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Ethical practice in speech pathology

Speech
Pathology
Australia

Acknowledgements

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Editorial

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The Ethics Board has produced an ethics supplement containing all the articles in *JCPSLP* written by members of the Ethics Board and colleagues over the past decade. For almost 10 years, Ethics Board members, professional colleagues, community members and National Office staff have been contributing to the body of knowledge about speech pathology practice and the national Code of Ethics that binds all members.

The Ethics Board has increasingly strengthened its commitment to member education in a variety of ways taking a pro-active and educative approach to ethical practice, ethical dilemmas, ethical problems and decision-making for all members. This includes those who are newly graduated as well as more experienced clinicians, academics and researchers who have developed a repertoire of strategies to deal with ethical problems in the workplace.

One of the primary goals of the Ethics Board is to respond to questions about ethics and develop education and training materials for members. To this end, the Ethics Board undertakes a workshop every year at the Speech Pathology Australia National Conference, which always has full attendance and stimulating debate. Following the 2010 revision of the Code of Ethics, the Board has recently revised and significantly updated the Ethics Education Package and developed a work book for members. Both the package and the workbook can be downloaded from the Speech Pathology Australia website and members can undertake activities, read theory, participate in team discussions and record their work. Work undertaken in the Ethics Education Package will be eligible for Professional Self-Regulation (PSR) points. In addition, the Board contributes a regular article or column to the *JCPSLP* (or the *ACQ* as it was known until a few years ago).

The Ethics Board has decided to aggregate all the articles written over the last decade into a single ethics supplement so that members can use this as an easy resource to add to the educational material available to them.

The Ethics Board understands that leaders who want to establish a practice of positive workplace ethics within their organisations should develop written ethics standards, provide ethics training and ensure that resources are available to staff who need advice or find themselves in ethical dilemmas. Speech Pathology Australia is at the forefront of this approach in developing a strong aspirational approach to ethics, a robust national Code of Ethics, comprehensive training material and a number of places where dialogue, debate and questions about ethics can be raised and discussed in a safe and constructive way.

Speech pathology is a comprehensive discipline that has a number of self-regulation functions built into the structure and function of the membership body. Speech Pathology Australia's reputation in dealing with ethical issues is growing and is seen as sustainable within the communities and sectors within which we operate. The Ethics Board uses a number of different fora to ensure that there is open and legitimate debate about ethical issues and that members and the community have avenues to raise areas of concern. The fact that we have a published set of procedures that are clearly defined and transparent engages members and the community to trust the Association in our ability to manage complaints and to ensure continued self-regulation.

The Ethics Board provides frameworks for members whereby they can consider how they make ethical decisions, what assistance they might need and how to develop a self learning approach to the application of ethics in standards, practice and behaviours.

We hope that you find this ethics supplement to be an accessible resource that you can draw on in your own reflective practice, whatever your stage of your professional journey.

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Emerging trends impacting on ethical practice in speech pathology

Marie Atherton and Lindy McAllister

The significant societal, systemic and technological changes of the past two decades have contributed to a number of specific challenges that the health system now faces. The increasing diversity and sophistication of health technology, the proliferation of legislation, the ageing health workforce and changing community demographics are key trends impacting on the future viability of health service provision within Australia and internationally. These trends will also impact on health practitioners' ability to provide care that meets demand while simultaneously meeting the moral and ethical considerations which are inherently tied to health service provision. In 2006, Speech Pathology Australia members identified a number of key ethical concerns related to these trends and challenges, including not only those that arise at an individual client–practitioner level but also at a systemic level. Specifically, Speech Pathology Australia members expressed concern regarding prioritisation of services, the impact of fiscal constraints on service delivery, and the potential for conflict between professional values and values that may underpin management decisions and health policies. Ethical issues associated with the delegation of tasks, the need for continuing professional development and the use of evidence-based practice were also identified. For the profession to meet current and future challenges, it is essential to remain vigilant and responsive to trends and changes that will impact on service provision. Practitioners must also demonstrate an ethical awareness that extends beyond specific "ethical dilemmas" as may arise in clinical practice to thinking and acting ethically in our daily routines.

The speech pathology profession has undergone significant change over the past 15–20 years, and these changes have important implications for the ethical practice of speech pathology. The knowledge and skill-set of the discipline have changed dramatically due to both internal and external forces. Changes in work settings, types and complexity of clients, new technologies in health care, and reimbursement for services continue to raise new challenges for speech pathologists as they seek to implement evidence-based ethical practice. Emerging technologies that can be used for telehealth, a growing trend for working in developing countries, and social models of practice offer exciting opportunities for expanding our practice along with increased risks to ethical practice.

Key trends impacting on ethical practice

A number of key trends raise the possibility of ethical risks to speech pathology practice as a whole.

Increasing health demands from an ageing population

The fact that Australia's population is ageing contributes to an increasing need for health services both in primary and tertiary care (Australian Government Productivity Commission, 2005). The increasing demand for limited health services poses a number of ethical considerations for the health practitioner. There is a need to ensure the limited health dollar is used most effectively and efficiently, but also to determine, at a transparent level, who will benefit from the limited health dollar and who will miss out. Often the speech pathologist must adhere to the directives of individual organisations regarding prioritisation of caseload, while at the same time making independent decisions regarding how prioritisation should look. This often presents many ethical challenges for clinicians who must work hard to meet both client and organisational needs in an ethical manner.

Furthermore, the increasing demographic of well-educated, articulate and financially well-off elders will see a rise in demand for more intensive and conveniently located services, in community settings and/or client's homes. The challenges and opportunities this will pose in relation to service provision by speech pathologists are likely to include the increasing use of allied health assistants, the use of telehealth and an increased emphasis

on community-based models of service delivery. Some of these issues will be discussed later in this article.

Increased prevalence of chronic disease and disability

Advances in the medical and surgical management of a range of conditions, diseases and injuries have reduced mortality, but increased morbidity and life expectancy. Examples include the improved survival rate of very premature infants and the survival of persons with severe head injuries. Life-prolonging procedures and technologies result in survivors now presenting with significant long-term disabilities that extend to communication and swallowing. As is likely the case with all health professionals, speech pathologists may hold concerns about the quality of life that ensues for people living with severe and complex disabilities.

Concerns may exist in relation to service provision for persons with chronic disease and disability; specifically, where this service should sit as part of a larger caseload, and how the speech pathologist should maximise the potential of clients with chronic disease and disability within the limited available resources. Ongoing limitations in the health budget will continue to place pressure upon clinicians to demonstrate the benefits of intervention with this group of clients, as with all clients; however, such gains may be more difficult to quantify if they are made over extended periods of time as is often the case with chronic disease and disability.

Chronic shortage of health workers

The chronic shortage of health workers in Australia has been recognised by both state and federal governments, and a suite of initiatives have been proposed to address the inherent problems of inadequate service provision (Australian Government Productivity Commission, 2005). For the speech pathologist, as with all health workers, a number of ethical considerations arise in relation to this, apart from those addressed earlier in relation to caseload prioritisation.

Speech pathologists may, on the one hand, consider that any service is better than no service. However, when armed with the knowledge and evidence that outcomes are maximised by certain types of interventions provided over certain timeframes, speech pathologists face a dilemma as to how and what to provide. Cost-driven decisions based on ever-increasing waiting lists and caseloads may force clinicians to terminate client treatment even though the potential for ongoing client gains is very real.

The increasing profile of allied health assistants and support workers reflects the unmet demand for health services. Suitably qualified allied health assistants offer an opportunity for allied health practitioners not only to increase the level of service provision to clients, but also to expand the profession's scope of practice. The concern for the speech pathologist, however, may be in understanding the role of the allied health assistant and the adequacy of their prior training, and in determining what type of work should be delegated. While guidance is provided to the profession through the *Parameters of Practice* document (Speech Pathology Australia, 2007b), this document reflects the position of the membership only and as such may hold only limited weight with other key stakeholders. Given that legal and professional responsibility rests ultimately with the clinician, the speech pathologist may grapple with questions related to the type and quality of services to be provided by allied health assistants, the degree of supervision that should be provided, and the mechanisms

that must be in place to ensure client outcomes and safety are maximised. The issue of protectionism and its potential to limit the development of the allied assistant role will need to be addressed by the profession, as will the standards of allied health assistant training, supervision and monitoring.

Increased complexity of clients and settings

Speech pathologists are providing services to clients who are sicker, and who present with more complex conditions, in more complex medical and community settings than ever before. Practitioners rightly express concern regarding the acquisition of skills and competencies to meet the demands associated with working effectively and safely with such clients. Unless a clinician is working in an organisation which has a well-developed competency attainment program, the individual clinician may be left to determine whether they possess the skills and knowledge that is required. As stated in the Association's *Code of Ethics* (2000), as practitioners we must "recognise the limits of our competence" (p. 2). This issue may be further compounded when an organisation does not acknowledge the benefit or need to support the clinician in attaining the necessary skills. A situation may then arise where the clinician must decide whether to refuse to see the client, see the client and engage in practice outside their level of expertise (hopefully while simultaneously engaging in professional development and mentoring to achieve competence in management of such clients), or refer the client on to another service, if indeed one exists. Clinicians and clients jointly must decide whether any service is better than no service, if geography or client immobility or social isolation preclude access to other more skilled clinicians.

Increasing client complexity has also coincided with increasing costs associated with professional indemnity insurance and with increasing rates of professional litigation. Practitioners, while acknowledging the right of all clients to receive the best care available, may be reluctant to engage in clinical practices that have the potential to pose an "increased risk" to the client. Not only does such a decision, based upon fear of litigation, restrict client autonomy in relation to their treatment, it also curbs aspects of speech pathology practice.

The increasing complexity of clients also raises the issue of caseload prioritisation. Nowhere is this more evident than in the profession's increased focus on the management of clients with dysphagia. The emphasis upon reduced length of hospital stay and community-based rehabilitation has seen those clients with dysphagia prioritised over those with communication problems. This surely poses an ethical dilemma when the maximisation of both communication and swallowing functions is (and must remain) a joint priority of the profession. Such situations are premised on the need for clients to be "safe" enough to discharge. Safe swallowing is undoubtedly needed, but so too is "safe" communication which will allow a client to maintain some level of social interaction with family and community to preserve mental health, and for example, to call for help in emergencies.

Increased emphasis upon evidence-based practice

The need for speech pathologists to inform their practice through the best available evidence was addressed in the first of the "Ethics conversations" columns (Eadie & Atherton, 2008). As noted in that article, "best evidence needs to be integrated with clinical reasoning in order to

make ethical decisions around service delivery for each of our clients" (p. 94). Undoubtedly, it is an ethical responsibility for individual clinicians to know what the literature says and what the available evidence is.

It is also critically important that speech pathologists stay abreast of developments in clinical knowledge and practice by engaging in continuing professional development (CPD) – this is an ethical responsibility, as reiterated in the Association's *Code of Ethics* (2000): "We strive to continually update and extend our professional knowledge and skills… and work towards the best possible standards of service to our clients" (p. 3).

Ethical concerns may arise, however, when due to caseload and other demands, time is not available to undertake CPD and/or access to relevant facilities and technology, such as the Internet, is restricted. This may be particularly the case for those services limited by budget and for those clinicians in rural and remote areas where access is not reliable. Such situations raise questions of "whose responsibility is it to ensure competence and fitness for practice: the employer's or the speech pathologist's?" Where employers decline or are unable to support CPD, our ethical duties to clients and colleagues and the profession mean individual speech pathologists must assume responsibility (and cost, in dollars and time) for their own CPD. The means by which a practitioner ensures currency of knowledge and ongoing fitness to practise may require creative and lateral thinking. A willingness to access mentoring, to engage the assistance and expertise of colleagues, as well as devote time to ongoing education may conflict with long waiting lists and organisational targets.

Extended scope of practice

The ongoing development of our profession together with workforce re-engineering precipitated by the health workforce shortage will lead to changes in our scope of practice. At one end of the continuum, scope of practice will extend to include roles and tasks not currently part of our practice, and at the other end our scope of practice may retract as more tasks are delegated to assistants or other professionals. Considerations in relation to changed scope of practice highlight a number of key professional issues: identifying the scope of speech pathology practice, determining the role of governance and risk management frameworks, specifying responsibilities for supervision of those to whom tasks are delegated, and determining the boundaries of legal liability.

Speech pathology practice in Australia is informed by key Association documents such as *Scope of Practice in Speech Pathology* (Speech Pathology Australia, 2003) and *Parameters of Practice* (Speech Pathology Australia, 2007a). Association position papers further inform specific areas of specialist clinical practice – for example, *Dysphagia: Modified Barium Swallow; Tracheostomy Position Paper; Fiberoptic Endoscopic Evaluation of Swallowing* (Speech Pathology Australia, 2005a, 2005b, 2007a). However, a speech pathologist's involvement in particular clinical practices will always be dependent upon a number of key factors including the preferred model of service delivery of an employing organisation, the support and explicit authorisation of an employing organisation for speech pathologists to perform particular tasks, access to training and demonstration of competence, and consideration of clinical governance issues. The challenge for the practitioner will be to ensure that service delivery models

in which they work meet the requirements of minimising risk and harm, while at the same time facilitating new skill development and ongoing expansion of the profession.

Community expectations

Through access to the Internet and other forms of media, consumers are now better informed about health care services. They have a greater expectation that services provided will reflect best practice and will provide value for money. This expectation requires practitioners to remain abreast of current knowledge and practice, and the information gleaned will arm consumers with the confidence to question practices which may be inappropriate or outdated. In addition, consumers may request services they have read or heard about which our profession considers to be unsupported by evidence. Speech pathologists will therefore need to be aware of the evidence across the range of their practice and be able to explain and defend their recommendations for management.

Increased consumer expectations will also inevitably lead to demand for more convenient location of services, including services closer to home and actually in the home. Practitioners therefore will need to consider new models of service delivery. As services increasingly move from secondary and tertiary medical settings to primary care (community-based) settings, practitioners may need to extend their repertoire of skills in needs assessment, training of others, delegation of tasks and supervision and mentoring of assistants, volunteers and carers.

Telehealth offers considerable promise for more flexible community-based and domiciliary service delivery. Elspeth pathology using high-end video-teleconference suites is already in use across Australia, enabling practitioners in major centres to provide services to rural and remote clients. Elspeth pathology using web-based delivery into clients' homes is rapidly becoming an option (Theodoros, 2008). These developments raise a number of ethical and legal concerns including maintaining privacy, confidentiality and security of information transmitted and held in electronic health records (Stanberry, 2000); ensuring standards for providing legally and professionally recognised services (Reed, McLaughlin & Milholland, 2000); and sorting out issues of reimbursement for services delivered by telehealth (Chetney, 2002). A growing ethical concern about telehealth in any form (via video-teleconference suites or webcam) is the impact it may have on what Stanberry (2000) refers to as the "traditional clinician–patient relationships" (p. 615). Cornford and Klecun-Dabrowska (2001) caution against "substitution of care with treatment" (p. 161). Speech pathologists do not yet have enough experience with telehealth to know how it impacts on consumer satisfaction with services.

The views of Australian speech pathologists regarding emerging ethical risks to practice

The authors ran a workshop at the National Conference of Speech Pathology Australia in Sydney in May 2006 to ascertain what Australian speech pathologists perceived as emerging ethical risks to practice. After a brief presentation summarising some of the above trends, some 50 speech pathologists were asked to discuss in small groups and then summarise emerging ethical issues. These are presented in table 1. The emerging ethical issues identified by workshop participants fell into 10 categories of concern.

By far the largest category of concerns were those related to resource allocation. These categories are discussed below.

Discussion

The emerging ethical issues identified in the workshop align well to the trends presented in the first part of this paper, particularising these to our professional practice, as well as raising some new concerns. Of interest in the discussions at this workshop was the focus on ethical issues at the systemic level rather than at the individual client–practitioner level. Inevitably, system level pressures will impact on services to clients but the discussion in the workshop was primarily around the larger contexts in which ethical practice must be ensured. Speech pathologists at the workshop spoke of the ethics of a medical emphasis on "saving lives at all costs", especially when the costs to quality of life are high. As a result, allied health professionals increasingly work with clients with complex disabilities who have care needs across the lifespan. This in turn impacts on resource allocation and prioritisation of services, which are already under strain with population ageing, fiscal constraints and a shrinking health care workforce.

Workshop participants identified several worrying trends in resource allocation and prioritisation, including the cutting of services to some client groups (e.g., those with fluency or voice disorders, children with speech and/or language impairments in the absence of concurrent behavioural problems) and some age groups. For example, in some states without school-based therapy services, school-aged children are not a high priority at health services. Further, service management policies sometimes limit the number of occasions of service to clients in ways which are not consistent with evidence-based practice or which may lead to discharge before an episode of care has achieved the established goals. As a result, practitioners often experience tension and conflict between the values of the profession and the values underpinning management policies (Cross, Leitão & McAllister, 2008). Such conflicts highlight the needs for continued work on expanding our evidence base and for advocacy at individual and professional levels. McLeod, writing in Body and McAllister (in press), suggests that reference to the United Nations *Convention on the Rights of the Child* (1989) and *Rights of Persons with Disabilities* (2006) may provide speech pathologists and their professional associations with arguments against resource allocation and prioritisation which exclude children and people with disabilities from speech pathology services.

It is clear that resources for health care need to undergo an allocation process; however, how such decisions are made is an ethical matter. If we want our clients to have access to a "decent minimum" (Beauchamp & Childress, 2009, p. 260) of health care, then the principles of "equal share" and "need" can be drawn upon. Allocating resources on the basis of an equal share for all belies the reality that some people have more health care needs than others. It may also result in virtually nobody getting effective care, "the jam being spread so thinly it can no longer be tasted" (Sim, 1997, p. 127). The alternative of providing different levels of health care according to need presents some challenges as well. A disproportionate amount of service may be needed to achieve gains, for example, for those whom we label "disadvantaged". On the other hand, a small amount of service may be all that is required to achieve significant outcomes for some people in so-called low priority categories. Body and McAllister (in press) consider the ethics of health economics and provide some discussion of factors to be considered in making resource allocations across health services and within speech pathology services themselves.

One of the outcomes of reducing services available in the public sector has been the growth of private practice. While recognising the many benefits of this trend to both clients and the profession, workshop participants expressed concern about standards in private practice, especially with regards to knowledge of the evidence base and maintenance of fitness for practice. It is worth noting that a majority of inquiries about possible ethics complaints received at National Office of Speech Pathology Australia pertain to service provision within private practice.

Table 1. Emerging ethical concerns for Australian speech pathologists

Medical focus on saving lives versus quality of life

Resource allocation and prioritisation issues

- Tension between service policies and values of profession
- Restricting rights of others by focusing on particular service areas
- Narrowing of services to some groups (e.g., fluency, voice)
- Families forced to seek private therapy due to decreased service in public sector
- Prioritisation – clinician choice versus service direction
- Clients with speech and language alone – low priority compared with clients with behaviour problems for "early intervention"
- Uneven decision making – acute versus disability
- Tightening of eligibility for service related to age
- How you engage with clients – limitations of service available
- Individual/one-size-fits-all decisions
- Push for discharge versus completion of episode of care
- Time limits imposed not evidence-based practice
- Services to clients of non-English speaking backgrounds especially in remote areas

Occupational health and safety (OH&S) risk management for organisation overrides client quality of life

Changing scope of practice

- Consultancy role for speech pathologists
- Expansion of roles in workplace in areas of care planning, advocacy

Use of allied health assistants/support workers

- Training needs
- Clarification of roles
- Accountability to whom? ward? team?
- Safety and risk

Discipline specific versus multi-disciplinary student placements

Managing expectations of clients

Private practice standards

- Accreditation issues

Evidence based practice

- What evidence? New/old evidence?
- Hard to "manage" the evidence
- Lack of evidence
- Are we ethically bound to research areas with poor/little evidence?

Fitness for practice

- Problems with access to continuing professional development (CPD)
- Supervision re "standards" for rural and remote speech pathologists
- Access to professional development resources and opportunities restricted by employers (e.g., backfill time not available to go to CPD; firewalls prevent access to Internet at work)

Staying on top of the growing evidence base for our practice and maintaining fitness for practice are concerns for the whole profession, not just private practice. Earlier in this paper we raised the issue of responsibility for CPD, which becomes particularly important as consumer expectations and knowledge of our evidence base increase with rising Internet access and information literacy of the community. In this context, and also that of changing scope of practice, ensuring fitness for practice of new graduates, clinicians changing work sectors (e.g., from health to disability, from education to health), and rural and remote practitioners becomes a major ethical obligation for employers, individuals and the professional association. Ensuring the competence and standards of practice for allied health assistants and other support workers will also become a major ethical issue as reshaping of the workforce occurs and delegation of some speech pathology tasks becomes more common.

The ethical issues involved in delegation should not be allowed to mask what Threats, writing in Body and McAllister (in press), refers to as "protectionism", however. In the absence of evidence that speech pathologists deliver superior treatment to that provided by assistants under their supervision, Threats argues that there are ethical considerations (as well as economic considerations) in allowing the extension of speech pathology services using assistants and volunteers to reach a greater number of people than the speech pathology workforce alone could deliver.

While fiscal constraints, workforce concerns, population trends and consumer preferences are driving shifts in resource allocations and modes of service delivery, increasing litigation is also driving management policies. As organisations seek to limit risk and litigation, some practitioners in the workshop reported incursions on clients' autonomy and quality of life. One workshop participant gave the example of an adult client requesting and successfully managing scotch thickened to accommodate his dysphagia, only to have this decision overturned by a risk-averse management. A "one-size-fits-all" approach to services is not working to ensure access and equity for all actual and potential speech pathology clients.

Concluding comments

Our workplaces will continue to experience significant societal, systemic and technological change, and in turn influence our practice. We will not be able to anticipate, prepare for, shield or pre-empt the impact of all these changes on ethical provision of our services. Consequently we need to stay vigilant, scanning the environment for trends and changes that may influence our practice, discussing their potential impacts on our services and engaging in CPD about ethics. As McAllister (2006) has previously discussed, we need to be ethically aware and think about ethics as a part of our daily planning, delivery and evaluation of services, not just as something that is called on when confronted with "dilemmas" pertinent to individual clients.

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Emerging ethical and professional issues

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The Ethics Board hard at work!

In this paper, Suze Leitão, Chair of the Speech Pathology Australia Ethics Board, reflects on emerging ethical and professional issues and discusses some of the Speech Pathology Australia documents that can act as a resource for members of the profession. Members of the Board were asked to respond to the question: "What do you consider to be emerging ethical and professional issues in your workplace?" This article discusses some of the key themes that emerged and reflects on the need to be pro-active in our professional lives.

When I began the task of devising a column based around the theme of "professional issues" with members of the Ethics Board, I started with the Speech Pathology Australia (SPA) Scope of Practice document (The Speech Pathology Australia Association, 2003). This document describes "the breadth of professional practice carried out within the speech pathology profession in Australia". It provides an overview of the who, what, where, why, and how of speech pathology practice. It describes not only the knowledge and skill-set required by speech pathologists, but also the attitudes and ethical behaviours expected of our profession. This document may be brief but it is certainly wide-ranging.

As I read through the key points, I reflected on some of the changes that we are confronted with in our rapidly evolving world. I wondered how these might be having an

impact on the demands being made of us – in terms of new knowledge and skills (just think about all the new mobile technologies and applications contained in smart phone and iPad apps!), the introduction of telehealth, and how the Internet is changing how we learn and deliver services. It is also worth reflecting on how global factors such as the GFC have had an impact on our scope of practice.

The SPA Ethics Board has many roles around promoting and managing the ethical standards of our profession – and one of these is to respond to complaints. We receive many complaints and while the greatest number of these are resolved with support and mediation, some of these progress to a formal investigation. Complaints are made by members of both the public and the profession. As a Board we have noticed an increasing number of complaints paralleled by an increase in the complexity of the issues raised.

From an allied health and clinical perspective

Balancing clinical requirements and prioritisation with resource allocation

"At a broad level this covers social justice concepts, in other words, considerations regarding the fair and equitable allocation of resources, rationing of services – also obliquely called prioritisation of services and the reality of dual servicing and agency policy about this. It causes real distress to clinicians who are not able to undertake good, let alone best, practice."

"This is a constant challenge for clinicians and includes limited capacity for clinical intervention, the non-servicing of some patient groups based on lack of resources, the ethics of prioritisation (what factors to consider in prioritisation)."

Given the focus of the current issue of the *Journal of Clinical Practice in Speech-Language Pathology*, members of the Ethics Board of SPA were asked to reflect on and respond to the question: "What do you consider to be emerging ethical and professional issues in your workplace?"

The Ethics Board of SPA consists of senior and elected members of the profession, as well as community representatives and the Senior Advisor Professional Issues. We come from a wide range of geographical locations and workplace contexts. We work in direct clinical practice, in management positions, in research, in teaching, and in policy and funding development. The Board members' responses to the question have been grouped together below into broad themes with reflections.

"There may be specific concerns in relation to waiting list management, for example, long waits for some patients which staff know will affect clinical outcomes in the long term and the issue of having to prioritise people who make complaints even if they are not the most urgent client."

"Inadequate staffing numbers to meet National Standards for service provision (e.g., Acute Stroke Guidelines), i.e., fairness and doing good."

"Resource allocation can so easily become focused on managing 'numbers' rather than 'people'!"

"The bigger issue is that there are simply not enough services available and rationing (which this effectively is) denies access and equity to a whole group of clients who are already compromised in their ability to advocate for themselves."

Interestingly, resource allocation was one of the top issues raised by participants in a SPA workshop in 2007. Body and McAllister (2009) reported that the largest number of concerns about emerging issues related to resource allocation and prioritisation of clients. While these are not, strictly speaking, new or emerging, some of the drivers that are bringing them into sharp focus include the current economic climate, increasing focus on privatisation, and private insurance. A system that makes decisions on services around funding and cost can lead to arbitrary "rules" about numbers of occasions of service or age or standardised score cut-offs to determine eligibility. This can of course impact on the services provided and foregrounds the next theme that emerged – that of evidence based practice (EBP).

Evidence based practice

Many of the responses drew in some way on concepts around evidence.

"The increasing trend for clinicians to explain their practice from an evidence based viewpoint."

"The increasing knowledge of consumers about clinical practice and evidence, and our need to stay ahead!"

Many also raised the impact that resource allocation and service-driven prioritisation can have on our clinical decision-making, and thus on our ability to draw on EBP.

This theme has taken on higher prominence with the launch of the 2011 CBOS document (The Speech Pathology Australia Association, 2011). In this document, which frames and defines our professional standards, the first of the four range of practice principles states: "In all work contexts and decision-making, the speech pathologist must consider the recommended evidence base for the speech pathology practice."

"Another ethical issue involves responsibility for how research findings are interpreted and applied in the professional community. Researchers are expected to share evidence that will facilitate quality of care and support the development and evaluation of intervention programs. However, there is a risk that emerging evidence may be misapplied resulting in less access, less choice, and less than satisfactory outcomes for certain clients. Here, the challenge is for researchers and clinicians to develop and maintain effective partnerships so that meaningful research informs quality professional practice."

"We worry about what policies and procedures are put in place by service providers and the impact their decisions can have on individual practitioners."

The impact of technology and electronic media and the ethics of safe communication

Another theme to emerge from the responses by the Board members was that of technology.

"There are potentially a wide number of issues related to social networking. For example, the extent to which staff may use and comment on hospital/health care related issues via media such as blogging; Facebook; twitter etc. This raises issues such as patient confidentiality; staff confidentiality. It also raises the issue of who sees the information and how is it monitored."

Technology is changing at such a rate that new possibilities often emerge before the social and ethical consequences become obvious (Millsteed, 2006). In addition, technology is moving at such a fast pace that research simply cannot keep up, and instead, consumers and professionals base their clinical decisions on

Internet discussion groups and forums, where claims cannot be validated. One of the hot topics in the field of speech pathology is of course around the use of mobile technologies and applications which are being readily embraced by clinicians and clients alike, without any scientific evidence base.

"I am not sure that people realise that communicating via email can be such a risk to privacy."

The ethics of safe communication was also discussed in contexts such as telehealth. This is a rapidly expanding area, particularly with the new Medicare item for GPs. Telehealth as a model of service delivery includes a range of methods of communication including email and Skype, and raises a host of new ethical issues around communication, security, confidentiality, data storage, and consent, as well as the limits of telehealth consultations and professional responsibility.

"Technology is not necessarily a 'cure all' that will replace inadequate staffing and resources and, if applied haphazardly, may distance speech pathologists from their communities."

Behaviour by others not in our profession

With many speech pathologists working in inter- and multidisciplinary teams, the behaviour and practice of others was noted in the responses.

"Speech pathologists have the Code of Ethics which clearly outlines the expectations in relation to our professional behaviour. The best course of action may be less clear when there is an issue with a co-worker. For example, in the event that suboptimal treatment by another health practitioner is observed and that clinician's manager fails to act despite the issue being raised; or what to do if the medical officer refuses access to allied health discipline/s (either our own or another discipline)." Again, this is highlighted in the CBOS (SPA, 2011) document in the fourth principle:

"Interprofessional practice is a critical component of competence for an entry-level speech pathologist."

It is worth noting that if working in the public sectors anywhere in Australia, speech pathologists can also be guided by Code of Ethics (The Speech Pathology Association of Australia Limited, 2010) and/or Code of Conduct documents which will be applicable to all professional groups.

Support for those within the profession

"Clinical support for new graduates (particularly those in community settings) to ensure they do no harm."

"There is a need for profession-specific supervision, mentoring and support for new graduates and younger speech pathologists. So many are moving straight into private practice where they may have little or no support."

"It's difficult for students and new graduates when they are perceived as 'troublemakers' for raising concerns that 'established' practice may not be 'best practice'."

The Board is increasingly receiving complaints where a common underlying theme seems to be a lack of mentoring or supervision for younger speech pathologists. Private practices are growing and there is a trend for larger clinics to develop that may be owned or run by members of different professions and discipline-specific support is lacking. Other professions, particularly nursing and midwifery, offer formal transition programs for new graduates in the workplace, and these models and the underpinning transition theory could be readily applied to speech pathology.

From a consumer and investigation panel perspective

Finances

"People today are facing so many challenges due to rising financial forces such as rising mortgage fees, fuel expenses, and power bills, to just name a few. People are also in general working longer hours and spending less family time together. These pressures on money, time, and family seem to be impacting decisions to bring forth a case to ethics with some people feeling hard done by or let down by member practitioners."

Business relationships

"From a member perspective, there also seems to be pressures on business relationships to succeed. At times complaints are being made that have to be sifted through by the panel to find the true and relevant ethical complaints and separate them apart from purely civil and financial ones. Complainants seem to be under more financial pressure than in the past and complaints at times seem to shift into this domain and may not at all be relevant to the Board."

From a research (and clinical) perspective

Consent

"People with communication disorders have the right to make informed decisions about whether to participate in research. To make an informed decision, information statements and consent forms must include content and format that is appropriate for the client and/or their carers. While it is vital that vulnerable clients are not coerced into participating in research, it is also important that people with severe communication issues have opportunities to take part in research – particularly when studies will provide evidence that may facilitate intervention for people with similar disorders. If we assume that research participation is an added burden for a client/family, then we can fail to recognise that some clients and their families experience pride and satisfaction from contributing to research that benefits the community. However, this outcome is likely to occur only if research participants are partners in the research process and their contributions are perceived as valued and managed with respect."

"We need to be very mindful of informed consent, particularly for culturally and linguistically diverse members of the community when we offer clinical services."

"We need to consider the impact of low health literacy. In the 2006 Australian literacy and life skills survey,[1] 47% of the 9000 people sampled had only Level 1 or Level 2 literacy which equates to about Grade 5 level literacy. This means they could read a short piece of text and find a single piece of information. This has an influence on how we write our research and treatment consent forms, our assessment reports, and handouts!"

Summary

Looking back over the themes that emerged, one could argue that, in some ways, this column could have been written at any point in time. Drivers such as money, lack of support, and technology have always had an impact on professional practice. It is the specifics of the current financial situation, the changing world economy, and the fast emerging newer types of technology that influence the current emerging issues. As practitioners, researchers, educators, and members of our professional community we need to be ever vigilant and mindful about these factors and be proactive in our professional lives.

