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INFLUENCES ON THE DEVELOPMENT OF ETHICAL DECISION-MAKING IN SPEECH-LANGUAGE PATHOLOGY STUDENTS: A PHENOMENOLOGICAL STUDY OF GRADUATE STUDENTS AND CLINICAL SUPERVISORS

by

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A Dissertation

Submitted to the Graduate Faculty

of the

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In partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

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December
2020

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Joni Mehrhoff
December 18, 2020

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ABSTRACT

Speech-language pathologists (SLPs) serve as members of the interprofessional team for complex patients. As such, SLPs are required to uphold ethical practices and respond to the needs of patients, their families, healthcare organizations, and the interprofessional team. Speech-language pathology graduates are part of the ethical healthcare team during clinical experiences. Yet, limited research is available to define the development of student ethical decision-making.

The purpose of this study was to explore what influences SLP graduate students and clinical supervisors ascribe to in the development of ethical decision-making. Participants included five SLP graduate students and six SLP clinical supervisors from accredited SLP programs in the Upper Midwest. Participants engaged in two, semi-structured interviews discussing their backgrounds and experiences in ethical decision-making.

A phenomenological method was used to analyze the results through the theoretical framework of epistemological development and healthcare higher education. The participants described dysphagia services, mandated reporting, and issues with the SLP scope of practice as their leading ethical dilemmas. They also detailed patients, family members, and other professionals as the main influences on their ethical reasoning. Recommendations include a focus on student development through best-practice healthcare education, interprofessional education, communities of practice, and scaffolded epistemological development.

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CHAPTER I

INTRODUCTION

Ethical decision-making is central to healthcare professionalism and high-quality patient care (Kummer & Turner, 2011; Tipton, 2017). Healthcare professionals must make choices about patient care and ethical reasoning (Kenny et al., 2007; Flatley et al., 2014). Subsequently, healthcare providers report difficulty navigating the various nuances of bioethical decision-making (Kenny et al., 2007; Rao & Martin, 2004).

Ethical reasoning is a multifaceted process for both experienced and novice providers as it is shaped by knowledge of bioethical principles, patient decision-making capacity, and local, state, national and organizational standards (Sharp, 2006). As healthcare providers, speech-language pathologists (SLP) are expected to have ethical reasoning proficiency (Kummer & Turner, 2011). The development of this reasoning often starts in SLP undergraduate and graduate programs (Kenny et al., 2015).

Speech-language pathology student clinicians must understand, and follow, ethical codes of conduct (ASHA, 2016b). They must develop skills for the complex problem solving linked to ethical situations. Therefore, training in ethical reasoning is key to the preparation of healthcare professionals; however, universities frequently struggle with cultivating student ethical development because of limited evidence guiding best practice for ethical pedagogies (AACU, 2010; Kenny et al., 2007).

Speech-Language Pathology Professional Entry

In the United States, SLPs are governed by the American Speech-Language-Hearing Association (ASHA, 2016c) and are professionals who engage "in professional practice in the areas of communication and swallowing across the life span" (par. 3). The SLP scope of practice can be divided into eight primary practice areas including: (1) fluency, (2) speech sound/production, (3) language (i.e. spoken and written language: listening, processing, speaking, reading, writing, pragmatics), (4) cognition (i.e. attention, memory, problem-solving, executive functioning), (5) voice, (6) resonance, (7) feeding and swallowing, and (8) auditory habilitation/rehabilitation. Within each of these practice areas, SLPs are trained to diagnose and treat individuals across the life span.

Because of the large SLP scope of practice, the typical progression for a higher-education student seeking to work as an SLP includes a bachelor's degree in the field of communication disorders or speech-language-hearing sciences, followed by a two-year (or five semester) SLP graduate program. Speech-language pathology graduate programs are accredited by the Council on Academic Accreditation (CAA) within ASHA. The CAA "serves the public by promoting excellence in the graduate education of audiologists and speech-language pathologists. Through a peer review process, the CAA establishes accreditation standards and facilitates continuous quality improvement of the programs it accredits. Graduates of CAA-accredited and candidate programs are educated in a core set of skills and knowledge required for entry into independent professional practice" (CAA, 2020, par. 1). The SLP graduate student is eligible to advance to a clinical fellowship (CF) after graduation. The CF is completed within a professional placement and supervised by another SLP with a certificate of clinical competence (CCC-SLP) for a total of 18 hours of direct and indirect observations.

Speech-language pathology professional practice settings are typically divided into education- and healthcare-based facilities. Education services include K-12, early childhood, and

college and university settings. Healthcare-based SLPs work in acute care, rehabilitation, psychiatric and pediatric hospitals, outpatient, private practice and university clinics, residential health care facilities (e.g. assisted living and skilled nursing facilities), nonresidential health care facilities (e.g. home health, early intervention, home-based private practice services) and public health departments (ASHA, 2020a). The number of SLPs employed in education settings is a little over one-half (51%) with ongoing increases the number of healthcare based SLPs (39.5%) (ASHA, 2019).

Speech-language pathology graduate students accrue 400 clock hours, 325 of which must be completed while enrolled in an accredited SLP graduate program (ASHA, 2020b). These clinical practicum hours, or experiences, must occur across the spectrum of ages and disorder areas to gain practice breadth and depth. An SLP clinical supervisor with a CCC-SLP and often state licensure supervises graduate student clinicians. As a result of these requirements, many students in SLP higher education programs do not have substantial direct client contact until they are accepted into an SLP graduate program.

The large breadth and depth of experiences can be daunting for the SLP graduate student. Consequently, new clinicians do not consistently demonstrate confidence across the spectrum of ethical decisions tied to the SLP scope of practice and clinical practice (Kenny, et al., 2007).

This study explored the role of ethical education in SLP students in higher education. With a focus on graduate student experiences, design implications and recommendations target graduate education. However, there exists potential for expansion to undergraduate education in many of the instructional methods presented.

Ethics in SLP

An investigation of the influences on ethical development and decision-making in graduate student speech-language clinicians has the potential to illuminate options for

instructional design in graduate education and development of ethical reasoning skills. A review of the clinical literature emphasizes the complexity of ethical reasoning in healthcare and the impact of ethics on professional development (Atherton & McAllister, 2015; Chabon & Morris, 2004). The ethical decisions of the practitioner reflect their professional behavior and values, yet the complexities of ethical reasoning go beyond right and wrong moral actions (Kummer & Turner, 2011). Speech-language pathologists must contemplate their ethics, as well as patient and coworker values, and available community resources when solving an ethical dilemma (Kenny, et al., 2007; Flatley, et al., 2014).

Factors that are both central and peripheral to patients and their immediate health needs complicate the choices between right and wrong and moral and immoral actions in medicine (Chabon & Donaldson, 2011). The SLP is a member of the healthcare team treating patients with a wide variety of diagnoses. One common SLP diagnosis and treatment area is swallowing disorders, dysphagia (Sharp & Genesen, 1996). Patients with dysphagia often require food texture and preparation modifications as well as diet limitations. Because food and drink are important to not only nutrition but also social engagements, celebrations, and overall quality of life, SLP dysphagia services contain innate ethical considerations. Speech-language pathologist in healthcare settings make daily decisions about ethical dysphagia services.

For example, an ethical dilemma may be encountered by an SLP when deciding on feeding options for a patient with late-stage dementia. The SLP must consider the wants and desires of patients prior to their illness, the feelings and beliefs of involved family members, and input from other members of the healthcare team before making a final recommendation. Graduate clinicians in the field of SLP are typically part of the team for patients with complex diagnoses. As a result, speech-language pathologists face routine ethical problems (Kenny et al.,

2007). With high incident caseloads, the SLP clinician is accountable to a wide variety of stakeholders (Kummer & Turner, 2011).

Ethical Decision-Making Stakeholders

The patient is the primary healthcare stakeholder and the center of the healthcare team (IPEC, 2011). Consequently, the SLP must have holistic knowledge of the patient's healthcare needs, personal desires, beliefs, culture, and decision-making capacity (Sharp, 2006). When discussing and making choices for treatment, it is helpful to recognize and understand the roles of each member of the patient's support system. Speech-language pathologists account for patient desires, as well as those of the involved family members and caregivers, when reasoning through an ethical dilemma (Sharp, 2006). Ideally, the patient and family will have a clear understanding of the patient's healthcare desires. However, this is often not the case and can include differing opinions among the decision makers. The SLP must provide systematic education to promote the patients' ability to make informed decisions regarding their healthcare needs (Kaizer et al., 2012).

External to the patient, but internal to the therapist, are the therapists' morals, values, and previous experiences (Chabon & Donaldson, 2011; Kenny et al., 2007). Speech-language pathologists consider their own values when weighing options during ethical situations. They must be internally aware of values, morals, biases, and weigh these factors together with the impact of external stakeholders.

Externally, interpersonal relationships with colleagues, and the organization for which they work, are balanced with the factors internal to the patient (Kenny et al., 2007). Further, providers must know and follow local, state, and national laws and professional codes of ethics (Atherton & McAllister, 2015). Collectively viewed, the SLP must consider values and preferences internal to their morals. Externally, attention is held on the roles and input from the

patient, other professionals within the team, and legal and ethical conduct rules outlining professional behavior. Other researchers have reinforced these SLP ethical decision-making considerations, with expansion to include social justice concepts.

Payne (2011) developed a model of the influences on the SLPs ethical decision-making, including science, economics, politics, law, religion, and culture (See Appendix A, Figure 1). Focusing on the role of social ethics, Payne (2011) reasoned that the profession of SLP emerged from the desire to serve and advocate for individuals with communication disorders. As a result, SLPs are called to serve as representatives of ethical treatment for individuals with communication disorders.

The intricacy of the outlined internal and external influences to ethical decision-making is reported as overwhelming for new providers, promoting feelings of isolation and frustration when solving ethical dilemmas (Kenny et al., 2007). Experienced clinicians rely heavily on past experiences when deciding on an action within an ethical situation (Kenny et al., 2010). For example, experienced SLPs use established professional relationships to guide advocation for the patient and ethical decision-making.

A lack of experience in novice SLP clinicians is one explanation for the reported deficiency in ethical reasoning confidence (Kenny et al., 2007). However, knowledge of this experience shortfall creates an opening for creative programming in healthcare higher education. For example, one way healthcare has approached enhancing student experiences is through the mentorship model. Clinical supervisors use their experiences to educate new student clinicians.

Working with and learning from knowledgeable supervisors and mentors guides the student in identifying and solving ethical conflicts (McCarthy et al., 2004). Students are primed for ethical decision-making through a mentor model, where clinical instructors and students work together to identify and solve ethical situations by modeling ethical behavior. Healthcare

higher education relies on the mentorship model as it promotes the passage of mentor experience to the student (Birden et al., 2013). Yet, there is limited research into the perspectives of SLP students and clinical supervisors related to development of ethical reasoning through mentorship (Buelow et al., 2010). Buelow, Mahan, and Garrity (2010) emphasized that research related to student perceptions can guide best-practice, student-centered pedagogies.

Development of Ethical Decision-Making

A look into the experiences of clinical students and supervisors in ethical decision-making (EDM) may serve as a starting point for understanding what enhances or inhibits the development of EDM. Experienced speech-language pathologists reported they used past experiences to guide their ethical decisions (Kenny et al., 2007). What is yet to be understood is how this experience might be fostered through higher education. A variety of EDM frameworks exist in healthcare literature (Tsai & Harasym, 2010). There is no gold-standard tool, though, for ethics instruction. Further, supervisors are not always aware of how to approach clinical education (Ferguson, 2005). An understanding of the experiences of student clinicians and supervisors when developing EDM skills may serve as a platform for building ethical education.

Consideration should be given to the thoughts and ideas experienced by new clinicians during ethical dilemmas. Ideally, students should be internally motivated when approaching a situation for learning (Mega et al., 2014). Motivation and positive emotions have been tied to greater student evaluation of learning, performance, and reflection. Extending to ethical decision-making experiences, negatively situated, clinical experiences can result in limitations on learning and resistance toward attempting the same situation again. This scenario of negative, underprepared ethical decision-making may be another explanation for the negative emotions reported by inexperienced clinicians when solving ethical dilemmas (Kenny et al., 2007).

A common struggle for novice speech-language clinicians is making sound ethical decisions (Kenny et al., 2007). The SLP must account for a variety of factors that influence the identification, reasoning, and decision-making required for ethical dilemmas. There is limited research to guide the development of ethical education frameworks in higher education (Pollard et al., 2018). A view of student and clinical supervisor experiences through an understanding of adult learning and epistemological development provided new insights into the ethical education of SLP graduate students. Epistemological development theory provided scaffolding for the complex nature of developing ethical reasoning. Baxter Magolda's (1996) epistemological development and Baxter Magolda's and King's (2004) learning partnerships models were used as lenses for understanding the experiences of teaching and learning ethical development in the SLP field. Concepts from community of practice and interprofessional education models also arose as strong potentials for instructional design considerations.

Epistemological Development Theory

Baxter Magolda's (1996) epistemological development model maps the patterns of student cognitive reasoning from absolute to contextual knowing. Through cycles of experience, students develop confidence in their learning, toward self-directed, contextual knowing. Baxter Magolda (2002) described epistemological development as "socially constructed, context-bound, fluid, and constituted by multiple realities" (p. 91). Epistemological development focuses on the complexity of student learning assumptions and the experiences that shape student understanding.

When viewed from a teaching and learning perspective, epistemological development may be challenged through careful instructional design. Students may be encouraged in their level of development (pattern of knowing), by systematically fostering more complex reasoning skills. One way to promote student epistemological development in the classroom is through

instructor modeling, teaching, and providing students opportunities to practice their learning in a variety of contexts (Baxter Magolda, 1999). Considering the ethical development needs of SLP graduate students, epistemological development models encourage instructors to meet students at their level of development and carefully balance the learning challenges and supports (Baxter Magolda & King, 2004). In addition, the fluidity of epistemological development matches to the fluid ethical reasoning reported by recent SLP graduates with the ongoing forward and backward movement patterns rather than stepwise progression to full self-authorship (Baxter Magolda, 2002; Kenny et al., 2007).

The development of strong ethical reasoning skills requires examination of personal values and beliefs. Baxter Magolda (1996) illustrated how instructors might use learning experiences to move students toward an increased level of reasoning. She further suggested using experience and framing to guide students in learning activities by

> "(1) capitalizing on students' experience, (2) creating particular experiences that students have not encountered, (3) framing class discussion that encourages the analysis of existing knowledge and personal biases, (4) asking students to support their beliefs in discussions or papers, (5) assignments that involve analyzing one's beliefs in the light of relevant knowledge, and (6) serving as a moderator for students to engage in these activities" (p. 302).

The foregoing elements might be used in a didactic classroom and in clinical field experiences to foster student ethical development. The learning partnerships model, described by Baxter Magolda and King (2004), takes the assumptions of epistemological theory and pairs the challenges of student development with suggested learning supports. For example, it can be a challenge for students to understand that "knowledge is mutually constructed via the sharing of expertise and authority" (Baxter Magolda & King, 2004, p. xix). However, pairing these

challenges with learning supports, such as working toward a mutually constructed understanding, offers a model for approaching diverse learners at the various epistemological development stages (Baxter Magolda & King, 2004).

An ultimate goal of epistemological development in higher education is self-authorship, or "the ability to reflect upon one's beliefs, organize one's thoughts and feelings in the context of, but separate from, the thoughts and feelings of others, and literally make up one's own mind" (Baxter Magolda, 1999, p. 6). The value of self-authorship in ethical reasoning is the capacity for contextualized, independent, and responsible decision-making during complex issues. Baxter-Magolda (1999) emphasized that self-authorship comes from transformative teaching and learning experiences. Yet, movement through the stages of epistemological development does not guarantee that a student will reach self-authorship. Rather, self-authorship, and skill with complex decision-making was often not observed until after college graduation (Baxter Magolda, 1999).

Epistemological development is an area where instructors may draw upon theory to scaffold student ethical learning experiences toward more complex learning assumptions and self-authorship. In order to understand the epistemological and ethical development of SLP graduate students, more consideration must be given to the ethical reasoning strengths and challenges faced by these students and their supervisors during clinical experiences. Understanding the self-reported influences and experiences of current SLP graduate students and supervisors toward their development of ethical decision-making has the power to guide future models for ethical education. In order to understand these influences for teaching and learning application, the student and supervisor experiences were viewed through the lens of epistemological development and a model of pedagogical challenges and supports found in the learning partnerships framework.

Additional ethical reasoning instructional design considerations were borrowed from communities of practice (COP) and interprofessional education/practice (IPE/IPP) models and literature (Attrill et al., 2018; Drinka & Clark, 2016; IPEC, 2011; Lave & Wenger, 1991; Merriam & Bierema, 2014). Community of practice models have the potential to provide further balance of student challenge/support toward increased mastery of complex ethical decisions (Lave & Wenger, 1991; Merriam & Bierema, 2014). Communities of practice include individuals at various levels of epistemic development. Focusing on the role of situated learning and experience, COPs foster student development moving them from a peripheral-to-central, apprentice-to-mastery. Integral to this experience is designing opportunities that nurture learning through experiences and shared histories. In this way, the mentorship model in healthcare higher education can look toward increased student participation within the COP during healthcare practicums. Novice SLPs struggled to gain footing during ethical decision-making. By situating the student within the community, they have the potential to gain further learning experiences while benefitting from the nearby clinical supervisor support.

Interprofessional education programming also looks to similar roles as a community of practice. Aiding students to learn with, from, and about each other calls for social learning (IPEC, 2011; WHO, 2010). Interprofessional education and practice call upon similar concepts as COP with potentials for creating and expanding upon learning communities found between both peers and/or healthcare professionals. Speech-language pathology graduate students are already embedded into COP and IPE/IPP environments. What is needed is increased awareness of how to best foster increased student engagement, learning, and epistemological development toward self-authorship and independent ethical decision-making.

