

# Experienced Speech-Language Pathologists' Responses to Ethical Dilemmas: An Integrated Approach to Ethical Reasoning

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**Purpose:** To investigate the approaches of experienced speech-language pathologists (SLPs) to ethical reasoning and the processes they use to resolve ethical dilemmas.

**Method:** Ten experienced SLPs participated in in-depth interviews. A narrative approach was used to guide participants' descriptions of how they resolved ethical dilemmas. Individual narrative transcriptions were analyzed by using the participant's words to develop an ethical story that described and interpreted their responses to dilemmas. Key concepts from individual stories were then coded into group themes to reflect participants' reasoning processes.

**Results:** Five major themes reflected participants' approaches to ethical reasoning: (a) focusing on the well-being of the client, (b) fulfilling professional roles and responsibilities, (c) attending to

professional relationships, (d) managing resources, and (e) integrating personal and professional values. SLPs demonstrated a range of ethical reasoning processes: applying bioethical principles, casuistry, and narrative reasoning when managing ethical dilemmas in the workplace.

**Conclusions:** The results indicate that experienced SLPs adopted an integrated approach to ethical reasoning. They supported clients' rights to make health care choices. Bioethical principles, casuistry, and narrative reasoning provided useful frameworks for facilitating health professionals' application of codes of ethics to complex professional practice issues.

**Key Words:** ethics, ethical reasoning, speech-language pathologists, code of ethics

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Ethical reasoning is a reflective process that involves the exploration and analysis of moral issues and problems in daily life (Berglund, 2007). Ethics is concerned with right and wrong, and encompasses individual and societal values of how we should act and who we should strive to be (Horner Catt, 2000). In response to the challenges of defining and living a "good" life, various philosophers have devised normative ethical theories to guide human behavior. For example, teleological theorists propose that ethical decision making must evaluate actions as right or wrong according to the balance of their good and bad consequences (Beauchamp & Childress, 2001). An alternative approach, deontology, dictates that some human actions are right or wrong in any circumstances; humans have duties and obligations that must be fulfilled irrespective of consequences (Berglund, 2007). Liberalist theorists have focused on the legal, ethical, and political rights of individuals and the responsibilities of communities toward

the care and protection of their members (Beauchamp & Childress, 2001). In contrast to liberalism, communitarian theory considers the interests and needs of the community, rather than the individual, as paramount in ethical analysis (Berglund, 2007). Additionally, virtue theorists suggest that the character, traits, and values of the decision maker are important determiners of ethical practice (Campbell, 2003).

Bioethics or "life ethics" may refer broadly to ethics of environmental and evolutionary issues but is generally interpreted as the ethics of medicine and biomedical research (Johnstone, 2009). Bioethical theorists have addressed ethical dilemmas specific to the health care domain, including the duties and rights of health care providers and consumers and the formulation of just health policies. An influential bioethical approach uses four clusters of moral principles—respect for autonomy, nonmaleficence, beneficence, and justice—as a guide for resolving ethical dilemmas in health care (Beauchamp & Childress, 2009). Professional associations

have adopted these bioethical principles in their codes of ethics for the purposes of supporting members' professional practice. Such codes represent shared values of the profession and define and publicize fundamental principles and standards for practice, research, and education (Chabon & Ulrich, 2006). The principles invest health professionals with obligations to respect the decision making of autonomous persons, balance benefits against risks, and fairly distribute these benefits and risks amongst clients (Beauchamp, 2003).

Professional associations have addressed changes in the scope of professional practice by revising their codes of ethics so that they reflect contemporary dilemmas in clinical practice and research (American Speech-Language-Hearing Association, 2003; Royal College of Speech and Language Therapists, 2006). Hence, codes of ethics may exert a powerful influence in defining and facilitating ethical practice by clearly stating expectations and responsibilities for members' ethical conduct (Health Professions Council, 2007; Speech Pathology Australia, 2000). The introduction of professional sanctions for members who violate their code of ethics reinforces the importance of adhering to ethical principles when fulfilling professional duties and obligations toward colleagues, clients and the community (American Speech-Language-Hearing Association, 2003).

Bioethical principles may be perceived as universally valid norms for moral behavior across cultural, political, religious, and social groups (Gillon, 1994, 2003) and thus provide a framework for making ethical decisions with diverse clinical populations (Macklin, 2003). However, because codes of ethics are developed for application across diverse health care settings and caseloads rather than specific clinical scenarios, they may leave many "blanks" for health professionals attempting to resolve ethical conflict (Brody, 2002). Codes of ethics afford no ethical principle *prima facie* status. Hence, it is equally important for a professional to prevent harm, do good, respect client autonomy, and provide a fair and just service. As a result, health professionals confronted by decisions involving conflict between bioethical principles may experience difficulties resolving ethical dilemmas.

Health professionals may draw on a range of approaches to apply codes of ethics to ethical decision making in clinical practice. Principle-based reasoning places bioethical principles as central to an ethical dilemma. Consequently, hypothetico-deductive reasoning models have been developed to apply bioethical principles to professional scenarios (Brown & Lamont, 2002). Such models employ a "theory down" approach to guide health professionals to examine the facts, identify bioethical principles at stake, and consider potential options and outcomes in a logical, sequential manner. Decision-making models may be applied to clinical vignettes to help health professionals apply bioethical principles in professional scenarios (Self, Wolinsky, & Baldwin, 1989; Yarborough, Jones, Cyr, Phillips, & Stelzner, 2000). However, principle-based approaches may not reflect the complex reality of ethical decision making required to meet the needs of individual clients or specific health care contexts (Carson, 2001). Moreover, principle-based models may fail to address the contextual, psychosocial factors that

may influence health professionals' motivation to act on the "right" decision.

In a narrative approach, understanding the client's personal story is the central factor in ethical decision making. Narrative ethics draws on an interpretive worldview whereby clients perceive options, benefits, and harm within the context of their life stories. Health professionals use these life stories as a framework for ethical decision making (Edwards, Braunack-Mayer, & Jones, 2005). The effectiveness of the narrative approach relies on professionals' skills in attending to the voices of all the participants in an ethical conflict and interpreting individual life stories (Nicholas & Gillett, 1997). Herein lies the major strength and potential weakness of the narrative approach; life stories are individual, subjective, and constantly evolving (McCarthy, 2003). Narrative analysis constructs and interprets meaning from the rich fabric of human experience (Hunter, 1996). Indeed, narrative ethicists have attempted to overcome the challenges of teaching, learning, and practicing ethical skills by suggesting that a narrative approach may inform ethical practice when stories are shared between professionals. According to H. L. Nelson (2002), health professionals use narratives to define, express consensus, and eliminate conflict in professional values and thus create a shared story based on expectations of ethical behavior. Rather than relying on individual perceptions, skills, and experience, health professionals draw on the wisdom of their professional community and the context of their clients' stories to resolve ethical conflict. Hence, narrative ethics may facilitate application and critical review of codes of ethics.