As a Board, we hope that the 2010 revision of the Code of Ethics is something that members of the profession can use in a proactive and positive way, for example during orientation, mentoring, and professional development activities and not just something to refer to when things go wrong. Through such proactive, "ethical thinking" we should always strive to avoid ethical problems arising, rather than wait until they do and then have to manage the problems.

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1   This survey is available at: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4228.0/

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Responsible and ethical clinical practice

A framework for knowledge translation

Belinda Kenny and Susan Block

**Belinda Kenny
(top) and Susan
Block**

In this paper Belinda Kenny and Susan Block, members of the Speech Pathology Australia Ethics Board, reflect upon the challenges and opportunities facing speech pathologists as they make decisions about client interactions and intervention. Such challenges can be particularly stressful when clinicians attempt to evaluate, interpret and maintain best practice and emerging evidence, and balance the demands of everyday clinical practice.

Professional perspectives

Many speech pathologists work in an environment where specialisation is neither possible nor appropriate. As a consequence, most of our colleagues work with a diverse caseload, with people of different ages, backgrounds, diagnoses, needs and demands. This means that clinicians have a wide scope of practice within which they need to continuously develop knowledge (SPA, 2003). Furthermore, pressures imposed by expanding waiting lists and managers who are often not speech pathologists, may create tensions between optimal treatment and service delivery policies (Kenny & Lincoln, 2012). Speech pathologists may then perceive a need to reduce the amount of treatment a client receives (McAllister, 2006). When such tension exists, it becomes imperative that the best possible treatment is delivered to maximise client outcomes. This goal requires us to carefully consider our knowledge base and how we translate evidence into our everyday practice. Indeed, the revised Code of Ethics (SPA, 2010) espouses speech pathologists' responsibility for knowledge and application of evidence as a fundamental professional value and requires that: "We maintain our currency of professional knowledge and practice and acknowledge the limits of these" (p. 1). Nonetheless, the process of developing, accessing and translating knowledge may be a difficult and confronting task for many of us (Cartwright, 2012).

Theoretical perspectives

One of the main methods of acquiring knowledge is through access to the publication of research findings. Dissemination of research findings aims to present new information that constructively impact upon the status quo. The nature of such impacts may involve changes to current treatment approaches, changes in treatment focus or timing and, changes in outcome measurement. New knowledge can be disseminated through publications, case presentations, conferences, professional development seminars or a range of discussions and meetings. Whatever the means, translation of knowledge is the significant process that underpins the flow of research knowledge to practice. In recognition of the importance of these events and their impacts upon professional development and client care, Speech Pathology Australia (SPA) has incorporated a range of such learning opportunities into the calculation of Professional Self Regulation (PSR) points for members (SPA, 2013).

The link between ethics and research has been clearly established, with human research ethics committees adopting a major gatekeeping role in monitoring benefits and risks of new research programs (Emanuel, Wendler & Grady, 2000). However, ethical considerations extend beyond the research studies themselves. Knowledge translation (KT) may be defined as:

> the exchange, synthesis and ethically sound *application of knowledge – within a complex system of interactions among researchers and users for the purposes of accelerating and capturing benefits of research through better health outcomes, more effective health services and resources, and a strengthened health care system. (Canadian Institutes of Health Research, 2009, emphasis added by authors)*

This definition is consistent with applying an ethics lens through which key KT decisions should be considered by researchers and clinicians.

Some of the ethical challenges of KT

The goals of KT, to create and implement new health care knowledge, may provide significant benefits for our clients, the profession and employers. However, ethically sound application of such knowledge requires critical reflection of both the research processes and their outcomes. Trevor-Deutsch, Allen and Ravitsky (2009) posed five questions to support such a reflective process:

1. What are the key ethical principles and values that should guide KT?
2. What are the responsibilities of different stakeholders in the KT process (e.g., researchers, research funders,

knowledge brokers, policy makers, decision makers, and the community)?

3. When is it appropriate to implement new knowledge with clinical populations?

4. What types of outcomes should be considered during the creation and action cycles of KT?

5. What mechanisms can be used to align KT processes with ethically sound practice?

When reflecting upon these questions, one must be mindful that ethically sound KT is underpinned by three key features (Graham & Tetroe, 2007). First, KT is grounded in the ethical principles of beneficence (to do good) and non-maleficence (to avoid harm). In keeping with these principles, KT aims to develop safe and efficacious interventions that avoid harm and provide significant benefits to clients. These aims depend upon researchers to provide valid and reliable evidence before findings are disseminated to practitioners. These aims also depend upon clinicians eschewing non-evidence-based practices that may be marketed to vulnerable clients through unregulated internet sources (Meredith, Firmin & McAllister, 2013). Moreover, clinicians must respond to the community expectations regarding access to knowledge in a format that is appropriate for their needs (O'Halloran & Rose, 2010). Second, KT interventions must meet ethical standards and comply with the legal and regulatory frameworks of the profession. The second feature acknowledges the role of the Professional Association and Board of Ethics in clearly articulating professional values that govern the application of knowledge. The third feature of KT is that the social and economic consequences of an intervention must be carefully considered since sustainability of health care programs may be impacted by budgetary constraints. This feature addresses the complex interplay between evidence and economics and the aims for KT to guide judicious use of health care resources. In other words, the "how, when and with whom", new knowledge is adopted in health care settings. These vexing issues have been addressed with ethical analysis.

Trevor-Deutsch, Allen and Ravitsky (2009) proposed a bioethical framework for KT based upon dual perspectives of utility and justice. Utilitarian perspectives dictate that decisions should be based upon achieving the greatest benefit for the greatest number of people (Freegard, 2006). Hence, any new practice or innovation should attempt to maximise benefits while taking commensurate steps to minimise risks. Further, resource allocation decisions should be based upon potential benefit to individuals and society. Evaluation of benefits and risks is multidimensional and needs to incorporate holistic and long-term vision. For example, a decision to provide an adult client with dysphagia treatment but limited or no communication intervention may initially appear ethically sound when a speech pathologist cannot meet caseload demands. However, such a decision fails to take into account the potential impacts of aphasia and the importance of rehabilitation during the early stages of recovery (Grohn, Worrall, Simmons-Mackie & Brown, 2012). A justice perspective determines that benefits resulting from KT should be fairly distributed among individuals, and within and among communities (Berglund, 2007). Here, justice is not simply interpreted as "each receives the same" but incorporates a concept of "each according to need" (Edwards, 1996). Just and fair resource allocation is not

an easy process – decisions regarding need and priority can be a source of great anxiety when they need to be balanced with equity and prognosis (Kenny, Lincoln, Blyth & Balandin, 2009). Furthermore, clinicians must be vigilant against gradually "watering down" best practice in response to resource constraints.

In accordance with utilitarian and justice principles, Lafrenière, Hurliman, Menuz and Godard (2013) reviewed the available KT literature and developed guiding questions for incorporating ethics into each step of the Knowledge to Action Process Framework (Graham et al., 2006). The summary presented in the following section, was drawn from their list of guiding questions.

Ethics applied to the Knowledge to Action Framework

During stages of *knowledge creation*, participants must make an informed and autonomous choice regarding their involvement in the research. Participants' privacy and the confidentiality of their personal information must be protected and strategies must be in place to avoid harming participants during research processes or in the presentation of findings (Smith, 2003). There must also be appropriate rationales for excluding individuals or groups from research opportunities because exclusion may result in some members of the community having no voice during the knowledge creation process (Leitão et al., 2012).

Identification of research problems must be based upon health care priorities. The needs and motivations of stakeholders need to be articulated and decision-making processes made transparent. The human, financial, temporal, and material resources invested in a research problem are expected to provide knowledge that will benefit individuals and society and such investments must be directed towards research that may have relatively greater benefits for a profession and community. To ensure this outcome, it is imperative that clinicians either communicate with researchers so that real clinical issues are pursued, or that clinicians undertake research in their clinical practice. Indeed, we need to close the gap between clinicians and researchers so that clinicians can direct research according to clinical need and researchers translate their findings into clinically useful strategies (Davies, Robertson, Stevens & Thomas, 2006). The Clinical Centre for Research Excellence in Australia, for example, has engaged in a comprehensive process of community engagement and developed strategies for translating aphasia research into innovative practice (Power & Worrall, 2011).

Knowledge must be adapted to the culture and worldview of consumers so that they may benefit from new approaches. Lafrenière et al. (2013) argued, for example, that the limited effectiveness of some public health programs in indigenous communities may be due to externally imposed strategies that ignore local understandings of health and illness and cultural mechanisms for sharing knowledge. Factors that may result in misapplication of knowledge and misuse of resources must be identified and addressed to avoid harming communities or individuals. Again, a close relationship between researchers, clinicians and the community may enhance the likelihood that knowledge will not be applied inappropriately and the best evidence will reach targeted communities (Kagan, Simmons-Mackie, Brenneman, Conklin & Elman, 2010).

During selection, tailoring and implementation of interventions, knowledge must be responsibly communicated to health care providers and the community. Responsible communication avoids inflating potential benefits and identifies potential risks in any new intervention. Importantly, competing interests are disclosed and contributions from each member of the research team are appropriately acknowledged during dissemination.

Knowledge use is monitored and opportunities identified for responding to values, priorities, preferences and cultural needs of knowledge consumers. Ethical practice means that rather than adopting a "BUT that research won't work for me, my clients, or this setting" stance, we are challenged to explore the strategies that will facilitate all people with communication or swallowing impairments to receive best practice interventions. For example, opportunities for change in indigenous communities rest upon mutual respect, willingness to work with existing services and flexible timeframes for service delivery (Webb, 2012).

Outcome evaluation may incorporate the broad spectrum of social, economic and environmental effects including potential positive and adverse effects of changes to assessment, intervention or models of service delivery. Outcomes must certainly provide quantitative data regarding number of clients, hours of service, and waiting list numbers impacted by change. However, it is equally important not to overlook impacts upon an individual client or family. Qualitative measures may provide meaningful outcome data especially when applying knowledge to clients and families from culturally and linguistically diverse backgrounds (Hand, 2011; Kovarsky & Curran, 2007). Access and appraisal of intervention research in speech pathology is available through www.speechbite.com

Finally, *sustainability of knowledge use* is addressed by making resources available to facilitate change and assist consumers adapting to and maintaining change. The "What Works" database (https://www. thecommunicationtrust.org.uk/whatworks) is one example of an educational resource that addresses sustainability of knowledge. The Communication Trust collaborated with the Better Communication Programme to develop this evidenced-based resource providing intervention resources to support children's speech, language and communication development. Free registration and clinician-friendly language facilitates access to research. Sustainability is further addressed by a year-long roll-out process incorporating consultation with practitioners to ensure the database is fit for purpose. Plans to add new research interventions, in response to identified gaps, may successfully maintain the engagement of the professional community.

Facilitating sustainability of knowledge as well as KT, within an ethical framework, is one of our major challenges. Clearly clinical care gaps between high-quality evidence and practice have major implications for quality of life (Buchan, 2004). Carey-Sargeant and Carey (2012) propose group peer consultation as one means of professional development. This model has many benefits as it can be workplace based, geographically based, topic based or related to whatever individuals feel most meets their needs. Interprofessional education and collaboration may also provide a strong platform from which to advocate and implement evidence based practice (Zwarenstein & Reeves, 2006).

Conclusion

This ethical conversation has raised a number of issues regarding the translation of knowledge to practice. We argue speech pathologists have professional and ethical obligations to contribute to knowledge creation, in a variety of ways and to continue to engage in knowledge development throughout their professional careers. This engagement can take many forms and SPA facilitates this through the PSR program. Knowledge of the Code of Ethics will support ethical decision-making when new knowledge is implemented or changes made to existing practice. Careful consideration of potential benefits and harms and issues of justice may ensure knowledge development within our profession brings positive, empowering change for people with communication and swallowing disorders. This in turn should enhance the well-being and quality of working life for speech pathologists.

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Think big, act locally

Responding to ethical dilemmas

Robyn Cross, Suze Leitão and Lindy McAllister

THIS ARTICLE HAS BEEN PEER-REVIEWED

Robyn Cross (top), Suze Leitão (centre) and Lindy McAllister

This paper asks speech pathologists to consider the impact of ethical dilemmas upon their own work–life balance. In raising awareness of the impact of workplace ethical dilemmas on individuals, this paper challenges speech pathologists to consider how systemic responses, in addition to individual action, may assist in developing and maintaining an equilibrium between work and life.

Act local, act global

"What ought one to do?" is the fundamental question of ethics (St James Ethics Centre, 2008). The term "ethics" can be defined as "relating to morals, treating or moral questions" (Sykes, 1976, p. 355), or, as noted by Speake (1979, p. 112), as "a set of standards by which a particular group or community decides to regulate its behaviour – to distinguish what is legitimate or accepted in pursuit of their aims from what is not". The speech pathology profession within Australia, under the auspices of Speech Pathology Australia has long sought to practice ethically, currently guided by its *Code of Ethics* (2000). The Association's revised *Code of Ethics* was developed in 1999/2000 (Speech Pathology Australia, 2000), and its application to practice was supported by the development of an *Ethics Education Package* (2002). Based on the concept of aspirational ethics (what we aspire to do well) as opposed to prescriptive ethics (what we must do/not do), and written in plain English, the code of ethics is again due for review.

The Speech Pathology Australia *Code of Ethics* (2000) contains standards with the intent of identifying the values of the profession, providing a means by which people outside the profession may evaluate us. It also provides a basis for the decision-making of the Association's Ethics Board. At an individual level, the standards are also stated to "reinforce the principles on which to make ethical decisions" and "assist members of our Association adopt legitimate and professionally acceptable behaviour in their speech pathology practice" (Speech Pathology Australia, 2000).

A convergence of ideas, values and language becomes apparent when comparing the Speech Pathology Australia *Code of Ethics* (2000) with the codes of ethics of other professional and public service agencies in the western world (ASHA, 2003; AMA 2006). The existence of a code draws distinctions between the values of the organisation and/or profession, the legal obligations of an individual or employee and the personal values of a professional. While there is a clear distinction between these three domains, there is also great overlap and potential for conflict between them.

Conflict between these domains may lead to ethical distress, which the authors suggest can be one factor contributing to disrupted work–life balance and indeed to professional burnout. This paper provides two frameworks for thinking about ethics in the workplace, which may assist professionals to avoid or manage ethical distress. These frameworks are proactive workplace ethical thinking (at the individual or local level), and professional lobbying and advocacy (at the bigger picture or global level). We provide examples of successful lobbying and advocacy conducted by the professional association in recent years that have helped client groups access appropriate services and which may have lead to reduced ethical distress of speech pathologists who were unable to adequately balance conflicting ethical principles and duties in their workplaces.

McAllister (2006) identifies escalating pressure on professionals from increasingly complex workplaces, highlighting the need for ethical awareness and broad ranging ethical thinking. She highlights the strengths and limitations of a code of ethics in guiding contemporary practice, citing health service rationing as just one example of how increasingly frequent ethical questions or dilemmas can seem removed from current approaches to ethical decision-making. An example of health service rationing is seen in the frequent prioritisation of preschool children for therapy over school-aged children, even though school-aged children may clearly need our services, given the risk of residual communication impairments having lifelong impacts on educational, social, employment and mental health outcomes (Felsenfeld, Broen & McGue, 1994).

As an interesting aside, let's have a quick look at the word "dilemma"; it comes from the Greek *di* (equivalent to) *lemma* (an assumption or premise). In other words, a dilemma is a situation in which, when a person is faced with a choice of alternatives, neither of which seems adequate or both of which seem equally desirable. The situation about health service rationing highlighted above presents such a dilemma: if we prioritise school-aged children over preschool children, we may deny services to children who also require them and for whom "early intervention" might yield significant and long-lasting gains. If we prioritise preschool children over school-aged children, what effect may that have on the quality of life of those children who go into adult life with untreated communication impairments? We know that competence in early speaking and listening and the transition to literacy are seen as a crucial protective factor in ensuring later academic success, as well as positive self-esteem and long-term life chances (ICAN,

2006). Such a situation underlines the conflict between the ethical principles of beneficence, non-maleficence and fairness, and duties to clients as well as employers who set workplace policies (Speech Pathology Australia, 2000). The sense of unease, distress and conflict that arises within an individual when confronting a dilemma such as this can significantly impact on the balance between "work" and "life". Personal as well as professional values will be challenged in such situations. The ability to draw on the principles within our *Code of Ethics* and to problem solve within its framework may assist in identifying and voicing our ethical concerns in the workplace setting, limiting the potential for any internal disquiet to impact on other parts of our lives.

Reviews by the Chair of the Ethics Board, Vice-President Communication and/or the Senior Advisor Professional Issues of the enquiries received by the Ethics Board of Speech Pathology Australia (informal summary reports to either National Council or Ethics Board, 2006–2008) reveal that this notion of "dilemma" is not just a theoretical concept. Members contact the Association seeking guidance, support and/or direction in responding to a range of issues, including:

- providing services to a group of clients demonstrating limited gains, while being aware that individuals who may benefit more from the service remain on the waiting list;
- ceasing services to clients when their quota of services has been fully utilised, yet who continue to make progress in intervention;
- managing a service within finite resources (staffing and/ or financial) and having to determine who is prioritised above others for service;
- being required to work through an assessment waiting list at such speed that the assessment does not follow the evidence base and is superficial;
- knowing that a colleague is doing their planning and report writing at home because they are unable to manage the load at work, raising issues of client confidentiality, underresourcing at the workplace and workforce burnout.

In each of these examples, individuals may struggle with decision making, with limitations in how the *Code of Ethics* can support thinking about the ethical issues involved and the decision-making required. How can the key principles of professional ethics be upheld in these situations? McAllister (2006) suggests that the *Code of Ethics* and decision-making protocols cannot account for all possibilities. So, how do we as individuals develop an ability to address these dilemmas and in so doing, maintain equilibrium between work and life?

Local and systemic responses to ethical dilemmas

McAllister (2006) notes the need for clinicians to think and act ethically in their daily work life, not just when faced with specific ethical dilemmas. In other words, part of the answer lies in the proactive application/use of the code to shape our practice, rather than only drawing on it in times of dilemma or ethical emergency. Proactive ethical thinking may support professionals in maintaining balance between work and life, rather than trying to recapture balance once an ethical dilemma or emergency arises.

Further, using the example of health care rationing pro-vided earlier in this paper, it is argued that, in addition to our individual level of response, we may also benefit as individuals and as a profession by stepping back from the immediate and "local" ethical dilemma facing us to gain a broader per-spective. Recognising that individual clinicians lobbying their individual managers is unlikely to lead to change at the local level compels us to approach these issues from a larger or systems level which attempts to influence public policy through the provision of "evidence" and economic arguments.

Rationing of health services, while not a new issue, has had greater prominence in the last 20 years. The Honourable Justice Michael Kirby, in the inaugural Kirby Lecture on Health, Law and Ethics (1996) highlighted "the complex public policy questions raised by the attempts to apply ethical principles to the allocation of health care resources and, in particular, to adopt cost benefit analysis in the context of healthcare". Adding a further layer of complexity, there is recognition that "health care" can be an ill-defined term, which not only encompasses the physical aspects of health but extends to the social and economic determinants of health. The National Health and Medical Research Council (1993, p.1) identifies that "the allocation process involves different levels of decision-making ranging from the macro level of the governmental policy maker to the … micro patient/physician level. As a result, ethical considerations cannot be introduced into the allocation debate directly and unilaterally." Given the above, the reality for a health professional working in a clinical setting may be that while attempting to address the impact of health care rationing at the personal level through advocacy, debate and discussion (McAllister 2006), ongoing ethical dilemmas may arise because health care rationing extends beyond the "local" clinical level, and is entrenched within the broader health system.

What are our roles as clinicians then? Without doubt, there is a requirement for us to continue to advocate for change; but if only limited effect can be gained at the local level, should we be resigned to this? It is suggested that we might also meet our obligations under the *Code of Ethics* if we address such ethical dilemmas through broader, more "global" mechanisms.

Advocacy – from the macro to the micro

At the most "macro" level, as participants in a democratic system our ability to vote is demonstration of our ability to actively support (or inversely deny our support of) the stated policies of political parties in relation to social, economic and health care policies. Our individual contribution in providing expert opinion and advocacy to national and state committees and lobby groups allows input to public policy debate, review and development. Similarly, as members of our professional organisation, our lobbying and representation of the profession and how it may contribute to the provision of health care and education allows us to contribute to the shaping of public policy. The introduction of Medicare Plus is one example of how public policy has attempted to meet the dilemma of restricted community access to allied health services. Previously, access to services was limited to allied health services in the public sector, or the individual client had to pay for private providers. Following a change in government policy, Medicare Plus now allows general practitioners to refer clients requiring support for a chronic condition to registered private allied health professionals at a subsidised cost for up to five sessions. Another example of influencing public policy is the submission by Speech Pathology Australia to the National Inquiry into the Teaching of Literacy (Speech Pathology Australia, 2005), which resulted in increased awareness of the role of speech pathologists in this area. As a consequence, speech pathologists were listed as appropriate service providers to those in the community with literacy problems, and the Department of Education, Science and Training (DEST) asked the Association for input into policy development.

Continuing at the macro-level, research and/or continuous quality improvement undertaken by the profession adds to the body of evidence to support further lobbying and debate on the value of health care services. This may include challenging the traditional scientific constructs of evidence, and ensuring that psycho-social and -economic factors are also considered. For example, data reported by Felsenfeld et al. (1994) refers to educational and occupational outcomes for adults identified in childhood as having speech impairment. Such data could be used by speech pathologists to lobby for provision of intervention services in childhood that are economically more cost effective than social welfare or work skills training later in life. Utilising this and other evidence, and presenting it against the framework of the profession's (and/or organisations') ethics could prove to be a powerful lobbying tool.

Our willingness as a profession to extend our education beyond the knowledge and skills required for provision of clinical services, to areas such as management, policy development and academia, further supports efforts to provide systemic responses to ethical dilemmas. The Speech Pathology Australia publication *ACQuiring Knowledge in Speech, Language & Hearing* regularly features speech pathologists who have continued to utilise their training and skills in arenas beyond that of the immediate clinician–client interface. In many cases, an impetus for pursuing change has been to allow individuals to further contribute, shape and/or drive development of initiatives in response to dilemmas arising from or frustrations experienced in clinical practice.

Raised public awareness through support of media campaigns promoting the profession and advocacy for relevant issues can build a momentum of political awareness. This was demonstrated by parent groups who successfully lobbied political parties during the recent federal election in relation to services for children with autism. The increase in Medicare funding for allied health services was similarly won through the influence of earlier lobbying campaigns.

Our ability to reflect and think critically about our own practice as clinicians, managers, researchers and academics assists us to be open to new ideas, welcome constructive challenge to our practice and trial new models and approaches. Many of the "grass roots" quality improvements that are implemented in the clinical setting contribute to the effectiveness of the services provided by clinicians and the outcomes for clients. And, at the most fundamental level, there is the everyday application of ethical thinking and action within the workplace. As argued by McAllister (2006), this requires personal courage.

From the big picture of national politics to the individual level, frameworks for thinking about ethics and a range of strategies that can assist us to proactively identify and respond to ethical dilemmas have been presented in this paper. These suggestions reflect the authors' views of how we may as individuals respond more "systemically" to ethical dilemmas in addition to responding at a "local" level in the workplace. These strategies will not provide a panacea for all ethical dilemmas that will be faced in the workplace. However, they may provide other means by which we can constructively and proactively address emerging or ongoing ethical dilemmas. In doing so, they may ultimately alleviate some internal conflicts about our practices that can impact on the work–life balance.

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Robyn Cross, Lindy McAllister and **Suze Leitão** are chair and senior members of the Speech Pathology Australia Ethics Board respectively. They all have a longstanding interest in ethics from a theoretical and applied perspective. This paper represents the first paper from the Ethics Board and aims to stimulate thinking and discussion among members of the profession.

Robyn is a senior manager within ACT Health, managing allied health at the Canberra Hospital and multidisciplinary diabetes services across both hospital and community settings. Suze works part-time at Curtin University as a senior lecturer in human communication science and part-time in private practice as a clinician. Lindy is an associate professor at Charles Sturt University, half-time in the speech pathology program in School of Community Health and half-time as deputy director of the Education for Practice Institute.

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Ethical conversations

Louise Brown and Chyrisse Heine

This is the first of what we hope will be a very stimulating, challenging and informative column focusing on ethical practice. We hope this column will stimulate discussion on the behaviours and thoughts which demonstrate ethical practice in speech pathology and also on the ethical dilemmas which can cause controversy or difficulty for us in the workplace. Marie Atherton, Senior Professional Issues for the Association, will be leading this column.

We are very keen for you to send your responses, comments or queries to her by email so that we can start to present a conversation about real reflections, practices and dilemmas you have raised. Marie will collate your comments and ask people, such as members of the Ethics Board and people who research and write about ethics, to consider and discuss the points raised.

There is an interesting set of documents in the Ethics Roundtable on the American Speech-Language-Hearing Association website (http://www.asha.org/about/ethics/roundtable/). This review evolved from a column in the ASHA magazine. Its format focuses largely on the sort of case based ethical dilemmas that make our working lives uncomfortable. There is always more than one commentary provided for each situation reflecting the range of individual interpretations and perspectives.

In this first column, we have reproduced a list of key trends and issues which Marie Atherton, Senior Advisor Professional Issues, presented at the Speech Pathology Australia National Conference in 2007.

Key trends and issues in ethical practice in speech pathology (Atherton, 2007)

Key trends

1. Increased demands of an ageing population
   - Effective use of the limited health dollar
   - Community care
   - Long-term care

2. Increased prevalence of chronic disease and disability
   - Increased survival rates
   - Life-prolonging procedures and technologies
   - Increased rates of long-term disability

3. Chronic shortage of health workers
   - Difficulty in meeting community needs
   - Support workers – opportunity or threat?
   - Delegation and legal liability

4. Increased complexity of clients and settings
   - Prioritisation of services
   - Waiting lists
   - Referral onwards

5. Changes in health policy and community expectations
   - Workplace policies
   - Availability of services closer to home
   - Better informed consumers

6. Increased emphasis on evidence-based practice
   - Access to relevant facilities
   - Budget constraints
   - Maintenance of up-to-date knowledge and skills
   - "Fit to practice"

7. Extended scope of practice
   - What is our scope of practice?
   - Governance frameworks
   - Legal liability

8. Increasing need for non-profession specific skills
   - Prioritisation of workload
   - Access to training and skills
   - What is core business for a speech pathologist?

9. Statutory regulation
   - Impact on safety guarantees for consumers
   - Impact on profession specific regulation – who knows best?

Key issues

1. Changes to speech pathology scope of practice have been extensive over the past 15 years
2. Population demographics are a driving force for change
3. Extended scope of practice by other professionals – is this a threat or an opportunity?
4. Evidence based practice is a priority
5. Compulsory external regulation may be introduced
6. Ethical considerations are complex and far reaching

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This emerging conversation about ethics in speech pathology commences with several questions about these key trends and issues in the list.

1. How do these trends and issues make you feel as you read through the list?
2. Does the list capture some of the key issues in your practice of speech pathology?
3. If so, are there specific examples you can share with us to demonstrate how and why these issues carry an ethical reality for you?
4. Are there key issues or trends which you feel may have been overlooked in this list?

To reply to the questions, to submit new questions or to be added to the list of people interested to respond to topics raised, please contact Marie Atherton at matherton@speechpathogyaustralia.org.au

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Webwords 29

Ethics and fidelity

Caroline Bowen

You may have heard that *Webwords* loves an incognito long weekend away: the change of scene, the new experiences, the chance to reflect and renew. The delicious anonymity that might allow you to challenge someone's sexist, racist or ageist opinions without having to worry about therapeutic neutrality, and the chance to use your pet cockroach to eat free in restaurants.

On the other hand you may not have heard that the quietly philanthropic group, the *Beneficent Friends of Webwords*, shares this passion for undercover work. A typical Friend is a conference tragic or CPD enthusiast, works furtively and alone, and travels the land developing illicit hoards of toiletries, pens, jotters, coffees, teas and sugars, sewing kits, shoe wipes, *Do Not Disturb* and *Make Up My Room Now Please* signs, coasters, and other collectables – to donate to charity, naturally.

The hospitality and the travel industries know a thing or two about such benevolent work, and are unappreciative, classifying it among the top three travel taboos: lying, cheating and stealing.

Chains

Tackling stealing with wry humour the Holiday Inn chain won an industry award by holding an annual Towel Amnesty Day when each guest was issued with a retro green-striped towel with a tiny message that read: 100% Cotton 100% Guilt-free 100% Yours.

Hoteliers have not come up with a funny way of dealing with patrons' propensity to nick lamps, irons, faxes, modems, bathmats and flat screen monitors, or to drink the Evian from the mini-bar and replace it with tap water. Tap water! That's bad. Even the **Beneficent Friends** would not rationalise *that* as a form of recycling and would not be caught doing it. But we can only wonder what twisted logic they would apply, or the conduct they would advise, in the following situation.

BYO ethics

Tired and hungry after a long flight, you and your budget-conscious companion check into an exclusive country hotel around 7:30 p.m., soon realising that the culinary extravaganza downstairs is seriously expensive. But wait! There is a moderately famous, good value BYO Italian in the next block. That's tempting. The only thing is, the sleepy town's bottle shop closed at seven. You've both noticed a very nice Pinot Noir gracing the mini-bar – three times the price you would normally pay for the same excellent drop. What now? Do you have a dry night, do you tick the box so that you will have to pay for the expensive bottle, or do you take the bottle to Antonello's without ticking the box and replace it with a well-priced bottle of the same thing from the local retailer next day? You can easily manage that before the guy comes around to restock the fridge. No probs. No one will be any the wiser, and after all, a red is a red is a red, right?

So what *is* the dilemma? And if there is a dilemma, what *kind* is it? Legal? Moral? Ethical? Are you thinking that you could live with your conscience for doing it but would not want the embarrassment of being caught? Are you justifying your cunning plan along the lines that if the mini-bar prices were remotely reasonable you would not be driven to extremes? That in fact you are not made of money and have a perfect *right* to economise and that it is the hotel's *fault* that you are guilt-tripping. Moreover, they deserve creative guest-behaviour if they persist in overpricing the grog *and* serving horrible meals to hideous music. Or are you thinking there is no dilemma, but a decision to be made: a choice to be taken from three obvious options. One, we pay top price for the Pinot and quaff it with gusto with our $16 Gnocchetti Cimbri with Leeks, Pancetta, and Cauliflower; two, we have the pancetta and cauli without bothering with wine tonight and be better organised with a legitimate BYO bottle by tomorrow; or three, we proceed with the money-saving deception. Choices, choices.

Certain principles

The **Speech Pathology Australia Code of Ethics**[1] reminds us that we do not have any choice when it comes to our fundamental professional responsibility to observe the highest standards of integrity and ethical principles. It does not say look for the loopholes or choose your standards, or regard ethical practice as a worthy but unobtainable goal that only a total goody two shoes could live up to. Not at all. Instead it sets out our moral obligation to follow a series of principles when we strive to make ethical decisions.

Our code's first principle is that of beneficence and non-maleficence. We seek to benefit others through our activities; and we also seek to prevent harm, and not to knowingly cause harm or make mischief. Principle two is truth: we tell the truth. The third is fairness and justice: we provide accurate information, we strive for equal access to services, and we deal fairly with everyone with whom we come in contact. Number four is autonomy: we respect the rights of our clients to self-determination and autonomy. And five is professional integrity or fidelity: we are respectful and courteous, we are competent and follow the association's Code of Ethics, and we keep promises and honour our commitments to clients, colleagues and professional organisations.

Clearly our Code of Ethics was not written with the quaffing quandary in mind. But let's have a go anyway. One: we embrace an opportunity, take the Pinot, replace it next day, and beneficence is upheld: the restaurant and the bottle shop have benefited and no harm has befallen the hotel. Two: we tell no lies. The waiter does not ask us where Pinot came from, the bottle shop salesperson does not query our purchase, and when the mini-bar guy comes we tell him the truth: we don't need a new bottle. Three: there has been no

disrespect. Four: fairness has been served. We pay a fair price for a fair drop. And five: that's professional integrity or fidelity, remember? We don't have to worry about that just now, do we? – after all, it's an incognito weekend away and we are not acting in our professional capacities.

