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

L'éthique en orthophonie : au-delà du code de déontologie

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Abstract

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

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Les codes de déontologie, comme celui de l'ACOA, veillent à ce que les droits des clients soient protégés, dans un cadre qui dépasse ce qui est simplement prescrit par la loi. Toutefois, il arrive très souvent que des dilemmes moraux surviennent dans l'exercice quotidien des fonctions professionnelles, des dilemmes qui ne sont peut-être pas tous directement couverts par le code de déontologie. Par exemple, y a-t-il un prix moral à payer pour acquérir une meilleure voix ou un meilleur dialecte ou pour « réduire » son accent? Quatre principes de pratique clinique éthique peuvent guider la prise de décisions en orthophonie : (1) autonomie; (2) bienfaits; (3) non-malfaisance; (4) justice. Pour prendre une décision d'ordre moral, il faut tenir compte d'un certain nombre de facteurs, dont le plus important pour le client – le respect de son identité. En conséquence, les orthophonistes doivent non seulement suivre leur code de déontologie, mais aussi regarder au-delà des règlements pour déterminer les éléments à caractère éthique de leur pratique quotidienne. Ainsi, cet article vise les objectifs suivants : (1) passer en revue la terminologie éthique pertinente et les fondements des codes de déontologie; (2) donner l'exemple d'un cas où l'éthique clinique a été mise en application; (3) examiner les incidences pour la recherche et la pratique clinique. Cet article conclut en faisant valoir la nécessité de tenir un forum permanent sur l'éthique clinique.

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

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Maria is a 69 year old Italian-Canadian woman who has been married for forty-seven years, has three married children and seven grandchildren, and lives in a rural community in Canada. Maria has lived in her town for fifty years and although she speaks Italian (her primary language) with her husband and some older members of her community, she has learned English and uses it in a limited fashion with her grandchildren. She has a history of hypertension and needs bilateral hearing aids due to a progressive hearing loss. Suddenly, Maria's life changes when she suffers a cerebrovascular accident (CVA) (i.e., stroke). The stroke leaves Maria temporarily dependent on nasogastric tube feeding for nutrition and with moderate expressive

aphasia, although her comprehension is quite good. The primary care physician recommends an evaluation of speech, language, and swallowing by the speech-language pathologist (S-LP). The S-LP evaluates Maria's oral-motor and swallowing abilities at bedside and then recommends a modified barium swallow (MBS) study because of her risk for aspiration. The S-LP does not evaluate her language or speech abilities at this time because of constraints on her job and because she does not have time to consult with Maria's family about her language preferences or capabilities prior to her stroke. In addition, the S-LP does not observe Maria's hearing aids on her bedside table. She merely tells Maria that her swallowing is impaired after her stroke and that she is not to eat anything orally for the time being. After conferring with the physician, the S-LP proceeds to book the MBS and notes it in the chart, although she does not have time to explain her results with Maria.

Maria is upset and confused by the tube in her nose and her inability to eat. Moreover, Maria is frustrated that communication is difficult with her husband, children, and especially with her grandchildren when they come to visit. No one remembers to help her with her hearing aids during these visits. She feels alone and helpless, and desperately wants to share her experiences. She feels her priority is to regain her communication with her family, although the health care team seems to be focused on improving her eating and swallowing and has not yet mentioned any kind of speech or language therapy. Her family also is distressed about Maria's overall condition and brings her food from home as well as wine to alleviate Maria's discomfort. One evening Maria pulls her feeding tube out. After the nursing staff discovers what Maria has done and that her family has been secretly feeding her, Maria is sent for a chest X-ray. The radiologist notes some fluid build up in her right lung. After learning these results, the S-LP concludes that due to Maria's noncompliance with the swallowing recommendations she will withdraw from Maria's care.

