Clinical and Professional Ethics in the Management of Motor Speech Disorders

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ABSTRACT

The field of biomedical ethics is increasingly discussed in speech-language pathology graduate school curricula as well as in continuing education forums. The application of the principles of medical ethics can be extremely helpful to the difficult decisions sometimes facing speech-language pathologists with respect to doing good for their patients while respecting both patients' autonomy and federal and state law. Professions have increasing attempted to codify professional issues relating to moral issues through codes of ethics and codes of conduct. This article focuses on applying selected principles of medical ethics and professional codes of conduct to the practice of speech pathology specific to motor speech disorders. Case examples are provided to illustrate ethical decision making through consideration of the American Speech-Language-Hearing Association (ASHA) Code of Ethics as well as a number of principles of medical ethics.

KEYWORDS: Motor speech disorders, biomedical ethics, professional ethics, professional conduct

Learning Outcomes: As a result of this activity, the participant will be able to (1) describe and discuss basic principles of medical ethics, (2) describe and discuss professional morality versus community morality and how that translates into the development of professional codes of conduct, and (3) describe and discuss the application of rules of conduct as well as principles of medical ethics to specific ethical dilemmas in the management of motor speech disorders.

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Theories and principles of biomedical ethics are increasingly being taught in medical schools and other allied health professional graduate programs as part of a rapid expansion of the field of biomedical ethics that has occurred in recent years. Speech-language pathologists are increasingly discussing issues related to clinical and professional ethics[1] because these issues are applicable to our clinical practice and to our clinician-patient relationships. The purpose of this article is to briefly introduce the concepts of professional and clinical ethics, and discuss the application of ethical principles as well as rules of conduct to the practice of medical speech-language pathology, focusing on those issues most relevant to the clinical management of motor speech disorders. Although there are numerous principles of medical ethics discussed in the literature, this article focuses on just a few that are frequently applicable to the management of adults and children who exhibit motor speech disorders. Several case examples of ethical dilemmas and problems related to the patient-professional relationship are presented. Discussion then focuses on applying rules of conduct and ethical principles toward the resolution of these problems. Although the scope of this article does not allow an exhaustive discussion, the purpose is to generate thought and dialogue about this important part of our clinical practice.

PROFESSIONAL ETHICS AND MORALITY

Those practicing medicine and medical speech-language pathology frequently face difficult ethical and moral dilemmas, and therefore, difficult ethical and moral decisions. Beauchamp and Childress[2] differentiate ethics and morality. Beauchamp and Childress use the term *morality* to refer to standards of right and wrong that are widely accepted and form a social consensus (e.g., it is wrong to lie, steal, or cause harm to others). They further describe "common morality" as encompassing all persons, versus "community-specific morality" in which moral standards come from specific cultures, religions, or institutions. They use the word *ethics* to refer to "ways of understanding and examining the moral life" (p. 1).[2] Ethical theories and principles are starting points that guide us in developing norms of conduct. This article pertains to another subset of morality—professional morality.

Professionals usually have specialized training and, as a group, may be committed to providing services to clients or patients who are the consumers. Professions typically maintain organizations that specify necessary credentials and qualifications for entry into the field and certify that the individuals, recognized as part of that profession, have the knowledge and skill to provide the service expected by the consumer. In the healthcare field, including speech-language pathology, carefully supervised training ensures the necessary background of knowledge and practice in clinical skill. Healthcare professions typically go beyond certification of basic knowledge and skill, and specify obligations that relate to the patient-professional relationship.

