Ethics in Speech-Language Pathology: Beyond the Codes and Canons

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Abstract

Ethical codes, such as CASLPA's Canon of Ethics, ensure that clients' rights are protected over and above what is simply prescribed by law. However, ethical dilemmas often arise in everyday practice for which the code does not provide specific guidance. For example, is there a moral cost to the quest towards acquiring a better voice or dialect, or "reducing" one's accent? Four principles of clinical ethics may guide ethical decision-making in speech-language pathology: (1) autonomy; (2) beneficence; (3) nonmaleficence; and (4) justice. Ethical decisions require consideration of a number of factors, including that which is most important to the client: his or her identity. Consequently, speech-language pathologists must not only follow their professional codes of ethics, but they must look beyond the rules and regulations and identify ethical elements within daily practice. Therefore, the purpose of this article is to: (1) review relevant ethical terminology and the foundations of professional codes of ethics; (2) illustrate the application of clinical ethics using a case example; and (3) examine ethical implications for both research and clinical practice. The paper concludes by demonstrating the need for an ongoing clinical ethics forum.

Keywords: professional ethics, clinical ethics, canon of ethics, speech-language pathology.

Maria is a 67 year old Italian-Canadian woman who has been married for forty-seven years, has three married children and seven grandchildren, and lives in a rural community in Canada. Maria has lived in her town for fifty years and although she speaks Italian (her primary language) with her husband and some older members of her community, she has learned English and uses it in a limited fashion with her grandchildren. She has a history of hypertension and needs bilateral hearing aids due to a progressive hearing loss. Suddenly, Maria's life changes when she suffers a cerebrovascular accident (CVA) (i.e., stroke). The stroke leaves Maria temporarily dependent on nasogastric tube feeding for nutrition and with moderate expressive...
as professionals is found in the client–clinician relationship (Sloan, 1992). In fact, the foundation of many codes and canons of ethics (provincial and federal associations, colleges, etc.) in speech-language pathology requires us to hold the interests of our clients paramount. Inherent in this principle is that communication is a foundation of human dignity, freedom and agency (Catt, 2000). These considerations are of utmost importance when making decisions in clinical practice and in fact constitute the ethics of our practice. In the brief case study of Maria, we encountered the longing for human connection, the basic need for self-determination, a poor respect for autonomy, lack of informed consent, and questionable clinical judgment. When examined closely, the S-LP involved in Maria’s case could be considered to be in violation of her professional code of ethics and could be held accountable under the review of an ethics committee (e.g., complaints committee, discipline committee). Ethics in speech-language pathology, however, constitutes more than just the rules and regulations of the profession. To understand these claims, we must not only become more familiar with our professional codes of ethics, but we must look beyond these codes and be aware that all clinical decisions can have ethical implications. The perspective of the client and what constitutes his or her moral community (i.e., national, cultural, linguistic, religious, professional, etc.) must always be considered of primary importance when making clinical decisions. Ethical codes and principles provide a safeguard that clients’ rights will be protected. Although laws outline the minimum conditions that any ethical code must meet, ethical codes go beyond the law in specifying ethical principles and ideals that professional conduct must meet over and above what is prescribed in law.

The purpose of the present article is to: (1) provide a review of ethical terminology and the foundations of professional codes of ethics; (2) illustrate the application of clinical ethics using a case example; and (3) examine ethical implications for both research and clinical practice. First, essential terminology and the foundation of professional codes of ethics will be examined. This discussion will be followed by a review of the principles of clinical ethics including autonomy (selfhood and decision making), beneficence (do good), nonmaleficence (bring no harm), and justice (equality to all). In order to illustrate these principles, Maria’s case will be re-examined, as well as other brief examples from speech-language pathology. Further, ethical issues from speech-language pathology will be examined relative to a client’s perspective and identity. Following this discussion, a framework for ethical decision-making will be outlined. Finally, implications for both research and clinical practice will be discussed.
Professional Ethics: Examining the Canon of Ethics