Maria's case study is representative of an experience in health care today, albeit not a positive example of exemplary clinical service. Maria, the S-LP, and all those internal and external to her health care are all moral characters. That is, these individuals are part of a greater community that affects the ethics of a situation. Moral characters or agents are defined by choices, large and small. The outcomes of these choices can either enhance or harm other individuals' lives. Like Maria, any client in whose life clinicians have shared an experience could provide the narrative context for the following discussion about ethics in speech-language pathology.

S-LPs who intervene on behalf of those with communication disorders serve a moral purpose and form a greater moral community (Catt, 2000). As moral characters, S-LPs are subject to the mores of the greater community (cultural, national, linguistic, religious, professional, etc.), and therefore serve a moral purpose in that community. The source of those moral obligations as professionals is found in the client-clinician relationship (Sloan, 1992). In fact, the foundation of many codes and canons of ethics (provincial and federal associations, colleges, etc.) in speech-language pathology requires us to hold the interests of our clients paramount. Inherent in this principle is that communication is a foundation of human dignity, freedom and agency (Catt, 2000). These considerations are of utmost importance when making decisions in clinical practice and in fact constitute the ethics of our practice. In the brief case study of Maria, we encountered the longing for human connection, the basic need for self-determination, a poor respect for autonomy, lack of informed consent, and questionable clinical judgment. When examined closely, the S-LP involved in Maria's case could be considered to be in violation of her professional code of ethics and could be held accountable under the review of an ethics committee (e.g., complaints committee, discipline committee). Ethics in speech-language pathology, however, constitutes more than just the rules and regulations of the profession. To understand these claims, we must not only become more familiar with our professional codes of ethics, but we must look beyond these codes and be aware that all clinical decisions can have ethical implications. The perspective of the client and what constitutes his or her moral community (i.e., national, cultural, linguistic, religious, professional, etc.) must always be considered of primary importance when making clinical decisions. Ethical codes and principles provide a safeguard that clients' rights will be protected. Although laws outline the minimum conditions that any ethical code must meet, ethical codes go beyond the law in specifying ethical principles and ideals that professional conduct must meet over and above what is prescribed in law.

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

Professional Ethics: Examining the Canon of Ethics

Ethics is a branch of philosophy that studies the concepts of good and bad, right and wrong. Ethical standards and rules, whether they are social, professional, or personal, are guidelines for realizing what we ought to do and what we ought to refrain from doing relative to conduct and character (Kluge, 1999). Ethical standards in speech-language pathology rely in part on the fact that it is a learned, scientific profession. Bernat (Reed & Evens, in Bernat, 1994) states that a learned profession includes a focus towards service, possesses a circumscribed and socially valuable body of knowledge, determines its own standards of knowledge, is largely free of outside control, and has a code of ethics that governs clinical practice. The purpose of a canon of ethics is to help guide the clinical practice of a profession. It is on the one hand an educational tool, outlining what requires ethical scrutiny and attention, and a regulatory tool, outlining shared principles and procedures for dealing with ethical problems.

The Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) last revised their canon of ethics in 1992 (CASLPA, 1992)[2]. Although other codes of ethics co-exist (e.g., provincial associations and colleges), they are all based upon a shared moral and legal foundation and, therefore, the CASLPA canon serves as an example. It also is most appropriate to review the CASLPA canon of ethics since the official professional organization journal (*JSLPA*) is received by CASLPA members. CASLPA's canon of ethics was created to reflect the beliefs and philosophies of its members regarding standards of integrity. It thereby encourages unity among professionals and collective accountability, and ideally fosters an exemplary level of service. The CASLPA canon is divided into three sections, first related to duties and responsibilities to the client and public, second addressing duties and responsibilities to the profession, and third, a general section at the end of the document that addresses general professional conduct (CASLPA, 1992).