Casuistry is an alternative approach to ethical reasoning whereby health professionals draw on their own experiences to develop responses to ethical dilemmas. Casuistry is a pragmatic approach to ethics that requires professionals to reflect on the values, facts, and cultural issues that influenced previous ethical decisions (Berglund, 2007). The professional then examines whether previous contexts and perceptions apply to an ethical problem by determining the extent to which a current case shares ethical concerns, contexts, and evidence with precedent cases (Jonsen, 1991). Critical analysis of the process and outcomes of previous decision making results in the professional retaining or rejecting a similar approach when ethical dilemmas reoccur in the workplace. With experience, a professional may establish a repertoire of cases as enduring and authoritative guides to ethical decision making (Beauchamp, 2003). Casuistry may support health professionals to draw on their experience to manage the challenges of bioethical approaches. However, one problematic outcome of casuistry may be a tendency for professionals to maintain ethical decision-making frameworks without adequate critical analysis (Nicholas & Gillett, 1997). A blanket approach to ethical reasoning does not address the individual needs and health care contexts of our clients. In response to such concerns, bioethicists have proposed a case-driven approach to resolving ethical dilemmas.

Described by Arras (1994, p. 389) as the "new casuistry," case-based approaches complement all moral theories by applying abstract principles within the context of individual cases. In contrast to top-down hypothetico-deductive approaches, case-based approaches place details of the case as

central to ethical reasoning. Jonsen, Siegler, and Winslade (2006) argued that every clinical case of ethical concern should be analyzed according to four topics: medical indications, patient preferences, quality of life, and contextual features. These topics function to organize facts of the case, draw attention to bioethical principles, and consider the individual goals and needs of each client. In clinical decision making, case-based approaches may be used to analyze diagnostic and prognostic evidence and to include important stakeholders—such as clients, families, and treating health care professionals—in management dialogues (McCormick-Gendzel & Jurchak, 2006; Purtilo, 2005). Hence, the adoption of case-based ethical reasoning is recommended in clinical areas of chronic and palliative care (McCormick-Gendzel & Jurchak, 2006; Sharp & Brady Wagner, 2007; Sharp & Genesen, 1996). Importantly, the case-based approach is based on the premise that an entire profession's moral knowledge develops incrementally in response to analysis of individual cases (Arras, 1994). It therefore follows that health professionals must develop competence in case analysis and share exemplary cases to facilitate ethical practice.

Many authors have contributed to our understanding of ethical issues in speech-language pathology and proposed guidelines for ethical decision making in professional practice (Brady Wagner, 2003; Chabon, Hale, & Wark, 2008; Costello Ingham, 2003; Helm-Estabrooks, 2003; Horner, 2003; Lubinski & Frattali, 2001; Pannbacker, Middleton, & Vekovius, 1996; Rao & Martin, 2004; Resnick, 1993). Such guidelines are based on the authors' extensive clinical practice and are not usually derived from the research process. Nevertheless, a recent study demonstrated that the ethical reasoning of new graduate speech-language pathologists (SLPs) involves a dynamic process of developing insight into ethical issues, independent reflection and problem solving, and seeking professional support (Kenny, Lincoln, & Balandin, 2007). However, experienced SLPs' strategies for managing ethical conflict and their integration of such alternative approaches as principle-based, casuistry, narrative, or case-based ethics have not been empirically investigated.

This study investigates the ethical reasoning skills demonstrated by experienced SLPs. The study answers the following questions: What are the approaches to ethical reasoning demonstrated by experienced SLPs in response to ethical dilemmas they identify in the workplace, and what principles and processes do they use to resolve these ethical dilemmas?

## Method

### Setting

Participants were employed within a large metropolitan Area Health Service in New South Wales, Australia. The Area Health Service provides acute, rehabilitation, community, primary, and specialist care to a population of over 1.3 million and encompasses over 6,000 km<sup>2</sup>. The health care setting covers inner-city (Sydney) and suburban local government areas. This health care community is one of the

fastest growing within the state, with projections of 20% growth by 2020. The most ethnically diverse community in Australia resides in this area; 39% of the population speaks a language other than English. Population demographics, including large numbers of new migrants, refugees, and families receiving welfare assistance, as well as significantly higher than state average levels of unemployment, place this community as one of the poorest in the state. However, there are significant variations between local government areas within this Area Health Service. Residential development in the outer suburban areas has resulted in an influx of young families and contributed to above-state-average birth rates in these communities. Significant numbers of elderly people are concentrated in the inner-city suburbs, and local hospitals report increased need for acute hospital bed days occupied by residents over 65 years of age (Health Services Planning, 2005). Hence, the Area Health Service is challenged to meet the needs of a diverse, socioeconomically disadvantaged population with projections for increased demand on pediatric and aged care services.

### Participants

A senior SLP, with area-wide management responsibilities, circulated information about our study to speech-language pathology departments within the Area Health Service. Experienced SLPs, with a minimum of 5 years' professional experience, were invited to participate in the study. Participant information stated that the purposes of the study were to identify the nature of ethical dilemmas experienced by SLPs and the strategies they used to resolve ethical issues. SLPs were asked to contact the first investigator to register interest in participation. Twelve SLPs sought further information about the study. One SLP was excluded because she did not meet the minimum experience criteria. Another SLP decided not to volunteer, citing concern about potential workplace repercussions from the study's findings. The remaining 10 experienced SLPs, from seven health care workplaces within the area, were included in the study.

Participants were women age 27–50 years with 5–20 years of professional experience. The participants reflected the nature of the speech-language pathology workforce in this setting, which was 98% female, with 75% below age 35 and only 2% older than 55 (Health Services Planning, 2005).

Seven of our participants (Alicia, Anne, Danielle, Eliza, Lisa, Megan, and Therese)<sup>1</sup> reported 5–10 years' experience in the professional workforce. This group had the youngest participants, with Megan the only member above 30 years of age. Two participants had accrued 10–15 years' employment experience (Gemma and Kelly). Rebecca was the most experienced clinician, having been employed in the profession for more than 20 years.

Four participants had been employed by the same organization from graduation until the time of this study (Alicia, Anne, Danielle, and Therese). The remaining participants reported diverse career paths, with experience in other metropolitan health services (Lisa, Kelly, and Megan),

<sup>1</sup>Pseudonyms are used to protect the identity of SLPs and their clients.

rural health services (Lisa, Gemma, Megan, and Rebecca), and international positions (Eliza, Gemma, and Lisa). Kelly and Gemma had previously undertaken consultancy roles beyond the scope of speech-language pathology practice. All participants described themselves as senior clinicians within their professional settings by nature of their experience, knowledge of the profession, and mentoring roles with less experienced staff members. Rebecca, Gemma, and Kelly were experienced managers responsible for developing workplace policies and procedures and staff management. Danielle and Anne were temporarily fulfilling the role of speech-language pathology managers and discussed the challenges of being new to management at the time of the study. Alicia's and Eliza's positions reflected their expertise in specialized areas of hospital speech-language pathology practice. They managed staff within the specialist areas of pediatrics, neurology, or surgical health care. For Alicia and Eliza, these positions presented an introduction to management roles. Three participants—Lisa, Therese, and Megan—did not identify with management roles. Lisa was developing new skills in the area of clinical education for speech-language pathology students at the time of the study. Therese described her professional strengths and passion for direct client care rather than administrative duties. Megan reported that she had reluctantly adopted administrative responsibilities following prolonged difficulties recruiting a manager at her workplace but did not intend to pursue a management career.

