Ethical Issues in Providing Services in Schools to Children With Swallowing and Feeding Disorders

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Individuals across the life span with swallowing and feeding disorders (dysphagia) receive treatment and management services from speech-language pathologists (SLPs). The 1999 American Speech-Language-Hearing Association (ASHA) Omnibus Survey reported that more than 50% of SLPs were involved in the clinical management of dysphagia (ASHA, 1999). Persons with dysphagia receive treatment in a variety of settings. Treatment occurs at home via home health care, at early intervention program sites, hospitals, residential facilities, nursing homes, daycare centers and nursery schools, facilities and worksites for individuals with developmental disabilities, rehabilitation facilities, clinics, agencies, and private practices. As part of their workload, SLPs in school-based settings routinely provide services to students who were born prematurely or who have neurologic conditions, craniofacial anomalies, complex medical conditions, head injury, or other serious chronic illnesses and injuries. Many of these students require dysphagia treatment and management. On the 2006 ASHA Schools Survey (ASHA, 2006a), 10% of respondents reported that they regularly serve students with dysphagia and that the average number served in the caseload was four students.

Regarding schools in relation to other, primarily medical, settings, Logemann and O'Toole (2000) observed, Differences between professionals working in each setting are decreasing for two reasons. First, more sick children are expected by their third-party payers to receive their dysphagia management in the schools and, second, schools are billing third parties for the kinds of speech and swallowing treatment being provided in the educational setting. Although, obviously, there are continuing differences between the various work settings, in the area of dysphagia, many commonalities exist between the medical and school settings. (p. 79)

This article will review and explore ethical issues in dysphagia treatment that confront the SLP, including practice and ethical considerations in the context of the school setting.

KEY WORDS: ethics, dysphagia, schools, competence

1Given the focus of this article on school-based practice, the term “student” is used when referring to infants, toddlers, children, and youth receiving services via school-based programs.
ETHICS AND DYSPHAGIA: LITERATURE REVIEW AND DISCUSSION

Basic Concepts: Biomedical and Professional Ethics

An understanding of basic ethical concepts of self-determination, beneficence, nonmaleficence, and justice (Beauchamp & Childress, 2001; Horner, 2003; Strand, 1995) is necessary for the provision of ethically responsible service to all persons who are served by SLPs. Self-determination or autonomy refers to the professional’s responsibility to respect the right of the individual to make care decisions for him- or herself. Beneficence refers to the professional’s responsibility to act for the benefit or good of the client. Nonmaleficence refers to the professional’s responsibility to avoid unnecessary harm to the client. Justice refers to the professional’s responsibility to act fairly, to distribute resources fairly, and to see that the client receives the service that he or she deserves.

Horner provided a tutorial on values, morality, philosophy, ethics, and law and their relationship to one another in guiding courses of action relative to these concepts. Consequently, in the provision of care to persons with dysphagia, SLPs must strive to (a) respect the wishes of their clients or their surrogate decision makers (e.g., desire for oral feeding/desire for tube feeding); (b) do good or do the “right thing” (e.g., provide for appropriate intake of nutrition); (c) prevent harm (e.g., reduce negative, even life-threatening, consequences associated with eating/feed); and (d) do this by fairly allocating resources, both human and financial.

Much of the speech-language pathology literature on ethical decision making in dysphagia explores in depth the concepts of self-determination, beneficence, nonmaleficence, and justice in various situations (Flather-Morgan, 1994; Goldsmith, 1999; Groher, 1990, 1994; Landes, 1999; Lazarus, 1996; Lefton-Greif, 2001; Lefton-Greif & Arvedson, 1997; Pittenger, 1997; Rubin, Wilson, Fischer, & Vaughn, 1992; Segal & Smith, 1995; Serradura-Russell, 1992; Sharp & Genesen, 1996; Shelley, 1995; Strand, 1995, 2003). In providing dysphagia services, SLPs must deal with medical realities, the client’s personal preferences, and considerations for quality of life. This must all be done within a larger context of considerations including family preferences, care team preferences, caregiver preferences, legal/regulatory rules, costs, and adherence to professional ethical obligations. Decision-making models for dysphagia services (as well as other life-impacting medically complex conditions) attempt to balance the basic tenets of autonomy, beneficence, nonmaleficence, and justice given the client’s circumstance (Beauchamp & Childress; 2001; Flather-Morgan, 1994; Lefton-Greif, 2001; Lefton-Greif & Arvedson, 1997; Sharp & Genesen, 1996; Strand, 1995, 2003).

Professional ethics are promulgated in codes of ethics such as the Code of Ethics of the American Speech-Language-Hearing Association (ASHA, 2003a). Professional codes involve rules or standards that have been agreed on by the members of the organization or profession and that govern the conduct and activities of its members.

The ASHA Code of Ethics (ASHA, 2003a) consists of four principles of ethics that constitute the moral basis for the code. These four principles deal with responsibilities to persons served professionally, responsibility for one’s professional competence, responsibility to the public, and responsibilities involving inter- and intraprofessional relationships. Each principle has its associated rules of ethics that further elaborate on acceptable or unacceptable conduct.

