Applying ethical reasoning approaches to complex cases in professional practice

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Abstract

Background: This study explored speech pathologists' experiences with dysphagia management—an ethically complex area of professional practice. It aimed to describe speech pathologists' responses to ethical dilemmas and to interpret their responses using four different approaches to ethical reasoning.

Research approach: Four cases were drawn from a multisite qualitative study of ethics in the speech pathology profession. Cases were based upon findings from individual interviews with experienced speech pathologists. Participants' narratives were analysed by mapping responses against features of bioethical principles, casuistry, narrative and ethics of care approaches.

Findings: Speech pathologists' ethical reasoning stories demonstrate how experienced professionals may apply elements of principle-based, casuistry, ethics of care and narrative approaches to resolve ethical conflict.

Conclusions: Contributions of each approach are discussed with examples of how theoretical approaches may guide healthcare professionals and students to manage ethically troubling scenarios.

Keywords: ethics, professional ethics, clinical speech–language pathology, deglutition disorders.

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Background

Healthcare educators must deliver ethics courses that focus upon improving the quality of patient care, facilitating understanding of ethical issues and providing strategies that enable graduates to resolve dilemmas and manage ethical distress (Elkin, 2004). Two issues of concern are selecting an ethical reasoning approach to guide students' decision-making and matching it to appropriate learning and teaching resources. When healthcare professionals manage ethical dilemmas, there may be no absolute right or wrong solutions. Whilst codes of ethics provide a foundation for ethical decision-making, each ethical dilemma includes unique features and requires sensitive consideration of relevant information, needs and consequences.

Selecting ethical reasoning approaches

Principle-based approaches that apply the bioethical principles of autonomy, beneficence, non-maleficence and justice underpin professional "codes of ethics" in international healthcare contexts (ASHA, 2010; Beauchamp & Childress, 2009). While bioethical principles are widely adopted in professional preparation programs, alternative approaches to ethical reasoning may be ignored in ethics curricula (Branch, 2000). Recent studies demonstrate that experienced health professionals adopt an integrated approach to ethical reasoning that goes beyond analysis of principles (Kenny, Lincoln, & Balandin, 2010; Kenny, Lincoln, Blyth, & Balandin, 2009). Casuistry, ethics of care and narrative approaches inform ethical reasoning in professional practice.

Casuistry guides health professionals to develop hypotheses inductively from precedent cases (Jonsen, 1991; Jonsen, Siegler, & Winslade, 2010). Accordingly, principles of adult learning, including learning from experience and reflective practice, underpin casuistry (Boud, Keogh, & Walker, 1985). Critical reflection then influences future responses to ethical conflict. Professional associations have also provided best practice guidelines and position papers to provide evidence to support quality care (SPA, 2002/2012). Furthermore, experts in the field may present worked case examples to model ethical reasoning for novice health professionals (Sharp & Brady Wagner, 2007).

Ethics of care focuses upon clients' relationships with family, community and the healthcare team. This approach encompasses themes of human relationships, sensitivity towards discriminatory practices, empowerment and social justice (Gilligan, 1982; Noddings, 2013). Effective healthcare is based upon the identification of individual care needs interwoven with the responsibilities of health professionals to work collaboratively to provide quality care (Clark, Cott, & Drinka, 2007; Furnari, 2004).

According to a narrative approach, healthcare clients consider choices, benefits and potential harm within the context of their life stories (Hunter Montgomery, 1996; Nelson, 2002). Hence, effective narrative reasoning is based upon interpretation of image, syntax and metaphor in spoken and written illness stories (Hudson Jones, 2002).

Table 1 draws upon the work of aforementioned bioethicists Beauchamp and Childress, Jonsen et al., and Gilligan, Noddings, Hunter Montgomery and Nelson to identify some key features of principle-based, casuistry, ethics of care and narrative reasoning approaches.

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Table 1
Comparing Four Ethical Reasoning Approaches

Approach*	Principles	Casuistry	Care	Narrative
Focus	Bioethical principles	Case	Relationships	Life story
Voice	Professional	Professional	Caregivers	Client
Tools	Code of ethics	Precedent cases	Interpersonal skills	Client's narrative
Professional role	Apply principles	Search for evidence	Identify care needs	Elicit narrative
Reasoning	Hypothetico-deductive	Inductive	Relational	Interpretive
3 Core Features	• Apply principles at stake • Access information • Evaluate options	• Rich case description • Draw upon previous cases • Compare cases	• Consult with carers • Address barriers to care • Advocate	• Attend to client's story • Analyse messages • Express story
Decision	Logic	Experience	Environment	Individual

* Principle-based, casuistry, ethics of care and narrative ethics require healthcare professionals to draw upon different knowledge bases and reasoning skills.

The four approaches contribute important perspectives for ethics analysis. Bioethical principles may be applied across healthcare contexts and provide a language and framework that supports students to engage in ethical reasoning rather than use their personal beliefs and emotions to resolve professional conflict (Angel & Simpson, 2007). Ethics courses based upon current ethical concerns of a profession may prepare graduates to address real ethical problems and diverse ethical viewpoints within a supported learning environment (Bowden, 2010). While each approach is highly relevant for healthcare ethics, Vergés (2010) posited that the best critical, ethical decision-making requires an application of theory to specific contexts. Introducing health profession students to diverse approaches may facilitate critical thinking during ethically challenging scenarios and equip graduates to manage new ethical challenges in changing healthcare environments. One way to introduce students to different ethical reasoning approaches is through empirically-grounded case studies.

Selecting learning and teaching resources

Perceived disconnection between ethical theory and "real life" professional experiences remains a key challenge for educators (Cowley, 2005; Kirklin, 2007; West & Chur-Hansen, 2004). Cases that are unduly controversial, oversimplified or address etiquette rather than ethics may undermine students' learning outcomes (Coope, 1996). Consequently, students may dismiss ethics as "common sense" or "irrelevant" rather than integral to professional practice.

