Professional ethics: What even good people need to know

Ilinois Speech-Language-Hearing Association Convention
Chicago, Illinois
February 8, 2020

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Definitions

- Morality – Community or culturally agreed upon views of right versus wrong, good versus evil. Is often the basis for values, ethics, and the law.
- Values – What is thought worth doing or principles to act upon
- Ethics - the scientific study or determination of moral behavior for a given situation or profession
- Law- Rules of conduct enforced by government

Examples of two countries Code of Ethics

- ASHA 2016 Code of Ethics
- Australia SLP Code of Ethics
  - https://www.speechpathologyaustralia.org.au/SPAWeb/Members/Ethics/spaweb/Members/Ethics/Ethics.aspx?hkey=5c5556d0-327f-4d06-8e89-fd1a638e543a

Code of Ethics and Clinical Ethics

- Code of Ethics- profession centered to as guidelines for what we should and should not do
- First one was Hippocratic Oath

Ethics and Evidence Based Practice

- Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills.
Morality, ethics, law

- Adultery is immoral? Even if yes, is it illegal and for whom?
- Free choice is a gift from God. Autonomy in health care is highest ethical calling.
- When should professional ethics be more important than personal morality?

Conflicts

- Morality and Professional Ethics
- Morality and the Law
- Professional Ethics and the Law

Must accept

- Sometimes no “right decision”
- Sometimes both options have negative consequences
- Sometimes will get “wrong”
- Sometimes will suffer or be punished

Differences between Morality and Professional Ethics

- Based on individual’s or community’s concept of what is right and wrong
- Informal (community standards) or Formal (religion)
- How one should be, what makes a person good, if which only one aspect is how approach professional
- Punitive community or religious sanctions (e.g., excommunication), exclusion from a group, self-punishment
- Should do as indication of being a righteous person

Differences between Law and Ethics

- Based on concepts inherent in that government
- Informal rules and guidelines
- Minimum standards “What is the least one should do”
- Coercive - can be punished by law
- Must do

Adapted from Dickerson, et. al. 1995
Law and Morality

- Is a law always moral?
- Can law be immoral?
- Do challenge a immoral law? Or just not follow it? If do not follow law, must be prepared to be punished

Laws, customs, and morality

- “Noncooperation with evil is as much a duty as cooperation with good”
  - Gandhi
- “The only thing necessary for the triumph of evil is for good men to do nothing”
  - Edmund Burke

Common identified conflicts

- Following government requirements concerning reimbursement
- Meeting employers production and financial expectations
- Conflict among team members, patients, and/or family about goal setting
- Determining decision making capacity

Law, Ethics, and Morality

- Government payer says will pay or support client with one disorder but not other. Your client has the “other” disorder. The clinician purposely puts down incorrect disorder in get client covered
- Legally, you have committed a crime
- Ethically, you can claim to have been operating with beneficence and may even claim to be shooting for justice
- Morally, you have lied

Classic Four Ethical Principles of Healthcare


- First to lay out guidelines-latest update 2009
- Respect for Autonomy
- Beneficence
- Nonmaleficence
- Justice

Criticism of Beaucamp and Childress Framework

- Too superficial
- Can be used to justify anything
- In conflict with each other
- Does not take into consideration relationship between client and professional
- Does not explicitly address removing barriers
Respect for Autonomy

- The right to self-determination
- Ability to make decisions about oneself
- Not being forced or coerced by others into an action or decision
- Decisions made by one’s own morality
- Must be respected by health professionals even if it conflicts or not in agreement with these professionals

International Classification of Functioning, Disability, and Health (ICF) - Ethical Principles

- In 2001, ICF published by World Health Organization to classify functional health status
- Significant concern that any classification system, by definition, could endanger four basic health care principles of autonomy, nonmalficence, beneficence, and justice

Ethical guidelines for use of the ICF

- Every scientific tool can be misused and abused. It would be naïve to believe that a classification system such as the ICF will never be used in ways that are harmful to people... It is hoped that attention to the provisions that follow will reduce the risk that ICF will be used in ways that are disrespectful and harmful to people with disabilities. WHO, 2001, p. 244

Respect and Confidentiality

- ICF should always be used so as to respect the inherent value and autonomy of individual persons.
- ICF should never be used to label people or otherwise identify them solely in terms of one or more disability categories.

Respect and Confidentiality- 2

- In clinical settings, ICF should always be used with the full knowledge, cooperation, and consent of the persons whose levels of functioning are being classified. If limitations of an individual’s cognitive capacity preclude this involvement, the individual’s advocate should be an active participant.