Ethics is a branch of philosophy that studies the concepts of good and bad, right and wrong. Ethical standards and rules, whether they are moral or professional, or personal, are guidelines for realizing what we ought to do and what we ought to refrain from doing relative to conduct that is harmful to clients, to the profession, to the profession's code of ethics, or to the profession's standards in speech-language pathology—in part on the fact that it is a learned, scientific profession. Bernat (Reed & Evens, 1994) states that a learned profession includes a focus towards service, possesses a circumscribed and socially valuable body of knowledge, determines its own standards of knowledge, is largely free of outside control, and has a code of ethics that governs clinical practice. The purpose of a code of ethics is to help guide the clinical practice of a profession. It is the code and an educational tool, outlining what requires ethical scrutiny and attention, and a regulatory tool, outlining shared principles and procedures for dealing with ethical problems.

The Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) has written their own code of ethics, which is received by CASLPA (CASLPA, 1992). Although other codes of ethics exist (e.g., provincial associations and colleges), they are all based on a shared moral and legal foundation and, therefore, the CASLPA's code serves as an example. It is also the code appropriate to review the CASLPA's code of ethics for the professional organization to receive a CASLPA's member's CASLPA. CASLPA's code of ethics was created to reflect the beliefs and philosophies of its members regarding standards of integrity. It thereby encourages unity among professionals and collective accountability, and ideally fosters a common level of service. The CASLPA's code is divided into three sections, first related to duties and responsibilities to the client and public, second addressing duties and responsibilities to the profession, and third, a general section on the end of the document that addresses general professional conduct (CASLPA, 1992).

The CASLPA code's first rule requires that clinicians meet national membership requirements and/or provincial registration (CASLPA, 1992, p.257). The code further articulates that clinicians must be competent, be fair, and canons of ethics, as well as learn how to apply these principles. Codes and canons of ethics often are profession-centered, whereas clinical ethics is client-centered. These aspects of ethics and practice are both necessary and act to complement one another. If clinicians are to make decisions based on real-life dilemmas and circumstances, they must examine clinical ethics (Lo, 1993).

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Principles.
adhered to by professional ethics also are shared by clinical ethics. These principles are outlined in the following section and are further illustrated using the case of Maria, as well as others in 1 speech-language pathology context.

**Principles of Clinical Ethics**

Clinical ethics is guided by ethical principles developed by Beauchamp and Childress (1994; cf. Englehardt, 1996). The principles include different categories of judgments to be considered when making ethical decisions. These principles are autonomy, beneficence, nonmaleficence, and justice. These principles or guidelines do not have specific content until applied to particular moral agents in particular situations, and may even conflict with one another (Englehardt, 1996; Kluge, 1999). Bearing this in mind, each term will be defined and Maria's case will be used as the primary example to illustrate these principles. Considerations from other areas of speech-language pathology will supplement those principles found in Maria's case.

**Autonomy.** The principle of autonomy is grounded in our respect for fellow human beings, that is, respect for the person as a person (Beauchamp & Childress, 1994). Autonomy refers to the right to self (aut) rule (nomos), or the right to decide for oneself about one's life (Catt, 2000). With regard to health care, autonomy means that clients have the right to choose actions consistent with their values, goals, and life plans, even if their choices are not in agreement with those of family members or their caregivers, including physicians and other health care professionals. If a clinician acts on behalf of her client, she can only do so after explaining goals and potential benefits and harms of treatments, and the client must give the clinician permission to act in a certain way. That is, clinicians must achieve informed consent for their actions. The client has the most to lose in deciding about his or her health care. Consequently, his or her decision should override all others, assuming the client is capable of comprehending and appreciating the consequences of his or her decision. These same principles apply to researchers who recruit those with disabilities to participate in scientific study. In summary, respect for autonomy reflects the right for the person as a moral agent responsible for his or her own life (Catt, 2000).

