



# Ethics Education Package



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## Introduction

This education package consists five sections which we hope will help you to understand, explore and utilise our Association's new *Code of Ethics*.

Section 1 provides an overview of the development and structure of the new code.

Section 2 illustrates sources of our values and provides a decision making process protocol for use in ethically reasoning your way through ethically challenging or complex situations.

Section 3 provides five case studies to which have been applied the decision making protocol outlined in section two. These case studies illustrate the complexities and procedures you employ in ethical reasoning; they do not provide absolute right/wrong answers to ethical dilemmas. Cases 1 to 4 describe situations requiring ethical reasoning in a range of clinical settings. Case five in this section illustrates the type of case where identifying a breach of the Code of Ethics is challenging and fraught with complexities and uncertainties, and the decision and timing of reporting is difficult to make.

Section 4 outlines the procedure for reporting suspected breaches of the *Code of Ethics* and the processes that will be followed by the Association in investigating such breaches.

Section 5 is written for university staff and clinical educators who help students develop ethical behaviour and ethical reasoning. It provides suggestions for university staff regarding ethics education for students, highlights common types of ethical problems experienced by students, and contains a case study of an increasingly common problem experienced by students: that of role conflict between the student role and other life and work roles.



# Section 1

## The Development of a *Code of Ethics*

Our *Code of Ethics* has been significantly rewritten for a number of reasons. First, the scope of practice for speech pathologists has expanded considerably since the last *Code of Ethics* was written (1986). We work with more diverse client groups in more diverse work settings, and our *Code of Ethics* needs to acknowledge that diversity. Secondly, like all health professionals, speech pathologists increasingly work in climates of uncertainty where complexity of client problems and needs, a proliferation of legislation, and accelerated rates of change make prescriptive statements about ethical practices of limited use. In such workplace climates, mandatory ethics which set down what shall and shall not be done in all circumstances quickly become outdated and are of limited utility in helping speech pathologists recognise and understand the complexity of ethical issues which impact on our practice.

In order to assist speech pathologists in ethical decision making, we felt that the provision of an aspirational code of ethics was more in tune with contemporary approaches to ethics and with the needs of health professionals (see Coady and Bloch, 1996). Aspirational ethics outline the principles and values we aspire to use in our ethical decision making, in contrast to mandatory codes which attempt to tell us what we should and should not do in a specified range of contexts.

Feedback from speech pathologists, speech pathology students and the public about the previous Code suggested it was difficult to understand and interpret. The complexity of the language used meant that many people were not sure what was meant. In addition, people found the negative tone of the old Code off-putting. Therefore in the preparation of this Code we engaged a Plain English Language Consultant (Mr Bill Tearle) to help us write the code in easily understood language and in a positive tone. Stakeholders consulted in the development process have told us the Code is now easy to understand and use.

The *Code of Ethics* uses five principles of ethics and five professional values underpin the Code. These five principles, are:

- beneficence (we bring about good) and non-maleficence (we prevent harm);
- truth (we tell the truth);
- fairness (we seek to ensure justice and equity for clients, colleagues and others);
- autonomy (we respect the rights of clients to self-determination and autonomy);
- professional integrity (we demonstrate professional integrity as people would expect).

The values which are embedded in our work as speech pathologists are:

- dignity;
- respect for client rights;
- non-discrimination;
- professional interests take precedence over personal interests;
- objectivity.

The framework for the *Code of Ethics* is structured around our duties to four stakeholder groups:

- clients and community;
- employers;
- profession;
- colleagues.

The *Code of Ethics* was developed by a task group using input from the profession, Council, other stakeholder groups, and the Plain English Language Consultant in an iterative process of drafting, consultation and feedback, and redrafting.



## Section 2

# Decision Making Process

In the previous section, you read that the *Code of Ethics* is aspirational, that is, it sets out the principles and values we aspire to use in our ethical decision making and our practice. The aim of this section is to help clarify and provide experience with this process. Some people will be extremely familiar with the concepts and processes discussed in this section. Others may find it clarifies and builds on their less extensive knowledge. Ethical dilemmas are frequently controversial and can cause distress and conflict. An understanding of ethical principles and an understanding of our own values and morals can help us when faced with situations which require ethical analysis, discussion and decision making.

## Sources of ethics and values

### 1. Ourselves

Different people can view the same situation but generate different decisions.

*For example, consider the following statements about the rights to treatment when two clients are equally impaired:*

*1st view: The client who is likely to improve at a lower cost (eg, requiring less input, using fewer resources etc.) should have priority over the client who can be helped, but at a higher cost, because this ultimately will allow more people to be helped when money is limited.*

*2nd view: It is unfair to discriminate against the client who happens to have a high cost disorder. Priority should not depend on the cost of treatment even if this means fewer clients have access to health services.*

*Which statement would be closer to your point of view?*

*Do you think everyone would make the same choice?*

*What do you think may have influenced your choice?*

When we are asked to make this type of decision, we typically call on our own values, morals and ethical beliefs. It is therefore important that we understand these sources of our own morality so that we are aware of their influences on our decision making.

One of the books that you may find useful in exploring this issue for yourself is *Ethical dimensions in the health professions* (Purtilo & Cassel, 1993).

The next step is to provide you with further information about and experience with the ethical principles and values set out in the Code. We will then explore how you might employ these principles and values in decision making in your professional practice.

### 2. Theories and principles of ethics

We can always add to our ethical knowledge and value system to improve our awareness of ethical decision making. Part of the aim of the *Code of Ethics* is to outline the principles and values we (as individuals and as members of the speech pathology profession) aspire to use in our ethical decision making. As previously mentioned, this is in contrast to purely mandatory codes which attempt to tell us what we should and should not do in a defined range of contexts.

The principles of ethics provide us with a guide for our decision making. When we are deciding about a situation, the principles which are involved need to be identified individually, then the relationship between them needs to be explored to facilitate reaching a satisfactory decision.



The principles set out in our *Code of Ethics* are described below. Examples are provided relating to some speech pathology situations. Examples of how these principles are often in conflict will also be given.

*As you read through these principles, try to identify examples which would relate specifically to your work situation.*

### Principle: Beneficence (we bring about good)

We should be sure that any treatment approach we select can reasonably be expected to benefit the client. This judgement would be based on evaluation of the client's needs and abilities as well as the evidence supporting the use of an approach. For example, we recognise social issues in a client's family likely to impact on client progress and family welfare, and seek to engage family members in discussion which might lead to recognition of the need for counselling and make an appropriate referral.

### Principle: Non-maleficence (we prevent harm)

We should aim to avoid using any approach to client assessment or management which we know has the potential to harm the client (or others). This harm could be physical or psychosocial.

Failure to refer clients or families for necessary psychosocial support or treatment, or failure to undertake mandatory notification, could be construed as maleficence.

Often the principles of beneficence and non-maleficence go hand in hand. For example, in dysphagia management:

- the client is thought to be suffering harm from aspiration, so non-oral feeding would be recommended (non-maleficence) and
- improved nutritional status from non-oral feeding would be beneficial (beneficence) but
- social isolation related to loss of meal-time contact should be avoided (non-maleficence) and
- pleasure derived from some ongoing oral intake should be considered (beneficence)

As we will discuss later, other factors such as status and preference and the setting may help to clarify which of these client considerations is most important.

### Principle: Truth (we tell the truth)

We would not make false claims about the likely success of a treatment technique we are recommending for a client.

We would not make promises about providing a service if we knew this service would not be forthcoming, for example, due to waiting list, service priorities, and so on.

You could have a dilemma regarding truth if you disagree with a diagnosis made by a doctor and don't know whether to discuss this with the client, but the client asks you specifically "Do you think the doctor is right?".

### Principle: Fairness (justice) (we seek to ensure justice and equity for clients, colleagues and so on)

We make decisions about caseload management taking into account notions of equity and justice.

In timetabling, we ensure that all client groups are seen equally frequently if that is the level of treatment they require. This means we would not normally spend more time with the really interesting clients or ones who pressure us or who can afford to pay!



## Principle: Autonomy (we respect the rights of clients to self-determination and autonomy)

Autonomy is often used with the terms “self-governance”, “individual choice”, and “freedom of will”. Autonomy is generally accepted to include two essential conditions: liberty and agency. Liberty refers to independence from controlling influences, such as health professionals, family members. Agency is defined as the capacity for intentional action.

If a client clearly indicates he/she does not wish to follow our recommended course of action, the client’s wishes should normally be respected. The client’s autonomous choice may also be to seek and follow the advice of the professional.

## Principle: Professional integrity (we aim to conduct ourselves as ethical professionals in line with reasonable community and client expectations of us; this is sometimes referred to as fidelity)

We aim to provide best-practice for our clients, recognising the constraints of workplace policies and resources.

We would ensure that we have the competencies to meet the reasonable expectations of community, colleagues and clients.