As a means of specifying these obligations, professional morality identifies general standards of conduct that are important to a particular profession, but may not be applicable to others. Professions, usually through their professional organizations, have increasingly attempted to codify professional issues relating to moral issues through codes of ethics and codes of conduct. A *code of ethics* may be published by professional organizations to ensure that members of that organization are committed to principled reasoning when faced with ethical decisions regarding the management of patients. Beauchamp and Walters[3] note that codes of ethics have recognized professional obligations for a long time. More recently, such codes have given more systematic thought to the moral and legal rights of patients. Examples of professional codes of ethics are the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association[4] and the American Medical Association Code of Ethics.[5] The Code of Ethics of the American Speech and Hearing Association provides for the "preservation of the highest standards of integrity and ethical principles," which is "vital to the responsible discharge of obligations by speech-language

pathologists, audiologists, and speech, language, and hearing scientists."[6] The Code of Ethics of the American Speech-Language-Hearing Association (ASHA) clearly delineates a set of guidelines that are meant to protect and ensure quality clinical service to the patient and hold the clinician to a set of principled standards of conduct. The preamble to the ASHA Code of Ethics states that the fundamentals of ethical conduct are described by both Principles of Ethics and by Rules of Ethics. These principles and rules relate to speech-language pathologists' responsibilities to the individuals they serve as well as to the public in general. They also relate to the conduct of research. It is beyond the scope of this article to discuss all aspects of the ASHA Code of Ethics that may be applicable to speech pathologists in the management of motor speech disorders. However, to exemplify how professional ethics play a role in guiding ethical and moral decision making, selected Rules of Ethics from the ASHA code will be highlighted in the case presentations. Table 1 lists selected examples of these Principles and Rules of Ethics.

Some of these standards are quite clear (e.g., "individuals shall not misrepresent their credentials," or "individuals shall not charge for services not rendered"). However, there are numerous controversial issues facing the practicing clinician for which the standard of conduct is not as clearly defined. For example, clinicians may find that working to "do good" for the patient may in fact jeopardize that patient's autonomy. Maintaining confidentiality about the patient's health status and health care is paramount, yet sometimes comes into conflict with state law. Telling the truth and keeping the patient's trust may seem unambiguous, but situations arise where veracity is not so simple. With shrinking financial resources, clinicians increasingly have to face ethical decisions regarding fair distribution of services. Individuals from a number of varied professions have emphasized the importance of professional codes of ethics, while recognizing their limitations in terms of solving complex ethical problems that may arise in clinical practice.[7–9] Although ethical codes can establish and clearly delineate particular values of a profession, and describe basic rules of practice, they may fall short in terms of helping the clinician in difficult, dynamic ethical problem solving.

In addition to a profession's code of ethics and/or code of conduct, the clinician may also turn to the field of biomedical ethics for guidance in ethical and moral decision making. Philosophical and theoretical foundations discussed in the biomedical ethics literature provide tools for deliberating many ethical problems that arise in clinical practice.

PRINCIPLES OF MEDICAL ETHICS

The literature of medical ethics relies heavily on the use of ethical principles as a guide to moral decision making. Several commonly discussed principles include the following: autonomy, beneficence, nonmaleficence, and justice. There are also a number of principles important to the patient-professional relationship, including veracity, confidentiality, and fidelity. Horner[10] provides additional discussion of these issues. These principles are described here briefly because they relate directly to the case examples presented below that illustrate how speech-language pathologists apply these issues in clinical decision making when working with patients who have motor speech disorders.

Autonomy

The biomedical ethics literature refers to autonomy as the right of the individual to self-determination. It is the right of the individual to determine his or her own course of action, including making decisions concerning his or her own medical care. Autonomous individuals are free of control or influence by either people or institutions. Some individuals have diminished autonomy because of personal limitations, such as cognitive deficits or dementia, or may simply be developmentally immature, as in early childhood. In these examples, the person's abil-