Statement of the Problem

Speech-language pathology student clinicians are part of the healthcare team expected to have complex, ethical decision-making skills (Kummer & Turner, 2011); however, new SLP graduates report less ethical reasoning proficiency when compared to experienced SLPs (Kenny et al., 2007; 2010). The discomfort of new graduates in ethical decision-making supports the necessity of ethical instruction for SLP graduate clinicians (McAllister & Lincoln, 2004). In healthcare, experienced healthcare professionals serve as role models for professionalism (Birden et al., 2013). The largest influence on student professional development is the behavior of their professional role models. Speech-language pathology clinical supervisors serve as ethical role models and educators to graduate students, though little is known about the experiences of the clinical supervisors and students during the development of ethical decision-making. This research was designed to investigate how ethical experiences interacted with SLP graduate students' development of ethical decision-making.

Statement of Purpose

The purpose of this study was to explore what influences speech-language pathology (SLP) graduate students and clinical supervisors ascribed to the development of ethical decision-making. When considering how to implement ethical programming into SLP graduate courses, a review of the research found limited models for guiding development of bioethical reasoning and understanding of ethical decision-making development in SLP students. Yet, research findings supported the role of higher education in professional, ethical development (AACU, 2010; Kenny et al., 2007; McCarthy et al., 2004; Pollard et al., 2018; Tsai & Harasym, 2010).

This study was completed via interviews with five SLP graduate students and six SLP clinical supervisors. A phenomenological approach was utilized to describe and understand the common experiences held by the participants, building from their individual reports into a central concept, essence (Creswell & Poth, 2018; Giorgi, 2012). Participants engaged in two, one-on-

one semi-structured interviews. The qualitative data from the interviews was transcribed, then analyzed using phenomenological analysis methods outlined by Moustakas (1994): horizontalization, textural, and structural description. The study addressed the following research questions:

(1) What do SLP graduate student clinicians, in the Upper Midwest, describe as influences on the essence of ethical decision-making development?

(2) What influences do SLP clinical supervisors, in the Upper Midwest, ascribe to the essence of ethical decision-making development?

(3) What epistemic assumptions do student clinicians and clinical supervisors, in the Upper Midwest, illustrate as influences on ethical decision-making development?

Significance of the Study

This study aimed to identify areas of growth and challenges to the SLP graduate students' ethical decision-making development. Phenomenological research was used to provide a central understanding of the experiences of two groups of participants: SLP graduate students and clinical supervisors. Interviews from the participants further defined what influenced the ethical decision-making of SLP graduate students and clinical supervisors when working with graduate students, providing the structural and textural descriptions of the EDM stories. Their collective ethical stories formed the essence of the group's experiences and influences during the development of ethical decision-making and highlighted the union of both perspectives. In addition, their experiences provided insights to the similarities and differences between experienced and inexperienced SLP practitioners during ethical decision-making.

The participants' stories emphasized the need for ethical decision-making in clinical education (Cloonan et al., 1999). This study expanded the body of literature on ethical decision-making in the field of SLP by responding to the need for understanding the student experience

and supervisory perspectives during ethical decision-making. Further, it advanced the understanding of epistemological development in SLP graduate students.

The participant's ethical essences underscored the utility of learning partnerships, epistemological development, and interprofessional education/practice within healthcare higher education for SLP graduate students. The intersections between teaching and learning and the field of SLP provided guidance for improved pedagogical ethical reasoning design based upon the student and supervisor experiences. These ethical decision-making essences expanded the understanding of facilitators and barriers to student epistemological development within the classroom and during clinical experiences. The results are useful toward improving not only the student experience during ethical decision-making, but also when guiding academic and clinical educators during ethical education. Suggested next steps toward best-practice ethical education are discussed in detail in Chapter V.

Delimitations

I aimed to investigate the experiences of a group of individuals and the co-construction of ethical reasoning that arises during student clinical experiences; consequently, I chose a qualitative inquiry approach with a phenomenological design. The results described the experiences of the participants but are not representative of all SLP student and supervisor ethical decision-making processes. Additionally, the student participants were limited to a criterion of having at least one healthcare clinical placement. This requirement limited the understanding of students engaged in ethical reasoning during educational-based practicums. Also, by focusing on healthcare placements, students were at least in their second and final year of graduate programming when recruitment began, thus more advanced in their practice.

The resulting data were subject to participant experiences, levels of experience, and development in ethical decision-making at the time of my interviews. This was an isolated

picture of the development of ethical decision-making by limiting participants to only those with healthcare-based experiences. This research, however, added to the ill-defined picture of SLP graduate student ethical decision-making through the participant interviews.

Definitions

This study is an intersection of two professional fields, speech-language pathology (SLP) and higher education. This section serves as an area of clarification for professional jargon and terminology.

- Baxter Magolda Epistemological Development Model (BMED): "longitudinal study of the cognitive development of male and female college students in Knowing and Reasoning in College (1992)" (Bock, 1999, p. 30). The resulting model includes four stages of student reasoning: absolute knowing, transitional knowing, independent knowing, and contextual knowing.
- Bioethics: considering right and wrong ethical actions in healthcare. The common principles of bioethics are autonomy, nonmaleficence, beneficence, and justice (Horner, 2003; Horner et al., 2016).
- Communities of Practice (COP): main concepts from COP models is that "learning is a process of participation in communities of practice, participation that is at first legitimately peripheral but that increases gradually in engagement and complexity" (Lave & Wenger, 1991, p. 2).
- Complex Problem Solving: "a collection of self-regulated psychological processes and activities necessary in dynamic environments to achieve ill-defined goals that cannot be reached by routine actions. Creative combinations of knowledge and a broad set of strategies are needed….The problem-solving process combines cognitive, emotional, and motivational aspects, particularly in high-stakes situations. Complex problems usually

involve knowledge-rich requirements and collaboration among different persons" (Dörner & Funke , 2017, p. 6).

- Dysphagia: "A swallowing disorder, known as dysphagia, may occur as a result of various medical conditions. Dysphagia is defined as problems involving the oral cavity, pharynx, esophagus, or gastroesophageal junction" (ASHA, 2018, par. 1).
- Epistemology: "the origin, nature, limits, methods and justification of human knowledge" (Hofer, 2002, p. 4).
- Interprofessional Education (IPE): "when students from two or more professions learn about, from and with each other, to enable effective collaboration and improve health outcomes" (WHO, 2010, p. 7).
- Nothing per oral/Nil per oral (NPO): patient is not to have any food, liquid, or medication by mouth and requires a nonoral source for medication, nutrition, and hydration access (Murry & Carrau, 2012).
- PEG Tube: "A percutaneous endoscopic gastrostomy (PEG) is a safe and effective way to provide food, liquids and medications (when appropriate) directly into the stomach. The procedure is done for patients who are having trouble swallowing" (Cleveland Clinic, 2020, par. 2)
- Self-authorship: "capacity to internally define a coherent belief system and identity that coordinates mutual relations with others" (Baxter Magolda & King, 2004, p. 8).
- Videofluoroscopic Swallow Study (VFSS or Video): "VFSS, also known as modified barium swallow, is a radiographic procedure that provides a direct, dynamic view of oral, pharyngeal, and upper esophageal function during swallowing. During this procedure, the SLP presents food and liquid mixed with barium. The barium is necessary to view structures via videofluoroscopy during the swallow" (ASHA, 2020b, par. 1).

Research Design

This study was designed utilizing a phenomenological approach because of the desire to reach a collective understanding of SLP graduate student experiences in ethical decision-making. A phenomenological design promoted the external description of data that is internal to the participants (Giorgi, 2012; Moustakas, 1994). One-on-one interviews were used to gain the perspectives of the participants and their self-reported influences and experiences. Phenomenological inquiry was also chosen because it takes the collective reports of a group of participants who have similar experiences creating a central concept or phenomenon to improve understanding. In this study, the central concept or phenomenon was the SLP graduate student ethical decision-making development.

The next chapter details the literature and theoretical frameworks used to guide, and then examine, this research design and results. It is followed by the study results including participant quotations and stories of the ethical situations and influences guiding and describing their ethical decision-making. Finally, the last chapter includes a discussion of the study results in the context of the theoretical framework and existing literature, providing limitations, suggestions for future research, and comparison to the existing literature base.

CHAPTER II

LITERATURE REVIEW

A review of the literature related to the development of ethical decision-making in speech-language pathology (SLP) graduate students incorporates ideas from bioethics, professional literature on ethics in SLP, and application of epistemological development theories to ethical education. The following discussion first reviews the field of bioethics and the interplay between the concepts of ethics, morals, values, and professionalism in healthcare. This introduction is followed by an overview of the literature regarding ethics and ethical reasoning specific to the field of SLP, a discussion of the role of higher education in ethical development, and the theoretical framework for the proposed research.

Introduction to Bioethics

An ethical dilemma occurs when an act has morally correct outcomes. However, it conflicts with an almost equivocal potential for wrong or negative results (Beauchamp & Childress, 2001). In medicine, the field for considering right and wrong ethical actions is termed bioethics. The common principles of bioethics are:

- autonomy—the right to self-discretion and decision-making, preservation of self-worth (Horner, 2003),
- non-maleficence—the avoidance of harm to the patient (Horner, 2003),
- beneficence—the promotion of health and healing (Horner, 2003), andjustice—“fair, equitable, and appropriate treatment” (Horner, 2003; Horner et al., 2016, p. 456).

This list can be expanded to include patient dignity and trust (Kummer & Turner, 2011). These principles pair with the concepts of morality to guide ethical behaviors and community betterment (Horner et al., 2016). In healthcare, the need to do what is right is often muddied by the negative side effects of healthcare treatment. As stated in Kummer and Tuner (2011), "certainly in modern times, there is no profession that is more conscious of ethics, or more plagued with ethical dilemmas, than medicine" (p. 331).

Values, Ethics, and Professionalism

The development of morals and ethics is an essential element in the education and preparation of healthcare professionals (Association of American Colleges and Universities, 2010; McAllister & Lincoln, 2004). Healthcare providers develop morals through childhood and into adulthood (Woolfolk, 2013). Healthcare students are asked to further challenge their personal morals through the consideration of bioethical dilemmas (McAllister & Lincoln, 2004). Ethical reasoning compels students to be aware of their personal values and morals, identify an ethical concern, and consider viable solutions, all while weighing the various outcomes (AACU, 2010). This complex process should not be left to chance; rather, it ought to be systematically presented throughout a healthcare curriculum (Poole & Solomon, 2010). Bioethical decisions hold real power for influencing the health and happiness of the patient and must be taken seriously (Kummer & Turner, 2011).

As a result, professional healthcare organizations have labored to provide their members with codes of ethics to guide interactions with patients and community. As a profession that holds paramount the ethical treatment of patients, the field of SLP has followed other healthcare organizations, such as the American Medical Association in 1847 and the American Nurses Association in 1950, with documents for directing professional behavior (Epstein & Turner, 2015; Riddick, 2003).

Ethics in SLP

The Code of Ethics for the field of SLP was first developed in 1952 and is published by the American Speech-Language-Hearing Association (ASHA, 2016a). The 2016 ASHA Code of Ethics highlights acceptable standards for professional conduct and decision-making; it includes as its primary role to preserve the value of the profession and the clients it serves. The ASHA (2016a) Code of Ethics contains four guiding principles: "(I) responsibility to persons served professionally and to research participants, both human and animal; (II) responsibility for one's professional competence; (III) responsibility to the public; and (IV) responsibility for professional relationships" (par. 5). Within each principle exists rules for "minimally acceptable as well as unacceptable professional conduct" (ASHA, 2016a, par. 5). The ASHA (2016a) Code of Ethics outlines ethical and professional behavior for students; it is an important consideration for educators when guiding students to develop an understanding of sound ethical conduct (ASHA, 2016a; Beauchamp & Childress, 2001). Healthcare Codes of Ethics, like those of ASHA, are part of the gatekeeping procedures put in place to promote a consistent, professional standard for behavior within a field.

Specialized knowledge and skills are required for entry into most healthcare professions (Beauchamp & Childress, 2001). This effort toward occupation gatekeeping aims to preserve the integrity of a profession and safety to the community receiving healthcare services. The safeguarding of public health is rooted in the professional's understanding of bioethical codes and standards. Speech-language pathology is not an exception. Within the clinical competency framework are standards of advanced education and knowledge of ethical behavior (ASHA, 2016b). Accordingly, accredited speech-language pathology graduate programs must provide documentation that new SLP graduates have knowledge of and the skills to follow the ASHA Code of Ethics (ASHA, 2016b). SLP students must be versed in ethical conduct, including a

clear understanding of the ASHA Code of Ethics and how to practice in an ethical manner. While SLPs may not face daily ethical dilemmas, they certainly find ethical decision-making a part of their daily clinical decision-making (Flatley et al., 2014).

A review of the research related to ethical decision-making in the field of SLP reveals the majority of studies have occurred with SLPs practicing in healthcare related service areas. Therefore, there are limitations to what is understood about how speech-language pathology programs might promote the development of ethical decision-making during academic and clinical programming (Pollard et al., 2018). An examination of the existing SLP ethical decision-making literature aided in the development of this study and framing of the future challenges SLP graduate students may face.

Ethical Reasoning in Speech-Language Pathologists

Researchers have investigated three-levels of clinical development in the daily and ethical reasoning of SLPs: novice, experienced, and administrators (Flatley et al., 2014; Kenny et al., 2007, 2010). However, the number of studies that have occurred at each level is limited to one or two publications. The majority of the published SLP ethical decision-making behavior research studies are credited to several Australian-based researchers. Belinda Kenny, Michelle Lincoln, Susan Baladin, Lindy McAllister, and Natalie Pollard are all noteworthy researchers across SLP ethical reasoning and higher education frameworks. A review of the four SLP ethical decision-making experience studies finds a graded progression of ethical and professional development; yet, an analysis of these studies found that practiced SLPs primarily rely upon experience when identifying, reasoning through, and utilizing available resources to solve an ethical dilemma.

Novice SLPs

Beginning with novice clinicians, Kenny et al. (2007) gathered the narrative reports of 10 Australian speech pathologists in the first one and one-half years of their professional careers regarding approaches to ethical reasoning. This is the only study discovered in the review of literature that focused on the ethical decision-making experiences of new SLP graduates. The authors found that new graduates experienced ethical issues in a variety of ways and complications occurred throughout the reasoning process. For example, participants found it difficult to identify ethical situations, questioned their level of responsibility in ethical dilemmas, felt isolated, feared backlash from coworkers, and were concerned about legal consequences. These clinicians wanted to seek out more experienced therapists and co-workers to aid in their decision-making, but this desire contrasted with a fear of appearing incompetent. The majority of the participants had gaps in their readiness for ethical situations. All participants reported use of previous, although limited, clinical experiences to aid in ethical decision-making.

Kenny et al. (2007) found novice clinicians have early strengths in compassion and desire to work through an ethical problem, but then again generalizable weaknesses in five elements: (1) ethical dilemma awareness, (2) independent problem solving, (3) supported problem-solving, (4) decision-making, and (5) evaluation of outcomes. Each of these elements was paired with a few clinical reasoning features (e.g., checking with other clinicians, lack of experience, and desire for self-protection), which either promoted or limited the clinicians' independence in moving through an ethical dilemma. The researchers used these elements of ethical reasoning and the participants' responses to ethical dilemmas to form a proposed Dynamic Model of Ethical Reasoning.

Within this model, new clinicians demonstrated fluidity in ethical reasoning, rather than step-by-step problem-solving. Kenny et al. (2007) discovered that new clinicians used a variety of methods to solve ethical dilemmas within each of the five ethical reasoning elements. The

authors reasoned against using these categories as a prescriptive model for solving ethical dilemmas and were inclined instead toward a model for the development of reasoning skills within each of the five elements. The authors suggested the use of the developed Dynamic Model of Ethical Reasoning (See Appendix B, Table 1) within their study for scaffolding, or providing temporary student learning supports that correlate to their development, within teaching and learning experiences in higher education (Great Schools Partnership, 2015).

The Kenny et al. (2007) study contrasted with much of the published research regarding teaching ethics in healthcare and higher education. The research related to ethical pedagogy in the field of SLP has primarily focused on step-by-step frameworks and supervisor questioning lines (Chabon & Morris, 2004; McCarthy et al., 2004). On the contrary, Kenny et al. (2007) found that new clinicians do not use a prescribed method of reasoning in ethical dilemmas. Consequently, step-by-step training in ethical education may not translate to clinical practice. Ethical dilemmas are complex, leading to a need for complex reasoning when solving ethical problems. These authors provided an overview of what goes into the ethical reasoning of new graduates. What is needed is an expanded view of speech-language pathology graduate student experiences during clinical, ethical education leading to that first professional placement.

Experienced SLPs

Kenny et al. (2010) also investigated the impact of clinical experience on ethical reasoning in speech pathologists with at least five years of experience. The researchers interviewed 10 experienced SLPs gaining narratives on how they resolved ethical dilemmas. The participants' narratives were then coded and grouped into themes of common reasoning processes.

There were similarities that emerged across the Kenny et al. (2007; 2010) studies, such as the desire to consult with colleagues when working through an ethical dilemma. Experienced,

like novice, SLPs found barriers and occasional reluctance toward collaboration from coworkers (Kenny et al, 2007, 2010; Kenny et al., 2009). Experienced providers focused on a holistic picture of the patient, including background and well-being. This finding contrasted with novice SLPs as they described weaknesses in the areas of identifying stakeholders and patient dynamics in ethical dilemmas (Kenny et al., 2007, 2009, 2010). Finally, while new providers were laying the groundwork for interprofessional relationships, experienced providers used their professional networks to advocate for the patient (Kenny et al., 2007, 2009, 2010). Collectively, practiced SLPs relied heavily on their experience when dealing with ethical dilemmas.

Kenny et al. (2010) outlined five approaches used by experienced SLPs to solve an ethical dilemma:

1. investigate clients' background, prognosis and perceptions of health;
2. explore clients' support networks, including family, community, and health care providers;
3. examine the duties and responsibilities of treating professionals;
4. critically evaluate the healthcare resources available; and
5. seek advice from colleagues to manage the political, psychosocial, or professional requirements of the dilemma (p. 128-129).