The current study describes four cases drawn from speech pathologists' experiences with dysphagia management. For some adults, swallowing difficulties (dysphagia) impact upon eating and drinking. In such cases, speech pathologists may recommend modified diets and strategies to facilitate safe swallowing (Crary & Groher, 2008).

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Speech pathologists may also recommend non-oral or enteral feeding when clients have severely impaired swallowing function (Sharp & Geneson, 1996). Speech pathologists must carefully examine their professional role when they perceive conflict between upholding clients' rights to make informed choices and their duties to provide safe, quality care. The potentially life-and-death nature of decision-making makes dysphagia management an ethically challenging area of speech pathology practice (Body & McAllister, 2009).

The cases presented here incorporate "real life" ethical conflict that health professional graduates may typically experience in hospital settings. Furthermore, the underlying ethical issues at stake have interdisciplinary application.

The aims of the study were to:

- describe speech pathologists' responses to ethical dilemmas in professional practice
- interpret complex practice dilemmas using four different approaches to ethical reasoning
- evaluate contributions of ethical reasoning approaches to "real-life" dilemmas in healthcare settings
- discuss learning and teaching applications of research findings.

Research approach

Participants' cases were drawn from a multisite qualitative study of ethics in the speech pathology profession conducted in Sydney, NSW. Twenty speech pathologists were included in the original study. Ethics approval for this research was obtained from the participating health service and university human research ethics committees. Participants volunteered to take part in the study and had no direct line management or professional relationships with the investigator. From this cohort, speech pathologists with more than five years professional experience contributed ethics cases to the current study.

Cases were obtained from individual interviews with participants in their work settings. Participants described ethical dilemmas and the investigator used follow up or probe questions to examine factors that influenced their ethical reasoning (DiCicco-Bloom & Crabtree, 2006). Interviews were transcribed verbatim and identifying information was excluded before participants and clients were assigned pseudonyms. In keeping with a narrative approach (Goodfellow, 1998), participants' own words were used to develop an ethical story that described and interpreted their response to ethical dilemmas. Transcripts and stories were shared with participants to support the process of narrative interpretation (Creswell, 2013).

Cases were selected based upon the following criteria: the participant discussed an adult client with reported decision-making capacity and presented a "true" dilemma involving conflict rather than a clear breach of professional ethics or single appropriate course of action. Four participants discussed cases that fulfilled these requirements. Alicia, Danielle, Eliza and Rebecca's stories were analysed for features consistent with bioethical principles, casuistry, ethics of care and narrative ethical reasoning approaches.

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Development of ethical case studies

Four experienced, practising speech pathologists' narratives were reviewed for examples consistent with principle-based, casuistry, ethics of care and narrative approaches towards ethical reasoning. Key features were identified from bioethics literature and used as a framework to analyse the case studies. Table 2 shows how these four approaches were applied during clinical decision-making. Case 1 (Alicia's case) was considered from a principle-based perspective because decision-making centred upon three of the bioethical principles addressed by Beauchamp and Childress (2009), namely beneficence, non-maleficence and autonomy. Case 2 (Danielle's case) was linked to Jonsen, Siegler and Winslade's (2010) work with an emphasis upon critical comparisons between a current and previous cases. An ethics of care framework was applied to Case 3 (Eliza's case)

Table 2
Application of Four Ethical Reasoning Approaches in Clinical Decision-making

Approach*	Principles (Case 1)	Casuistry (Case 2)	Care (Case 3)	Narrative (Case 4)
Focus	Focus upon principles during ethical reasoning, interpreting beneficence/non-maleficence and autonomy according client's health goals	Focus upon details of the case, including diagnosis, prognosis, clinical presentation and intervention history	Focus upon relationships between client, carers and interdisciplinary team	Focus upon individual client story and values
Planning	Prioritise bioethical principles in response to client's changing healthcare needs	Draw from professional experience, evidence and expert colleagues	Collaborate with care network to develop functional plan	Consider perspectives of client, family and interdisciplinary team to align future plan with values
Roles	Identify professional roles and responsibilities to uphold each principle	Identify professional duties to provide care consistent with best practice	Define roles and responsibilities for team members providing quality care	Attend to client's story, including important past events, current concerns and future needs
Actions	Develop reasonable strategies and solutions based upon available information and principles at stake	Make an informed decision based upon predicted consequences of actions	Address conflict between client's goals and concerns of carers and healthcare providers	Ensure client's voice is not lost during decision-making
Outcomes	Evaluate healthcare outcomes by examining benefits, risks and consequences	Evaluate outcomes according to fulfilment of professional responsibilities and best practice guidelines	Evaluate outcomes by monitoring acceptance and impacts for clients and their carers	Evaluate outcomes by reflecting upon achievement of client-centred goals

* Each clinical case illustrates how a bioethical approach may facilitate healthcare professionals' ethical reasoning.

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to focus upon the nature of caring relationships and the importance of care networks (Gilligan, 1982; Nodding, 1984), and a narrative framework was applied to Case 4 (Rebecca's case) to illustrate how narrative understandings (Hunter Montgomery, 1996; Nelson, 2002) can support health professionals to manage client choices that may conflict with their own personal or professional values.

While it is beyond the scope of this paper to provide a comprehensive critique of the four bioethical approaches, examples from each case have been selected to indicate how each ethical reasoning approach may be applied in "real-life" healthcare contexts. Participants' words, presented in italicised format, are interwoven with descriptions of their experiences.

Discussion of case studies

Alicia's case (1): Principle-based approach

Alicia was an experienced speech pathologist employed within a large teaching hospital. She reported specialist skills in the management of clients from acute care, intensive care and head and neck surgical wards. Alicia's work place responsibilities included planning and coordinating the provision of speech pathology services to adult clients and supervising and mentoring less experienced colleagues.

Alicia presented the story of Barry, a man aged 40 years with laryngeal cancer. Alicia focused upon the bioethical principles of beneficence, non-maleficence and autonomy as she managed this client. Alicia described her professional role as supporting Barry to make *reasonable decisions* as his swallowing function deteriorated. Table 2 summarises her approach.