Table 1 Examples of Principles and Rules of Ethics from the ASHA Code of Ethics

Principle of Ethics I	Principle of Ethics II	Principle of Ethics III	Principle of Ethics IV
Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally	**Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence**	**Individuals shall honor their responsibility to the public by promoting public understanding of the professions by supporting the development of services to fulfill the needs of the public**	**Individuals shall uphold the dignity and autonomy of the professions, and accept the professions' self-imposed standards**
1. Individuals shall not reveal, without authorization, any professional or personal information about identified persons served professionally 2. Individuals shall use every resource, including referral, to ensure that high quality service is provided 3. Individuals shall provide all services competently 4. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered	1. Individuals shall engage in the provision of clinical services only when they hold the appropriate CCC or are in the process of certification and are supervised 2. Individuals shall engage in only those aspects of the professions that are within the scope of their competence 3. Individuals shall continue their professional development throughout their careers	1. Individuals shall not misrepresent their credentials, competence, education, training, experience, or research contributions 2. Individuals shall not participate in professional activities that constitute a conflict of interest	1. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source 2. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics

ASHA, American Speech-Language-Hearing Association.

ity to make personal decisions is compromised. Historically, there was a paternalistic attitude in medicine in which physicians and allied medical healthcare providers often made decisions for patients. In recent years, however, clinicians (e.g., physicians or speech pathologists) have shifted away from this paternalistic attitude and moved toward respecting the autonomy of patients to make decisions for themselves. In fact, for the last three decades, respect for patients' autonomy has increasingly taken precedence over paternalism.

Beneficence

Beneficence refers to "doing good for the patient" and includes those actions that will result in benefiting another. In medical practice, therefore, the principle of beneficence refers to facilitating the health and well-being of the patient. It includes being kind and merciful as well as taking steps to prevent or remove harm. When writing about the principle of beneficence, Beauchamp and Childress[11] note that beneficence goes beyond being good and kind. They stress that healthcare providers are obligated to balance the potential good against potential harm that might result from any action or decision. This is important because one may not be able to perform actions that are beneficial, or that prevent harm, without also creating some risk. Therefore, the speech pathologist must always balance the potential good versus potential harm when making clinical decisions.

Nonmaleficence

Nonmaleficence refers to the idea of "noninfliction of harm" on others. Although the principle of beneficence includes acts to prevent harm, nonmaleficence goes further in that it makes salient our obligation *not* to injure others. Although the principles of beneficence and nonmaleficence are not easily separable, they are considered distinct because the obligation not to harm someone is distinct from, and usually more stringent than, the responsibility to benefit others. Further, nonmaleficence involves the avoidance of both intentional harm and the risk of harm. The line between these is not always clear. As shown in the case examples that follow, the principles of beneficence and nonmaleficence often come into conflict with the principle of autonomy.

Justice

A number of different theories of justice are described in the literature that attempt to clarify diverse notions of justice. In particular, these theories have been used to determine how healthcare services should be distributed. In general, the formulation of a single unifying theory of justice has been elusive.[12] Some theories (egalitarian) emphasize equal access to health care. Other theories (libertarian) stress fair procedures rather than equal or "fair" outcomes. A third category of theories (utilitarian) emphasizes a variety of different criteria to maximize the public good. In this view, there are trade-offs in balancing private and public benefit.

In the current healthcare environment, important questions are raised concerning the right to equal access to health care as well as the right to a particular standard of care. Clinicians are often faced with decisions relating to establishing priorities when allocating health care. These questions all involve the principle of justice and answers to any particular problem will necessarily depend on the theoretical perspective taken.

In the field of biomedical ethics, the discussion of justice often focuses on the distribution of services, including the amount of treatment provided to individuals, given limited resources. Although speech-language pathologists are not usually in the front lines of establishing systems of healthcare delivery, they do struggle with problems related to patients' access to both assessment and treatment. Frequently, speech-language pathologists are faced with decisions regarding how much treatment is appropriate, the maximal treatment one can recommend given the financial resources available, and who will receive treatment and who will not, in light of limited resources. In the area of motor speech disorders, many people are seen in medical set-

tings where there are increasingly shorter stays in rehabilitation units and fewer authorized visits for outpatient treatment. One also should consider speech-language pathologists in the public schools who are treating children with motor speech disorders. Because of the necessity to incorporate the principles of motor learning in remediation of these motor speech disorders, clinicians know that it is important to schedule frequent sessions. In fact, the principle of beneficence would suggest that the therapist see the child on an individual basis every day. Given a large caseload, however, that would mean denying or curtailing service to other children. The theories regarding the principle of justice may then be invoked to facilitate speech-language pathologists' decisions in these matters.