### *All the principles in one example*

*Try to decide which principles apply in the following example (see answers below)*

*When deciding to conduct a videofluoroscopy, we expect there to be benefit to the client if we can identify strategies to enable improvement in swallowing (1). However, we may risk causing some harm to the client if there is a risk he/she will aspirate significantly during the process (thus not conforming with the principle of (2)). In this case, a clinician will balance the extent of the likely benefit with the severity of the possible risk to establish whether the likely benefit outweighs the likely risk.*

*Our response to the case discussed above would be to:*

- *discuss the known advantages and risks of the procedure with the client to ensure he/she is fully informed (3);*
- *having confirmed that the client understands the procedure, the advantages and risks, ask whether he/she will consent to such a procedure being used. The client needs to be enabled to make a personal choice rather than expected to simply consent to someone else’s choice (4);*
- *not punish a decision to refuse to undertake the videofluoroscopy, by reducing the client’s access to our services (5), though we may feel that the risks subsequently arising for the client require a review of the client’s management (6);*
- *fulfil the client’s right to expect that the clinician is clinically competent in working with people with dysphagia (7). This would include an expectation that the clinician will follow appropriate food handling and infection control procedures as well as clinical speech pathology procedures.*

1. Beneficence  
5. Fairness

2. Non-maleficence  
6. Non-maleficence

3. Truth  
7. Professional integrity

4. Autonomy



### 3. Values

In addition to the principles, the aspirational section of the Code sets out several values which are embodied in our work as speech pathologists:

- dignity (we respect the unique dignity of each individual);
- respect for client rights (we respect the intrinsic rights of our clients, and seek to protect their individuality and rights through our advocacy, professional skills and interventions);
- non-discrimination (in our professional lives, we do not unfairly discriminate on the basis of race, religion,
- gender, sexual preference, marital status, age, disability, beliefs or contribution to society, socio-economic status);
- professional interests take precedence over personal interests (our primary obligation to provide professional services takes precedence over our personal interests, aims and opinions);
- objectivity (we act in an objective and disciplined way to help individuals, groups and communities, particularly with regard to communicating and swallowing).

*Again, try to identify specific examples in your workplace to demonstrate the application of these values.*

*Notes and Reflections*



# Ethical decision making

Our daily clinical practice is full of ethical decision making opportunities. At times, these decisions are clear and easy. At other times our stated ethical principles may be in conflict with each other, or with other external factors. Presented below is a suggested procedure which can help when it is difficult to be sure of an ethical course of action. In Section 3 of this package, you will find several case studies in which this decision making protocol is applied.

*You may wish to apply this procedure to a recent event in your workplace in which you felt some discomfort about the ethics involved in the decision making.*

Note: Speech Pathology Australia publishes documents which may be of relevance, such as *CBOS* (2001), *Principles of Practice* (2001) and position papers which may be appropriate to refer to in particular situations.

## Decision Making Protocol

*Prepared by Louise Brown and Sue Lamont*

### 1. The facts

- What are the facts and how did you learn about them?
- Who is involved?
- What are the client-related factors?
- What are the external considerations?
- Do you need any other facts or information?

### 2. Is there a problem which requires action?

List possible actions which you are considering at this early stage of your ethical reasoning. What are the practical actions and alternatives and likely outcomes?

### 3. The problem

- Which ethical principles apply:
  - beneficence (bring about good) and non-maleficence (prevent harm);
  - truth;
  - fairness (justice);
  - autonomy;
  - professional integrity (fidelity).
- Which duties, obligations or rules are not being met:
  - standards of practice set out in the Code of Ethics;
  - laws;
  - *CBOS*;
  - employer's policies;
  - other.
- What is the conflict? Where and what is the conflict? (e.g., between principles; between duty versus outcome; between ethics and external factors).

### 4. Proposed decision and action plan

Make a decision and indicate your action plan.

### 5. Evaluation plan

Consider how you will evaluate and reflect on this process and its outcome.



## Section 3

### Case Studies to Explore *Code of Ethics*

In this section five hypothetical case studies are presented. These studies are introduced to identify different types of ethical issues which may confront a speech pathologist. In each case, the decision making protocol presented in the previous section is applied. These cases are presented only to give examples of how ethical issues may be resolved. They do not provide a complete overview of ethical issues in speech pathology. Similarly the interpretation, decisions and actions presented are not the only possible, appropriate interpretation, decisions and actions.

1. *You will probably have alternative or additional ideas and interpretations as you read these case studies, because you bring your own experiences, morals and values to the situation.*
2. *You may choose to work through the decision making protocol for yourself, then compare your response with the interpretation we have supplied.*
3. *Alternatively, you may wish to note your ideas / reactions as you read through the decision making protocol for each case.*

## Case Study 1

### Client and family disagree with speech pathology recommendation

You are a speech pathologist working in a local hospital. You are referred a client called Mary who is a 32 year old woman with spastic quadriplegia. Mary is extremely malnourished, weighting only 25 kg. She has recurrent chest infections and her lung condition is deteriorating. She has severe dysphagia (difficulty in eating/drinking).

Mary lives in a group home with paid carers who assist with her care. She is dependent on others for her basic care. She has a severe communication impairment and is unable to communicate verbally. She predominantly communicates through her parents or familiar people who interpret her communication signals.

On modified barium swallow Mary is found to aspirate on all food and fluid consistencies (ie, the food/ fluid penetrates her vocal folds, into her bronchi). Due to the significant risk of aspiration pneumonia or choking, you and the medical team (including doctors, dietitians and nursing staff) recommend that she cease oral intake and be fed by alternate non-oral means (eg, g-tube).

You provide Mary and her family information about her dysphagia status, treatment options, the risks of the treatment options and the recommendations of the team and its rationale. You and other members of the team explain the risks of refusing treatment and continuing to be fed orally, including the risks of aspiration pneumonia, malnutrition, dehydration and eventually death. However, despite the risks, Mary and her family indicate that she wants to continue to be fed orally and she also refuses alternate non-oral feeding. It should be noted that during oral feeds she frequently coughs and chokes and looks quite distressed but indicates that she wants to continue. Nursing staff and Mary's paid carers do not want to feed her if she is at risk of aspirating and choking.

### Discussion of the case using Decision Making Protocol

#### 1. The facts

*What are the facts and how did you learn about them?*

- Mary is unable to feed herself and is dependent on others to do this.
- Mary is severely dysphagic and is aspirating, she has recurrent chest infections and her lung condition is deteriorating.
- Mary is malnourished and underweight.



- Mary has a severe communication impairment and is dependent on others for her communication.
  - Mary and her family have been provided with information about her condition but still want her to continue to be fed orally.
  - Mary and her family are refusing alternate feeding.
  - Mary appears to be distressed by coughing and choking during oral intake.
  - Her paid carers do not want to feed her if it is doing harm to her.
- These facts have been learned from the speech pathologist and hospital medical records.

*Who is involved?*

This is an issue that affects Mary, her family, health professionals, her paid carers, the health service, the owners of the residential unit in which she lives.

*What are the client-related factors?*

- She has spastic quadriplegia - Mary is 32.
- She is malnourished.
- She has recurrent chest infections and her lung condition is deteriorating.
- She is dysphagic.
- She has a severe communication impairment.
- She is unable to feed herself.
- She is dependent on others for her care and her communication.
- She refuses non-oral feeds, but her ability to make an informed decision regarding her oral intake is not known.

*What are the external considerations?*

- The position of the health service in respect to the issues raised.
- Legal advice from the health service's solicitors.
- The right to autonomy of the carers and their right to not be forced to do harm.
- The rights of Mary's family.

*Do you need any other facts or information?*

- Is Mary competent to make an informed decision regarding her eating/drinking?
- Further information is required regarding her receptive language skills and her cognitive status.
- What is the evidence that she should cease all oral intake?
- How effective were strategies on modified barium swallow to decrease aspiration eg, positioning?
- What strategies have been implemented or are possible to reduce the risks of aspiration?
- Are there any significant medical risks associated with alternate feeds eg, gastrostomy?
- Are there carers who are willing to feed her?
- How often do her parents visit? Is it possible for them to feed her?
- Are there other friends or family members willing to feed Mary?
- Does Mary have a guardian? If so, what sort?
- As Mary's wishes are communicated through others, are we satisfied that this truly represents Mary's wishes? That is, how accurately are others communicating Mary's wishes?
- Information is required about why the carers and nursing staff are not comfortable feeding Mary.
- Information is required regarding the legal implications of feeding Mary, and her nutritional status.

## 2. Is there a problem which requires action?

Management of Mary's nutritional respiratory status needs an urgent decision to be made. The family and client's views are opposed to the views of the health care team.

*What are the practical actions and alternatives and likely outcomes?*

- If Mary is competent to make the decision to be orally fed, the speech pathologist may recommend that Mary continue to be fed orally by nursing staff and carers. The likely outcome is that Mary would aspirate or choke and her nutritional status may continue to decline leading to adverse consequences for her health.



- If Mary is competent to make the decision to be orally fed and the nursing staff and carers refuse to feed her, the speech pathologist may recommend that her family feed her.
- If Mary is competent to make the decision to be fed orally and the speech pathologist supports her wishes the family could seek alternate accommodation or employ someone to feed Mary.
- If Mary is competent to make the decision, the speech pathologist could provide the nursing staff and carers with education regarding strategies to minimise the risk of oral feeding and their ethical responsibilities. This may increase their confidence and enable them to orally feed Mary.
- A harm minimisation plan may need to be developed while gathering further information as outlined above.
- If Mary is not considered competent to make the decision to be fed orally, the speech pathologist could recommend that Mary not continue to be fed orally. The likely outcome is that Mary would reject alternate non-oral feeding. This would have a negative impact on her nutritional status.
- A compromise could be discussed with Mary in which she could eat small amounts of food for pleasure while non-oral feeding would meet her nutritional requirements.

### 3. The problem

The problem is that because Mary is unable to feed herself, she requires other people to do this. As she is severely dysphagic, being fed orally will do her harm.