Professional ethics and biomedical ethics are indeed intertwined. As students with medically compromising issues (such as dysphagia) continue to enter school caseloads, SLPs in schools will find themselves involved in discussions not only within the framework of professional ethics but also, and to a greater extent than previously, within the framework of biomedical ethics. That is, balancing what is of benefit to the student (beneficence) with doing no harm (nonmaleficence); considering the wishes of a parent or a surrogate acting on behalf of the student who legally, and/or because of age, or because of the degree of disability, is unable to express wishes or participate in decisions (client autonomy in self-determination); or determining type, intensity, and frequency of services given the school district’s resources (justice).

Arvedson (2000), Brady (1998a), Lefton-Greif and Arvedson (1997), and Lefton-Greif (2001) focused on pediatric populations. Informed decision making brings its own set of issues in pediatric populations where parents act on behalf of their child. For example, questions may arise as to whether in acting “on behalf of their child” a parent is acting “in the child’s best interest.” Treatment planning also brings its own set of considerations. For example, in the pediatric population, children are developing and changing. Their medical and communicative status must be monitored as a function of growth and development or lack thereof. As children change or present with additional challenges, modifications in treatment may need to occur or new technology may need to be introduced. Issues between caregivers and care providers on how to proceed may arise and need to be resolved. Service delivery in natural environments (home, daycare centers, preschools, schools) has its set of considerations. For example, issues may have to be resolved regarding safety, availability of emergency help, transition from one setting to another, or consistency of techniques between settings (e.g., home and school) and caregivers.

Riquelme (2004) explored dysphagia services with regard to the SLP’s cultural competence. He wrote that decisions are influenced by client/family dietary rules and conventions, concepts of wellness, concepts of time, feelings about types of medical intervention, access to medical care, family rules for decision making, beliefs about medicine, and the primary treatment provider used by the family. All have potential issues of ethical significance in dysphagia treatment. Sensitivity and respect for what the client brings to the situation is critical. ASHA’s Issues in Ethics statement — Cultural Competence (ASHA, 2005a) — provides an expanded discussion of cultural competence, ethics, and the need for the practitioner to recognize one’s own cultural and life experience as well as that of the client in planning and delivering ethically responsible services.

Case Scenarios

Ethical issues, dilemmas, and debates usually arise because of circumstances and relationships surrounding the people involved, such as issues of attitude, competence, education, and expectations. Ethical issues also arise out of circumstances involving workplace systems, workplace operating procedures, legal mandates, regulatory requirements, reimbursement streams, employer expectations, and site-specific planning and preparedness or lack thereof. When considering ethical issues in providing services to individuals with dysphagia, instructive guidance comes through the presentation of
case studies. By reviewing and analyzing case scenarios, it becomes clear that there may not be a “single” or “right” or “wrong” answer to the ethical questions posed; rather, there may be several ethically responsive alternatives to handling a situation. As Groher stated, “each individual presents with a unique set of medical circumstances and a unique set of beliefs as they relate to their medical care” (1994, p. 11). Groher continued by pointing out that the complexity of interactions between the persons involved (i.e., client, physician, parent, family members, professionals, other team members) rarely results in the same decision when identical dysphagia scenarios are presented (1994). Several case studies are available (Brady, 1996a, 1996b, 1997a, 1997b, 1998b, 1999, 2000, 2001; Goldsmith, 1999; Lefton-Greif, 2001; Lefton-Greif & Arvedson, 1997; Pittenger, 1997; Sharp & Genesen, 1996; Strand, 1995). Table 1 depicts a representative example of topics of ethical interest in dysphagia that are covered in these case scenarios.

One case study (Brady, 2001) will be elaborated on primarily because it takes place in a school setting. It is demonstrative of the dynamic between parent, teacher, SLP, and physician. This scenario is illustrative of ethical issues related to autonomy, in terms of respecting the wishes of the child’s parent/decision maker; beneficence, in terms of the SLP’s need to promote what is believed to be good for the child; and nonmaleficence, in terms of the SLP’s concern that oral feeding may cause harm. In Brady’s opinion, the scenario represents “one of the most challenging ethical dilemmas speech-language pathologists face—when the expressed preference of a parent for their child is in direct opposition to what is at least initially seen to be the most ‘beneficial’ plan of care” (p. 20).

