a big thing Michelle has worked for. It's her whole career here. And a big part of my motivation, too, is just to make ourselves known in this giant pool of doctors and nurses and nurse practitioners and other physicians. Just saying, "Okay, this is what we do this [and] how we can help. And this is what I can offer you to benefit. And these are the recommendations I offer. And, you know, this is what I would do. And this is how I specialize. And this is how we're going to, hopefully, reach the next step together. You know, just promoting yourself and advocating for your patients based on what you do. And that's always hard. I remember when I first came to the hospital, and I saw people with white coats or doctors, I was terrified to ever talk to a doctor. You know, they were on this pedestal. But you know, that goes away very quickly. And you realize that they're looking at you to get your opinion for certain things. And when you talk to them, you need to know what you're talking about, too, or else they will remember that and they won't counsel you as much. So, just knowing your stuff and always being on your toes to promote your specialty. And do it in an accurate manner that is meaningful for your patient's recovery. That's, I think, a big challenge for some people, to not freeze on those moments when a doctor pulls you aside and says, "Hey, what's going on here, here, here, and here. I need answers." And giving them answers to convince them that you know what you're talking about, that's always the hard part

Mattie Murrey

Very true. Can each of you share with us a story of a patient you will never forget? Who has made an impact on your career?

Michelle Lytle

I had a patient that... She came in with a stroke. She had a right-sided CVA. And she not only had a right hemisphere deficit, she also had pretty significant dysphagia. And I remember her humor was intact. And she, at baseline, her family told me kind of how she was the life of the party and the comedian of the family. And she loved hard. And she was just kind of that light that walks into a room. And a lot of that was taken away by her stroke, but I could still see a lot of who she was. And, you know, my job at that time was to make sure she was safe-swallowing. And after a swallow study, I had to put her on a pureed diet and thickened liquids for safety. And it was hard for her to really understand the reason why, but also, you know, she didn't like it. Most people on those diets don't enjoy it. But she filled up our sessions with humor and laughter. And I got very, very close to her family. Her sister was actually a speech therapist. She worked in the schools for a long time. And so I just kind of felt this immediate bond. And she ended up going to a rehab facility. And a few weeks later, I was contacted by her sister that she was back in the hospital. And it turned out that she was diagnosed with cancer, and they didn't know about it until then. And she kind of had a quick decline.

I had her back on my caseload and kind of did what I could for her at that moment, but she ended up transferring to an inpatient hospice unit. And I stayed in touch, and after she passed, the family reached out to me and they just kind of thanked me for what I had given her and how I had helped, I guess, as I could, even toward the end of her life. And palliative care in our

field has become such a big focus. I think that, especially when you're young and you're coming into the field, you want to fix and you want to make it better, and you sometimes forget that we need to look at these patients as a whole. And so, being able to kind of offer what I could to make her as comfortable [as possible] and to enjoy her quality of life toward the end was really important to me. And that's also become a big passion of mine, evaluating or treating our patients toward the end of life. And I ended up going to her funeral, which was actually the only patient funeral I've been to, and her family just filled that room with love. And they really — and this is not to toot my horn — spoke of what I had offered her toward the end. And it really just solidified that I'm in the career that I love and this is what I want to be able to do for people. And I think that sometimes, especially in the acute care setting, we have these very hard cases, these patients that are going through the worst time in their life, and then we kind of do what we can and then we say goodbye. And we kind of don't know what happens, but it is nice to know the long impact that we can make on patients and their families.

Mattie Murrey

I love that story because so many speech pathologists may choose... Bret, I don't know what your story is. But so many speech pathologists are like, all these great successes, but we need to reconsider [and] redefine what success is. And sometimes, in this case, it's honoring those who are going to be passing on and making their life as comfortable as we can the end with the least amount of suffering so they can have their goodbyes and their final good memories. Great, very honoring story. Thank you for sharing that.

Bret Stuckenschnieder

So, I mean, I have had so many people to think about. And I do have a story very similar to Michelle's, where I could talk about you know the palliative care side of things. But I think because she touched base on that, I'll kind of go a different direction with more of a rehabilitation standpoint. And this is in my CFY, actually, where my hospital was a big Level I trauma center, and we saw a lot of crazy things come through our doors. But one person I'll never forget was this 30-year-old guy that I had seen, and he had just gotten in a car accident. So, he had a pretty severe brain injury. And he was in the hospital for probably six months or so, which is a very, very long time to be in the acute care hospital. But I remember being the first one to see him. And I remember looking at him, and he was nearly completely paralyzed — you know, no movement in anything besides his eyes. You could see his eyes moving. And his eyes were so expressive. And you could see him looking at you, and you could see all these things that I never experienced before. And so I remember just talking to people about that. You know, “What does that mean? Like, I can see his eyes. He's there. He's understanding, even though he has no movement [and] he's not speaking.”