In the case of Maria, there are many instances of the clinician violating the principle of autonomy. First, the clinician did not explain the reasons behind wanting to assess Maria's swallowing, nor did she ask Maria's consent to take this course of action. Further, she did not ask Maria about her goals for rehabilitation. For example, Maria's primary goal was to improve her communication with her family, yet these skills were not assessed or considered as an essential element of rehabilitation/treatment. Finally, after the S-1P was notified about Maria removing her NG tube and the health professional knew what was best for her client (Kluge, 1999), Maria, under the principle of informed consent and autonomy, had every right to disagree with her caregivers, and perhaps might not have done so if she had been given adequate information at this point about the dysphagia management. Despite suffering a stroke, Maria demonstrated good comprehension, and was deemed to have the capacity to make her own decisions. Furthermore, the fact that she had difficulty with communication because of her stroke, used English as a second language, and had bilateral hearing loss means that Maria was particularly vulnerable to this kind of disregard. The S-1P was ethically bound to ensure the autonomy of this client who had a communication and swallowing disorder, and this responsibility was not upheld.

The most important element of the principle of autonomy is informed consent. If a clinician's decision-making capacity about treatment interventions or other health-related matters is uncertain, an individualized assessment is in order. Capacity typically is judged by a health care practitioner or a team through observation and testing over time, and includes multiple levels (e.g., partial capacity may be defined in individuals who become confused at the end of the day or under the influence of medication and can make health care decisions when they are lucid) (Merck Manual of Geriatrics). Assuming an individual has the capacity to make his or her own health care decisions, these decisions must be upheld. For example, after a stroke or a head injury, an individual may be deemed unable by the health care team to care for himself at home. However, if that person is capable of making treatment decisions based on information related to the risks and benefits of returning home, then the health care team should defer to his decision. This is based on the principle that all individuals be treated as moral agents in deciding about their own lives (Merck Manual of Geriatrics). Other ethical issues may arise when caregivers are asked to make decisions on behalf of their family members, children, or spouses. Ethical dilemmas may arise when it appears that the wishes of the client himself or herself are at odds with his or her caregiver or when the perspective of the client is not valued. These issues can be especially prominent when judgments that promote "good" for the client conflict with his or her autonomy. In this light, the principle of beneficence is now examined.

**Beneficence.** Beauchamp and Childress (1994) describe beneficence as actions that are done for the benefit of others, as well as one's own good. What is "good" is defined by the client from his or her perspective, be it material, emotional, or spiritual in nature (Pellegino & Thomasma, 1993). In the case of
Maria, she was most concerned with improving her communication skills and, thereby, the ability to communicate expressed thoughts was important to Maria's emotional well-being. This consideration was not addressed by the S-LP. In addition, some good could have been derived. In order to determine what constituted to Maria's pneumonitis, and if there was a way to minimize the risk for a repeated occurrence. However, the clinician did not perform this assessment. In fact, this omission may have brought harm to Maria (see nonmaleficence).

Barker (2002) suggests that in order for “good” to occur, the treatment must be beneficial to the client. The benefit must be shown via “profile” outcomes and evidence demonstrating that the treatment works. For example, if the S-LP had gotten ahead with aphasia treatment for Maria, the S-LP would have been bound ethically to choose an approach that was suitable for Maria’s abilities as well as to be grounded in theoretical and empirical knowledge about aphasia. The S-LP also would need to consider the most important outcomes for Maria (i.e., those that would most affect her quality of life) (Barker, 2002). Finally, the S-LP would need a method of measuring these outcomes based on the multidimensionality of the problem (Coyte, 1992).