To summarize, a parent obtained a prescription from the physician ordering oral feeding for her daughter who was receiving tube-fed nutrition, hydration, and medications. The prescription was sent to the child’s teacher, who showed it to the SLP. It was the opinion of the SLP that it would be against professional standard to allow the child to eat orally. Further, the SLP questioned what she perceived to be the mother’s and physician’s limited understanding of what was in the child’s best interest. Brady makes a number of key points. First, this scenario (parent–SLP–physician disagreement) is not an unfamiliar experience for school-based SLPs. Rather, what may be unfamiliar is the urgency and nature of concern for potentially medically compromising, life-threatening outcomes. Second, a typical approach to ethical questions is to seek an answer that promotes a single course of action that is the “right” way to go. Brady points out that in the framework of clinical ethics, the emphasis is on “developing practical solutions that comprise a range of options” (p. 18) given each individual case and its facts and context. In this scenario, Brady suggests that the first line of consideration be recognizing that the “team” extends beyond the school walls and that the team must be operating with the same set of facts. Thus, all interested parties need to be identified, involved, and communicating regularly. Third, Brady reminds the reader that adults who have identified a proxy have likely had discussions with that proxy whereby instruction has been given about wishes. Children, on the other hand, may not have the capability to express wishes or make self-determining decisions. Thus, when dealing with the parent/proxy decision maker as in this scenario, it is helpful for the team to identify and discuss together the concerns that might have motivated the request for oral feeding. Presumably, parents act in the child’s best interest. Consider that in this scenario, the parent has not requested that the feeding tube be removed. The parent is not ignoring the child’s needs. Rather, the request may be coming from a quality-of-life perspective viewing feeding as a social activity integral to the parent–child relationship.

Where issues of disagreement, safety, doing harm versus doing good, and urgency exist, as in this case, team leadership, communication, negotiation, and consideration of an array of possible alternatives are key. An ethically responsive plan that emerged in this instance was a carefully considered and monitored time-limited

Table 1. Topics of ethical interest in dysphagia from case studies.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Citation(s) of case scenario(s)</th>
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<tbody>
<tr>
<td>Family insisting on intense therapy (frequency and duration) from</td>
<td>Brady (2000)</td>
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<tr>
<td>SLP; family insisting for more care than would have been recommended</td>
<td>Brady (1998a, 1999, 2001), Lefton-Greif &amp; Arvedson (1997, Case 1)</td>
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<tr>
<td>Team member disagreement/conflict; SLP disagreeing with colleagues;</td>
<td>Brady (1997a)</td>
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<tr>
<td>conflict in opinion and professional judgment</td>
<td>Brady (1997b, 1998a)</td>
</tr>
<tr>
<td>Disagreement between team and client/family</td>
<td>Brady (1998b)</td>
</tr>
<tr>
<td>• refusal of team recommendations</td>
<td>Sharp &amp; Genesen (1996, Case 2)</td>
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<tr>
<td>• unilateral decision of team parent and physician</td>
<td>Brady (1998a)</td>
</tr>
<tr>
<td>Sensitivity to cultural factors</td>
<td>Brady (1997b, 1998a)</td>
</tr>
<tr>
<td>Patient preference; decision-making capacity; surrogate decision</td>
<td>Brady (1997a)</td>
</tr>
<tr>
<td>maker</td>
<td>Brady (1997b, 1998a)</td>
</tr>
<tr>
<td>Informed consent</td>
<td>Brady (1997b, 1998a)</td>
</tr>
<tr>
<td>Caregiver not able to carry through with recommendations and</td>
<td>Brady (1997b, 1998a)</td>
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<tr>
<td>strategies</td>
<td>Brady (1998b)</td>
</tr>
<tr>
<td>Oral diet under certain conditions</td>
<td>Sharp &amp; Genesen (1996, Case 2)</td>
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trial with defined and detailed conditions, roles, and observations. Following the time-limited trial, a jointly developed plan of action emerged.

The ethical issues raised in this and the other scenarios listed in Table 1 are particularly instructive to school-based SLPs because the ethical questions and dilemmas raised transcend a variety of worksites, including a skilled nursing facility, a rehabilitation hospital, a public school, and a private residential school. The issues around team conflict, caregivers’ management of clients, parent/surrogate decision makers, special diets, defined conditions for certain eating activities, family demands for treatment beyond what would have been recommended, and educating less informed colleagues are quite within the realm of experience of school-based SLPs.

In discussions of basic concepts in ethics and through presentations of case studies, authors identify key questions to ask and propose models to use in order to make decisions that are ethically responsible for dysphagia services. Consistent across all decision-making frameworks is the importance of (a) gathering the facts, (b) carefully outlining the ethical concerns, (c) listing the alternatives and the pros and cons of potential outcomes for each alternative, (d) arriving at an ethically responsible course(s) of action acknowledging that there may be no single answer, and (e) reflection and analysis (Goldsmith, 1999; Landes, 1999; Lefton-Greif, 2001; Lefton-Greif & Arvedson, 1997; Pittenger, 1997; Rubin et al., 1992; Segal & Smith, 1995; Serradura-Russell, 1992; Sharp & Genesen, 1996; Strand, 1995).

From a professional ethics point of view, Huffman (2001) and Chabon and Morris (2004) offered strategies for analyzing ethical problems that can be applied to issues surrounding dysphagia. In an ASHA publication, Ethics and IDEA (2003b), ethical decision-making strategies are presented through the study of vignettes drawn from issues related to the Individuals With Disabilities Education Act (IDEA, 1990). The focus is on ethically responsible conduct in the context of regulatory rules, including team functioning, outside referral, and employer demands.