Together these approaches reflect the value of experience when solving ethical dilemmas. Speech-language pathologists with greater than five years of experience rely upon their experiences, networks of colleagues, and understanding of the clinical resources available to them when reasoning through ethical dilemmas (Kenny et al., 2010). Experienced SLPs reflected a stronger level of comfort in not only identifying, but managing the various solutions to an ethical problem, and relied on external resources without fear of retaliation. The comfort with both intra- and interpersonal resources is reflective of an ethical development pattern not found

in new graduates. The researchers did not address how the clinical experiences shaped the development of ethical decision-making in the experienced SLPs. An exploration of the influences shaping experienced clinicians may shed further light into the clinical development of ethical approaches. The progression from new graduate through clinical experience and into administrative positions is a common trend for practicing SLPs. The research into speech-language pathology administrators revealed both similarities and differences to new and experienced practicing SLPs. These differences added to the picture of potential ethical challenges throughout an SLP career.

Administrative SLPs

Flatley et al. (2014) researched the ethical issues faced by private practice owners and managers through qualitative interviews with 10 female SLPs practicing in Australia. The narratives of the participants reflected the impact of administrative positions on ethical experiences. Several themes from this study were of greater impact in the private practice group when compared to novice and experienced SLPs including concerns for distribution of resources, staffing, and business practices. However, comparable to both novice and experienced clinical SLPs, private practice administrators encountered ethical dilemmas related to patient care and interactions with colleagues (Flatley et al., 2014; Kenny et al., 2007, 2010); specifically, they met issues surrounding patient diagnosis and the ethical behavior of coworkers.

Summary of SLP Ethical Decision-Making Research

Overall, the findings on ethical experiences of SLPs promoted the value of experience when responding to ethical dilemmas (Flatley et al., 2014; Kenny et al., 2007, 2010). Across practices speech-language pathologists encounter many of the same ethical situations; yet the stories of experienced SLPs created a picture of a holistic and effective response pattern to ethical situations contrasted by the considerable effort described by new graduates (Flatley et al.,

2014; Kenny et al., 2007; 2009; 2010). The insecurities and discomforts reflected in new graduates were not found in advanced-practice SLPs (Kenny et al., 2007, 2010). This conclusion endorses the need for ethical instruction for students in SLP higher education programs, specifically it promotes the role of experience in gaining proficiency (McAllister & Lincoln, 2004).

Further, novice SLPs demonstrated dynamic problem-solving when working through an ethical dilemma (Kenny et al., 2007, 2010). The dynamic reasoning approach used by new clinicians was not reflected in the narratives of experienced SLPs. Consequently, there is limited knowledge on how the reasoning methods of experienced and inexperienced SLPs might come together in the development of ethical reasoning or during clinical mentorship experiences.

The literature on the ethical decision-making of practicing SLPs describes the importance of experience in ethical reasoning. However, there is a gap in the understanding of what students and clinical supervisors report as barriers and facilitators to the development of ethical decision-making in SLP graduate students. A summary of the experiences of practicing SLPs does not detail the experiences of students, or the intersection of experienced and novice reasoning.

An investigation of what graduate students and mentors report as influencing ethical decision-making has potential to guide understanding of ethical, epistemological development and the design of ethical pedagogy. The existing field of literature on ethical development in SLP education looks to the role of mentorship in training new student clinicians. Frameworks, based on expert opinion, guide the practices of clinical supervisors as they work through ethical dilemmas through feedback and stages to ethical reasoning. The following sections include an examination of the ethical reasoning resources available to SLP clinical graduate students and supervisors and served as a context when discussing participant experiences.

Frameworks for SLP Ethics Education

The American Speech-Language-Hearing Association (2018) defined the knowledge and skills for clinical supervisors as including “skill in modeling and nurturing clinical decision-making, including (a) using information to support clinical decisions and solve problems, and (b) responding appropriately to ethical dilemmas” (par. 3). Within the literature, there is support for the benefits of feedback and reflection in clinical education for professionalism (Birden et al., 2013). In a systematic review, Birden et al. (2013) advocated for the use of highly qualified role models and mentors when working on higher education programming for healthcare personnel professional development. The authors warned that there exists limited research to support the best-practices for teaching professionalism. While this research did not directly evaluate the impact of ethical learning in SLP students, it did demonstrate the potentials for student learning through experienced practitioners. It also underscored the shortage of studies that provide an understanding of the actual experiences of supervisors and student clinicians during ethical decision-making. The existing literature related to ethical reasoning in SLP ties to the role of clinical supervisors and problem-solving frameworks.

Clinical Supervision

McCarthy et al. (2004) and Body and McAllister (2009) argued for the role of supervisors in the ethical education of SLP student clinicians. McCarthy et al. (2004) provided clinical supervisors with steps for scaffolding discussions of ethical dilemmas with student clinicians. These authors recommended five steps for precepting ethical situations with student clinicians, which are: (1) discuss the problem, (2) assess legal/ethical issues, (3) determine who is affected, (4) identify options, and (5) reflect. Within these stages the authors emphasized the role of the preceptor to aid the student in a vision outside of the error or ethical situation, acting as a guide to ethical decision-making. The use of frameworks guiding ethical decision-making was found across healthcare profession literature (Fornari, 2015; Manson, 2012; Pollard et al.

2018; Tsai & Harasym, 2010). However, there is a demand for a systematic evaluation of their use in practice. Expansion is needed on if and how these frameworks are employed formally, or informally, during clinical practice and education.

Chabon and Morris (2004) also offered a model for ethical decision-making, stepping the reader through identification of the ethical issue, courses of action, potential impact of actions, relation of action to personal values, consideration of ASHA code of ethics, and finally determination if the action is a consensus agreement or "does not impinge upon the personal and professional integrity of those involved" (p. 18). Similar to McCarthy et al. (2004), these authors emphasized a step-by-step process that can be outlined when working through an ethical dilemma. Conversely, Kenny et al. (2007) stated that novice SLPs employed fluid, rather than stage-wise, reasoning when working through ethical dilemmas. The existing models may limit new clinicians in their critical thinking during an ethical situation. It is unknown if these models provide too much support or challenges to the beginning SLP. What has yet to be investigated is if ethical decision-making models are useful to the development of ethical decision-making. Further research into what clinical supervisors and student clinicians are using to guide their ethical reasoning may highlight other areas of consideration—beyond the provided professional models.

Additional researchers described guidelines for the ethical responsibilities of students and clinical supervisors. For example, Chabon et al. (2008) emphasized the complex relationships that surround ethics during clinical supervision. These authors supported students and clinical supervisors by outlining the roles of each within a clinical experience and encouraging open communication of roles within the student-supervisor-patient relationship. Chabon et al. (2008) discussed the need for "enhancing ethical decision-making and minimizing ethical dilemmas" (p.26). The authors considered mentorship checks-and-balances, student development, patient

acceptance, transparency, and university support as relationship paradigms driving the effective clinical experience.

Collectively, the literature supporting ethics in SLP clinical supervision is composed of expert opinions, frameworks, role clarifications, and the ASHA (2016a) Code of Ethics. There is an absence of research into how supervisors and students are working through ethical dilemmas in clinical practice. Clinical supervisors are supported by these publications but have limited guidance on how to account for the diverse needs of students, patients, and the circumstances surrounding an ethical problem. The provided frameworks may be a starting point for supervisors. It is not known, however, if, or how, these frameworks are utilized within clinical experiences or mentorships because of a lack research evaluating framework use.

Supervisors often feel unprepared (Ferguson, 2005). Clinical SLPs do not have formal education in the epistemological development and adult learning needs of the graduate student clinician. Yet, the relationship between the supervisor and student is important to the development of clinical skills, including ethical reasoning (Body & McAllister, 2009). An increased understanding of this relationship served to guide how students and clinicians are experiencing ethical decision-making, including the influences on student development. When considering the instruction of ethics outside of the student-supervisor relationship, a review of the literature offers further suggestions for ethical pedagogy in the SLP field.

Ethical Pedagogies in SLP

Poole and Solomon (2010) discussed the implications of the variety of ways that SLP graduate programs are addressing the need for student education in ethics. The researchers argued that while ethics can be an issue of professional-level practice, the variability in graduate curricula is leading to inconsistencies in ethical readiness and potential shortfalls in future clinicians. The authors collected a series of suggested professional behavior projects and

activities from a group attending a professional conference for higher education programs in communication disorders. The result was a list of curriculum options for contemporary professional issues, including ethical conduct and dilemmas. In overview, the authors provided activities such as interviewing patients regarding appropriate professional behavior, developing a presentation related to ethical dilemmas, and a debate for and against living wills. These items were organized into a table by the corresponding Bloom's stage of intellectual behavior. Poole and Solomon (2010) encouraged the use of relevant, everyday clinical experiences to enhance student engagement and meaning-making. While this article provided an outline of classroom activities tied to teaching and learning philosophies, others have evaluated the effectiveness of existing ethical case-based activities.

Stewart and Gonzalez (2006) implemented a cooperative learning project targeting professional issues, including ethical reasoning. The researchers examined the student ethical reasoning outcomes following a cooperative learning, complex ethical scenario assignment. The participants included 29 students enrolled in a senior-level communication disorders course. The authors describe the assignment elements and targeted learning objectives, such as working cooperatively, and "selecting, analyzing, and synthesizing material to formulate an ethical and defensible position on a professional issue" (Stewart & Gonzalez, 2006, p. 162). Instructor evaluations found that students met learning outcomes. Student feedback reflected a desire for additional support and resources when working through the assignment. Suggested future adjustments included inducing an ethical reasoning framework, such as the Chabon and Morris (2004) model for ethical decision-making.

The student feedback in the Stewart and Gonzalez (2006) research reflected the inconsistencies found in student epistemological development at the undergraduate level (Baxter Magolda & King, 2004). Students desired additional support for an activity, which they found to

be challenging. When viewed in the context of epistemological development, these comments are reflective of students who struggle with self-authorship and still look to authority to aid them in determining right from wrong. This challenge of self-authorship becomes increasingly more complex when working through complex ethical issues. The inclusion of student feedback strengthened the holistic view of ethical education in SLP (Stewart & Gonzalez, 2006); however, other research into SLP ethical education has failed to look toward student feedback.

Other researchers studied the levels of reasoning elicited by ethical case studies. Kenny et al. (2015) investigated the role of ethical cases for engaging SLP students and clinicians in ethical reasoning behaviors, studying differences in student, new graduate, and experienced SLP responses to a written, ethical dilemma. The student participants were undergraduates who had enrolled in introductory ethical learning modules and lectures with limited-to-no prior clinical experiences. New graduates and experienced SLPs were all practicing within healthcare or private practice. Overall, the researchers found that practicing clinicians described more complexities in the ethical cases when compared to students. New and experienced SLPs viewed the ethical case holistically and provided creative solutions. Students, on the other hand, struggled to describe nuances of interpersonal issues and possible available resources. Kenny et al. (2015) argued that ethical cases did elicit different levels of ethical reasoning because of the variability found across students and practitioner participants. The researchers reasoned that ethical cases can promote student ethical reasoning and should be used to advance the critical thinking of students. Further instruction might include comparisons of the students' responses to those formulated by experienced SLPs.

Collectively, the presented models and ethical pedagogy research all focused on the role of experiencing ethical reasoning in a variety of forms. Options for instructional design included structured didactic training, role modeling, presentation of ethical cases, and clinical supervisor

questioning frameworks (Birden et al., 2013; Body & McAllister, 2009; Kenny et al., 2015; McCarthy et al., 2004; Poole & Solomon, 2010). One research article included student feedback on the effectiveness of ethical case study activities (Stewart & Gonzalez, 2006).

The shortage of student voice in the academic literature does not provide a clear picture of student development in SLP ethics education. In addition, the body of primarily expert opinion does not give voice to the students learning ethics for healthcare practice. There is a need for further research regarding teaching SLP students in the area of ethical development. The existing models do not account for diverse student needs. They do not consider student development and the need for support and challenges when learning.

One growing model in healthcare education is interprofessional education and interprofessional practice (IPE/IPP) (Drinka & Clark, 2016; IPEC, 2011). In IPE/IPP, students often learn in cooperative teams to solve complex issues, such as ethical dilemmas. Interprofessional education focuses on the core values of collaborative healthcare services.

Interprofessional Education and Practice

The goal of IPE is to establish a team of individuals from different healthcare fields who come together into a collaborative learning framework. Interprofessional education occurs "when students from two or more professions learn about, from and with each other, to enable effective collaboration and improve health outcomes" (WHO, 2010, p. 7). Understood as a best-practice healthcare communication format, IPE/IPP has expanded across healthcare higher education (HPAC, 2019). The nature of ethical decision-making as a community, team-based also decision lends to the IPE/IPP model. Classrooms with IPE are often involved in active learning activities, simulations, labs, and case studies (Dryan & Murphy, 2013). This framework infuses best-practice andragogy and healthcare collaborations.

While it is known to have many strengths, IPE is not without its challenges to buy-in, successful planning, and follow-through (Gilbert, 2009; Hammic et al., 2007). The establishment of sound, effective IPE requires time and cost considerations. Therefore, more should be understood about the current status of student ethical learning experiences to promote effective IPE/IPP design within SLP graduate programs. One way to expand the utility of IPE/IPP is through an understanding of the role that interprofessional communities of practice play in student development.

Communities of Practice

Healthcare higher education is often situated into small- and large-scale communities of practice (COP) (Attrill et al., 2018; Lave & Wenger, 1991; Merriam & Bierema, 2014). Communities of practice include groups of individuals with varied levels of expertise working as a team. Speech-language pathology graduate students engage in formal and informal COP across their academic coursework and clinical placements. In this way, COP frameworks can be applied to the ethical education of SLP students within clinicals and classrooms. An emphasis of COP literature is the role of moving from an apprentice-to-mastery level community member (Lave & Wenger, 1991). Lave and Wenger (1991) described this transition as a gradual movement from peripheral participation to a more complex and engaged member of the learning community.

A study by Attrill et al. (2018) investigated the perspectives of clinical preceptors, or placement facilitators, when integrating SLP graduate students into an early childhood, interprofessional COP. The study revealed that when SLP graduate students were considered legitimate and active partners in an interprofessional COP, there was a reciprocal, respectful learning relationship between students and their placement facilitators. As such, the impact of power and respect differences between novice and master learners was diffused through appropriate orientation to the practice environment and student willingness to engage in

interdisciplinary activities, crossing into other service delivery areas. These actions moved students from peripheral, into legitimate, COP members. Finally, once the students were situated as legitimate COP members the team worked more collaboratively, extending their holistic approach to early childhood education.

In this way, IPE/IPP and COP reflect potentials for best-practice ethical education in SLP graduate programming; however, what is not known is how these factors may be already influencing the ethical development of SLP graduate students. Consequently, the proposed research considers the relationship between ethical experiences and development in SLP graduate students. Epistemological development theories were used to frame the essence of the participants' ethical learning and decision-making experiences.

Theoretical Framework

The literature related to ethical reasoning in speech-language pathology programs has called for an increased focus on ethics within professional preparatory programs (Kenny et al., 2009; McCarthy et al., 2004; Poole & Solomon, 2010; Stewart and Gonzalez, 2006). As ethical reasoning is vital to preservation of patients and the profession, it should be taught in conjunction with clinical decision-making skills (ASHA, 2016b; Hoben et al., 2007). Although the breadth and depth of research related to the ethical dilemmas faced by SLPs is limited, the initial findings do provide an early outline of pedagogical ideas. Experienced SLPs rely on their established relationships and holistic knowledge of the patient when reasoning through ethical situations (Kenny, 2010). Speaking to the strengths of experience and interpersonal learning, concepts of epistemological development and self-authorship also promote the role of experience and context in learning. Further, community of practice and interprofessional education models provide frameworks for instructional design and deeper situated learning opportunities with student peers and mentors.

Teaching best practices should look toward the development of clinical and ethical reasoning in new SLP clinicians (McAllister & Lincoln, 2004; Pownall, 2004). This instructional design is, however, difficult because of the limited knowledge base related to the influences on, and experiences of, SLP students and professionals during ethical dilemmas (Kenny et al., 2007; McCarthy et al., 2004). Only one study evaluated the SLP students' insights into ethical learning activities (Steward & Gonzalez, 2006). It is known, however, that ethical development is complex and requires students to work through intra- and interpersonal relationships together with mature decision-making and problem-solving (Baxter Magolda & King, 2004). Theories of epistemological development recognize the importance of instructional design to promoting student development and have the potential to frame the preparation of healthcare higher education students in bioethical principles and reasoning.

Epistemological Development

Ethics and learning experiences are central to epistemological development (Baxter Magolda, 1996; Bock, 1999; Moore, 2002). Epistemological theory considers "the origin, nature, limits, methods and justification of human knowledge" (Hofer, 2002, p. 4). Therefore, epistemological development theories focus on "how the individual develops conceptions of knowledge and knowing and utilizes them in developing understanding of the world. This includes beliefs about the definition of knowledge and how knowledge is constructed, how knowledge is evaluated, where knowledge resides, and how knowing occurs" (Hofer, 2002, p. 4).

Starting in 1970, epistemology was used to describe the series of developmental knowing positions held by students attending Harvard College in the 1950s and 1960s (Moore, 2002; Perry, 1998). Since that time, the epistemic positions have been extended through research into gender implications, the longitudinal nature of knowledge, the role of learning reflections, and argument skills, to name a few (Belenky et al. 1986; Baxter Magolda 1992; King and Kitchener,

1994; Kuhn, 1991; Moore, 2002). This extensive research has amplified the view of adult learners as individual, global citizens. These researchers described how adult instruction might respond to student experience and epistemological development.

Baxter Magolda (1992) conducted longitudinal research on male and female college students as they progressed through their college years and following. The researcher found that the participants evolved through a series of four learning perspectives. Within Baxter Magolda's (1992) epistemological development model, the student progresses from a level of absolute knowing, through transitional, independent, and finally, contextual knowing. Through these stages, the student learns to question perceived absolutes and consider opinion and fact toward new understanding, and the ultimate goal of self-authorship. The following sections provide descriptions of student behaviors in each stage, including potential ethical development patterns, through Baxter Magolda's (1996) epistemological development model (BMED).