Participants were drawn from different health care contexts, including metropolitan (Alicia, Eliza, Gemma, Lisa, Megan, and Therese), outer suburbs (Anne and Kelly), and semirural locations (Danielle and Rebecca) in the Area Health Service. Their caseloads reflected community demographics. Anne, Gemma, and Therese worked with families in community health settings. Alicia, Eliza, Lisa, and Megan provided inpatient hospital services, and Danielle managed adult clients who required outpatient rehabilitation. Rebecca provided speech-language pathology intervention for a mixed community caseload, and Kelly provided specialist disability services.

### **Investigators**

The first author, responsible for data collection and analysis, is an experienced SLP, clinical educator, and member of the Speech Pathology Association of Australia. The author's professional experience is primarily in neurogenic communication, swallowing disorders, and teaching professional issues, including ethics, to undergraduate speech-language pathology students from the University of Sydney. The second and third authors are experienced SLPs. They were senior academic staff members from the Discipline of Speech Pathology, University of Sydney, at the time of this study.

### **Data Collection**

To explore the nature of each participant's ethical reasoning, the first author conducted and audio-taped an in-depth interview in the work setting. A narrative approach (Goodfellow, 1998) was used to elicit participants' descriptions

of how they resolved ethical dilemmas. The investigator asked participants to "tell the story" of ethical dilemmas they had experienced at work and used follow-up or probe questions to examine the thoughts, feelings, and motivations that influenced participants' ethical decision making (Rubin & Rubin, 2005). Narratives were based on case examples or stories of specific events where participants identified ethical conflict. Participants identified the nature of the ethical dilemma and then narrated the sequence of strategies, actions, and events that unfolded as they attempted to resolve it. Participants were encouraged to reflect on the outcomes of their ethical decisions. The interview concluded when participants indicated there were no further ethical dilemmas they wished to discuss.

### **Data Analysis**

Each interview was transcribed verbatim, and identifying information was removed. Pseudonyms were used to protect participants' anonymity. The first author commenced the process of transcription by reviewing a participant's field notes and listening to the audio-taped interview in its entirety. The interview was transcribed in 5-min intervals with revisions for meaning and clarity. Each completed interview transcript was compared with the audio-taped interview in its entirety and by 5-min interval review on a minimum of two separate occasions prior to individual and group analysis.

*Individual analysis.* The first author used the participants' own words to develop an ethical story that described and interpreted their response to ethical issues. Following the steps outlined by Goodfellow (1998), the investigator searched for important features in the transcripts. Key words and phrases were identified in participants' descriptions of how they managed ethical dilemmas, and these were elaborated by the investigator. For example, a key phrase identified in Eliza's approach to managing ethical dilemmas with clients was "giving them all the options." The investigator elaborated the key phrase by identifying the methods Eliza used to provide her clients with a range of treatment options such as "educating," "telling them why," and "showing them," and noted that Eliza focused on providing clients with opportunities for informed health care choices. Ethical stories were structured using an introduction describing the participant's professional experience; this was followed by a description of the ethical dilemmas and how ethical conflicts were resolved. Outcomes of ethical decision making were also noted. The conclusion included participants' reflections on ethical dilemmas in their professional practice. Transcripts and stories were shared with participants to determine the authenticity of the interviewer's interpretations of their experience (Chase, 2000). Two participants made minor changes to their stories that did not affect the analysis or interpretation.

*Group analysis.* Thematic analysis, using the process described by Braun and Clarke (2006), was used to compare results across the group of participants. This analysis included the following four steps: First, familiarization with data occurred during transcription, reading, and creating individual ethical stories. Second, the key words and concepts from individual stories were coded into themes. Third,

the themes were reviewed against individual transcripts to determine whether they captured the nature of the participants' ethical reasoning. Finally, themes from individual participants were collated to generate group themes. Mapping group themes resulted in the identification of five main themes that were present in the 10 participants' approaches to ethics in the workplace. The first and second authors reviewed group themes against individual stories to confirm that they represented participants' approaches toward a range of ethical dilemmas and to reach consensus over the strategies participants used to support ethical reasoning.

## Results

Comparison of participants' ethical stories revealed that although SLPs experienced a diverse range of ethical dilemmas, there were similarities in the ways that they managed ethical issues. The results and discussion of the thematic analysis of SLPs' ethical reasoning processes are presented concurrently to avoid repetition (Patton, 2005). Our findings present the approaches to ethical reasoning demonstrated by experienced SLPs in response to ethical dilemmas they identified in the workplace, and we discuss the principles and processes the participants used to resolve these ethical dilemmas.

There were five approaches to ethical reasoning that consistently featured in experienced SLPs' narratives:

1. Focusing on the well-being of the client
2. Fulfilling professional roles and responsibilities
3. Attending to professional relationships
4. Managing resources
5. Integrating personal and professional values

A sample of participants' voices and responses was selected to exemplify ethical reasoning approaches shared by all our participants.

### ***Approach 1: Focusing on the Well-Being of the Client—Considering the Broad Picture***

Experienced SLPs adopted a client-focused approach toward ethical dilemmas. Such an approach was characterized by sensitivity to clients' needs, perceiving the client as an equal partner in decision making, and focusing on potential client outcomes from ethical decisions. Furthermore, the client-focused approach was underpinned by SLPs' needs to obtain and interpret information on the range of factors significant to clients' health and well-being. All SLPs reported identifying critical factors in clients' background, presentation, or prognosis that needed to be addressed during ethical reasoning. Eliza, a clinician and manager in a large hospital department, considered clients' medical diagnosis and prognosis as critical factors in ethical decision making in dysphagia management: "On a medical line looking at the condition that they have presented with, their medical history, their prognosis for their outcome, are they gonna improve or are they gonna get worse or are they in that palliative phase?"

Analysis of clients' histories assisted our participants to identify and balance issues of benefit and harm. Gemma explained that "broad picture thinking" was required to evaluate such issues. In pediatric settings, a "broad picture" included an understanding of the immediate and long-term impact of communication disorders on clients' social, educational, and vocational opportunities. Quality of life was perceived as a determiner of well-being that was just as important as safety for many clients with complex medical problems. Danielle's experience providing domiciliary care for clients with motor neuron disease facilitated her understanding of how clients take health risks to participate in everyday activities: "It's important not to develop aspiration pneumonia and get sick and die from that, but at the same time he *is* dying, and what is important for him now can be such small things like 'I can smell someone having a cup of coffee. I just feel like a sip of coffee.'"

When there was conflict between clients' health care choices and professional recommendations, our participants emphasized quality of life as a key indicator of health care outcomes. The strategies used by experienced SLPs as part of a client-focused approach to ethical reasoning were consistent with a holistic approach toward reasoning where the importance of illness is interpreted within the contexts of people's lives.