**Ethics and School-Based Dysphagia Services**

The importance of the educational preparation and competency of the school-based SLP in the area of dysphagia is emphasized by Power-deFur (2000). In reviewing state requirements for certification/licensure in speech-language pathology, Power-deFur found mention of competency in dysphagia to be “rare” (p. 77). One exception was the state of Virginia, where candidates for education (i.e., teacher certification) licensure were expected to demonstrate “understanding of the knowledge, skills and processes of the evaluation and treatment of disorders of the oral and pharyngeal mechanisms as they relate to communication, including but not limited to dysphagia” (p. 77).

Power-deFur (2000) directs attention to the ASHA Code of Ethics and the ASHA-certified SLP’s affirmative obligation to “engage in only those aspects of the professions that are within the scope of their competence, considering their level of education, training and experience” and “to continue their professional development throughout their careers” (ASHA, 2003b, p. 14). In the area of dysphagia, continuing education goes beyond self-study and should include observation of experienced clinicians and opportunities for supervised clinical experiences. In discussing the need for school-based SLPs to pursue continuing education to develop and maintain expertise in dysphagia, Power-deFur makes a potent point:

Failing to attain this competency [in dysphagia] results in three outcomes: (a) failure to provide dysphagia services to the student by any school personnel, (b) provision of dysphagia services to the student by other health-related school personnel who may not have the knowledge and skills to assess or treat dysphagia (e.g., the occupational therapist, the school nurse) or school personnel with limited awareness or knowledge of dysphagia (e.g. the teacher, school paraprofessionals), or (c) provision of services by a speech-language pathologist who is inadequately prepared. (p. 78)

Power-deFur suggests that each school district have at least one SLP who has received the necessary continuing education to provide appropriate services to students with swallowing and feeding disorders.

O’Too’s discussion (2000), although more focused on handling dysphagia services from a regulatory process point of view under IDEA, does touch on ethical, liability, and risk management considerations as they relate to practice under IDEA. He primarily addresses the need for practitioners to obtain education and training beyond that necessary for ASHA clinical certification standards that were in effect at that time.2

Owre (2001) cited concerns related to the education and clinical training of SLPs; the range of dysphagia expertise found in school systems; the appropriateness of various service delivery models; attitudes among SLPs as to whether or not dysphagia intervention belongs in the school setting; employer demands to become familiar with dysphagia intervention as part of third-party reimbursement programs; and the lack of understanding among school district administrators, parents, and school staff regarding the role of the SLP in managing swallowing and feeding disorders.

Arvedson and Homer (2006) emphasized the need for a school-based dysphagia team, suggesting that “no one discipline can, nor should, manage children with issues surrounding their feeding and swallowing” (p. 8). It is critical that school-based teams and medically based teams communicate regularly so that “all health, developmental, and feeding issues are handled in ways that maximize each student’s safety for oral [or tube] feeding and to facilitate the ability to participate fully in the academic process” (p. 8).

Owre (2006a, 2006b) reported on the results of an informal questionnaire for school-based SLPs providing dysphagia services. The questionnaire was developed by a committee established in 2005 to coordinate the efforts of ASHA Special Interest Divisions 13 (Swallowing and Swallowing Disorders) and 16 (School-Based Issues) on dysphagia management in school settings. It was disseminated to 7,781 affiliates of the two divisions via their respective newsletters, Perspectives. There were 187 respondents. Owre (2006a, p. 16) summarized,

Concern about liability issues was prominent in the concerns of SLPs, as was lack of experience/expertise and proving “educational relevance”. Probably the strongest reaction from respondents was the expressed need for more courses and training in dysphagia management in colleges/universities. Additional needs included development of an ASHA position statement and guidelines for dysphagia management in schools, the development of basic competencies and the need for more information on the topic via professional development offerings. (p. 17)3

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2Effective January 2005, ASHA certification requirements specify demonstration of knowledge and skills in swallowing processes; swallowing disorders; and their prevention, assessment, and intervention (ASHA, 2006b).

3The 2005 (ASHA Dysphagia in Schools Coordinating Committee members were Joan Sheppard (Chair), Sheryl Amaral, Joan Arvedson, Emily Homer, DeAnne Wellman Owre, Celia Hooper (ASHA Vice President for Professional Practices in Speech-Language Pathology and monitoring Vice President), and Janet Brown (ASHA Director of Health Care Services in Speech-Language Pathology, Ex Officio).
The questionnaire asked school-based SLPs to indicate how they were involved in the delivery of dysphagia services. A broad range of activities was identified. The 10 most frequently reported areas (Owre, 2006a, p.16) for SLP involvement were as follows:

1. Evaluating and providing of “hands on” therapy (e.g. oral motor exercises, swallowing techniques) – 42%
2. Providing in-service to school staff regarding dysphagia and safe feeding – 39%
3. Obtaining medical information from the child’s physician – 37%
4. Identifying and referring to medical personnel (e.g. medically-based SLP) as indicated – 35%
5. Collaborating with other professionals (e.g. OT, PT and/or nurse) in the dysphagia management process – 30%
6. Managing dysphagia interventions independently – 26%
7. Coordinating with medical SLP and school team (including family members) to evaluate and establish intervention plan in the school setting (SLP writes school plan) – 26%
8. Obtaining medical clearance from a physician for dysphagia intervention – 25%
9. Establishing accommodations and precautions only and ensuring follow-through as a consultant – 25%
10. Implementing established district-wide dysphagia program and procedures – 14%