THE RELATIONSHIP BETWEEEN PATIENTS AND HEALTHCARE PROFESSIONALS

A number of principles are pertinent to the relationship between the patient and the speech-language pathologist. These include the principles of veracity, confidentiality, and fidelity. These three principles overlap both in practice and in principle. Furthermore, as happens with autonomy, these principles together sometimes come in conflict with beneficence and obedience to the law, and are often discussed as "obligations" of the healthcare professional to the patient.

The principle of veracity relates to "telling the truth." Beauchamp and Childress[11] offer arguments for the obligation of veracity. They suggest that veracity is obligatory because of the respect that is due to others. They also note that the necessity to tell the truth comes from the obligation of fidelity, which relates to keeping promises. When speech-language pathologists are in a caregiving relationship with the patient, they promise to be truthful and not to deceive. Finally, Beauchamp and Childress note that the obligation for veracity stems from the necessary relationship of trust between a healthcare provider (in this case, the speech pathologist) and the patient. The patient expects the speech-language pathologist to be honest, and the speech-language pathologist expects the patient, in turn, to be truthful and open about his or her concerns, attitudes, and information regarding his or her health. Finally, the patient has an expectation that information about his or her own health care will remain confidential.

This principle of confidentiality has been considered of grave importance historically, and is certainly considered extremely important in today's health care environment. This principle implies that the healthcare professional may not reveal the confidence entrusted to him or her in the course of medical attention. Confidentiality is often very difficult to implement in clinical practice because of the number of people who have access to a patient's chart. Those speech-language pathologists who work with motor speech disorders in medical centers often have a great deal of information about a patient's medical history and health status. The principle of confidentiality obligates us not to disclose any information to which we have access. This also is essential to preserving fidelity.

The principle of fidelity relates to the speech-language pathologist's obligation of keeping promises or agreements with a patient. These promises relate to a number of principles of medical ethics, including being beneficent, not doing harm, telling the truth, and maintaining confidentiality.

CASE EXAMPLES IN MOTOR SPEECH DISORDERS

The principles of clinical and professional ethics are important to our clinical decision making when we work with patients who have motor speech disorders. The principles often overlap in practice and are not always separable. In the case examples that follow, the challenges of ethical practice will be explored in relation to both professional codes of conduct and basic principles of medical ethics.

Acute Care Practice

Differential diagnosis of motor speech disorders frequently occurs in the acute medical setting. The principles of confidentially and fidelity are especially applicable in acute care hospital wards. Because speech-language pathologists have ac-

cess to the entire medical chart, they may gain knowledge of a great deal of the patient's medical and social history. There is usually no directive as to what information is confidential and what is not. As a result, speech-language pathologists must adhere to the principle of confidentiality by not disclosing any information that they may have accessed from the patient's chart, or throughout interaction with patients' families at bedside. Furthermore, it is important to maintain confidentiality about speech-language assessment findings. The ASHA Code of Ethics addresses this directly under Principle of Ethics I (Table 1). Although the principle of confidentiality is generally considered to be of great importance, and is therefore discussed in many codes, maintaining confidentiality may be difficult and requires conscious attention. The following example illustrates this point.

Case 1. While taking the elevator to another floor, a speech-language pathologist and a physical therapy colleague were discussing a new referral on the acute ward. This patient was currently undergoing tests for differential diagnosis of the neurologic problem and had been evaluated by both therapists. Although there were other people in the elevator, the following discussion occurred.

SLP: Have you seen the gentleman in M 204?

PT: Yes, he's really in bad shape.

SLP: He has a mixed dysarthria suggestive of a Parkinson's plus syndrome. The prognosis is probably not very good.