Absolute Knowing

In absolute knowing, students gain understanding from authority figures (Baxter Magolda, 1996; Bock, 1999). Absolute knowing has been characterized as the learning behaviors often observed in young, undergraduate students. A key characteristic of absolute knowing is that students are receivers of the teacher-provided knowledge. As Bock (1999) stated, "they assume that their role and the role of their peers is to obtain knowledge from teachers" (p. 31). Absolute knowers do not question the accuracy of the teacher's knowledge and respond well to black-and-white milieus. In the context of ethical reasoning, absolute knowers struggled with the gray areas that surround ethical decisions. Students with absolute thinking might look to supervisors or instructors to provide them with the correct course of action, without attentiveness to a variety of thoughts, beliefs, and morals. During interactions with peers, students in this stage will look to them to confirm what is known as absolute (Baxter Magolda, 1999).

Transitional Knowing

The second stage of BMED is transitional knowing. Transitional knowing consists of the first steps toward questioning authoritative conclusions (Bock, 1999). In transitional knowing, students begin to understand learning as a process rather than strict right and wrong response patterns. Transitional knowers look to develop an understanding through others (Baxter Magolda, 1999). This is the stage where peer interactions become important to new learning and peer relationships are marked by gender patterns. In impersonal patterns, males tend to view peers strictly as a way to increase their personal understanding. In contrast, women use interpersonal patterns and peer interactions to construct their knowledge through the assessments of others. In both circumstances, the instructor is still viewed as an authority for evaluating the accuracy of student understanding (Baxter Magolda & King, 2004). During ethical decision-making, transitional knowers might rely on other professionals to aid in determining the right, or wrong, solution to an ethical dilemma. Further, they may simply gather peer recommendations, rather than critically evaluate peer input. With limited clear authority figures to judge the accuracy of an ethical decision, the transitional knower may feel perpetually uncertain about their ethical reasoning knowledge (Bock, 1999). However, the peer interactions in transitional knowing become the groundwork for a student to move toward independent knowing (Baxter Magolda, 1999). After the student experiences growths in how to learn, the transitional knowing stage, they emerge into independent knowing, where they have strong use of opinion in reasoning.

Independent Knowing

Independent knowing is the third stage in BMED (Bock, 1999). The hallmark of independent knowing is the “students’ discovery that most knowledge is uncertain” (Bock, 1999, p. 34). Consequently, students begin to approach learning in different ways. The instructor is no

longer an authority of accurate knowledge, but rather a contributor to the learning process, similar to peers. Independent knowers polish their understanding through peers during open disagreements about a topic. As independent knowers construct knowledge, they begin to apply their individual understanding to solve multifaceted, contextual issues. Viewed in ethical decision-making, independent knowers collect the opinions of others, and make arguments for, or against, the course of action.

Contextual Knowing

The final stage of BMED is contextual knowing (Baxter Magolda, 1996). Students with contextual knowing integrate context and their own understanding, discerning important evidence and create their own truth by gathering information from a variety of sources. They seek out expert advice, opinions of others, and use their own conclusions to create a holistic understanding of the situation (Baxter Magolda, 1999). In ethical reasoning, contextual knowers should feel comfortable making ethical decisions, relying on their own opinions and a variety of evaluated resources. Drawing from the examples of experienced SLPs, the contextual knower may look to their available resources, cognitive knowledge, and opinions of coworkers to solve an ethical dilemma (Baxter Magolda, 1999; Kenny et al., 2010).

Epistemological development is not an automatic, streamlined, and step-by-step process; rather, there are areas of progress and set-back (Bock, 1999). Growing pains happen. A similar pattern of growth in understanding is reflected in the ethical decision-making of new SLPs (Kenny et al., 2010). Like epistemological development, the ethical development of speech-language pathologists relies upon exposure to ethical dilemmas and ongoing personal experiences (Kenny et al., 2010). Epistemological development not only views the contributions of previous experiences, intrapersonal, interpersonal, and contextual influences on meaning-

making, but also how these factors combine to enhance personal integrity and ethics (Baxter Magolda, 2002; Baxter Magolda & King, 2004).

Self-Authorship

Self-authorship emerges from the assumptions about knowledge uncertainty found in contextual knowing (Baxter Magolda, 1999). Similar to contextual knowers, individuals with self-authorship seek input from others to aid them when organizing complex experiences and authoring their own understanding (Baxter Magolda & King, 2004). Baxter Magolda (1999) asserted that this high-level of meaning-making is not often attained within the college years because students often lack the meaningful experiences needed to challenge them toward self-authorship. Yet, a sense of self-authorship is required to become a meaningful member of a team, organization, and wider community (Baxter Magolda & King, 2004).

The need for epistemological development toward self-authorship is not only useful within the adult learning classroom, but it is important for "meeting responsible citizenship expectations" and contributions "to the common good" (Baxter Magolda & King, 2004, p. xviii). A holistic view of epistemological and ethical development in SLP graduate students observes that there is potential for meaning-making experiences to occur across higher education classrooms and clinical placements. The link between epistemological development, "employment, community and personal life" is central to Baxter Magolda and King's (2004) learning partnerships model.

Learning Partnerships

Baxter Magolda and King (2004) created a learning partnerships model that integrates contexts that challenge and support learning and epistemological development (See Appendix C, Figure 2). The learning partnerships model relies on "three principles: validating learning capacity as knowledge constructors, situating learning in learners' experience, and defining

learning as mutually constructing meaning" (Baxter Magolda & King, 2004, p. xix). This model also incorporates three key assumptions that interplay with the foregoing principles: "knowledge is complex and socially constructed, one's identity plays a central role in crafting knowledge claims, and knowledge is mutually constructed via the sharing of expertise and authority" (Baxter Magolda & King, 2004, p. xix). The role of the learning partnerships model is to promote student epistemological development through their own experiences, considering what makes for a challenging, but supported, learning context. The understanding of these principles and assumptions, as well as supporting and challenging conditions, have the potential to scaffold the understanding the participant experiences in the proposed research.

Baxter Magolda and King (2004) argued for the role of higher education in the promotion of contextual knowing and the development of self-authorship. The researchers described the importance of self-authorship in the development of ethical behavior not only as individuals but for effective citizenship that encompasses "coherent, ethical action; for good of all; and intercultural maturity" (Baxter Magolda & King, 2004, p. 7). Baxter Magolda and King (2004) reasoned that ethical reasoning was an intersection of cognitive maturity, mature relationships, and integrated identity, all goals of higher education. Epistemological development theories tie well to the reasons for ethical education in healthcare higher education. What is needed is further research into what impacts the development of ethical reasoning in SLP practice and how these influences intersect with epistemological development and learning partnerships.

A potential developmental pattern for ethical decision-making was introduced in the review of BMED stages; however, it is not clear if the experiences of SLP clinical students and supervisors are supportive of systematic, epistemological development. The learning partnerships model is useful in understanding the intersection between epistemological theory and andragogy. The development of ethical decision-making should be investigated through an

examination of described influences and experiences from the clinical supervisors and students. Epistemological development theory provided the framework for understanding the experiences of the participants in the development of ethical decision-making. Further ideas for construction of learning might borrow from community of practice and interprofessional education/practice models.

Conclusion

Ethical reasoning is part of the routine clinical decision-making process in healthcare-based speech-language pathology (Body & McAllister, 2009). The ASHA (2016a) Code of Ethics outlined the behaviors that are expected of professionals in the field of SLP; however, that document does not provide a complete picture of what is occurring in the daily decisions made by SLPs. A review of the literature regarding ethical decision-making in SLP found that experience had a strong impact on the skills needed to reason through a dilemma (Flatley et al., 2014; Kenny et al., 2007, 2010).

Subsequently, it is important for SLP students to have adequate experience in the roles of ethical decision-making prior to independent clinical practice (McAllister & Lincoln, 2004). While there is limited evidence to guide pedagogical design for teaching bioethics in SLP education, epistemological development theory does describe the value of learning experiences that lead to growth in cognitive, intra- and interpersonal foundations (Baxter Magolda & King, 2004). All primary factors in the development of self-authorship.

Although frameworks exist for guiding students in ethical reasoning, they are not a result of research into student experiences or influences during ethical dilemmas (Birden et al., 2013; Body & McAllister, 2009; McCarthy et al.., 2004; Poole & Solomon, 2010). This gap in understanding contributes to the questions of how to best-scaffold ethical decision-making in SLP students. An examination of the influences related to ethical development experienced by

students enrolled in SLP graduate programs, and SLP clinical supervisors, aids in the development of best-practice standards for professional education.

CHAPTER III

METHODS

The purpose of this phenomenological study was to explore the perceived influences and experiences of speech-language pathology (SLP) graduate students and clinical supervisors in the development of ethical decision-making skills. Participants were SLP graduate students who had experienced ethical decision-making and clinical supervisors who instructed students through ethical decision-making situations during healthcare placements. Semi-structured personal interviews were used to gather the "meanings and essences" of the participants' experiences surrounding ethical decision-making (Moustakas, 1994, p. 21). Qualitative interview data was transcribed, then analyzed using phenomenological analysis methods outlined by Moustakas (1994): horizontalization, structural and textural description.

In this study, participant horizons were significant statements such as those surrounding student or personal ethical development, influences that shaped epistemological development and/or ethical reasoning, faced ethical dilemmas, thoughts and actions during ethical dilemmas, feelings, attitudes, and self-reflections. The participants' horizons came together into three collective ethical dilemma horizons defining how the participants experienced ethical decision-making. The collective ethical dilemmas created a description of the ethical decision-making structural contexts. In turn, the textural descriptions arose from the details of what happened within these structural contexts by interpreting the influences surrounding and within the participants' ethical decision-making.

The structural and textural descriptions were used to create an essence of the participant's experiences leading to an understanding of the common experience dimensions (Giorgi et al., 2017; Lopez & Willis, 2004). While the underlying phenomenon of ethical decision-making was experienced individually, it was brought together into an understanding of the collective phenomenon including settings, experiences, external and internal influences, and development patterns. The essences were areas of ethical decision-making that defined and connected the participants' experiences and were essential to their phenomenon of ethical decision-making development.

This study aimed to describe the development of ethical decision-making in SLP graduate students through the following research questions:

(1) What do SLP graduate student clinicians, in the Upper Midwest, describe as influences on the essence of ethical decision-making development?

(2) What influences do SLP clinical supervisors, in the Upper Midwest, ascribe to the essence of ethical decision-making development?

(3) What epistemic assumptions do student clinicians and clinical supervisors, in the Upper Midwest, illustrate as influences on ethical decision-making development?

Phenomenological Design

Creswell and Poth (2018) discussed qualitative research as "addressing the meaning individuals or groups ascribe to a social or human problem" (p. 8). Following the call for insightful meaning-making and the desire to understand an experience, this study was narrowed to a phenomenological design, which was chosen because of the desire to understand participants' firsthand accounts of the influences and experiences they encounter during ethical decision-making (Creswell, 2016; Creswell & Poth, 2018). The role of a phenomenological

design in qualitative inquiry is to guide external understanding of factors that are internal to the participants (Moustakas, 1994).

Phenomenological research focuses on a common experience of the participants building toward knowledge of a central concept or phenomenon (Creswell, 2016). In phenomenological research, concepts and theories create a framework through which contextualized data, gathered from those experiencing the phenomenon, are used to describe and understand (Giorgi et al., 2017). In this inquiry, knowledge was shaped through inductive, ground-up, and contextual reasoning (Moustakas, 1994).

A challenge of this research design was the use of two separate participant groups with varied experiences and perspectives during ethical decision-making. However, the initial piloting of research design and methods revealed that participants spoke more of the role of student development during the ethical decision-making process. Further, while experiences were varied across groups, common ethical decision-making essences and influences were reported by both supervisors and students.

The study focused on "the wholeness of experience rather than solely on this objects or parts, searching for meanings and essences of experience rather than measurements or explanations" (Moustakas, 1994, p. 21). The researcher conducted a series of two, one-on-one interviews and used that data to develop structural and textural descriptions toward a central understanding of ethical development from the students' and clinical supervisors' perspectives. While bracketing of my personal biases was important to define the essence of the participants' experiences, the data was also interpreted through the conceptual framework lens regarding higher education and ethical development in SLP graduate students. Initially, experiential learning was considered for the theoretical framework based upon the importance of experience across the current SLP ethical reasoning literature and reputable experiential learning models in

higher education (Kenny, 2010; Kolb, 2014); however, this model did not encompass the detail of student development found during ethical reasoning. Consequently, this study reviewed the epistemological elements that influenced the participants' experiences to enhance the understanding of SLP ethical decision-making perspectives.

The focus of this study was to describe the phenomenon of ethical decision-making development across the participants and understand the possible influences of epistemological, intra- and interpersonal dimensions on ethical development. The goal of this research was to increase the understanding of best-practice teaching and learning procedures for SLP clinical ethics. The use of description, context, and experience, together with the creation of a broader understanding, ties to interpretive phenomenological research (Lopez & Willis, 2004). The objective of this research was to improve the understanding of participant experiences regarding best-practice clinical, ethics instruction and training. These research philosophies were used to determine the study methods, participants, and research questions. These assumptions also shaped the understandings derived from the participant interviews.

Participants

This study included two groups of participants: (1) students enrolled in an SLP or communication disorders graduate programs who had engaged in at least one clinical, healthcare-based experience, and (2) current and former supervisors of SLP graduate clinicians in healthcare placements. The purpose of interviewing students and supervisors was to create a collective understanding of the teaching and learning experiences within clinical, ethical decision-making. It was important to understand the perspectives of both groups to develop an essence of the ethical development experience. The study was designed for two participant groups to offer a richer description of the clinical experiences leading to ethical decision-making development and to understand the students' and supervisors' perspectives during clinical,

ethical reasoning. Further, the design was a partial response to the literature highlighting the role of experience and student development tied to ethical reasoning viewing this phenomenon through the lens of experience and inexperienced clinicians. The study looked to investigate participant perspectives within a professional community of practice. The role of both the supervisor and student and their respective, collective view of student development within a learning community working toward self-authorship. Phenomenological design was used across these groups to understand the collective, ethical decision-making essence.

Eleven participants engaged in one-on-one interviews, five student clinicians and six clinical supervisors, all identified as female. Table 2 (Appendix D) provides an overview of participant roles and experiences. All students began participation in the second (last) year of their SLP graduate program. Three began a clinical fellowship year before completing a second interview. Supervisors had work experience ranging from 5 to 25 years; all had multiple supervisory experiences with SLP graduate students. The collective list of participant practice environments included: outpatient adult and pediatric clinics, university clinics, inpatient adult and pediatric hospitals, skilled nursing facilities, neonatal intensive care units, inpatient rehabilitation hospitals, home healthcare, and early services. This list represented most of the clinical healthcare placements in the field of SLP.

Participants self-identified as having at least one semester of student clinical experience or clinical supervision of graduate clinicians. It was important to recruit participants with at least one semester of experience because this study focused on the reported influences and perceptions of the participants related to their development, or instruction, of ethical decision-making in clinical practice. Consequently, participants must have had an opportunity for ethical decision-making during clinical practice. One interested student participant was excluded from

participation because they did not have one semester of SLP clinical experience in a healthcare setting.

Procedures

Participants were gathered through convenience, snowball, and criterion sampling (Creswell, 2016). Students and supervisors were recruited through principal investigator (PI) contacts at ASHA accredited SLP graduate programs in the Upper Midwest via electronic letters and in-person announcements when available (See Appendix E for the complete announcement). Snowball sampling occurred when recruited participants either forwarded or shared PI electronic letters with other prospective participants (Maxwell & Satake, 2006). Students and supervisors were invited to engage in research on the topic of ethical decision-making in clinical practice. Participant criteria was outlined in verbal and written materials. This study was approved by the university Institutional Research Board prior to initiation of recruitment. Interviews started in spring 2019 and continued through summer 2020.

Interested participants were asked to contact the PI through electronic mail or telephone to arrange a one-on-one interview. Prior to, or at the time of the scheduled interview, participants were provided with a copy of the consent form and it was verbally reviewed before signing. Participants were informed of confidentiality measures through the use of pseudonyms and were provided the opportunity to select their own pseudonym. Participants received electronic and/or paper copies of their signed informed consent materials. Agreement for participation in the interview proceedings was completed through the signing of the consent form. All participants had the option to withdraw from participation at any time, without penalty.

Data Collection

To gain accounts of participant experiences, data collection occurred through individual interviews (Creswell, 2016). Face-to-face interviews were the preferred method of data

collection (Edwards & Holland, 2003). However, an extension of procedures to online (e.g., Skype) interviews was used in situations where the participants' location was at a distance from the researcher (i.e., greater than 100 miles) and also during the COVID-19 pandemic to ensure appropriate social distancing. Interviews took place in a private space, either in a conference room or in the participant's home, office, or other meeting space that allowed for reduced noise and distractions when feasible (Edwards & Holland, 2003).

Data collection occurred through two-point interviews with each participant, which lasted 30 to 45 minutes each. The utility of using a multiple-point interview method was to aid in contextualizing the participants' experiences. Seidman (2006) suggested a three-point interview where each stage draws the study further into the experiences of the participants, starting with an establishment of present context, followed by reconstruction of details related to an experience and finally, reflection on the meaning of experiences. The balance of this process was achieved through the interview protocol design and a two-point interview procedure. The first semi-structured interview asked participants to provide background on their personal history and educational experiences that influenced their ethical decision-making behaviors. These questions were followed by descriptions of ethical scenarios encountered by the participants and the reported influences on their decision-making. In the second interview, the participants were asked to reflect on these experiences in providing strengths and challenges to the process from the viewpoint of the supervisor and student clinician. The second-stage interview was also utilized for reflection and also clarification, expansion, or adding additional statements on ethical issues from the initial interview. A two-point interview was favored over a three-point interview in this study because of the initial goal to capture students within their graduate program before they entered independent clinical practice and became more experienced, clinical practitioners.

Further, the initial interview was extended to capture both the establishment of present ethical decision-making contexts and reconstruction of past contexts.

The PI completed all interviews. Following agreement from the participants, the audio for each interview was digitally recorded. Digital content was secured on the PI's password protected computer. Hard copy data was kept in the PI's locked office. A transcription service that ensures confidentiality and privacy, was used for creation of electronic and/or paper transcriptions of some completed interviews.

Interviews were guided by a list of open-ended questions for supervisors and students, including broad requests for experiences and contexts (See Appendix F and G for respective supervisor and student protocols). For example, one prompt was: "Please tell me about a time you faced an ethical situation." Topic areas covered identification of ethical dilemmas, the typical process used to solve ethical dilemmas, methods used to guide students through ethical dilemmas, and key factors that influenced their ethical decision-making. With the focus on extracting episodic memories, the PI asked participants to recall events that they reported as having shaped their ethical decision-making (Maxwell, 2013).