Steadfast

If you have the space and time to think about them, on a peaceful weekend away, for example, each of the key words denoting the five principles can evoke deep reflection. It is interesting, even inspiring, to consider the import of words like beneficence, truth, fairness, justice, autonomy, respect, honour, integrity and fidelity. That final word is possibly the most intriguing – a pleasantly antiquated, graceful one, associated with ideas of allegiance, fealty and loyalty – that means faithfulness to obligations or to duties, or to observances. And it meshes so exquisitely with its close relation, "integrity" with its message of steadfast adherence to a strict moral or ethical code.

Some time during a reflective long weekend away Webwords made some important decisions. She sent the cockroach back to his people, abandoned all thoughts of wining and dining scams, and made a note to have a stern chat to the Friends about their hunting and gathering activities. She confided later that she could not honestly ascribe these decisions to newfound insights into the meanings of fidelity and integrity. No, she insisted, it was something about the word steadfast. Webwords wanted to be steadfast: to be steady, firmly loyal, constant, unswerving, trustworthy and true to herself. By thinking about it, it had become clear to her that ethical conduct was not simply a worthy goal or a moral obligation specifically related to our practice as professionals. It was not to be abandoned on the weekends when professional hats were removed, or manipulated for our own purposes when it suited. Rather, ethical conduct was for all the time. It was a way of being. I felt so proud of her, and said so.

She smiled happily, placed two Antonello's coasters on the table between us, and said, "Good". Her mischievous eyes twinkled, "Now, if you pass me the Pinot Noir we can drink to that". And we did.

Link

1. http://www.speechpathologyaustralia.org.au/Content.aspx?p=19

Webwords 29 is at http://speech-language-therapy.com/webwords29.htm with just one live link this time, to the Speech Pathology Australia Code of Ethics.

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Ethics in the workplace

More than just using ethical decision-making protocols

Lindy McAllister

This paper asks speech pathologists to reflect on what it means to think and act ethically in routine clinical practice. The purposes of the paper are fourfold. First, I discuss my views of the strengths and limitations of the current Code of Ethics of Speech Pathology Australia (2000) and Ethical Decision-Making Protocol contained in the Ethics Education Package (Speech Pathology Australia, 2002). Second, I discuss some pressures in contemporary practice which call for ethical thinking deeply embedded in daily practice rather than a focus just on ethical dilemmas. Third, routine challenges for speech pathologists in thinking ethically are considered, and finally I conclude with some suggestions for approaches to professional development of ethical thinking.

This paper is based on an invited presentation entitled *Ethics: Why does it matter*, delivered at the annual conference of Speech Pathology Australia in May 2005. While there are scholarly publications regarding ethics in speech pathology practice (see for example Pannbacker, Middleton & Vekovius, 1996; The Ethics Roundtables and other statements on ethics of the American Speech-Language Hearing Association (ASHA) over the years), these are not based on research into ethical reasoning and ethical conduct in speech pathologists. Smith (2002), Kenny, Lincoln and Reed (2004) and Wilson and McAllister (in progress) have researched the development of ethical reasoning in students. In the absence of research and a literature base on ethics in practicing speech-language pathologists, this paper reflects my opinions and experiences as: a co-author of the Code of Ethics (Speech Pathology Australia, 2000) and the Ethics Education Package (Speech Pathology Australia, 2002), as a university educator helping students learn to think and act ethically, and as a mentor to practising clinicians with a range of professional practice experience. I would like to acknowledge the contributions to the development of my thinking about ethics of Dr Teresa Anderson, Louise Brown and Meredith Kilminster, coauthors with me of the Code of Ethics and the Ethics Education Package. My critiques of the Code of Ethics and the Ethics Education Package

are in no way to be seen as a critique of their work, but rather as a reflection on my own growing understanding of what we mean by "ethics" and ethical conduct. Any misinterpretations or erroneous assertions are mine alone.

The Code of Ethics of Speech Pathology Australia

The Speech Pathology Australia Code of Ethics is based on a number of key principles of professional ethics (Beauchamp & Childress, 2001):

- beneficence – we seek to benefit others;
- non-maleficence – we seek to prevent harm to others;
- truth – we tell the truth;
- fairness – we strive for equal access to services for our clients and do not show bias or favouritism;
- autonomy – we respect the rights of our clients to selfdetermination and autonomy;
- professional integrity – we are respectful, courteous, competent and honour promises and commitments.

As detailed on the Code of Ethics, these principles are enacted through attending to a range of duties to our clients and community, employers, profession and colleagues. These principles and duties are explained and application of them is illustrated in the Ethics Education Package (Speech Pathology Australia, 2002).

The ethical decision-making protocol

Brown and Lamont (no date) developed a five-stage protocol which was included in the Speech Pathology Australia Ethics Education Package. Several case studies were developed to which this protocol was applied. The stages in the protocol are to ascertain:

- the facts of the case and the ethical scenario;
- whether an ethical problem exists which requires action;
- the nature of the problem;
- a proposed decision and action plan;
- an evaluation plan to see if the ethical dilemma has been successfully managed.

Strengths and weaknesses of the Code of Ethics and the Ethics Education Package

In many ways our Code of Ethics is a powerful tool. The code uses a framework of aspirational ethics. That is, the code is expressed in language of "we aim to…" rather than the traditional "thou shalt not …" approach to writing codes

of ethics. By not attempting the impossible task of prescribing and delimiting what is ethical behaviour and proscribing unethical behaviour, the code has the potential to encourage speech pathologists to think ethically and integrate ethical principles into their diverse, complex and rapidly changing daily work practices. However, my discussions as a mentor with speech pathologists about ethical matters suggests that this diffusion into everyday thinking and practice is not easily or routinely occurring for all clinicians. Ethics is more than following ethical decision-making protocols. As Midgely (1993, p. 25) noted:

judging is not simply accepting one or two ready made alternatives as the right one. It cannot be done by tossing up. It is seeing reason to think and act in a particular way. It is a comprehensive function, involving our whole nature, by which we direct ourselves and find our way through a whole forest of possibilities … We are always moving into new territories. All the same, some explicit maps and some general guidelines for explorers do exist and can be referred to. There is constant use of rationality; the area is cognitive; we can know things. We are not just guessing or gambling.

In pursuing our ideals as a profession for ethical conduct of members, we need to do more than focus just on ethical dilemmas. In the absence of research into ethics in our profession we can extrapolate from other health professions (such as occupational therapy), which share similar underpinning values about client relationships, to guide considerations of an expanded view of what it means to think and act ethically. Wright-St Clair and Seedhouse (2004, p. 18) argue that:

By their very nature, professional codes of ethics contribute a shift in emphasis from morality being considered as integral to relating in the everyday practice world towards being something that directs decisions about how to act, particularly in ethically challenging situations.

They suggest that the commonplace nature of morality consigns it to routine, habitual ways of acting in the world and that these ways are rarely subjected to scrutiny. They suggest that it is only when something unusual happens, such as the presentation of an ethical dilemma, that the way we think and act with regard to ethics is considered. I ask speech pathologists to consider whether this "fascination in extraordinary events" (Wright-St Clair & Seedhouse, 2004, p. 19) in the form of ethical dilemmas, rather than the moral practice of everyday work, also occurs in speech pathology. I question whether the focus of the Ethics Education Package on a decision-making protocol to resolve ethical dilemmas inadvertently reinforces this notion that ethics comes into play only when we are faced with unusual, rather than daily situations.

Moving beyond a focus on dilemmas, I also suggest that as a profession we may be too focused on our ethical duties to clients, to the neglect of meeting our ethical duties towards community, employer, profession and colleagues. There may be many good reasons for this and I want to move on now to a consideration of some of the pressures which obscure awareness of the broad ethical context in which we operate.

Pressures on ethical thinking and action

Since the founding of health care professions and the promulgation of the Hippocratic Oath for doctors in millennia past, health professionals have striven to practice ethically. This desire was driven mainly from altruistic principles of client-centred care and a need for professionals to be seen as acting with integrity so as not to impugn the good name of their professions. These motivations undoubtedly still remain but are now located within contexts of increasingly complex societies and workplaces. Four pressures facing speech language pathologists are: increasingly complex caseloads, increasing workplace pressures, increasing litigation and increasing demands for evidence-based practice. Given the diverse settings in which speech-language pathologists work, the inadequacy of biomedical approaches as frameworks for discussions of ethics in speech pathology is also considered.

Increasingly complex caseloads

Increasing neonatal and adult trauma survival rates, lifesaving and life-prolonging medical and surgical technologies and procedures, increasing adult trauma survival rates, and the ageing of the population, among many other advances in modern medicine, have lead to increased rates of disability in schools and community settings. As a result, health professionals now routinely work with clients with complex, life-threatening or disabling conditions. The case study of Mary in the Ethics Education Package illustrates just such a case. Key features of the case study include:

- Mary is 32 years of age; she has spastic quadriplegia, severe dysphagia, aspiration of all food and fluid consistencies, severe communication impairment and is malnourished;
- team members recommend only non-oral feeding;
- Mary and family want to continue oral feeding (issues of quality of life and autonomy);
- nursing staff and paid carers fear risks of oral feeding.

This case study involves conflict between all the ethical principles and duties outlined earlier. Consideration of ethical issues in this case is compounded by the fact that Mary lives with a chronic disability, staff are engaged in long term, caring relationships with her, and care about her quality of life. For these reasons, codes of ethics which are founded only on biomedical principles are inadequate in guiding action to resolve the issues involved.

Limitations of our current biomedically oriented ethical principles

Most codes of ethics in the health professions are derived from a biomedical paradigm of practice (Beauchamp & Childress, 1994). However, speech pathologists, like many allied health professionals, work across biomedical, social and educational models of practice. We are engaged in sustained relationships with our clients, and as a result have an ongoing duty of care. We are concerned with quality of life issues, not just issues of "saving of life". Noddings (1984) has written extensively about an "ethic of care". How can we as speech pathologists integrate and foreground this ethical principle of care into our existing principles? How might this ethic of care be expressed in our daily work? In addition, the relational nature of our work and the use of self-as therapeutic agent mean decision-making is not "clinical" or "black and white". Instead as Schön (1987) suggests, professional practice deals in the "grey areas" and "the swampy lowlands" of professional practice. To act ethically in contemporary speech pathology practice forces

us daily into these grey, swampy areas. We need more than an ethical decision-making protocol to navigate our way through these swamps: we need to think and act ethically in proactive not reactive ways. Does our current code and decision-making protocol help us do this?

Increasingly complex workplaces

Economic rationalism has significantly changed our workplaces (Baum, 2002; Gardner, 2002). Many services for the public are now managed as businesses, which some will argue compromises client care. For example, the pressure to reduce length of stay in hospitals has had significant and often adverse effects on our clients who may be discharged with little if any rehabilitation of their ongoing communication needs. Further, as mentioned earlier, more clients now require our services and many of these clients present with increasingly complex needs. Services typically have responded to these pressures not by increasing staffing levels but by imposing stringent policies about client prioritisation, waiting lists, failure-to-attend, and number of sessions provided. Often such policies are in direct conflict with the principles of evidence-based practice for the management of communication and swallowing impairments.

Such workplace pressures and policies bring us daily into dealing with conflict of ethical principles. How can we act with integrity and truthfulness in pursuit of beneficence and justice for a client who has experienced a CVA and according to the clinical pathway has had their quota of therapy and is about to be discharged, yet continues to have potentially treatable communication and swallowing impairments? How do we reconcile conflicting ethical principles and duties towards a preschooler with stuttering and his/her family, when our employer tells us that preschool-aged clients can have only six sessions of treatment per term, semester or year? The evidence base tells us that the mean treatment time for preschool-aged children who stutter is greater than this (Jones, Onslow, Harrison & Packman., 2001; Kingston, Huber, Onslow, Jones & Packman, 2003). These two scenarios exemplify other common scenarios where there may well be conflict in our duties to our clients and our duties to our employers, who expect us to implement their policies. Some speech pathologists resolve such situations by ignoring official policies, but this compromises their integrity. How can we fulfil our duties to our community, which, in an affluent social democracy, expects the best possible outcomes for all citizens? How many of us actively advocate for change, to improve services for clients and to enable ourselves to act ethically?

Increasing litigation

According to reports in the popular press, Australia has become one of the world's most litigious societies. To the best of my knowledge, there have been no court cases resulting in successful prosecution of speech pathologists by clients in Australia. However, given the trends in our profession in the United States of America and in other allied health professions in Australia, speech pathologists may be at risk of legal action. The increasing complexity of client needs and workplace pressures discussed above, the pace of workplaces with intractable time pressures, together with better informed health care consumers are some of the factors driving increased litigation risks for health professionals. Applying an ethical decision-making protocol after an ethical dilemma has arisen will not protect

us from litigation. Nor will following the law necessarily protect us from ethics complaints. The interplay of ethical and legal conduct can be envisaged as follows:

| unethical but legal | ethical and legal |
| unethical and illegal | ethical but illegal |

We assume we readily will recognise illegal practice; can we readily recognise unethical practice? How attuned are we to practice that may be legal but not ethical, and conversely ethical but not legal? For example, reading the findings of the ASHA Ethics Board published in the ASHA Leader reveals cases where speech pathologists have been overly generous in interpreting treatment data as showing progress, so that clients can stay in treatment paid for by insurers. Some of these clinicians have attempted inadequately to reconcile conflicting ethical principles and duties to clients versus employers and insurers. We increasingly work in ethically and legally grey areas of practice.

Increasing demands for evidence-based practice

Workplace pressures and mandates do create ethical dilemmas for us as professionals beyond those involving face-to-face interactions with clients. In the section on duties to our employers, the Code of Ethics (Speech Pathology Australia, 2002) states that we "make sure that we follow best practice standards" (p. 5) and that "we strive to continually update and to extend our professional knowledge and skills;" (p.5). Not all speech pathologists are conversant with the principles of evidence-based practice or have the facilities to access literature and the skills to critically review literature to derive evidence for best practice. Budgets for professional development which might provide this upskilling and resources are severely constrained in many workplaces. As well as a duty to clients to be competent, we have a duty to our profession to not bring the profession into disrepute by offering ineffective assessments and treatments for clients. Given these ethical imperatives, whose responsibility is it to ensure we as individuals are knowledgeable and skilled to provide best practice and can fulfil concurrent and perhaps conflicting duties to ourselves, our clients and our employers regarding best practice? What should we do as an individual colleague or as a service manager when we aware that colleagues are not "fit for practice", for whatever reason? How do we balance duties to clients, colleagues, employers and the profession by ensuring staff are competent? There may be workplace barriers and penalties embodied in public service acts for speaking out against our employers. What other solutions can we adopt? Working towards solutions for these problems requires acting ethically on several fronts as well as moral courage.

So far in this paper, I have suggested that as a profession we may be narrowly focused on ethics as involving only client issues and too focused on the dilemmas of practice. Ethics in professional life involves more than just following ethical decision-making protocols. It also involves learning to make ongoing moral judgements. It involves not just making decisions about unusual ethics situations but thinking and acting ethically within the routine, ordinariness of professional life. Ethical practice is about pre-empting possible ethical issues as well as responding to those that have arisen.

Ethics in ordinary everyday practice

In her role as Vice-President Communication of Speech Pathology Australia, in a review of major types of complaints to the Ethics Board of Speech Pathology Australia, Russell noted that some major reasons for consumers' complaints are due to failure of speech pathologists to think and act ethically about ordinary events amidst busy professional lives (personal communication, 1 May 2005). Clients complained about their concerns over what they were being billed for and perceptions of overbilling, and about reports not being provided in a timely fashion. These two scenarios are avoidable by using good planning skills to make time for paper work, including report writing, and good communication skills to explain what we are doing and why. Problems that may prevent honouring agreements, such as sending reports within the agreed timeframe, need to be discussed. There are many other potential sources of complaint arising in ordinary clinical practice. Many are related to failure to explore the assumptions, expectations and emotional needs of clients and to consider these in communicating clinical management decisions, for example, those pertaining to service delivery models and therapy approaches offered, and discharge planning (Hersh, 2003). "Thinking ethically" would allow professionals to pre-empt such situations by sensing and discussing concerns clients might have and addressing them before they become problems.

Becoming ethically aware and thinking ethically

What would it mean to be always thinking and acting ethically in the workplace? According to Purtilo (1999), this would mean acting as a "moral agent" in the workplace, acting with personal integrity, despite personal and professional costs that may ensue. We may have to engage in conflict with management when polices or management decisions block our ability to act with integrity. We may need to engage in difficult discussions with staff who are not acting beneficently towards clients, not honouring clients' rights to autonomy, not pursuing justice for their clients, and perhaps even acting maleficently by not being competent to provide services they are, or should be offering, in line with best practice. We may, in extreme cases, need to report colleagues to supervisors/managers, or to the Ethics Board. Such acts require courage and support from mentors, supervisors or colleagues. At the very least, acting as a moral agent in the workplace means seeking to raise awareness in others about ethical issues, through conversation, role modeling or professional development.

Professional development of ethical reasoning

How can we increase our ethics awareness and abilities to think and act ethically? There is little research into ethical reasoning and conduct in speech pathologists. I would suggest that, like most professional skills, ethical and moral reasoning develop with experience, and that this development can be supported through mentoring, workplace supervision and professional development programs.

Benner (1984) noted that with increasing expertise, skills become automatic and require little conscious attention, unless a novel or extraordinary situation arises. "Being aware" also becomes somewhat automatic with experience. Torbert (1978) suggested that there are four interacting qualities of experience: the outside world, one's own behaviour, thought and feeling, and intuition, intention, and consciousness. He believed that while the outside world can be accessed through our senses, the other three qualities are accessible only through attuning our attention to their interplay. He believed that normally we "do not educate our attention to commute between figure, ground, and region, among focus, feeling, and intention, among task, process, and purpose" (Torbert, 1978, p. 112), to achieve a higher quality of attention. Torbert (1978) argued that a heightened awareness, what he called a "higher quality of attention", becomes a constant state of being in experienced professionals. In contrast, for less experienced professionals, awareness requires a deliberative focus (Dreyfus & Dreyfus, 1985).

Deliberative focus (a cognitive process) on potentially ethically challenging situations is likely to be difficult for less experienced professionals to sustain amidst the myriad of things to which they must pay attention. However, recent work in emotional intelligence (Goleman, 1995), in professional reasoning in nurse educators (Titchen, 1998) and in reasoning in clinical educators (McAllister, 2001), highlights the role of intuition and feelings in bringing heightened emotional awareness to professional work. Titchen (1998) in her critical companionship model, identified a rationality-intuitive domain which she saw as a blend of technical-rational and intuitive approaches to educating. Two of the concepts identified by Titchen in this domain, intentionality (conscious self-aware thoughtfulness) and saliency (the ability to know consciously or intuitively what is important), are useful concepts for consideration in developing ethical and moral reasoning. McAllister (2001) found that participants in her study both intuitively and consciously knew what was important to attend to. Further, as described in Titchen's model, they used both conscious and intuitive levels of awareness, depending on experience and ability, what seemed important at the time and what factors were influencing attention levels. The more experienced clinical educators used conscious and intuitive levels of both cognitive and emotional awareness. Less experienced educators relied more on emotional awareness but could later think through information obtained through intuition and what they referred to as "gut feeling". Mentoring, supervision and professional development would have therefore important roles to play in helping less experienced professionals utilise feelings and emotions about ethical situations to develop ongoing cognitive awareness and ethical reasoning.

In the absence of an evidence base on developing ethical awareness and reasoning, there is a need for research which could inform systematic professional development of ethical and moral reasoning. I would encourage the profession, at both workplace and association levels, to develop professional development programs aimed at raising consciousness about ethics, heightening awareness of potential ethical issues and learning to think and act ethically in ways that are deeply embedded in routine practice. These skills and attributes would be additional to skills in identifying and resolving dilemmas. Such professional development could consist of formal presentations, discussion groups about real or hypothetical ethical issues and dilemmas, and regular case reviews. There remains however, the need for individual speech pathologists to develop their own ethical reasoning. Reflection-on-practice is a hallmark of professionals (Schön, 1987). This could be extended to include reflection on ethical practice, using whatever tools sit most comfortably

with the individual. These tools could include journaling, critical conversation (which protects the confidentiality of those concerned) with a colleague or friend (Smith, 1999), mentoring (Rose, 2005), or formal, external, paid supervision external to the workplace such as occurs routinely in social work and mental health (Ferguson, 2005).

Conclusion

In this paper I have argued that codes of ethics and ethical decision-making protocols have both strengths and limitations. They cannot account for all possibilities in our increasingly complex and conflicted workplaces. I have argued that what is needed in addition to such protocols is a need for professionals to think and act ethically in the daily routines of the workplace, not just when confronted with an ethical dilemma. I have acknowledged that learning to think and act in this way is a developmental task which can be fostered through professional development and supported by mentors, managers and colleagues. While workplaces and the Association certainly have roles to play in professional development of ethical and moral reasoning, I believe the responsibility for thinking and acting ethically ultimately lies with the individual professional. I invite readers to reflect on what they are already doing as individuals to develop their ethical and moral reasoning, and abilities to act as a moral agent in their workplace.

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Ethics in clinical decision-making

Belinda Kenny

Ethics are an integral factor in effective clinical decision-making. While codes of ethics do not provide a recipe for resolving ethical dilemmas, knowledge and open discussion of bioethical principles may facilitate ethical practice in the speech pathology profession. This paper focuses upon some of the ethical issues that may confront speech pathologists in contemporary health care practice and aims to facilitate discussion of ethical practice in the speech pathology profession.

Ethics seek to determine how human actions may be judged right or wrong (Garrett, Baillie & Garrett, 2001). Professional ethics encompass diverse aspects of clinical work including intervention planning, management and outcome evaluation. Furthermore, professional ethics are important when defining professional relationships with clients, carers, managers and the community. While ethical decision-making may be focused towards doing the "right thing", the complexities of clinical practice may present challenges for a speech pathologist. Unfortunately, it is not always easy to determine the "right thing" when there may be differences between clients' and professionals' perspectives of good health care outcomes, quality of life and expectations for standards of care. Clinical decision-making may require speech pathologists to examine "grey areas" in client management where there may be multiple "half right" or "not as bad" options. Consider, for example, the issues encountered by a speech pathologist who is managing the swallowing and communication needs of a young adult diagnosed with a progressive neurological disorder in a community setting. What is a "good" versus harmful outcome for this client?

Professional associations, including Speech Pathology Australia, have developed codes of ethics to guide members' decision-making towards "right" or "good" actions and outcomes consistent with professional values. Our Code of Ethics identifies five bioethical principles: beneficence/non-maleficence; truth; fairness (justice); autonomy; and professional integrity (Speech Pathology Australia, 2000). Adhering to ethical principles is the hallmark of professional behaviour. To practice ethically, speech pathologists are urged to seek benefit and avoid harm to others, to tell the truth, deal fairly with others, provide accurate information, strive for equality in service provision, respect the rights of our clients to self-determination, maintain competence in our practice, and honour professional commitments (Speech Pathology Australia, 2002). The bio-ethical principles, described in the Code of Ethics, provide an aspirational guide rather than rigid rules of ethical practice. Thus, speech pathologists must interpret and apply these principles in their individual work settings.

What is an ethical dilemma?

Clinical decision-making often requires a professional to consider more than one ethical principle. An ethical dilemma may arise when there is a conflict among personal and/or professional values, organisational philosophies and expectations for standards of practice. Such conflict poses a problem in making decisions based on standards of fairness, justice and responsibility (Hinderer & Hinderer, 2001). For example, a speech pathologist may be concerned that providing a client with an accurate diagnosis and prognosis may adversely affect a client's motivation to participate in a rehabilitation program. The ethical principles of truth, autonomy, beneficence/non-maleficence and professional integrity may be at stake in this dilemma between the client's "right to know" and the professional's intention to avoid harm by controlling the content or timing of information. This dilemma may be further complicated if carers request that medical information is withheld from a client. Additionally, conflict may occur between principles of autonomy and beneficence when clients or carers refuse intervention or seek support for quality of life decisions with potentially harmful medical consequences. The client's right to self-determination is at odds with the professional's desire to benefit the client by providing evidence based practice.

Further ethical conflict may stem from caseload management policies. Speech pathologists managing large caseloads and long waiting lists may experience ethical conflict between principles of fairness (providing an equal but limited service to many clients) versus beneficence (providing a quality service to a small group while others remain on the waiting list). The caseload management strategy of withdrawing treatment in response to clients' poor attendance or compliance with home activities is also ethically fraught. Is it fair that Jack, who has a severe language disorder but inconsistently attends treatment sessions, should receive ongoing intervention when there are many clients on the waiting list who may derive significantly more benefit from the service? Will Jack be

significantly harmed by withdrawing the limited input and opportunity for change? Do all clients have the same right to a service even though personal circumstances may prevent their full participation? How much responsibility does the service provider need to take in adapting the "one size fits all" model for clients with complex and diverse needs? Resolving ethical dilemmas requires sensitivity to ethical issues, effective reasoning skills, motivation to demonstrate ethical practice and the courage to act upon ethical decisions (Armstrong, Ketz & Owsen 2003; Thorne, 1998).

Difficulties in ethical reasoning

In theory every member of the profession may state "Of course I am ethical!" By being part of a helping profession there is an assumption that our primary intention is to provide a beneficial service to the community. In practice, making an ethical decision is not always simple or straightforward. Why? Professional ethics may conflict with personal ethics or beliefs. Freegard (2006) described this type of dilemma as a conflict of conscience. A professional may have strong beliefs and values regarding the role of families, importance of education, death and dying and these values may be challenged by a client, carer or colleague. Clients may challenge our principles of fairness and professional integrity when the care we offer is influenced by our perception that they have knowingly contributed to their ill health, have a social history that may include criminal activities, domestic violence, or substance abuse. Additionally, clients whose attitudes, behaviours or expectations are perceived as "difficult" may present ethical challenges for the treating professional (Finlay, 1997). Speech pathologists' conflicts of conscience may subtly affect their preparation, intervention strategies, case management and discharge decisions. For example, speech pathologists working in acute settings may be constantly juggling caseload priorities to manage new referrals. There may be difficulties ensuring that clients with cognitive disorders, clients from culturally and linguistically diverse backgrounds and/or clients with demanding carers receive an equitable service. An English-speaking patient receives a comprehensive communication assessment while the Vietnamese-speaking patient in the bed opposite receives a basic communication screening because it is difficult, time-consuming or expensive to organise for an interpreter to be present. Ethical reasoning requires insight and reflection about the influence of value judgments on clinical decisions and not allowing personal values to negatively impact quality of care. Furthermore, health professionals are challenged to monitor and address the balance between economics of health care and ethical practice (Purtilo, 2000).

When might breaches of ethical principles occur?

Breaches of ethical principles may occur unintentionally when professionals do not consider ethical implications of their actions. A speech pathologist may continue to treat a client, Andrea, whose complex communication disorder requires referral to specialist services. Quality of care is limited by a professional's competence and Andrea is harmed when she does not access the most appropriate services for her communication needs. Breaches of ethics may also occur in regards to client confidentiality. Confidential client information may be disclosed by professionals during conversations in playgrounds, canteens and hospital lifts without consent and without due consideration of the potential for harm.

Conflicts of interest are not always straightforward and may lead to unethical practice (Handelsman, 2006). For example, a speech pathologist employed in a rural community may engage in sporting, religious or social activities with carers and experience challenges in separating personal and professional roles. Handelsman noted that professionals do not always recognise the strings attached to "harmless" invitations and small gifts from clients. Such strings may include expectations regarding the nature or quantity of care provided. Similarly, there may be strings to avoid in professional relationships. For example, a referral agent from a private service expects clients to receive priority or a reciprocal referral arrangement.

Speech pathologists may perceive that their ability to provide an ethical service is constrained by workplace policies and limited resources. For example, in an effort to provide a service with inadequate staffing and resources, speech pathologists may decide to "water down" evidence based interventions. Another difficulty that may be encountered in ethical decision-making is that upholding ethical principles may result in interpersonal conflict. Challenging a team member when they express discriminatory comments in a case conference report, questioning a colleague regarding a management approach that is not evidence based or advocating against policies and procedures that reduce the quality of care provided to clients is professionally and often personally challenging. Does keeping silent, ignoring or avoiding ethical issues erode our professional integrity and make us complicit in attitudes or work practices that may harm some of our clients (Pannbacker, 1998). Resolving ethical dilemmas requires an understanding of our Code of Ethics and the tenacity to actively address dilemmas in ethical practice.

What can speech pathologists do to support ethical work practices?

The complexity of ethical decision-making indicates that there is a need for professional support and guidance for clinicians in this area. The first step in forming an ethical decision is to identify when a clinical issue involves ethical principles. Is a client's well-being or autonomy threatened by the nature or actions of a service provider? Are the ethical principles of truth and professional integrity at stake in an interdisciplinary team conflict? Will proposed models of service delivery provide fair and just distribution of speech pathology resources to all members of the community? Sensitivity towards ethical issues may facilitate speech pathologists' management of ethical dilemmas and reduce breaches of ethics. Clearly, ethical sensitivity is based upon knowledge of the Code of Ethics and reflection upon ethical issues in everyday practice.

The second step is to actively incorporate ethics in decision-making by carefully considering how ethical principles may be applied during problem-solving and managing professional issues. Open discussion of ethical issues and support for professionals who are managing ethical issues in the workforce during case discussions and mentoring will support ethical practice. Two approaches that may support speech pathologists' application of codes of ethics are ethics of care and narrative ethics. An ethics of care approach (Gilligan, 1982) emphasises the importance of the rights of patients and their families to participate in health care decisions that involve ethical dilemmas. Benefit and harm are determined according to the family's

perceptions of health and well-being and the individual's social and physical environment. Narrative ethics focuses upon the professional community during ethical decision-making (Benner, 1991). According to a narrative approach, speech pathologists are part of moral communities whose members influence others by appealing to mutually recognised values and use those same values to refine understanding, extend consensus and eliminate ethical conflict (Nelson, 2002). The narrative approach emphasises the need for professionals to share their ethical concerns and discuss their strategies for managing ethical dilemmas. An ethical story may include the context of the dilemma, the history of the clients involved, perspectives of different stakeholders in the dilemma, and discussion and analysis of options available and potential outcomes. By sharing ethical stories, speech pathologists may clarify expectations for ethical practice in a rapidly changing health care environment. Finally, considering outcomes of decision-making from an ethical perspective may reinforce the need to develop policies and procedures that protect ethical principles and the rights of clients to receive a service governed by beneficence, truth, autonomy, fairness and professional integrity.

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Ethical reflections

Readability of written speech pathology reports

Suze Leitão, Nerina Scarinci and Cheryl Koenig

Peter had been struggling at school since year 1. He was now in year 3 and his teacher suggested he be assessed by a speech pathologist as he was still not reading fluently. Peter's dad was keen for him to be assessed – he himself had left school early with limited education and did not want the same for his son. Peter's mum felt that he would grow out of it, as his older sister had "got the hang of reading in the end", but she agreed to the testing.

The assessment was carried out by a speech pathologist employed by the school and the report arrived by post. It included the following:

A series of non-words were presented to Peter to assess his ability to apply letter-sound correspondence rules in reading. He scored 0/5 on this task. Peter used a top down approach when attempting these words, and tended to guess them as real words according to the first one or two phonemes.

On the phonemic decoding efficiency subtest from the Test of Word Reading Efficiency Peter's standard score was 60.

Working memory and semantic knowledge were tested using the Word Classes subtest from the CELF-4 which evaluates the ability to perceive the associative relationships between word concepts. Peter obtained a standard score of 6.

In summary, Peter has weak reading skills with a profile concomitant with a diagnosis of dyslexia. He will require support.

In this column of "Ethical reflections" we have chosen to focus on the topic of report writing. Why should we need to draw on our professional Code of Ethics (2000) when we have to write a client report? We know that the Competency Based Occupational Standards (CBOS, 2001) require us to record information objectively, effectively, accurately and in accordance with the requirements as stipulated by our workplace. We also know that on request, our documentation must be supplied for legal purposes. And, when we think about ethics and clinical reporting, it is clear we must adhere to confidentiality guidelines and obtain consent for distribution of information about a client. But what about ethical principles such as truth, fairness, autonomy and beneficence?

Let us start with *truth* (we tell the truth) and *fairness* (we provide accurate information, strive for equal access to services and deal fairly with all our clients). When working with speech pathology students in the early stages of their training, academics focus their teaching on the difference between objective, factual observations (e.g., the child cried during the session) and subjective interpretations (e.g., the child was tired and unhappy today). We may argue that both of these observations are "true" but we must be clear about the difference.