*Which ethical principles apply?*

- **Beneficence and non-maleficence:**  
By recommending that Mary be fed non-orally, the speech pathologist is trying to uphold the principles of beneficence and non-maleficence. The speech pathologist wants to improve Mary's nutritional status and protect her from harm (ie, aspirating or choking).
- **Non-maleficence:**  
If Mary's right to autonomy is upheld and the speech pathologist recommends that staff continue to feed her orally, then she may knowingly be doing Mary harm and thus failing to uphold the principle of non-maleficence.  
Insisting that Mary be fed non-orally may also do her harm (non-maleficence). Force feeding Mary through alternate means may do her harm, emotionally and physically. The gastrostomy may do her harm. There are limited options for Mary, eating/drinking may be the one thing that gives Mary pleasure and enables her to have extended contact with another person. Therefore denying her this may do her harm.
- **Truth:**  
The speech pathologist and medical team need to ensure that they tell the truth regarding Mary's condition and all options available.
- **Fairness:**  
If Mary were able to communicate directly without a facilitator would her right to autonomy be upheld. If this is the case and her decision is over ruled then the principle of fairness (justice) has not been upheld.
- **Autonomy:**  
However, if Mary is prevented from being fed orally, then her right to autonomy is not upheld. If Mary's right to autonomy is upheld and the nursing staff and carers are advised to orally feed her, then their right to autonomy and wish to not do harm (non-maleficence) is not being upheld.

*Which duties, obligations or rules are not being met?*

Standards of practice set out in the *Code of Ethics*

- To the client and community:
  - What is the speech pathologist's duty of care? Would the speech pathologist be legally negligent in encouraging staff to feed Mary orally even though it was medically contraindicated, or would she be negligent in preventing her from being fed orally and insisting on non-oral alternatives?
  - Would the speech pathologist's duty of care be upheld if she agreed that Mary be orally fed as safely as possible?
  - The speech pathologist has a duty to advocate for Mary's rights and that her best interests are expressed and protected.



- The speech pathologist has attempted to fulfil her duty of care by providing Mary and her family with accurate information in order for them to make an informed decision regarding her management. A problem, however, is that because of the severity of Mary's communication impairment, it is difficult to assess whether she has been adequately informed, whether she has appreciated and understood the information that has been provided.
- The speech pathologist has a duty to practice the highest standards of professional competence.
- She needs to ensure that her decision is based on the best available evidence, that she is operating within the limits of her competence, and that she has made all appropriate referrals.
- What is the speech pathologist's duty of care when Mary goes home on weekends? She has a duty of care to ensure that Mary's family knows how to feed her as safely as possible.
- To colleagues:
  - The speech pathologist also has duties to her colleagues including the paid carers and nursing staff. She could uphold her duties to her colleagues by providing them with accurate information on how they could feed Mary as safely as possible. She is upholding her duties to them by involving them in decision making.
- To the employer:
  - The speech pathologist also has a duty to her employer following best practice standards and exercising due care and attention to detail. This would include seeking a second opinion if the speech pathologist is not confident regarding her decision.
- To the profession:
  - The speech pathologist is upholding her duty to the profession and CBOS requirement, in that she is competent to practise in dysphagia as an experienced clinician.

#### Laws

- Legal situation in this case is unclear and may vary from state to state.
- Current views on best practice may be relevant to legal decisions.

#### *What is the conflict?*

This case presents a conflict between the ethical principles of autonomy, beneficence, non-maleficence and fairness. The conflict is essentially in balancing the ethical principles and their application to all participants in the processes. The conflict is between the client's wishes and the advice of the medical team.

## 4. Proposed decision and action plan

- Arrange an assessment of Mary's competence. If Mary is found to be competent to make an informed decision regarding her management, then this should be respected, regardless of the impact on her health. If Mary is not found to be competent, then referral to the Guardianship Board for an objective opinion would be warranted.
- Review Mary's modified barium swallow results in the context of her everyday life and determine whether appropriate risk minimisation strategies can be used to enable her to have some or all oral intake.
- Avoid making a hasty decision.
- Seek support and advice from senior speech pathologists or from clinicians experienced in working with clients with spastic quadriplegia.
- Use most recent evidence.
- Obtain a second opinion, obtain a specialised/independent view of alternate options.
- Meet with team members to explore the ethical issues involved and prepare written information for Mary and her family.
- Involve the social worker.
- Involve other palliative care doctors for an expert opinion as they may be able to provide a different perspective.
- Meet with Mary and her family to discuss their expectations.
- Arrange a case conference with Mary, her family and team members to again inform Mary and her family about her dysphagia, management options and their implications including risks. Ensure that they also are provided with written information that is in an accessible format. Explain to Mary and



her family the ethical dilemma that is faced by staff so that they understand their perspectives. Try to negotiate a resolution that all members of the team (including Mary and her carers) feel comfortable with. For example, Mary may agree to have only small amounts of food orally for pleasure while other nutrition is provided by gastrostomy or naso-gastric tube feeds. Document the outcomes of the case conference in Mary's medical record and ensure that Mary and her family also have a copy.

- If Mary is considered competent, a trial period of oral feeding could be instituted with strict review of her condition. A follow-up meeting could then be held to determine if this is the appropriate course of action.
- Arrange debriefing for all staff, particularly those who have fed or are required to feed Mary.
- Develop a program to continue to monitor Mary's condition including nutritional status (whether she is orally or non-orally fed). Feedback to her family and team members and review your recommendations at negotiated time periods.
- If the decision is for Mary to be non-oral, the speech pathologist will need to develop an oral stimulation program for Mary.
- The speech pathologist should advise her employer regarding the matter.

## 5. Evaluation plan

- Review Mary's case with other senior speech pathologists and health care staff.
- Review with Mary and her family their satisfaction with the outcomes of the process.
- Review with team members including the paid carers, their satisfaction with the outcomes of the process.
- Undertake a review of Mary's condition (health status, weight gain/weight maintenance) in light of the recommendations made and implemented.

### *Notes and Reflections*



## Case Study 2

### Consent to participate in research

You are a speech pathologist working as a member of a stroke unit in a large teaching hospital. You have just met Geoff, a new patient in the Emergency Department, who has moderate right-sided weakness and obvious language deficit with both receptive and expressive components and it is believed that he has had a stroke. He has no family or friends with him.

Your hospital has just agreed to participate in a trial for a new drug which it is hoped will decrease the severity of disability following stroke. The primary investigator approaches you to see if he will be able to obtain informed consent from the Geoff for participation in the research trial. (The primary investigator is a neurologist and is in charge of the stroke team in which you work.) The time during which the medication is thought to have optimal effect is very limited and according to the trial protocol the time limit expires in several hours. The written information sheet and consent form seem quite linguistically complex. You inform the investigator that you would need to assess the client's language, and possibly design a modified information sheet and consent form which is appropriate to his language needs.

### Discussion of the case using Decision Making Protocol

#### 1. The facts

*What are the facts and how did you learn about them?*

- You are employed in a teaching hospital, and are a member of the stroke team. The head of the research team is principal investigator in a trial evaluating a drug to be used with stroke patients. The hypothesis being investigated is that the drug will decrease severity of disability following stroke.
- The patient, Geoff, has probably had a stroke and appears to have difficulties with comprehension and expression, in addition to right hemiplegia.
- You have been asked if the patient can give informed consent to participate in the trial without yet being able to fully assess his language ability.
- You obtained the information from direct observation and consultation with Emergency Department staff.

*Who is involved?*

Geoff, the principal investigator, speech pathologist.

*What are the client-related factors?*

- He has had a stroke very recently.
- The level of his language deficit may prevent him understanding the information about the research sufficiently and providing informed consent.
- He is a patient in the hospital, needing medical care. He is probably confused, anxious and feeling unwell and possibly feeling vulnerable.

*What are the external considerations?*

- Possibility of participating in a research trial which may have positive outcome for this and future patients but could have detrimental effects on Geoff (such as an adverse drug reaction).
- Your line manager is also the principal investigator.
- No family or friends are available.
- The trial protocol specifies that the drug must be administered within several hours.

*Do you need any other facts or information?*

- What information is there about the trial - the drug, the protocol, etc?
- Has the trial been approved by the hospital's Ethics Committee? Did they specifically approve the use of the information sheet and consent form which the researcher wanted to use with Geoff?



*What is Geoff's actual language status and communicative ability?*

- Does Geoff have family or friends in the vicinity who could support him and help protect his interests?
- Does the investigator want you to participate in or be responsible for obtaining consent?
- Did Geoff ever express an opinion about such a situation or does he have a Medical Treatment Power of Attorney?

## 2. Is there a problem which requires action?

Yes, there is a problem with subject consent processes for this study.

*What are the practical actions and alternatives and likely outcomes?*

- Inform the investigator that Geoff cannot be approached to give consent until a language and cognitive assessment have been completed.
- Assess Geoff, having reallocated all your other clients. This will require adequate testing conditions and access to the patient at a time when other staff may be needing to assess and provide care to him.
- Refuse to participate in the process because you cannot confidently provide a consent process suitable to this patient's needs in the time available; the outcome could be that the patient is included in the study with "informed consent" which may not be valid or that he is excluded from participation.
- Attempt to assist the principal investigator to obtain informed consent from Geoff as well as you can. This may have a risk of being (seen as) coercive in this situation as you try to ensure comprehension, you could be seen to be encouraging agreement.
- Offer to assist the research team to prepare a modified consent form which could be used in the future.
- Advise the hospital Ethics Committee of the issues and ways to overcome them in future.

## 3. The problem

The patient may not be capable of providing informed consent within the time available, but may wish to participate in the study, and may potentially benefit from it. He should not be included in the trial without consent, but his potential for recovery may be lessened if not included.