Although the therapists were not intending to breach confidentiality and were careful not to use names, having said the room number in front of others in the elevator is certainly problematic. It is possible the patient's family could have been in the elevator, and might not have spoken with the physician. It is more often the casual rather than deliberate communication that results in a breach of confidentiality and therefore a threat to fidelity.

Patient autonomy may also come into play in the acute care setting. The following example illustrates how respect for patient autonomy often comes into conflict with the principle of beneficence and our desire to "do good" for the patient.

Case 2. A 62-year-old male is referred for evaluation and differential diagnosis of his significant dysarthria. He has a history of metastatic cancer, has had both chemotherapy and radiation, and is hospitalized for another recurrence. When the speech pathologist entered the room and introduced himself, the patient said: "I don't want an evaluation. I don't want to have speech therapy. I've sounded like this for awhile, and I don't want any help." Upon observing the patient, the therapist felt strongly that much could be gained from some treatment targeting both intelligibility and comprehensibility (understandability in context) and tried to explain that to the patient. The patient was not receptive to any explanation and continued to refuse. The therapist went to his supervisor and asked how to handle the situation. A discussion of respect for autonomy versus beneficence for the patient ensued. After a lengthy discussion, the therapist decided to adhere to the principle of autonomy by not scheduling the patient for daily therapy. To adhere to the principle of beneficence, however, he got permission from the patient to meet with the family. He then discussed a number of issues related to comprehensibility that they could implement which would improve the patient's overall ability to communicate.

Degenerative Disease

Speech-language pathologists who work with motor speech disorders frequently assess and treat patients with dysarthria caused by degenerative disease. A number of difficult issues often arise when working with patients who have no hope of improving physiologic function, and who may be facing cognitive decline, impending death, or both. Individuals with degenerative disease may come to the speech pathologist shortly after being given the diagnosis. They may have a number of questions that have not been answered. These range from "Will my speech get worse?" to "Will I die from this disease?" The principle of veracity may come into play in these situations. The obligation of fidelity includes a promise to "be truthful." It is difficult,

yet important to answer these questions as honestly as is possible, without being vague or misleading. It is possible to be beneficent, however, by also illustrating how we can help the patient manage all of the increasing difficulties of communicating as he or she lives with the disease. Consider the following example.

Case 3. A 48-year-old woman had been experiencing slurred speech and increasing difficulty with swallowing for about 7 months. Her primary care physician referred her for a speech pathology examination. During the history, the speech pathologist learned the patient had also noticed more difficulty walking up stairs and that her upper extremity strength seemed slightly diminished. She had occasional cramping in her legs. The speech evaluation indicated a mixed spastic-flaccid dysarthria. The speech pathologist also noticed significant lingual fasciculations as well as fasciculations on her arm. The patient had not yet been referred to a neurologist and had been told by her physician that she "might have MS [multiple sclerosis]." The patient was very concerned that this may be the case, and asked the speech pathologist if that was indeed what she had. Although the speech pathologist was quite sure the woman had amyotrophic lateral sclerosis (ALS), he believed it was important to have a neurologist see her to make the medical diagnosis. At the same time, the principle of veracity requires that he "tell the truth." The therapist handled this situation by explaining to the patient that her speech problem did indicate a neurologic problem, but not one typically characteristic of MS. He then encouraged her to talk to her physician about a referral to a neurologist for more testing. The patient went on to ask if her speech would get worse. He explained that because her speech problem had been progressively getting worse, it was possible that the progression would continue. He then took time to explain that there was a great deal that could be done to help her communicate, even if her dysarthria worsened.

Veracity is part of living up to our obligation of fidelity. Another aspect of fidelity is that of loyalty. All clinicians have worked with individuals who may try our patience. Lack of compliance, a disagreeable attitude, or even personality conflicts may lead to difficult decisions regarding being beneficent and maintaining fidelity. Situations may also arise in which necessity to preserve fidelity (e.g., by telling the truth and maintaining confidentiality) sometimes can come in conflict with one's duty to obey the laws of an individual state or country. Consider the following example.