During the early stages of Barry's management, Alicia described her role as a *straight forward speech pathology intervention.* Alicia recommended dietary modifications, including thickening Barry's fluids, to facilitate his swallowing safety. Barry was highly motivated to maintain his health and avoid hospital admission so there was no conflict between the bioethical principles of beneficence, non-maleficence and autonomy during this stage of intervention. However, ethical issues occurred when Barry's health deteriorated and he was admitted to hospital.

Alicia's professional role aligned with the healthcare team's goal of optimising Barry's surgical outcomes. In keeping with Barry's medical goals, Alicia advocated for speech pathology intervention strategies that reduced his risks of aspiration pneumonia. *When he was planned for theatre, it was a matter of preserving the chest, preparing him for theatre [and] preparing him for the post-operative condition of having a total laryngectomy.* Consequently, Barry was placed on nil by mouth and received enteral nutrition. Alicia's story indicated a shift towards medical interpretations of benefit and harm, and decision-making by his surgical team. *It's also been quite complex in terms of managing him … and … giving him I guess control but at some points very little.* In response, Alicia sought opportunities to reduce the negative impacts of intervention. For example, she requested the ENT prescribe a more comfortable form of feeding tube for Barry. *Oh he's really uncomfortable with that* (size of tube). *He needs to stay nil by mouth. Can we exchange it*

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for a fine bore? This example demonstrated Alicia's active role within the healthcare team and her concern for reducing the negative impacts of nasogastric feeding.

Barry's management changed again when diagnostic testing contraindicated his planned surgery. As Barry's intervention transitioned to palliative care, Alicia's approach adapted to support his return to the community. A revised medical prognosis reassigned decision-making to Barry and supported options for maintaining his quality of life. Alicia acknowledged that Barry valued the opportunities to resume his former social activities, *and on discharge,* [he] *will be at the bowling club and will be drinking with his dad*. Barry's choices raised potentially negative medical consequences. *Well, this man's going to get admitted. He knows that. It's his choice.* Alicia attributed her acceptance of clients' decisions as a change in *locus of control*. While Alicia did not entirely concur with Barry's decision, she accepted his right to choose between medical health and quality of life.

Alicia's narrative demonstrates how ethical principles may guide decision-making when professional intervention spans the course of a client's illness. Importantly, Alicia's interpretation of ethical principles is based upon the dynamic healthcare context. When Barry has a positive medical prognosis, Alicia's intervention is consistent with minimising health risks and achieving beneficial surgical outcomes. However, when Barry's prognosis deteriorates, his quality of life becomes an essential outcome. At each stage of Barry's intervention, Alicia reflects upon her responsibilities to uphold ethical principles and define her role as a member of an interdisciplinary healthcare team. Figure 1 presents reflective questions drawn from this case.

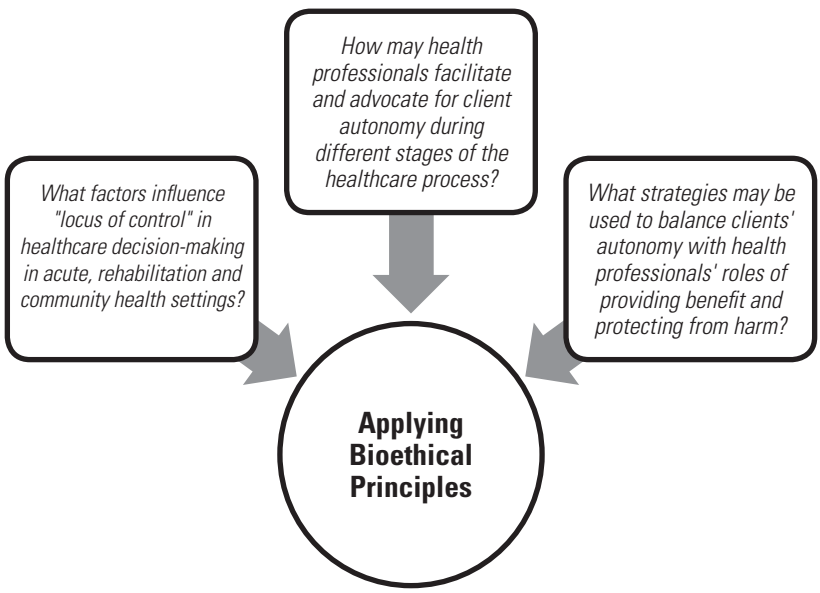

Figure 1. Learning and teaching questions for principles-based approach.
Case 1 raises issues regarding the complex interaction between benefit, harm and autonomy in healthcare settings.

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Danielle's case (2): Casuistry approach

Danielle was employed as an acting manager of a speech pathology team within a general suburban hospital. She reported professional experience in aged care, community work with adults and acute healthcare settings. Danielle identified professional expertise in working with adults with progressive, neurological conditions.

Danielle' case, Max, aged 40 years, was diagnosed with motor neurone disease (MND). Danielle recommended enteral (PEG) feeding to supplement Max's nutrition and hydration because mealtimes were becoming increasingly effortful for him. Max agreed to supplementary enteral feeding as a strategy to enable him to enjoy meals without pressure to consume prescribed quantities of calories and fluids. However, unexpectedly, Max developed aspiration pneumonia during the week prior to his surgery for insertion of a gastrostomy feeding tube (PEG). *The ethical dilemma came when he actually had the PEG procedure done and the medical team there decided . . . he had to be nil by mouth.* The hospital medical team overruled Danielle's recommendations for continued oral feeding in response to Max's medical prognosis and his recent chest infection. Danielle's story focused upon the interaction between professional and client as they responded to these discharge recommendations.