For example, S-LPs often must demonstrate and justify treatment for individuals with traumatic brain injuries (TBI) to insurance companies who are funding treatment. That is, clinicians must adhere to the highest standards of evidence-based clinical practice (EBCP). Although EBCP is difficult, S-LPs need to demonstrate that intervention is both necessary and ethically responsible. In Canada, it behooves clinicians to follow EBCP in all aspects of their practice. Despite funding shortages in our health care system, we often forget the liberty that we have in serving our clients (i.e., number of sessions, intensity of sessions, etc.) when compared with other health care systems in the world. These choices include the approach to treatment, including that which is a best not only for the client “profile”, but also for that individual. The clinician is also ethically bound to advocate on behalf of his or her client, not only to third party payers, but also to others who care for that individual, including family members, and other members of a health care team (CASLPA, 1992). For example, a S-LP may need to lobby others on the health care team to encourage a particular test or assessment (e.g., a physiatrist who does not see the benefit of a swallowing evaluation) (see the case of "Mike", Muirhead et al., 1995, p.188), or continued treatment (e.g., to promote a continuum of care at end of life) (Coyte, 1992) in order to best serve his or her client, and avoid harmful consequences.

Nonmaleficence. The counterpart to beneficence is nonmaleficence, which means actions that bring no harm. The principle of nonmaleficence may include issues that seek to take power away from clients, or actions that may be selfish or deceptive or even if well-intentioned procedures, in creating the risk of a negative consequence. For example, in Maria's case, the S-LP's recommendations of a formal swallowing evaluation were well-intentioned. Based on what the S-LP knew about Maria, the S-LP assumed that she knew what was in Maria's best interest and undermined the good that the client might have achieved by making her own decision on her own terms and in her best interests. In addition, the S-LP abandoned Maria after realizing that Maria had chosen not to “comply” with her treatment recommendations. The S-LP was ethically bound to find a compromise, and at the very least offer continued follow-up and guidance, as well as offer aphasia treatment. In abandoning Maria, the S-LP was doing “harm” and not allowing Maria to realize her full functional potential relative to her swallowing and communication difficulties.

Additional issues in speech-language pathology involving harm can arise with inadequate supervision of students and communicative disorders assistants, inadequate training and/or experience for performing particular procedures, in creating the risk of a negative consequence. These include the concepts of equality and fairness in all addressed in professional codes of ethics and regulated health protection acts in order to ensure an individual's rights, health, and well-being. These concerns also are most often cited as sources of professional and clinical ethical problems surrounding the care of individuals with communication disorders (Buie, 1997).

Justice. Beauchamp and Childress (1994) suggest that justice includes the concepts of equality and fairness. For example, individuals who are similarly situated should be treated in similar manners (e.g., all individuals who have had a stroke should be given the opportunity to be evaluated for a rehabilitation program). Fairness, however, is based on need. Not every person would have to receive the same treatment to be treated fairly, as this would vary on a case-by-case basis. For example, after a severe stroke, some individuals are not able to endure intensive therapy. Nevertheless, even if some clients receive more and some less intervention, the end result may be equal. Factor rendering "race, religion, gender, sexual preference, marital status, age or disability must not be used as factors for differential treatment" (CASLPA, 1992, rule 4, p. 257). For example, if there had been a younger stroke victim on the same ward as Maria who had garnered more attention and aphasia

treatment from the S-LP simply because of his age, this would violate the principle of justice and nondiscrimination.

Clinicians are ethically bound to truthful assessments of individuals with communicative disorders irrespective of influence from parents or caregivers who may wish a particular type of treatment (see the case of "Nicholas" in Muirhead et al., 1995, p. 192). Issues related to justice and equality of treatment also are often encountered and questioned in decisions related to access to treatment and limits posed by external factors (e.g., institutional policies, funding access, etc.), as well as how to prioritize treatment (Riise, 1997). However, if communication is an essential human "good", it would be a serious moral harm to deprive any client of the opportunity to use speech-language pathology services (Catt, 2000).

In summary, clinical ethics and its principles of autonomy, beneficence, nonmaleficence, and justice pervade everyday clinical judgments. As previously stated, clinical ethics is client-centered and, therefore, clinicians must examine each individual's values and wishes when considering the right course of action relative to each particular ethical dilemma. One's values and morals are based upon who we are as individuals — that is, personal identity. How an individual perceives himself or herself is influenced by age, gender, education, socioeconomic status, psychological make-up and personality, and cultural background, to name a few factors. Therefore, ethical issues also must be considered in light of these factors. Three examples from speech-language pathology are examined in the next section relative to these perspective and identity considerations.