The CASLPA canon's first rule requires that clinicians meet national membership requirements and/or provincial registration (CASLPA, 1992, p.257). The canon further articulates that clinicians be competent, be fair with regards to whom to treat, maintain adequate records, educate the public, exercise independent professional judgment, confer with other professionals, and avoid conflicts of interest, etc. Much of CASLPA's canon of ethics and its rules emphasize the importance of technical competency. For example, rule number 2 states that "members must not attempt to provide assessment/ diagnostic or treatment services for which they have not been adequately prepared, nor may they misrepresent their training or competence" (CASLPA, 1992, p.257). Other rules outline social (and legal) concepts of right and wrong to dissuade clinicians from doing bad/wrong acts, acts that might harm either clients or the profession's integrity, or both. However, it is rule number 6 that is held paramount – that which emphasizes the moral and not merely the technical aspects of our foundation. It states, "that members will respect the intrinsic worth of clients and act to ensure through reasonable advocacy and other intervention activities that their dignity, individuality, and rights are safe guarded" (CASLPA, 1992, p. 257).

Catt (2000) states that being a member of a profession means being both loyal and a steward. Professionals are loyal to their clients and hold their interests paramount over their own interests (Pellegrino & Thomasma, 1988). Professionals are also stewards of the knowledge base of the profession (speech-language pathology), and not merely proprietors (Catt, 2000; Pellegrino & Thomasma, 1993). That is, the knowledge base is acquired not for its own sake but for the good of individuals with communication disorders. These virtues of interest form the foundation of the specific terms of the canon. Other virtues of professional interest include benevolence, caring, fairness, fortitude, patience, prudence, temperance, compassion, truth-telling, and trust (Beauchamp & Childress, 1994; Pellegrino & Thomasma, 1993).

When a member violates a rule in CASLPA's canon, he or she may be the subject of a complaint to the CASLPA Ethics Committee. If this rule is also a federal or provincial law, that member may also be subject to legal ramifications within that jurisdiction. The extended overlap between the CASLPA canon of ethics and laws regulating licensed professionals means that professionals under investigation may be subject to a review by both the regulating body of the province and one or more professional associations. However, it is important to remember that the primary objective of a professional association's canon of ethics is to reflect the beliefs and philosophies of a group of professionals, not to act only as a disciplinary tool. A canon of ethics "does not and cannot offer definite solutions to all controversies that arise. Rather, it offers guidelines which when followed, will promote professional responsibility" (CASLPA Ethics Committee, 1992, p. 261). A canon or code of ethics therefore is necessary but sometimes insufficient to help individuals decide everyday ethical decisions. In fact, a canon of ethics may run the risk of being interpreted a minimum rather than the optimum standard of behaviour unless (1) abstract rules and ideals are integrated into daily practice; (2) rules and ideals place the client first; and (3) ethical terminology becomes part of our everyday discourse (Catt, 2000). Thus, it is critical that clinicians become familiar with their codes and canons of ethics, as well as learn how to apply these principles.

Codes and canons of ethics often are profession-centred, whereas clinical ethics is client-centred. These aspects of ethics and practice are both necessary and act to complement one another. If clinicians are to make decisions based on real-life dilemmas and circumstances, they must examine clinical ethics (Lo, 1995). The principles

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

Principles of Clinical Ethics

Clinical ethics is guided by ethical principles developed by Beauchamp and Childress (1994; cf. Englehardt, 1996)[3]. The principles include different categories of judgments to be considered when making ethical decisions. These principles are autonomy, beneficence, nonmaleficence, and justice. These principles or guidelines do not have specific content until applied to particular moral agents in particular situations, and may even conflict with one another (Englehardt, 1996; Kluge, 1999). Bearing this in mind, each term will be defined and Maria's case will be used as the primary example to illustrate these principles. Considerations from other areas of speech-language pathology will supplement those principles found in Maria's case.