Failure of the research team and possibly the hospital's Ethics Committee to predict that there would need to be particular consent provision for aphasic patients is a concern.

*Which ethical principles apply?*

- **Beneficence:**

This research has the potential to benefit this patient. His participation could also be seen as being for the greater good of future patients with aphasia.

- **Non-maleficence:**

Possible side effects of or adverse reactions to the drug may be an issue in any drug trial. This should be understood by the subjects when evaluating their potential to participate.

- **Truth:**

The details of the study may not be able to be explained truthfully or completely to the patient, with the explanation being simplified or presented as part of the treatment process. The truth is generally interpreted as being the "whole truth", not a partially understood nor partially explained version of the truth. The key features and risks must be able to be explained and understood, and the patient must be able to ask questions and receive understandable and truthful answers.

- **Fairness:**

He should not be prevented from participating in a study which may benefit him on the basis of having aphasia. (The benefit could include a reduced impairment, sense of value and worth from being able to contribute.)

- **Autonomy:**

This is a key issue as he has the right to participate in decision making and we have the responsibility to ensure that he can make autonomous decisions regarding his care, within his capability. The risk is that the speech pathologist could be seen as coercive if seeming to encourage consent by going over the process to ensure comprehension.



- Professional integrity:

The role of the speech pathologist is potentially being undermined if the professional opinion is not considered. This could jeopardise her perceived professional integrity. There could also be an issue of autonomy or professional respect for the speech pathologist who is prevented from autonomous participation in the research process affecting her patients.

*Which duties, obligations or rules are not being met?*

- Standards of practice set out in the *Code of Ethics*  
We should not knowingly withhold information about something in our field which may be of benefit. Participation in this trial may be of benefit if it can reduce severity or impact of aphasia, so we should attempt to obtain consent if feasible.
- CBOS**  
Elements 1.4, 4.5 and 5.7  
1.4 Undertakes assessment within the ethical guidelines of the profession and all relevant legislation and legal constraints, including medico-legal responsibilities.  
4.5 Undertakes management and implementation within the ethical guidelines of the profession and all relevant legislation and legal constraints, including medico-legal responsibilities.  
5.7 Demonstrates adherence to professionally accepted scientific principles in work practices.
- NH&MRC guidelines for participation in research:  
“...research must be so designed that each participant’s consent is clearly established...” (National Health and Medical Research Council, 1999, p. 12). Information about the study should be understood, there should be no perception of coercion and consent should be obtained directly from the patient, or, in some circumstances, “...the patient’s relative or legal representative...” (National Health and Medical Research Council, 1999, p. 29).
- Laws  
Legislation regarding consent by substituted decision maker varies in each state - though in this case there is no clear proxy (family/carer etc) and the intervention probably cannot be seen as a basic part of emergency clinical intervention (which can be provided without consent) and could possibly be construed as battery or assault if provided without consent (Kerridge, Lowe & McPhee, 1998).

*What is the conflict?*

- The conflict is between ethical principles:
  - beneficence vs. autonomy predominantly
  - beneficence vs. non-maleficence
- Also conflict between NHMRC guidelines/state legislation and beneficence.
- Some conflict arises because of the roles of the speech pathologist as the care provider as well as the agent for obtaining consent (and the supervisee of the researcher).
- Between your *Principles of Practice/Code of Ethics* and the hospital’s decision if it supported this research.

#### 4. Proposed decision and action plan

- Obtain required information about the study protocol:
  - Has it been passed by the relevant ethics committee?
  - What are the risks and likely benefits?
  - How complex are the patient information sheet and the consent form?
- If it seems feasible that the patient could benefit from and be of benefit to the study, undertake a screening language assessment.
- If it seems possible that he could understand the information sheet and consent form, proceed to attempt to involve the patient in the informed consent process. It would be necessary for the investigator to be present during the process to clarify factual data. Geoff should understand that you are not obtaining consent as a requirement for receiving other care.
- If, as a result of the steps above, you think it unlikely that Geoff could understand and provide informed consent, advise the principal researcher that he would not be eligible to participate.



- Offer to assist in the refinement of the protocol to enable future patients with aphasia to participate and ensure that these modifications were explained to and approved by the hospital's Ethics Committee.

## 5. Evaluation plan

- Review the effectiveness of the consent process used with subsequent patients
- Review decision making by Ethics Committee to ensure they consider needs of aphasic patients.

### *Notes and Reflections*



## Case Study 3

### Service delivery model and type of speech pathology services provided

You are the speech pathologist in a school. Your line manager is the school principal. Your professional supervisor is a senior speech pathologist at a different site who is not responsible to your principal.

Your caseload is full and you have difficulty getting everything done. In preparation for an Individual Education Plan (IEP) annual review, you have decided to recommend reduced frequency of direct intervention for Jennifer, a six year old with cerebral palsy, from once a week to twice monthly direct service. An existing program of intervention implemented by the teacher aide and teacher in the classroom will continue to address her speech therapy goals.

Although Jennifer may continue to benefit from weekly direct intervention, you believe the services can be adequately maintained in the classroom. In addition, you will free up some time to see a new referral and another student needing speech therapy services. Jennifer's parents are very vocal and have been assertive on their daughter's behalf in the past. You hear they are going to vigorously oppose reduction of therapy. The principal does not want any conflict so advises you to see Jennifer weekly to keep the peace.

### Discussion of the case using Decision Making Protocol

#### 1. The facts

*What are the facts and how did you learn them?*

- Jennifer has an ongoing need for continued speech pathology intervention. Other team members are successfully supporting the speech pathology program at present. The speech pathologist doesn't have enough time to maintain a direct model of service delivery as well as meeting the needs of other clients. All reported by the speech pathologist.
- The principal is the line manager for the speech pathologist but not the professional supervisor. Parents are key members of the educational team and have legal rights to be involved. These facts are known through legislation and through departmental documents.

*Who is involved?*

- Speech pathologist, principal, teacher, teacher aide, parents, child.
- Students on waiting list.

*What are the client-related factors?*

- Jennifer requires ongoing speech pathology intervention.
- An existing class based speech pathology program is effective for Jennifer.
- Jennifer's needs could be met with the proposed service delivery model.

*What are the external considerations?*

- Principal's resistance to a conflict situation.
- Teacher and teacher aide support of class based program.
- Parent resistance to change in service delivery model.
- Unserved caseload and staff at the school.

*Do you need any other facts or information?*

- Latest research on evidence based practice for speech pathology services in schools.
- Consult Speech Pathology Australia position paper, *Speech Pathology Services in Schools*.
- Prioritisation processes for schools.
- Access to other agencies e.g., Cerebral Palsy Association.
- Role of senior speech pathologist in supporting the speech pathologist.



## 2. Is there a problem which requires action?

Yes, the speech pathologist needs to be confident that the decision to change the type of service for Jennifer is based on sound professional evidence rather than the need to have time to support other clients. Is Jennifer receiving the best possible service?

*What are the practical actions and alternatives and likely outcomes?*

- Maintain weekly support for Jennifer and manage waiting list.
- Provide fortnightly direct service and supplement it with continued class support (include this in IEP).

## 3. The problem

This is an ethical issue for the speech pathologist who needs to be confident she is providing the best possible service for Jennifer and that the needs of other clients are not influencing the decision. This is also an ethical issue for the principal, in terms of the principles of non-maleficence and equal access to resources. Another factor to consider would be the manager's profession's code of ethics or his/her legislative obligations.

*Which ethical principles apply?*

- **Beneficence:**  
The speech pathologist is upholding this principle by trying to provide a service to a number of clients effectively.
- **Non-maleficence:**  
The speech pathologist must be sure the lack of direct intervention for Jennifer will not do harm.
- **Truth:**  
The evidence supporting the model should be available and presented to the team and family.
- **Fairness:**  
The speech pathologist is trying to be just in considering service delivery options for a number of clients, striving for equal access to services and dealing fairly with all clients.
- **Autonomy:**  
The speech pathologist wants to respect the autonomy of the parents in relation to service delivery but also needs to ensure her professional autonomy is upheld.
- **Professional integrity:**  
The role of the speech pathologist is being undermined in this process, jeopardising her perceived professional integrity. There could also be an issue of autonomy or professional respect for the speech pathologist who is prevented from implementing recommended clinical services.

*Which duties, obligations or rules are not being met?*

Standards of practice set out in the *Code of Ethics*

- To clients and community:
  - Practice to the highest standards of professional competence.
  - Advocate for equity of access for clients.
- To employer:
  - Resolve conflict between principal's directive and provision of efficient and effective speech pathology services and professional standards.
- To profession:
  - Upholding professional standards.
  - Exercise independent professional judgement.
- To colleagues:
  - Teacher and teacher aide should be expected to undertake speech pathology activities within their competence.
  - Clearly define range and scope of speech pathology services.



*CBOS*

- Unit 5 Element 5.4 - Manages Workload. Manages caseload effectively considering service delivery models and client needs.

*What is the conflict?*

- The conflict is predominantly between the ethical principles of fairness and professional integrity.

#### 4. Proposed decision and action plan

- Re-present the case to principal and teacher in the context of the Code of Ethics, best practice data and any other relevant documentation (before IEP meeting).
- Trial fortnightly intervention supported by teacher and teacher aide programs for a term and review (three to six months).
- Clearly record the speech pathology program to be implemented in the classroom and the expectations of the teacher and teacher aide - incorporate this into the IEP process - ensure that the teacher and teacher aide are skilled and competent to carry out the program in the classroom.
- Meet with the parents to discuss their expectations of therapy and to fully explain the speech pathology intervention and the expected outcomes.
- Seek support and advice from supervising speech pathologist.
- Undertake professional development activities for school staff (including the principal) and parents on the range of service delivery models, the evidence based data and the educational outcomes.