Max's diagnosis of *end stage* progressive neurological disease was an important medical consideration. Danielle obtained further information during a community visit following Max's discharge from hospital. *I wanted to do a swallowing assessment myself just to see how he was going.* Following clinical assessment, Max disclosed that he was unwilling to comply with hospital recommendations. *He said, "Oh, I'll have a cup of tea or coffee."* Danielle's assessment demonstrated that Max's swallowing functioning had definitely *deteriorated*, but he managed sips of fluids without *obvious aspiration* or becoming *overly uncomfortable.* Danielle considered the implications of Max continuing to take small amounts of oral liquids, balancing health risks with wellbeing. *In the whole scheme of things, even if it was one cup a day, I still don't think it would've been that bad.*

Danielle's professional relationship with Max also influenced her decision-making. *I'd been seeing him for two years, and I probably knew him better than any of that* [hospital] *team.* Danielle explained that ethical dilemmas of safety versus quality of life reoccur in palliative care settings. *I've worked with people with motor neurone disease and one of the ethical dilemmas that's come up is when they're nearing what we might class as "end stage of the disease" and it's recommended that they shouldn't have any oral intake because they're at risk of aspiration and making that recommendation when maybe the patient feels that they still want to eat for quality of life reasons.*

Consequently, her management approach evolved from *very strict* recommendations to *letting the patient make the decision* in response to clients who opted to continue eating for psychosocial reasons. Danielle acknowledged that many clients self-managed their diets without negative clinical outcomes; *it hasn't always been to their detriment.* Danielle's emphasis upon developing *realistic* healthcare recommendations was informed by continuing professional development programs in palliative care. She reiterated a recent conversation with a palliative care specialist: *these people are dying* and so it may

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be important to provide them with food they enjoy if this is not *uncomfortable*. Based upon her knowledge and experience, Danielle was prepared to support Max's decision to resume eating and drinking. *I told him the truth that he probably would be aspirating some of it and* [it is] *essentially his decision, and I kind of knew that no matter what, he's still going to have his couple of sips a day.* Danielle indicated that she *weighed up what's important* to resolve the dilemma. Table 2 illustrates ethical reasoning strategies consistent with casuistry.

Danielle emphasised that there is no *flat rule* when resolving ethical dilemmas in dysphagia management. She considered each case according to the safety, comfort and needs of the client. Danielle integrated knowledge of Max's case by critical reflection to resolve this ethical dilemma. Her palliative care framework has changed from strict safety recommendations to quality of life perspectives. For Danielle, a "realistic" healthcare decision encompassed negotiation and empathy with her client during the final stages of his illness. Learning and teaching questions are presented in Figure 2.

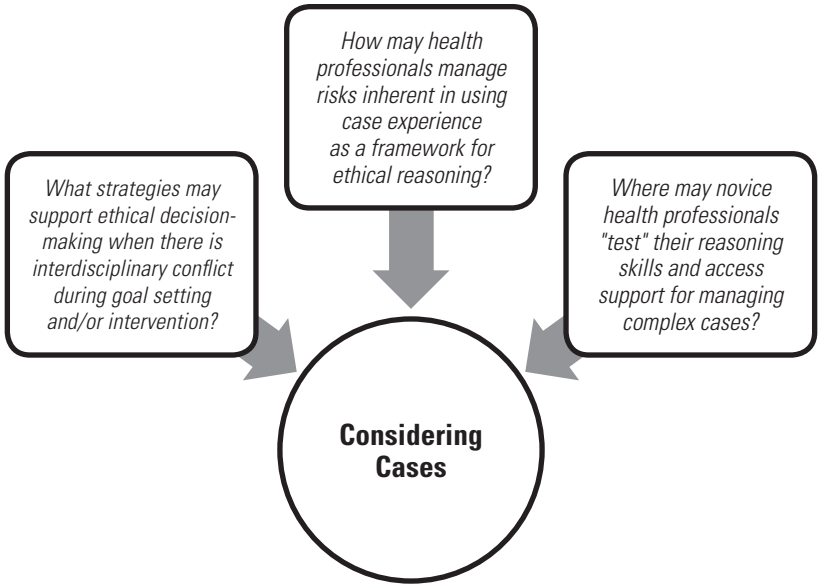

Figure 2. Learning and teaching questions for facilitating casuistry.
Issues regarding internal and external influences upon case-based reasoning may be drawn from Case 2.

Eliza's case (3): Ethics of care approach

Eliza was a senior speech pathologist employed within a major teaching hospital. She had diverse professional experience in international settings and her dilemma was drawn from experiences working in a British health service. Eliza specialised in treating adult clients with communication and swallowing impairments of acquired neurological origin.

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Eliza's case, George, presented with lifelong physical disabilities and multiple hospital admissions resulting from chest infections. Eliza identified ethical conflict when the healthcare team, George and his carers expressed different management goals and values.

Eliza described her professional responsibility as providing accurate and objective information to enable George and his medical team to develop a rehabilitation plan. *I think our role is to find out the information, so to do these objective assessments to find out is it actually safe or does it just appear to be unsafe?* She evaluated the impact of swallowing impairment as a causal factor in George's recurrent pneumonia. *We did more objective assessment in modified barium swallow* [video fluoroscopic swallowing examination] *and demonstrated that he wasn't safe to eat or drink. So he actually aspirated on puree, he aspirated on fluids so it was very unsafe.* Despite evidence of severe swallowing impairment, George *was determined that he wasn't going to stop eating and drinking*.

Eliza explored important factors for George's care plan. *He was wheelchair bound; he had to be hoisted from bed to wheelchair and couldn't do a lot for himself so relied on others.* George was diagnosed with mental health issues following the recent death of his wife; *he was quite depressed.* Importantly, George remained *very passionate about eating* and indicated that mealtimes provide *one enjoyment* where he exercised choice in his environment.