While many of the tests we use in clinical practice allow us to gather numerical "objective" data, the interpretation of these data and the language we use to report our findings will be influenced by our own therapeutic philosophies and theoretical constructs. The choice of test itself may even be influenced by a service provider's policy about eligibility for services. When we come to gathering informal assessment data, it is even more important to understand how the underlying framework we draw on (consciously or unconsciously) dictates not only what we observe, but also how we interpret and understand our observations, i.e., our version of "the truth".

Our Code of Ethics also talks about *beneficence* – seeking to benefit our clients and not knowingly causing harm. This balance can sometimes be hard to achieve. An example would be the tension we may feel when wishing to advocate for services for a client, but at the same time meeting our professional responsibility to accurately report the client's assessment results. How do we deal with the desire to have a child accepted into a service if their data don't exactly fit the eligibility criteria – do we downplay aspects of it, emphasise others? And if we do so, is this being truthful? Another situation may be when reporting information that we feel may be unexpected or distressing to a family – how do we strike a balance between accuracy/truth and beneficence/non-maleficence? How do we "word" a document such that the truth is told, but in the most sensitive way possible? The importance of showing sensitivity to parents' and carers' feelings and concerns must be acknowledged by speech pathologists. Research suggests that parents value reports which document both their child's strengths as well as weaknesses in order to portray a complete picture of their child (Donaldson, McDermott, Hollands, Copely & Davidson, 2004). Perhaps inclusion of such information may help speech pathologists to meet the ethical principle of beneficence.

In terms of competencies, CBOS element 2.5 is the most relevant to reporting: "Provides feedback on results

of interpreted speech pathology assessments to the client and/or significant others, and referral sources, and discusses management." This involves us determining the following:

- Who is to receive the feedback/report?
- How will we consult with the client and/or significant others, and/or the referral source about the content of the report?
- How is the report to be provided (oral and/or written)?
- How will we modify the language within our report to meet the needs of our client (and other readers)?

Reports often form the primary source of communication between speech pathologists and clients – they provide one way of facilitating communication and including the parent/carer in the assessment and intervention process. What happens however if the report cannot be understood? Are speech pathologists meeting their ethical obligations if reports are not accessible to the reader? Unfortunately it is common practice to see phrases such as the ones below included in paediatric speech pathology assessment reports:

On the phonemic decoding efficiency subtest from the Test of Word Reading Efficiency Stephen's standard score was 60.

The phonological processes: stopping, assimilation, final consonant deletion, and context-sensitive voicing indicate a phonological delay. The processes of initial consonant deletion, medial consonant deletion, and consonant cluster simplification are deviant processes.

Aidan achieved a standard score of 4 on the Formulating Sentences subtest. He was unable to use coordinating conjunctions and did not consistently use conjunctional adverbs in his discourse.

For practising speech pathologists, such terminology may be easy to understand; however for the parents and carers of our clients who come from varied educational backgrounds and occupations, these types of phrases are extremely difficult, if not impossible to understand. Research suggests that when parents are confronted with such terminology, they either completely disregard that section of the report, or attempt to guess the meaning of the unfamiliar terms (Donaldson et al., 2004).

So how do you make a report "readable" for our clients? Perhaps the best way to address this is to use a working example. Consider: "Sarah's phonological awareness, assessed by the SPAT, demonstrated her difficulties with phonemic segmentation, especially clusters, identification of coda, and phoneme deletion." This sentence is not accessible to Sarah's parents because professional jargon and acronyms have been used. A more accessible version of this report could read:

Phonological awareness refers to the ability to rhyme, break words into parts and blend sounds in words – these skills are important when learning to read and spell. Sarah's phonological awareness was tested using the Sutherland Phonological Awareness Test. This test is commonly used to assess children's reading skills. Results of this test showed Sarah is able to identify the sounds at the beginning of words (e.g., what is the first sound in "bike"?). However, she had difficulties identifying sounds in longer words when there were two sounds together, such as "dr" (e.g., tell me the sounds in "dream") and in identifying the final sounds in words (e.g., what is the last sound in

"knife"?). Sarah also had difficulty removing one of the sounds from a word and then saying the word that remained (e.g., say "farm" without the "f").

In order to foster respectful and effective relationships between families and clinicians, speech pathology reports must be accessible. Research into professional reports consistently indicates that the usefulness of reports to consumers is limited. Studies suggest that reports are often poorly written, poorly organised and easily misunderstood (Cranwell & Miller, 1987; Donaldson et al., 2004; Flynn & Parsons, 1994). Reports from speech pathologists tend to be ambiguous, contain excessive jargon, and are frequently written at a level that requires high level language skills (Tallent & Reiss, 1959; Weddig, 1984). This results in poor understanding and misinterpretation by parents, which in turn prevents effective communication and excludes the reader from the therapeutic process (Weddig, 1984).

To overcome issues of readability and access, reports should wherever possible not contain jargon, abbreviations or ambiguous language. In addition, reports should use short sentences, and should explain and interpret the assessment results in functional terms (Cranwell & Miller, 1987; Donaldson et al., 2004; Flynn & Parsons, 1994; Grime, 1990). Recommendations should be concrete, and test scores should be clearly interpreted with reference to the referral question.

The ethical principle most relevant to issues of readability and clarity is that of *autonomy*. Speech pathologists must respect clients' rights to self-determination and autonomy, by providing written material that allows them to make informed decisions and to be active in a meaningful way in the therapeutic process. After all, parents will be central to affecting change in their child's communication ability, and therefore, as specialists in communication, we have an ethical obligation to ensure that parents have access to the information they require. Parents have a legal right to be properly informed – failure by a clinician to provide information that is understandable to a parent may mean that informed consent has not been obtained.

Consumer response

Surviving the initial stages of shock and often denial following a child's diagnosis of speech and/or language difficulties is challenging for any parent. Families may be confused and overwhelmed, and these emotions can destroy a family's confidence and trust in their own judgment.

Compassion and empathy for this upheaval to family life is greatly appreciated by families. Most families respect and understand the need for professionals to adhere to their clinical training, but a "softening" of fixed and scientific views of humans as "statistical" beings is also greatly appreciated by consumers. Of course science has its important role to play, but human development cannot always be accurately determined by science, nor can potential be predicted, or spirit measured.

At times parents may feel bombarded with so much information that any information conveyed, especially verbal, has the potential to be forgotten, mislaid, or not understood. Sometimes parents may be so overwhelmed with the situation they won't always ask the "right" questions, and communication lines between therapist and parent may become blurred. Clear, concisely written reports are required. Further to this, information regarding services to be provided and fees payable, especially any additional fees for written reports and assessments, must

be preferably produced in written format, must be openly discussed and formally agreed to, prior to intervention commencing.

Also worth noting is that when parents and families are meaningfully engaged as part of a "team", better outcomes will ultimately be achieved! As stated by Dr Lisa V. Rubinstein, president of the US Society of General Internal Medicine, "Sharing in decision-making will help raise the quality of care given by any clinician, because it will sharpen the focus on the key decision points and help the clinician put a plan in place that the client understands and agrees with" (Chen, 2009).

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Ethical conversations

Patricia Eadie and Marie Atherton

The purpose of this "Ethical conversations" column is to promote reflection and discussion on what demonstrates ethical practice in speech pathology, and to encourage us to think about using a framework that considers ethical practice in a proactive way. We may think about the Association's *Code of Ethics* (2000) as something to turn to when faced with a dilemma, but it can also be a useful guide in our everyday practice, "in thinking and acting ethically within the routine, ordinariness of professional life" (McAllister, 2006).

There is rarely one opinion or right answer when it comes to ethical dilemmas in clinical practice. These dilemmas deal with real people in real life situations which can be complicated and messy. In order to practice speech pathology ethically we must be able to think through and clearly communicate the ethical issues that arise in our daily practice. The following case scenario deals with one of the nine key trends and issues in ethical practice in speech pathology (Atherton, 2007), that is the increased emphasis on evidence-based practice. There will be many different responses to it. It is hoped it also stimulates many conversations.

Case scenario

You are a speech pathologist working in private practice. Julie is a 7-year-old with severe receptive and expressive language impairment and literacy difficulties. You have provided weekly sessions for Julie for several months. Her mother, Geraldine, has done lots of reading about language impairment and is very involved in Julie's therapy.

Geraldine arrives at this week's session to tell you she has found information about a "new" therapy on the web. It is a computer-based intervention and requires the outlay of several thousand dollars. The information suggests Julie could make significant improvements in minimal periods of time. Geraldine asks for your opinion about whether she should stretch the family budget and enrol Julie in the treatment.

Response from Karen Walter and Mandy Brent, speech pathologists, Extra Ed, Victoria

This is certainly a familiar scenario for therapists in our practice – questions from parents have arisen in response to a number of "new" therapies. As parents ourselves we certainly appreciate the attraction of the claimed new therapy outcomes and Geraldine's powerful urge to do everything she possibly can to support and assist her child. However, we have a clear responsibility to Geraldine to help her assess the value of alternate therapies and approaches. The key to giving an ethical answer is to check the research and present the scientific evidence to date.

In seeking to adequately advise Geraldine, most of us would start with the most obvious sources of information and check with trusted work colleagues and associates. The Internet also has become an invaluable resource, at least as a more general orientation to a topic or approach. Of course, just because an opinion is posted on the web doesn't mean it's of high quality or comes from an authoritative source. So it's important to try and weigh up those issues as you trawl through the literature and web-based material. Sometimes it's possible to find "responses" to new therapies and approaches by speech pathologists and/or researchers with some authority. This can give you a sense of how the new therapy is being received and viewed by the profession more generally. However, some of what is on the web will be media pieces extolling the new therapy, and so must be treated with caution.

Having learnt as much as we can locally we might seek further counsel and contact researchers or academics at the local children's hospital or university speech pathology department. They are always most generous with their knowledge and welcome contact with therapists in the community over questions like this one.

Finally though, it's time to report back to Geraldine. Occasionally, this can be straightforward when your research has yielded conclusive results either for or against the therapy approach in question. However, more often the picture is inconclusive. For example, there may be conflicting views about the new approach. Alternatively, there may be some encouraging early results for some children but it may not be possible currently to say whether the treatment will be of significant value for Julie. Nonetheless, it is important to present what you have learned, the view that you have formed and why.

Of course, it is ultimately Geraldine's decision whether to proceed, and it may be difficult for the therapist if a parent decides to proceed despite the research results presented to them. However, there is very little that can be done about this and in the end what matters is that you have presented the information in an accurate and unbiased manner and

have conducted yourself ethically. Failure to do reflects poorly on our profession.

Response from Kate Short, acting head of Liverpool Hospital Speech Pathology Department, New South Wales

This is not an uncommon scenario for those of us working in a large public hospital and one which we sometimes discuss over lunch and in supervision. We encourage discussion of these issues and often include them in our monthly case presentations. There are a number of ethical dilemmas that require consideration here.

Conflict of interest

If working as a private practitioner, I would benefit financially from Julie continuing to attend weekly sessions with me. However, if Geraldine, chooses for Julie to begin the "new" treatment, it may mean that Julie must attend a different clinic, thereby terminating sessions with me and impacting me financially. As such, I may benefit from Geraldine choosing not to undertake the "new" treatment. Conversely, I may be able to provide this "new" treatment to Julie. It may require the delivery of more intensive services by me; thus I may gain by Geraldine's decision for her daughter to undertake the "new" treatment.

Evidence base for the treatment

The "new" treatment may not have a strong evidence base. If I know little about the treatment I cannot support nor deny it. I need to provide Geraldine with the information and the means to analyse and understand the treatment. I may assist with identifying questions Geraldine could pose to those promoting the "new" treatment and provide Geraldine with a background regarding the standard, accepted current treatment methods in this area and why they are accepted.

I often speak in generic terms with parents and carers about non-mainstream treatments and the pitfalls of some of these. Parents and carers are alerted to and can be mindful of the pitfalls when making their decision as to whether or not to support a new treatment. It is important to preface any discussion regarding a treatment with an honest disclosure of any bias I may have in relation to a treatment's validity. This discussion and assessment of validity will (hopefully!) be based on the presence or absence of accepted research and evidence. A discussion may also be required on the unknown and unclear outcomes of treatment techniques that lack research and/ or are poorly researched. It is important to keep in mind that both accepted and unaccepted treatments are often poorly researched.

Lack of knowledge/professional learning

If I do not know about the "new" treatment, it may be time to investigate and learn more: literature searches, discussion with peers, contacting the service myself. I have a responsibility to know about such treatments, provide guiding information, know if I am discussing a treatment that may do harm. However, in the prioritisation of time, not all new "fads" can be investigated and I need to make decisions regarding their importance before investing significant time in researching their validity.

Professional role

I feel trusted by Geraldine as she is asking my opinion about this "new" treatment. I need to make it clear that this difficult decision is hers and I will respect the decision she

makes, whatever my bias. My role is to provide information empowering her to make a decision. The persuasive power of the "expert" role is a force I am always aware of and aim to limit as much as possible. This scenario has the potential for me to take the "expert" role rather than one that empowers parents/carers to assess the program themselves.

Parents often seek "expert" advice, which is not a bad thing. However, it is important to present the information in such a way that parents/carers can still make informed decisions. Using statements such as "my assessment of this is…", "this could mean…", "the risks may be….", and "the benefits seem to be …". In the end parents and carers may make a decision against my advice, yet my aim should always be to respect their decision. Arming our clients with the tools that facilitate autonomous decision-making ("Autonomy", Principle 4 of our *Code of Ethics*; Speech Pathology Australia, 2000) is the key.

Response from Dr Patricia Eadie, Speech Pathology Australia Ethics Board member

This scenario generates questions around each of the five principles that form our Association's *Code of Ethics* (2000).

1 *Beneficence* (we bring about good) *and non-maleficence* (we prevent harm). Is there evidence that different interventions improve the well-being of our clients and to the same degree, or do some potentially do harm?

2 *Truth* (we tell the truth). What evidence exists regarding the effectiveness of our interventions and what do we discuss with our clients? How do we find information about best practice recommendations?

3 *Fairness* (we seek to ensure justice and equity for clients, colleagues and others). If we know the evidence for some interventions is better than others, do we advocate this for all clients equally? Do we consider external factors such as financial hardship when discussing options with clients?

4 *Autonomy* (we respect the rights of clients to self-determination and autonomy). Despite our own opinions, do we provide our clients with enough information about alternative interventions and service delivery options so they can make their own informed decisions?

5 *Professional integrity* (we demonstrate professional integrity as people would expect). When we present information about different interventions do we do so in an unbiased way and clearly state what our own stake in the choices might be?

Within the scope of this column, it is impossible to answer all of the ethical questions posed above. However, it is important to address the key issue here – that of evidence based practice (EBP). EBP is not just the latest fad; it's been around too long to be considered that! EBP requires us to integrate all of our clinical experience and expertise with the latest well-conducted research so as to understand whether what we do works. We also have to consider the context for both the family and service provider (which may include finances and geography through to age and motivation).

In order to address Geraldine's question, the speech pathologist must integrate the results of systematic and peer-reviewed research on language interventions for school-aged children with his/her own experiences in clinical practice. Excellent resources to do this include (but are not limited to): the Cochrane Collaboration (http:// www.cochrane.org/), *Evidence Based Practice in Speech*

Pathology (Reilly, Douglas & Oates, 2004), the new SpeechBITE™ initiative from Speech Pathology Australia and the University of Sydney (http://www.speechbite.com/)

It is important to balance clinical expertise with the necessity for evidence from systematic clinical trials of interventions. For example, a randomised control trial recently published by Gillam et al. (2008) draws some important conclusions about different treatment conditions (e.g., computer-assisted language intervention and individualized language intervention) and the variety of activities that can facilitate development. In a recent ASHA forum, Hoffman (2008), a practising speech pathologist and researcher, reflected on her experience of participating in this large clinical trial:

> For every child who ate a particular type of treatment up with a proverbial spoon, there was one for whom that treatment was as appealing as dry toast. It was then that I truly understood the necessity of large scale trials … I could see that clinical expertise is built on individual results, it very clearly shows the trees, but across a large scale that particular compass can't guide one out of the forest very well.

With the best available evidence on intervention outcomes, a conversation between Geraldine and the speech pathologist can begin to consider:

- the available evidence for each intervention type;
- what improvements Julie might be expected to make;
- what commitments, both time and financial, the family will need to make;
- what language and educational support Julie can expect to get within her school;
- any other information Geraldine would like to help her with her decisions. This might include, for example, research on long-term outcome for children with language impairments.

This conversation must also lay plain the potential conflict of interest for the speech pathologist – if a choice between interventions is made, will the speech pathologist lose a client?

I began by saying real-life is complex and can be messy and in the end, the evidence may or may not be clear about the effectiveness of all our interventions. However, *it IS our ethical responsibility to know what the available evidence tells us*. Every individual client is different and will respond to interventions differently. The best evidence needs to be integrated with clinical reasoning in order to make ethical decisions around service delivery for each of our clients.

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The ethics of interprofessional health care

Considerations for speech pathologists

Trish Bradd, Helen Smith, Noel Muller and Christina Wilson

From top to bottom: Trish Bradd, Helen Smith, Noel Muller and Christina Wilson

Ethical practice is fundamental to the profession of speech pathology. This article explores ethical factors relating to interprofessional practice which may arise when speech pathologists work as part of a clinical team in the provision of care to patients/clients.

Upholding high standards of ethical practice is fundamental for health care professionals, including those within the profession of speech pathology (Speech Pathology Australia [SPA], 2010; Clark, Cott & Drinka, 2007). In health care settings, ethical issues can be described as "standards of practice linked to the dyadic responsibilities of individual providers towards their patients and with each other as professionals" (Clark et al., 2007, p. 591).

The Speech Pathology Australia Code of Ethics (2010) describes the values, principles and standards of practice that underpin the profession of speech pathology in Australia. Professional standards within this code (see 3.4.1) exhort us to work in cooperation with colleagues in order to meet client and community needs as well as those of the profession (SPA, 2010). According to Reeves et al. (2008), patient care is a complex activity which necessitates the effective coordination of health and social care professionals' work, thus there is a responsibility for providers of health care, such as speech pathologists, to work in collaboration with other professionals in the interest of enhanced patient care (Clark et al., 2007).

Interprofessional collaboration (IPC) has been defined as "two or more healthcare team members from different professions working together to provide more integrated care to patients" (Braithwaite et al., 2013, p. 8). In practice, this might include the management of a person with chronic disease with nutritional needs; a child who requires structured learning support at school or a young adult returning to work after a traumatic brain injury.

IPC is a process which positively impacts health care (Zwarenstein, Goldman & Reeves, 2009), and it collectively includes interprofessional learning and interprofessional practice (Braithwaite et al., 2013; Shulman et al., 2007). Speech pathologists participate as members of teams in many workplaces with interprofessional practice considered a core and critical competency for entry level clinicians (SPA, 2011). These teams may be multidisciplinary, interdisciplinary or transdisciplinary in nature (D'Amour, Ferrada-Videla, Rodriguez & Beaulieu, 2005; SPA, 2009)

and many national and international guidelines now stress the fundamental nature of IPC to best practice intervention (National Stroke Foundation, 2010).

Interprofessional teamwork is characterised by a high degree of professional collaboration encompassing sharing, partnership and interdependency across health care professionals (D'Armour et al., 2005; Wright & Bratjman, 2011). In such teams, there is a common element of ownership and decision-making as well as an explicit integration of the knowledge and skills of each professional in order to address complex clinical problems (D'Armour et al., 2005).

Policymakers, clinicians, managers and researchers have reported that improved patient safety and quality of clinical care can be positively influenced by strong IPC (Braithwaite et al., 2013; Reeves et al., 2008; Wright & Bratjman, 2011). Other benefits of collaborative interprofessional care have been described as enhanced morale in the health care team, improved patient and family satisfaction and more efficient service provision (Wright & Bratjman, 2011).

Ethical challenges for interprofessional practice

There are a range of barriers to interprofessional practice which may impede effective collaboration at the level of service delivery (Irvine, Kerridge, McPhee & Freeman, 2002). In their Cochrane review of the literature, Zwareinstein et al. (2009) found when different professionals work together in IPC various issues can arise, such as challenging power dynamics, poor understanding of the roles and responsibility of self and others, problematic communication patterns and conflicts in approaches to patient care.

The barriers to interprofessional practice have been described as structural (which impede the development of working relationships at the level of service delivery) as well as cultural or "how things are done around here" (Boomer & McCormack, 2010, p. 636). Here are some examples, within these broad areas, of issues often encountered:

a) structural barriers
- professional divisions with variable authority and divisions of labour (Irvine et al., 2002)
- perceptions of boundary infringements (Reeves et al., 2008)
- medical dominance, including legal responsibility for patient care (Irvine et al., 2002)
- different frames of reference for prioritising clinical problems (Irvine et al., 2002)
- poor coordination of teamwork (Reeves et al., 2008)

b) cultural barriers
- profession-specific world views, where there may be differences in language, vocabulary, approaches to clinical care and different understanding of values and issues (Hall, 2005)
- intellectual and qualitative differences (Irvine et al., 2002)
- issues of professional identity (Braithwaite et al., 2013; Irvine et al., 2002)
- lack of understanding of others' roles (Reeves et al., 2008).

Thus, there is a need to develop and to clearly articulate a shared understanding of the role of the speech pathologist with respect to the interprofessional team in order to minimise the impact of interprofessional barriers. Such interprofessional discussions could include perspectives on moral reasoning and ethics (Wright & Bratjman, 2011). Indeed, professional ethics is one force which can drive the reform of interprofessional relationships in order to ensure greater team effectiveness (Irvine et al., 2002) and ultimately better health outcomes.

While there are a range of approaches to ethical critiques, understanding interprofessional care requires an appreciation of the diversity of subject viewpoints, including those between and within health care professions (Irvine et al., 2002). This, Irvine et al. (2002) suggest, necessitates an openness to concepts of practice ideology, such as understanding and accepting both the social and medical aspects to client care. In practice, this may take numerous forms, for example, how a clinical team incorporates the opinion of the speech pathologist when planning to discharge a patient from the ward.

Attitudes towards interprofessional collaboration

One factor in determining whether IPC is successful lies in the extent to which the attitudes of health professionals are aligned in support of IPC in practice (Braithwaite et al., 2013). In their recent longitudinal Australian study, Braithwaite et al. (2013) concluded that personnel from the major health professions (including speech pathology) generally value IPC, with allied health having the most favourable attitude towards interprofessional practice and doctors the least. More specifically, allied health professionals had more favourable ratings in relation to the quality of interprofessional care, teamwork and collaboration (Braithwaite et al., 2013).

In a practical sense, differences in attitudes may have ethical implications for speech pathologists working in interprofessional teams. Different views of IPC can lead to dilemmas in terms of the delivery of services to clients, for example in areas of confidentiality and privacy, and service provision where there may be differing views of how these are best approached. These differences may need to be explored, discussed and resolved locally in order to "provide clients with access to services consistent with their need" (SPA, 2010, p. 10). For example, negotiating which team members should attend a clinical outreach flight to a remote area community when only three of five members of a paediatric assessment team can be accommodated on the flight.

Ethical reflection in an interprofessional context

Reflective practice is a self-regulatory process that facilitates an enhanced understanding of both the self and the situation with the intention that future actions can be informed by this understanding (Sandars, 2009). Reflection promotes self-awareness, self-monitoring, self-regulation and mindfulness (Mann, Gordon & MacLeod, 2009). Stone, Groesbeck and Parham (2007) note that critical reflection is one of several principles that should underpin the work of community health workers, stating "it is ethically very important to examine practices, structures, and concepts that may maintain inequitable power imbalances" (p. 360). This notion could be extrapolated to speech pathologists working in health care and other team settings. Feedback from professional development activities, student teaching and research in speech pathology settings indicate that critical reflection is used as a tool more often by more experienced clinicians in order to identify and articulate ethical dilemmas. It becomes a part of daily professional practice.

Reflective questions might include:
- What specific knowledge or skills do I bring to the team?
- How could the functioning of the team be improved to benefit the needs of clients?
- Do I hold attitudes which may be restricting optimal teamwork?

Interprofessional practice and ethics as a moral issue

Ethics involves exercising our moral obligation and duty (Clark et al., 2007). In noting that a sole disciplinary perspective is inadequate to account for the diversity of a person's health care needs (biological, psychological, social and spiritual), Wright and Bratjman (2011) suggest that the impetus for health professions to work collaboratively is a moral one. As Zwarenstein et al. (2009) assert, how well different health care professionals work together can influence the quality of the health care provided. Thus, they suggest, if there are difficulties with how health care professionals communicate and interact with each other, problems in patient care can occur (Zwarenstein et al., 2009).

Interdisciplinary moral deliberations are required for reflective and balanced clinical decisions to be achieved in complex clinical scenarios. As health ethics may be viewed differently across disciplines (for example, medical ethics versus social work ethics), a patient-centred approach focused on how patients might be best treated should be taken (Wright & Bratjman, 2011). Wright and Bratjman (2011) also caution that, despite this intent, individual professions may have specific ideas in relation to their contributions in relation to what entails optimal care and how that care is delivered. Such an issue highlights the importance of giving patients and carers a voice in defining "good" health care outcomes.

Ethics and interprofessional practice – addressing the issues

Health care systems are complex entities characterised by competing demands, ongoing workplace reform and changing work environments (Firestone, 2010; McAlearney, 2008; Miller & Gallicchio, 2007). The complex dynamics of individual professionals and their health care team must function within this messy environment (Clark et al., 2007). Addressing the ethical issues which arise from interprofessional practice can similarly be challenging.

An interprofessional ethics framework

As described above, the effectiveness of an interprofessional team is influenced by a range of factors, including shared understanding of team roles and function,

views of the patient/client and their carers, and the strength, experience and limitations of individual disciplines. Teamwork efficiency is promoted by clear team and organisational processes which support teams in their efforts to be effective and efficient (Clark et al., 2007).

In reviewing teamwork within an ethical framework, the principles of beneficence, non-maleficence, truth, integrity, respect for autonomy and justice must be considered by the interprofessional team and should be reflected in how clinical decisions are made (Clark et al., 2007; SPA 2010). For example, an effective family meeting may involve a treating team "pre-meeting" to explore treatment options and ensure a shared understanding of the current clinical picture before presenting the realistic achievable options to patients and their families. It could also include discussion in relation to how team members can demonstrate mutual respect for each contribution to the patient's goals.

Clark et al. (2007) propose a conceptual framework to assist health care teams to understand the ethical parameters of interprofessional teamwork. This comprises three elements which function at individual, team and organisational levels:

- *Principles* – general guidelines for behaviour based on ethical concepts. For example, accepted practice standards of the professions in a team.
- *Structures* – formal and informal processes which include forms of knowledge and patterns of behaviour for individuals and collectively related to teamwork within an organisation. For example, shared awareness of the practice of other professionals on a team.
- *Processes* – procedural factors of interprofessional practice. For example, the development of open communication and dialogue.

The use of such a framework can assist speech pathologists and their teams to further the "discourse on interprofessional ethics" (p. 601) in order to better understand these issues and develop solutions to address them (Clark et al., 2007). Furthermore, collaboration should be understood as a human process as much as a professional one, encompassing both what we know and who we are (D'Amour et al., 2005).

An interprofessional ethic of care therefore may better facilitate patient-centred decisions, particularly if considered within a reflective framework such as the one described.

IPC practice-based interventions

IPC practice-based interventions are strategies put into place in health care settings to improve work interactions and processes between two or more types of health care professionals (Zwarenstein et al., 2009). In their review of the literature, Zwarenstein and colleagues (2009) describe a small number of promising activities which were shown, to varying degrees of robustness, to have positive effects on IPC. These included interprofessional rounds, interprofessional meetings and externally facilitated interprofessional audit processes.

Speech pathologists may have the opportunity to participate in these forms of interventions in their workplace and, where interprofessional skills are not practised, consider advocating for their adoption. For instance, they could reflect on how ward rounds and meetings may be adapted so that perceived power imbalances could be addressed allowing for more opportunities for shared goals and planning. In considering resource allocation, organisations may also need to empower health professionals with the necessary time to participate in IPC.

Interprofessional education

Interprofessional education (IPE) is also seen as one area which may offer a potential avenue for improved collaboration and patient care (Reeves et al., 2008). IPE facilitates an opportunity for different health professionals to engage in shared learning in order to improve collaborative practice and the health care of patients. It therefore has greater potential for improving IPC than multidisciplinary (where there are shared learning experiences but no interaction) or uniprofessional education (where professionals learn independently from one another) (Reeves et al., 2009). Further detailed information in relation to interprofessional health education can be found in the comprehensive literature review completed by the Learning and Teaching for Interprofessional Practice (LTIP) Australia project team (2011).

It is noted that application of an interprofessional approach is growing in student education by higher education providers (LTIP, 2011). A work culture that facilitates this practice is thus important so that students do not disengage when they enter the workforce.

Expanded scope of practice

Currently in Australia, there is much discussion about expanded scope of practice roles particularly for nursing and allied health practitioners; for example, see work undertaken by Health Workforce Australia (2013). These changes in understandings of professional boundaries may lend themselves to conflict and concerns both intra- and interprofessionally (Shulman et al., 2009). For instance, the concept of speech pathologists being credentialed to independently perform FEES or suction through a tracheostomy has led to much controversy in some work places in relation to competency and to issues of potential quality and safety impacts.

Implications for speech pathologists

As members of the health care team, speech pathologists play an important role in the successful application of interprofessional clinical and team-based care in practice. However, as we have endeavoured to demonstrate, interprofessional ways of working may result in speech pathologists facing a range of complex ethical challenges.

In updating and revising the 2002 SPA Ethics Education Package, the SPA Ethics Board has taken the approach of encouraging speech pathologists to integrate ethical decision-making into every day practice, including the way in which ethical dilemmas are viewed and the approaches taken to resolve them. To assist this process, the existing *Ethics Education Package* is being updated and revised to include additional protocols and tools designed to help clinicians to explore, better understand and resolve ethical issues.

These tools provide an excellent resource to assist speech pathologists grappling with issues in relation to interprofessional collaboration. Clinicians are encouraged to reflect on these issues as relevant to their own context and to explore ways to improve interprofessional practice in the interests of enhanced patient care.

Conclusion

As stated in the profession's Code of Ethics, speech pathologists observe the highest standards of integrity and ethical practice as a fundamental professional responsibility (SPA, 2010). In undertaking this work, speech pathologists are obliged to consider our clients in a broad context and in

the community in which they operate. Clients with multiple or complex needs will be increasingly engaging in interventions provided by a range of different practitioners using a range of treatment and care modalities. The profession as a whole as well as individual practitioners need to consider how we respect, collaborate and work with other professionals to improve clinical outcomes and enhance the seamless delivery of services. Interprofessional collaboration including interprofessional learning and practice offers a process with benefits and challenges for practitioners.

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Communicatively accessible healthcare environments

Ethics and informed consent

Deborah Hersh and Melanie Breese talk to Suze Leitão

Deborah Hersh (top), Suze Leitão (centre) and Melanie Breese

Suze

When most clinicians reflect on the topic of informed consent, they tend to think about it in the research context. The topic of this issue of *ACQ* – Communicatively Accessible Healthcare Environments – made me reflect on the role that informed consent plays in making healthcare environments accessible for our clients. It reminded me that informed consent is also critically important in making decisions, for example, about treatment.

Deborah

Informed consent for treatment is "not a discreet event but a process of information exchange and autonomous decision making" (Berglund, 2004, p. 79). It involves sharing and understanding the details, including benefits and risks, and choices about treatment, making a voluntary, competent decision, and being able to express that decision. However, we know as speech pathologists that it is precisely a difficulty with elements of that process which often prompts a person to seek our services in the first place. Informed consent for treatment can be a difficult area when judging whether someone has decision-making capacity, whether to rely on a family member as a proxy or to refer for guardianship. For those with capacity but with communication disorder, speech pathologists may need to be creative about how to make information truly accessible.

So when we think about informed consent for treatment, it is useful to look beyond the classic choice between two medical procedures or signing on the dotted line of a consent form (important as those may be) to also consider how we might enable our clients to be more fully informed and involved in negotiations about intervention. Body and McAllister (2009) point out that access to meaningful information is important for health, and reduces client and carer stress. The timing, format, and manner of delivery are all important. Information may need to be shared regularly and reviewed over time.