Identity and the Client's Perspective

In his book entitled "Better than well: American medicine meets the American dream", American bioethicist Carl Elliott (2003) proposes that enhancement technologies are driven by the North American need to conform to the sociality in which one lives. There is an inherent tension between the "self" and how one "presents oneself". Elliott questions whether there is a moral cost to conform to the society in which one lives. There is an inherent tension between the "self" and how one "presents oneself". Elliott questions whether there is a moral cost to conform to the society in which one lives. Therefore, ethical issues also must be considered in light of these factors. Three examples from speech-language pathology are examined in the next section relative to these perspective and identity considerations.

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Gender dysphoria.

A second example offered by Elliott (2003) is that of male-to-female (MTF) transgenders. For postoperative MTF transgenders, success or failure of this effort rests on the ability to pass. Many North Americans can feel threatened, offended, or repulsed by the transgender identity. Failing to "pass" as a transgendered person can be both physically and socially dangerous. S-LPs may offer voice therapy to transgendered individuals to promote a natural-sounding voice for the chosen gender by targeting changes in pitch,
quality, intensity, variability, and intonation patterns in spontaneous speech (Geller, 1999). This type of therapy is unique to American English dialects; individuals feel this involves a degree of self-conscious impersonation. However, as false or alien as a female voice for a MTF transgendered individual can feel at first, many MTF transgendered individuals find it acceptable to use the voice as an enhancement technology (e.g., Botox to eliminate one’s wrinkles; drugs to eliminate normal anxiety) in which one strives to change one’s identity so as to raise one’s status in society.

Accent reduction and dialectal change. Finally, Elliott (2003) suggests a third example that seeks to illustrate the relationship between one’s identity and the search for the “perfect voice.” He notes that one listened to Al Pacino in the Godfather and how he would talk about the different dialects of the American South and that one would hear him spoken with a noticeable southern drawl. He then describes his meeting with a S-LP in the south who runs what he calls an “accent reduction clinic.” More specifically, this clinician was offering service to speakers of various American English dialects who wished to acquire proficiency in a dialect other than their own. The target of most of this therapy is Standard American English (SAE), given that this is the linguistic variety used by governments, mass media, business, education, science and the arts in the United States (ASHA, 2003b). Elliott’s (2003) ethical dilemma with this sort of therapy is that unlike a Chinese or Cuban immigrant who speaks English with an accent, the people who seek therapy from the S-LP in his example were raised to speak with a southern drawl. They are seeking therapy to change their “accents” (i.e., the dialect), but in doing so, Elliott (2003) asks whether they are rejecting who they are since this is part of their Southern culture and background. Several authors have used this type of reasoning in questioning the ethics behind mandatory dialectal change for those who speak African American English or Appalachian English (ASHA, 1987). Elliott (2003) argues that accent reduction is akin to other types of self-improvement strategies that are enas- trated by taking advantage of the perception (or perhaps the reality) that non-Southerners and Southerners themselves see a “southern accent” as something to be hidden or overcome. This type of therapy, he argues, is like an enhancement technology (e.g., Botox to eliminate one’s wrinkles; drugs to eliminate normal anxiety) in which one strives to change one’s identity so as to raise one’s status in society.

In order to address the ethical implications of arguments such as those posed by Elliott (2003), the American Speech-Language-Hearing Association (ASHA) has drafted a technical paper (ASHA, 2003b). In it, ASHA asserts that every dialectal variety of American English is functional and effective and serves a communicative as well as social-solidarity function. Each dialect is a symbolic representation of the geographic, historical, social, and cultural background of its speakers. Given this recognition, a S-LP must recognize what is a true language difference versus a language disorder, in addition to being attentive to the personal and cultural identities of speakers of different dialects. When a language difference exists, a client may elect to seek the assistance of a S-LP given the advantages of learning to speak SAE. Despite the carefully worded statement regarding American English Dialects (cf. ASHA, 2003b), Elliott (2003) reminds his readers of the underlying ethical dimension in the words that are used for this kind of “treatment.” For example, an individual with a Southern accent seeks out a speech-language “pathologist,” to undergo accent “reduction therapy” in a “clinic” (i.e., implying it is something that has gone wrong and deserved from the norm and therefore, needs treatment). The purpose of this discussion, however, is not to judge whether this type of therapy is “right” or “wrong,” but rather to raise clinical awareness of the ethical dimensions that are associated with a particular situation that is within the scope of professional practice in speech-language pathology.