Data Management and Analysis

The study was completed at an Upper Midwest university. Approval for this study was gained from the university Institutional Research Board and data collection completed in spring 2019 through spring 2020. Paper data were stored in the PI's locked office and electronic data stored on a password protected device. All material was de-identified for participants' names using either assigned or chosen pseudonyms. Recordings will be kept for no less than three years following the date of the interviews. These procedures were clearly explained to the participants verbally and/or via consent form.

A phenomenological method aids in the analysis of data for themes and connections between concepts, via participant interviews (Creswell & Poth, 2018). The purpose of these interviews was to collect data on ethical decision-making from students and clinical supervisors. Data were analyzed for horizons and influences, including possible relationships between these groups with the goal to further describe the phenomenon of ethical decision-making in SLP students.

Data analysis took place through the process outlined by Moustakas (1994). Starting with horizontalization of participant statements into topics, themes, or horizons, were then generalized from topics. The creation of textural and structural descriptions, and interpretations followed and then finalized with "an integration of textures and structures into meanings and essences of the phenomenon" (Moustakas, 1994, p. 118). In the horizontalization process, each statement within an individual transcript is considered for topic relevancy (Moustakas, 1994). In this study, each participant statement was coded based upon the concept of influencing the development of ethical decision-making. The relevant, participant statements outlined "a horizon of the experience" (Moustakas, 1994, p. 121). Once the horizons were known, they were collectively evaluated for ones that are necessary to the individual's experience. Unnecessary or redundant horizons were removed from the coding. Participant responses linked to educational setting experiences were not coded. The remaining horizons, or codes, were grouped into textural and structural descriptions.

Moustakas (1994) described the development of themes as "clustering" (p. 121). In clustering, the core themes of that participant's experience are gathered together. This process begins to shape an individual textural description, where the researcher reviews these clusters of horizons against the transcript record for explicit or implicit compatibility with the individual's statements. Compatible themes were kept; incompatible themes were discarded.

The researcher then engaged in imaginative variation, where the "how" and "what" are envisioned (Moustakas, 1994). Imagination is employed to view the experience of developing ethical decision-making from a variety of angles, with receptivity to a variety of possibilities. The textural-structural descriptions for each participant were derived from the consideration of horizons and imaginative variations. These individual essences were then placed into a "composite description of the meanings and essences of the experience, representing the group as a whole" (Moustakas, 1994, p. 121). The building of horizons occurred across each participant, then participant groups, and into a collective story of the participants' structural and textural essences. The results underscored the common essences between groups, while still allowing for variation of the student and supervisor voices. While these may not be enduring essences, the findings represent the collective participants at that time and place in history. This was the process used to analyze the results of this study and determine the influences on ethical decision-making in students from the essences of the clinical supervisor and student experiences.

Integrity

Creswell (2016) suggested the use of two-to-three validity measures to promote qualitative research accuracy. In this study, researcher, participant, and reviewer validation occurred to confirm interpretations. Creswell (2016) stated that through data analysis, the researcher can promote validity with disconfirming evidence. Validation in this study was accomplished with the coding procedures outlined in phenomenological research, including the development of horizons, textural, and structural descriptions of experiences. Through the process of clustering and compatibility checks, the codes and descriptions are validated against the participant's statements (Moustakas, 1994).

Secondary Reviewer

Further, data analysis was cross-checked by a secondary reviewer with experience in qualitative analysis and awareness of phenomenological analysis. The secondary reviewer completed a cursory review of five coded transcripts, evaluating for accuracy of topic creation and textural descriptions. Creswell and Poth (2018) explained this process as a way to gain cross-checking of methods and analysis through another researcher. The role of the secondary reviewer is to provide a critical, outside view of the research process.

Member Checking

Finally, because of the role of participant experience in phenomenological research, member checking occurred through review of transcript records and sharing interpretations by all willing participants, to ensure representativeness (Maxwell, 2013). Maxwell (2013) identified member checking as "the single most important way of ruling out the possibility of misinterpreting the meaning of what participants say and do and perspective they have" (p. 126). Guba and Lincoln (1989) explained that member checking should occur in a variety of ways throughout the process of data analysis and reporting of findings. These authors highlighted benefits such as participants clarifying their statements, adding to the validity of findings, as well as an opportunity to correct errors in the textural and structural descriptions. All transcripts were sent to the participants in May and June of 2020 with requests for clarification of content. Following feedback on transcripts, coding was completed, and coded segments returned to all participants in June of 2020 to ensure initial analysis reflected the essence of their ethical decision-making experiences.

Reflexivity

Important to the quality of phenomenological research is a conscious attempt at bracketing or partitioning out researcher bias. Further, addressing and acknowledging the impact of researcher experiences on the qualitative study (Creswell & Poth, 2018; Giorgi, 2012;

Maxwell, 2013). This study was developed as a result of my personal and professional experiences in ethical decision-making. After graduating with my master's degree, I reflected that while I was prepared to make straightforward clinical decisions, I did not start clinical practice with a strong capacity for making ethical decisions. When I became a clinical supervisor, I also observed hesitations in graduate clinicians. I noted student clinicians were reluctant to take on ethical dilemmas and often did not know where to start when solving the problem. Thus, my bias is toward the need for additional ethical training in SLP graduate programs.

Further, because I strongly relied on the interprofessional team, specifically nursing, during my first years as a clinician, I have a bias toward the role of interprofessionalism in ethical reasoning. When reviewing the data collected, it was important to acknowledge these assumptions and biases to promote accuracy in telling the story of participant experiences over my own (Maxwell, 2013). During my research, I used reflective written and audio memos to counter these personal biases and build an audit trail. These memos provided a point of validation and clarification toward detailing my own ethical journey, comparing and contrasting with the participant's ethical development and experiences. The audit trail provided a comparison point for what was expected, but not found, in the ethical development of students. For example, I expected to encounter details on the impact of industry, management, and facility rules, such as productivity. Productivity and practice patterns like point of service delivery are areas that highly impact the daily work of the healthcare based SLPs; however, they did not arise as a horizon or part of the essence of the participants' ethical stories. Another missing area, or horizon, was time management. Clinical instructional activities take time. This teaching time is often viewed as "unproductive" time by management. Consequently, I was also surprised that clinical supervisors did not detail the impact of student learning on their time and efficiency at

work. I believe these factors do highly impact the education of SLP graduate clinicians; however, they were not common horizons across the participant group. I used my audit trails for validation and clarification of my own bias and movement toward highlighting the participants' voices, stories, and essences.

I also found myself in a personal healthcare crisis and then a global pandemic while collecting and analyzing data. In the first few months of data collection, my infant son developed a serious seizure disorder halting my research progress and placing me on the receiving end of three different healthcare systems. These events shaped my view of healthcare and impacted my research on internal and external levels. Internally, I reflected on my role as a healthcare consumer. I felt as though these experiences "broke" my healthcare provider armor. I had to step out of blood draws and procedures. I could no longer separate the necessity of a healthcare procedure from my emotions. Procedures that I had previously explained, calmed, and prepared my patients for were now scary and unknown. I lost my edge but gained a stronger perspective on advocacy, medical necessity, and patient complacency. This furthered my drive to understand how to prepare students for EDM and tied to the participant description on the importance of the patient in EDM.

Externally, my interviews took longer to complete and in a way I lost mental "track" of my progress with the participants. While this created a broader look at student experiences, I felt it was more difficult to stop and restart my research process. I interviewed some participants in early spring 2019; however, I was not able to complete secondary interviews with some student participants until they were starting their careers as entry level speech-language pathologists in Fall 2019 or later. While this was initially not my intended design, it did serve to extend my view of epistemological development across students and placements, benefitting efforts toward triangulation of participant horizons.

Starting March 2020, the global COVID-19 (coronavirus) pandemic impacted the personal and professional lives of myself and the participants. These events shaped my lens when analyzing and writing about participant experiences. Within my data analysis I considered the impact of COVID-19 as an outlier to the group ethical decision-making essence and did not place it within the results; however, I believe there is potential for these areas to be explored in future work. I have written about this context as a reflexive statement and acknowledge the impact of these experiences on my data analysis and forward recommendations for healthcare instruction.

CHAPTER IV

RESULTS

Confidence in ethical decision-making (EDM) separates novice and experienced speech-language pathologists (SLPs). Yet, the role of EDM in the clinical education of SLP graduate students is largely unknown. The participants in this study each described their experiences and ways they were influenced during EDM. The horizons from these participant stories came together into a collective story of ethical decision-making in speech-language pathology. The students and supervisors recounted people, places, feelings, and circumstances.

While EDM is a complex process, it was consistently placed within the routine experiences of the students and supervisors. Because it is inseparable from the SLPs clinical work, these stories require a response in the formal and informal educational experiences of SLP graduate students. The goal of this study was to further define these ethical experiences and influences toward improved understanding of student development and ethical instruction.

Each of the participants described situations where their ethical problem-solving was put to the test. These ethical situations linked to the ethical stakeholders discussed in previous literature: patients and families, facilities, and other professionals (Atherton & McAllister, 2015; Payne, 2011). These influences are further examined in the textural and structural descriptions of the participants' EDM.

The following sections describe the participants' EDM experiences and influences, often portrayed in their own words. The bulk of this chapter was broken into two main sections: (1) ethical contexts and dilemmas (structural descriptions) and (2) influences on EDM (textural

descriptions). Each of these sections is divided further into participant horizon details. The end of this chapter examines student development reflections and horizons.

Beginning with the role of EDM in the work of SLP, the participants' ethical stories depicted the circumstances and encountered ethical dilemmas. These ethical dilemmas created the structural description of the participants contexts. They detail the importance of EDM to effective SLP services. The encountered ethical problems provide the foundations of how the participants experienced EDM.

Following the ethical dilemma stories is a discussion of the internal and external influences surrounding the participants during EDM. These influences provide the textural descriptions of what impacted the students and supervisors. Finally, the last section of this chapter reviews the student development reflections underscored across the student and supervisor stories.

Ethical Contexts and Dilemmas

The participants' narratives depicted the nature of healthcare ethical decision-making for these speech-language pathology (SLP) students and supervisors. Their experiences occurred in a variety of healthcare facilities. The participants worked in a wide variety of practice settings including outpatient adult and pediatric clinics, university clinics, inpatient adult and pediatric hospitals, skilled nursing facilities, neonatal intensive care units, inpatient rehabilitation hospitals, home healthcare, and early intervention services.

Participant recruitment occurred through principal investigator contacts in accredited SLP programs in the Upper Midwest. Thus, the participants practiced in geographic locations that ranged from metropolitan to highly rural settings, all positioned in the Upper Midwest. These contexts included a diverse collection of personal interactions with patients, families, and other professionals. All participants identified as female. The spaces, places, and people surrounding

the participants set the stage for their ethical stories and thoughts on problem-solving. The ethical dilemmas encountered in these surroundings formed the structural description of their EDM.

No setting was immune to complex situations. Ethical issues arose in infant to older adult clinical cases. Dilemmas occurred in patient homes, hospitals, and clinics. Each story shared by the participants uncovered more about the common and unique complexities tied to ethical cases. The portrait of EDM found in the collective stories revealed the innate problems tied to the large SLP scope of practice and complex stakeholders.

Beyond locations and age ranges, the clinicians worked with patients from a variety of age groups, cultures, races, sexual orientations, gender identities, values, and primary languages that did and did not match their own. These interactions were frequently on a one-on-one basis; yet, not all stakeholders were consistently present during final ethical decisions. Communication occurred when standing next to a hospital bed, in a radiology suite, sitting down in a therapy office or gym, during care conferences, on a telephone call, and in private conversations with other healthcare providers.

A motto for the speech-language pathology field is “communication for life.” The participants portrayed various depths of challenging communication and life meaning surrounding SLP EDM. The participants each detailed the weight of ethical decisions on their professional, and sometimes personal, lives. Ethical decisions were foundational to the SLP’s line of work.

Just in the Line of Work

During the study the student and supervisor participants told of the ethical dilemmas that shaped their EDM. While each story also included influencing factors, those influences will be discussed later in this chapter. This separation of dilemmas and influences aids in creating a

holistic picture of the structures surrounding the students and supervisors before analysis of the points of influence.

The following sections focus on the shared ethical dilemma essences. The dilemmas broke into three collective horizons and are separated into the following sections: (1) dysphagia services, (2) mandated reporting for abuse and neglect, and (3) in our scope (SLP scope of practice). While these categories did not encompass all the dilemmas faced by the participants, they are the common areas found to be integral to the essence of the group's ethical experiences.

Serving patients with dysphagia was the most common ethical dilemma faced by the participants. This was followed by mandated reporting in pediatrics and then understanding the SLP scope of practice. The students and supervisors provided examples of these experiences within their individual interviews. Those structural, ethical dilemma descriptions are discussed in the following sections, converging the student and supervisor voices.

Dysphagia Services

Bea was a clinical supervisor with approximately 20 years of experience, primarily in acute healthcare settings. She had a strong sense of her role as an SLP in EDM and that came across in her account of the frequency of ethical decisions in her daily work. When asked about her ethical experiences, Bea responded:

> Well, yeah. I mean, I feel like we face that quite frequently just in the line of work. You know, working at the hospital where more like with...what the right thing to do is, with severe dysphagia cases, and just making sure everyone's on the same page. Just recently I had a patient who should be NPO [nothing per oral], did a video [Videofluoroscopic swallow study]. The video supported severe dysphagia, [the patient] couldn't safely eat, and the particular physician involved, just he was really promoting an oral diet and things, so we just had to have difficult conversations with the family to understand. It's a

hard situation…So we had a family care conference just talking about what the right thing to do for this patient. Maybe even though the physician didn't agree with it, just being professional and advocating for the patient… the physician was minimizing things and minimizing what we were recommending…Yeah, just having to…think to do what's right for the patient… The patient and the family decided they were in agreement with what we were recommending. So eventually we got the physician on board to do a PEG tube and then continue therapy to get stronger.

During this ethical decision, Bea found herself positioned between the family and another professional. She believed in advocating for the patient. She demonstrated confidence in her ability to respectfully disagree to protect patients' bioethical rights. Bea engaged in several ethical reasoning discussions, ultimately leading to a group care conference and final decision. Bea was somewhat casual in her overview, just in the line of work, indicating she was accustomed to the impact of EDM on her daily professional duties. All participants acknowledged the role of dysphagia management in ethical reasoning. While not all had, or could recall, recent experiences with this topic it became a clear example of the impact of bioethics and ethical codes in the SLP field. Dysphagia services require attention to detail and high-level decision-making. It is a disorder area that frequently intimidates students because of the risk to patient safety, health, and quality of life.

Erica, a second-year graduate student, also told of commonplace EDM and an ethical situation from her healthcare internship.

I feel like it happens every other day [patient refuses SLP's safest recommended diet]. One that I can think of was an elderly woman who had... She was maybe in her nineties and she was aspirating. So, we had to tell her that and we had to say, here are our recommendations, but also at least one of her kids was there too. So, her family was

there. And then we basically just, in that specific scenario though, I feel like we really said, 'These are our recommendations, but we also really understand quality of life. And so ultimately it's up to you'…I think it was her daughter and son in law that were in there. And I guess in that particular situation they didn't have a strong opinion. They weren't like, 'No, she's going to keep drinking.' Or like, I think they were just very contemplative. I think that the patient and the family were both just taking our recommendations seriously. But also, I feel like they were very weighing it.

Erica had observed a situation where the SLP's recommendation was a potential conflict with the patient's desires and an enhanced quality of life. The SLP team provided education about the safest diet with a caveat to allow for self-determination between the patient and her family members. They knew they were entering into an ethical situation and approached with an open mind for patient desires. Of the participants discussing dysphagia ethics, all emphasized the importance of patient wishes and SLP education when making final diet recommendation decisions. The participants understood the impact of diet on a patient's quality of life, engagement in social activities, access to nutrition and oral medications, and the difficult decisions tied to making this choice with or for the patient. The patient was not the only stakeholder during dysphagia-based EDM. The SLP students and professionals were required to balance the wants and needs of the patient, the patient's family, other healthcare providers, and administrators.

Stakeholders. Laura was a clinical supervisor with almost 25 years of SLP experience working in a variety of healthcare and educational placements. She addressed the varied ethical nuances when treating patients with dysphagia:

There's been many, many, many situations where, working at a site where they're saying, that patient is saying 'I'm not eating that stuff.' Or they're [the patient] refusing

the diet, that type of thing. And family is saying look we want them to have it, he is 94 years old, we are accepting the risks. Where then the administration will come down and have them sign a waiver so it's all good, they can have whatever they want to have, so speech can be done. So, I have been able to model, and learn from that myself personally, but also model that for some CFY [clinical fellowship year] and for my practicum student that I had. In the importance of not just allowing that [administration having the patient sign a diet waiver] to be the decision maker because…sometimes it's hard to have those tough conversations with family, but also with administration. Because sometimes you feel like your job is on the line, but I always try to educate them…you need to keep educating families, the director of nursing, or the head RN, or whoever's making those kinds of decisions, so that at a minimum you're at least included in the decision-making. Ultimately patients have the right to do what they want and to eat what they want, but if you ethically want to feel right about that, I think you have to educate and know that you at least provided the education for the risks that come along with those diets. Yeah, I could think of many…instances where you could be challenged.

Laura underlined the multifaceted nature of EDM. It is a skill that requires high-level problem-solving and attention to detail. She had experienced administrators stepping in to allow for patient self-determination via medial diet waivers. However, Laura believed it was important to reinforce the value of SLP-patient communication and education even when a patient refused SLP recommendations. After being left out of a final ethical decision herself, Laura did not want her students to face the same issue. She advocated for the role of the SLP in EDM. Within this context, Laura added to Bea's and Erica's list of dysphagia service stakeholders.

The participants considered facility administration, patients, nursing staff, nursing administration, physician, and family actions when finalizing a dysphagia plan of care. Not only

were these relationships complex, the SLPs needed to understand principles of death and dying including advance directives. The purpose of advance directives is to provide patient wishes when they are unable to speak for themselves. It is to preserve self-determination; yet, the participants found that advance directives were not consistently implemented by families and healthcare staff.