Clinical use of the ICF

- Wherever possible, the clinician should explain to the individual or the individual’s advocate the purpose of the use of the ICF and invite questions about the appropriateness of using it to classify the person’s level of functioning.
Clinical use of ICF - 2
- Wherever possible, the person whose level of functioning is being classified (or the person's advocate) should have the opportunity to participate, and in particular to challenge or affirm the appropriateness of the category being used and the assessment assigned.

Social use of ICF information
- ICF information should be used, to the greatest extent feasible, with the collaboration of individuals to enhance their choices and their control over their lives.
- ICF information should be used towards the development of social policy and political change that seeks to enhance and support the participation of individuals.

Social use of ICF information - 2
- Individuals classed together under ICF may still differ in many ways. Laws and regulations that refer to the ICF classification should not assume more homogeneity than intended and should ensure that those whose levels of functioning are being classified are considered as individuals.
  - WHO 2001, p. 245

Beneficence
- Actions for the benefit or help of others
- Actions that produce good outcomes
- Weighing potential positive consequences of action by possible negative consequences
- "Good" determined by
  - Best evidence for treatment available
  - Clinician expertise and experience
  - What patient views as helpful

Nonmaleficence
- Avoid causing harm
- Avoiding actions that could persons at risk for any type of harm, including psychological or social
- Actions that are primarily for the good of the provider or are deceptive

Justice
- Advocating for all persons to be able to receive appropriate services
- Advocating for the fair treatment of all persons with functional limitations or disabilities
- Treating all persons as having equal worth, respect, and services
- Distribution of services or equipment fairly
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**Resource allocation and the greater good**
- Vaccines for children versus comprehensive care for persons in late stage of Alzheimer’s Disease
- Use of therapy assistants or aids – “Best” services, limited services

**Justice**
- All persons should be treated fairly but what if you see differences based on income, race, or age?
- What does the government or an employer owe its employees if they become disabled?
- What are you willing to do to help all persons with communication disorders have most fulfilled lives and decreased barriers?

**Principles of Beneficence and Nonmaleficience**
- What is the patient’s medical problem? History? Diagnosis? Prognosis?
- What are the goals of treatment?
- What are the probabilities of success?
- Is severe, how can this patient be benefited by medical and nursing care and how can harm be avoided?

**Patient Preferences**
- The Principles of Respect for Autonomy
  - Is the patient’s right to choose being respected to the extent possible in ethics and law?
  - Has the patient expressed prior preferences, e.g., Advanced Directives?
  - If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making?
  - If competent, what is the patient stating about preferences for treatment?
  - Is the patient mentally capable and legally competent? Is there evidence of incapacity?

**50 people get best evidenced based intervention or 100 getting good but not the best.**

- Is getting all speech/language therapy need worth cutting back on number of psychology sessions everyone gets? Older persons not getting chemotherapy?
Quality of Life
The Principles of Beneficence and Nonmaleficence and Respect for Autonomy
• What are the prospects, with or without treatment, for a return to normal life?
• What physical, mental, and social deficits is the child likely to experience if treatment succeeds?
• Are there biases that might prejudice the provider’s evaluation of the patient’s quality of life?
• Is the patient’s present or future condition such that his or her continued life might be judged undesirable?
• Is there any plan and rationale to forego treatment?
• Are there plans for comfort and palliative care?

Autonomy
• On surface, appears straightforward—persons should have say in their treatment
• What if their opinion conflicts with therapists’ judgment?
  ▪ What if patient is cognitively impaired?
  ▪ What if patient is relatively intact cognitively but significant communication disorders?
  ▪ What if patient is depressed

Types of Consent
• Formal or Full Consent— the client is given, in writing, complete and specific information in a legal document to sign.
• Verbal Consent – the clinician and the client have a conversation about the assessment and intervention. The clinician documents the interaction including what was presented and questions the client asked. The joint conclusions are then documented.
• Assent— informal in which the person generally agrees to some level of assessment and intervention.

Contextual Features
The Principles of Loyalty and Fairness
• Are there family issues that might influence treatment decisions?
• Are there provider (physicians and nurses) issues that might influence treatment decisions?
• Are there financial and economic factors?
• Are there religious or cultural factors?
• Are there limits on confidentiality?
• Are there problems of allocation of resources?
• How does the law affect treatment decisions?
• Is there any conflict of interest on the part of the providers or the institution?