Case 4. A 68-year-old woman with Parkinson's disease came in for evaluation of her dysarthria. The speech pathologist noticed significant bruising on her arms, and one particularly bad bruise on her left cheek. The therapist asked if she was experiencing falls. The patient said, "Yes, I am falling often." Later in the examination, the patient began to cry and explained that her paid caregiver was becoming increasingly impatient because of the patient's increasing physical limitations, and was hurting her. She begged the clinician not to tell anyone, because she relied on this caregiver for all of her needs. The therapist knew it was her legal responsibility to report this. However, she believed that if she did, she would be violating the principle of fidelity to the patient, as well as confidentiality. In an effort to respect the individual's autonomy, maintain fidelity, and yet be beneficent, the therapist arranged to have the patient return for follow-up the next day. She then made sure she understood the laws of the state regarding abuse of the elderly. She also talked to the medical social worker (without disclosing the identity of the patient) about possible solutions to the problem of losing a caregiver. When the patient came back, she explained her legal obligation to report the abuse. She also let her know that other options for caregivers were available and that with the patient's permission, she would arrange for her to see the social worker. The patient was fearful, but also somewhat relieved, and agreed to see the social worker.

Cognitive changes may be associated with a number of neurologic diseases resulting in motor speech disorders. In these situations, the

principle of patient autonomy may be difficult to apply. For example, patients with Huntington's disease, advanced Parkinson's disease, and a number of the neurodegenerative diseases have associated cognitive changes that result in diminished autonomy. That is, the dementia or cognitive impairment compromises the person's ability to make personal decisions regarding his or her health care.[13] It may be difficult to determine when the patient reaches the point where diminished capacity necessarily reduces or eliminates personal autonomy. The speech pathologist may be asked to provide an opinion regarding diminished cognitive capacity. That can cause conflict for the therapist who wants to respect autonomy and preserve patient fidelity and trust, but must also be beneficent in terms of the patient's well-being. Although there is no answer to this conflict, the process of clinical ethics can lead the clinician to principled decisions.

Augmentative Communication

Individuals with severe motor speech disorders may benefit from augmentative communication. Although assistive technology and augmentative devices may make communication possible or more efficient, patients sometimes refuse. This kind of situation brings many principles of ethics into play as well as issues related to the patient-healthcare professional relationship, especially autonomy versus beneficence and fidelity. Consider the following example, which also emphasizes the principle of veracity:

> *Case 5.* A 42-year-old female suffered an embolic ischemic cerebrovascular accident (CVA) during surgery. She had therapy in the acute care setting and for a few months as an outpatient. Six years later, she was still exhibiting an inability to communicate verbally. A friend of her father's then had a stroke and worked with a speech pathologist in a neighboring town for his aphasia. He regained a great deal of language functioning. She decided to seek help from this same speech pathologist, believing she would be able to talk again also. The speech pathologist's evaluation indicated almost normal auditory comprehension, good cognitive skills, very mild deficits in reading, difficulty writing (because of her right upper extremity paresis and spelling deficits), and severe apraxia of speech. Given the severity of the apraxia and the long time since onset, the speech pathologist believed prognosis for functional verbal communication to be very poor, and recommended a high-technology augmentative system to help make communication more efficient. The patient refused because the system "would draw attention to my disability."

The therapist was faced with a situation that put beneficence in conflict with the patient's autonomy. She believed it was in the patient's best interest to use the augmentative system. At the same time, she recognized that the patient had good cognitive skills, was educated, self-sufficient in activities of daily living, and well informed about the options open to her. Given these facts, the therapist realized that it was the patient's right to decide not to invest time, money, and effort to use a system that would not be acceptable to her. Another dilemma, however, presented itself.