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

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

The most important element of the principle of autonomy is informed consent. If a client's decision-making capacity about treatment interventions or other health-related matters is uncertain, an individualized assessment is in order. Capacity typically is judged by a health care practitioner or a team through observation and testing over time, and includes multiple levels (e.g., partial capacity may be defined in individuals who become confused at the end of the day or under the influence of medication and can make health care decisions when they are lucid) (Merck Manual of Geriatrics)[4]. Assuming an individual has the capacity to make his or her own health care decisions, these decisions must be upheld. For example, after a stroke or a head injury, an individual may be deemed unable by the health care team to care for himself at home. However, if that person is capable of making treatment decisions based on information related to the risks and benefits of returning home, then the health care team should defer to his decision. This is based on the principle that all individuals be treated as moral agents in deciding about their own lives (Merck Manual of Geriatrics). Other ethical issues may arise when caregivers are asked to make decisions on behalf of their family members, children, or spouses. Ethical dilemmas may arise when it appears that the wishes of the client himself or herself are at odds with his or her caregiver or when the perspective of the client is not valued. These issues can be especially prominent when judgments that promote "good" for the client contrast with his or her autonomy. In this light, the principle of beneficence is now examined.

Beneficence. Beauchamp and Childress (1994) describe beneficence as actions that are done for the benefit of others, as well as those that produce good. What is "good" is defined by the client from his or her perspective, be it material, emotional, or spiritual in nature (Pellegrino & Thomasma, 1993). In the case of

Maria, she was most concerned with improving her communication skills and, thereby, easing the ability to communicate with her family. The ability to communicate and express thoughts was important to Maria's emotional well-being. This consideration was not addressed by the S-LP. In addition, some good could have come from the swallowing evaluation in order to determine what contributed to Maria's pneumonia, and if there was a way to minimize the risk for a repeated occurrence. However, the clinician did not perform this assessment. In fact, this omission may have brought harm to Maria (see nonmaleficence).

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

For example, S-LPs often must demonstrate and justify treatment for individuals with traumatic brain injuries (TBI) to insurance companies who are funding treatment. That is, clinicians must adhere to the highest standards of evidence-based clinical practice (EBCP). Although EBCP is difficult, S-LPs need to demonstrate that intervention is both necessary and ethically responsible. In Canada, it behooves clinicians to follow EBCP in all aspects of their practice. Despite funding shortages in our health care system, we often forget the liberty that we have in serving our clients (i.e., number of sessions, intensity of sessions, etc.) when compared with other health care systems in the world. These choices include the approach to treatment, including that which is best not only for the client's "profile", but also for that individual. The clinician is also ethically bound to advocate on behalf of his or her client, not only to third party payers, but also to others who care for that individual, including family members and other members of a health care team (CASLPA, 1992). For example, a S-LP may need to lobby others on the health care team to encourage a particular test or assessment (e.g., a physiatrist who does not see the benefit of a modified barium swallow examination) (see the case of "Mike", Muirhead et al., 1995, p.188), or continued treatment (e.g., to promote a continuum of care at end of life) (Myers, 2003) in order to best serve his or her client, and avoid harmful consequences.

Nonmaleficence. The counterpart to beneficence is nonmaleficence, which means actions that bring no harm. The principle of nonmaleficence may include issues that seek to take power away from clients, or actions that may be selfish or deceptive or even if well-intentioned, can increase the risk of a negative consequence. For example, in Maria's case, the S-LP's recommendations of a formal swallowing evaluation were well-intentioned. Based on what the S-LP knew from formal and practical training, Maria posed a risk for aspiration due to a possibly weakened and disordered swallowing mechanism post-stroke. However, in not informing Maria of the potential benefits and risks of such an evaluation or diet modifications, the S-LP's actions became paternalistic and unidirectional. The S-LP assumed that she knew what was in Maria's best interest and undermined the good that the client might have achieved by making her own decision on her own terms and in her best interests. In addition, the S-LP abandoned Maria after realizing that Maria had chosen not to "comply" with her recommendations.[5] However, the S-LP was ethically bound to find a compromise, and at the very least offer continued follow-up and guidance, as well as offer aphasia treatment. In abandoning Maria, the S-LP was doing "harm" and not allowing Maria to realize her full functional potential relative to her swallowing and communication difficulties.