#### 5. Evaluation plan

- Review the outcome of the term trial.
- Check satisfaction of parents, teacher and teacher aide.
- Provide feedback to the principal.
- Use IEP process to evaluate service outcomes.

*Notes and Reflections*



## Case Study 4

### Paediatric language lack of resources/interpreter services; inadequate servicing imposed by management

You are a relatively new graduate working as the sole speech pathologist in a rural community health centre. Some months ago you assessed a five year old bilingual girl, referred by her preschool teacher because she does not talk much at preschool. The child's second language is English, which she has been exposed to only since the family's arrival in Australia one year ago. Her Australian aunt accompanied her to the assessment and explained that because the child's parents do not speak much English, they did not wish to come to the centre, but nonetheless wish their daughter to receive help. You asked your allied health services coordinator to approve payment for an interpreter for the assessment. He said the centre could not afford to pay for this service and suggested you use a family member to interpret. The Australian aunt did this to the best of her ability, as although she speaks and understands the language to some extent, she is not a native speaker of the family's language. On the basis of your assessment, you believe the girl does have a language problem and have been seeing her for therapy, with the aunt's involvement in those sessions. After some weeks, you are questioning whether you have an accurate picture of the child's language skills, and are anxious that therapy goals may be inappropriate.

### Discussion of the case using Decision Making Protocol

#### 1. The facts

*What are the facts and how did you learn about them?*

- The child is five years old and has only been in Australia a short time.
- There is concern about her language development, as reported by preschool teacher.
- No interpreter has assisted with assessment or treatment.
- The diagnosis of a language impairment is being reconsidered by the speech pathologist.
- The speech pathologist feels she is not delivering "best practice" therapy.
- The parents who speak little English have not been involved in assessment, planning management or therapy because of lack of interpreter services.
- All these facts have been reported by speech pathologist.

*Who is involved?*

Speech pathologist, allied health services coordinator, child, aunt, preschool teacher, family, interpreter service.

*What are the client-related factors?*

- She is from a non-English speaking background.
- She is five years old (critical age for establishment of literacy and social skills at school).
- Possible language disorder, no diagnosis.
- Less than best-practice therapy being delivered.

*What are the external considerations?*

- No interpreter.
- Allied health services coordinator says lack of funds for interpreter, therefore use Australian- born aunt.
- Parents not directly involved - a concern about informed consent for service to daughter; and a query about motivation levels.

*Do you need any other facts or information?*

- Accurate profile of child's language skills and bilingualism at home, school and in clinic.
- Family views and information.
- Knowledge of language environment and use at home.
- Is there really no money for interpreter service or is centre trying to save money?



- Knowledge of family's culture, local supports and their knowledge of child development and services.
- Is aunt able to give cultural information, as a non-native speaker?

## 2. Is there a problem which requires action?

Yes, not enough information on home culture and language, and child's language skills to ascertain if there is a problem or not. There is a problem of inadequate service, not following best-practice guidelines.

*What are the practical actions and alternatives and likely outcomes?*

- Re-present the case and concerns about treatment to date to the allied health services coordinator.
- Find another (non-family) member of the language community to interpret.
- Have family pay for interpreter.
- Go to centre manager and present case and negotiate for interpreter services.

## 3. The problem

This is an ethical issue for the speech pathologist. She knows she is not providing the best possible service. This is also an ethical issue for the allied health services coordinator, in terms of their own professional code of ethics, especially regarding principles of non-maleficence and equal access to resources. They may also have legislative obligations to ensure non-discriminatory equity and access to services.

*Which ethical principles apply?*

- **Beneficence:**  
The speech pathologist is upholding the principles of beneficence and distributive justice by attempting to provide a service, and upholding the value of non-discrimination (she could justify non-service perhaps on the basis of no interpreter).
- **Non-maleficence:**  
She is unable to uphold the principle of non-maleficence, as she cannot be sure she is not doing harm through lack of information and an accurate diagnosis.
- **Truth:**  
Should she truthfully say to the client that she cannot get an interpreter, or does she outline the resource constraints and jointly make a decision about how to proceed.
- **Fairness:**  
She has attempted to uphold the principle of fairness - providing equal access to therapy resources and striving to provide equal access to other resources (interpreters) but has been thwarted by her team leader.
- **Autonomy and professional integrity:**  
Because the family have not been consulted, due to lack of interpreter, their autonomy, liberty and agency have not been upheld. The speech pathologist's autonomy has been overridden by the allied health coordinator and her professional integrity is being compromised.

*Which duties, obligations or rules are not being met?*

Standards of practice set out in the *Code of Ethics*. Because of imposed constraints on her, the speech pathologist is not meeting her duties to the client and family, and preschool for:

- the provision of accurate information (as she cannot access that or provide an accurate diagnosis and a discussion of prognosis due to lack of interpreting);
- the exercise of professional competence (as without interpreting she cannot deliver the best possible service);
- advocacy for interpreting services.

Although she is upholding the implications of the anti-discrimination legislation, she is not following the requirements of *CBOS* or the *Working in a Multilingual and Culturally Diverse Society* (Speech Pathology Australia, 2001) position paper.



The speech pathologist is also not meeting her duties to her employer to resolve conflict between policy (no funds for interpreter) and professional standards. To attempt this requires more confidence and maturity than this new graduate has, and also the support of a senior speech pathologist, to whom she has no access.

The speech pathologist is not meeting her duties to the profession in terms of upholding professional standards. She may also be putting at risk professional reputation if the community becomes aware that she is providing a less than best practice service.

*What is the conflict?*

The conflict is between ethical principles, particularly the principles of non-maleficence and autonomy, and external factors which prevent the provision of interpreter services. There is a conflict between fiscal constraints and anti-discrimination legislation.

#### 4. Proposed decision and action plan

The clinician can:

- Re-present case and request to allied health services coordinator in light of findings and concerns, and in the context of the following:
  - *Code of Ethics*;
  - best-practice data;
  - relevant position paper;
  - anti-discrimination legislation.
- Take a senior colleague with her to this meeting, particularly as she is a relatively new graduate. Seek support from mentor if no senior colleague available. Document allied health services coordinator response and reasons in file.
- Go to centre manager if appeal to allied health services coordinator is ineffective, with same information as above. Document response and reasons in file.
- Use someone who speaks the family's language as their first language to act as interpreter and cultural informant, or ask family to pay for an interpreter, to ascertain family's understanding of situation and rights.
- Provide the family with information on the relevant Health Rights Tribunal, Complaints Commission, Ombudsman or other appropriate advocacy or rights office.
- Document all contacts and concerns in file, to protect herself medico-legally.

#### 5. Evaluation plan

- Check if funds have become available for interpreter
- If unsuccessful, begin/become involved in community advocacy program for interpreters.

*Notes and Reflections*



## Case Study 5

Should this situation lead to a report to the Association's Ethics Board?

### Phase 1

You are a speech pathologist working in an outpatient rehabilitation setting. Jim is a new client who is attending your clinic with his wife Ellen. He had a severe stroke two years ago and still has severe dysphasia and is currently in residential care. He received inpatient rehabilitation in another branch of your health service. When you ask Jim and Ellen about previous speech pathology input, she replies:

*“When he was in the rehabilitation hospital he had speech therapy every day for a while. They were concerned that he had stopped improving, and that therapy was making him more frustrated and distressed. There is a speech therapist who sometimes visits his residential accommodation and she has recommended that he should have treatment from her twice a week for a year. She has promised us that this will make a big difference because he is so frustrated at the moment. What do you think?”*

### Discussion of the case using Decision Making Protocol

#### 1. The facts

*What are the facts and how did you learn about them?*

- The client has severe dysphasia from a stroke two years ago. He lives in residential care. He and his wife have come to see you in an outpatient rehabilitation setting (information from your observations, previous therapist and files).
- His wife has told you:
  - He had inpatient rehabilitation with daily speech pathology input.
  - Treatment was ceased when improvement ceased and frustration and distress were of concern.
  - A visiting speech pathologist has reportedly advised that treatment from her, twice a week for a year, would make a big difference. She feels he is frustrated at present.
- You have not yet spoken to the other speech pathologist to ascertain her perspective on Jim and what she has told the family.

*Who is involved?*

- Client; wife; speech pathologist visiting the residential accommodation; speech pathologist at the outpatient service (you); the speech pathologist previously involved with Jim at your inpatient service.

*What are the client-related factors?*

- Severe dysphasia, onset two years ago; treatment was provided then was ceased because of reported lack of progress and frustration; Jim lives in supported accommodation; he is reportedly frustrated now.
- Wife is anxious for more therapy for Jim.
- What potential for improvement in communication status is possible/likely?

*What are the external considerations?*

- Frequency of treatment which could be provided by your facility with recognition of need to ensure equity and access to treatment for all eligible clients.
- Who can or should provide treatment?
- Funding for treatment (possibilities include: publicly funded at outpatient service; funded by the residential accommodation; private health fund; self funded by family).

*Do you need any other facts or information?*

- Details about client's history and inpatient rehabilitation. You will need to review the client's file.
- Information about client's current status (communication and psychosocial) and needs.
- You will need to conduct a search of the literature for evidence of best practice regarding treatment at this stage post-CVA and for appropriate approach and frequency of therapy.