George's daughter, Jan, had assumed primary care responsibilities. Eliza explained that Jan *was very supportive, the daughter, but felt that he was not making the right decision for him. I think his daughter wanted to prolong his life and to keep him safe. So that was quite a difficult thing, especially seeing that there was conflict between what the daughter and what he wanted.* Jan favoured withdrawal of all oral food and fluids and provision of enteral nutrition. George's medical team was also very *keen to stop him coming to hospital* because recurrent admissions place burden upon health service resources. Eliza perceived that effective healthcare required her to provide clients with *all the information they need to make their own decision and advocating for that.*

Eliza adopted a leadership role to address conflicting expectations in George's case. *I was the one that initiated that we need to have a family conference about this or we need to get together and make a plan.* An effective care plan involved George, Jan and the interdisciplinary team. *So between the doctors and the hospital, myself, the dietician, the patient and his daughter and his GP*, [we] *made the decision … we presented all the information from all our disciplines.*

George *made the* [informed] *decision that he would eat and drink* with knowledge his life expectancy may be reduced and that he would access community rather than hospital medical services. Jan agreed to provide food and fluids of modified consistencies; *her compromise, that she would go for the safer option but if he wanted* [a glass of water], *he would have to get it himself.* George and Jan do not completely resolve their different attitudes towards choosing favourite versus safer foods. However, Eliza's advice regarding relative risks associated with different foods empowered George and his daughter to negotiate mealtimes. Her approach is summarised in Table 2.

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Eliza is sensitive to care relationships—George's relationship with Jan, who is struggling to accept his desire for oral intake, and his healthcare team, who wish to prevent readmissions. *I think our other role is to educate the patient and the other team members, like they may not be aware of the difficulties that the person is having and the implications*. Importantly, Eliza's role as advocate redresses potential power imbalances in this scenario. George remains a central participant in decision-making, and his goals are prioritised during healthcare planning. Eliza positively evaluated strategies she implemented to resolve this ethical dilemma, specifically *coordinating that plan and having the support of everyone, and it was all very clearly documented in terms of reports.* Eliza facilitated a decision that upheld George's wishes and respected the concerns of his daughter and healthcare team. *And I think for him it was probably a good outcome because you could tell in his interaction the way he was very passionate about eating, and he knew that's what he wanted and it's like an end of life request.*

Potential learning and teaching questions are presented in Figure 3.

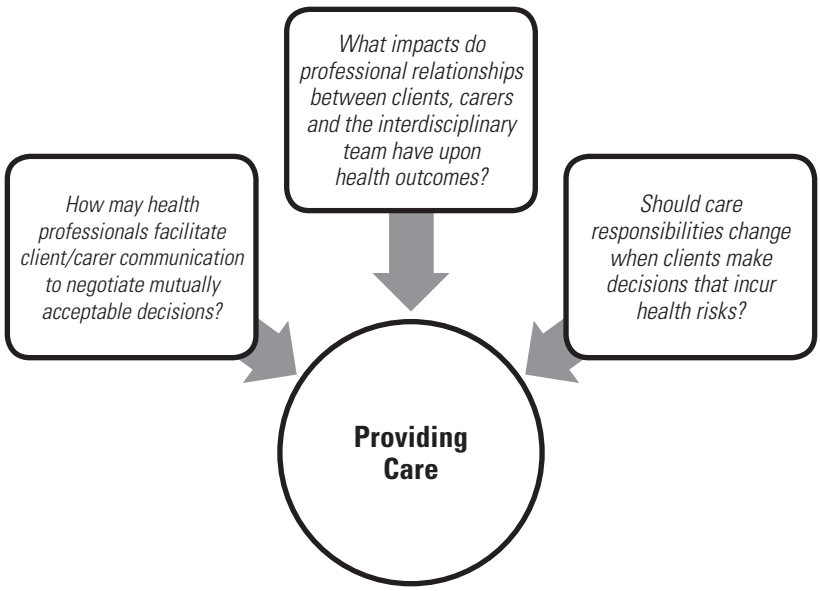

Figure 3. Learning and teaching questions for ethics of care.
Case 3 presents examples of professional and interpersonal relationships that may be considered during goal setting.

Rebecca's case (4): Narrative approach

Rebecca reported more than 20 years professional experience in diverse work settings. She occupied a position as speech pathology manager employed within a semi-rural healthcare facility at the time of the study. Rebecca's caseload included clients with a wide spectrum of paediatric and adult communication and swallowing disorders.

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Rebecca's dilemma concerned perceived conflict between *active* and *aggressive* care during her management of Laurel, a frail, aged inpatient in an aged-care hospital ward. *Laurel was in her eighties, she'd been living at home and she came in with pneumonia, very thin, and from the neighbour's discussions we discovered that she probably hadn't been eating well for quite a long time.* Laurel was referred by nursing staff members who were concerned by her inadequate oral intake and weight loss. Rebecca recommended a video fluoroscopic swallowing examination and *remarkably, when we did the x-ray, she was actually swallowing really well.* In the absence of significant physical or neurological factors, Rebecca implemented strategies to improve Laurel's intake. However, Laurel is reportedly unhappy with dietary changes. *We put her onto a puree diet which she was most annoyed about. She kept saying, "I don't like this. I don't like this food."*

Rebecca then described an interdisciplinary response directed towards improving Laurel's intake. *We were trying to explain to her that the reason she was on the puree was because she wasn't chewing very well; she was very weak; she'd had one choking episode.* Accordingly, nursing staff members encouraged Laurel to complete meals and the dietician ordered high energy supplements. *You must eat! You need to get stronger. Is there something else we can give you?* Rebecca co-opted Laurel's friend to *buy her lots of treats.* These strategies proved unsuccessful. Laurel's frustration was expressed with non-verbal resistance. *She just would put her head on the tray and just not eat.*

Rebecca described the allied health team as *quite cohesive; we support each other* when difficult decisions arise during client care. Yet as Laurel's motivation to eat declined, the team needed to negotiate how and when to intervene. *Over the next few weeks she just literally stopped eating, and so then there was a lot of discussion about whether she should have a nasogastric tube*.