### ***Approach 2: Fulfilling Professional Roles and Responsibilities—Thinking as an SLP***

The SLPs in this study focused on their duties and responsibilities as members of a health profession when managing ethical dilemmas. The professional responsibilities approach was based on participants' perceptions of what it means to be an SLP, their skills and confidence in fulfilling professional roles, and their willingness to negotiate changing workplace demands. All participants indicated that interpreting and fulfilling their professional roles and responsibilities were essential for resolving ethical dilemmas. Duties toward clients and carers were generally based on the rights of clients to participate in informed health care decisions. Alicia, Eliza, Danielle, and Megan referred to their roles as information providers and educators rather than enforcers of health care policies. In the words of Alicia, discussing "locus of control" as an issue when providing outpatient speech-language pathology services for clients who survived head and neck surgical procedures: "Well, they're really in charge, and all I'm doing is giving my professional opinion on what they should do, and really they'll do what they think is best."

The perception of the health care client as an autonomous decision maker shifted SLPs' duties from facilitating safety to facilitating informed choice and then advocating for that informed choice within the health care team. Seven of the eight SLPs who managed adult clients reported that client autonomy was an important feature of their ethical decision making. This result contrasted with Kelner and Bourgeault's (1993) findings that health professionals were resistant to entering into partnerships with clients when client autonomy was perceived as a challenge to their professional judgment. Our participants were concerned when client choices

resulted in significant health consequences. However, they readily engaged in collaborative client partnerships, providing their knowledge and insight to facilitate informed decision making by clients and carers.

Autonomy was a challenging principle to uphold when participants identified conflict between carers. Kelly, a senior professional working in a disability services team, adopted an independent, impartial role when conflict occurred around the management of her clients in community settings. Kelly recounted an ethical dilemma when carers of a teenage client with complex disabilities complained that staff members were not appropriately managing their son's feeding and communication issues. The carers requested their son receive oral intake in addition to gastrostomy feeds when he attended a social day center. Day center staff members reported that the client became distressed and demonstrated choking behaviors when he was offered oral foods. While Kelly attended to the concerns of both parties, she perceived her role as providing an independent, evidence-based professional recommendation: "I had the staff's concerns, and I had the carers' concerns, and I needed to focus on the client, use the medical history and my observational assessment to make an objective decision."

Alicia, Danielle, and Eliza discussed a similar response to managing conflict between carers. In such circumstances, our participants reported that their role was to search for the facts and use their diagnostic skills and knowledge of evidence-based practice to inform decision making.

Our participants working in pediatric settings sometimes experienced conflict between their duties toward the client versus the carer. However, in such dilemmas, experienced SLPs perceived the safety of the pediatric client as paramount. Anne, for example, discussed the need for SLPs to occasionally breach carers' privacy so that appropriate support services could be organized for children in her community: "I'm really aware of clients' rights and consent, and abide by it 100%, but in my experience, there have been only a few clinical cases where, for the benefit of the client, you have to take that extra step to help them." (Anne reported that her community experience facilitated identification of carers who were unable to respond appropriately to their children's health care needs.)

Anne justified the need to contact support services, without a carer's consent, when she perceived that a child would experience significant learning or social problems if she failed to take action. Therese and Gemma also reported the need to directly intervene in children's care in "special circumstances." Importantly, these SLPs perceived that their experience working with vulnerable families enabled them to recognize cases where they needed to strongly advocate on behalf of a child. Such cases typically included single-parent carers, isolated within the community, with preexisting health or psychosocial difficulties and children with complex and severe communication impairment. Anne discussed her reasons for contacting support services, without carer consent, for a 5-year-old client who failed to attend intervention:

Mum's lack of insight and awareness was a really major concern so that she wouldn't or couldn't see the need to

get support. Sometimes that happens with parents.

Thinking of a child who couldn't possibly cope at school, the implications of doing nothing for this little girl were kind of much worse.

Defining the scope of a health professional's duties requires attention to limits in professional responsibility. All participants reflected on boundaries in health care relationships. Generally, experienced SLPs were willing to work within existing boundaries governing health professionals' roles and responsibilities. However, three SLPs reported that professional boundaries sometimes prevented them from resolving ethical dilemmas that had an impact on clients' or colleagues' well-being. One of the SLPs, Rebecca, contrasted examples of clients and families experiencing the process of death and dying. In one case, a 65-year-old woman was admitted following a severe stroke. Her family requested no active intervention (including nutrition), and the client survived for some days poststroke, conscious but unable to communicate. Rebecca said, "The doctor removed the referral. He said, 'O.K., she's palliative. There's no active treatment. That's it. So don't see her'... which we all abided by but we all felt a bit uncomfortable about." Rebecca discussed the personal and professional challenges of "doing nothing," when she had the knowledge and skills to provide some comfort to this client, and her desire to confirm that the family's decision accurately reflected her client's choices about dying.

### ***Approach 3: Attending to Professional Relationships—Building, Maintaining, and Repairing Bridges***

The SLPs focused on managing health care relationships affected by ethical dilemmas. The professional relationship approach reflected their attentiveness toward relationships with carers, colleagues, employers, and the community. Eight SLPs argued that effective professional relationships were based on openness and trust. Our community SLPs noted that families' prior negative experiences with health and educational professionals were barriers to developing health care partnerships. Gemma, an experienced community health clinician and manager, discussed the importance of building a supportive therapeutic environment with carers before raising concerns about problems additional to their child's communication diagnosis. Management of mental health issues within the community was ethically fraught when the SLP was the only link between a vulnerable carer and health services. With one client, Gemma monitored his self-harming behaviors and disconnection from the school environment, and waited for the right moment to discuss the family's referral to mental health services:

What gave me allowance to really push it was mum saying to me once, "I don't know what's wrong with him. Why can't he do anything? Why does he act like he does?" And I latched onto it, and that gave me the motivation to say, "Yes, I can push this because she does see it." From that we opened up, and we could talk about the behaviors.

Experienced SLPs actively investigated clients' thoughts and feelings about health-related matters. They maintained professional relationships by addressing clients' beliefs and attitudes in a nonjudgmental, mutually respectful manner. Danielle discussed the importance of maintaining open communication when working with clients diagnosed with progressive neurological conditions. She argued that it was important to avoid rigid or punitive responses toward clients so that she could gain a clear picture of how they were functioning at home: "If you're very strict with the recommendations, especially with patients in the community, not so much in the hospital, it's like they lose. ... They don't wanna tell you the truth, ever."

By facilitating open communication with clients, our participants were able to identify and advocate for their health care needs. Danielle suggested that open communication provided opportunities for education and support, and such opportunities were lost when clients were discharged for noncompliance with treatment protocols.

Our results were consistent with Sorlie, Lindseth, Uden, and Norberg's (2000) findings that women valued a team approach toward ethical reasoning with complex clients. Our participants sought to incorporate team insights on ethical dilemmas and to develop team-based solutions. Eliza reflected on her increased participation in discussions of ethical practice as she gained skills, experience, and confidence in her work setting: "Having a rapport with the doctors and being able to be assertive enough to say, 'Well, this is my clinical judgment—this is what I think. I understand that is your decision, but this is my input.'" She perceived that her professional knowledge and skills were highly valued during her international locum positions, and she reported high levels of professional confidence.