Advanced Directives

Most participant accounts of dysphagia ethics shared a common thread of advanced age, end of life, and/or quality of life decision-making. These factors were discussed by supervisors and students who had served adult and pediatric populations. Heather was a SLP clinical supervisor with approximately five years of experience as an adult-based SLP. At the time of our interviews, she was the only SLP on staff at a hospital with inpatient, rehab, and outpatient therapy services. Heather outlined a situation related to end of life wishes and going against advanced directives from her facility:

> It's a gray area, they look at advanced directives, paperwork…that they [the patient] had filled out…and it's a gray area because they put alternative nutrition separately from supports and ventilators. And in this case [the patient] initially wanted to be DNR and then while she was still a little bit alert, getting admitted, and family…hospice providers [felt] that they kind of guilt tripped her into switching back to full code, just that not wanting to give up on your family kind of thing. Her statement before she was intubated was that she wanted to be full code. And then they do take those [advanced directives] out and then we find out it's just a guideline. There's nothing legally in these papers that it's not a legal paperwork…it's just used as a guideline. It does limit what the providers can do based on, [what] that patient had filled out years ago maybe.

End of life and quality of life were common ethical concerns discussed in the participant interviews. All adult-based therapists, and one pediatric therapist, related to the gray areas associated with inconsistent living wills, family and/or best healthcare advice versus patient desires or quality of life. Some participants believed the final decision was truly up to the physician, patient, and family; other participants believed the SLP was there to advocate for patient desires above all else.

In all situations, the SLP students and supervisors acknowledge the ongoing impact of SLP diet recommendations on patient quality of life. During dysphagia services, the participants perceived the impact of all bioethical principles: autonomy, nonmaleficence, beneficence, and justice (Horner, 2003; Horner et al., 2016). These decisions were further complicated by the complex relationships surrounding food and liquid including nutrition, hydration, health, medication access, socialization, quality and quantity of life, and religious foundations. The participants understood the ethical nuances of dysphagia services; however, students and supervisors struggled to realize the best way to promote student success with EDM during dysphagia services. Another area that the participants found difficulty navigating was mandated reporting for suspected abuse and neglect.

Mandated Reporting

As with dysphagia, patient beneficence and nonmaleficence conflicts arose during participant accounts of mandated reporting of suspected abuse and neglect. When considering those participants who had practiced in pediatric placements, domestic concerns, cultural considerations, and patient complexity were shared participant horizons. Clinical supervisors in pediatric placements wrestled with mandated reporting. Katie had 15 years of experience and worked as an outpatient SLP. She described one common ethical issue in her practice:

> We have a lot of kids that have a low socioeconomic status. We do find out about neglect situations so making decisions about whether or not we have to report them. There have been those kinds of things. We know that the parents are probably trying their best, they just aren't making the decisions so do I just let that go or do I report them? And if I report them then they are going to know it's me and dealing with the repercussions of that? That's never fun.

Katie expanded on her concerns with mandated reporting for abuse and neglect. She found she was often unable to acquire the key information needed to make a holistic ethical decision for her report. She reflected on her attempts to look at all possibilities before reporting a concern to social services. In a follow-up interview, she added:

> I guess that's probably maybe where I'm coming from and I don't want to just 'Oh, it's automatically the parent's fault. The child could have had a meltdown and refused [to follow the plan] that morning and they didn't have time to fight it. There's so many different options. Even if it doesn't necessarily make it right or wrong, the way I'm viewing…it [black and white thinking] makes it harder to have compassion really. I guess. I don't know.

While Katie was an experienced clinician, she displayed ongoing uncertainty during these ethical situations. This EDM uncertainty was echoed by other participants and found more in the pediatric clinicians over the adult-based practitioners. While there were long-lasting effects of both dysphagia services and mandated reporting, the supervisors in pediatric positions had more doubt about the correct path during ethical reporting. This may be in part because while dysphagia services were found in the daily work of many adult therapists, mandated reporting did not occur as frequently. Further, there were less reported resources for mandated reporting when compared to dysphagia services. Together, mandated reporting and dysphagia services had

a large number of ethical stakeholders. Consequently, supervisors used their best judgment when guiding students in ethical actions for mandated reporting.

Stacy, another veteran supervisor, had decades of pediatric experience. She outlined navigating uncertain domestic concerns with a graduate student clinician:

> There's so often that I've had students on and off and stuff. There's been more than one time that a student has said, 'Hey, come here. You got to listen to this.' I'm like, 'Yeah, let's call…Yeah, we're going to have to report that', and that kind of thing.

Stacy's interviews reflected confidence when working through a mandated reporting situation. She had a clear view of what caused an ethical concern in her practice. She clearly guided students during ethical reporting. In her initial interview Stacy also stressed the impact of limited communication skills in the patients she serves:

> If there's a funny bruise that, a lot of our kids don't have the language to tell you what happened. Especially when we are removed from the home environment. I can't assess that setting, I can't assess what's going on there because that's not where I am. Some of our kids…we might not see the family [routinely].

These pediatric SLPs were put in a place of reading between the lines when making ethical decisions. They are required by law to report anything of concern; however, the repercussions of reporting are not universally positive. While these ethical decisions may not occur daily, the therapists were in a routine state of uncertainty between right and wrong. Despite years of experience, the supervisors struggled with the best path when solving domestic, ethical decisions. The supervisors directed student actions during domestic reporting and did not ask the students to complete the phone calls or reports. They also modeled the use of other professionals as an EDM resource.

Their reliance upon others will be discussed in later sections on the influences of other professionals. Still, it is important to highlight that both Katie and Stacy leaned on social work staff during mandated reporting. Another gray area that frequently arose in the participant interviews was understanding the boundaries of the SLP scope of practice.

In Our Scope of Practice

The SLP scope of practice was discussed by four students and two supervisors across adult and pediatric placements. The scope of practice became one of the larger ethical dilemma structures defined by the participants. Thus, highlighting the ongoing conflicts with a field practicing across a bulky spectrum of disorders and differences, from birth through death. Participants outlined diverse, best-practice concerns. In her initial interview, Stacy contemplated the role of the SLP in holistic education with families following a significant diagnosis or injury. Stacy reflected on a situation where she wanted to be honest with a family about a child's prognosis but feared back-lash of overstepping her scope of practice when providing parent education. Stacy recalled:

> Here is another dilemma, because how much do you say and how much does the family understand [about a disorder or prognosis]? How much has other physician teams said to them? Especially throw in on top of things, the fact that some of these families are [culturally diverse]. That I'm not overstepping somebody else's-Their scope of practices, 'Is it my job to tell them that their child will never eat or is it your job to tell them that their child will probably never eat or walk or do all of these other things?' Sometimes I've emailed physicians of the [question], 'How much do you believe they understand?' Sometimes I've talked to the families and [asked], 'Tell me more about what their [the parents] perspective is.' That's really hard. As a family to grieve and those kinds of things too. To come to that realization, that things are never going to be what they were

> hoping they would be [their child eating and walking]. That also comes with the idea of autism and the diagnosis of autism and, 'When do we bring that up? Is this family ready or are they not ready? If I would mention that word, are they going to run screaming in the opposite direction…?

Stacy believed it was necessary to educate families on realistic prognoses. As a member of an interprofessional team, the SLP understands basic expectations across several healthcare fields. Stacy, however, did not want to overstep the SLP scope of practice and make diagnostic statements outside of her field. She spoke about her experiences navigating these difficult topics with families. She detailed the balancing act of providing accurate, timely information but not overwhelming or alienating the patient and their families. It was often a situation with no clear positive or negative outcomes.

Emelia was an SLP with approximately 15 years of experience in skilled nursing, rehabilitation, transitional care, and home health services. Related to the SLP scope of practice, she was concerned about appropriate training and expectations of SLPs in home-based services:

> So, in my mind I was like this [helping with ambulation] is not in my scope of practice. There's literally, I have not taken a CNA course, I do not, I don't know how to measure feet. I don't know, you know, as far as ambulating, was this person safe, transferring.

Like Stacy, Emelia attempted to find the right balance when working interprofessionally. She did not want to overstep the SLPs scope of practice and her own knowledgebase. Emelia believed she was unprepared for some of her expected roles in home health and this concern created an ethical scenario. She commented on her lack of background in the area of ambulation and felt uncomfortable reaching outside the SLP scope of practice to create a holistic patient evaluation because of improper training and education. Both Stacy and Emelia wanted to be meaningful members of the team; however, they disliked the blurred professional boundaries.

Charlene, a second-year graduate student and eventual clinical fellow with experiences in adult and pediatric placements, reflected on a student experience where she was not certain about a child qualifying for SLP services. She recalled an ethical situation:

> The one that I was talking about and not necessarily pressured to recommend services or not, but just like [questioning] does this fall within our area? So, this is a clinic…And so there is a child that we evaluated, and mom's concerns were like artic [speech sound disorder]. And we were seeing some more social things going on. And then trying to piece out…they had a complex history, [the child] has witnessed some pretty big things...And then this [kid] has talked and said concerning things. And so, essentially, trying to piece out, is this really falling under our realm and is this kind of either a social communication or an executive functioning thing that this child doing? They are having problem behaviors at school and stuff like that. So, is it that they are having difficulty transitioning away from things and inhibition of something, or knowing how to talk to peers, or come up with their own ideas, initiating things? Or is this more a mental health area? And so that was one…And I felt like I was more on the fence than the supervisor.

Charlene's uncertainty related to providing this child's services within the SLP scope of practice. She had apprehensions about the best-practice boundaries. Yet, she did not bring these up immediately to the supervisor because she did not observe hesitancies in the supervisor's decision-making. Later, Charlene spoke with her supervisor about these concerns and they decided to abbreviate services and make further referrals for this child. In this way, Charlene was uncomfortable with the recommendations provided and faced an ethical decision of staying within her scope or overextending into a mental health disorder. Like the supervisor accounts, Charlene struggled with helping the patient, alienating them, or providing inappropriate

recommendations. Additional students echoed concerns for SLP boundaries related to mental health.

Sarah was a second-year graduate student and a healthcare-based clinical fellow at the time of the two interviews. During her first interview, Sarah remembered difficulty staying within the SLP scope of practice when working with a patient for transgender voice services. She recalled feeling awkward about professional boundaries.

> There was just like something off with their voice, we were doing everything that we did research on and nothing was helping their voice. It ended up being more of like a psychological issue, but we consulted an outside person from [midsize hospital company] to come in and help us because we didn't really know what we were doing… 'Do I continue to see them, or do I refer them to psychology?' Which they were already seeing a psychologist and a counselor. It was kind of that fine line of 'what am I doing?' There were tears involved. Like 'am I helping this patient?' I guess I was just frustrated that I wasn't directly seeing any progress from them…at times I felt like 'K, I'm going to listen, but I cannot provide you any sort of direction or counseling or anything like that…I was just a listening ear mostly, like you know, but we did so many different voice things. Worked on their voice and their strength and their tone and that sort of thing too. But I feel like it was more of a psychological thing for them, they just kind of had to work through it. And it was weird that they did it during our sessions and not counseling sessions.

Sarah explored the intimacy between psychology and voice concerns during this experience (Boone et al., 2015). She knew she was not the best professional to help the patient through all concerns, yet she found herself in the middle of two different professional scopes of practice. Sarah recalled the emotional impact of uncertainty when she was attempting to learn a

new area of service delivery. She lacked clarity in her role, yet, wanted to support her patient. The field of SLP intersects with a variety of other professions. These muddied professional boundaries resulted in difficult ethical choices for supervisors and students when attempting to stay within the SLP scope of practice.

Collectively, when the participants discussed ethical concerns, they depicted SLPs stuck between stakeholders with no clear path to right or wrong. They were conflicted by primary bioethical red flags. These ethical dilemma accounts created a composite, structural description of the students' and clinical supervisors' lifeworld. The ethical decisions occurred across all settings and created opportunities for EDM experiences and development. Without these ethical dilemmas, understanding of the contexts faced by the participants, and the essences of their EDM structures, would be limited. These ethical dilemmas portrayed how the participants experienced EDM.

The participants experienced issues related to service areas, their roles as interprofessional team members, and protecting their vulnerable patients. The SLP students and supervisors all desired to provide best-practice services for their patients; however, doing what was right was not always clear. The ethical balancing act was common, individualized, and multidimensional. The participants confronted complex issues and had varying levels of comfort with EDM.

Five common EDM influences also emerged across the participants' ethical stories creating the layers, textures of what occurred during their EDM. The participants illustrated the impact of patients and families, supervisor and student nuances, other professionals, and emotions during their EDM work and development. Each section begins with the influence as described by the students and is followed by supervisor descriptions.

Influences on Ethical Decision-Making

Effective ethical decision-making (EDM) requires attention to the internal and external factors surrounding the speech-language pathologists (SLPs) and ethical situation (Chabon & Donaldson, 2011; Kenny et al., 2007: Sharp, 2006). Previous research prescribed the EDM considerations for SLP students and supervisors. This study investigated the participants view of EDM influences. While many of the participants' EDM influences correlate with previous EDM considerations, the following sections explore what students, then supervisors, detailed about the influences of patients, one another, other professionals, and emotional aspects of EDM.

The following sections are divided into four primary influences: (1) patients and families, (2) supervisors, (3) students, and (4) other professionals. There is an outline provided within each of these headings to clarify the participant experiences and horizon map.

Patients and Families

The influence of patients and their families was divided into four horizons, two student and two supervisor horizons. These horizons are used to organize the patient and family's section and proceed as: (1) balancing rapport (student), (2) culture and language (student), (3) patient wishes (supervisor), (4) family dynamics (supervisor).

Patients are central to the healthcare decision-making team (IPEC, 2011). Fitting with the existing literature on EDM stakeholders, participants regularly discussed patients and families during our interviews (Sharp, 2006). These textural descriptions centered around the impact of the patient and their family members during ethical reasoning. Students spoke about patient variables less than supervisors. However, they added to the multifaceted picture of the speech-language pathologist-patient EDM relationship. Student interviews revealed nuances when working with complex patients, they reflected the importance of patient rapport, culture, and cooperative decision-making models (Sharp, 2006). The students found rapport building challenging, but necessary during ethical situations.

Balancing Rapport

Most student participants discussed the value of patient perspectives when working through EDM. Students built patient rapport through perspective taking and listening. They detailed difficult cases where they empathized with the patient and their wishes. The students wanted to please the patient and make them feel heard during tough clinical situations.

As a second-year graduate student in her second healthcare placement, Hannah detailed a difficult conversation with an adult patient declining an Augmentative and Alternative Communication (AAC) device:

> And he was kind of like, 'Nope, I'm done.' He had made up his mind. And so, there wasn't any way for us to force it. We gave him more information, not necessarily saying, oh you should just try it one more week or take it home with you for one more week. It had to be more like, okay, I hear what you're saying. I see these things. We want to be able to help you, but it also has to be on your terms. Kind of that motivational interviewing, understanding that the clinician can't do it all for them, and so we need to know whether or not they're willing to put in the work too.

Not only was Hannah attempting to see the patient's perspective, she understood that deciding for the patient will not result in the patient using an AAC device. She recognized the limits of SLP recommendations. Like Hannah, other students also emphasized the role of relationships with patients and families. Sarah, a student with acute hospital, rehabilitation center, and outpatient clinic experiences, described her approach when dealing with a patient going through a personal crisis. She stated:

> I feel like I, I'm a good listener and people just tell me things. And building rapport with people is probably a strong suit of mine. And she [the patient] just felt comfortable with me to offload all that information and there I was like I don't know what I'm supposed to

> be doing with all of this… I guess I just found myself mostly listening to her. Yeah, mostly listening and consulting with my supervisor.

When looking to support her patients, Sarah relied on her listening and rapport building skills to help her, and her patients, through difficult situations. Sarah's listening ear facilitated the rapport building process but also brought her into some ethical considerations on how to help the patient with what she heard. The line for creating rapport boundaries was also on the minds of other students. Students reflected on the importance of keeping professional boundaries, and not becoming too invested in the conflicts between their own and patient values.

Hannah expanded on an inner battle when building relationships with patients who refuse recommendations and services. She continued:

> I think building that rapport with the client was important. He was kind of a person that was hard to read or to work with, and some of his language was very harsh. And there was a part of me that almost wanted to take a step back or separate myself from him a little bit, but also really needing to get on his level and understand where he's coming from. And so, I think that is something that I'll take forward is just making sure, even if he's not somebody that I like right off the bat, still doing my best to meet him where he's at.

Rapport building is often one of the first goals in a patient-SLP relationship. The students understood this as a foundation for teamwork and EDM. They did not always feel comfortable establishing these connections but pushed through for the purposes of meeting the patient on their level. The students recognized the significance of understanding the patient's viewpoint and wishes instead of asserting the SLP agenda. The complexities of rapport building were challenging; however, the students' interpersonal strengths provided a strong balance between the supports and challenges. Patient relationships fostered student development.

The students' skills in rapport building included perspective taking, knowing their boundaries, listening, emphasizing, and occasionally separating their internal investment for self- or relationship-preservation. Students built patient relationships in patient homes, hospitals, skilled nursing facilities and beyond. Conversations with family members were also woven into these patient interactions. When discussing family influences, students remarked the most on the textures created by culture and language within their EDM development.

Culture and Language

The families and cultures surrounding the patient were integral to the student experience. All student participants related to the impact of SLP services on the family's trust, resources, and emotions. The students spoke of the weight of family education, refusal of SLP services, and cultural competence as they worked through EDM. Three of five students highlighted the impact of cultural competence and language barriers when interacting with patients and families.

Sierra, a second-year graduate student, had experience in adult outpatient and skilled nursing facilities before starting an early intervention placement. When discussing cultural competence across several settings, Sierra detailed her uncertainty during an interaction with one adult patient from a different culture than her own:

> But things like eye contact, and they're [the culture group] very specific about how elders are treated and for example, when we go into his room, he would not make eye contact with us. And so, I don't know if ... I felt as though when I went in, he didn't respond well to me. And I don't know if it's because I was a student and I was younger, or if it was just because that's how their culture is and that's just how they interact. Like that's how he interacts?