Team members expressed divergent views regarding Laurel's care plans. Rebecca described the dietician becoming *very distressed that there wasn't a more aggressive role taken* in providing nutrition and the treating doctor's reluctance to *"force feed"* Laurel. *He said "We know she can swallow from the modified barium swallow, and she is electing not to eat."* Rebecca considered both viewpoints and questioned, *Where do you draw the line?* in such a *"grey area"* of decision-making.

Rebecca explored Laurel's past story. Neighbors, in Laurel's community, adopted caring roles with aged residents. Laurel's neighbor was deeply conflicted by her empathy for Laurel's determination to live independently and her concerns for Laurel's physical wellbeing. The neighbour informed the team that *the house was in a bad state. It wasn't clean. She couldn't go back. She couldn't manage; she was falling. The neighbour was doing all the shopping, but the neighbour wasn't there enough to make sure that she wasn't on the ground for long periods.* Laurel's neighbour explained, *"I feel such a traitor to her but . . . I can't let her go home."* Understanding the context surrounding Laurel's admission helped Rebecca understand her presentation on the ward.

Laurel's future story developed as *the admission progressed; everybody realised she couldn't go home; she was just getting more and more frail.* Recommendations for nursing home placement impacted Laurel's motivation to participate in rehabilitation. *The crunch for*

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her was going to the nursing home, with the realisation that she couldn't go back home. Rebecca perceived that Laurel rejected future nursing home placement.

Rebecca considered the arguments presented by interdisciplinary team members. *I could actually see with this one, there were two sides to it.* A solution was based upon an interpretation of whether nasogastric feeding was either an active or aggressive health response in Laurel's story. Rebecca also noted that this was a team decision. *We can only put the facts on the table. Like, we haven't got to make the ultimate decision.*

The medical team met with Laurel, her close friend and neighbor, who reject enteral feeding. Following this decision to avoid enteral feeding, the team focus shifted from active rehabilitation to discharge planning. *So she was eating very small amounts and she stabilised medically and her pneumonia improved a little bit and she was discharged to a nursing home and then she died about a week later.*

Upon reflection, Rebecca considered that Laurel made a decision not to eat. *In the end, it was almost like it was her decision. With this very elderly lady you're saying, "OK, it's her choice."* She further considered that the team had provided appropriate care for Laurel. *In her case, I didn't really feel it was appropriate to put a nasogastric tube down because I just felt we would be very invasive.*

In keeping with a narrative approach, Rebecca has focused upon Laurel's individual story to resolve this dilemma (Table 2).

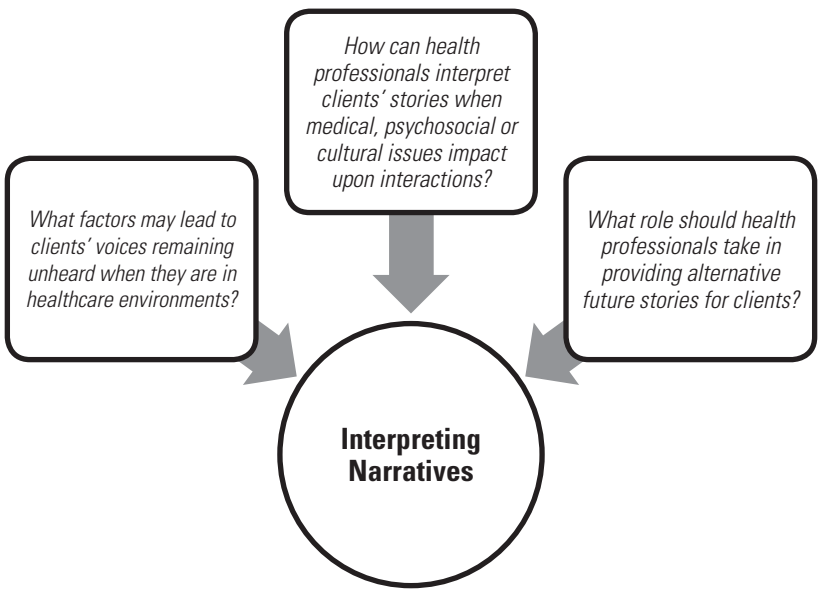

Figure 4. Learning and teaching questions for facilitating narrative ethics.
Case 4 addresses challenges in making clients' voices heard in healthcare facilities.

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A narrative approach guides health professionals to consider personal context during ethical reasoning; Rebecca carefully attended to a neighbor's concerns about Laurel's past struggles to maintain independence. Perhaps Laurel may have received more support to express her feelings and concerns verbally, or she could have been provided with counselling to adjust her responses to nursing home placement. Nevertheless, Rebecca is sensitive to Laurel's behaviour and the emotional impact of the dilemma upon her client, carers and team members. As Laurel's story unfolded, Rebecca demonstrated awareness of her client's vulnerability as a healthcare consumer, particularly when it became clear that Laurel was not able to return to her home. Figure 4 includes ethics discussion questions pertinent to this case.

Comparing ethical reasoning approaches to complex cases

Comparing the application of ethical reasoning approaches to complex cases provides opportunities for considering the contributions and challenges associated with each perspective. As bioethical principles are grounded in healthcare ethics, issues of beneficence, non-maleficence, autonomy and justice have wide application across healthcare settings. Alicia's case may be adapted to reflect conflict between these principles from interprofessional viewpoints. The four principles are core features of ethics curricula (Branch, 2000) and provide a familiar and shared language for interdisciplinary case discussion. Furthermore, bioethical principles are incorporated in professional codes of ethics (ASHA, 2010; SPA, 2010), providing a bridge between theory and practice. However, Alicia's case illustrated a potential drawback of a principle-based approach. A health professional may need to weigh the relative importance of conflicting principles in client care. Branch (2000) suggested that changing healthcare demands drive bias towards one of the four principles when dilemmas occur. The author argued that early medical bias towards beneficence has been replaced by a focus upon autonomy. Alicia grappled with the interpretation of autonomy and her client's locus of control during critical stages of care. Health professionals must consider how locus of control influences their perception and that of their clients so that clients' values and beliefs become the cornerstone for intervention (Roe & Leslie, 2010). Such an approach combines the provision of expert advice with support for clients' decisions. Health professionals may also be increasingly challenged to prioritise the bioethical principle of justice, as economic constraints highlight resource distribution issues in ethical decision-making (Branch, 2000).