SLPs were also asked to identify dysphagia management barriers in school settings. In order of priority (Owre, 2006a, p. 17), they were:

a. liability issues
b. own lack of experience/expertise in dysphagia
c. restrictions of a school setting versus a medical setting

Regarding future involvement of ASHA and Divisions 13 and 16 in addressing issues identified, the questionnaire asked SLPs to prioritize the kinds of support needed for the acquisition of knowledge, expertise, and competence in dysphagia management in schools. Respondents gave highest priority (Owre, 2006a, p. 17) to the following:

a. Promotion of more courses, offerings and training in school-based dysphagia management at the university/college level,
b. Development of guidelines and position statement for dysphagia management in schools,
c. Development of recommended basic competencies for the SLP providing dysphagia management in schools,
d. Provision of information via The ASHA Leader, ASHA Division Perspectives, Web forums, etc.

Given the wide range of areas of SLP involvement in the delivery of dysphagia services in the school setting, and the barriers identified by school-based SLPs currently providing services to students with dysphagia, the questionnaire results offer rather clear direction with regard to next steps for the profession based on the expressed needs of SLPs.4

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4The results of this questionnaire were the impetus for ASHA to form a Working Group on Dysphagia in Schools charged with developing a new guidelines document, Guidelines for Speech-Language Pathologists Providing Dysphagia Services in Schools (ASHA, 2007).

**DISCUSSION AND CONSIDERATIONS FOR ETHICALLY RESPONSIVE PLANNING FOR THE PROVISION OF SERVICES IN SCHOOL SETTINGS TO STUDENTS WITH DYSPHAGIA**

SLPs involved with school-based dysphagia services should be familiar with ASHA’s Scope of Practice in Speech-Language Pathology (2001b), Preferred Practice Patterns for the Profession of Speech-Language Pathology (2004c), and Code of Ethics (2003a). ASHA’s Scope of Practice in Speech-Language Pathology defines areas of professional practice for, and services rendered by, ASHA-certified SLPs. It is a statement to various “publics” (e.g. other professionals, consumers, regulators, educators, health care personnel), and a reminder to SLP practitioners themselves, of what SLPs are competent to do based on their education, training, and experience. ASHA’s Preferred Practice Patterns for the Profession of Speech-Language Pathology defines activities (such as #40 Swallowing and Feeding Assessment—Children, or #41 Swallowing and Feeding Intervention—Children) that fall within the SLP scope of practice and current practice patterns that would “apply across all settings in which the procedure is performed” (p. iii). The setting in which SLPs work does not “define” scope of practice. In other words, there is not a “scope of practice” for schools or hospitals or other practice settings. The setting in which SLPs work, however, often influences how services in the professional scope of practice are carried out. To illustrate, ASHA’s Guidelines for the Roles and Responsibilities of the School-Based Speech-Language Pathologist (2000b), while consistent with ASHA’s scope of practice and preferred practice patterns, addresses issues, practices, and roles that are specific to school-based SLPs; and, pertinent for this discussion, addresses swallowing intervention in the school setting.

The ASHA Code of Ethics (2003a) undergirds professional practice. It embraces the profession’s values and defines ethical commitments for ASHA members, whether certified or not; ASHA nonmembers who hold the certificate of clinical competence (CCC); applicants for ASHA membership or certification; or clinical fellows seeking to fulfill standards for ASHA certification.

**Education and Competence**

Attention to competence is a valid ethical concern in any setting when a client presents with a disorder with which the SLP has had little or no experience. School-based SLPs are asking for more academic and clinical preparation as well as the development of guidelines and competencies for the provision of school-based management of dysphagia (Owre, 2006b). Current ASHA standards for the CCC require demonstration of knowledge in the area of swallowing, including supervised practicum with client populations with various types and severities of communication and/or related disorders (ASHA, 2006b). Those SLPs who were certified before the implementation of current standards may have had limited, perhaps no, preservice education and training. Current certification standards, however, also require all holders of the CCC-SLP to demonstrate continued professional development for maintenance of certification. Thus, even though certified, a need exists for SLPs to seek continuing education in dysphagia.