Competency- Its not All or None
• Legal competency – decided by legal system and involves one’s overall ability to enter into legal contracts, financial arraignments, conduct one’s daily affairs, and make major health decisions such as whether to have an operation or not.
Competency versus Decisional Capacity

- Decisional capacity is a clinical, not legal, term and consist of the following:
  - Comprehension of diagnosis and other information given regarding treatment and non-treatment options
  - Manipulation of these options and their consequences in relation to personal goals and values
  - Reasoning through a decision
  - Ability to communicate these preferences

Decisional Capacity with those with cognitive and/or communication disorders

- May or may not be declared legally competent, but this does not determine how much autonomy you give them in your intervention decisions.
- Is about personal preferences, not necessarily life or death matters, such as preferred method of communication or what goals want to work on. In principle of autonomy, achieving persons’ goals is highest ethical calling.

Difficulties with Decision Capacity

- No universal agreement on how to access and it is specific to task
- If assume decision capacity and they do not have it, then have violated principle of beneficence if they make a poor decision.
- If assume do not have decisional capacity when they do, then have violated principle of autonomy.

Autonomy versus Beneficence

- Autonomy is preferred but what if persons’ cognitive ability or decisional capacity do not allow them to make the best decisions for themselves.
- Can you make the decision for them?
- Who would be an appropriate proxy or in ICF language “advocate” for the person?
- Difference between legal and moral representation

Autonomy – “Poor Decisions”

- What if person is considered legally competent, but have questions, but not proof, of their decreased decisional capacity?
- Persons have a “right” to make a “mistake”
- What if feel someone else is coercing the client? Example- Otolaryngologist wants to try new voice surgery that you doubt will help the client’s voice.

Autonomy and Self-Stereotyping

- Gallois and Pittam (2002) discuss that having a disability is one minority group that can join as an adult
- What if have negative feelings towards persons with disabilities and now have one themselves
- Can be own best advocate if now have reduced self-view of your worth? And what if not meet the “criterion” of being having clinical depression?
Ethical dilemmas - Greater good?

- A competent 65 year old man with aphasia has been receiving speech-language therapy and his therapist has recommended discharge. His adult daughter objects to this discharge because she thinks her father is still improving and besides it gives him something to do twice a week.” The hospital tells you to see the man for more therapy because his daughter is wealthy and has stated may be interested in giving a large donation to the hospital.

Ethical Dilemmas – Helping one’s family

- You are under pressure to see more patients or your position may be eliminated. There is a patient who is borderline in terms of whether they are really benefiting from therapy. With this patient you are over your informal “quota” and keep your job which means keep insurance coverage for my child’s chronic health condition.

Ethical Dilemmas- Who’s the best advocate?

- The wife of a person who has had a severe head trauma wants his g-tube removed. He has minimum interaction with others and scans show limited brain activity. She says is cruel to keep alive. The man’s brother objects and says that the wife just wants his insurance money and was already planning to divorce him because having an affair.

Ethical Dilemmas- Feeling desire to help

- A daughter comes and feeds her mother in a long term care facility. Her mother has dementia and dysphagia and is dependent on feeding by others. The daughter brings in foods which inconsistent with MD order and SLP recommendations. Despite repeated family education regarding the risk to the resident, the daughter continues to feed contraindicated consistencies. The daughter has the medical legal power of attorney and has not agreed to the recommendations.
- Is your answer different if patient also has end stage cancer?

Geriatric care – common tricks of employers

- Padding time – “Perfectly legal via Medicare”
- Seeing people until coverage runs out “What do you have against older people?”
- Inappropriate clients- “She has a communication disorder doesn’t she?” “Just have switch caseloads” “Can’t write in a way that would be paid for?”
- Seeing clients when ill “Unless physician order stating cannot treat, then treat”

ASHA Code of Ethics

- Individuals who hold the Certificate of Clinical Competence may delegate tasks related to the provision of clinical services to aides, assistants, technicians, support personnel, or any other persons only if those persons are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.
Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, judgment, or credentials that are within the scope of their profession to aides, assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.

Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession only if those students are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.

Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.

Licensure and Morality

- Is having a license a moral obligation to protect the public?
- Is having a license just an excuse to limit clinicians and thus decreasing availability of therapy services?
- Why limit paraprofessionals?

Our own look in mirror

- Can someone do part of our job as well as us and cheaper?
- Is our work worth taking away some other medical service?
- Are you worth your salary?

Societal Ethical Challenge of Professions

- Education of health care professionals and public that just because impairment of communication does NOT mean –
  - That there is no or limited cognitive activity
  - That cannot read at minimum facial expressions and body language
  - That they have no quality of life
  - That they can be mistreated
Fighting the good fight

- Moral distress – feeling not doing the right thing
- Lose one’s soul little bit at time
- Cynicism the ultimate betrayal of your oath

What to do

- Balance between “Everything must be right” and “It is what it is”
- Know when lose, not in vain- knowing that tried
- Progress and success on the shoulders of those who came before you