Suze

Yes, there is a responsibility for us, as speech pathologists, to make sure our healthcare environments and the assessments and interventions we offer within them, are as accessible as possible. We need to ensure we present information in a clear and concise manner. We have to remember that our clients, and their families, may not being making a fully informed decision about the therapy process. Sometimes, I think we assume that "implied consent" is the same thing as "informed consent".

Deborah

Speech pathologists know about the importance of presenting oral and written information in accessible ways, using alternative and augmentative communication, involving family members appropriately, adapting the environment effectively to promote communication and checking for feedback that information has been understood. In addition, ethical principles can help guide the process such as through respecting autonomy, veracity or telling the truth, and beneficence or doing the best one can to bring benefit to the client. However, it is also worth stating the obvious – that the quality of the relationship and the level of trust between clinician and client have a contribution to making information accessible. Obtaining informed consent for treatment is not just giving information but involves sharing information, something which is more effective when two people understand each other well. Perhaps it is also worth adding that if the speech pathologist is viewed as accessible (easy to talk to, someone who really listens, someone who is available to answer questions and provide reassurance), then it is more likely that the information provided will be accessible too.

Suze

I agree. On a number of occasions, family members have talked to me about their experiences with other therapists. Sometimes, they have not really felt comfortable with what was going on in therapy for their loved one, and have not really understood the reasons behind it. However, this has been difficult for them to tackle because of the assumption that the therapist is the expert and must know what he or she is doing. One of the suggestions I talk through with them is to try to make an appointment to sit and talk through the therapy process with the speech pathologist, and ask questions about the goals, the reasons underlying the approach, and the process itself. It seems as though in these cases, the clinician has not been viewed as "accessible".

Melanie, in your clinical practice, how do you deal with consent for treatment in people with dementia and cognitive damage who have already been judged as "lacking in competence"?

Melanie

I try to consider several ethical principles in these cases:
1. Respect for human life and dignity.

2. Respect for individual's right to self determination/autonomy, which includes informed consent, disclosure of information to the patient, duty of confidentiality.

3. Beneficence and non-maleficence, which includes treatment that is in the patient's best interest, evidence based best treatment, and duty of care.

4. Justice, which includes fairness in allocation and use of resources, and the greatest good for the greatest number of people.

The right to autonomy (principle 2) can come into conflict with treatment which is in the patient's best interest (principle 3), as in the following example.

An 80-year-old gentleman who is on an inpatient ward following a stroke has a swallowing disorder diagnosed by the speech pathologist and requires a modified diet and thickened fluid in order to avoid the risk of aspiration. He has a background of cerebrovascular disease with a known "Mini-Mental" (Folstein) score of 15 /30, consistent with a moderate dementia (likely vascular dementia). He becomes agitated on the ward, refusing to drink any thickened fluid, and demanding a cup of tea. The speech pathologist tries to explain the risks of aspiration to the patient but is unsuccessful in persuading him from his position. Following this, the psychiatrist is called to assess the patient's competence.

She deems the patient to be lacking in decision-making competence. In this instance, since the patient lacks competence, consideration needs to be made of:

• what is in the patient's best interest. This would be to continue the speech pathology recommendations of thickened fluid and a modified diet. If these recommendations are not followed there may be a risk of aspiration and subsequent death.

• whether the patient has an "Advance Healthcare Directive" ("Living Will") on his file with a statement of values in which he favours quality of life, and ability to eat and drink what he chooses, over prolongation of life.

This is where the ethical principles above of 2 and 3 come into conflict, and the "Advance Healthcare Directive" reflecting the patient's wishes would have to be followed at the expense of medically acting in the patient's best interest. However, the directive would be upheld only if the patient had been sufficiently specific about what treatment he would refuse. If there is no directive, other paths need to be considered, including:

• whether the patient (when competent) has nominated someone to have "Power of Guardianship". If he has then that person will have the decision-making capacity on behalf of the patient.

• whether a family member is prepared to be a proxy decision-maker. This is the commonest outcome, but can be problematic.

A potentially difficult scenario may be the proxy decision-maker. There may be conflict between family members about who is to be the proxy decision-maker, and each family member may have different ideas about what is in the patient's "best interest "– and each person has a right to self- determination. I often have relatives saying things like: "But he just loves his cup of tea, surely you can't take that simple pleasure away from him, when he has so little else in life".

So, in practice, there is discussion with the patient's decision-maker about the risks of not adhering to speech pathology recommendations. After explanation, the decision-maker usually understands the risks, and then helps to persuade the patient to take the recommended

modified diet and thickened fluids. If not, we return to principle 2 "in the patient's best interests". This produces more possible scenarios:

1. If the patient is at the end stage of his illness (which is often the case), then deeming him of "palliative" status would allow him to consume whatever diet and fluid he wishes. This may be considered to be in his "best interests". Even in this case, the decision-maker has to agree with the palliative status, and all discussions and actions would be fully documented. If the decision-maker does not agree to palliative status, we would continue to attempt to get the patient to accept modified diet and fluid if possible.

2. In the case of the non-palliative patient, the speech pathology recommendations are still in the patient's medical "best interest", and would therefore be upheld. In this case if the patient still refuses modified diet and fluid, or the decision-maker allows the patient to drink cups of tea (as a way of exercising the patient's right to self-determination), this would be documented in detail to avoid liability on the part of the health authority, in the event of the patient's health status declining, or of these actions causing the patient's death.

Suze

Thank you, Deb and Melanie, for sharing your thoughts on this very important aspect of ethical practice. We must be mindful of the need to ensure that the people we work with understand that they are partners in the therapeutic process. They should be fully informed about the assessments and interventions we offer them, and we need to make our information, ourselves as clinicians, and our healthcare environments as accessible as we can.

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Digital possibilities and ethical considerations

Speech-language pathologists and the web

Grant Meredith, Sally Firmin and Lindy McAllister

Grant Meredith (top), Sally Firmin (centre) and Lindy McAllister

The world wide web offers the promise and means of continual development and improved access to speech-language pathology services for people with communication disorders. In this paper we describe practices and possibilities for service provision for this population, using telehealth and emergent virtual worlds. We illustrate these technologies with a particular focus on research and developments for people with communication disorders. We then highlight some of the ethical risks associated with the web in terms of the promotion of non-evidence based practices, client–patient relationships and the storage and access of client data. These concerns are discussed with reference to Speech Pathology Australia's Code of Ethics, and provide guidance to speech-language pathologists regarding the potential dangers associated with service provision over digital platforms.

Last year the world wide web (the web) turned 21, and now over 72% of Australian households are connected to it (Australian Bureau of Statistics, 2011). The web is a collection of web pages which function as a resource of the Internet (the world's largest network consisting of millions of linked computers) (Morley, 2011). Today, the Internet and the web enable people around the world to communicate, interact, and share information on a large scale for activities such as commerce, health care, education, socialising, and gaming. However, global inequality of access and knowledge of information and communication technologies (ICT), known as the *digital divide* (Wei, Teo, Chan, & Tan, 2011) does exist. Consequently, the Australian federal government has recently begun rolling out its highly publicised National Broadband Network (NBN) which aims to connect all Australians to a high-speed web by 2020, enabling a digitally supported economy (Department of Broadband, Communications & the Digital Economy, 2011).

As an ICT infrastructure develops, it is the role of all public sectors, including health, to utilise and plan for its inclusion into a digital future. The first purpose of this paper is to outline developments within telehealth, and work associated with the emergent virtual world platforms, with regard to the provision of speech-language pathology (SLP) services. The second aim of this paper is to outline for SLPs some major ethical concerns associated with embracing these emergent and evolving technologies; that is, serving a digital community while abiding by the profession's Code of Ethics. We commence our discussion of these applications of the web in regards to people with communication disorders (PWCD) through a short review of the more established area of telehealth.

Telehealth

Telehealth is not a new digital phenomenon. Modern telehealth started in the 1960s largely driven by the needs of the military and of space exploration. Early technologies included the use of television and the telephone (World Health Organisation [WHO], 2010). Contemporary telehealth includes:

> *The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities. (WHO, 2010, p. 38)*

The provision of health services to remote sites is supported by a wide range of technologies (see Table 1 for a list of resources commonly used by SLPs to support their service delivery). Technologies such as videoconferencing suites, email, tele-imaging, and more recently, rich multimedia approaches such as video-streaming are commonly used (WHO, 2010). The use of fixed, high-tech videoconferencing suites to provide telehealth services through public health departments is well established. One example of the use of this technology occurs within the Southern Inland Health Initiative which delivers telehealth services including videoconferencing and remote diagnosis to outpatients in rural and remote areas in Western Australian (Department of Health, 2011). A second tool is the portable *e-hab* system, developed by Theodoros and colleagues, for telehealth service delivery to people with a range of communication and swallowing impairments (see for example, Sharma, Ward, Burns, Theodoros & Russell, 2011). Another technology being investigated for service provision is desktop videoconferencing applications such as Skype, which is envisaged to play an important role in future delivery of low-risk clinical functions (Armfield, Gray & Smith, 2012; Carey et al., 2010).

Table 1. Websites of interest to SLPs		
Name	Description	URL
Dropbox	A storage website that allows file storage and sharing	https://www.dropbox.com/
Facebook	A social networking website that allows account holders to create profiles, upload images, video and text chat over the Internet	http://www.facebook.com
Second life	A 3D virtual world where users can communicate using free voice and text chat	http://www.secondlife.com
Skype	A platform that allows text, voice and video calls over the Internet	http://www.skype.com
Twitter	A social networking website that allows account holders to post short text messages	http://www.twitter.com/
YouTube	High-quality video streaming technology that offers support for nearly every video format	http://www.youtube.com

Virtual worlds

An emergent web-based platform that may be new in concept and practice to SLPs are virtual worlds. Virtual worlds are on-line three-dimensional (3D) environments which attract large numbers of registered and concurrent users for a range of purposes including commerce, education, and socialisation. An example of a popular virtual world is *Second Life* (http://secondlife.com/). In 2011 the number of registered users across virtual worlds was approximately 1.185 billion (Wasko, Teigland, Leidner, & Jarvenpaa, 2011), indicating these virtual environments have become well accepted in modern society. Users within virtual worlds represent themselves as an *avatar*. An avatar is a user controlled virtual character through which the user can portray and play out their identity (Novak, 2012). Through avatars users can personalise their appearance and their movements to a high degree, enabling complex interaction with other avatars in the form of virtual gestures, instant text messaging, and speech. These virtual environments are currently being used and trialled across many sectors for simulated scenarios, for learning, and for provision of support services (see Wasko et al., 2011).

Virtual worlds are currently not well utilised or researched by SLPs (Brundage, 2007; Brundage, Graap, Gibbons, Ferrer, & Brooks, 2006; Packman & Meredith, 2011; Meredith, Miller, & Simmons, 2012), but they do offer new possibilities for client services and education. For instance, Brundage and colleagues developed and evaluated simulated job-interview scenarios using people who stutter which were presented to the user through the use of elaborate virtual reality (VR) headgear. Participants were led through a simulated process which situated them within a 3D virtual setting of an office environment and job interview. The virtual interviewer was controlled externally by the researchers to give it a sense of autonomous in-world life. The ability to control the interviewer avatar and responses enabled the researchers to inject variability, mood, manner and stress into the environment. Results indicated that the general fluency levels of the participants were the same within the virtual environment as they were in real life, and that they experienced similar feelings and apprehensions associated with the real-world alternative. The participants indicated that they generally found the VR experience to be realistic. These findings suggest that virtual environments, if designed and implemented well, could be alternative environments within which clients can test and practice intervention strategies.

Virtual worlds also hold great promise for education of SLP students, and self-advocacy for consumers. There have been significant advancements in the use of virtual worlds for simulation and service delivery across many health sectors. For instance, the Northern Michigan University's Speech-Language and Hearing Science Island (Bickley, 2009) within *Second Life* was designed as a speech language pathology and hearing science experience for students, patients, and other interested individuals. The island also offers a conceptual

virtual SLP clinical environment, an interactive larynx model, and an educational area concerning stuttering.

Similarly, the Virtual Stuttering Support Centre (VSSC) (Meredith, 2011), located on the University of Ballarat's virtual island within *Second Life*, houses a virtual campus and a range of interactive virtual experiences. The VSSC contains a series of interactive scenarios which a person who stutters can work through in order to practise their fluency (Packman & Meredith, 2011). The scenarios are hosted by *Bots* (software-controlled avatars which look similar in appearance to a human-controlled avatar, giving the scenario a sense of autonomy and validity). The VSSC also has the capabilities to hold virtual meetings, conferences, and social functions for people who stutter all over the world to interact with, share ideas, and build on-line support structures.

Ethical challenges for SLPs using web-based services

So far in this paper we have drawn on developments in telehealth and virtual worlds, with particular reference to applications of these technologies to people who stutter, to illustrate the potential of the web to improve access to SLP services for PWCD. In this section, we consider ethical issues that may arise with telehealth and virtual worlds, and some implications for practice with regards to Speech Pathology Australia's (SPA) Code of Ethics.

There are numerous ethical issues arising from the use of the web for the delivery of SLP services including ease of client access to information and treatments that are not evidence-based, the impact of technology on the clinician–client relationship, and privacy and data storage.

Unregulated and non-evidence based information and practices

One of the dangers involved with the web is the freedom that it offers. It is now easy for a private individual anywhere in the world to create their own website and advertise an unsubstantiated, non-researched claim of assistance, cure and treatment. Such claims of instant or rapid cures may be accessed by vulnerable individuals seeking a solution to chronic or debilitating conditions. Concerns have been raised within a variety of health fields ranging from alternative medicine to autism spectrum disorder and stuttering about such sites (British Stammering Association, 2011; Cienki & Zaret, 2010; Harmse, Pottas, & Takeda, 2010). Websites offering such interventions are difficult to police and shut down due to being internationally hosted and to the legislative complexity surrounding the global governance of websites. These websites are problematic for SLPs in at least two major ways. First, because members of the public are often not in a position to judge the quality of information on websites, they may not be able to distinguish between evidence based SLP practices and those promoted on websites that are not evidence based.

Evidence based treatments have been ethically researched, scrutinised by peers and have proof of their general effectiveness. The opposite can be said for some web-based treatments and therapies already in existence. Second, non-research based information on a website may be used by PWCD to self-diagnose and perhaps self-treat their communication disorder. The risk for these people can be significant in terms of financial commitments and wasted effort learning techniques taught by unqualified people. Another risk for PWCD could be loss of faith in the associated SLP profession due to the technique not providing them with a promised "cure" or "elimination" of their communication disorders. SLPs have ethical duties to educate clients, their families and carers, and the community at large, about evidence based approaches that are known to be effective and provide accurate and timely information about those practices which are not evidence based (SPA, 2010, Practice 3.1). Professional associations may play a role in monitoring these sites. The SLP profession itself has a responsibility to actively educate members and clients about trusted websites and supported techniques. At the very least, individual SLPs need to be able to make informed and ethical comments about web-based information if asked by clients (SPA, 2010, Practice 3.1).

Clinician–patient relationships

The interpersonal aspects of therapeutic interventions delivered via the web need careful consideration and management by SLPs to fulfil their ethical duties to their clients (SPA, 2010, Practice 3.1).

A growing area of ethical concern in the use and expansion of virtual worlds, telehealth and other web-based services is the impact that they may have on the "traditional clinician–patient relationships" (Stanberry, 2000, p. 615). Cornford and Klecun-Dabrowska (2001) caution against the "substitution of care with treatment" (p. 161). Very little research has been conducted to examine patient satisfaction with the quality of interactions in telehealth relationships (Ellis, 2004), although recent work and understanding has suggested that client satisfaction and acceptance of telehealth is on the rise (Theodoros, 2012).

It is possible that the impersonal nature of some telehealth practices and virtual worlds hosted by automated avatars, or even completely unmoderated, may increase a sense of alienation commonly experienced by some clients (Bauer, 2010).

Developers of on-line practices must be careful to supply information to clients and potential clients in easily understood language. Checking the comprehension of information provided to clients is easier to do in face-to-face clinical settings. In on-line and largely unmoderated environments information needs to be provided with attention to the complexity and language used (Worrall, Rose, Howe, McKenna & Hickson, 2007).

Privacy and data storage

The Code of Ethics requires SLPs to protect client confidentially and ensure the safety and welfare of their clients (SPA, 2010, Standards 3.1.4 and 3.1.7). The use of web based speech-language pathology services and digital records create additional complexities and ethical concerns for both clients and SLPs to manage. Telehealth and virtual worlds, as well as older technologies like email, require the storage, retrieval and transmission of various forms and levels of personal data concerning users at both client and practitioner levels.

Privacy of data

Informational privacy (control over the flow of our personal information) is threatened through the use of the web (Tavani, 2011). In a telehealth context, personal information can be transmitted using a variety of technologies including the traditional approaches such as email, videoconferencing and the web or in new and emerging technologies such as cloud computing (applications and services which are offered over the Internet, collectively termed the *cloud* [Creeger, 2009]), and virtual worlds.

SLPs need to adopt standards, data policies and procedures in order to minimise the impact of the above technologies (Darkins, 2012). This could include a range of privacy protection approaches such as phish detection filters, the use of strong passwords and sign-out, the use of anti-virus and anti-spyware protection, maximising browser privacy enhancing capabilities, and the adoption of authentication and encryption protocols particularly when cloud computing and mobile technologies are utilised (Tavani, 2011; Zhang & Zhang, 2011). In addition, Darkins (2012) suggests organisations adopt a systems approach (a holistic and analytical approach) as an overall model for thinking about data privacy issues in the implementation of telehealth programs. This suggests organisations think about their telehealth as part of their overall health delivery and not in isolation.

SLPs need to be aware of the *Privacy Act 1988* (Cth) which regulates the way personal information is collected, stored, used and disclosed (McDermid, 2008), and the *Privacy Amendment (Private Sector) Act 2000* (Cth). This legislation extended the protection of information privacy to include many private sector organisations, and organisations that provide health services or store health-related information (McDermid, 2008). The legislation includes a list of ten national privacy principles which set the minimum standard for information privacy. The intent of this legislation is governance for organisations in the information economy, and is of particular relevance to SLPs ensuring protection of client confidentiality, safety and welfare.

Storage of data

Another issue of concern is the enormous volume of data (e.g., practitioner notes, lab test results, scans) digitally generated and the storage of that data. Telehealth practitioners need to consider what type of data should be stored, how much should be stored, for how long, and in what format. Currently, legislation requires health practitioners to store files for seven years after a client finishes treatment, or until the child reaches 25 years of age. This requires enormous data storage capacity. Telehealth providers are considering the use of cloud computing as an option to overcome their data storage dilemmas; however, storage in the cloud provides its own set of privacy and security concerns. Some suggest the use of *private clouds*, where data is restricted to servers in specific locations, and the development of standards and metrics to measure performance and regulations compliance by cloud computing vendors (Herold, 2012) will be important. This emerging landscape may provide SLPs adopting telehealth services or using other digital services with an alternative solution, but will require preservation of ethical standards required by SPA.

In conclusion

The web offers new frontiers like media rich telehealth and virtual worlds for SLPs to venture into, explore and appraise. These digital platforms offer new avenues for treatment and education provision to clients. They also aid SLPs to deliver services across large geographical areas in cost-efficient and ethically considered ways, through implementation of processes and organisational philosophies which protect the privacy and storage of data. Both telehealth and virtual

worlds require further rigorous trialling, evaluation, management and development in order to be seen as viable and ethical alternatives for conventional SLP-client interactions. Clients themselves need to be educated about the possible dangers of the largely unregulated Internet. More importantly SLPs need to understand how to use the web wisely to deliver services without breaching professional standards and ethical codes of conduct.

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Ethical issues in augmentative and alternative communication

Bronwyn Hemsley

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In this "Ethical conversations" some common ethical issues and resources relevant to the provision of augmentative and alternative communication (AAC) or multi-modal communication in Australia are discussed. Guiding theoretical frameworks and Association documents are related to topical situations in speech pathology management in populations with complex communication needs. This paper is not intended as a review of the literature or as a guideline in relation to AAC practice which is forthcoming in the Association's Clinical Guideline on Augmentative and Alternative Communication. Rather, common issues that might confront clinicians in the dynamic field of AAC are discussed in the light of existing theoretical frameworks and Association documents. Bringing these issues to light at this time of rapid change in the field may help clinicians to arrive at good decisions to the benefit of people with complex communication needs and their families.

Guiding frameworks and principles

According to the St James Ethics Centre (n.d.), "Ethics is about answering the question 'What ought I to do?'" – a question that arises in any clinical decision, ideally well before any conflict or dilemma might arise. In recognition of the importance of ethical decisions in speech pathology, there are several resources pertaining to ethical practice (see Body & McAllister, 2009; Chabon, Denton, Lansing, Scudder, & Shinn, 2007; Speech Pathology Australia, 2002, 2010, 2012a) that are relevant in (a) assisting clinicians and all stakeholders to arrive at good, balanced, and evidence based decisions that are in the best interests of the person with complex communication needs, and (b) providing guidance to both prevent and resolve conflicts and establish positive working relationships among all those affected by a decision.

In the dynamic field of augmentative and alternative communication (AAC), the multi-modal communication

range of practice of the Competency-Based Occupational Standards (CBOS) for speech pathologists (Speech Pathology Australia, 2011), existing theoretical frameworks (e.g., participation model of AAC, the International Classification of Functioning, Disability, and Health [World Health Organization, 2001]), and the Speech Pathology Australia Clinical Guideline on Augmentative and Alternative Communication (2012b) are useful resources to help guide clinicians in arriving at good clinical decisions. If at all possible, at all stages in the process of providing AAC services (see the participation model of AAC, Beukelman & Mirenda, 2005), the person with complex communication needs and their communication partners are engaged in informing and making decisions on the course of action for intervention (Williams, Krezman, & MacNaughton, 2008). As do professionals in other areas of practice, speech pathologists will continue to be confronted with situations where the course of action might not be clear to all parties involved in the decision. Complexities arise in clinical decisions about communication interventions as people with severe communication disabilities frequently have high support needs owing to physical or cognitive impairments and many areas of life participation are affected.

Ethical decision-making with the person with complex communication needs or any other person responsible includes consideration of: the facts on assessment findings, all available intervention options and associated evidence, risks and benefits associated with each course of action, and values and beliefs of those involved in and affected by the decision. Tension might exist between doing what one *ought* to do and doing what one might be *able* or supported to do within the clinician's competencies and available resources, wishes of the client, and workplace or residential care policies. As such, it is important that speech pathologists apply not only the Code of Ethics of the Association (Speech Pathology Australia, 2010), but also a theoretically sound ethical decision-making framework (e.g., Speech Pathology Australia, 2002, 2012a; Markula Centre, 2012). Arriving at an ethical decision also requires consideration of a person's rights (see United Nations Convention on the Rights of Persons with Disabilities, 2006) and legal position, as well as risks or benefits relating to many other aspects of the person's life and preferences.

Other ethical considerations

In addition to the general principles and issues noted above, there are a number of ethical considerations relating

to AAC that all practitioners need to be aware of. These are:

- the ethical imperative to maintain and expand clinical competence in AAC
- a rapidly expanding field
- consenting to assessment and intervention
- ensuring that the AAC authentically represents the voice of the person
- ethical resource allocation in AAC: working within available resources, and seeking to expand resources.
- mobile technologies: an expanding range of AAC options
- risks to privacy and confidentiality in AAC communications.

The ethical imperative to maintain and expand clinical competence in AAC

Although speech pathologists will graduate with knowledge and skill in the range of practice of multi-modal communication (Speech Pathology Australia, 2011), there are many clinicians in the field who have had limited clinical experience in the area and who might actively avoid introducing AAC because of their knowledge limitations (Sutherland, Gillon, & Yoder, 2006). Indeed, few speech pathologists feel competent in advising on AAC interventions or developing AAC programs (Sutherland et al., 2006). Communication is a fundamental characteristic of human interaction (Kaiser & Goetz, 1993) and is recognised as a human right (see United Nations, 2006, Articles, 2, 3, 9, 16, 17, 21, and 24). People with communication disorders should not be denied the opportunity to communicate to the best of their ability and in their preferred mode(s). Therefore, clinicians meeting clients who would potentially benefit from AAC – that is, those who cannot rely upon spoken language to communicate – face an ethical imperative to maintain and extend their skills where a demand or need for a service exists. Their actions would include striving to practise the highest standards of professional competence and extending professional knowledge through professional development, consulting the literature, collaborating with more skilled members of the AAC team, and engaging the support of a mentor or supervisor in the field (see the Association's Clinical Guideline on Augmentative and Alternative Communication).

A rapidly expanding field

AAC is a dynamic and rapidly expanding field due to advances in technology and active international research endeavours. This situation has given rise to two important ethical issues for clinicians in the field. First, an untested but promising AAC intervention might be promoted directly to consumers through social media and accompanied by anecdotal evidence (e.g., blogs, YouTube videos) resulting in consumer uptake prior to a formal assessment. Once involved in assessing a person's communication needs, speech pathologists have an ethical responsibility to conduct a full assessment, and consider all available options and the potential risks and benefits of these prior to recommending intervention options. This includes consideration of options already selected by people with complex communication needs and their families prior to the assessment. Second, owing to the rapid expansion of available assistive technologies, it might not be possible or feasible for clinicians to keep abreast of all technological advances of tools for AAC, or for any expansion in

populations who might benefit. In order to reach an ethical decision in a rapidly expanding field, clinicians are reminded to appraise any new strategy on its theoretical foundations and evaluate these in relation to existing research and published evidence on AAC. Clinicians need to be mindful of the value of the full range of communication strategies and techniques that might be necessary in addition to any high technology options, including non-AAC intervention (e.g., training communication partners to interpret behaviours as communicative), unaided AAC (e.g., sign and gesture), and low or light technologies (e.g., communication boards, single message devices). A person's communication needs are not likely to be met with the provision of one type of communication aid, and often a range of multi-modal communication options need to be explored (Beukelman & Mirenda, 2005).

Consenting to assessment and intervention

According to the Speech Pathology Australia Code of Ethics (2010), clinicians "strive to ensure informed consent has been obtained from clients for the services we offer" (p. 2). Thus, people with complex communication needs must be given the opportunity to provide informed consent to a particular procedure or intervention, either directly or, in situations in which they have been assessed as being incapable of providing consent, through a proxy (primary support person or legal guardian). Some people with intellectual disability are deemed to be not competent in decision-making about services and interventions. As such, speech pathologists seek to gain informed consent from a person responsible, involve the person with disability to the level of his or her capacity, and strive to attain the ability to recognise when the person's assent is provided. Observing the person's behaviours and non-verbal communications can assist clinicians in determining the person's wishes, but these interpretations should be checked with people who know the person with disability well and are familiar with their communicative behaviours (see Goldbart & Marshall, 2011).

It can be difficult to determine a person's consent for a service when the person does not already have a functional method of communication. To address this problem, clinicians may need to establish a functional and effective method of communication with the person with complex communication needs for the process of obtaining consent for future decisions. Obtaining consent would involve providing information about decisions in formats that are accessible to people with communication difficulty – an ethical imperative according to the World Health Organization (2010). Communication supports for the process of ascertaining the person's willingness, assent, or consent to decisions include accessible information sheets and consent forms, information displays, schedules, appropriate photographs, pictographs, sign or gesture or objects to help the person participate in each decision to the extent that they are able or desire. Reliance upon a yes/no system is common in the early stages of an AAC assessment. However, the person with complex communication needs must have every opportunity to participate with more than a yes/no response wherever possible.

Ensuring that the AAC authentically represents the voice of the person

The ethical principles of *veracity* or truthfulness and *autonomy* also inform the design of AAC systems, which

necessarily involves the collaborative input of a range of stakeholders including the person with complex communication needs. However, the priorities over design and inclusion of topics and vocabulary should rest with the person's own needs and preferences and not only those of their communication partners (see McNaughton & Beukelman, 2010). All people have a right to communicate for themselves to the extent that they are able (World Health Organization, 2010; United Nations, 2006). Thus, each person's communication system should be validated as reflecting his or her own preferences and reflecting his or her own voice. Establishing autonomy in communication is of vital importance in the field of AAC, as people with complex communication needs often rely upon communication partners to set up a system that can be accessed by them without influence. Access to the system might also depend upon the involvement of a range of communication partners in determining the person's message (e.g., partner assisted scanning, encoded communication). Nonetheless, it is possible that a person with complex communication needs may have direct and/or indirect access to a communication aid, and continue to maintain independence or autonomy in communication.

Many technologies are now available and in development to support both direct and indirect independent access to computers and communication aids, and reduce reliance upon communication partners to assist in message selection (e.g., various new switch technologies, eye gaze technologies, brain computer interface technologies). Where the speech pathologist considers that a person's AAC system might not represent his or her true voice, or that the person does not have autonomy in expressing his or her own thoughts, they have an ethical responsibility to (a) raise these concerns with the person and their communication partners so that further actions may be taken to remove harms, and to help the person towards an AAC system that does reflect their own views and preferences; and (b) consult with the Speech Pathology Australia's Senior Advisor Professional Issues who would then advise if it was a matter to go to the ethics board, which involves a written complaint process.

Ethical resource allocation in AAC: working within available resources and seeking to expand resources

The ethics of resource allocation are highly relevant in the field of AAC. The demands for AAC services are likely to increase in line with increased survival rates associated with developmental and acquired disabilities, the ageing of the population, public awareness of AAC, and the possibilities afforded by new assistive technologies. Adolescents and adults with lifelong disabilities who use AAC are particularly vulnerable to the impact of increased service demands that are not matched with expanding resources, at a time when they are in transition and moving to a greater need for communicative autonomy (McNaughton & Beukelman, 2010). Ideally, clinicians strive to source the best available research evidence for the AAC intervention and instructional methods, and source resources that will be required for each treatment option. However, not all necessary resources might be available for all potential options. Thus, speech pathologists may be faced with knowing they can do *something* for the person with complex communication needs, while realising that they might not be able to do

everything that might be necessary or of benefit to the person. Applying the ethical principle of *beneficence* helps guide clinicians in determining whether their level of expertise and limited involvement might do the person good while avoiding any associated harms (principle of *non-maleficence*) (see also Speech Pathology Australia, 2010).

The influence of the environment and communication partners over the success or otherwise of any AAC intervention must be considered (see Beukelman & Mirenda, 2005; World Health Organization, 2001). An ethical dilemma may arise when a particular AAC intervention, such as the provision of a speech-generating device, requires accompanying service hours for effective use of the device which might not be available or covered by existing funding arrangements. It might not be considered ethical to conduct a full assessment, then trial of a range of devices, and obtain funding to purchase a device, if there is not also adequate follow-up support to ensure that the device is useful and is not abandoned through lack of support. Potential harms in such a situation of failure and abandonment include communication partners and the person with complex communication needs being reticent to attempt other interventions that might be better supported in the future (Williams et al., 2008). Nonetheless, potential benefits to the person of having the system available and the opportunity for improvements in the communicative environment to occur must also be taken into account.

Ethical dilemmas can also arise in relation to decisions based on the relative costs of each AAC option that might suit the person. Provision of a relatively cheap communication aid (e.g., mobile technology AAC system) might or might not be helpful if the communication aid has so few individualisation options that the person can only access some features of the device or only use it in some situations (AAC-RERC, 2010). Nonetheless, while a low-cost system might not meet all of the person's needs, it might provide some benefit as to warrant exploration as an option for intervention to meet some of the person's communication needs. Speech pathologists, therefore, have an ethical responsibility to (a) advocate on behalf of clients to funding bodies and governments to remove cost as a barrier to a person's best option in AAC, and (b) pursue follow-up support and training for the person and communication partners that can be obtained through distributors and manufacturers of the device, and also through formalised peer-mentoring systems if these can be arranged (Ballin et al., 2012). It is also important that clinicians who are aware of unmet needs in relation to multi-modal communication advocate for expanding resources available to meet those needs.