The ASHA Code of Ethics (2003a) repeatedly speaks to competence on the part of the clinical service provider as well as supervisors of staff who are SLPs:

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Huffman & Owre: Ethical Issues in Providing Services in Schools
“Individuals shall provide all services competently.” (Principle I, Rule A)

“Individuals shall engage in only those aspects of the professions that are within the scope of their competence, considering their level of education, training, and experience.” (Principle II, Rule B)

“Individuals shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member’s competence, level of education, training, and experience.” (Principle II, Rule C)

“Individuals shall continue their professional development throughout their careers.” (Principle II, Rule C)

SLP responsibilities and roles in all settings must be responsive to progress in medicine and technology and impact on diagnosis and treatment. Consideration of one’s knowledge and skills and acknowledging what one knows and does not know are critically important for the SLP in today’s ever-changing and challenging clinical environment. This acknowledgment and associated self-reflection serve as a basis for an SLP’s professional development to fulfill the ethical obligations of holding client welfare paramount and continuing professional development throughout one’s career (ASHA, 2003a). Thus, in the context of this discussion, an ethically responsive SLP would design and execute a continuing competency plan to develop and/or hone knowledge and skills in dysphagia diagnosis, management, and treatment. There are continuing education opportunities and venues in this regard including academic coursework, formal continuing education workshops, independent study, self-study, mentorships, journal study groups, clinical exchanges, and teleseminars.

On a different note, it would be profoundly disturbing if a practitioner were to cite lack of competence as an excuse or a screen to hide behind in order to avoid any involvement or responsibility in handling an unfamiliar or challenging case. The ASHA Code of Ethics is instructive here as well:

“Individuals shall use every resource, including referral (emphasis added) when appropriate, to ensure that high-quality service is provided.” (Principle I, Rule B)

“Individuals shall not discriminate in the delivery of professional services or the conduct of research and scholarly activities on the basis of age, religion, national origin, sexual orientation, or disability (emphasis added).” (Principle I, Rule C)

ASHA’s Code of Ethics (2003a) focuses on the ethical responsibilities of individuals. However, as an employer of SLPs, a school district also has a strong, educationally relevant, and ethical incentive to provide professional development in dysphagia. From a pragmatic perspective, schools have an obligation to ensure that children are safe while at school, which includes ensuring a safe eating environment. During the course of the day, nutritious meals (breakfast, school lunch) are available to all students. Snacks are very much a part of the typical school day as well. For all students, social communication skills development is connected to social activities that involve meals and snacks in school. Schools are already accommodating students who have food allergies, special diet requirements, or frequency of eating requirements. Of course, health services are considered a related service under IDEA, and certain health and related services are reimbursable under public and private health insurance.

By supporting and providing opportunities for continuing education for SLPs and other key personnel, school districts are more likely to recognize that eating and taking nourishment is a major life function that is impaired by dysphagia and requires accommodation during the school day. Districts are more likely to have increased awareness of issues faced by students with dysphagia and how their alertness, well-being, potential for learning, and participation in the academic process is facilitated by appropriate services. Thus, guided by the tenets of self-determination, beneficence, nonmaleficence, and justice, school districts are more likely to develop a dysphagia management program that meets professional standards of care, satisfies legal and regulatory requirements, involves risk management planning, and addresses the safety of students with dysphagia.

Working on Multidisciplinary Teams and Scope of Practice

School-based dysphagia management and treatment programs require a team of players from within and beyond the school walls (Arvedson & Homer, 2006). It is the team that makes decisions balancing self-determination, beneficence, nonmaleficence, and justice. Teamwork calls for a level of interdependence based on the skills and knowledge that each member brings to the table. Teamwork also calls for respect of the scope of practice and expertise of each member. Teams may include parents, nurses, dieticians, paraprofessionals, physicians, SLPs, SLP consultants, occupational therapists, physical therapists, building principals, higher level administrators, regular and special education teachers, transportation providers, cafeteria workers, and social workers. The list changes as the student’s needs change.

In the quest to act on the given principles of self-determination, beneficence, nonmaleficence, and justice, teams are faced with challenges such as those associated with scope of practice, shared roles, levels of expertise, cultural competence, strong opinions, attitudes, and expectations. A skilled team leader with excellent communication skills will promote collaboration and cooperation among team members, resulting in utilization of the “best from each” given their expertise and scopes of practice.

Dysphagia is part of the speech-language pathology scope of practice (ASHA, 2001b). Therefore, in school districts around the country, SLPs are seen as a primary provider and often the point person in the management of dysphagia services (Arvedson & Homer, 2006; Owre, 2006a, 2006b). Although this may be true, scope of practice issues do arise. ASHA’s position statement and technical report, Speech-Language Pathologists Training and Supervising Other Professionals in the Delivery of Services to Individuals With Swallowing and Feeding Disorders (2004e, 2004f), reinforces the importance of multidisciplinary teams and addresses SLPs’ scope of practice: “This statement recognizes the importance of other professionals working with SLPs on a multidisciplinary and interdisciplinary team to address all the needs of the client/patient in swallowing and feeding; however the role of the SLP is not replaceable by members of other professions” (2004e, p. 1). These documents (2004e, 2004f) are cautionary about teaching and training others to perform an activity that is clearly within the speech-language pathology scope of practice.