Additional issues in speech-language pathology involving harm can arise with inadequate supervision of students and communicative disorders assistants, inadequate training and/or experience for performing particular procedures, violating client confidentiality, performing treatment that is unnecessary or without benefit, or allowing a colleague to engage in unethical conduct that brings harm to the client. These issues are all addressed in professional codes of ethics and regulated health protection acts in order to ensure an individual's rights, health, and well-being. These concerns also are most often cited as sources of professional and clinical ethical problems surrounding the care of individuals with communication disorders (Buie, 1997).

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

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

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

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

Identity and the Client's Perspective

In his book entitled "Better than well: American medicine meets the American dream", American bioethicist Carl Elliott (2003) proposes that enhancement technologies are driven by the North American need to conform to the society in which one lives. There is an inherent tension between the "self" and how one "presents oneself". Elliott questions whether there is a moral cost to the quest to become better and/or different. For example, in a chapter that addresses voice related issues, Elliott examines several examples of what he would characterize as enhancement technologies in the treatment of one's voice and speech. He purports that the theme of identity is central to these ethical dilemmas. In fact, if one examined the principles of clinical ethics including autonomy, beneficence, nonmaleficence, and justice, one could argue that these judgments also are based on an individual's identity. For example, what is considered important to each person will be expressed in his or her choices for the self (autonomy), what is ultimately good or bad for oneself (beneficence/nonmaleficence), or what is considered "just". Elliott uses three examples to illustrate how the drive for achieving the "perfect voice", and thus clinical decisions, are related to a client's perspective and identity.

Augmentative and/or alternative communication. The first example that Elliott (2003) uses is that of individuals who use augmentative and/or alternative communicative (AAC) devices. He first describes how the English physicist Stephen Hawking, suffering from a variant of amyotrophic lateral sclerosis (ALS), uses a computer program to help him communicate. Hawking selects words from a series of menus on a computer screen by pressing a switch or by moving his head or eyes and then a voice synthesizer transforms the chosen words into speech. The computer program used by Hawking was developed in the United States and, thus, the voice synthesizer has "an American accent". However, Hawking noted years later that he would not want to change that voice even if he were offered a British-sounding voice, because he had begun to feel that the American voice was his own. Hawking started to identify with that voice, and he wrote that by changing it, he "would feel [he] had become a different person" (Hawking, 1993, p. 26, in Elliott, 2003).

Hawking's remarks about his voice synthesizer are a reflection of two tensions in modern identity according to Elliott (2003). First, there is a tension between the natural and the artificial, or what is given and what is created. The fact that Hawking identifies with a computer-generated (created) voice, instead of what is natural (or given), is akin to a person saying that when he is taking an antidepressant such as Prozac, he feels more like himself. The second tension is between the self as it feels from the inside, and the self as it is presented to others. Most individuals, according to Elliott, feel that the true self is the one that sits alone in a room rather than the persona presented to a group of people. But Hawking, in identifying with the American-accented computer voice, closes the gap between the self and self-presentation. One must, therefore, consider which "self" is the one with whom we seek to make clinical decisions. Which perspective is right? For example, because Stephen Hawking believes the computer voice is his, he may not choose to upgrade that voice, even if offered a system with faster and better technology. That is, a seemingly typical therapeutic scenario in which one strives to upgrade an AAC device also might have an ethical dimension. The outcome of that decision is ultimately affected by how that person identifies with the device itself, as well as its output.

Gender dysphoria. A second example offered by Elliott (2003) is that of male-to-female (MTF) transgenders. For postoperative MTF transgenders, success or failure of this effort rests on the ability to pass as a woman. Many North Americans can feel threatened, offended, or repulsed by the transgender identity. Failing to "pass" as a transgendered person can be both physically and socially dangerous. S-LPs may offer voice therapy to transgendered individuals to promote a natural-sounding voice for the chosen gender by targeting changes in pitch,

quality, intensity, variability, and intonation patterns in spontaneous speech (Gelfer, 1999). This type of therapy is intensive because most transgendered individuals feel this involves a degree of self-conscious impersonation. However, as false or alien as a female voice for a MTF transgendered individual can feel at first, many MTF transgenders begin to identify with their new female voices (Transsexual Voice and Speech Therapy electronic discussion group, in Elliott, 2003, p. 24). Like Stephen Hawking and his voice synthesizer, they begin to feel as if this new voice is truly their own (Elliott, 2003). Their self-presentation then matches who they feel they are — that is their true identity. Again, this example illustrates how identity may influence clinical decisions. How a transgendered individual identifies with his or her voice may influence decisions such as what is regarded as good or harmful to that person.