> *Case 5, continued.* After much discussion, the therapist let the patient know that although she believed the augmentative system would be in the patient's best interest, she also accepted the patient's decision not to use one. The patient then wanted to schedule therapy sessions to improve verbal production. The motor speech examination had shown that the patient had difficulty imitating even consonant-vowel syllable shapes, even with tactile cueing and slow rate. It was unlikely that she would make much progress both because of the severity of her disability and time since onset. The patient wanted desperately to pursue therapy. The therapist worried that if she told the patient about the prognosis, the patient would feel abandoned. Yet, the therapist realized her obligations to the principle of veracity and knew she had to be truthful and not give the patient unrealistic expectations. She began her discussion with the patient

by assuring her that she would do everything she could to work with her to help her communicate, and that the decision to refuse the augmentative system would in no way jeopardize that. The therapist then carefully explained to the patient that the services she wished would in all likelihood not result in functional verbal communication. She took the time to explain why and answered all of the patient's questions.

The example cited above also relates to a basic rule of ethics from Principle of Ethics I in the ASHA Code of Ethics (Table 1). The code of conduct states that speech pathologists "shall fully inform the persons they serve of the nature and possible effects of services rendered." When "fully informing" the patient involves telling him or her that therapy may not help them, the patient can feel as if the therapist has "given up" on them. In these difficult situations, the therapist may want to talk with the patient about fidelity, which involves not only loyalty to the patient, but includes being beneficent and telling the truth.

Motor Speech Disorders in Children

Many of the ethical dilemmas in the management of children with motor speech disorders revolve around the issues of autonomy and beneficence. At times, the attitudes or wishes of the parents may come into conflict with what the speech pathologist may think is best for the child.

Another issue that may arise relates to justice in the delivery of service. Consider the following example:

Case 6. An 8-year-old girl was being discharged from the rehabilitation center to home 6 weeks after traumatic brain injury (TBI) as a result of a motor vehicle accident. She had mild cognitive deficits, a mild aphasia, and a moderate apraxia of speech. She had made significant gains during her rehabilitation stay, and prognosis for continued improvement was excellent. The speech pathologist had made detailed recommendations to the school speech-language pathologist for continued speech and language therapy. Her recommendation included the statement that the child needed daily treatment on an individual basis to continue her current rate of progress. The school speech-language pathologist serves two elementary schools and one junior high school. She has a caseload of 65 children. She sees most children only once or twice a week, and usually in a group. In this case, the caseload demands and the current method of service delivery are in conflict with the optimal treatment needs of this child. A decision to treat the child 4 or 5 days a week may curtail treatment to others. A decision not to treat frequently may have an impact on the rate and overall degree of improvement, especially in motor speech performance. The principles of beneficence and theories of justice may help the therapist with this ethical problem. The principle of beneficence states that the therapist must "do good" for the child. Yet if one accepts a libertarian approach to service delivery, the therapist would have to provide equal access to treatment to all children on her caseload. Conversely, if she makes decisions from a utilitarian perspective, the time she spends with each child would depend on a number of individualized factors, including severity, prognosis, and potential final outcome. The school speech-language pathologist decided to solve the problem by devising a home practice program for several children with minor residual articulation errors, reducing their sessions to from twice to once a week. This allowed her to see the child with apraxia three times per week.

CONCLUSION

Our ASHA Code of Ethics, as well as the basic principles of medical ethics, can help speech-language pathologists make difficult decisions regarding management of patients with motor speech disorders. Practicing "clinical ethics" involves using a structured approach to identify, analyze, and resolve ethical issues.[12] It is important to remember that solving moral dilemmas is a process involving gathering and understanding all the facts of the case, identifying which principles of ethics and which rules from one's professional code of conduct may play a

role, and being aware of barriers to ethical decision making.[1] Frequently, there are no right or wrong answers. Just as they gather experience in clinical management of patients, therapists gather experience and gain skill in resolving ethical dilemmas. Just as knowledge from textbooks and the research literature combines with our clinical experience to make us better clinicians, knowledge of the principles of medical ethics and one's professional code of conduct combine to make us better at making ethical decisions in clinical practice.

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