Mobile technologies: an expanding range of AAC options

The advent of mobile technologies (i.e., touch screen devices that connect to the Internet) with AAC software applications and switches to access mobile device AAC apps (see Farrall, n.d.; 2012) has been hailed a paradigm shift in the field and practice of AAC, owing to the much wider availability and recognition of AAC in the community and a much greater availability of speech aids to people who previously did not have access to these (AAC-RERC, 2010). The introduction and development of mobile technology AAC mean that speech pathologists and others

need to consider a wider range of options than previously available in arriving at ethical decisions. Speech pathologists have an ethical responsibility to work with families who desire mobile devices and provide unbiased information and advice in regards to the potential benefit to the person who uses AAC. However, mobile technology AAC does not currently provide all of the features and functions available within dedicated speech-generating devices, and it is important that all relevant AAC options be considered in a feature matching assessment (AAC-RERC, 2010).

Risks to privacy and confidentiality in AAC communications

A distinctive risk relating to privacy in the field of AAC is related to (a) the involvement of communication partners in supporting communication and thus being privy to what might otherwise have been treated as private conversations (e.g., consultations with the doctor or legal representatives), and (b) the potential for communications delivered by AAC to be captured and kept in a file (commonly called "history") within the speech-generating device or mobile technology app for AAC. It is recognised that collection of a history of the person's communications might be of benefit, but there may be less awareness of the potential harms arising from the storage and retrieval of messages in the history. The record or log of every keystroke, word, or phrase entered into an AAC system is akin to recording the person's voice. It should be treated as containing potentially sensitive and private communications and subject to the same restrictions and permissions prior to collection, storage, or release as audio or video recordings of the person.

As yet, there is no industry standard on the processes for designing a history feature of a speech-generating device or mobile technology app that takes into account all ethical issues pertaining to privacy, confidentiality of communications, freedom of choice and autonomy, and safety. An AAC system that does not enable the history feature to be switched on and off or to clear or delete messages potentially places the person at risk of breaches of privacy and confidentiality. Speech pathologists need to consider the potential harms of sensitive information shared with one person becoming known to people other than the intended communication partner. Risks to privacy posed by the history feature of a system is particularly pertinent to the situation where people with complex communication needs might wish to discuss personal issues or report abuse (see Bryen, Carey, & Frantz, 2003).

Conclusion

In summary, speech pathologists, being aware of ethical issues in AAC, have an important role in ensuring that AAC interventions are not only timely and effective, but also of greatest benefit and least harm to people who use AAC. Considering the range of options available, effective and ethical practice will rest heavily upon person-centred, collaborative, and evidence based practice. In this way, multi-modal communication services may truly improve the lives of people with complex communication needs, their families, and society as a whole.

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Ethical issues in augmentative and alternative communication

Barbara Solarsh and Meredith Allan

In this edition of Ethical conversations we consider ethical issues that may arise when working with people who require an augmentative and alternative communication device. Communication is a basic human right. This fact is at the core of all debate about augmentative and alternative communication (AAC) and ethical practice. Everyone has the right to a means of communication. People have the right to the communication aid and strategy that will enable them to have the best quality of life.

> I was happy with my communication device without voice output, until I saw a voice output device. Although it took months and months to acquire the voice output device, I did not mind. I had something to look forward to. Now I know the empowerment of voice, I do not like being without it. I can manage without voice output, but I do not like going back to second best. (AAC user)

These rights have been clearly endorsed in the United Nations Declaration on the Rights of People with Disability (2006; http://www.un.org/disabilities/convention/facts.shtml) to which Australia is a signatory. For the first time ever, communication using an AAC device or strategy is recognised as a legitimate means of communication for people who do not speak, just as sign language is recognised as the communication system used by people who are deaf. As a signatory, Australia has made a commitment to work towards practice of these human rights for people who require and use AAC.

The complexity of providing AAC intervention is embodied in the belief that "a communication disability does not just belong to the individual. It belongs to the entire environment of which that person is the focal point" (Sandwell Centre, UK, personal communication). AAC intervention cannot succeed without the inclusion of people and issues related to the "entire environment". AAC intervention is also applied across a wide range of disabilities and cognitive levels. It may include electronic communication devices and/or non-electronic communication aids and strategies.

For the speech pathologist working with an individual who uses AAC, four areas of intervention are key:

1. all aspects related to the individual, including physical ability, cognitive level, and diagnosis must be considered;
2. focus must also be upon environmental factors which will impact the success of the AAC intervention in real life;
3. the appropriate communication device, aid or strategy must be selected, with a particular focus on the inclusion of the communication aid user or family members, remembering the need for multi-modal intervention;
4. advocacy for an individual using AAC is imperative to enable the person to communicate effectively in the face of many practical limitations.

The "Participation model" as described by Beukelman and Mirenda (2005) provides practitioners with a comprehensive framework for AAC assessment and intervention. It identifies the barriers to participation that must be addressed if a person using a communication aid is to become a successful communicator. To identify such barriers, a comprehensive assessment of the skills and abilities of the communication aid user (identify access barriers) is required, together with a review of relevant factors in the environment (identify opportunity barriers). Traditionally speech pathologists have developed a high level of skill in dealing with *the individual* with the communication difficulty, in this case the AAC user and the access barriers related to the individual. However, they also need to address the opportunity barriers related to the environment in which the person communicates. In reality, the essence of AAC intervention is based on a balance between what is ideal for the person, what the system provides, and what the therapist can deliver.

The scenarios below highlight some of the ethical issues AAC practitioners may face. These issues apply to both electronic communication aids (e.g., a Dynavox™ or Lightwriter™) and non-electronic communication aids (e.g., a picture-based communication book or board, or alphabet board). In addition to these aided strategies, they also apply to unaided strategies, such as key word signing (e.g., Makaton). The issues that arise will be considered within the ethical principles of: beneficence and non-maleficence (do no harm); truth; justice (fairness); autonomy; and professional integrity.

Case scenario: Jenny

Background

Jenny is a 4-year-old little girl with Down's syndrome, who lives with her mum Mandy, and 8-year-old brother, in a small regional town. Jenny is starting to show signs of frustration when she wants something and her mum cannot understand what she wants. Jenny does not use

Barbara Solarsh (top) and Meredith Allan

speech, but vocalises and will sometimes take her mum to something she wants and point to it. The visiting early intervention speech pathologist, Bev, has assessed Jenny and provided a comprehensive report, recommending that Jenny should use Makaton key word signing plus picture-based communication aids. Jenny was very responsive when Bev used basic gestures to ask Jenny to bring a ball. Bev also recommended that Jenny attend the local preschool where teachers have agreed to accept her but have expressed a need for information and support as they have never had a child with disability at the preschool before. They have also expressed the need for a teacher's aide. Bev feels that, with time, Jenny could learn to use a basic speech-generating device to make simple choices, like choosing a song at school, or to help her to actively participate at circle time (e.g., have animal sounds recorded on the device so she can "sing" "Old MacDonald had a farm").

Jenny's mum, Mandy, works part-time and is overwhelmed by the need to learn Makaton and become the agent for developing all the aided language resources Jenny needs in order to learn to communicate effectively. Mandy is also concerned that if she introduces other ways of communicating, Jenny will never learn to speak. Bev can only offer her services monthly according to the service model of her organisation because of the demand for speech pathology services in her region.

Ethical dilemmas

Beneficence / non-maleficence: Bev has a good understanding of what Jenny needs and the critical importance of introducing communication strategies immediately. She has the skills to offer the support needed, but does not know how she will do all this within a monthly visit of 2 hours. If Bev does not provide support both to mum and the teachers there is the potential for maleficence in that negative attitudes will develop towards the communication intervention and towards Jenny, placing strain on the system. Bev is very aware that Mandy is already feeling stressed by all the intervention Jenny will need. Bev realises that her hours with the family would be most beneficial if directed to developing Mandy's skills and confidence in facilitating Jenny's communication and to working with the teachers, rather than working directly with Jenny.

Truth: There is evidence of the importance of early intervention for AAC in establishing patterns for active communication, for cognitive development, and for social participation. Visual aids provide an immediate form of communication, but have to be designed, produced, and introduced in all communication environments. Makaton key word signing is an unaided strategy and Jenny has responded well to gesture, so there is good likelihood that Jenny will take to Makaton. It is also very effective in conveying meaning, but the system must be learnt by Mandy and Jenny's brother as well as the teachers. Bev also sees the potential for a basic electronic communication aid which she will need to apply for, and which again will require training and monitoring.

Justice: Bev needs many more funded hours for an effective AAC intervention. In addition to applying for the communication device, she needs to motivate and lobby for a class aide for Jenny. Travelling to a centre where a Makaton course may be held is not an option for Mandy, but it is possible for her to purchase a DVD and learn

Makaton signing that way. This will require her to be very committed to the task. A class aide would take much pressure off the teachers, but Bev still needs to go through the process of applying, and it may take time.

Autonomy: Mandy has reservations about Makaton and aided language which will impact on her attitude to learning and implementing the communication strategies. Bev needs to counsel Mandy to help her understand the evidence that aided language and Makaton key word signing facilitate oral language. However, if Mandy is not convinced by Bev's information, it is her right to refuse to use aided language. This would be very difficult for Bev, who knows how important this is for the development of communication.

Professional integrity: Bev is not a Makaton trainer, but could show Mandy some signs and refer her to the Makaton DVD. She could show Mandy and the teachers how to encourage Jenny to sign using the "hand-over-hand" technique (http://en.wikipedia.org/wiki/Tactile_signing). She could also assist Mandy by informing her about the Adapted Learning website (Adaptedlearning.com), a website set up by Boardmaker™ for parents to share picture based resources. She could inform Mandy about Boardmaker™ and try to encourage the local library to purchase it. She realises the need to respond to the many opportunity barriers, but does not have sufficient hours to do so as effectively as she would like. She knows that unless Mandy and Jenny's teachers are motivated, Jenny's progress in learning Makaton will be slower than it should be.

Case scenario: Rachel
Background

Rachel is a 21-year-old woman with traumatic brain injury due to a hit-and-run car accident. While she is able to walk, her fine motor skills have not improved as well as the health professionals expected. Her parents and some family members can understand her dysarthric speech, but she is not understood by people who do not know her. She has a Lightwriter™ but due to a tremor in her better hand, her access is slow. She also has some problems with her memory.

Rachel's court case is scheduled for one month's time. She is determined to give evidence in court, but is very anxious that she will not be understood, that she will be slow when using her Lightwriter™, and that her evidence will not be taken at full value. When giving evidence, Rachel will need a communication assistant/facilitator to assist in the interpretation of her speech or to convey the messages composed on the Lightwriter™. At their last speech pathology session funded by the Transport Accident Commission (TAC; http://www.tac.vic.gov.au/jsp/corporate/homepage/home.jsp?gclid=CJHqsuyswJ0CFc0vpAodgBRssA), Rachel's speech pathologist, Susie, suggested that she have a word-based communication board made up, with sentences and phrases in case she becomes fatigued during the long hearing. It may also help her remember some important points she wishes to make. Rachel wants her speech pathologist to support her in court, but Susie has not been funded by TAC for this purpose.

Rachel's family has heard that Communication Rights Australia[1] (CRA) have a communication support worker service[2] which is equivalent to a sign language interpreter service for the deaf. On making enquiries, they have been informed that they only have a small pool of communication

support workers (CSW), none of whom are available at that time. If Rachel could find someone to take that role, CRA would offer the required training. It is very important that the communication support worker understands the CRA Code of Ethics (http://www.caus.com.au/Products/tabid/57/Default.aspx) which must be complied with in carrying out this role, to ensure that the message conveyed is what the communication aid user intended and is not influenced by the CSW. In addition to training the communication support worker, CRA would also need to train members of the legal team about hearing evidence from a person who uses a communication aid and the role of the CSW.

Ethical dilemmas

Beneficence and non-maleficence: The issue of the court case was brought up at the last funded speech pathology session. Susie is in the best position to prepare Rachel for the court case, but time for an application to TAC for additional speech pathology hours is short. As Susie knows Rachel's parents would not be able to afford the fees, should she provide a few additional sessions to Rachel in the hope that money will be forthcoming? Preparing the word-based communication board would certainly take 2–3 sessions to ensure that the correct vocabulary and information was included. Having someone who is not adequately skilled design the communication board, or not having the communication board at the hearing could compromise the strength of Rachel's evidence.

Truth: Susie prognosticated early on in therapy that Rachel's dysarthria was severe and that she would need AAC to meet her communication needs in the future. However, Rachel has only reluctantly agreed to get a Lightwriter™, which she finds frustrating due to the slow pace of communication. Susie has continued to do basic speech therapy while encouraging practice of the Lightwriter™. She has wrestled with where to put the emphasis of therapy, however, and now feels that Rachel needs more therapy to support her to use the Lightwriter™. TAC has indicated that Rachel should now have a break in therapy. Susie knows Rachel needs a number of different ways of communicating, but she feels she has not been able to achieve this.

Justice: TAC has funded a significant number of speech pathology hours as well as providing attendant care dollars. Even if additional therapy hours are allocated after the 6-month break, it will not help Rachel with the court hearing. Rachel obtained her Lightwriter™ from the Aids and Equipment Program (http://www.dhs.vic.gov.au/disability/supports_for_people/living_in_my_home/aids_and_equipment_program), but Susie feels there are other communication devices that Rachel could try when she is ready.

Autonomy: Susie feels that Rachel's dysarthria is unlikely to improve further and that Rachel would be advised to use her Lightwriter™ or word communication board in court. However, Rachel wants to use speech and only revert to AAC if necessary. This is her choice, although it is Susie's view that it may not be in her best interest.

Professional integrity: If Susie was to act as the CSW, she would need to be trained by CRA even though she is a qualified speech pathologist. She would need to be aware of and understand the CSW Code of Ethics. Susie would also have to accept that she would not be paid speech pathology fees, but at the rate of a CSW.

Conclusion

The two scenarios outlined above demonstrate that AAC practice is highly complex, with many factors influencing the outcomes from the preschool classroom to the courtroom. Further, although people who apply to the Aids and Equipment Programs for communication aids across the country usually do receive a device, funding differs markedly between states. In Victoria, for example, 700 communication aids are allocated per year, where statistics indicate there are 10,220 people with complex communication needs (ABS, 2006). Our concerns are not only with those who never receive the AAC intervention they require, but also with those who do receive an AAC device without the appropriate support. When technology fails repeatedly, the desire to communicate decreases (Williams, Krezman, & McNaughton, 2008). Our journey towards ethical practice and AAC has just begun – a long road lies ahead.

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1. Also known as CAUS – Communication Aid Users Society http://www.caus.com.au/

2. Communication support worker (CSW): CSWs are specifically trained to understand a range of communication methods and devices, and support and/or relay communication from a person with little or no speech to another person (Communication Rights Australia)

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Dysphagia assessment and management at the end of life

Some ethical considerations

Helen Smith, Noel Muller, and Trish Bradd

Assessing and managing people with dysphagia at the end of their life is an integral part of most adult speech pathologists' everyday practice in hospitals, nursing homes, and domiciliary care settings throughout Australia. Good palliative care is no longer viewed as important only for people with cancer. Long-term, life-limiting conditions such as increasing frailty, vital organ failure, dementia, and degenerative neurological conditions (e.g., amyotrophic lateral sclerosis, multiple sclerosis, or Parkinson's disease) account for 47% of deaths (Kellehear, 2009; Mahtani-Chungani, Gonzalez-Castro, Saenz de Ormijana-Hernandez, Martin-Fernandez, & Fernandez de la Vega, 2010). Where people have long-term, life-limiting conditions and are receiving care, speech pathologists have a clear role in supporting those clients (who develop dysphagia as part of their symptoms) and their carers through the cycles of wellness and decline in chronic palliative care as well as in the final phases of a terminal illness.

Managing the implications of dysphagia for people in the final phases of a terminal illness or for people suffering from an advanced life-limiting illness that impairs their quality of life raises a number of professional and ethical issues. This article uses a case study to discuss the importance of accurate diagnosis and prognosis to ensure that ethical decision-making processes are used in making informed decisions about care planning. It will briefly discuss available management options and will consider comfort, quality of life, harm reduction, and treatment futility inherent in some of these options. The critical roles that health literacy and teamwork play in ethical decision-making will also be considered.

The client: presentation and history

Mrs Demarco[1] is an 89-year-old woman of Italian descent who lives at home with her daughter Anna. She presents to hospital following a fall when going to the toilet. She presents with delirium, dehydration, and a urinary tract infection (UTI). She also suffers from mild heart failure and reflux. This is her third admission to hospital in 6 months. She has lost 10 kg since her last admission and is now essentially bed-bound with cachexia[2].

During Mrs Demarco's first admission the medical team diagnosed her with dementia and an ulcerated leg. During her second admission she was diagnosed with aspiration pneumonia, and the speech pathologist prescribed a modified food and fluids diet in response to her moderate difficulties in swallowing (dysphagia) and the fact that she had developed aspiration pneumonia.

The client: diagnosis and prognosis

Despite reduced alertness, poor communication in English and Italian, and difficulty managing oral secretions, the general medical team think that with intravenous fluids and antibiotics for the UTI, Mrs Demarco's general state of alertness may improve. The general medical team in consultation with Mrs Demarco's daughter have decided to treat Mrs Demarco actively, that is, by using therapeutic agents such as antibiotics to improve her general condition and to reduce some of her symptoms. As Mrs Demarco's status is for active medical treatment, the speech pathologist recommends that Mrs Demarco not eat or drink food and fluids (either modified or unmodified) at this point in time and that instructions for "nil by mouth" be noted in the file and by her bedside.

Mrs Demarco's daughter, Anna, is very concerned about her mother's restrictions in oral intake and her mother's inability to take her heart medications orally. Anna insists the doctors insert a nasogastric feeding tube (NGT) so that her mother will be able to receive nutrition via the tube. The medical team agree to insert the NGT as a therapeutic trial (to be reviewed after seven to ten days). After the first seven days, Mrs Demarco's conscious state improves, but as she becomes more alert, her tolerance for the NGT decreases. Mrs Demarco pulls the tube out five times in the next three days. The NGT is removed as it is causing Mrs Demarco great distress. Mrs Demarco also repeatedly pulls out the intra venous (IV) cannula (drip) that provides her with hydration.

On day ten Mrs Demarco is awake but unable to communicate effectively in either Italian or English. She is not able to get out of bed without assistance and cannot sit, stand, or walk, even with physiotherapy assistance. Mrs Demarco remains severely dysphagic and can tolerate only minimal amounts of extremely thickened fluids and pureed solids. Her ability to cooperate in taking modified food and fluids orally is variable and inconsistent. For the next few days Mrs Demarco intermittently appears to aspirate small amounts of food and fluid, particularly when tired. However, she has a strong cough and aspiration of small amounts of food and fluid do not appear to make her breathing uncomfortable.

Helen Smith (top), Noel Muller (centre), and Trish Bradd

Anna has heard about percutaneous endoscopic gastrostomy (PEG) feeding tubes as Anna's friend's mother had one placed after a stroke. The friend's mother eventually made a good recovery and went home after 3 months of rehabilitation. Anna asks if her mother can have a PEG feeding tube because she does not want her mother to be hungry or thirsty.

Critical questions for the management team

This section discusses some of the key questions that the general medical team responsible for the management of Mrs Demarco's health care must consider in evaluating the next steps and the decisions they must make for her ongoing care.

1. Is this patient suffering from an advanced life-limiting illness impairing quality of life?

In the past six months the trajectory of Mrs Demarco's health has shown cycles of wellness and decline. Despite maximal treatment during this admission (i.e., antibiotics, hydration therapy) and a trial of artificial feeding via the NGT, Mrs Demarco has not regained her pre-admission level of function, which was already compromised. An inability to increase oral intake, a decrease in cognitive function, refusal of food, recurrent chest infections, and multiple medical conditions are generally poor prognostic signs in dementia (Enck, 2010; Mino & Frattini, 2009). The general medical team agree that, based on their observations and medical interventions, Mrs Demarco exhibits signs of end-stage dementia and is unlikely to significantly improve in functional abilities of eating, hydration, general mobility, and physical safety. Her confusion associated with the dementia remains largely unchanged.

2. A percutaneous endoscopic gastrostomy feeding tube is considered an invasive medical procedure. Should it be considered as an option for Mrs Demarco?

There is increasing evidence over the past decade that the use of a PEG feeding tube with the unwell elderly and with people with advanced dementia does not improve survival or other clinical outcomes (Anonymous, 2010). In fact, the mortality rate following a PEG feeding tube in people with advanced dementia is 90% at one year post-insertion (Shah, 2006). Of all elderly patients undergoing insertion of a PEG feeding tube, the mortality of dementia patients in particular remains significantly high (Shah, 2006). The general medical team who are responsible for Mrs Demarco's care has an obligation to provide the best possible treatment (duty of care obligations) and must make a decision about the insertion of a PEG feeding tube supported by evidence and prognostic markers including increasing age, severe cognitive impairment, hospitalisation, past history of aspiration, and physician-predicted poor prognosis (Shah, 2006) that in this case predict a poor outcome.

The general medical team believes that Anna could learn to manage the PEG feeding tube at home if necessary. However, Mrs Demarco has clearly demonstrated that she finds tubes uncomfortable by repeatedly pulling out IV cannulas and NGTs. A PEG feeding tube may be an added burden that could potentially increase Mrs Demarco's agitation. If this were to occur, it may be necessary for Mrs Demarco to have additional medications that result in sedation, precipitate her admission to an aged care agency permanently, and in the worst case scenario force the introduction of physical restraints. These scenarios could place Mrs Demarco at risk of further medical complications and harm as well as increasing distress to her and her family (Anonymous, 2010; DiBartolo, 2006). Common medical complications of PEG feeding tubes include infection, bleeding, diarrhoea, and aspiration of refluxed feed (Tyler-Boltrek, Bonin, & Webb, 2009).

3. Is comfort oral feeding an option, despite the aspiration risk?

Speech pathology assessment shows that although Mrs Demarco is at risk of aspiration, eating a modified diet, drinking thickened fluids or water, and sucking on ice chips appear comfortable for Mrs Demarco, that is, they do not result in her coughing excessively or make her breathing rapid or distressed. Mrs Demarco does require significant assistance with eating orally and will not achieve adequate nutrition and hydration via this route. It appears to the speech pathologist and Anna that when Mrs Demarco accepts some food or fluids she seems relaxed and shows preference for some items over others; however; Mrs Demarco is unable to reliably take her medications orally. Anna has demonstrated the ability to assist her mother with eating and drinking in a way that maximises her swallowing safety.

Clinical management

This section discusses some of the critical aspects of providing high quality care in a woman with complex and challenging health care problems.

1. Informing the family using accurate and easy to understand facts and material

The general medical team, including the consultant medical officer, determine the diagnosis and prognosis of the patient. The consultant medical officer is unavailable to talk with Mrs Demarco's family in a reasonably urgent time frame, and suggests the family seek a referral and meeting with the palliative care team. The palliative care team agrees to assist with the family meeting. Part of the palliative care team's function is to ensure that effective multidisciplinary palliative care planning assists the family and the patient to make informed decisions about the next stages of the care plan.

2. Education regarding the risks and benefits of all options, acknowledging language and health literacy levels

The speech pathologist has spoken with Anna throughout the admission and has kept her informed of the outcomes of various speech pathology assessments. Anna was keen for her mother to have a "little pasta" but the speech pathologist explained the choking risk of these food items and why they were not recommended given the severity of Mrs Demarco's dysphagia. Anna acknowledged that her mother had appeared to "choke" several times even before this most recent admission and was happy to follow the speech pathologist's recommendations. She was very keen to assist her mother to eat and after some discussion and

education about appropriate consistencies Anna brought in appropriate home-made foods for her mother to eat.

Anna had asked the speech pathologist about the PEG feeding tube. The speech pathologist had explained in detail what it was and provided an information booklet. The booklet contained a worksheet for patients/families considering a PEG feeding tube procedure that included the advantages and disadvantages of feeding tubes. The speech pathologist was not sure Anna fully understood the information in the booklet. She revisited the information with an interpreter present. Anna still had many questions and the speech pathologist wondered about Anna's exposure to and understanding of health information matters. After a series of meetings and discussions, she thought that Anna demonstrated a basic understanding of the procedure and its complications.

3. Establishing who can give consent

The social worker has established that Mrs Demarco's daughter has legal guardianship but that Mrs Demarco has not made any advanced directives or statement of choices regarding medical treatment or insertion of a feeding tube. Mrs Demarco has two other children. The physiotherapist has established that Mrs Demarco is now bed-bound and cannot stand or transfer safely. Mrs Demarco's three children need to understand Mrs Demarco's capabilities and difficulties before making any informed decisions about their mother's future care.

4. The importance of team work

Anna's English, while functional, appears limited for complex health-related information. Accordingly the social worker arranges for an interpreter to be present at the family meeting. Anna and her two brothers attend the family meeting. Mrs Demarco is not in attendance as she is unable to participate in the discussion and decision-making due to her decreased cognitive abilities.

At the family meeting the general medical team provides the family with information regarding Mrs Demarco's diagnoses and prognosis. The signs of end-stage dementia are stressed. The family agree they have seen a marked deterioration in Mrs Demarco over the past six months in general and this admission in particular. The speech pathologist explains the difficulties that Mrs Demarco has with eating and drinking and the associated problems with choking and aspirating.

Anna asks again about the option of the PEG feeding tube as she does not want her mother to starve. The palliative care team explain how at the end of life people often stop feeling hunger and thirst. The team describe the role that comfort-feeding of foods that will not obstruct her airway, (that is, the choice of relatively low risk non-choke foods) and exemplary mouth care could play in maintaining Mrs Demarco's quality of life and comfort.

5. The importance of time

The palliative care team sensitively explains to Anna why her mother's situation is different to that of her friend's mother. Anna begins to gently weep. The general medical and palliative care teams offer to give Anna and her brothers more time to discuss all the information and agree to revisit the issue in a couple of days. Over the ensuing days Anna asks many questions of all members of the team about PEG feeding tubes and comfort-feeding and end-stage palliative care. The palliative care social worker talks with the family about what supports could be provided at home or in a hospice or nursing home.

At the next meeting Anna and the family decide to take Mrs Demarco home with supports (including visiting nurses and home help) and to use comfort oral intake. Three months later Mrs Demarco passes away at home in her sleep after many meals of her favourite home-made gelato.

Ethical questions raised

Box 1 lists a number of ethical questions raised in this case study. Refer to the Speech Pathology Australia Code of Ethics (Speech Pathology Australia, 2010) for more information.

Box 1. Ethical questions to ask when considering placement of a feeding tube in a client with life-limiting disease

- Does the multidisciplinary team agree on the client's diagnosis and prognosis?
- Does the client understand her/his diagnosis and prognosis?
- Can the client make informed decisions about her/his medical care or is surrogate decision-making necessary?
- Has clear and accurate information (couched in terms that suit the family's level of health literacy) been provided to the family to enable them to make informed decisions (autonomy) and provide informed consent?
- Has the family had the opportunity to express their opinion and participate in the decision-making process?
- When considering active treatment has "non-maleficience" been considered (i.e., harm prevention and not intentionally causing harm)?
- Have the client's comfort and quality of life been considered (i.e., "beneficence" / benefiting others through our actions?)
- Is it possible to enhance the client's level of function or is active intervention "futile"?
- What level of clinical expertise is required? If necessary, have senior speech pathologists been consulted?

Implications for speech pathologists

This case study attempts to illustrate the importance of accurate, meaningful dysphagia assessment, the complexity of truly informed consent, the importance of the consideration of futility of intervention or treatment and doing no harm, balanced with quality-of-life decisions and doing "good" in end of life dysphagia management.

These ethical considerations, however, illustrate that there are no easy answers to complex situations. Some clients presenting to hospital with life-limiting disease and dysphagia may not be provided with all options. These clients may receive PEG feeding tubes, may be sedated so they do not pull them out, and may receive the recommendation of "nil orally" to manage the risk of aspiration and pneumonia. Families may not be provided with essential information about the end-of-life process or may not be in a position to hear this information (because they may find it difficult to accept that their loved one is in the process of dying). The speech pathologist has an important role in facilitating complex conversations and communication of detailed and sometimes distressing information to the patient and the family.

While this type of situation is part of the daily life of many speech pathologists, students and clinicians inexperienced

in this area need the mentoring, support, and guidance from experienced speech pathologists to help them navigate the complex interplay between clinical safety and quality-of-life issues to ensure the best care for our most vulnerable elderly and unwell patients.

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1   Names have been changed to protect the privacy of the client.
2   Cachexia = generally unwell with emaciation, usually occurring with cancer or a chronic infectious disease or illness.

Helen Smith is elected by members to the Speech Pathology Australia Ethics Board. Helen has over 23 years of clinical, education, and management experience in speech pathology. She has practised professionally in the UK, Canada, Zimbabwe, and in metropolitan, rural, and remote Australia. She has a research interest in ethical practice and student education, and a clinical interest in palliative care. She is currently employed as the manager of speech pathology at The Queen Elizabeth Hospital in Adelaide and regularly presents to undergraduate and postgraduate students.

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A reflection on ethical policy development

A case example of a hospital patient with dysphagia

Helen Smith and Christina Wilson

Helen Smith (top) and Christina Wilson

The Speech Pathology Australia Code of Ethics challenges speech pathologists to incorporate ethical practice into all aspects of their professional roles. Policy development and implementation may be part of a speech pathologist's role particularly in institutional settings. This article illustrates, using a case example of a gentleman with dysphagia, a number of models which may assist speech pathologists and their colleagues to reflect ethically during policy development, implementation and sustenance processes.

In this issue's "ethical reflection" we wish to consider tools that may assist speech pathologists in facilitating ethical policy development and implementation. The Speech Pathology Australia Code of Ethics (SPA, 2010) challenges speech pathologists to provide quality services not only to individuals but also to communities and service providers. According to the Code of Ethics, one of the ways speech pathologists meet ethical responsibilities is by contributing to the development of employers' policies and procedures that relate to the provision of high-quality, efficient and effective services. Policy development and implementation have the potential to impact not just on individual clients but on whole organisations and client groups (Frolic, Drolet, Bryanton, Caron, Cupido, Flaherty, Fung and McCall, 2012) and therefore are critical to speech pathologists' professional roles. A conundrum for clinicians can be that some policies, while legally sound, are ethically problematic.

In Australia, the legal framework governing decision-making when patients no longer have capacity, such as when they may be close to the end of life, is impacted by different state, territory and federal laws. This can lead to drastically different outcomes for patients depending on the jurisdiction in which they live. Terminology also differs from state to state[1]. Substitute decision-makers and advance care directives are used only when patients no longer have capacity to make their own informed decisions. Substitute decision-makers may include immediate family members, carers or guardians. Formal substitute decision-makers, nominated and legally endorsed by the patient, may be

called enduring power of attorney (medical treatment), enduring power of attorney for personal and health matters, medical agent or medical power of attorney.

Patients can write down their wishes in a document that is called an advance care directive (ACD). If a patient has an ACD, and it relates to the current decision, then it is considered legally binding. Substitute decision-makers are obliged to adhere to the ACD as they are obligated to make decisions they believe the patient would have made. While ACDs usually record decisions about refusing life-sustaining treatments, they are not limited to end-of-life decisions and can be used to support patient choices in their medical care. This "ethical" conversation presents a case whose significant issues are around choices in eating and drinking. Organisations are obliged to translate legal frameworks into the development of appropriate policies at an organisational level to deal with the needs of all stakeholder groups, respect the values and culture of the organisation and the individual patients who come in contact with it.

Institutional policies developed to support/manage patients' options around safe eating and drinking, if patients are at risk of choking (given choking can lead to multiple medical problems and even death), must cover patients who have decision-making capacity, an informal or formal substitute decision-maker and/or an advance care directive in place. It is important that staff and family are aware of the role and responsibilities, and the legalities around substitute decision-making and ACDs including the right to refuse medical treatments. Generally if an ACD exists it should be used as the basis for the decision.

Speech pathologists bring a unique contribution and perspective to interdisciplinary decision-making affecting clients with communication and swallowing disorders. A speech pathologist, in their role as a manager or as clinical lead in a policy working party, can use the principles outlined in the SPA Code of Ethics as a useful reference for reflecting on potential benefits and harms for patients, the impact policy may have on autonomy and informed choices for patients, issues of fairness and access to care, and finally the impact any policy may have on the professional integrity of individual clinicians and the profession as a whole. The Speech Pathology Australia Code of Ethics may be a useful reference when working with colleagues to ensure a shared understanding of the ethical issues being discussed.