Sierra lacked confidence in her interactions with this patient and this layered into how effective she believed she was when helping him through an ethical situation. She understood his

cultural norms; however, struggled to know how to approach his nonverbal communication. This experience furthered Sierra's awareness of the need for cultural competence during EDM.

Hannah's work at a metropolitan hospital provided her with opportunities to work with patients from many cultures. During her second interview, she added her own concerns on culture and healthcare provider influences:

> There's also parts where people who come into this [metro hospital] um, based off cultural background they have more trust in healthcare professionals than, can be safe… because we might give them suggestions and can kind of coerce them to taking practices that we don't – that we feel are right, but might not be right for them.

Hannah had concerns about coercive practices related to cultural competence. Throughout her interviews, Hannah expressed strong feelings on cultural competence and staying close to her own standards during multilingual services. Hannah and other students also struggled with what they saw their supervisors doing about cultural competence and the ethical tones layered into their relationships with patients and families.

During a pediatric clinical experience, Sierra observed her supervisor struggle to be culturally aware of traditions and interpreter expectations across two families from different cultures. When discussing the impact of cultural competence, Sierra recalled:

> She's [my supervisor] like, 'And it's just so different for me because I have a lot of families that are foreign and they're good at telling me things like that, and then I just adjust because it's an easy thing to do.' But this one family she's like, 'They don't really communicate with me at all, so it's difficult to know.

Sierra's experience reflected the role of family when establishing SLP cultural competence. Sierra and her supervisor found inconsistent openness to cultural education across families and Sierra felt conflict in this cultural competence mismatch.

Overall, the students understood the value of cultural competence and looked to increase their cultural knowledge to provide best-practice services. They noted, though, the innate ethical textures within multicultural services. The influences of culture and language both promoted, and limited, student development. The students grasped cultural foundations but that did not result in cultural certainty during EDM. They recognized the gray areas related to patient values. The language and culture discussion continued with other students identifying the need for ethical interpreter services.

Interpreters. The ethics of interpreter services were discussed by three of five student participants. Speech-language pathology practice standards state that SLPs should use trained interpreters whenever possible when working with linguistically diverse patients (ASHA, 2020c). The students in this study encountered ethically challenging interpreter situations during their clinical experiences. As a graduate student, Hannah had a negative experience with gray interpreter guidelines, and this concern carried forward in both of her interviews.

> So, a big one has been…I was doing work in Spanish and my supervisor did not speak Spanish. And we did not have an interpreter, she, my supervisor, mostly spoke [another language] and could kinda understand and was learning Spanish…but wasn't fully trained and did not have the skills for Spanish. And I was still giving therapy to this family. Fully in Spanish, and sometimes I had pressure to interpret for the family with the supervisor. So, there was that – very gray area. I felt very stuck. Um, I felt very much like this was my first semester of grad school. I didn't know what to expect or what was expected of me. So, I had this pressure on me and I didn't have the skills to do what I was supposed to be doing there and it was really tough for me to figure out how to go about changing it or bringing up my discomfort. Because maybe it might be expected to do that.

> And I didn't, I didn't have the full knowledge base. I was told that I was expected to that and it should be okay, but it, it didn't feel right to me.

Hannah remarked on her role in this ethical situation and feeling as if she was not doing to right thing for the patient and family. Her words conveyed feelings of vulnerability and discomfort. She lacked confidence in her ability to advocate for her patient and herself. As a bilingual therapist, Hannah discussed this topic across her interviews. She discussed ongoing conflicts in the role of interpreter services. She had strong feelings about using appropriate interpretation during SLP sessions. The role of SLPs in linguistically diverse services had a significant influence on Hannah's EDM development.

During her second interview, Sarah also spoke of providing SLP services without an interpreter and about difficulty with ethical services for linguistically diverse patients.

> There was this patient whose primary language was Spanish. They were very aphasic, and we did, we saw them [in another setting] very soon after their stroke…But their first language was Spanish, and we didn't use a translator, we just used their [family member] there. Which you're not really supposed to use family members, but we did because I know a little bit of Spanish, so I could kind of tell, or at least nouns and verbs, like 'what are they talking about, are they talking about the right things?' I guess that was kind of an ethical decision.

While Sarah's emotional connection to this topic was different than Hannah's, she also acknowledged the difficulties linked to interpreter services. Hannah and Sarah, as well as other students, faced unethical interpretation use during SLP services. They felt uncomfortable with the expectations of interpreter certifications, services, and their role as student clinicians.

In her second interview, then as a clinical fellow, Hannah returned to this topic and clarified her concerns:

> Yeah, I talked about this briefly in the last interview with the Spanish speaking client. And it's even now today…come up in my clinical fellowships, kind of that experience helped me solidify where my lines are drawn and knowing that it's not set in stone in very many places. Very few places have those policies set up so far. And so, where is it that I'm an interpreter versus a speech pathologist? Where am I an ELL teacher versus a speech pathologist? And kind of drawing the lines of where is my scope of practice and where should that be? I kind of created that for myself in order to protect my clients and protect my skills and practice. And so now that I've kind of drawn those lines for myself, I'm experiencing like, oh, those lines are different for other people in order help the clients. And so, I'm kind of coming across like I've built these walls in order to protect myself from this situation happening again, but it's conflicting with other people's point of view. And so, we're kind of trying to figure out where the lines can be redrawn a little bit almost in order to fit into the setting that we're in.

Hannah discussed the interplay between facility rules, the SLP scope of practice, and her own comfort-level with linguistically diverse services. She found a conflicting point between what she believed was best practice and facility expectations. Through further experience, Hannah grew comfortable prioritizing patient needs over employer expectations. She shifted from a level of not knowing where to turn, to relying upon her solidified beliefs when working with culturally and linguistically diverse populations.

Sarah had fewer emotional ties to this topic but highlighted the impact of poor interpreter access across SLPs practices and environments. These students confirmed the impact of poor cultural competence and linguistic services on EDM.

As professionals who hold paramount the impact of communication, SLPs should place culturally and linguistically appropriate services at the forefront in patient-centered care. While

cultural competence emerged in most student interviews, only two supervisors mentioned cultural needs when discussing EDM. Alternatively, supervisors concentrated on the dynamics of patient values, family members, and patient and family education during EDM. The following sections tell the stories of the supervisors' patient-family influences.

Patient Wishes

Like student participants, supervisors also attempted to use patient perspective during ethical dilemmas. Supervisor's discussed the influencing textures of patient advocacy, understanding patient wishes, going the extra step to ensure patient rights, and the consequences of effective patient and family education.

Heather was the only SLP in a facility linked to a large hospital network. She reflected on her unique role and service to her patients. Heather stated:

> I do think it's [the role of the speech-language pathologist] unique because we deal with the eating aspect. And I would say in my experience, a lot of patients still one of their last wishes is to eat something we all enjoy eating. And it is unique because we make that decision. It could also be unique because sometimes we can meet some of those goals of trying to reduce the risk of aspiration or what have you, but also meet some of their wishes as well. I do think it we play a unique role.

She expanded upon her role as part of a team and patient advocate in her facility as the sole SLP:

> I would say I had to fight a lot to patient wishes here, which was actually if you think about it, we still have to recommend, but I just felt like a patient still needs their wishes. So, I'd say the culture here is, um, definitely a little bit...I wouldn't say old fashioned but needs a little bit freshness of what's the newest research, literature. Definitely changing the culture, a little bit. I did feel like I had to- and still am.

Heather took on a direct advocate role for patient rights and her own profession. Like students, supervisors also discussed efforts to keep patient desires central during ethical decisions. However, the supervisors' experiences created a more extensive view of the importance of patient desires to the work of EDM.

Four supervisors provided examples of how the patient influenced their ethical actions. Bea re-counted a complex scenario surrounding patient desires at her hospital:

> I can think of a patient a few months ago where the [healthcare] team was not listening. They weren't doing the best things for this patient who happened to have a family member who [was very involved]. The medical team was trying to do everything they could in their power to get this patient better, who clearly for weeks was not changing. A different path should've been taken much sooner than it was for this patient. I mean, she was suffering. She wasn't made comfortable or anything….We had to keep her NPO, so I did not feel good about it for multiple days...So eventually, I just contacted the palliative care team and the nurse, made a big group message or whatever, but just to get everyone on board. And then after that, then steps were taken for a family care conference….No one was listening to her, and she would say that. And the palliative nurse said that... She said that nothing was getting done until we spoke up, so that was good that... I was trying to let the doctors take the lead for a few days, and then finally I stepped outside of my bounds a little- but trying to advocate for the patient.

In this account and others, Bea believed strongly about her role as a patient advocate. She and other supervisors saw the value in allowing the patient time, and freedom, to make choices about the future. They took pride in their patient advocacy and reported a desire to instill this importance in student clinicians.

The supervisory approach to honoring patient wishes was consistent across the participant interviews. The SLPs provided their safest, least restrictive recommendations and ultimately deferred the final decision to the patient's wishes. Most supervisors easily stated the format they used when educating a patient during a possible ethical situation, such as during dysphagia services. It was clear that experience had provided the supervisors confidence during patient and family encounters. Many had educational scripts for ethical encounters. When asked how she navigated patient wishes during diagnostic conversations, Heather described her approach:

> I feel as an SLP with my education and everything that we do, I always make the recommendation clinically that I know I have to, but just my own personal experiences outside of my profession and work life, I do carry a more quality of life kind of outlook, but I know I have to keep that away in my professional area. So, I still recommend what I know I have to clinically. I don't encourage them, but I do...if they're already not buying into it from day one or let's say they have, I don't know, very good rationale of why they're not going to follow what I'm recommending, I do remind them that it is their decision and I am here to recommend what's the safest. So just always, I guess, maybe bringing up that they do have a choice in the matter. It is their life, but yeah, always keeping in mind that I have to recommend clinically what I see and what we're educated to do.

Bea was straight-forward in her binary recommendations that flowed from patient desires. She echoed Heather's feelings on patient choice:

> We've had a patient…they aren't sure how aggressive they want to be with their treatment. Our recommendations are if the patient and the family want to be aggressive, then we're going to recommend this, more restrictive and exercises and all the things that

go with that. If not, then this is our recommendation. Sometimes it's okay to just leave it open and up to the medical team.

Supervisors acknowledged the strong impact of their actions on the patient's quality of life. In their descriptions of the patient, supervisors consistently wanted to honor the desires of the patient first and foremost. Laura's summary of patient's rights included many of the hallmarks of other participants related to patient desires and the impact of SLP services. She stated:

> Ultimately patients have the right to do what they want and to eat what they want, but if you ethically want to feel right about that, I think you have to educate and know that you at least provided the education for the risks that come along with those diets.

Supervisors also desired students to hold patient wishes paramount after their clinical supervision. When asked about the strengths she's found in student clinicians, Heather noted, "I would just say, that listening and compassion towards their patients." Patients were the focus of EDM during the supervisors' interviews. They had well thought-out patient education scripts, developed over time and experiences.

When compared to the student voices, supervisors demonstrated strong opinions about their ethical boundaries and decision-making practices. The SLPs made efforts to understand and support their patients' wishes. Family also played a role when advocating for patient desires. Supervisors outlined complex relationships between the patient, family, and healthcare team.

Family Dynamics

Patient-family dynamics served as barriers and facilitators to EDM. During interviews, families were consistently listed as members of the EDM team and a resource in complex patients. Katie summarized her perspective of family resources for complex pediatric patients, "Just get as much information as you can from the family. Sometimes that's easier said than

done." Katie underlined the importance of family perspectives during EDM. Families tend to know their loved one the most; they can be a valuable resource when making difficult decisions. Still, families may also act as barriers to realistic patient goal setting. As Emelia recalled her experiences, she explained the occasional subtleties of families during care conferences:

> Tough care conferences…Tough family dynamics, where they [the family] are aggressive, they are having a very hard time absorbing any information. Possibly, caregiver burnout when they are on burnout, burnout, burnout, and we're recommending maybe something they don't agree with. When they are holding on trying unrealistic expectations, goals, things like that. I would say that would be a tough conversation. When discharge recommendations are not their expectations. Things like that.

The undertone in Emelia's comments was family acceptance—acceptance of patient goals, abilities, and prognosis. This concept ran across all supervisor horizons, created ethical dilemmas, and influenced the supervisors. It also impacted the role students had during interactions with patients and their families.

Student-Family Roles. Building rapport with patients was important to students; however, during supervisor interviews, students were often not initially part of the SLP, patient, and family decision-making team. Heather described the student clinician's typical role in family education under her supervision:

> Usually, for the first few their kind of in back observing as long as family feels comfortable with that. And then, just depending on the rapport that I have with the family, or that the student can have if they can start that conversation. I'm telling them that I'm always here for backup to kind of pipe in if I need to or if it's going spiraling down to kind of help that or just whatever they feel comfortable with because just depending on what the student has been exposed to and different things like that.

Heather was systematic about introducing the student as the primary therapist to the patient and family. This format was echoed in most supervisor interviews. Students were often slowly introduced to the complex EDM process. Heather expanded on this thought and the impact of family members on her EDM development:

> And I remember just fresh out of school trying to put it [bad news/prognosis] very frank, but also trying to be nice about it. And family just picking up on the one or two words that you said that they totally twisted and didn't take it as the way that you intended. I've learned document as much as you can, go back, make sure they're understanding what you're saying…And I definitely kind of follow up a three instance type education to make sure we can't judge if someone understands our education on let's say the risk of aspiration in one setting. And as we know, patient's status is always changing. And as ongoing as I possibly can is probably what I would say.

Heather noted the importance of thorough, effective family education to resolving ethical issues. She had experienced a downfall in education as an inexperienced clinician. Therefore, she took measured steps to guide student clinicians through these difficult interactions.

All participants recalled the impact of family members on the EDM process. Supervisors saw families as a source of information, as well as a barrier to pursuit of patient wishes and best-practice healthcare. Whereas students considered the impact of SLP services on families and cultural competence. Supervisors were deliberate when introducing the student into the patient-family decision-making dynamic. They understood the importance of family but had also seen difficult family dynamics. Supervisors used their past experiences with students and families to guide their future actions. In a sense, they attempted to protect the student and family from one another. The influences of supervisor experiences on student development in EDM went beyond relationships with family members.

Supervisors

The following sections detailing supervisor influences is divided into six segments including: (1) role models (student horizon), (2) in a learning avenue (student horizon), (3) supervisor learning experiences (supervisor horizon), (4) whole body, whole patient (supervisor horizon), (5) I tend to handle the tough things (supervisor horizon), and (6) upbringing (supervisor horizon). When discussing supervisors, the participants' narratives revealed multidimensional relationships between student clinicians and supervisors. Factors internal to the supervisors also shaped student ethical decision-making (EDM). Accounts of student-supervisor conversations, supervisor experiences, supervisor worldviews, and external stakeholders created the textural descriptions of supervisor-student relationships and the influences on EDM. The next sections outline the larger supervisor influences, as described by the student participants.

Role Models

All students illustrated the supervisor as a role model for ethical, or unethical, behavior. The student participants reflected on what they would like to do the same, or change, about their professional conduct based upon their supervisors' behavior. Additionally, they struggled when their supervisor's values did not match their own.

As she neared graduation, Erica recalled her supervisor's empathy and how that made a lasting impression on her:

> I feel like she was very compassionate with patients and always giving them the time, something that I hopefully will never forget but she said instead of, when you're talking to a patient and giving results or whatever, instead of saying like, 'Do you have any questions?' Say like, 'What questions do you have for me?' So, I feel like just little things like that that I learned from her just a better way of talking.

Erica understood that her supervisor was experienced with diagnostic counseling. She had watched her supervisor closely, and desired to incorporate that experience into her own professional behavior. In the same interview, Erica recalled interactions between her supervisor and other professionals:

> And I think I really learned a lot the things that my supervisor would do or say to the doctors or we would get an order and I would just keep thinking, putting myself in her shoes. What if I was the SLP [speech-language pathologist]? Personally, if I got any orders for a video, I would just do them because in my mind the doctor's in charge. But she would review some of them and even call the doctor and be like, 'I really don't think that we need to do a video. And this is why.' So yeah, we had a lot of discussions.

By putting herself in the supervisor's shoes, Erica started conceptualizing her future professional behaviors. She was visualizing herself in difficult conversations, anticipating her response and observing the differences in her supervisor. In a similar way, students observed less-professional supervisor interactions.

Less Professional. When asked what was not helpful to the development of EDM, students detailed specific supervisor behaviors. One student noted discomfort during interactions between her supervisor and other employees when discussing their boss. She stated, "a lot of talking behind their back or things that I don't feel were appropriate. I feel like that didn't go well. Like maybe they could have presented themselves in a more professional way even to me."

Sarah was a new graduate at the time of her first interview. By the time her second interview took place she had progressed into her clinical fellowship year (CFY). Sarah discussed an ineffectual supervisor interaction:

> One time my supervisor, we were like just working through…and then she just started telling me her beliefs and she's like, 'Well, I don't believe that, blah, blah, blah.' It's like,

okay, well, this is weird now. Like I don't even know what to say because my beliefs were different than hers. So, I just think that keeping like political beliefs, all of those sort of things out of the... I don't know, it's hard because it's like an ethical decision, right? Is it right or wrong, but then like keeping politics and religious beliefs kind of out of it a little bit too, because everybody has different beliefs and our patients have different beliefs too. So, it's kind of just this, I don't know if that just wasn't helpful in that situation for her to bring up.

Sarah discovered the conflicting personal belief layers between various EDM stakeholders. She hinted at the SLP setting aside their own personal beliefs for that of the patient, yet, back tracked to the morality conflicts innate to EDM. She disliked the close-ended nature of the supervisor's definitive belief statements and found it disruptive to her EDM. Hannah also reflected on the impact of incongruent values between student and supervisors. In her initial interview, Hannah spoke of EDM facilitators and barriers in her experiences:

> Yeah I think the people I look up to most are those that take a more I would say strict view of those ethical decisions, um and they sometimes I disagree where that line should be, but I still respect them whole heartedly on how they choose to practice. Um I'm thinking of one specific supervisor who was very HIPAA compliant and told us that she wouldn't discuss any clients with her husband or family members and those sorts of things and was I admired her for that. And striving to be - having those role models is nice, knowing that I can look up to them as ethical supervisors, as ethical colleague's um kind of helps me to feel that I want to continue that or want to put that into practice as well. There have also been times when I have had other professionals who have, who urge me to maybe go the way that I maybe don't feel is ethical, um and I would admit that there have been times I think that because of their, uh, power maybe if they're

supervisors now and I'm a student and that divide, I've been, I've maybe practiced something that now I know I wouldn't want to, it doesn't feel ethical to me. It's not ethical. Um and so I wish there's, it can be good and bad. The way that our colleagues and other professionals interact with us. Though there are people who inspire me to be a more ethical practitioner, there are others who suggest practices that I don't feel are ethical.