- What do Jim and his wife want from you? Do they want you to confirm or refute the visiting speech pathologist's claims; to provide ongoing treatment or counselling regarding Jim's status or other?

## 2. Is there a problem which requires action?

It appears there may be a problem, but the nature and extent of the problem is uncertain.

- You need to clarify what Jim and his wife want from you. If the family is asking for treatment at the outpatient service, you would need to assess and decide on appropriate management strategy, after a review of the evidence based practice (EBP) literature. It is uncertain that therapy could/should be provided with the intensity and for the duration reportedly outlined by the visiting speech pathologist.
- If the family is asking for a second opinion about whether they should accept the therapy from the visiting speech pathologist, you would still need to assess the client and outline the treatment which you feel may assist Jim, providing evidence for any such recommendations. You would not directly comment on the reported claims of the visiting speech pathologist.
- If the wife is asking you to comment on what the visiting speech pathologist has offered, you would ask the wife's consent to contact the other speech pathologist.
- If you think treatment is likely to be of benefit, you could contact the other speech pathologist to discuss the most appropriate provision of that treatment.
- Whatever the reason for the wife's approach, you would ask her consent to discuss the matter with the other speech pathologist. In doing this, you would make clear to the other speech pathologist your reasons for contacting her, which is to support the family in making what appears to them to be a difficult decision.

## 3. The problem

*Which ethical principles apply?*

- **Beneficence:**
  - Depending on the literature review for best practice with clients like Jim, treatment may benefit the client and his family if it improves their communication together and/or their understanding and acceptance of his status.
  - More intensive treatment may be more beneficial than the amount of treatment you can provide.
- **Non-maleficence:**
  - It appeared that Jim had become frustrated when he ceased to benefit from treatment so ongoing treatment could cause harm if his mood deteriorates.
  - If false expectations are created about progress, this may damage the psychological health and motivation of both Jim and his wife.
- **Truth:**
  - It is not clear that the other speech pathologist is truthfully advising the wife about the potential benefits of treatment (see points under "Professional integrity" below).
- **Fairness:**
  - The issue relating to this principle is about fair access to scarce resources (speech therapy services).
  - If the client has already had treatment and failed to benefit, it may be more fair to provide therapy for other clients who have more potential for improvement; on the other hand, if he could now benefit from treatment, it would not be fair to withhold such treatment.
  - The source of funding (public, health insurance or private) may also be relevant to the consideration of fairness.
- **Autonomy:**
  - The family has the right to full information to ensure that an appropriate autonomous decision about treatment options can be made. Improved communication may provide the client with more autonomy.
- **Professional integrity:**
  - If a review of the EBP literature for clients of this type suggests frequent individual therapy is not justified, then the integrity of the other speech pathologist may be questioned if evidence does not support the level of treatment to which she is suggesting the family commit.



Your professional integrity could be challenged if you do not explain the evidence to Jim's wife and if you do not make contact with the other speech pathologist and discuss the possibility of a less than best-practice service being offered in the light of the EBP literature. Your professional integrity would also be questionable if you make insupportable negative claims or unsubstantiated comments about the therapy offered, and the clinician offering it.

*Which duties, obligations or rules are not being met?*

Standards of practice set out in the *Code of Ethics*

- To clients and community:
  - Accurate information: on the basis of a file review and EBP literature, it may not be clear that the family has received "accurate and up-to-date information" about the required intensity and duration of treatment nor of the likely consequences.
  - Professional competence: Will the visiting speech pathologist be able to fulfil her reported undertakings to her potential client?
  - Evaluation: We should provide services "only if our clients can reasonably expect to benefit from them". Some benefit may be expected, but the extent of the benefit which was expected by the family may not be achievable.

- To the profession:

Professional reputation: for the external clinician, it may be thought that she is engaging in behaviour which would bring the profession into disrepute, if she delivers services which research proves to be ineffective. For yourself, there is a risk you could be engaging in behaviour which would bring the profession into disrepute, if you "disparage the skills, knowledge or services" of your colleague.

Laws

- No laws or other community standards appear to have been violated.

*What is the conflict?*

The main conflicts are between:

- Beneficence (the client may improve), truth (is there evidence that the intensity and duration of the treatment is likely to be of major benefit?).
- Beneficence (the client may improve) and non-maleficence (however intervention may not be warranted and may be psychologically damaging).
- Professional integrity should you identify your concerns about the claims reported to you, or would this be inappropriate disparagement of a colleague?

## 4. Proposed decision and action plan

You need to know more about the client and his abilities and potential before you can take any further action.

You will assess the client, do an EBP literature search for best practice for clients like Jim and critically evaluate the literature to determine current best practice. You will compare literature with assessment results. If literature suggests therapy may be beneficial, with issues of equity and access for other clients and Jim's psychological health in mind, you would offer a brief period of trial therapy including the wife so she can participate and actively evaluate the outcome. (This assumes that the client does not indicate reluctance to participate.) Through evaluation of the potential to improve communication, you will be able to advise the family on any recommendations for management and outline the options for obtaining such intervention.

If the EBP search and evaluation suggests that therapy is not likely to be beneficial for clients like Jim, you would counsel the wife regarding this, and discuss other options, such as a communication group, carer training to enhance communication, etc.



## 5. Evaluation plan

If therapy is indicated, keep outcome data to evaluate impact of therapy.

If therapy is not indicated, the process will have been successful if the family can make an informed decision regarding their preferences for the communication management of the client.

### Phase 2

Your assessment and literature review suggests that the client may benefit from involvement in a functional communication group for clients and their families, which meets weekly at your centre. You explain this to Jim's wife but she chooses to take up the offer of the visiting speech pathologist of intensive treatment. She says she is happy with the information you have provided, but feels she should not deny any opportunity for her husband to improve. She therefore asks you to contact the other therapist to give your results and other relevant background information. You agree to contact the visiting speech pathologist to discuss the client's management.

The visiting speech pathologist confirms that she believes that some improvements may be possible, though they may not be great. When you ask her why she believes this, she provides non-specific answers. She also comments that she feels the original therapy he received was not very good, although she does not justify this assertion. She also comments that different therapy would lead to improvements, but she does not outline the nature of the therapy she proposes. She comments that the family seem to have the financial means to support additional therapy.

Jim and his wife commence the intensive therapy. The wife returns after three weeks, distressed because the therapy is not proving successful despite the financial outlay which she says could create hardship. Her husband is becoming extremely frustrated and they both feel treatment should be terminated. Jim's wife reports that the therapist is insistent that he should not be deprived of therapy when great gains may be very close. She again asks for your advice and asks you to take over management of the case.

What do you do now?

## Discussion of the case using Decision Making Protocol

### 1. The facts

*What are the facts and how did you learn about them?*

Based on your previous review of the literature and previous assessment, you feel group work would be of most benefit. However, the wife wants to pursue private therapy as previously outlined. She wants you to hand over relevant information to the other speech pathologist. The other speech pathologist in discussion with you made several claims about potential therapy with the client:

- likely not to make "great" improvement;
- perceives family as "having means to pay" for frequent therapy;
- claims previous therapy was not very good.

After three weeks, wife returns to discuss concerns about the private therapy received, client's frustration and the other speech pathologist's encouragement of continuation with offers of future gains.

*Who is involved?*

- Client; wife; speech pathologist visiting the residential accommodation; speech pathologist at the outpatient service (you); the speech pathologist previously involved with Jim at your inpatient service.

*What are the client-related factors?*

- Increasing frustration; client/wife wish to terminate treatment; still looking for improvement.



*What are the external considerations?*

- Taking over management of a client being seen elsewhere; how to convey this request to other speech pathologist professionally but with due regard for potential ethical issues.

*Do you need any other facts or information?*

- You need information from other speech pathologist about her perceptions of Jim, the nature of treatment, rate of progress, etc.

## 2. Is there a problem which requires action?

*What are the practical actions and alternatives and likely outcomes?*

On the basis of your EBP literature review, assessment, discussion with other speech pathologist, limited progress, and information reported by wife, there appears to be enough information now for you to be concerned that the other clinician is behaving unethically. If she is, as a member of Speech Pathology Australia, you are obliged under the *Code of Ethics* to report the violation.

Other action could include talking to the other speech pathologist directly to relay your concerns and clarify her understanding of the situation. You could also discuss the situation in confidence with a colleague.

You could after consultation with the visiting speech pathologist again recommend including the client and his wife in your group program.

## 3. The problem

*Which ethical principles apply?*

- **Beneficence:**  
On the basis of your understanding of the client and a literature review, you believe that benefit may be possible with your recommendations for group therapy, and it appears there is little benefit for the client in the current treatment.
- **Non-maleficence:**  
There is a risk that the frustration suffered by the client may be damaging to his psychological health. Further, what the wife has said suggests there may be possible financial hardship if the family is paying directly for such frequent treatment.
- **Truth:**  
Again claims of potential for improvement seem not based in truth or evidence.
- **Fairness:**  
These apply less now as no public client is being denied access to your services by Jim receiving frequent therapy.
- **Autonomy:**  
If client and wife are being coerced into treatment, their autonomy is being violated
- **Professional integrity:**  
If a review of the EBP literature for patients of this type suggests frequent individual therapy is not justified, then the integrity of the other speech pathologist may be questioned if evidence does not support the level of treatment to which she is suggesting the family commit.

Your professional integrity could be challenged if you do not explain the evidence to Jim's wife and if you do not make contact with the other speech pathologist and discuss the possibility of a less than best-practice service being offered in the light of the EBP literature. Your professional integrity would also be questionable if you make insupportable negative claims or unsubstantiated comments about the therapy offered, and the clinician offering it.