All three of Elliott’s (2003) examples illustrate how one’s identity and self-perception can affect decisions made in a clinical setting. Although subtle, the examples raise awareness of the ethical dimensions and implications of clinical decisions. The underlying message of these illustrations is that when clinical decisions are made with a client, the S-LP always must ensure that she or he understands the perspective of the client in order to best address the four principles of autonomy, beneficence/ nonmaleficence, and justice. The process for making those decisions in an ethical manner is outlined in the following section.

Implications for Practice: Making Ethical Decisions

Ethical implications from a variety of situations were outlined in the previous sections of this paper. However, becoming aware of these ethical dimensions is only the first step to helping S-LPs make ethical decisions. Before outlining the problem-solving process, it is necessary to examine three types of ethical dilemmas (Catt, 2000). The first occurs when moral obligation and self-interest conflict. The health professional has obligations to the client but his or her own interests consciously or unconsciously influence the choice of treatment (Catt, 2000). For example, if the S-LP in Maria’s case believed that a younger client on the ward should receive more speech therapy than Maria because of that person’s age, the S-LP would be putting her own biases ahead of her obligations to Maria. In this instance, an ethical dilemma could arise. The second type of dilemma occurs when a situation of moral uncertainty exists in that some evidence indicates that the act is morally right, and some evidence indicates that the act is morally wrong. Evidence on both
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...and pattern of decision making was like, what was considered rewarding or unacceptable in his or her life, sort of person this was when capacitated, what his or her interests of others. For example, what must be gathered from family and friends, as well as...of clinical ethics outlined by Beauchamp and Childress (1993): autonomy, beneficence, nonmaleficence, and justice, as well as other pertinent factors. In order to illustrate the problem-solving sequence of ethical decision-making, the case example of Maria will be re-examined.

Ethical decision-making process. First, all empirical data should be gathered, including clinical, social, cultural, religious, psychological, and economic factors, as well as other personal factors pertinent to the problem. The dilemmas experienced by the S-LP will, in part, help determine which of these factors are most relevant to the resolution of the conflict. In Maria’s case, there is much detail that was not considered by the S-LP and the health care team. For example, Maria came from an Italian family in which food and realtime were especially important in family relationships and roles. The S-LP should have considered these aspects when making decisions about Maria’s dysphagia management. This consideration made the explanation about possible risks of aspiration and other related problems even more important for Maria and her family to understand. Additionally, Maria was known as being “very social, and quite a talker” before her stroke. Her aphasia afterwards hampered her ability to communicate in both Italian and English, and left her feeling not only frustrated but upset about the change in her communication abilities. Finally, Maria had been the one to make meals for her husband and to perform certain roles in her household before her stroke. This new dependence on her family and her husband for both nutrition and communication left her feeling uncomfortable about this change in their roles and relationships. All of these factors should have been considered by the S-LP in making any decisions about Maria’s aphasia or dysphagia treatment.

The second factor to consider is ethical problem-solving holds that the autonomy (interests of the client are paramount) to any decisions made about that individual. Further, if the individual is not deemed to have the capacity (or is legally incompetent) for decision-making related to health care, then facts about that person must be gathered from family and friends, as well as considering the interests of others. For example, what sort of person this was when capacitated, what his or her lifestyle and pattern of decision making was like, what was considered rewarding or unacceptable in his or her...and how he or she evaluated the quality of life and a meaningful existence are all facts of great importance when evaluating substituted judgment (Merck Manual of Geriatrics). In the case of Maria, she was deemed incapacitated to make her medical decisions, despite expressive language difficulties. This is the principle most often violated by the S-LP, who should have given her the opportunity to make decisions regarding her course of treatment (e.g., medication, diet, speech therapy) in order to respect her as a moral agent.