Speech-language pathologists (SLPs) are primary providers of evaluation and treatment for swallowing and feeding disorders…. It is...
the position of the American Speech-Language-Hearing Association that speech-language pathologists (SLPs) should not train, via professional education courses or on-the-job training, or provide direct clinical supervision to individuals or groups of individuals from other professions in the delivery of evaluation and treatment for infants, children, and adults with swallowing and feeding disorders. (ASHA, 2004e, p. 1)

This is consistent with Principle II, Rule D of the ASHA Code of Ethics:

Individuals shall delegate the provision of clinical services only to: (1) persons who hold the appropriate Certificate of Clinical Competence; (2) persons in the education or certification process who are appropriately supervised by an individual who holds the appropriate Certificate of Clinical Competence; or (3) assistants, technicians, or support personnel who are adequately supervised by an individual who holds the appropriate Certificate of Clinical Competence. (ASHA, 2003a)

However, the position statement (ASHA, 2004e) also indicates what SLPs can do both ethically and professionally. For example, SLPs can share information for “purposes such as teaching another professional to screen for potential dysphagia” (ASHA, 2004e, p. 1) or recognize signs of dysphagia in order to refer a student for evaluation by an SLP. SLPs can share information for “advancing the scientific knowledge base across professions” (2004e, p. 1) so others will have increased understanding of the disorder and how it is treated. SLPs can “inservice other professionals and nonprofessionals about the role and activities of SLPs in evaluating and treating swallowing disorders” (2004e, p. 1). SLPs can and should train family members, caregivers, paraprofessionals, and others to use patient-specific techniques that have been developed as a result of the SLP’s evaluation and treatment planning to help the individual with dysphagia carry over skills outside the treatment session.

Existing Models

Concern regarding the restrictions of a school setting versus a medical setting has been identified as a barrier to dysphagia management in schools (Owre, 2006a, 2006b). Fortunately, there are school-based dysphagia management programs in place that can be replicated. The following program elements should be considered and defined when developing a dysphagia management program: team composition, protocols for referral, evaluation, planning, medical support, consultations, student feeding/swallowing plans, diet prescription documentation, responsibilities of persons involved with the student, handling emergencies, education, and in-service training (Arvedson & Homer, 2006; Homer, 2003; Homer & Arvedson, 2006; Homer, Bickerton, Hill, Parham, & Taylor, 2000). Overall, programs require extensive planning and support by the school district administration in view of its overarching responsibility relative to self-determination, beneficence, non-maleficence, and justice. District allocation of resources such as legal counsel is integral to program planning, procedure development, and assurance of adherence to procedures (Arvedson & Homer, 2006; Homer & Arvedson, 2006). Programs give attention to addressing and monitoring accountability standards, risk management, and liability in order to protect the student, the employee, and the district.

Existing dysphagia management programs have also been presented and described as part of continuing education offerings such as ASHA convention short courses (Arvedson, Homer, Owre, & Amaral, 2005) and teleseminars (Homer & Arvedson, 2006). Kurjan (2000) and Arvedson et al. (2005) provide accounts of SLP leadership in a school district’s planning and service provision.

Finally, there are several ASHA policy documents that are instructive (some to a greater extent than others) to the management and treatment of dysphagia in school settings and the establishment of school-based programs for dysphagia management (ASHA, 2000a, 2000b, 2001a, 2002a, 2002b, 2002c, 2002d, 2004a, 2004b, 2004d, 2004e, 2004f, 2005b, 2005c). Two documents are of particular interest: Guidelines for Speech-Language Pathologists Providing Dysphagia Services in Schools (ASHA, 2007) and Guidelines for the Roles and Responsibilities of the School-Based Speech-Language Pathologist (2000b). The ASHA Web site (http://www.asha.org/members/slp/clinical/dysphagia) offers extensive resources under topics such as pediatric dysphagia and dysphagia practice issues, discussion via ASHA members’ forums, consumer information, professional development products, technical assistance packets, special interest division articles (Division 13 and Division 16 sites), The ASHA Leader articles, ASHA journal articles, and Access Schools.

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**CLINICAL IMPLICATIONS**

Considering this discussion on ethics issues associated with the provision of services in school settings to students with dysphagia, Tables 2 and 3 provide examples of ethically responsive actions and ethically questionable actions/potentially unethical actions by school-based SLPs. Table 2 focuses on SLPs who are knowledgeable and skilled in dysphagia. Table 3 focuses on SLPs who do not have knowledge and skills in the area of dysphagia.

The evaluation, treatment, and management of dysphagia is a challenging area of speech-language pathology practice regardless of work setting. Even though schools are educating students with medical issues that must be dealt with on a daily basis, schools are educational institutions, not medical sites. They are under the aegis of education administrators, boards of education, and state departments of instruction. Related service providers typically see themselves as part of the educational institution, not the medical setting, where the priority is on medical services and where medical support is readily accessible.

When dealing with medically fragile students, school districts and staff are thrust into handling the life-threatening issues that these students face. School districts today are providing education and related services to students with many kinds of disabilities, including serious medical conditions. The nature of services has evolved to the point where it is not uncommon in today’s school environment to see a one-on-one paraprofessional or full-time nurse assigned to a particular student; medical plans and do-not-resuscitate orders as part of a student’s health plan; or student service teams extending far beyond the schoolhouse walls and consisting of a variety of players such as dieticians, physicians, and consultants.