*Which duties, obligations or rules are not being met?*

Standards of practice set out in the *Code of Ethics*

- To clients and community:
  - **Accurate information:** on the basis of a file review and EBP literature, it may not be clear that the family has received "accurate and up-to-date information" about the required intensity and duration of treatment nor of the likely consequences.



- Professional competence: Will the visiting speech pathologist be able to fulfil her reported undertakings to her potential client?
- Evaluation: We should provide services “only if our clients can reasonably expect to benefit from them”. Some benefit may be expected, but the extent of the benefit which was expected by the family may not be achievable.
- To the profession:  
Professional reputation: for the external clinician, it may be thought that she is engaging in behaviour which would bring the profession into disrepute, by delivering services which research proves to be ineffective. For yourself, there is a risk you could be engaging in behaviour which would bring the profession into disrepute, if you “disparage the skills, knowledge or services” of your colleague.

The evidence of claims of benefit of frequent therapy which cannot be substantiated, and coercion of the client and his wife are now clearer.

#### Laws

- There is no apparent breach of any laws

#### *What is the conflict?*

As more evidence has become available, the balance of these conflicts has shifted.

The lack of truth of claims made is being supported by the lack of progress, distress and frustration of client, and possible harm occurring.

It is more clear that the other clinician could be thought to be bringing the profession into disrepute by her actions, thus the action of reporting becomes more easily supported.

## 4. Proposed decision and action plan

It seems appropriate to take on the client for group program.

You need to consider reporting the clinician to the Vice President Communications of Speech Pathology Australia after further discussion with the other speech pathologist to clarify her position, views and understanding of the issues involved.

Contact the other speech pathologist to advise that you will plan to take over the client at the wife's request. Ascertain her understanding of the issues that have lead to distress of client and wife, and possible ethical issues involved. If, as a result of the conversation, you feel she has acted unethically, and is unaware that this is the case, you could attempt to help her understand your concerns. If she proves resistant to considering the ethical aspects of this case, you could report the situation to the Vice President Communications.

## 5. Evaluation plan

- Does Jim's communication improve and frustration diminish through participation in the group?
- Does the visiting speech pathologist recognise that her behaviour could have been construed as unethical and undertake to act with more consideration of ethical practice in future (either as a result of your direct discussion with her, or subsequent investigation and action by the Association's Ethics Board)?

#### *Notes and Reflections*



## Section 4

# What Do You Do If You Think Someone Has Breached the *Code of Ethics*?

### What do you do if you decide to make a formal complaint?

If you decide to make a formal complaint, Speech Pathology Australia's Vice President Communications (VPC) will provide you with relevant information on the process. If you require assistance in preparing the written complaint, the VPC can provide you with assistance.

### What does the Association do with a formal complaint?

The Ethics Board of Speech Pathology Australia will meet to review your formal complaint within 28 days of receiving it. If, after reviewing the complaint, the Ethics Board considers that it does not merit any further investigation, it will make a recommendation to the Speech Pathology Australia Council (the Council) that the matter not be pursued. If Council supports this recommendation, you (the complainant) will be advised in writing. If, after reviewing the complaint, the Ethics Board considers that it merits further investigation, the Ethics Board will allocate three of its members to an "Investigation Panel" which will investigate the complaint.

If a complaint is received in relation to someone who is not a current member of the Association, the complainant will be referred to the appropriate organisation within their State or Territory (for example the Health Services Commissioner).

### How does the Association investigate a complaint?

All aspects of any investigation will remain strictly confidential.

Details of the complaint will be sent to the person who allegedly breached the *Code of Ethics* (the respondent). If the alleged breach is of a serious nature, the Ethics Board has the discretion to continue the investigation, even if you do not wish to pursue the matter.

All details of the complaint will be provided to the respondent, including the name of the complainant. Your contact details will not be provided.

Both you and the person referred to in the complaint may be asked to provide evidence in respect to the complaint. The Investigation Panel of the Ethics Board may ask you and other sources for further written information. Oral evidence may also be taken. Where oral evidence is taken, written transcripts will be prepared and signed. Both you and the person who allegedly breached the *Code of Ethics* may be represented by another person who is not legally qualified. However, if it is a serious breach of the *Code of Ethics*, the Council may give permission for legal representation. In such circumstances, all parties would be responsible for their own costs.

You and other sources will have 28 days to provide this information. It is important to note that the Investigation Panel will not reveal your identity or that of the person who allegedly breached the *Code of Ethics* to other sources without your permission.

If you and the person who allegedly breached the *Code of Ethics* agree, the Investigation Panel may refer your complaint to an independent conciliator if appropriate. The nature of independent conciliation will be determined based on the needs of the case.

### What happens after the Investigation Panel completes its investigation?

Within 28 days of completing the investigation of your complaint, the Investigation Panel of the Ethics Board will prepare a brief for Council that will include:

- its recommendations as to whether or not there has been a breach of the *Code of Ethics*;



- all relevant material including investigations undertaken, written reasons for their recommendations, witness statements and transcripts of oral evidence if available;
- its recommendation regarding the nature and severity of penalty (if any) if it has found that there was a breach of the *Code of Ethics*.

## Who makes the final decision?

The Council is responsible for making the final decision on the outcome of a formal complaint based on the recommendation and other information provided by the Investigation Panel. The Council must satisfy itself that the Investigation Panel has undertaken appropriate investigations, that the process has been fair and correct and that the questions asked were appropriate.

The Council will notify the Investigation Panel of its findings and decision in writing. The Vice President Communications will inform both you and the person who allegedly breached the *Code of Ethics* in writing within 28 days of Council's decision.

## What are the penalties that Council can impose for a Breach of the *Code of Ethics*?

The penalties imposed by Council for breach of the *Code of Ethics* are at its discretion and are dependent on the nature and severity of the breach. These penalties could include censure, fine, financial recompense to the complainant, suspension of membership of the Association and expulsion from the Association.

## What do you do if you have a problem with the decision?

You are able to seek a review of the Council's decision by writing to the Association within 28 days of receiving notice of the decision. If you seek a review, the Association will establish a review panel, which will consist of a practising barrister (chairperson) and two members of the Ethics Board who were not on the Investigation Panel for that complaint (a senior representative of the Association and a representative of the community).

## What does the review panel do?

The review panel will consider your submission within 28 days of receiving it and consider submissions from relevant parties. It will then determine whether the decision is within the power of the Council in accordance with the Constitution of Speech Pathology Australia and if the process was in accordance with the principles of procedural fairness. Once a unanimous decision has been reached by the Review Panel, it will notify Council of its decision in writing, advising Council of the reasons for this decision.

On completion of the review the Review Panel will either find that the decision was made in accordance with the principles of procedural fairness and is within the power of Council or will refer the decision back to Council for reconsideration in light of the Review Panel's findings.

You will be notified of the outcome by the Ethics Board within 21 days of the Review Panel's decision.

## What happens next?

The decision of Council becomes final once any review procedures have been completed. If there is no review, the Council decision will become final 29 days after the person who was alleged to have breached the *Code of Ethics* has received notice of the Council's decision.



## Section 5

# Educating Students About Ethical Behaviour

Students need to be educated about our *Code of Ethics*, how it applies to them as students as well as to their prospective professional positions. They also need to be aware of common ethical pitfalls which students may encounter. Both university staff and clinical educators who have students on clinical placements have a role in the education of students regarding ethics. They also have a responsibility to role model ethical behaviour and make their ethical reasoning explicit to students. University staff should develop guidelines for students about overlapping roles (see for example Case Study 6 and scenarios 2 - 4 below), which identify for them the ethical, legal and educational boundaries.

It is suggested that university staff introduce students to the *Code of Ethics* early in their course, certainly before they begin their introductory clinical experiences. They should revisit ethics regularly throughout the course, approaching the topic each time with added complexity, and new insights gained from the students' growing clinical experiences. An introduction to ethics for students in year 1 might simply consist of an overview of ethical principles, the importance of ethics in professional practice, a discussion of how we develop ethical behaviour, the structure of our Code, and a discussion of the ethical issues likely to be encountered by year 1 students during clinical observations (eg, the need to protect the confidentiality and privacy of clients by not recording identifying information on notes made in clinics, and not removing client files from the clinic, perhaps for the purposes of course assignments).

As students begin direct clinical work in on- or off-campus clinics, and assume more responsibility for clients, ethics education needs to be revisited. Students need to become quite familiar with the *Code of Ethics*, particularly if they are student members of the Association, as it will guide ethical management of clients. They may find the ethical decision making protocol outlined in Section 2 helpful in ethical and clinical reasoning. The case study provided in this section and the five case studies in Section 3 can be used to guide them through the use of this protocol, the *Code of Ethics*, and best practice documentation. A typical case study around the issue of role conflict is provided in this section. A list of typical ethical dilemmas encountered by students is provided below.

In addition to formal teaching sessions around ethics and ethical reasoning, lecturers and clinical educators should also be continually alert to "teachable moments", that is, opportunities that arise in classes or clinical practice which provide vehicles for revisiting ethical principles decision making, and applying them to the situation at hand.

Students in the final stages of the course can use their own clinical experience to generate case studies for higher level discussions of ethics. Their clinical experiences will have highlighted for them ethical "grey areas", the complexities of ethical reasoning and the challenges in identifying and reporting breaches of the *Code of Ethics*. As they move towards graduation, a discussion of reporting procedures and how reports of suspected breaches of the Code will be managed is appropriate.