Alicia explained that an effective professional relationship with nursing staff members enabled her to manage dilemmas resulting from conflicting recommendations for client care. She perceived that mutual respect between professionals challenged traditional medical models and facilitated quality care. She felt that intense, team-based intervention on the oncology and surgical wards facilitated a shared understanding of client care between SLPs and nurses:

I made the call "I think you should leave him nil by mouth. If the doctor wants to talk to me, he can ring me at home and I will talk to him." So almost to take it out of the hands of the nurses because they are in the ethical dilemma then. The doctors documented "Give thin fluids." They know that I've documented "He's aspirating saliva."

Experienced SLPs such as Alicia were generally willing to challenge professional relationships when client care was at stake. Courage and resilience were demonstrated by seven SLPs when client advocacy placed them in direct conflict with professional colleagues. Kelly reported several serious professional conflicts between underresourced service providers and her interdisciplinary disability team when she advocated for clients' rights to an education.

#### ***Approach 4: Managing Resources—Weighing Priorities and Balancing Needs***

SLPs recognized the role of economics in health care. The resource management approach incorporated SLPs' goals for providing an effective and efficient service while maintaining the quality of health care services. Furthermore, the theme was reflected in professionals coming to terms with resource limitations in their workplaces.

Our SLPs reported using two main strategies to manage caseloads within existing resources. The first strategy, described by four of the six community health SLPs, was to distribute services equally across their caseload. This strategy generally assigned each client a predetermined number of intervention sessions. The rationale our participants provided for this strategy was that services must be equally balanced because all clients have equal rights and needs. Therese explained this approach to carers who complained about waiting lists: "I understand that it's your child and you're only interested in your child, but as a therapist all the children are important to me, and all the children need it just as much, so I can't prioritize." (Therese's health service recorded 1–2-year waiting lists for assessment and intervention.)

The second strategy, widely used by SLPs from hospital and community settings, was weighing treatment priorities based on who would benefit most from intervention or who was most at risk from withholding health services. At Alicia's hospital, SLPs assigned all new referrals a priority rating to determine waiting time for assessment and intervention. Alicia was responsible for helping SLPs in her team identify client priorities and ensuring that clients from non-acute settings were not consistently relegated to the bottom of the priority list: "In an ideal world, I could provide all of my patients with what they needed and so could our speech pathologists in rehab, but the reality of the health care system is that we do need to prioritize our services."

Client safety was an important determiner of priority because of the medicolegal implications arising from limited services in hospital settings. Hence, clients with acute dysphagia were generally prioritized for intervention. The nature and severity of the client's disorder and evidence to support intervention with specific client groups formed additional rationales for setting priorities. For example, evidence-based practice supporting early intervention prioritized the preschool over the school-age population in some centers. Additionally, client motivation influenced priority decisions for two SLPs who argued that highly motivated clients were more likely to benefit from intervention than clients who were passive health care recipients. In one case, a young woman and her partner pleaded with Danielle for urgent speech-language pathology intervention: "They were so passionate about it and really pushing ... and so I thought 'Yeah, okay, you *really, really* want this. All right, I can put you in a little bit earlier.'" (Danielle reported that such high levels of motivation were not typical of her caseload.)

Our participants observed widening gaps between supply and demand for health care services in their workplaces. Four SLPs reported difficulties using effective strategies to provide an adequate quality and quantity of intervention for

their clients. When SLPs experienced difficulties meeting unrealistic workload demands, they reported becoming more self-focused. Lisa discussed the personal and professional frustration she experienced when her workload became a barrier to evidence-based intervention:

It really has just been a lot of assessments, and the occasional review, the occasional therapy. I think it's just a matter of being tired now, and I'm just sick of doing initial assessments. I just think to myself "Well, there's no way I'm doing more than two or three new assessments a day!"

Our participants expressed concern for the long-term implications of accepting longer waiting lists and reduced services by health professionals and the community. Megan was concerned by her observations that health professionals, overwhelmed by service demands, were beginning to accept a lower level of client care: "When a situation has continued over some time and you've tried a number of strategies to try and push the cause and change the situation ... I find I become less aggressive about it and more accepting of it."

There is some evidence that moral distress arising from resource constraints may be linked to burnout in the health professions (Kalvemark, Hoglund, Hansson, Westerholm, & Ametz, 2004). Our study also raises concerns for the well-being of allied health professionals who struggled to provide quality of care and retain job satisfaction in underresourced health settings.

### ***Approach 5: Integrating Personal and Professional Values—Piecing Together the Puzzle***

Cusick (2001) argued that as professionals take on roles and establish identities in the workplace, their worldviews will inevitably influence their practice. Our participants differentiated between personal and professional values when resolving ethical dilemmas. This process did not necessarily exclude personal beliefs from the reasoning process, but the experienced professional was conscious of examining these beliefs against professional duties and obligations. When dilemmas arose in the care of clients with severe progressive or end-stage illnesses, our participants were generally willing to provide families with the full range of treatment options even when they held strong personal beliefs about prolonging life.

The SLPs reported "working through" the personal and professional issues that emerged in ethical conflict. For example, SLPs from hospital settings reported that the dilemma of whether to provide enteral feeding was a recurring and manageable issue in client management. Megan observed that families perceived well-being from a "medical" or "alternative" perspective, and she attempted to provide consistency between their perspective and her intervention: "Seeing someone who's severely demented and inserting a PEG tube and basically keeping them alive despite no quality of life, my personal opinion on that is going to be very different from a lot of the people I work with."

Additionally, participants reflected that previous ethical mistakes based on personal values shaped their current

practice. Therese recalled a case in which her personal involvement in a carer's complex social problems negatively affected the management of domestic violence issues within the family:

I've experienced getting possibly a bit too close to clients. Yeah, at a personal level and offering them support that goes beyond my qualifications as a speech pathologist. I had an incident with one client, and I learnt the hard way.

It was not always easy for our participants to manage conflict between personal and professional attitudes and values. Lisa perceived that the medical team was performing gastrostomy procedures to expedite client discharge, and such an approach denied clients opportunities for intensive inpatient swallowing rehabilitation: "And I guess really what I've done, which is probably a bit nasty, I've always made sure that I've contacted them after the [modified barium swallow] to tell them the results. 'Oh. Just to let you know about this patient. He actually did end up commencing [an oral diet].'" (Lisa reported that she used the modified barium swallow results for personal and professional vindication.)

Our participants generally sought support when they experienced conflict between personal and professional issues or when ethical dilemmas were new or particularly challenging. Nine SLPs indicated that it was important to share ethical dilemmas with their colleagues. Alicia sought professional support so that options for managing ethical issues were not overlooked: "I call [a colleague] and say, 'Am I missing something here? I feel like there's a piece missing.'"