In this discussion we will use a hypothetical case example to illustrate the use of a process to assist ethical

The patient

Currently on the medical ward there is a frail, elderly patient of Italian heritage with multiple medical problems who is doing quite poorly. Through clinical assessment and a modified barium swallow study, he has been diagnosed by a speech pathologist as being at risk of choking. The team has recommended a highly modified diet that he finds unappetising and boring.

The patient has said he has had enough of life. He has capacity and he wants to eat food that he enjoys. There are also strong cultural and social norms, particularly for his generation, about the healing power of food and his wife is very upset that she can no longer feed him particular foods as she feels this is a role she can play in his healing.

The patient and his family want him to be able to eat some of the foods they bring from home that he has loved over the years. The patient and the family are all prepared to take the risk of him choking as they feel his quality of life is suffering; he is unhappy, depressed and losing weight.

The rule

Currently the unwritten hospital rule is that dysphagic patients who are at risk of choking are not provided with or fed "choke risk" foods by the hospital during their inpatient stay.

There has been conflict between staff members and patients and families over this "rule." It is felt a clear written policy would decrease conflict around this issue and clarify what procedures to follow in the event of any team managing a patient who has been diagnosed as being at risk of choking.

The differing perspectives

- Some staff support the approach of not providing food to patients who are at risk of choking, in order to not harm (potentially kill) patients.
- Some staff believe patients' autonomy should be respected and patients should be provided with the food they (or their designated decision-makers) request as long as they are informed of the risk.
- Some staff are distressed at the thought of providing or feeding a patient with food they might choke on as they have observed a person choking to death.

reflection on policy formulation and analysis of the potential impact of the policy.

The impact of policy

While acknowledging policy development may be a small part of many speech pathologists' roles, the potential impact of a policy or policy change may be broad. Within a hospital context Frolic et al. (2012) suggests policies and policy changes may impact at least six distinct stakeholder groups. Applying Frolic's groups to a current Australian hospital system these groups may include:

1. the hospital as an institution and possibly the local health network more broadly;
2. the patients and families who may (or may not) receive care;
3. staff, students and volunteers at the hospital;
4. other government, non-government and volunteer service providers in the region;

1. **The hospital as an institution and possibly the local health network more broadly**
   Another hospital within the local area network recently had a coroner's case concerning a patient choking to death. The coroner's findings were very clear regarding the need to follow the speech pathologist's diet modifications and recommendations (when choking due to dysphagia was identified as a risk to patients). Consistent policies across the network are therefore essential.

2. **The patients and families who may (or may not) receive care**
   - *Patients:* Malnutrition is often an issue for hospital inpatients and many patients have very clear food preferences.
   - *Families:* Many hospital patients come from multicultural backgrounds for which the provision of food and particular foods is a cultural indicator of "care". Family members, trusted friends or carers who may hold an enduring power of attorney (medical treatment act) or an advance care directive from the patient are integral to the decision-making processes that will occur in relation to policy and procedures.
   - *Delegated decision-makers:* Many dysphagic patients in hospital also have an element of cognitive impairment and therefore enduring power of attorney (medical treatment act) or care directives or delegated decision-makers may be involved.

3. **Staff, students and volunteers at the hospital**
   - *Consultants* often want their patients to "just eat more". When patients lose weight, they lose muscle tone, stamina and capacity to undertake daily self-care activities.
   - *Nurses* who have seen patients choke, sometimes to death, do not want to be forced to feed a patient at risk. Other nurses think patients should be able to eat whatever they like.
   - *Kitchen staff* who deliver food and drinks from the kitchen do not want to provide food that could potentially "kill" someone.
   - *Students and new graduates* of all disciplines want a clear policy to follow, particularly in sensitive cases. Accurate and detailed policy and procedures inform the staff as to what to do and how to document this.

4. **Other government, non-government and volunteer service providers in the region**
   If the hospital/local area health network introduces a "no choke" risk policy, this may impact on *disability service providers* providing institutional care, local nursing homes, hospices, rehabilitation organisations and individual carers at home.

5. **The local community that relies on the hospital/ health network for care**
   Advocates for people with disabilities would stress the importance of autonomy and clients' rights to the least restrictive intervention possible, particularly in the community.

6. **Related agencies such as social services**
   Community members fund health services through taxes. They are invested in health services improving patients' health status efficiently and effectively, and safely.
   The office for the public advocate may provide guardianship advice.
   Solicitors from the public trustees' office may provide legal advice (particularly given previous coroners' findings).

Text box C. "Issues" analysis for this case

1. **Multiple ethical issues are involved**
   - Autonomy of patients including aspects of informed consent
   - Staff duty of care "Do no harm"
   - Staff ethic of care regarding the social and cultural aspects of eating
   - Organisational legal advice based on the coroner's recommendations including risk assessment
   - Community service providers patient advocacy for beneficence (quality of life) particularly for people with long-term disabilities

2. **The facts**
   - Currently the hospital kitchen will not provide "choke risk" food to a patient requiring a speech pathology modified diet.
   - A speech pathology modified diet order can be overridden by a written order by a consultant medical officer.
   - Patients on modified diets who have capacity and physical mobility can independently purchase and consume "choke risk "foods from the hospital public cafeteria.
   - Patients who are physically impaired but cognitively able may request family members to provide "choke risk" foods for them to consume even after the risks have been explained.
   - Patients who do not have capacity to provide informed consent may have a designated decision-maker decide to provide "choke risk foods" to them even after the risks have been explained.
   - Staff (medical and nursing) who disagree with the current unwritten policy may privately provide patients without family and physical capacity with "choke risk food" independent of the hospital supply.
   - Professional community-based carers may provide "choke risk" foods to patients with or without cognitive capacity.

3. **Potential recommendations**
   - As per legal advice, the hospital will not provide "choke risk" food to patients.
   - Staff may refuse to feed patients at risk of choking non-modified consistency food as a conscientious objector.
   - Patients *with capacity* have the right to refuse treatment including modified consistency diet prescriptions and once they have been educated and informed of the risks may choose not to receive modified consistency diets.
   - For patients *without capacity*, their designated decision-maker once informed of the risks can organise and provide "choke risk" food to the patient without the involvement of hospital staff.

4. **Focus questions to understand the values and duties**
   - How do we respect the right of patients to choose their treatments? How do we ensure substitute decision-makers are acting in the best interest of the client?
   - How do we ensure the safety of vulnerable patients as an institution?
   - How do we protect the legal and ethical duties of staff in acts that might lead to the preventable death of a patient?
   - What are the values and principles that underpin the organisation and how are they applied during the development of the policy (e.g. respect, compassion, patient-centred practice)?

5. **Evaluate and Justify options**
   In the worked example the policy development group including the speech pathology manager met with key stakeholders to review the options and form a consensus response. It was decided:
   - Hospitals were institutions designed to provide safe treatment to patients. Staff had an ethical and legal duty of care that "choke risk" foods would not be provided to patients by the hospital.
   - If patients or their substitute decision-makers sourced and provided "choke risk" food, after being informed of the risks by a senior speech pathologist or senior medical officer and educated in methods to provide the desired items as safely as possible, hospital staff would not prevent this from occurring. Resuscitation status would be discussed with the patient/substitute decision-maker and documented by the medical team prior to the provision of "choke risk" food.
   - The patient, family or designated decision-maker will be asked to provide written confirmation of these decisions.
   - For patients without physical or cognitive capacity and no designated decision-maker, the matter would be referred to the guardianship board for advice and direction as this was likely to be a rare occurrence.

6. **Sustain and review the policy (plus reflection on practice) and uptake**
   - An education program to launch the new policy was designed for medical, nursing, allied health and kitchen staff by the policy team with the speech pathologist taking a lead role.
   - Adverse incidents related to diet modified food and choking episodes were to be reviewed quarterly by the clinical leads on the policy development group including the speech pathology manager, and provided to the quality assurance committee.
   - The issue was to be added to the hospital risk register and reviewed by the quality manager quarterly. Trend data is required to be collected to analyse the impact of the policy on patients as well as counting adverse events or near misses.
   - The policy was to be reviewed by the policy development team including the speech pathologist initially after 12 months and there after every 3 years.

5. the local community that relies on the hospital/health network for care;
6. related agencies such as social services.

It is important to acknowledge that each of these groups may hold differing opinions regarding a new policy or policy change. Ideally, the processes involved in developing a new policy around a sensitive topic with many divergent views would occur through exploration and discussion of values and desired outcomes from patients, family, relevant health care professionals and decision-makers in the organisation.

Hospitals are institutions and it is important to acknowledge that health care in hospitals is practised by (multidisciplinary) teams and not individual practitioners (Winkler, 2005) and this has implications for ethical policy development. Winkler argues that when formulating hospital-wide policies, consensus-building processes including all stakeholders will ultimately result in fair and efficient (and we would suggest may facilitate *ethical*) clinical decision-making at the bedside. Thus, for an ethical policy approach to our case, we need to consult with key stakeholders to build an ethical, acceptable and implementable response.

Formulating an ethical policy

So how do we begin to reflect ethically on policy development? Mintrom (2010) suggests it starts with those involved in policy work upholding ethical principles. This is a fundamental concept in using underlying principles to drive the translation into policy and procedure. Mintrom's ethical principles correlate well with the SPA Code of Ethics (SPA, 2010) values of integrity, professionalism, respect and care, quality standards and continuing competence. Integral to ethical policy construction according to Mintrom are concerns for others and a deep understanding of the community that may be affected by the policy. Frolic et al. (2012) suggest using an "ISSUES" guideline to facilitate organisational policy review. This is a 6-step framework:

1. **I**dentify the ethical issues raised by the policy
2. **S**tudy the facts
3. **S**elect the potential recommendations
4. **U**nderstand the values and duties
5. **E**valuate and justify options
6. **S**ustain and review the policy

The successful implementation of policy

New policies or changes to policy generally arise from identified problems. Kingdom (1995) delineated three streams in systems that need to coalesce to form a policy window, which then maximises the uptake of new policies. Initially problems may be identified that appear to be addressed by a policy. In Kingdom's model this is known as the *problem stream*. Objective reports of the size and extent of the problem, a crisis or feedback may help highlight a problem. Once the problem has been delineated a *policy stream* is commenced in which ideas and ways of managing the problem are gathered. Some ideas are trialled and if successful may lead to attempts to achieve broader implementation. For the new policy to be enshrined, however, there needs to be political will or the *political stream* needs to be in play. This might occur because of organisational mood, pressure groups or a new

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Text box D. How Kingdom's model assisted uptake of our case's new policy

1. **The problems stream**
   The problem had been clearly identified through risk assessment and analysis plus review of critical incidents in the hospital system related to choking.

   The investigation into the matter included a literature review of relevant laws and acts as well as information from the coroner's office and data about dysphagia management.

   Key stakeholders were engaged in the development process, including the consumers' voice, health professionals, quality improvement and risk personnel and hospital decision-makers.

2. **The policy stream**
   A new policy was written after many options were evaluated, including drafts for circulation and comment.

3. **The political stream**
   With a change in the hospital catering services management and a new hospital coming on line, hospital administrators were keen to have clear policies around the provision of modified food and fluids for all patients.

   The policy developers met with clinicians, management and the quality and safety committee to ensure executive sign off and commitment. They valued the work that had been done and endorsed the new policy.

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management/administration team. Chiarella (2013) suggested that successful stakeholders worked to complete the problem stream and policy stream so if and when the political stream aligned they could "surf the policy wave" and have the momentum to implement change.

People affected by potentially life limiting or chronic illnesses and their families and the health care professionals who care for them are important stakeholders in the consultation and development of policy and practice that supports individuals and allows them the quality of life they choose to enjoy. For many health professionals, there is uncertainty and ambiguity in the legal frameworks that may affect treatment and support, and in the frameworks and protections regarding treatment decisions (particularly if substitute decision-makers are involved). The lack of uniformity among health professionals can lead to challenging experiences for vulnerable patients and their families.

Clearly, ethical policy development and implementation is a time-intensive, collaborative process. Knowledge of Speech Pathology Australia's Code of Ethics can inform ethical analysis of policies and can be used by speech pathologists as a reference when working on policy development. Speech pathologists, through their application of the Code of Ethics and clinical knowledge, have a unique perspective to bring to the consideration and development of policies and procedures that will affect patients with disorders of swallowing who are compromised in their ability to enjoy a normal range of foods and fluids. Speech pathologists involved in policy development are encouraged to include ethical deliberation as an integral part of the process.

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1   See Smith and Muller (2009) for further discussion of substitute decision-making.

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To tube or not to tube: Who can ethically answer that question?

Helen Smith and Noel Muller

In this edition of Ethical Conversations, we consider ethical issues related to informed consent and the placement of feeding tubes. Informed consent is the right of individuals to make decisions about their treatment based on all relevant information of the risks and benefits of that treatment (Mitchell, Kerridge, & Lovatt, 1996). It is predicated on the principle of client autonomy. Autonomy is about respecting the rights of people to self-determination in relation to decisions which affect them (Speech Pathology Australia, 2000). Autonomy is the principle that underpins issues such as consent, refusal of treatment, and confidentiality (Smith, 2007).

In certain circumstances a person's right to give consent may be removed. This can occur as a result of impaired capacity to make decisions or in the case of severe mental health issues when a person's choice could result in harm to themselves or others (Trobec, Herbst, & Žvanut, 2009). In these circumstances another person or statutory body may become the designated substitute decision-maker.

Three cases are provided to illustrate a number of issues speech pathologists may want to consider when contemplating substituted informed consent for the placement of feeding tubes (either short-term such as nasogastric tubes [NGTs] or long-term such as percutaneous endoscopic gastrostomy tubes [PEG tubes]).

Case scenarios

Case 1

John is in his early 30s and has a long history of schizophrenia. John's schizophrenia is being managed by medication and is currently stable. He is single and lives with his very caring father. On this most recent admission to hospital, John presents with swallowing problems as a result of treatment for cerebral lymphoma. He is unable to communicate coherently nor is he able to eat, drink, or swallow his medications safely. He pulls out all NGTs and intravenous therapy. The medical team propose surgically placing a PEG feeding tube into John's stomach to provide nutrition, hydration, and medications while he continues his treatment for lymphoma. There is a good prognosis for his lymphoma treatment.

Case 2

Anna is in her late 60s and has suffered a stroke. On the day after her stroke she has severe language impairment (dysphasia) and is unable to speak or answer simple yes/no questions. She has profound dysphagia and her poor swallowing prevents her from taking any food, fluid, or medication by mouth. Anna has no family but has a legally prepared Advanced Care Directive[1] that states she does not want artificial (tube) feeding. Medical management favours placement of a temporary NGT so Anna can be given urgent cardiac medication which can only be given via a tube or by mouth. If she does not receive this medication she is at risk of a heart attack or further strokes.

Case 3

Max is an 88-year-old resident in a nursing home. He has advanced dementia. He presents to hospital with a severe pneumonia as a result of profound dysphagia which is due to his end-stage dementia. He has no advanced care directives and no family. His financial affairs are managed by the public guardian. Medical management favours placement of a PEG so that Max can be discharged back to his nursing home as soon as possible.

Discussion

Who can give informed consent?

Each of these cases raises different issues for the team with regard to who can provide informed consent. When considering substituted consent, speech pathologists need to be aware of not only ethical considerations that arise in individual cases but also relevant laws and legislation. These may include:

- *Emergency decisions* If there was an urgent (life and death) emergency need for medications for John, Anna or Max, then two doctors could consent to the placement of a NGT (or PEG, including administration of anaesthetic). Placement of a NGT for delivery of medication could most easily be argued by medical teams in Anna's situation.

- *Mental health act* An important consideration for John is whether he is covered by a mental health act.[2] Each Australian state and territory has a different mental health act. In some states, treatment decisions may be made for John by the State Director of Mental Health Services (a psychiatrist). Establishing whether John is covered under a mental health act is simply done by contacting his treating mental health team. If he was covered by a mental health Act his affairs may have been handed over to an adult guardian. The adult guardian would then be the substitute decision-maker for John's general health and well being. If John was not covered by a mental health act then his father would be considered his next of kin and would be the substitute decision-maker.

- *Consent to treatment and palliative care acts* Unfortunately, in Anna and Max's cases there are no clearly designated decision-makers to assist in determining appropriate treatment options. The challenge in Anna's case is the advanced care directive simply stating she does not want tube for feeding. Is this the same as refusing a tube for medication? Would Anna perceive a tube for medication as an extraordinary measure and refuse it if able?

- It is reasonable and ethical to respect Anna's right to have control over the end of her life. From state to state, however, there are different views about advanced care directives and their legality and validity.[3] In Anna's case, if we are to consider the principle of autonomy, it would suggest her clearly expressed wish should be respected and form part of the treating team's deliberations. The absence of

Helen Smith (top) and Noel Muller

family or a medical power of attorney to reinforce Anna's advanced directive means the treating team have to consider even more strongly what Anna would want.

Role of guardianship boards

In Max's case he has a right to treatment that will be effective despite his age and cognitive capacity. This may involve the treating team providing best practice medical management for his pneumonia and referring to a speech pathologist for advice on swallowing management. However, a doctor is not obligated to provide futile treatment, and in Max's case best practice evidence might suggest insertion of a PEG to be futile (Meier, Ahronheim, Morris, Baskin-Lyons & Morrison, 2001), even placing him at greater risk of aspiration (Hoffer, 2006). If the team wishes to consider consent for a PEG as a non-urgent surgical treatment, a substitute decision-maker would be required.[4]

Further ethical considerations for the speech pathologist

Justice

In all three cases it is important for speech pathologists to consider the principle of justice, that is, fairness and equity of access to services for John, Anne and Max. This may involve ensuring John is not discriminated against due to his longstanding mental health issues. For Anna it may be advocating against treatment she would not want. It might be ensuring Max receives reasonable treatment for a reversible medical condition but does not receive futile treatment.

Beneficence/non-maleficence

The principle of beneficence/non-maleficence or "to do good" is also relevant in the cases of John and Max. John has a potentially reversible dysphagia and communication impairment, but needs nutrition, hydration and access to medications while he is receiving treatment for lymphoma. In John's case a PEG, which he may find less irritating than a NGT, may be better tolerated. Similarly, by assessing Max's swallowing we may be able to show beneficence by being able to provide him with oral intake he is able to tolerate comfortably. By highlighting the complications and risks of PEGs in individuals such as Max with end stage dementia, we may also prevent doing harm through the potentially unnecessary placement of a feeding tube.

Duties to clients

When considering our duties to clients we may contribute to discussions with substitute decision-makers by providing information that meaningfully informs the decision-making process. Such information may include for example, the risks and benefits of NGT or PEG tubes, or the meaning of "comfort" oral intake, that is oral intake which may be aspirated but is still provided for patient centered symptom management and family care in individuals receiving palliative care (Waldrop and Kirkendall, 2009). It may be information provided in conjunction with other members of a treating team such as gastroenterologists, dieticians and physicians.

Conclusion

In this column we have highlighted the many and varied deliberations a treating team may undertake when determining the placement of feeding tubes to provide non-oral nutrition, hydration and medication. As has been discussed, many ethical and legal issues need to be considered by the treating team when contemplating substituted informed consent. Speech pathologists have a vital role to play in these deliberations and are well placed to positively influence the decisions that are made and the actions undertaken. Our clients will clearly benefit from our ability to discuss these issues in an open and informed manner with other team members and the relevant decision-makers.

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2. http://www.mhca.org.au/documents/Definitionsofmentalhealth.pdf
3. For more information on a state-by-state basis see the following: Consent to Medical Treatment and Palliative Care Act 1995, SA; Health Act 1911, WA; Natural Death Act 1988, NT; Medical Treatment Act 1988 ,Vic; Medical Treatment – Health Directions Act 2006, ACT; Health Services Act 1960, Tas; Consent to Medical Treatment – Patient Information 2004, NSW.
4. The appropriate "substitute decision-maker" will vary from state to state – it may be a member of the Guardianship Board or other authority.

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Ethical awareness in allied health students on clinical placements

Case examples and strategies for student support

Elizabeth Bourne, Lyndal Sheepway, Natalie Charlton, Andrew Kilgour, Julia Blackford, Marcelle Alam and Lindy McAllister

This paper takes an interprofessional view of the types of scenarios allied health students, including those in speech pathology, may encounter on placement. The paper highlights that students are ethically aware and in some cases may experience ethical distress as a result of what they experience on placement. Sometimes the cause of this distress is the behaviour of the clinical educator, who cannot therefore be a support to the student in managing their ethical concerns. We suggest a structured approach to pre-placement preparation, support during placement, and post-placement for students, which provides a range of resources, personnel and educational strategies to assist them to develop their ethical reasoning and manage ethical concerns.

The goal of clinical education is to develop not just students' technical skills but also their professional attributes such as ethical practice in order to prepare them for entry into their chosen health profession (Physiotherapy Board of Australia, 2010; Speech Pathology Australia, 2010). To be good ethical practitioners, clinicians need to be ethically aware and proactive (McAllister, 2006). Practising clinicians continue to experience ethical dilemmas related to themes such as client management, professional relationships, service delivery and personal/professional identity (Kenny, Lincoln, Grono & Balandin, 2009). Therefore, it is important that all graduates are equipped with the ability to identify and manage *ethical tensions* (Kinsella, Park, Appiagyei, Chang & Chow, 2008) before they become dilemmas. Clinicians may experience different types of ethical tensions throughout their professional career, including ethical uncertainty, ethical distress or ethical dilemmas. Ethical uncertainty occurs "when an individual is uncertain about which moral principles apply or whether a situation is indeed a moral problem" (Kinsella et al., 2008, p. 177). Ethical distress occurs when an individual is aware of the right course of action but feels compelled to do otherwise by an institution. Ethical dilemmas occur when an individual "faces two or more equally unpleasant alternatives that are mutually exclusive" (Kinsella et al., 2008, p. 177).

As with any other area of competency, students' growth into ethical practitioners needs to be facilitated by both university staff and clinical educators in the workplace. The speech-language pathology competency assessment tool (*Competency assessment in speech pathology* COMPASS®; McAllister, Lincoln, Ferguson & McAllister, 2006) describes this growth on a developmental continuum similar to other areas of competence. It suggests novice students can participate in discussions around ethical principles and values and also follow workplace procedures such as maintaining confidentiality (McAllister et al., 2006). Intermediate students are developing awareness of how to put these principles and values into practice, but need "monitoring and feedback" from the clinical educator (CE) to manage all aspects of situations effectively (McAllister et al., 2006). At entry level, it is still appropriate for students to require support in applying ethical principles and values in more complex situations (McAllister et al., 2006). Hence, regardless of their level of experience, clinical placements have a vital role in helping students work through ethical tensions.

In speech pathology no published research has explored students' level of awareness of ethical matters and the nature of the tensions they perceive. However, from other disciplines it is clear that health care students have some level of ethical awareness and identify ethical tensions across a range of clinical practice areas. Erdil and Korkmaz (2009) surveyed 153 third- and fourth-year nursing students regarding ethical problems encountered during clinical placement and the approaches taken by nurses in solving these dilemmas. They found that all the nursing students observed ethical tensions while on clinical placement. Similarly, Geddes, Wessel and Williams (2004) found ethical issues were mentioned by 53 of the 56 students when reviewing physiotherapy students' reflective journals. Major themes related to respect, professionalism and professional collegiality. Minor themes were allocation of resources, advocacy and informed consent (Geddes, Wessel & Williams, 2004). Kinsella et al. (2008) conducted a study of 25 occupational therapy students who were asked to describe ethical tensions either experienced or observed while on clinical placement. These students must have successfully completed 22.5 hours of ethics education to take part in the study. Among themes identified were "systemic constraints" (p. 179) including staffing limitations, resulting in sub-optimal client care. Due to some similarity in clinical contexts it is likely that this is a universal issue for health care students.

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Speech pathology graduates have been reported to experience significant "ethical distress" in response to systemic constraints (McAllister, Penn, Smith, Van Dort & Wilson, 2010, p. 45). Penn (2009) discusses ethical distress in the context of a student witnessing ethically questionable behaviour in a colleague but feeling uncertain, powerless and fearful about reporting it. Kinsella et al. (2008) also identified ethical distress in situations where occupational therapy students experienced an ethical concern and had to decide whether to verbalise this to their supervisor and/ or patient. While this causes worry and anxiety, students often feel unable to express these concerns within the clinical placement setting due to their low status, limited knowledge and perceived consequences for their clinical assessment (Kinsella et al., 2008; Erdil & Korkmaz, 2009). Clinical educators have a key role in helping students develop ethical awareness as well as the language and confidence to attend to feelings of ethical concern and distress and express them appropriately.

This paper draws on our experiences as clinical educators of allied health students. To illustrate the common ethics concerns of students, we present vignettes drawn from speech-language pathology, occupational therapy, physiotherapy and diagnostic radiography. These vignettes are drawn from ethical concerns which students have raised with us in formal contexts such as lectures and assignments, and regularly in other activities such as emails, conversations, and debriefs after placements. We discuss the vignettes briefly in relation to principles and duties enshrined in codes of ethics, codes of conduct and mandatory reporting requirements. We offer suggestions for ways in which clinical educators can assist students to manage their ethical concerns and distress.

Vignettes

1. Observing bullying and intimidating interactions between professionals

Thuy is a third-year physiotherapy student on her first clinical placement on an acute medical ward. Her educator is a senior physiotherapist who is also responsible for the supervision of the new graduate, Clare, on rotation in the same ward. During the first week of her placement, Thuy observes a conversation between her educator and Clare. The educator is questioning an intervention that Clare performed on a patient; the educator is using a raised voice and accusing tone. She does not allow Clare to explain her rationale for the intervention she chose. The interaction takes place at the nurses' station in front of several of their colleagues. Clare appears to be upset by the educator's behaviour but continues with her morning caseload. Later that week Thuy hears another conversation between the educator and Clare with the educator accusing Clare of being lazy and incompetent when she arrives a few minutes late to the ward that morning. Thuy later finds Clare visibly upset in the staff toilets. Thuy feels uncomfortable, feeling sorry for Clare but is unsure of what she should say to her.

2. Asking students to undertake tasks from their previous profession

Hamish is a registered nurse who is in his final year of a two-year postgraduate course in diagnostic radiography. He is allocated to a major regional trauma hospital radiology department for his first clinical placement. Hamish tells the radiographers that he is working with that he is a registered nurse. On his second week, Hamish is rostered with Boris, a senior radiographer, to work in fluoroscopy. An oncology patient is booked to have a peripherally inserted central catheter (PICC) inserted for his chemotherapy, but the radiology nurse has called in sick. Boris insists that Hamish scrub and perform the radiology nurse's role assisting the radiologist to insert the PICC.

3. Respecting autonomy and dignity of patients

Ibrahim is a second-year diagnostic radiography undergraduate student on placement in a major metropolitan hospital radiology department. He is rostered to work with Horatio, the senior radiographer in the emergency department. Horatio is very experienced, but his clinical reasoning skills are subservient to his insistence on strictly following imaging protocols. An elderly patient, Agnes, arrives in the department in a wheelchair. She is known to have mild dementia, but can communicate quite coherently. Agnes has fallen on her shoulder, and the emergency medical team, suspecting a fractured neck of humerus, have requested a shoulder x-ray series. The imaging protocol manual dictates that the humerus should be internally and externally rotated for two projections in the series, and Horatio instructs Ibrahim to do just this. When Ibrahim attempts to move Agnes' arm, she screams in pain, and says "leave me alone". Ibrahim stops immediately, but Horatio instructs him to continue. When Ibrahim refuses, Horatio is very angry, and forces the patient to continue with the examination, despite her protests. With a dismissive tone he says to Ibrahim, "She is demented, so just ignore what she says. We have to obtain the images."

4. Explaining procedures to patients from non-English speaking backgrounds (and getting family members to interpret)

Madeleine is a fourth-year occupational therapy undergraduate student completing her final clinical placement block. Along with a senior occupational therapist, Madeleine is assisting in the home visit to Amira, a 35-year-old Iraqi woman with advanced breast cancer, who does not speak or understand English. An interpreter has been booked for the visit. Madeleine and the senior occupational therapist arrive at Amira's home. Amira's husband meets them outside as they arrive. He speaks reasonably fluent English. At the last minute, the interpreter calls to inform the therapist she is unable to attend as she has been called away to assist with a more urgent patient. Amira's husband insists that they would like to go ahead with the appointment and that he would be able to interpret for his wife, as he has done this numerous times before at her previous medical appointments. The senior occupational therapist agrees to this request and explains her reasoning to Madeleine. As they are about to enter the house, Madeleine overhears Amira's husband state during a phone call that he will not be telling Amira anything about her diagnosis as he does not want her knowing that she has cancer, believing that she will lose the will to live if told.

5. Caseload management and patient prioritisation systems in workplaces

Kate is completing her last clinical placement of her four-year undergraduate speech-language pathology degree at her local tertiary referral hospital. Due to staffing shortages, there are not enough speech pathology work hours to cover the patients who could benefit from the service. Clinicians are guided by their well-established

(From the top) Andrew Kilgour, Julia Blackford, Marcelle Alam and Lindy McAllister

patient prioritisation system which identifies assessing new patients as the top priority, closely followed by reviews of those with acute dysphagia. At the lowest level of priority are patients who require communication therapy. On Monday of her second week Kate conducts an initial swallowing and communication assessment with a 68-year-old previously independent woman who presents with a stroke. The woman is found to have mild-moderate receptive and expressive aphasia and mild swallowing difficulties. She is placed on a modified diet and instructed in safe swallowing strategies. On Tuesday Kate briefly sees the patient at lunchtime and observes no swallowing difficulties. Kate's clinical educator speaks with the nurses caring for the woman and no concerns are reported about her swallowing. The patient's daughter and husband catch Kate as she is searching for the medical file and ask what will happen with the lady's speech. Kate has already been told by her clinical educator that they may not be able to see this patient again this week.

6. Seeing non-evidence based practice occurring/being delivered by one's clinical educator

Emma is a third-year undergraduate speech-language pathology student who really enjoyed her child speech lectures. She is excited to start a placement in a community clinic where they have a number of clients with speech disorders. One of Emma's allocated clients is a 4 years 7-month-old boy who is stopping all fricatives, reducing consonant clusters and fronting velars. Emma's clinical educator has already seen this boy for two sessions but Emma will see him for the remaining six sessions of his last therapy block with the service. Emma's clinical educator has been working on stimulating *k* and *g* sounds and suggests that Emma continues working on these targets in nonsense words before moving on to word and phrase level. She mentions that by the end of the block Emma will need to prepare a comprehensive home program so the boy's mother can continue working on his speech before he goes to school. At home that night Emma begins working on the plan for her first session. As she thinks more about this boy she wonders why her clinical educator has chosen these targets and treatment approach, particularly when there are so few therapy sessions. She also struggles to find literature to complete her rationale for the therapy goals she has been given.

Discussion

The six vignettes presented above portray a range of ethical issues experienced by allied health students. Not all are drawn from speech pathology practice, but the issues are generalisable. Further, as allied health students and clinicians work increasingly in teams, being alert to ethical issues in other disciplines and having some strategies to support student peers and colleagues to manage ethical issues are essential.

Vignettes 1 and 2 are concerned with respect for colleagues including students. Students are both witnesses to and recipients of bullying in the workplace. As recipients, they have a clear course of action they can take in seeking support from their university clinical coordinator. The course of action is less clear when the recipient of the bullying is another member of staff, especially when the perpetrator is one's educator. Fear of reprisal and being marked down in assessment of clinical performance will no doubt be in Thuy's mind should she choose to speak to her clinical

educator. Concern for the invasion of Clare's privacy might also be on Thuy's mind as she weighs up options for action. Vignette 2 illustrates an increasingly common concern expressed by students. Many allied health students are undertaking study to change careers from being teachers, nurses, allied health assistants and so on. They bring with them knowledge and skills which will enhance their new roles but it is outside the scope of practice of their "new" profession to apply procedural skills from their old profession. They are not credentialled to do this and insurance will not cover them. For clinical educators to request them to undertake such procedures shows a lack of respect for the students as well as a lack of awareness of insurance arrangements in place in the clinical educators' practice settings. It can be very difficult for students to resist such requests because of the power imbalance and fear of reprisal (through poor assessment).