And so, it came down the road that he actually had locked in syndrome. And he was one of those rare patients who was locked in. And it was, you know, a lot of us going and promoting, "he is there, you can tell he's there," to all the doctors and everybody who thought he was nearly brain dead. And so, kind of working with him, with physical therapy, occupational therapy, and us working, trying to get him to eat something, trying to get him to speak again,

was a huge, huge goal. And like I said, this was months of seeing him. But I remember, this is the first case I got so invested in as a new clinician. Like, I was so excited and so invested. Every time I went to work, I requested that I see that patient because I just thought it was so interesting. And I developed this incredible bond with his family and his kids. And I remember the little strides we would make, where he would start moving his hands a little bit and start moving his arms a little bit, and then, even getting to the point where he was starting to try to mimic sounds. And you know, he was slowly coming out of the whole process. And his brain injury was slowly resolving. He was healing. And he went from a feeding tube for a long period of time to, we eventually got him to where he could tolerate a pureed diet with no thickened liquids. That was a first. And so, he was eating. And that was a huge step. That was somebody we never thought would eat again. We never thought he would really live. And then, from there, being able to eat, then speak, and just seeing the whole progress from a start of nothing [to an] ending where he finally discharged on a regular diet and was speaking full conversations. And that always stuck with me my whole career because that's somebody that I think people could have easily given up on with how severe his deficits were, and where he was in his recovery. But that's where our job comes into play. You have to be able to recognize these subtle things that some people might just overlook because we're spending the most time with these patients, besides their nurses. We're looking at other things that their nurses aren't. I mean, we're spending one-on-one time looking at them directly in the face, assessing their body every single day, and nobody else does that. And so, a lot of it relies on us to say, "These are the small changes we're seeing. And no, we cannot give up. We have to keep pushing because he's making small improvements." And so, I just remember him getting to the end of it and being so thankful to all of us. And his family was so thankful. It was just an incredible story. I'll never forget, and I'm sure the colleagues I worked with will never forget it either.

Mattie Murrey

For those who don't know, what is locked-in syndrome?

Bret Stuckenschnieder

So, it's essentially [when] your brain is active, but your body is essentially paralyzed. Your body from your neck down — even sometimes your facial movements, besides your eyes — everything is paralyzed, except your eyes. So, you're thinking. You're understanding. It's like being in a comatose state, but you're aware. You know, you see what's going on. You just have no control of anything but your eyes. And you're "locked in." You're stuck. You're in this space where it has to be incredibly scary because your brain's working. You're still yourself, but your body is gone. And so, it's like those horror stories where we hear people who are in surgery and they wake up in surgery, but they have no ability to talk, they have no ability to communicate that they're awake. They have no ability to move. It was kind of a similar circumstance, but more from a brain injury standpoint.

Mattie Murrey

Excellent stories to share why we do what we do. Final question: What words of advice would you give SLP grads, clinical fellows, or transitioning SLPs?

Michelle Lytle

I would say... My advice is always to just keep asking questions. Even in a new setting. Even if you've been here for almost 10 years, like I have. I'm always asking questions, and I always tell my students, you know, you're never not learning something. And the day that you think that you know it at all is almost the day that you're doing a disservice to yourself [and] your patients in the field because things are always changing. And it's impossible to know at all. And so I always, always tell my students and always tell new clinicians and even parents, "Please don't ever hesitate to ask questions, collaborate." Bret and I just called a colleague the other day about a patient for some advice. That would be my number one. And also, to really work on building rapport with the people — not only the people you work with, but in our setting, it's so important (Bret kind of touched on this), you know, establishing good rapport with doctors, nurses, the dietitians, social workers. It's kind of what makes the whole hospital go around. And if we are in good standing and have established a great relationship with those members of our team, we're going to be successful and our patients are going to be successful.

Bret Stuckenschnieder

Yeah. I don't think Michelle could have said it any better. I think the medical setting of this job is such a rarity to learn about in grad school. A lot of it you're learning on the fly, and you're going to be introduced to things that you don't quite have a full grasp on. And that's good. That means it's pushing you. Only people who have been, you know, working in acute care for 25 years can have a pretty honest grasp of everything that's going on, and even then, they're still learning. So, a lot of speech therapists are Type A, and they don't ever want to be wrong, and they want to show that they know everything. I'm including myself here. There's a lot of putting your pride aside because you don't know everything. You have to have to ask. You have to research things. You have to be open to the possibility that you could be wrong, and that likely you're going to be wrong several times. That's all part of the learning process. And don't just go in on your own and develop these harmful learning tactics that are incorrect, or you're practicing this way because it's how you've been doing it your whole life, when that way is wrong.

So, I think that what Michelle said is the most pivotal thing, that you just have to keep striving to learn more, and not just in the field of dysphagia. You know, the whole head, neck, everything. Learning about neuroanatomy. Learning about the function, the muscles, everything that is involved with the things that we evaluate for. Because, unless you know everything to a T, you don't really know how to treat it. You have to know where the root of it is, and that's how you target. So, I think just continuing to strive to learn. Reading up on the latest articles, research articles. Reading even different specialty books, you know? I'm in the process of reading a book on otolaryngology, just because they want to know more about the head and neck, and I want to see what is going on and how to speak to doctors in their own terms. I think that's the biggest thing, my motivation to do that. It's because I want to be able to use their terminology

so they can think I know what I'm talking about. And we do. And you know, they always say, "Fake it 'til you make it." And that is a part of it. You can never put your guard down. You have to act like you know what you're talking about. Otherwise, you know, this field is competitive and it will not allow for that.

Mattie Murrey

Well, thank you, Bret and Michelle. This was wonderful. Excellent. We went so far longer than we normally do, but there was so much to cover and so much to share. So, thank you for coming on.

Michelle Lytle

Thank you for having us.

Bret Stuckenschnieder

Thank you so much.