Danielle's case showed that professional craft knowledge (White, 2001) may exert a powerful influence upon ethical reasoning. Casuistry provides a tool for improving quality of care by learning from experience, evidence and expert cases. Hence, this approach may be well suited to expert clinicians, specialist clinical settings and health professionals who engage in reflective practice. Yet, there are risks associated with casuistry. Students and new graduates may have limited case experience and require support to generate and evaluate ethical decisions (Kenny et al., 2007). Work place culture may cast positive or negative influences upon case-based reasoning (Handelsman, Gottlieb, & Knapp, 2005). Novice health professionals have vulnerable professional identities and avoid conflict with more experienced colleagues (Kenny et al., 2007) so

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they may be unwilling to challenge ingrained practices with new evidence. Experienced professionals risk ethical reasoning becoming overgeneralised if they do not continue to critically reflect upon individual features of new cases.

Eliza's case was consistent with Maeckelberghe's (2004) concept of care cycles that include health professionals' responsibilities for addressing barriers to quality care. A focus upon accessible healthcare and strengthening support networks are strengths of ethics of care approaches. Ethics of care focuses upon relationships and may be essential when a client's carers or community are impacted by care issues. This approach may foster interdisciplinary cooperation to resolve ethical concerns. In Eliza's case, the speech pathologist, hospital rehabilitation team, community GP and family needed to negotiate client-focused care goals and processes. Here, speech pathologists have a specific role in developing strategies to facilitate clients' communication skills for decision-making, promoting positive interactions with carers and providing and receiving information for quality care (Pollens, 2004). Clearly, ethics of care relies upon highly-developed interpersonal skills, and personal and professional maturity. Students may benefit from support in understanding political and historical issues that shape professional relationships within healthcare organisations and identifying appropriate advocacy strategies.

Rebecca's case highlights positive features of narrative reasoning approaches. Effective narrative reasoning provides a means for health professionals to elicit and interpret clients' stories and then retell these stories in a coherent, meaningful way (Hudson Jones, 2002). The approach rests upon the quality of communication between healthcare providers and clients. Narrative reasoning may facilitate health professionals to explore and manage conflict between their professional and personal values and the attitudes and beliefs of their clients. Importantly, ethical decision-making interprets healthcare within the context of an individual's life story. However, as Rebecca discovered, eliciting clients' stories may take time, careful observation and motivation to search for missing information. Clients with communication disorders may require additional support to engage in narrative decision-making, and speech pathologists have an important role in facilitating complex conversations and presenting important and potentially distressing information to clients and carers (Smith, Muller, & Bradd, 2011). Clinical practice in end-of-life care requires knowledge and self-awareness regarding beliefs about dying as well as skills to work with clients who are nearing death and their carers (Pollens, 2012).

A model for ethics education

An educational model that uses complex case studies to introduce students to multiple ethical approaches may have several advantages over traditional educational programs that focus upon identifying ethical issues embedded within a case and solving a dilemma. Exposure to alternative approaches may elicit deep learning by focusing upon the process of ethical reasoning rather than finding an immediate answer. Kirklin (2008) suggested that an interpretive approach to ethical analysis, involving an examination of the process by which ethical arguments are constructed, can build connections between theory and practice. Students' perceptions of ethics as simply

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"common sense" may be challenged during opportunities to debate "how" and "why" alternative ethics frameworks are relevant to contemporary professional issues. Whilst complex cases may be "messy" because they incorporate diverse issues, such cases offer opportunities for exploring "what-ifs?" and for considering the contributions and challenges involved in the application of ethical reasoning approaches. The four cases and approaches presented here may be interchanged for the purpose of comparing strengths and challenges inherent in each approach.

Body & McAllister (2009) argued that dilemma-focused educational models may overlook the relevance of ethics to clinical decision-making in daily professional practice. Moreover, the authors proposed that changing healthcare contexts and evolving scopes of professional practice create dynamic, shifting ethical environments for health profession graduates. Ethics educational models that incorporate bioethical principles, casuistry, ethics of care and narrative reasoning may go some way towards embedding ethics within everyday clinical reasoning (Leitão et al., 2014).

Conclusion

Harm minimisation and quality of life issues form a nexus between many decisions in healthcare practice. Alicia, Danielle, Eliza and Rebecca do not provide textbook examples of ethical decision-making frameworks. There are overlaps between the four dilemmas and some missing opportunities for ethical analyses. Nonetheless, their stories illustrate how real-life cases may be used to demonstrate merits and disadvantages of ethical reasoning approaches. Learning and teaching activities may explore ways in which the professional could have enhanced or modified an approach to facilitate care outcomes. By providing opportunities for critical reflection and discussion, rather than a neat decision-making trail, such comparison cases may engage health profession students in exploring ethical responsibilities in complex care scenarios.

References

American Speech-Language-Hearing Association (ASHA). (2010). *Code of ethics*. doi:10.1044/policy.ET2010-00309

Angel, L. A., & Simpson, M. D. (2007). Report of best practice: Development of an ethics manual as an integral component of undergraduate curriculum and application for graduates and practitioners. *Journal of Learning Design*, *2*(1), 1−13.

Beauchamp T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (6th ed.). New York, NY: Oxford University Press.

Body, R., & McAllister, L. (Eds.). (2009). *Ethics in speech and language therapy.* Oxford, England: John Wiley & Sons.

Boud, D., Keough, R., & Walker, D. (1985). *Reflection: Turning experience into learning.* London, England: Kogan Page.

Bowden, P. (2010). Teaching ethics to engineers: A research-based perspective. *European Journal of Engineering Education*, *35*(5), 563−572.