Vignettes 3 and 4 illustrate failures of respect for the autonomy and dignity of patients. The ageing population with concomitant problems such as dementia and an increasingly multicultural society mean that situations like these will be familiar to many practitioners. The issue of informed consent is present in both these vignettes. We know that the decision to continue the procedure without an attempt to modify it in some way to reduce pain or to explain to Agnes why pain is necessary shows not only a violation of the patient's autonomy and dignity but also demonstrates maleficence. It suggests "elder abuse". Vignette 4 illustrates a patient being denied the truth by her next of kin, who is also intentionally drawing staff and students into the deception. The patient's autonomy to make a range of decisions is compromised, and the cultural differences as well as the collusion involved create ethical distress for the student.

Vignette 5 illustrates an increasingly common situation in speech pathology practice (Atherton & McAllister, 2009), where micro-economics collide with beneficence. Prioritisation systems are often a response to restrictions in resource allocation. The ethical principles of justice and beneficence are not served in this vignette. It is likely that this woman will be discharged once she has been determined to have a safe swallow. Togher (2009) and Cruice (2009) discuss the safety issues in discharging patients with no effective communication system. Situations like this will cause ethical distress to clinicians and students as they witness patients' bewilderment and distress. The principle of "need" and a different approach to service rationing must be considered in situations like this one.

Vignette 6 is typical of situations frequently raised with university staff by students who witness non-evidence based practice on placements. Students tell us that when they try to question such practice they receive a range of responses from their clinical educators who may see their behaviour as impertinent, may be defensive, not understand evidence-based practice or see it as not relevant to the real world of practice. The power imbalance often prevents students raising the issue and if they do, they may compromise a positive relationship and learning environment.

It is clear in the vignettes presented above that students are ethically aware. They may also experience ethical distress. If it is not behaviours or attitudes of the clinical educator that are the cause of a student's ethical concerns, a student can discuss their concerns with the educator and consider options for appropriate action. However, particularly if experienced, clinicians might have developed a level of expertise in their practice as well as their ethical

thinking, such that their ethical competence has become "automatic", unconsciously embedded in their practice, and they may find it hard to articulate the issues for students. Students will still need strategies for thinking through their ethical concerns and making ethical decisions.

Sometimes it is behaviours or attitudes of the clinical educator that pose ethical concerns for students, as in Vignettes 1, 2, 3, and 6. In this case the student will need a range of alternatives to help them reason their way through their concerns. These may include discussion with peers, a safe third party on placement (this should be included in site orientation materials), or the university clinical coordinator. We suggest the following as a structured way to prepare students to develop and respond to ethical tensions.

Preparation at university

The process of informing and advancing a student's ethical awareness should begin at university (Cooper, Orrell & Bowden, 2010). Interactive classes held before students initially enter the clinical environment and throughout the duration of their program are an essential tool in the development of students who possess the capacity to ethically reason, make appropriate judgements and responses when faced with an ethical dilemma, and possess coping mechanisms and strategies to minimise the possibility of ethical distress occurring (Clark & Taxis, 2003). Ideally, some of these classes will be interprofessional, so that students begin to understand that different disciplines may bring different lenses to examining ethical issues (Cloonan, Davis & Bagley Burnett, 1999).

These classes can be confronting to students on a number of levels as they are being asked to examine and reassess their values and views on a range of ethical issues. Students' ethical growth occurs along a novice to entry level continuum (and beyond), and students often express difficulty in identifying and managing ethical issues due to a lack of experience (especially in the earlier years of the program). Ethics education must include a reflective component which educates students on how to reflect on a situation in order to improve their ethical reasoning (Lemonidou, Papathanassoglou, Giannakopoulou, Patiraki, & Papadatou, 2004). In novice level students, this beginning process of ethical awareness can be facilitated by asking them to draw on real-life experiences unrelated to clinical placement where they have experienced a dilemma. Students can be asked to look at all of the factors in the dilemma, thus encouraging them to see things not just in black and white, but in "grey" as well. Before commencing placement, students can be briefed on their profession's code of ethics, in addition to the code of ethics/conduct from relevant health authorities.

Structured ethics learning opportunities on placement

Structured discussion times should be built into a placement schedule to allow students the opportunity to discuss ethical issues and ask any questions regarding issues of concern to minimise the potential for ethical distress. Suitable times should be organised by the clinical educator before the commencement of the placement and discussed with the student during the orientation session. Discussions may occur on a one-to-one basis or in a group setting, thereby maximising opportunities for learning. Appropriate strategies for the structure and effective facilitation of ethics-focused conversations with students may need to be provided to clinical educators by university staff. This is a challenging area and it should not be assumed that clinical educators possess these skills or knowledge. Workshops conducted by universities and/or information sheets they distribute are examples of ways in which this knowledge can be disseminated.

The completion of an ethics case study while on placement is a powerful tool in developing students' ethical awareness. For example, students could be asked to apply their knowledge of ethical principles to a workplace situation and provide a detailed discussion of an ethical dilemma which they experienced. Students should be encouraged to reflect on how the situation was handled and provide examples of how they would handle this situation if faced with it in future. Reflective journals and reports can assist students' learning in this regard.

Learning support during placement

We suggest the development of an online discussion board to further support the development of ethical awareness in students. This strategy allows students to connect with their peers and university staff to share experiences, give and receive advice, promote ethical reasoning and devise effective coping mechanisms and strategies to manage an ethical problem. Lemonidou et al. (2004) suggest that continuous support from peers is essential in fostering and refining students' perceptions of ethical and moral situations. As students can be placed in numerous clinical sites across the country (including rural and remote settings), an online discussion board hosted on a university learning management system would allow for this development to occur. The discussion board would allow for postings of students' questions or topics, with peers and/or university staff participating to facilitate the exchange of ideas. The site must be facilitated by a university educator regularly, with posts being sent by students to the staff to be scanned for appropriate content before being posted. Students must be briefed about this process before placement begins, with rules for the content and display of information explicitly articulated on the discussion board. While this may be onerous on educators, it should be considered as an important component of a students' ethical awareness development.

Students can also be encouraged to use their peers as resources to manage ethical concerns, with confidentiality and privacy concerns being appropriately addressed. To use peers well, students will need prior preparation at university in both dialogic and activity-based peer learning strategies (Baldry Currens, 2010). Students need input on how to actively engage in peer learning opportunities as well as on the sorts of communication skills needed to learn with peers. Being able to ask questions that provoke deep learning, providing feedback and offering comments that are respectful and inoffensive, focusing on the task not the person are examples of dialogic peer learning skills.

Debriefing

Debriefing sessions conducted at the university after placements allow students the opportunity to explore and discuss in depth any ethical tensions and dilemmas experienced. Classes should assist students in further developing strategies for effectively managing ethical dilemmas through the exchange of ideas with peers and university staff. A trusting, supportive environment is essential for the effective facilitation of this process, where no fear of retribution exists. Confidentiality should be maintained at all times, with students being made aware of this at the beginning of each class in order to encourage honesty. Individual meetings with the university clinical coordinator may be indicated to discuss further issues or

provide additional support for students who are continuing to experience ethical distress. It must be noted that although this is a confidential process, educators have an obligation to report any suspected cases of abuse to their employer or relevant authority.

Conclusion

It is clear that students are ethically aware and require guidance and facilitation to become ethical practitioners. At entry level, it is still appropriate for graduates to require assistance with ethical dilemmas. Both university and clinical educators play a vital role in students' ethical development, which can be facilitated in the following ways.

Clinicians must be ethically aware and cognisant that students may find a situation ethically challenging. Offering opportunities for structured debriefing sessions will allow students the opportunity to discuss ethical issues witnessed and augment their knowledge base. It is vital for clinicians to provide students with a welcoming environment where they are made to feel comfortable and encouraged to discuss any ethical dilemmas. University educators and clinicians must inform the student of appropriate people at the placement site with whom they can discuss ethical tensions or dilemmas. This is an essential component in ensuring that any ethical issues experienced by students are addressed early, before ethical dilemmas or distress occur.

University educators must fully brief students before they commence clinical placement to the possibility of ethical tensions arising, how to identify them and effective strategies for dealing with these. Students must also be provided with the skills required to reflect on these ethical issues and opportunities to share and learn from their reflections, thereby reinforcing their knowledge and understanding in this area.

The implementation of appropriate strategies such as interactive classes (e.g., role play in a case-based learning environment; structured discussion times and learning opportunities during clinical placement; completion of an ethics case study while on placement; use of online discussion boards; structured peer learning opportunities and debriefing sessions) can assist students in developing their awareness while minimising the potential for ethical distress occurring.

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Ethical reasoning in clinical education

Achieving the balance

Michelle Quail, Brooke Sanderson and Suze Leitão

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Ethical reasoning within the context of clinical education is explored using the casuistry approach to ethical decision-making through the layers of the Seedhouse ethical grid (a decision-making tool). The casuistry approach guides clinicians' actions by encouraging them to map previous experiences onto the profession's underlying principles in order to help them proactively plan for future clinical education experiences. In this paper, we present a model which highlights the unique and delicate balance between the multiple stakeholders involved in clinical education, and the shift in responsibilities and relationships that can occur. The need to understand ethical decision-making processes, be proactive with ethical thinking, and ensure clarity in expectations is discussed. A framework is proposed to assist clinical educators in finding the balance between their ethical obligations to their students, their clients and themselves.

Ethical reasoning skills are fundamental to all professional practice, allowing "the highest standards of integrity and ethical practice" and creating the foundation for evidence based practice (Speech Pathology Australia, 2012, p. 3). Speech-language pathologists constantly engage in a process of ethical reasoning when making decisions on both a professional and a personal level. This complex process is made more challenging within the context of clinical education, where, given the number of stakeholders, there is an ongoing shift in the responsibilities and relationships for all involved. This highlights the importance of proactive ethical planning within clinical education.

The ethical issues that speech-language pathologists face within the context of clinical education are unique in origin but not in action. As for any area of clinical practice, the use of theoretical frameworks in ethical reasoning is an essential component of the decision-making process. Ethical frameworks can assist us in not only working through ethical problems, but also in being proactive in preventing these.

Traditionally, speech-language pathologists have adopted a "principles approach" towards ethical reasoning (Speech Pathology Australia Ethics Board, 2011). This approach draws on the Speech Pathology Australia Code of Ethics (Speech Pathology Australia, 2012) as the core basis for decision-making but is less suited for use in proactive planning. As a point of contrast, the casuistry approach to ethical reasoning (Speech Pathology Australia Ethics Board, 2011) encourages speech-language pathologists to draw on their previous experiences and map these onto the underlying principles of our profession to inform future planning.

The Seedhouse ethical grid (Seedhouse, 1998) is a useful tool (Figure 1) that can be applied within the casuistry approach to facilitate ethical reasoning. The grid is made up of four layers; at the core is the "Basis or rationale for health care", surrounded by "Duties aligning to key ethical principles", "Consequences" and finally the outermost layer, "Other contextual factors". The four layers within the grid allow for the analysis of ethical issues at a range of levels, from the principles-based core of the traditional approach to broader considerations where consequences and effects can be considered (Seedhouse, 1998). The grid can be used flexibly, targeting the layers and components that are most relevant for a particular issue (Body & McAllister, 2009). In this way, the grid supports speech-language pathologists working through ethical issues by looking at the whole story, rather than at the issue in isolation.

This tool is valuable in the context of clinical education because of its multifactorial nature, which reflects the complexities of clinical education beyond those that may be represented by the principles alone. The process and outcome of clinical education is dictated to a large extent by the type and extent of experience of both the student and the clinical educator. In this context, the use of the Seedhouse grid within the casuistry approach (where experience is of particular value) facilitates the opportunity for dynamic and comprehensive ethical reasoning and decision-making.

In this article, the casuistry approach will be used to identify a number of key ethical challenges posed to all stakeholders involved in clinical education and discuss these within the multiple layers of the Seedhouse ethical grid (Seedhouse, 1998). This article also provides a framework which can be used to facilitate proactive ethical reasoning and assist clinical educators in finding the balance between their ethical obligations to their students, their clients and themselves.

Clinical education – the context

Clinical training is mandatory for successful completion of all professional entry-level health courses. Clinical placements provide students with the opportunity to gain clinical and professional skills before they assume the responsibility of independent client care (Department of Health, 2011). The quality of clinical education can be viewed as a key factor in assuring the future quality of health care; with high-quality education in the real-world setting enabling students to gain the experience required to develop competency in their delivery of health care services. In the context of speech pathology, an extending scope of practice, diversification in workplaces, increased demand for speech pathology services and increased fiscal constraints make for a challenging clinical education environment.

Figure 1. Ethical grid

Source: http://www.priory.com/ethics.htm with permission from Professor David Seedhouse

Speech-language pathologists are expected to contribute to the development of the profession by "participating in clinical education and supervision" (Speech Pathology Australia, 2001; 2012, p. 3). When choosing to supervise speech pathology students, clinical educators are meeting their obligation to support the training of the future speech pathology workforce; however, this responsibility needs to be balanced with their responsibility to their clients. The overriding priority during clinical placements must be that client care is safe, of high quality and effective (Health Workforce Australia, 2011).

This balance is depicted in Figure 2, and emphasises the clinical educator as the key platform between the student and the client, while the fulcrum is depicted as a triangle underpinned by both the foundational responsibility to the university for whom they are providing the clinical placement, and to the profession as a whole. While balancing the link between the student and the client, the clinical educator is in a position of constant change, whereby they can shift closer to the student or the client depending on the demands on their responsibility, time and expertise at that point in time. This movement has an immediate effect on the equilibrium of the relationship, shifting the primary balance towards either the student *or* the client (figures 3 and 4).

A clinical educator may be faced with a situation such as a student experiencing difficulty managing a client's behaviour and hence feel the need to become more prescriptive and actively involved in a student's session. Although this allows greater control over the service being provided at the time, it can also limit the student's opportunity for autonomy and to "make mistakes", reflect and learn from these. In this situation the client is kept grounded and close to the profession's aim of the best
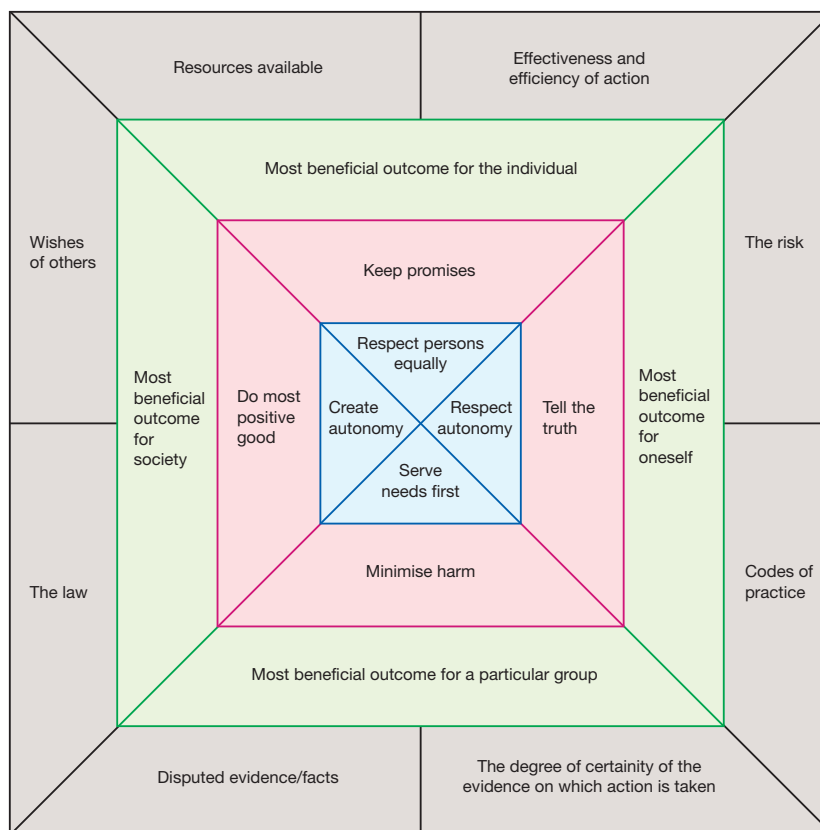
quality service (Figure 3), but this moves the student further away from the university's aim to develop independent and competent professionals.

In contrast, a clinical educator faced with the same scenario, but who provides a student with this independence while providing a safe learning environment and foundation to build confidence, may jeopardise high-quality client care (Figure 4). Establishing the right balance between these parties can be extremely difficult and is complicated by the desire to provide the best learning opportunity for the student and the professional obligation to provide the best possible service, while maintaining ethical responsibilities to both. A more experienced clinical educator is able to draw on previous experiences in this role to support such ethical decision-making, while a novice clinical educator may draw on their own experiences as a student. The casuistry approach, where reasoning is informed by similar cases and dilemmas, and the successful outcomes of previous cases, provides clinical educators with a useful framework for such decision-making.

The ethical grid in clinical education

In light of the ethical issues that commonly arise within clinical education, in particular the potential tension between a clinical educator's responsibility to the student and the client, the need for proactive ethical planning is apparent. The framework presented in Table 1 is based on the layers of the Seedhouse grid (Seedhouse, 1998), and is designed to frame orientation discussions between a clinical educator and student. It might also form part of a clinical placement manual and could be used to structure supervision discussions throughout the placement.
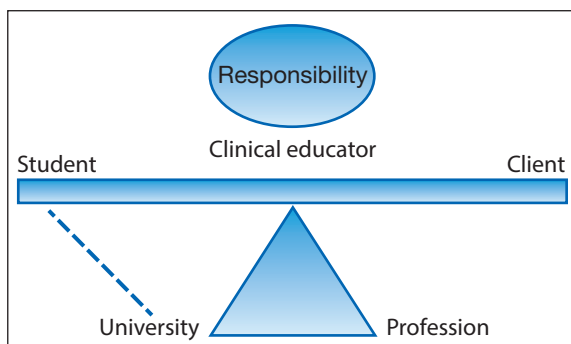
Figure 2. The clinical education balance
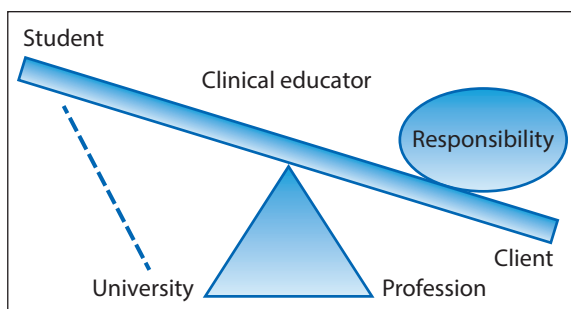
Figure 3. The client focused clinical education balance
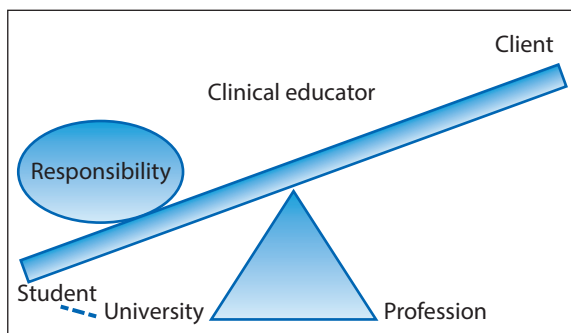
Figure 4. The student focused clinical education balance

This paper will now explore some of the recurring ethical issues that arise in clinical education, in particular those related to balancing the needs of the client and student, drawing on the casuistry approach and the ethical grid as a tool (Seedhouse, 1998). The grid is presented in four layers to highlight the need to consider these four aspects in a comprehensive ethical analysis of a situation. It can be used in many ways, and in this context we have chosen to start in the innermost layer and work outwards.

Basis or rationale for health care

The core of the ethical grid addresses the key concept of autonomy – specifically, the need to both respect and create the opportunity for all parties to be actively involved (Kummer & Turner, 2011). This concept underpins the delicate balance depicted in Figure 2, in that clinical educators are attempting to balance the opportunity for students to develop independence, while ensuring the clients are actively involved in the therapy and decision-making process. The clinical educator also needs to respect the autonomy of the client and their family to provide and withdraw consent for working with a student at any time, while respecting the autonomy of the student in acknowledging and encouraging perspectives and opinions different to their own. Although the client is attending in

order to receive a service and be provided with support, this also applies to the student – who attends the clinic to receive support and guidance from the clinical educator.

Ethical planning is a practical strategy that can support a balanced approach. A key component to this is the need for transparency. Ensuring clarity among all parties underlies the success of almost every aspect of clinical education. There is a need for clinical educators, students and clients to take an objective step back and discuss the processes, relationships, responsibilities and expectations. Examples of focus questions are provided in Table 1. This will be facilitated by reflection on past experiences and drawing on successes. Such a pro-ethical step could be embedded by providing this level of detail within orientation packages and materials placed in waiting rooms in an effort to prevent potential ethical dilemmas from arising.

Duties aligning to key ethical principles

This layer of the grid aligns closely with that of the SPA Code of Ethics (Speech Pathology Australia, 2012), specifically addressing the principles of truth, fidelity, beneficence and non-maleficence. Beneficence in the clinical education context extends beyond the common understanding of ensuring the "most positive good" (Seedhouse, 1998) for our clients. It also encompasses responsibility towards the student, and is dependent on understanding the role clinical educators play in student learning. It is suggested that clinical educators spend time discussing the code with their students and reflecting on its application to clients and clinical experiences (see Table 1).

The key component in this relationship is *education*. As a clinical educator, the speech-language pathologist is responsible for teaching, nurturing and providing feedback. This involves taking responsibility for imparting, rather than only expecting knowledge. Herein lies the difference between clinical education and supervision – those who teach and develop skills and those who monitor and assess skills (McAllister & Lincoln, 2004). McAllister and Lincoln's (2004) discussion of clinical educators creating learning contracts for themselves (in addition to using these with their students) is a valid suggestion which emphasises that they too need to be constantly reflecting on their performance and experiences.

The past experiences of a clinical educator provide significant support for decision-making if these situations arise again. For example, when supervising a marginal student, the clinical educator needs to take responsibility for their role as a "gatekeeper" for future professionals, and be honest with the student in giving them the required feedback. These difficult decisions and discussions align with the concept of truthfulness and loyalty, and reflecting on previous experiences and drawing on past successful outcomes can assist in supporting the clinical educator with their current decision-making.

Consequences

The next layer of the grid considers a broader perspective of ethical issues, and the potential consequences for society, students, clients and clinical educators themselves.

For example, when considering the most beneficial outcome for the student, the clinical educator may wish to select clients taking into account the requirements of a student to develop specific competencies, the level of skill of that student and the limitations and opportunities of the workplace. However, this may come into conflict with the

Table 1. Pro-ethical practice in clinical education		
Aim	**Justification**	**Strategies**
To facilitate and respect autonomy in the student and clients	*Basis of rationale for health care* The clinical educator is responsible for ensuring the student and clients are clear on their responsibilities. This explicit discussion is a vital step in being proactive with ethical reasoning by ensuring that role expectations are clear and no assumptions are made.	Discuss roles and responsibilities of: • Clinical educator • Student • Client Discuss clinical education process: • Relationships • Supervision • Feedback • Learning opportunities Develop clinical placement contract Discuss responsibilities within the clinic: • How does the clinic work? • Who is responsible to whom? • And why? • What are the processes and responsibilities? • Does everyone know this?
To facilitate students' practical understanding of the Code of Ethics in the clinical placement context	*Duties aligning to key ethical principles* The Code of Ethics and principles of truth, fidelity, beneficence and non-maleficence should be explicitly discussed with reference to clinical education and duties within the current clinical placement.	Discuss the Code of Ethics: • What does the code mean to you? • Do you understand the values, principles and duties? • When might you need to apply the code in this placement? • How will the code frame our decision-making? Look at the Code of Ethics together and discuss examples from previous practice/placements
To motivate the student and ensure a broad perspective to facilitate well considered decision-making	*Consequences* It is essential that the outcomes of the clinical placement are discussed. This will facilitate students' broad understanding of the process of clinical education / placements and the need to consider all parties in their decision-making throughout the placement.	Discuss outcomes and the contribution the placement makes to: • The local community (society) • A student • Our clients • Clinical educator For each point above, discuss self-management, readiness, preparation and motivation for the clinical placement from both the clinical educator and student point of view.
To ensure the student is making decisions with an understanding of the external considerations of the placement context	*Other contextual factors (legal and social)* The clinical educator is responsible for ensuring the student and clients are clear on their responsibilities. The external factors depicted in the outer layer of the grid highlight the range of considerations that may differ between contexts.	Draw on the resources provided in the reference list to guide your discussions (including legislation, policies and procedures that guide service delivery such as risk management) • Do you have any questions about your responsibilities within these?

principle of fairness (Speech Pathology Australia, 2012) and the need for all clients to have equitable access to services, within the presence of waitlists and other constraints on the service. Such decisions are delicately balanced as presented in Figure 2, and the consequences of these decisions cannot be ignored, for both the student and the client who the student will (or won't) see. It is advantageous for the clinical educator to draw upon their previous experiences in client management, student development and clinical education, to ensure they allow all parties the best possible outcome when selecting clients within the difficult balance of clinical education. Asking oneself questions such as: "Have I experienced a case like this before? How did I manage this? What were the outcomes? Should I respond in a similar way or modify my decision-making?" will help guide the clinical educator in their current planning.

It must not be forgotten, however, that often the placement of students facilitates expanded service delivery. The end product of students' clinical education (being graduation and entry into the workforce) has benefits for

society in bringing about growth in the health workforce, while the actual process of their training is also beneficial in some way to all clients that they come into contact with on their clinical placements. In that sense it is important to consider that although a session may not run optimally, any effect may be short-term, balanced against the longer term outcome for the client (as the student will learn from the experience and invest additional time in their planning) and society. Table 1 includes discussion points that can be used by clinical educators to facilitate students' broad understanding of the process of clinical education and the specific placement itself.

A broader ethical issue encompasses the significant diversification of our profession and society as a whole. Universities have a responsibility to embrace student diversity, and Lincoln (2012) discusses the need for clinical educators to adapt to universities recruiting more Indigenous, culturally and linguistically diverse and international students. As this shift is a relatively new one in our profession, the opportunity for clinical educators to draw upon previous experience is reduced. The current needs of these students may not align with clinical

educators' previous experience, but with each occurrence a new "case" is added to the clinical educator's toolbox. For example, there may be a discrepancy between a student's professional competencies and English language competencies, and it may take longer for international students to reach the required competencies. There is therefore the need for universities, students and clinical educators to work together, to learn from emerging cases and ensure these students are supported to develop their skills and contribute successfully to the profession, while balancing the needs of the clients they are servicing.

Unsurprisingly speech-language pathologists rarely consider the most beneficial outcomes for themselves, despite this being included in the revised Code of Ethics (Speech Pathology Australia, 2012). It is documented that speech-language pathologists regularly suffer burnout (McAllister & Lincoln, 2004), and there may be cases where clinical education can exacerbate workplace pressures. Better short-term outcomes for the clinical educator may be achieved through the balance represented in Figure 3. This represents the dynamic that would be present in typical clinical practice, whereby the balance is tipped towards the client, which may feel more comfortable for the clinical educator. Better long-term outcomes however are likely to be achieved from a delicate balance that favours neither side more than the other, but regularly shifts at different points on the placement. It is essential that clinical educators regularly reflect on their own personal styles and investments, and analyse how they respond and support particular students.

Other contextual factors (legal and social)

The outer layer of the Seedhouse ethical grid (Seedhouse, 1998) takes the broadest look at ethical issues, considering the resources, constraints, evidence and implications for decisions. These external considerations are often overlooked, yet the necessity for proactive ethical behaviour is the key to ensuring these elements are addressed. Analysis of the risks, duties and wishes of others can not only be used to reason through existing ethical issues, but are essential in preventing potential dilemmas from occurring. All speech-language pathologists and, in particular, all clinical educators and students need to have a solid understanding of their Code of Ethics (Speech Pathology Australia, 2012) and feel confident that they have frameworks and processes to use when ethical issues arise. In addition, clients should always be well informed as to their rights and the expectations they should have for the service they are receiving. This clarity on all accounts ensures that the wishes of others are always considered, and allows clinical education to be a collaborative and proactive process. These three parties together can achieve the right balance by openly discussing an ethical practice framework in a proactive manner at every level of a service (see Table 1).

Conclusion

Clinical education is a key element in producing entry-level graduates with the competencies required for entry into the speech pathology profession. It is widely accepted that clinical education is not the sole responsibility of the tertiary sector, rather, that all speech-language pathologists should contribute to the clinical education of speech pathology students (Speech Pathology Australia, 2012). The clinical educator is thus responsible for achieving a unique balance between the student, themselves and the client and this brings about the potential for a significant range of ethical tensions. The key to striking the balance between these parties has three parts; assuring understanding of and access to ethical decision-making frameworks and approaches, ensuring measures are in place to help prevent these issues from developing in the first instance, and finally ensuring transparent communication of expectations and processes.

To promote pro-ethical practice you need to talk about ethical practice. Within a clinical education context this is even more paramount because of the multiple lines of responsibility (as explored in Figure 2). Ethical planning and decision-making should not be seen as a reactive process to be brought in only if and when required, but an integral part of all processes from the ground up. In line with the casuistry approach (Speech Pathology Australia Ethics Board, 2011), it should also continuously involve reflection on lived experiences.

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Useful links

The Ethics page on the SPA website
http://www.speechpathologyaustralia.org.au/about-spa/code-of-ethics

The Code of Ethics
http://www.speechpathologyaustralia.org.au/
library/Ethics/CodeofEthics.pdf

The Ethics Board Procedures
This document provides an overview of the Ethics Board procedures and provides a flowchart depicting the steps in the investigation process.
http://www.speechpathologyaustralia.org.au/
library/Ethics/Ethics_Board_Procedures_
Sept_2012.pdf

The Scope of Practice

This document describes the breadth of professional practice carried out within the speech pathology profession in Australia. It provides an overview of the 'who, what, where, why, and how' of speech pathology practice. It not only describes the knowledge and skill-set required by speech pathologists, but also the attitudes and ethical behaviours expected from members of the profession.
http://www.speechpathologyaustralia.org.au/library/Core_Assoc_Doc/Scope_of_Practice.pdf
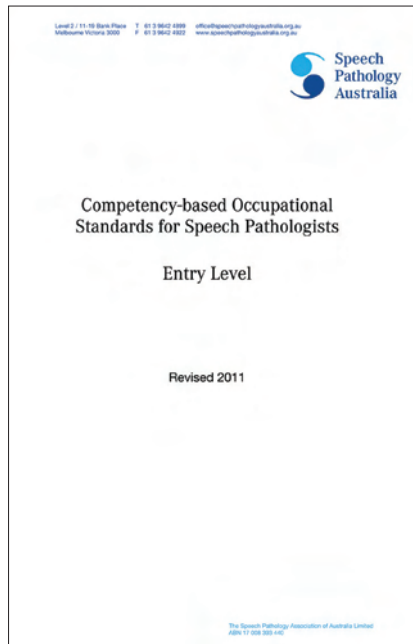
Competency-based Occupational Standards

This document sets out the Competency-based Occupational Standards (CBOS) and outlines the minimum skills, knowledge base and professional standards required for entry-level practice in speech pathology in Australia.
http://www.speechpathologyaustralia.org.au/library/Core_Assoc_Doc/CBOS_for_Speech_Pathologists_2011.pdf
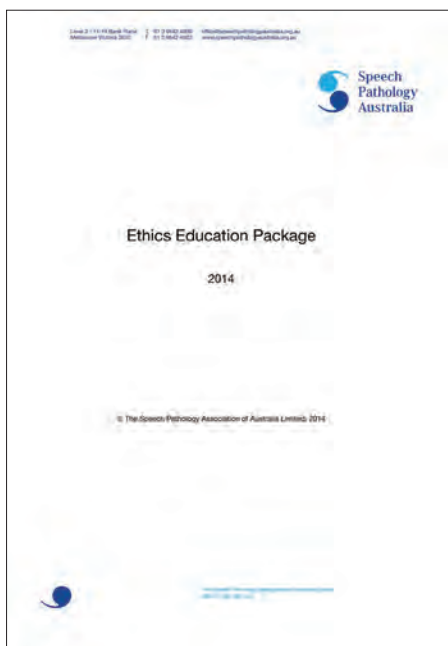
The Ethics Education Package

To access this package – log in to SPA via http://www.speechpathologyaustralia.org.au

The Code of Ethics poster