Third, beneficence and nonmaleficence require careful analysis of the interests and obligations of the parties involved. For example, it is most likely to be the most affected by the outcome of the decision, and therefore, that person’s interests should remain the overriding factor. In Maria’s case, the clinician and other health professionals should have discussed the nature of therapy (e.g., aphasia vs. dysphagia) and what was most important for Maria to achieve in order to make a meaningful change in her life.

Fourth, the process must be just, in that people are treated fairly and resources are allocated in an equitable and just manner. Barker (2001) outlines an ethics framework suggested by Dr. Michael Coughlin, an Ethics Consultant for St. Joseph’s Healthcare and Associate Professor at McMaster University in Hamilton, Ontario. This framework includes: (1) acknowledging your own feelings as a professional; (2) identifying the problem and possible conflicts; (3) determining ethically relevant facts such as diagnosis, prognosis, and other factors; (4) considering alternatives for treatment and likely consequences; (5) examining the values of both the client and others; (6) evaluating alternatives including a ranking and justification of client values and goals; (7) articulating the decision relative to the values; and (8) implementing the plan. This framework could be used throughout the decision-making process. Finally, the actual statement of the decision in addition to its implementation should be reconciled with professional ethics, institutional policy, and legal principles (Barker, 2001).

Clinical and research implications. Coughlin (in Barker, 2001) states that by using his framework for ethical decision-making, ethical problems and dilemmas are not always solveable, but only resolvable. While autonomy and holding the client’s interests are paramount, there are inevitable conflicts with competing ethical principles. This tension is commonly felt by clinicians, particularly when resources that are currebly available conflict with a client’s best interest (i.e., beneficence/nonmaleficence) (Muirhead et al., 1995). One must also remember that resolution of problems may mean the exclusion of the worst of many undesirable alternatives (Barker, 2001). One’s responsibility for providing ethical care, therefore, becomes a matter of broadening one’s clinical perspective and recognizing obligations to the client, the profession, and society.

Ethical obligations also are demonstrated in the search for efficacious treatment outcomes in research, establishing clinical guidelines, and determining decision-
making policies (Murhead et al., 1995). At the heart of these investigations is the use of a clinical framework for assessment and treatment that is most meaningful to the clients whom we serve (Coyte, 1992). Further, it is a speech-language pathologist's ethical responsibility to continue to protect the rights of individuals with communication disorders to the social and political arenas. This is especially important in times of scarce health care resources: S-LPs and other health care professionals must continue to prove their value and worth to those who provide financing for these decisions. This continued lobbying is necessary in order to protect the good that comes from the provision of speech-language pathology services to those most vulnerable to manipulation—those individuals with communication disorders.

In the interim, it would benefit all S-LPs in Canada to continue to discuss these issues with colleagues, both in informal and formal manners. One method of discussion may be through use of CASLPA's online learning portal that was created for this very purpose—for the discussion of current professional issues among CASLPA members. Other associations in North America already use the internet as a forum for discussing clinical ethics. For example, ASHA uses its online "Ethics Roundtable" to provide clinicians with a forum to discuss ethical issues (ASHA, 2003a). Current topics include: (1) assessing and treating individuals with diverse cultural and linguistic backgrounds; (2) ensuring confidentiality; (3) examining ethics in research; (4) discussing parent vs. clinician wishes for children with communication disorders; (5) examining differences between ethical and legal obligations; (6) supervising students; (7) prescribing hearing aids and (8) examining issues related to end-of-life care. Although Canadian interests are often similar to their American counterparts, the Canadian health care system uniquely provides its own considerations. Thus, a CASLPA forum would help clinicians understand the legal and ethical underpinnings of the canon of ethics, as well as helping colleagues make difficult ethical decisions.