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

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

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

Implications for Practice: Making Ethical Decisions

Ethical implications from a variety of situations were outlined in the previous sections of this paper. However, becoming aware of these ethical dimensions is only the first step to helping S-LPs make ethical decisions. Before outlining the problem-solving process, it is necessary to examine three types of ethical dilemmas (Catt, 2000). The first occurs when moral obligation and self-interest conflict. The health professional has obligations to the client but his or her own interests consciously or unconsciously influence the choice of treatment (Catt, 2000). For example, if the S-LP in Maria's case believed that a younger client on the ward should receive more aphasia therapy than Maria because of that person's age, the S-LP would be putting her own biases ahead of her obligations to Maria. In this instance, an ethical dilemma could arise. The second type of dilemma occurs when a situation of moral uncertainty exists in that some evidence indicates that the act is morally right, and some evidence indicates that the act is morally wrong. Evidence on both

sides may be inconclusive. For instance, this might occur in an instance where an approach to treatment is inconclusive, or not studied enough to make firm conclusions about its benefit (or risks) over other established approaches. Finally, ethical dilemmas occur most often when two moral principles conflict. For example, even if Maria had been given all of the information about her case, she may have disagreed with the health professionals' recommendations about her diet and swallowing modifications. In this case, it might have benefited her to follow these recommendations (beneficence/nonmaleficence), yet to respect her choice is to respect her autonomy. Despite these ethical dilemmas, most ethical decisions can be guided by the key principles of clinical ethics outlined by Beauchamp and Childress (1993): autonomy, beneficence, nonmaleficence, and justice, as well as other pertinent factors. In order to illustrate the problem-solving sequence of ethical decision-making, the case example of Maria will be re-examined.

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

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

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

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

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

Ethical obligations also are demonstrated in the search for efficacious treatment outcomes in research, establishing clinical guidelines, and determining decision-

making policies (Muirhead et al., 1995). At the heart of these investigations is the use of a clinical framework for assessment and treatment that is most meaningful to the clients whom we serve (Coyte, 1992). Further, it is a speech-language pathologist's ethical responsibility to continue to protect the rights of individuals with communication disorders in both the social and political arenas. This is especially important in times of scarce health care resources; S-LPs and other health care professionals must continue to prove their value and worth to those who make administrative decisions. This continued lobbying is necessary in order to protect the good that comes from the provision of speech-language pathology services to those most vulnerable to manipulation – those individuals with communication disorders.

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

Conclusions

The purpose of this paper was to: (1) summarize and review ethical terminology, as well as responsibilities of codes of ethics; (2) consider how clinical ethics may be applied, and how these decisions reflect a client's identity; and (3) examine ethical implications for both research and clinical practice. The underlying theme of this article revealed that the ethical and moral purpose of health professionals in general, and S-LPs in particular, is to serve the interests and values of their client as defined by the client (Catt, 2000). A professional ethical code is grounded in moral theory, and is highlighted in the trust and compassion that form the foundation of client-clinician relationships. Similarly, this foundation is found in the principles of clinical ethics: autonomy, beneficence, nonmaleficence, and justice. These types of ethical judgments were illustrated by examining an instructive case example. More subtle ethical issues were examined through the theme of identity. Elliott's (2003) case examples also were examined to illustrate how one's perspective can change the ethical outcome of a clinical decision. Finally, an ethical decision-making process was outlined and ethical implications for both research and clinical practice were discussed.

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

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Footnotes

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

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

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

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

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

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

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