However, six of our SLPs had experienced difficulty accessing appropriate professional support when managing ethical dilemmas. Rebecca discussed the isolation experienced by rural clinicians who manage ethical issues during the care of frail, elderly members of the community:

It's always the issue of how far to push the intervention, how aggressive to be with the intervention, and because this is a country facility we don't have any registrars or residents. So often it's hard to talk to the doctors because they're coming and going at odd times.

Organizational structures provided administrative support but limited opportunities for SLPs to raise and discuss ethical concerns. Our findings suggest that experienced SLPs are still grappling with some of the complex ethical issues surrounding changing scopes of practice and the demands to provide more services with fewer resources. Clearly, even experienced SLPs benefit from the support of their colleagues when professional issues involve ethical conflict. Without such support, there was a tendency for our participants to turn inward toward personal morals as a gauge for professional ethical practice.

Experienced SLPs' narratives included examples of all five approaches to managing ethical dilemmas. When our participants identified an ethical dilemma in professional practice, they generally:

1. investigated clients' background, prognosis and perceptions of health;
2. explored clients' support networks, including family, community, and health care providers;

3. examined the duties and responsibilities of treating professionals;
4. critically evaluated the health care resources available;
5. sought advice from colleagues to manage the political, psychosocial, or professional requirements of the dilemma.

Hence, the five approaches may be perceived as an integrated and interdependent framework for ethical reasoning. Each approach provided a complementary lens through which experienced SLPs perceived ethical dilemmas. The following section addresses the ethical reasoning processes our SLPs used to resolve these dilemmas.

### ***Ethical Reasoning Principles and Processes Demonstrated by Experienced SLPs***

None of our SLPs reported using a particular ethical philosophy to help resolve ethical dilemmas. Nonetheless, clients' and communities' rights and responsibilities, professional duties and virtues, and perceived consequences of health care practices all featured in their stories.

*Principle-based approaches.* Experienced SLPs' approaches to ethical dilemmas were consistent with bioethical principle-based reasoning processes. Our participants referred to issues of benefit and harm when they considered clients' welfare, defined professional roles and responsibilities, and managed resource constraints. Ethical dilemmas required participants to consider benefit and harm in relation to clients' autonomy. For example, Alicia, Eliza, Megan, and Danielle specifically considered beneficence and nonmaleficence within the context of clients' diagnosis and prognosis when ethical issues emerged in dysphagia management. However, they interpreted the principles of beneficence and nonmaleficence as a responsibility to provide information necessary for clients to make informed health care decisions. Hence, an experienced SLP educated clients about the benefits and risks of intervention options so that they could accept or reject professional recommendations.

Gillon (2003, p. 267) argued that autonomy should be regarded as "first among equals" of the bioethical principles because respect for others' autonomy underpins moral concerns of benefit, harm, and justice. There was consensus among our participants that SLPs should facilitate, accept, and advocate for adult clients' health care choices. Danielle described this empathetic process as "walking in the shoes" of her clients. Such an approach marked a shift in focus from health professionals making decisions they perceived as meeting clients' best interests to supporting clients' decisions that reflected individual values and beliefs about health. By emphasizing client autonomy, our SLPs were able to resolve conflict that occurred in intervention planning and develop inclusive management plans that were responsive to clients' changing life circumstances.

However, participants perceived that there were some clinical scenarios where they could not support client autonomy. During situations of conflict between carers or when pediatric clients were at risk, SLPs' ethical reasoning focused less on autonomy and more toward the principle of nonmaleficence. Anne described this professional role as

"taking the extra step" to protect vulnerable clients. This finding suggested that experienced SLPs retain a gate-keeping role whereby they consider whether clients have the capacity to make autonomous health care decisions. When adult clients were deemed incompetent to make health care decisions, experienced SLPs turned to surrogate decision makers, particularly in resolving issues surrounding artificial hydration and nutrition. Generally, our SLPs accepted the decisions of surrogate decision makers. Megan, for example, observed that clients and their families usually shared a "medical" or "quality of life" perspective in managing chronic illness or palliative care; hence, family members provided judgment based on their knowledge of the client's values and lifestyle choices. Eliza highlighted the importance of family case conferences where surrogate decision makers were informed and educated about treatment options and supported to make decisions consistent with clients' best interests. However, Rebecca explained that when surrogate decision makers refused treatment for adult clients who were still quite young or when there was conflict between family members over management plans, ethical dilemmas of autonomy versus nonmaleficence were difficult to resolve. In such cases, experienced SLPs generally sought external support to protect clients' welfare.

Management of service delivery issues required SLPs to consider the principle of justice. Our participants considered justice from the perspectives of process and outcome of service delivery. They argued for fair distribution of resources across their community but remained vigilant to the needs of clients perceived as disadvantaged within their communities. Megan described this process as "juggling" the needs of individuals and the community against a backdrop of resource limitations.

Clearly the bioethical principles of autonomy, beneficence, nonmaleficence, and justice were relevant in managing ethical dilemmas experienced by SLPs. However, the complexity of the ethical dilemmas experienced by our participants provided challenges in resolving conflict between these principles. In such circumstances, experienced SLPs did not indicate that ethics literature, codes of ethics, published case studies, or hypothetico-deductive problem-solving models facilitated their ethical reasoning.

This finding may represent a weakness in experienced SLPs' application of bioethical principles. Increasing SLPs' familiarity with the values, standards, and obligations contained in their codes of ethics may have facilitated their ethical reasoning skills. Indeed, a professional code of ethics may serve as an important resource against which professionals may test options derived from personal morals, clinical experience, or strategies generated by families or colleagues. The preamble to the ASHA Code of Ethics states that "the preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists" (American Speech-Language-Hearing Association, 2003). Our SLPs were challenged by the needs of their complex clients and changing workplace demands. Competent speech-language pathology practice in such contexts requires an understanding of the principles and values contained in codes of ethics.

Our findings demonstrate that ethics is integral to SLPs' attending to clients' needs, defining professional roles, managing health care resources, and modeling professional values. SLPs' interpretation of the bioethical principles of autonomy, beneficence, and harm may significantly influence the nature of their professional relationships and client care. Their interpretation of the bioethical principle of justice may affect models of service delivery and priorities in a health care setting. SLPs' ethical arguments for supporting client autonomy or changing service delivery models may be enhanced by accessing discipline-specific decision-making models that draw on their code of ethics (Chabon & Morris, 2004). Such resources support transparency and consistency in health professionals' decision making.

*Casuistry.* Experienced SLPs identified recurring ethical issues in their work settings. For example, the dilemmas of whether to provide active intervention by enteral feeding for clients who were frail and aged were regular care issues for SLPs from hospital settings. Casuistry supported these SLPs to resolve conflicts between ethical principles. Megan discussed the importance of developing "frameworks" to resolve issues of quality of life versus safety for adults with dysphagia: "All those dilemmas that surround feeding issues I've had to think through at different stages. So I've got a framework to work within." (Megan's clinical experiences covered acute, neurology, rehabilitation, aged care, psycho-geriatric, and outpatient settings.)