Branch, Jr., W. T. (2000). The ethics of caring and medical education. *Academic Medicine*, *75*(2), 127−132.

ISSN 1442-1100

Clark, P. G., Cott, C., & Drinka, T. J. K. (2007). Theory and practice in interprofessional ethics: A framework for understanding ethics issues in health care teams. *Journal of Interprofessional Care*, *21*(6), 591–603.

Coope, C. (1996). Does teaching by cases mislead us about morality? *Journal of Medical Ethics*, *22*, 46–52.

Cowley, C. (2005). The dangers of medical ethics. *Journal of Medical Ethics*, *31*, 739–742.

Crary, M. A., & Groher, M. E (2008). *Introduction to adult swallowing disorders.* St. Louis, MO: Butterworth Heinemann.

Creswell, J. (2013). *Research design: Qualitative, quantitative and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, *40*(4), 314–321.

Elkin S. A. (2004). The integration of ethics teaching in the therapy professions. *Focus on Health Professional Education: A Multi-Disciplinary Journal*, *5*(3), 1–6.

Furnari, M. G. (2004). Bioethics, women and the voice of care. *International Journal of Ethics*, *3*, 355–369.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Goodfellow, J. (1998). Analysing data in narrative inquiry research. In J. Higgs (Ed.), *Writing qualitative research* (pp. 105–120). Five Dock, NSW, Australia: Hampden Press.

Handelsman, M. M., Gottlieb, M. C., & Knapp, S. (2005). Training ethical psychologists: An acculturation model. *Professional Psychology: Research and Practice*, *36*(1), 59–65.

Hudson Jones, A. (2002). The colour of the wallpaper: Training for narrative ethics. In R. Charon & M. Montello (Eds.), *Stories matter: The role of narrative in medical ethics* (pp. 160–167). New York, NY: Routledge.

Hunter Montgomery, K. (1996). Narrative, literature, and the clinical exercise of practical reason. *The Journal of Medicine and Philosophy*, *21*, 303–320.

Jonsen, A. R. (1991). Casuistry as methodology in clinical ethics. *Theoretical Medicine*, *12*(4), 295–307.

Jonsen, A. R., Siegler, M., & Winslade, W. J. (2010). *Clinical ethics: A practical approach to ethical decisions in clinical medicine* (7th ed.). New York, NY: McGraw-Hill.

Kenny, B., Lincoln, M., & Balandin, S. (2007). A dynamic model of ethical reasoning in speech pathology. *Journal of Medical Ethics*, *33*, 508–513.

Kenny, B., Lincoln, M., & Balandin, S. (2010). Experienced speech pathologists' response to ethical dilemmas: An integrated approach to ethical reasoning. *American Journal Speech–Language Pathology*, *19*(2), 121–134.

Kenny, B., Lincoln, M., Blyth, K., & Balandin, S. (2009). Ethical perspective on quality of care: The nature of ethical dilemmas identified by new graduate and experienced speech pathologists. *International Journal of Language and Communication Disorders*, *44*, 421–439.

ISSN 1442-1100

Kirklin, D. (2007). Minding the gap between logic and intuition: An interpretive approach to ethical analysis. *Journal of Medical Ethics*, *33*, 386–389.

Leitão, S., Bradd, P., McAllister, L., Russell, A., Block, S., Kenny, B., . . . Wilson, C. (2014). *The 2014 ethics education package*. Melbourne, Australia: Speech Pathology Association of Australia.

Maeckelberghe, E. (2004). Feminist ethic of care: A third alternative approach. *Health Care Analysis*, *12*(4), 317–327.

Nelson, H. L. (2002). Context: Backwards, sideways and forward. In R. Charon & M. Montello (Eds.), *Stories matter: The role of narrative in medical ethics* (pp. 39–47). New York, NY: Routledge.

Noddings, N. (2013). *Caring: A relational approach to ethics and moral education*. Berkeley, CA: University of California Press.

Pollens, R. (2004). Role of the speech-language pathologist in palliative hospice care. *Journal of Palliative Medicine*, *7*(5), 694–702.

Pollens, R. (2012). Integrating speech-language pathology services in palliative end-of-life care. *Topics in Language Disorders*, *32*(2), 137–148.

Roe, J. W. G., & Leslie, P. (2010). Beginning of the end? Ending the therapeutic relationship in palliative care. *International Journal of Speech-Language Pathology*, *12*(4), 304–308.

Sharp, M., & Brady Wagner, L. (2007). Ethics, informed consent, and decisions about nonoral feeding for patients with dysphagia. *Topics in Geriatric Rehabilitation*, *23*(3), 240–248.

Sharp, H. M., & Geneson, L. B. (1996). Ethical decision-making in dysphagia management. *American Journal of Speech-Language Pathology*, *5*, 15–22.

Smith, H., Muller, N., & Bradd, T. (2011). Dysphagia assessment and management at the end of life: Some ethical considerations. *ACQuiring Knowledge in Speech, Language, and Hearing*, *13*(2), 88–91.

Speech Pathology Australia (SPA). (2012). *Dysphagia clinical guidelines.* Melbourne, Australia: Author.

Speech Pathology Australia (SPA). (2010). *Code of ethics*. Melbourne, Australia: Author.

Speech Pathology Australia (SPA). (2002) *Dysphagia: Position paper*. Melbourne, Australia: Author.

Vergés, A. (2010). Integrating contextual issues in ethical decision making. *Ethics & Behaviour*, *20*(6), 497–507.

West, C., & Chur-Hansen, A. (2004). Ethical enculturation: The informal and hidden ethics curricula at an Australian medical school. *Focus on Health Professional Education: A Multi-Disciplinary Journal*, *6*(1), 85–99.

White, K. (2001). Professional craft knowledge and ethical decision making. In J. Higgs & A. Titchen (Eds.), *Practice knowledge and expertise in the health professions* (pp. 142–149). Oxford, England: Butterworth-Heinemann.

ISSN 1442-1100