### Typical ethical issues encountered by students<sup>1</sup>

Have students discuss these scenarios with their peers, identifying if there is an ethical problem, and if so the nature of that problem, and possible solutions for managing the problem. In discussing these dilemmas, your role as a staff member will be to highlight the medico-legal and professional courtesy issues, as well as ethical issues involved.

1. You have a good friend at netball/football/part-time job/church whose grandfather recently suffered a stroke which has left him with aphasia. He has been through rehab at the local hospital and is now no longer able to access any more speech pathology services in his local area. Knowing that you are a speech pathology student, they ask you if you could see him once or twice a week, to provide some speech therapy. They offer you \$30 a week to do this. You could do this - he lives not far from you and you have completed your aphasia lectures and clinical placement.

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<sup>1</sup> The work of Dr Michelle Lincoln, School of Communication Sciences and Disorders, University of Sydney, in developing scenarios of this type for students' ethics education seminars is acknowledged.



2. You have answered an advertisement placed on your university students' noticeboard by the mother of a child with Down syndrome to become a paid, after-school carer for her child. Part of your responsibility will be to work through a speech pathology home program provided by her child's speech pathologist, who is based at the local community health centre.
3. You have accepted the position above and are spending about four hours per week working on the child's speech pathology home program, as part of your ten hours per week after-school care job. You would like to count these hours towards your clinical education program requirements at university. You decide to talk with your Clinical Coordinator.
4. You have been working for six months with this child on the home programs provided by the local speech pathologist, when she decides to leave that position. The family is advised that it will be several months before the position is filled. The child has been making good progress working with you, but needs a new home program. As you have only one semester to go before graduation, the child's mother asks you if you would mind providing some new ideas and activities for her child, to tide them over until the new speech pathologist arrives in town.
5. To support your program planning for a client you are working with on your current clinical placement, you videotape a client session and take it home to replay it and analyse certain communication behaviours. Your flatmates come home while you are playing it, and are fascinated by what you are doing with the client. They want to know more about the client and their problem, and what you are doing with them.

*Notes and Reflections*



## Case Study 6

### Role conflict

*The following case study highlights an increasingly common case of role conflict as more mature age students with prior professional qualifications undertake speech pathology degrees. We suggest you provide students with the case outline and the ethical decision making protocol, and allow them to work through it with their peers, generating their own solutions to the ethical dilemma posed. These could be discussed with staff, before resending them with the possible solutions presented in this package.*

Before you commenced your speech pathology degree you qualified as a child care worker. You are now a final year speech pathology student with some clinical placement experience in child speech and language assessment and treatment. To support yourself through university, you work in a child care setting one day per week, and in university holidays. As a carer you have a responsibility to monitor and develop the skills of the children in your care (fine/gross motor, speech/language, literacy, social and emotional). You signed a contract stating that you will provide activities and where necessary special attention to develop these skills in all children in your care. Five of the seven children assigned to your care have speech and/or language problems and one of these children is globally delayed. Most of these children also spend more time in care than they do with their parents.

Knowing that you are also a speech pathology student, the parents of the children expect you to do therapy with their children even though it has been explained to them that you can not, as you are not yet qualified. Such demands from these parents have recently increased as they have now all been referred to the speech pathologist at the local community health centre but are on an 8 - 12 month waiting list for assessment. In the meantime, according to regulations you are required to assist these children with their speech and language development. As a final year student you feel you could do a lot to help these children, but are unsure what your role should be. It is hard to know what is therapy and what is everyday language stimulation that any well informed carer could do. As a student member of Speech Pathology Australia, and as a result of classes on ethics, you understand the *Code of Ethics* and are anxious not to breach the Code. But you are worried about fulfilling your obligations and ethics as a carer to the best of your ability.

### Discussion of the case using Decision Making Protocol

#### 1. The facts

*What are the facts and how did you learn about them?*

- As a carer and a student speech pathologist, two codes of ethics to adhere to.
- Children who need speech and language stimulation which you can provide as a carer.
- Children who need speech and language therapy which you have the skills and knowledge to provide as a final year speech pathology student, but not the qualifications to provide. You know all these things from your educational programs and self-assessment.
- Parents expect you to do “therapy” during day care, as requested by parents.
- Long waiting list at local community health centre, as reported by parents.

*Who is involved?*

Children, parents, your manager, your university clinical coordinator.

*What are the client-related factors?*

- Children with language therapy needs.
- Children with a long wait for therapy at local community health centre.
- Age of the children (critical period for language development).
- Anxious parents pressuring for services.

*What are the external considerations?*

- Local community health centre has long wait for assessment for the children.
- Critical period for language input may pass before assessment can occur.



- Carer has dual sets of skills but not yet qualified as speech pathologist.
- Job description of the carer.

*Do you need any other facts or information?*

- What are the expectations of the manager of the care setting for the carer to respond to parent pressure?
- Nature and content of training as a carer regarding communication development.
- Carer/student's own expectations of self.
- Carer/student's ability to identify nature of dilemma in which she finds herself.
- Care settings policy on monitoring and provision of education and support to parents of children with special needs.
- Nature of children's communication problems.
- Would local community health centre speech pathologist come to care setting, assess children and leave programs for staff to implement, as alternative to long wait for centre-based assessment?
- Definition of "therapy" vs "stimulation".
- What is the role of the boss in dealing with such situations?

## 2. Is there a problem which requires action?

First Problem:

Yes, student is being pressured by parents to provide service beyond her level of qualification.

*What are the practical actions and alternatives and likely outcomes?*

- Student says no, defines roles to parents and only does routine language stimulation as taught in carer training program.
- Student bows to pressure and does "therapy".
- Student asks university staff to supervise her therapy at care setting ie, turns it into a placement.
- As a professional carer, she, or her manager, could lobby for increased speech pathology services in the area.
- Local community health centre speech pathologist comes to care setting, does assessment, leaves programs for staff to follow.
- Student says no and asks manager for new caseload of children without special needs.

Second Problem:

Yes, manager is not protecting staff (the carer) from undue pressure from families.

*What are the practical actions and alternatives and likely outcomes?*

- Manager delineates boundaries with families.
- Manager helps carer explore her role and its boundaries, supports carer to say no.

## 3. The problem

The problem is one of delineating boundaries between roles as carer and student, and achieving balance between the two codes of ethics which the student must adhere to: Speech Pathology Australia's Code and the child care workers' code. There is also tension in ensuring two ethical principles are followed: beneficence and non-maleficence. At some level, there is also a management problem occurring within the care setting, in that the student/carer is not being supported by her manager.

*Which ethical principles apply?*

As a student member of Speech Pathology Australia, she is obliged to uphold the principles of the profession to:

- **Beneficence:**  
Act with beneficence and benefit the children with her knowledge and skills.
- **Non-maleficence:**  
Avoid harm, which may well come from being on 8 - 12 month waiting list, when she has the skills to help significantly. If because of lack of knowledge and skills she offers "therapy" which is not appropriate then she breaches this principle.



- Fairness:  
Strive for fairness in terms of access for her clients to speech pathology services.
- Professional integrity:  
Maintain professional integrity. Act with fidelity, ensuring the parents understand the limitations of her skills as a speech pathologist.

*Which duties, obligations or rules are not being met?*

- She is required to fulfil her duties to clients:
  - to provide best possible care (which may not be yet within the scope of her expertise).
- To the families and community:
  - to provide accurate information and to advocate for clients.
  - to act within the limits of her professional competence. As a student she cannot claim professional competence to provide speech and language therapy independently.
- To the profession of speech pathology:
  - to work within her recognised level of competence.
  - to uphold the reputation of the profession.
- To her employer:
  - to practise only within the scope of her qualifications and legal requirements.

If she is working in Queensland which has registration of speech pathologists, she must not breach the legal requirements of the *Speech Pathologists Registration Act (2001)*.

*What is the conflict?*

There are several areas of conflict:

- Between ethical principles of beneficence and non-maleficence;
- Between parental demands, and ethics (especially non-maleficence and professional integrity) and perhaps legal requirements (eg, registration);
- Possibly between Speech Pathology Australia's *Code of Ethics* and the carers' code.

#### 4. Proposed decision and action plan

- Seek support from university clinical coordinator or other staff member about the role conflict and establishing boundaries and appropriate roles.
- Advise parents you will not be acting as a speech pathologist and providing therapy for their children. Avoid making diagnoses and planning speech and language therapy programs, but use enhanced knowledge and skills as a carer with subsequent education to provide high quality language enrichment and stimulation.
- Have your manager contact the speech pathologist at the local community health centre and advocate for early assessment and provision of speech and language therapy programs, so that you can implement these using a collaborative model of service delivery, as would normally be the case under best practice guidelines.
- Have your manager make clear to parents in writing the limits of your role as a carer, establishing professional boundaries, while outlining what can reasonably and ethically be provided in collaboration with the local speech pathologist.
- As a qualified carer advocate for increased speech pathology services in the area.
- Document contacts with parents, speech pathologist and local agencies re this matter.
- Maintain clear records of what you do to implement the speech and language therapy program in the care setting, as well as any self-generated language enrichment activities you implement.



## 5. Evaluation plan

Document your work in providing general language stimulation and in following speech pathology programs for the children. If steady progress is being made, keep on with current actions until children are seen for therapy at the local community health centre, then request revised plans for implementation in care setting. If no progress is being made, advise local speech pathologist at community health centre and request urgent assessments. Advise parents of actions and outcomes, and advise them to lobby for increased speech pathology services if indicated.

*Notes and Reflections*

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