Frameworks were drawn from previous clinical cases and provided alternative treatment options based on clients' diagnosis, prognosis, and social and cultural background. Alicia's, Eliza's, and Danielle's work in the community provided many case examples of adults who elected to continue eating or drinking "unsafe" consistencies. They accepted that clients may prioritize quality of life over safety and supported autonomous decision making by adult clients and their carers. Hence, casuistry supported the bioethical shift in SLPs' decision making toward client autonomy. A more flexible approach to clients' risk taking was based on SLPs' previous experiences in which clients reported that quality of life benefits exceeded health consequences. Generally, our participants drew on cases in which they perceived that the process and outcomes of ethical reasoning were positive. Therese adopted a different perspective and suggested that negative cases, for which she perceived that her approach had resulted in unintended consequences, remained enduring guides for her to avoid unethical practice.

A criticism of casuistry as an ethical reasoning approach is that health professionals may rely on pattern recognition to resolve ethical dilemmas rather than attend to the individual features of background, context, and values underpinning conflict (Nicholas & Gillett, 1997). While frameworks were important, our participants avoided a formulaic approach toward ethical reasoning. Eliza explained that it was important to adapt any approach or strategy according to the specific client context surrounding the ethical dilemma: "That's quite difficult for less experienced people because they want a formula. They want to say, 'Well if they do this, then we do this,' but it just can't work like that, especially with these ethical situations." Eliza was consulted when new graduates identified ethical dilemmas during client

management. She insisted on reading all the case notes and meeting and/or observing the client before providing recommendations.

Our findings indicate that experiential learning, including reflection, is a significant driver of ethical practice in speech pathology. Clearly, our SLPs developed their approaches to ethical dilemmas based on their learning in health care settings. However, Jaeger (2001) argued that health professionals must remain open to the possibility that clients may have different moral frameworks for considering health and quality of life. Hence, Jaeger recommended that rather than considering "how would I feel?" SLPs need to be open to new frameworks of thinking about ethical issues. A similar caution was expressed by Nicholas and Gillett (1997) when they identified a negative consequence of casuistic approaches as a tendency for professionals to maintain the privilege of ethical frameworks and assumptions without ongoing critical evaluation.

Our SLPs may have benefitted from further critique of their experiences and ethical frameworks. Self-evaluation and reflection may be enhanced by comparing one's approaches to resolving ethical dilemmas with the approaches adopted by experienced professional colleagues. Publications that explore ethical issues related to specific clinical populations—including clients with dysphagia and cognitive communication impairment—ethics, and medicolegal issues and service delivery were relevant to our SLPs' experiences (Brady Wagner, 2003; Horner, 2003; Landes, 1999; Rao & Martin, 2004; Sharp & Brady Wagner, 2007; Worrall, 2006). By testing their established approaches to managing ethical dilemmas against the approaches of experienced colleagues, SLPs may be challenged to rationalize and revise their ethical decision making in keeping with the profession's guidelines for ethical practice. SLPs' openness to revising decision-making frameworks is important when community expectations and professional roles change. Our SLPs needed to adapt their decision making in response to clients' choices rather than prescribe and control intervention options. They needed to adopt case-based understanding of ethical dilemmas. Findings confirmed that ethical reasoning requires a range of professional competencies including the knowledge to define and assess ethical issues, skills in processes of negotiation and conflict resolution, and interpersonal skills in attending and communicating effectively with others (Aulisio, Arnold, & Youngner, 2000). It is vital for SLPs to master these competencies in ethics assessment, reasoning processes, and interpersonal interactions so that they are equipped to manage complex issues of benefit, harm, autonomy, and justice in their professional workplaces. Such competencies may be acquired with professional experience and individual reflection. Access to continuing professional development, ethics consultation, and guidance from professional associations may also support SLPs in managing complex ethical issues.

*Narrative approaches.* Participants were asked to "tell the story" of what happened during their ethical dilemma, so it may be argued that they were guided toward narrative processes. However, these SLPs provided more than a story of a critical incident. Instead, they told their clients' stories and shared their own professional stories as they explained

their approach to ethical reasoning. This use of narrative is exemplified by Gemma, who was confronted by the dilemma of whether to discharge a client who had a poor attendance record and had demonstrated limited response to intervention. Gemma provided the “backward story” for her client who was from an indigenous background and whose father was incarcerated and whose mother had a depressive illness. H. L. Nelson (2002) argued that economic, cultural, class, gender, and religious factors are important in a narrative approach because of what they reveal about the identities of participants. Based on her clinical experience, Gemma predicted a negative “forward story” of disengagement from school and poor social and vocational outcomes if intervention were withdrawn. An alternative forward story may be crafted by Gemma collaborating with this family. Hence narratives provide a tool for exploring significant background contexts and potential outcomes of ethical decision making (Gemma’s example is presented in the Appendix).

The narrative focus on the individual context of a client is consistent with an emphasis on autonomy in health care decision making. By attending to a client’s story, SLPs may acquire insight into individual interpretations of health and well-being. An advantage of the narrative approach is that ethical choice is not viewed as a matter of logic or preference exercised at a moment but as a longer reasoning process intertwined with history, identity, culture, and life meaning (Hunter, 1996). Hence, the narrative approach is sensitive to changes in human experience and offers a means of interpreting ethical practice in different health care contexts. However, the narrative approach may only facilitate client autonomy when SLPs have developed the skills of attending to and interpreting clients’ stories. Previous studies have indicated that SLPs do not always listen and respond appropriately to clients’ needs, particularly when there is conflict between the SLP’s values and the client’s goals (Worrall, 2006). Clearly, SLPs must learn to hear and respond to individual stories so that vulnerable clients’ autonomy is upheld in the health care system.

There was evidence to suggest that SLPs adopted narrative approaches to share their experiences of ethics in the workplace. The story was an effective tool for debriefing when they identified ethical dilemmas in client care. As Alicia said,

There’re always terrible stories if you remember the person whose problem it is, but you know—a really good story. I love it! I’m all for it, for some, bizarre medical thing. I’m really quite interested in that sort of thing. So I tend to tell the story of what happened, “This is what we did” or, “You won’t believe!”

Furthermore, the SLPs perceived that sharing ethical stories could facilitate ethical practice and prevent unethical behavior. Therese suggested that other professionals could benefit from hearing one of her stories, a conflict of interest that evolved into a complex ethical dilemma:

I didn’t share it with the rest of my team, but perhaps in retrospect I should have because other people that haven’t had this situation need to see that if you do this, this is

what can happen. You know, don’t even go down that path! Don’t even start that!

Therese suggested that by “hiding” ethical dilemmas, other SLPs might fall victim to ethical traps.

Our SLPs included parts of their own stories as they discussed how their approaches to ethical reasoning changed with experience. Megan recalled that her focus, as a new graduate SLP, was ensuring clients’ safety during dysphagia management. Megan now interpreted her inexperience as a “scared perspective” not in keeping with her current focus on autonomy and quality of life. Previous research has indicated that graduates entering the speech-language pathology profession were very concerned with following rules and avoiding conflict and the potential for litigation when they managed ethical dilemmas (Kenny et al., 2007).