Not all school districts employ certified SLPs, and even where they do, not all certified SLPs are competent in dysphagia. Nonetheless, the SLP does have professional and ethical responsibility to ensure that students receive appropriate services while in school. A professional activity is not deemed to be “ethical” or “unethical” based on the setting in which it is delivered. Rather, ethical principles, including those associated with biomedical ethics...
Table 2. Suggestions for ethically responsive actions or options available to the school-based speech-language pathologist (SLP) who is knowledgeable in the area of dysphagia management and treatment.

<table>
<thead>
<tr>
<th>Examples of ethically responsive actions</th>
<th>ASHA Code of Ethics principle(s) and rule(s) relative to this action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Be proactive and take a leadership role in your school district to develop a plan for managing dysphagia.</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Help administrators understand the nature of dysphagia and the gravity of potential problems associated with swallowing and feeding disorders.</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Work with school administrators to advocate for workload accommodations when managing students with swallowing and feeding disorders.</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Facilitate the training of SLPs in the district who may not be competent in dysphagia.</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Work with the dysphagia team to develop procedures (e.g., referral, evaluation, setting up special diets, and handling emergency situations).</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Develop appropriate forms and checklists for procedures, releases or other activities.</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Provide in-service to school staff about dysphagia (what it is, risk for, signs and symptoms, complications of, the need for a safe eating environment).</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Work with the dysphagia team in developing and executing the treatment plan; train in-school caregivers.</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Engage in continuing education.</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Engage in interdisciplinary consultation; facilitate and be involved in monitoring/observing various procedures.</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Consider the basic ethical principles of self-determination, beneficence, nonmaleficence, and justice in making decisions regarding the student.</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
<tr>
<td>• Address issues with administrators that may preclude your involvement in a dysphagia management program so alternatives can be explored.</td>
<td>ASHA Code of Ethics, Principle I, Rules A, B</td>
</tr>
</tbody>
</table>

Examples of ethically questionable/potentially unethical actions

| • Act “solo” without regard for team planning and expertise of team members. | ASHA Code of Ethics, Principle I; Principle I, Rule B |
| • Refuse to be involved (client abandonment). | ASHA Code of Ethics, Principle I, Rule B |
| • Train/teach other professionals to do what is in the SLP scope of practice (evaluation, developing feeding/eating treatment plans, supervising dysphagia treatment). | ASHA Code of Ethics, Principle I, Rule B |

Table 3. Ethically responsive actions or options available to the school-based SLP who is not knowledgeable in the area of dysphagia management and treatment.

<table>
<thead>
<tr>
<th>Examples of ethically responsive actions</th>
<th>ASHA Code of Ethics principle(s) and rule(s) relative to this action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Give advance warning to your district of areas of practice where you have limited or no knowledge and competency. Explore strategies for acquisition of competency.</td>
<td>ASHA Code of Ethics, Principle II, Rules B, C</td>
</tr>
<tr>
<td>• Work with the district to arrange for a consultant SLP who is experienced in dysphagia to be involved. Continue to be involved on the student’s team and in team planning.</td>
<td>ASHA Code of Ethics, Principle I, Rule B</td>
</tr>
<tr>
<td>• Advocate for the establishment of a dysphagia management program and be involved in its planning. Use available resources to determine what questions to ask and what needs to be addressed.</td>
<td>ASHA Code of Ethics, Principle I, Rule B</td>
</tr>
<tr>
<td>• Facilitate and advocate in-service of school staff.</td>
<td>ASHA Code of Ethics, Principle I, Rule B</td>
</tr>
<tr>
<td>• Research and study available resources, such as ASHA position statements relating to dysphagia, case scenarios, preferred practice patterns, and SLP scope of practice.</td>
<td>ASHA Code of Ethics, Principle I, Rule B</td>
</tr>
<tr>
<td>• Engage in continuing education.</td>
<td>ASHA Code of Ethics, Principle I, Rule B</td>
</tr>
<tr>
<td>• Acquire and/or enhance clinical skills.</td>
<td>ASHA Code of Ethics, Principle I, Rule B</td>
</tr>
</tbody>
</table>

Examples of ethically questionable/potentially unethical actions

| • Avoid any involvement. | ASHA Code of Ethics, Principle I, Rule A; Principle II, Rule B |
| • Refuse to use resources available such as outside consultants. | ASHA Code of Ethics, Principle I, Rule B |
| • Refuse to participate on the school team. | ASHA Code of Ethics, Principle I, Rule B |
| • Refuse to engage in professional development to improve skills. | ASHA Code of Ethics, Principle I, Rule B |
| • Refuse to refer. | ASHA Code of Ethics, Principle I, Rule B |
and professional ethics, must be considered and applied in the practice of speech-language pathology wherever it takes place. By virtue of current certification standards (ASHA, 2006b), scope of practice (ASHA, 2001b), and affirmative ethical obligations (ASHA, 2003a), the SLP is frequently the leader that the school district relies on to develop and oversee safe eating programs for students with dysphagia. Therefore, it is incumbent on the SLP to promulgate, by advocacy and example, ethically responsible practices.

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