Conclusions

The purpose of this paper was to: (1) summarize and review ethical terminology, as well as responsibilities of professionals in general, and S-LPs in particular, is to serve the interests and values of their client as defined by the client (Catt, 2000). A professional ethical code is grounded in moral theory, and is highlighted in the trust and compassion that form the foundation of client- clinician relationships. Similarly, this foundation is found in the principles of clinical ethics: autonomy, beneficence, nonmaleficence, and justice. These types of ethical judgments were illustrated by examining an instructive case example. More subtle ethical issues were examined through the theme of identity. Elliott's (2003) case examples were also examined to illustrate how one's perspective can change the ethical outcome of a clinical decision. Finally, on ethical decision-making process was outlined and ethical implications for both research and clinical practice were discussed.

Each individual with a communication disorder has a story, a set of values and a perspective on what is important in his or her life. Ethical implications are derived from these factors. As health professionals, we confront moral uncertainty, conflicts, and discomfort in daily practice. However, a moral community, we should strive on behalf of our clients to be reflective, self-conscious, virtuous and bound to our ethical principles. Through this process and a continued clinical forum, we will arrive at a deeper understanding of the ethical duties engulfing the profession of speech-language pathology.

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Footnotes

1 This article's treatment of dignity, agency and freedom relative to human rights was adapted from Gewirth (1996) and Cap (2000). For comprehensive examination of biomedical ethical theory and guiding principles, the reader is referred to Beauchamp and Childress (1994) and Pellegrino and Thomasma (1988, 1993). The reader also is referred to Muirhead, Griener, and James (1995) for an examination of principle-centred decision-making in human communication disorders, as well as to Barker (2001, 2002) or Cascella (2002). For application to clinical dilemmas, the reader should see Jonsen, Siegler, and Winslade (1998) and Lo (1995). Finally, a tutorial by Catt (2000) is extremely helpful in outlining ethical terminology and other ethical examples in clinical practice.

2 The CASLPA Ethics Committee has recently revised its canon of ethics to update its language and philosophies to agree with modern practice. The revised canon is now called a code of ethics. Although its philosophical foundations remain the same (autonomy, beneficence, nonmaleficence, justice), the rules are structured differently. Because of this, the rules outlined specifically in this manuscript may not coincide exactly with the new code. Values such as integrity, professionalism, caring, respect, high standards, and continuing competency are held as core to each of the areas addressed (e.g., professional competence, delegation, telepractice, informed consent, etc.). It is anticipated that the code of ethics will be available in late spring 2005, after it is approved by CASLPA's Board of Directors.

3 The Principilist approach to ethical decision-making advocated by Beauchamp and Childress (1994) is probably the most popular. Institutionally entrenched, the approach to professional ethics in North America today. But it is not the only approach. Other approaches and perspectives include virtue ethics, casuistry (e.g., Jonsen & Toulmin, 1986), feminism (e.g., Sherwin, 1992) and even anti-theory (e.g., Elliott, 1999).

4 Although the terms capacity and competence are frequently used as synonyms, the terms have different meanings. Competence is a legal status usually declared at age 18 when a person has the "cognitive ability to negotiate certain legal tasks, such as entering into a contract or making a will" (Merck Manual of Geriatrics). A court of law determines whether an individual is competent by reviewing the results of functional assessments of decision-making abilities. Those deemed incompetent are appointed a guardian who then has power to make legal decisions.

5 It is possible that a professional's personal ethics may conflict with the professional demands of her occupation (e.g., a physician who does not believe in performing abortions due to personal religious beliefs: a pharmacist who does not wish to dispense the "morning after" pill because he or she does not believe in abortions). In such cases, referral to another professional is sometimes considered an acceptable response. This problem is dealt with in different ways by different professions depending on the nature of the problem and the conflict in question.

6 CASLPA's online learning portal can be found at: http://www.learninglibrary.com/caslpa/. ASHA's Ethics Roundtable can be found at: http://www.asha.org/about/ethics/ethics-education/default.htm.

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