Ethical stories may provide reflective learning experiences for the storyteller and the professional community (Benner, 1991). Additionally, sharing ethical stories provides opportunities for health professionals to analyze and debate the application of codes of ethics to contemporary issues affecting the profession. This study indicated that health professionals need to share their stories of ethical dilemmas experienced at work. However, sharing stories, when not all of the characters are heroines and not all of the endings are happy, requires a professionally safe environment. A challenge for managers is to create such an environment where differences in staff members’ attitudes and values may be raised and discussed during professional communication interactions. Many SLPs may share Alicia’s enjoyment of “a good story,” and the nature of ethical conflict may be of interest to professional and nonprofessional audiences. A safe environment must ensure that stories cannot harm clients or colleagues by breaching confidentiality or disseminating hearsay. SLPs must carefully consider the professional context for sharing ethical dilemmas so that their storytelling does not violate others’ ethical and legal rights.

Our findings suggest that experienced SLPs accessed informal support networks to share ethical stories. While they perceived that sharing ethical stories could facilitate ethical outcomes, our participants did not seek counsel from work-based committees or through their professional association. By seeking another level of ethical support, SLPs may gain the opportunity to learn from the stories of health professionals with expertise in ethics. Sharing ethical stories with work-based ethics committees may address some of the interdisciplinary and context-based aspects of SLPs’ ethical dilemmas. Professional associations provide a forum for SLPs to critically reflect on their approaches to resolving ethical dilemmas by discussing ethical conflict within a confidential environment removed from workplace cultures. Such support networks may help SLPs to develop a shared narrative of ethical practice and responses to ethical conflict in contemporary health care practice.

## Conclusion

This study explored the ethical reasoning processes of 10 experienced SLPs employed in a metropolitan health service. Findings suggest that narrative is an important tool that

supports SLPs to reflect on their approach to ethical dilemmas, to understand how thinking about ethical issues may evolve, and to identify the support they require to manage ethical conflict in the workplace.

The results of this study have implications for facilitating the development of ethical reasoning skills in new graduates and for supporting experienced professionals who are managing ethical dilemmas. It cannot be assumed that a professional's ethical reasoning skills will develop concurrently as he or she acquires skills and experience in professional practice. Unless ethical issues are explicitly raised and discussed in appropriate professional forums, individuals may not be challenged to reexamine their personal moral frameworks against their professional codes of ethics. Individuals may develop a narrow understanding of bioethical principles based on their beliefs and experiences. Our study indicated that SLPs' knowledge of bioethical principles was important for resolving ethical dilemmas in diverse health care settings. Knowledge of broad ethical philosophy, including teleological, deontological, liberalist, communitarian, and virtue theories, may increase SLPs' insight into the nature of workplace ethical dilemmas. Liberalist ethical philosophy is singularly relevant to the trend toward increasing client autonomy in health care decision making. Furthermore, such ethical reasoning approaches as casuistry and narrative ethics may support SLPs to develop and apply ethical decision-making frameworks in their professional practice by identifying patterns and individual contexts in ethical dilemmas.

Ultimately, competent professional practice relies on an understanding of the standards and conduct of the professional community (Chabon & Ulrich, 2006). Hence, ethical practice must be perceived as an essential ingredient for planning, delivering, and evaluating effective speech-language pathology services rather than as "icing on the cake." SLPs may contribute to ethical practice by maintaining a working knowledge of their code of ethics, critically evaluating their frameworks for ethical reasoning, and seeking evidence and expert advice to support decision making.

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## Appendix

### Should We Discharge Cody?

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Gemma is asked to resolve the dilemma of whether to discharge Cody, who has severe communication impairment but a poor attendance record. Cody's "backward story" suggests that he is not a good candidate for speech-language pathology intervention:

The clinician really wanted to discharge him from the service, saying "Look, he just doesn't turn up. He's really bad and school are worried, but he doesn't turn up, and I get no gains with him because it's so erratic that I see him. He's got poor attention. He's got behavior issues."

However, Gemma says that there are features of the client's story that indicate his need for support services:

He is now 6 years old, and he is severely unintelligible. Unfortunately, for a range of reasons he's been in and out of our service. This child's history is that he has a mother with a mental illness. He has a father that goes in and out of jail.

When considering the nature of the advice she should provide, Gemma considers the negative "forward story" that may result from Cody's discharge from speech-language pathology services:

Learned helplessness kicks in very heavily at 7 years old. You see it in Year 2 kids.<sup>a</sup> "I can't do it! I can't learn anymore!" We need to get in some positives before he gets to that point. Year 3, we've got a lost cause; school is just too big. He'll start truanting.

Gemma questions whether speech-language pathology intervention may offer Cody's family opportunities to change his forward story: "We have to make allowance for that child because he is one of those kids that will definitely have long-term impact, and we could disrupt that—we could change that outcome if we give him treatment." She perceives that the current issue of poor attendance is a symptom of a family in crisis rather than a family who rejects health care services: "Where there's other long-term language kids, I don't think I would make that decision, and I would say, 'Well they're choosing not to come, don't come!' but this child was different."

Gemma includes part of her own story as she discusses the role of experience in recognizing priorities in caseload management:

New grads are not good at making that prioritization decision of "this is the one to let go, and this is not the one to let go. This is the one you change the service delivery for, and this one you don't." And I think that's time and experience and prognostics and just knowing what happens with families.

Furthermore, retaining empathy for clients is an important feature of Gemma's professional decision making:

I definitely see people harden when they've been having to face waiting lists for a long time; having to manage failures and families not attending. I work very hard at not hardening 'cause I think there are always masses of reasons why people fail to attend, and I think we can help manage a lot of those situations, but they often have to be individually dealt with, which is hard, and time-consuming.

Gemma decides to resolve the dilemma by preventing harm toward Cody and his family:

Ethically I felt we were bound to this child. We never adapted our service to him, yet we know he is one of the severest of the severe, and we know that he's got very long-term implications with his impairment if we don't manage him.

Changes to the model of service delivery may facilitate a successful intervention outcome for Cody and his treating clinician:

We decided that we'd say to mum, "We'll give you a short burst of 3 weeks of twice a week." So we wanted to see if we saw him more often, do we get some gains? Can mum commit to a short period, not a long period of time?

The short-term outcomes of Gemma's decision were positive:

The clinician's feeding back to me about how he's going and they've made a change! For the first time in 6 years, the kid's learning new consonants [laugh], and they've only had three sessions. And they've attended every single one!

Clearly, there would be ongoing challenges in managing this client's needs. Nonetheless, Gemma expressed confidence in achieving long-term changes with Cody's family:

We've actually started to grapple with the issues a lot more, and we've got a better connection with mum. We'll know mum better, and we'll be able to work better with mum, and he's getting a connection with us, and he'll make some change.

Hence, Cody's story provides a positive example of how dilemmas may be resolved by looking backward and forward to gain insight into an ethical issue.

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<sup>a</sup>Children enrolled in New South Wales public schools typically complete kindergarten followed by Year 1 and Year 2.