Hannah labeled the dynamic between herself and supervisors as that of power. Hannah had thoughts on behaviors but did not consistently feel free to open that dialogue. As she reflected on her occasional lack of confidence in EDM, she made decisive statements about the positive and negative influences from different supervisors. She hinted at a regret for practicing in a way she "wouldn't want to" because of the divide between the student and supervisor. This power divide was something that arose in other student reflections as well. However, Hannah was the only student to decisively label it as a power dynamic.

Collectively, the students saw their supervisors as professional and giving practitioners. The supervisors were clear role models and students looked up to their supervisors more when their personal values matched rather than contrasted. The students closely watched, observed, and retained the supervisor's behaviors during EDM.

Students believed they were there to observe the supervisor during their ethical experiences. They relied upon their supervisor as their first resource when considering EDM options. They relied heavily upon their supervisor's advice for ethical reasoning. The following section reviews the student clinician experiences during guiding ethical conversations with their supervisors.

In a Learning Avenue

Ethical conversations were held across all settings and participants; however, student opinion was not consistently valued, especially if it contrasted with the views of the supervising SLP. Students played a role in conversations about EDM. All student participants detailed conversations between their supervisors and themselves related to tough decisions; however, the students regularly found themselves in a secondary role during final conversations with patients and families. This limited student role was considered a result of reduced time for the student to build rapport and decreased ownership of the patient, and the supervisor view of the student needing to be an observer over an active participant.

During her second interview as she approached her CFY, Erica answered to a question about her response to an ethical dilemma:

> What would I have done if this was my patient and I was in charge? I'm not sure. So yeah, that was my reaction. But also, my supervisor is an amazing therapist and I completely respect her opinion. And whenever she was listing these things, I was in agreement with all of them. So, it made sense.

If Erica felt unsure about an ethical decision, she relied upon her supervisor for the correct response. She noted her respect correlated with agreement. Erica lacked confidence in her own EDM and used her supervisor's reasoning for her own. She initially had limited reflection on her own thoughts toward this ethical situation. During further discussion though, Erica added:

> I feel like a lot of it was my supervisor educating me because from my perspective, and also it's hard when you develop a friendship with your patients and an emotional... That makes it harder because from my perspective I'm like, 'We can put these things in place. This is what we can do in order for them to go home.' But I feel like then my supervisor was more like educating me. Well realistically, they wouldn't be able to do this and this and this because... So, she was I feel maybe bringing me up back to reality and saying,

> well... As far as the conversations with us and the OT, I did a lot of listening. Both of them were very super talkative and super had a lot of strong opinions about it. So, I learned a lot, but my opinion didn't matter.

When expanding upon this experience, Erica had held back on sharing her ideas. She believed her thoughts did not matter during the supervisor-student conversation. Erica's ideas were not viewed as valued, or realistic, by the other team members. This statement expanded the view of her role and interaction pattern with the supervisor. In this example, and in other student narratives, students expressed concerns with speaking-up either because of self-limiting concerns, poor confidence in their thoughts and ideas, supervisor influence and power nuances, or a history of their ideas previously being shut down by the supervisor.

By the time of her second interview, Charlene had started a clinical fellowship position. She also reflected on being a student clinician during an ethical situation.

> I think I could have done better at having, not like disagreeing, but just having a little bit different of an opinion than my supervisor's boss. So, I think I was, so it was sort of like my boss' boss, and I was the intern. I don't know, I was kind of undervaluing my skills and my opinion I guess. And so, I would say, I was more candid when I was with my supervisors than when I was with the supervisor's boss. With her I was just like 'Oh yeah maybe' but then with my supervisor I would say what I thought, which I could have done better.

Charlene limited her input during EDM because of reduced confidence in her skills. Her statements also reflected some of the power concepts Hannah discussed within supervisor-student relationships. For example, returning to Hannah's reflection on being advised a wrong direction and following despite her own questioning because of decreased confidence and power divide.

Adding to the picture of supervisory power was Sierra's narrative of student-supervisor interactions. Sierra displayed confidence in her personal morals and values. However, confidence did not extend to her interactions with some supervisors. When asked about her student clinician role in EDM, Sierra summarized:

> I guess as of right now, being technically... Even when I was treating clients I wasn't technically their SLP, I was just more of a brainstorm in all of the situations that I've been in. I would bring something up and then we would talk about it and decide, 'Is this okay, is this not okay,' type of a thing. Or if it's something that I happen to see but I didn't really know if it was okay or not, then after my supervisor would just talk to me about it and be like, 'This is why this is or isn't okay,' I guess. I was more of a brainstormer, kind of still in a learning avenue for sure on it.

Sierra's words portrayed limited patient ownership. She was treating the patients but did not identify as the SLP. She saw the role of the student clinician as a follower, behind the supervising SLP. Sierra further described her role:

> My supervisor is like, 'Well, you can take over my case load whenever you want,' and I would have been taking over the case load from day one. But part of me is like, 'Well, does she want me to observe some?' If I'm not, if I choose that I don't want to just observe, a lot of it for me is like, is this going to make me look like I'm not trying. Especially since my summer internship she was like, 'You're too independent.' She was like, 'You don't ask enough questions,' that kind of a thing. She told me I was too independent and so I'm trying to get…in between those. Being it is early intervention and I can't go in by myself, you're always watched.

Sierra was second guessing her moves in becoming the primary therapist, taking over the caseload and what past supervisors had reported to her as too independent. When probed further

about her having a conversation with her supervisor about these concerns, Sierra conveyed that she had not. Seeing Sierra's thoughts put into words provided another layer to the internal dialogue happening within students during supervisor conversations. It also displayed the impact of previous supervisors on the student's future actions. Students were listening closely. Sierra placed considerable weight on the feedback of previous supervisors.

Sarah experienced two different supervisory approaches during her EDM experiences. She reflected on the positive and negative aspects of these supervisor-student communications:

> I feel like I had to come up with answers and if I was not on the right track... Like [my second supervisor] would straight out tell me like, 'Nope, this is what I would do.' But I feel like [my first supervisor] was more like, 'What do you think?' Try to think through it a little bit, whereas my [second} supervisor would just kind of listen to me and then just be like, 'Nope, this is what I would do.' So, two different styles for sure.

These interactions further describe the impact of supervisory style on the student participants' experiences during EDM. The students characterized supervisors as role models for appropriate and inappropriate professional behaviors. They found barriers in personal value conflicts. Their stories told of observations and worries of speaking up. The students faced uncertainty in the power dynamics between experienced supervisors and their self-perceptions. While some students were comforted by the supervisor taking primary ownership of EDM, others appreciated scaffolding of tough decisions—thus reflecting the varied levels of development across the student participants.

Students did not consistently believe they had a primary role in the EDM team. These beliefs were influenced by student confidence and supervisor approach. Many accounts found the student taking a "learning avenue" because of self-limiting thoughts and concerns about how they would be perceived by the supervisor. They did not believe they had adequate time to build

strong rapport with all patients before making an ethical decision. Students lacked the confidence to step in as the primary therapist. The supervisors also placed students in a secondary role because of family dynamics. Strong supervision supports were thoughtful questioning and thinking frameworks over directives.

In the discussion of EDM, supervisors examined their own thoughts, actions, and backgrounds in EDM. These influencing textures also shaped the EDM process. Supervisors relied upon past experiences during EDM and attempted to use those experiences when educating students.

Supervisor Learning Experiences

Supervisors held steadfast to the role of experience in their own and student EDM. All supervisors discussed how they approached ethical situations and the influencing personal and external backgrounds. The impact of supervisory experience was a consistent influencing texture to the development of student EDM. Katie described her view of experience as follows: “if you mess up once you learn but you don’t want to mess up again. So, it’s good, but it’d be nice not to mess up the first time.” In this statement Katie hoped students would learn from supervisory experiences, as well as their own. She continued to discuss the learning process during ethical scenarios, “It’s definitely a learning experience every time there is something like that. You’re never too old to learn and you’re always learning something.”

Katie reflected on the role of negative consequences toward improved EDM. Laura added to the layering of supervisory experiences and student development. When discussing an ethical scenario, she reflected on her previous supervisors facilitating her future clinical supervision,

> So, this was a great lesson and one that I have to say I was very thankful for my planning ahead, I mean not really planning for it, but I had good supervision when I went to school and even as a CFY. But anyways, I had documented and guided the CFY, we were

teamworking on this one. But we had talked a lot about concerns we had and so one of the great things was we had documented quite heavily.

In this example, Laura discussed how she and a clinical fellow had avoided a potential lawsuit through aggressive documentation during an ethical dilemma. Her pervious supervisors guided her in that tactic, and she was thankful for the experience when approaching her own professional behavior. Heather also described experiences she found beneficial when developing EDM:

> I would say, well, of course in graduate classes you had a touch of these are possible ethical situations you could run into. But I would say honestly, most of it comes from just practicing as an SLP and running into these scenarios.

Emelia expanded on this concept of learning through experience and the role of student clinicians saying, "sometimes I think that [comfort in ethical dilemmas] comes with like years of experience too of just get near, being able to tolerate that stuff, because sometimes it is either, deer the headlights or it's a crying moment...." She highlighted the growing pains that can join EDM. She also believed that experience was the strongest resource in ethical decision-making. Emelia stated:

> I think, am big, big, big on experience. So, I think just conversations. Obviously there is always handouts. There's always education, there's always websites…there's a plethora of resources out there. I feel like, hell there's YouTube you can learn anything on YouTube. So, I feel like there is just the internet itself …you can go [to] college websites or, research-based things that you can get. But I think the best things that you can do with students is share your experiences. Have kind of specific conversations, this is the family dynamic, this is the patient status, this is what we did, this is what we recommend, and this is what happened after that…recounting your experiences and having conversations

> like that. I know from a student, I learned, I feel like and I always say this is, that I learned the most in my internships...I felt like I understood the classroom portion as so much more going through as an internship. So that's how I think even just sitting down and talking to students, your experiences and conversations

In Emelia's discussion, she underlined the multifaceted nature of EDM. The complex considerations and balancing act of stakeholders, influences, and circumstances. The supervisors had been down these EDM roads. They could anticipate many of the turns; however, the student participants could not. The students feared taking that road alone and, as Katie discussed, messing up. As the supervisors reflected on their experiences, they quickly itemized the impact of experience and previous guidance on their own EDM. Collectively, supervisors believed that experiences increased their confidence, knowledge of resources and trusted professionals, determination when reporting concerns, documentation and patient education skills, and shifted their worldview. Part of this perspective shift related to holistic treatment.

Whole Body, Whole Patient

Supervisors spoke about their increasingly holistic view of the patient through experience. They recalled seeing the situation in a variety of small, individualized parts as new therapists. With experience, the clinicians moved from making recommendations strictly based upon the role of the SLP to understanding the holistic patient. They saw differences in their patient education, counseling, interactions with other professionals, perspective taking, abstract thinking, and humanistic view. Heather remarked on how experience in EDM had improved her confidence and skill in EDM. She summarized,

> I would just say every situation I'm exposed to you just become more confident in your skills, more confident way that you can approach kind of that live and learn. Try not to word it this way or validate their emotions. Just more of that counseling type piece and

just allowing family to state everything to the patient. And just having other professionals, whether that's a speech therapist or not, just kind of discussing it. Care conferences, team meetings I find a lot of strength in those that we can help put that whole body, whole patient together because I think we each I say have our own recommendation, but until you really sit down and talk as a team that team support I think is what I find the most helpful.

This ability to counsel patients and families during ethical situations was also a skill the supervisors looked for in students. Within this statement, Heather attributed this skill to increasingly holistic thinking and experience. She had learned take the perspective of not only the patient but other members of the healthcare team. She highly valued the team input during EDM. Experience had enhanced her network for ethical problem-solving.

Katie added to the picture of holistic thinking when discussing the pros and cons of absolute versus open-ended decision-making:

> So, I guess there're strengths in both. Or there're pros to both. I think it would be helpful if those black and white [reasoning] people were at least able to slow down and think about the other options. What else could be going on in this situation? And even if they came to the same conclusion, at least they took the time to think about the other things that were going on or the other outcomes or the other ways to handle it.

Katie believed she had developed a strength in seeing situations from a variety of angles and preferred a holistic pattern to black and white, fast-paced decision-making. The supervisors reflected on the need for thoughtful consideration when making an ethical decision. They emphasized the need to acknowledge EDM complexities. The nature of EDM is gray with no clear right or wrong action; consequently, absolute reasoning does not lend well to effective EDM. The supervisors recognized this concern and gave themselves space and time to

contemplate the best solution. Emelia described her development of ethical reasoning and the impact of human connection:

> Oh yeah, I can say that there have been times when I have, I guess when I think about ethical things, there's been times where I'll go back and I'll question myself. Did you do absolutely everything?, did you provide absolutely everything. That's where the only time I feel ethically imbalanced, in a way. I think it's more about humanity guilt than a professional guilt or just…I always go back to thinking like at some point these were our children where…I don't know, like regrouping. When I say ethical decisions, I think that's the only time that going back that I have ever questioned something. I may have questions on that.

Emelia recalled times where she had lost confidence in her ability to holistically view a situation. When she lacked confidence, she also struggled with the emotional impact of EDM because of human connection. The concept of human, individualized care was important across the supervisors' interviews. They valued the unique concerns within each case and aimed to provide holistic, considerate care. Through experience they had realized the impact of bioethical principles foremost over their healthcare recommendations. Supervisors understood the impact of thoughtful reasoning and patient counseling. This holistic, human connection also directed the supervisors' vision of their role in student EDM.

I Tend to Handle the Tough Things

Supervisors were asked to describe the role students play in EDM experiences. During interviews, a large spectrum of supervisor responses emerged regarding the role of students during EDM. Certainly, all engaged in conversations with student clinicians about ethical situations. Not all students, though, directed difficult conversations with other ethical stakeholders.

Bea had previously experienced a student padding therapy minutes for billing. Consequently, when asked if she allowed students to take charge in awkward, ethical conversations with physicians she stated, “No. I mean, I typically tend to handle the tough things. They do a lot of observing, or I support them in a conversation. But I guess, in this setting, I don’t always let the students have full reign…” Laura was a supervisor with more than 20 years of experience. She clarified her perspective on student roles in EDM:

> I take full ownership if there’s an ethical situation because I feel like that’s why you’re in that position, I have a licensure. So, I guess I would say that I take ownership of it and would definitely defend the student or maybe the other, a CFY, either way, if I felt like they were in the right or they were doing what I saw as ethical based on, helping them kind of make a factual document or make some factual statements. But if they’re in the wrong, I would certainly own up to that, but I would definitely be clear that that wouldn’t be an ethical practice too. But I think that as supervisor you have to take ownership, I mean, they’re kind of looking to you for direction and that learning experience, so I think you have to face quite a bit of ownership.’ Stacy reflected the same viewpoints in her reply, ‘I guess I’ve never given them the opportunity to follow through with [mandated reporting]. If it’s something concerning, then I usually jump in and, ‘Well this is what we’re going to do then.’ Because as a clinical supervisor, these are my patients, ‘This is what we’re going to do.

The supervisors recognized the importance of their duty to their patients, licensure, personal morals, and facilities when determining student EDM roles. The supervisors faced significant legal or personal consequences if a student made a wrong ethical move under their supervision. These obligations became forefront in many of the ethical situations, over the role of the student

clinician. Consequently, students were watched and guided during EDM. Katie detailed a typical ethical decision with a student,

> I would just walk through what we are doing. We have a social worker at our clinic so definitely talking about getting your social worker involved since we have that option. She has lots of insight on if this is a type of thing we should be reporting or something we should just talk to the parents about and saying 'This is what we are seeing. But we are mandated reporters, so we have to do something about it, we can't just let it go.' And there have been times where we report it, or we call the parents and tell them what we saw, and we still have to navigate it. Like if we say it looks like he was hit but they are saying no he fell, so trying to figure out how far to take it that first time. But as far as the student, I would just walk them through it while I am writing it up and describe why I'm writing what I'm writing and why we're doing this instead of just talking to the parents.

Supervisors understood the importance of bringing the student along in EDM; however, they did not always center the student into the EDM team. The supervisors wanted the students with them for EDM; however, waited a considerable time before asking them to direct "tough" interactions. The supervisors believed in the need to maintain ownership of the ethical decision or risk consequences with the patient, their jobs, and/or licensure. Consequently, the supervisor's moral compass and background were also seen as influences on student development during EDM.

Upbringing

Students expressed concerns about mismatches between their own, and their supervisors, values during EDM. Five of six supervisors also tied their values and background to the development of EDM. Supervisors believed that their values were of high importance to EDM. Emelia reviewed her understanding of ethics and personal values:

> I feel like ethics is something that started very young, so you come into something with kind of this, hopefully you come in with a predisposition, pre knowledge of what ethics is, what you consider to be morally right and wrong. So, I think if we're talking about like patient care…therapy and knowing ethically, ethical decision-making is providing the best patient care or whatever you're treating…. but also balancing that with what you know to be right or wrong.

While Emelia described being predisposed to ethical choices, Katie was not clear on where her moral compass started. She simply understood it as an integral part of professional work:

> We get asked in our annual reviews like 'How are you an ethical person?' I just am. I don't feel like we should get judged or graded by other people on this because you have to be an ethical person to be in our field. So, I think it's probably just my standards that has led me.

Emelia and Katie described their moral lens as the foundation of their EDM. Other supervisors had defining characteristics that shaped their clinical methods and ethical reasoning. Heather and Stacy attributed their upbringing to some of the ways they approached EDM. Heather allowed:

> Yeah. I would say personally just my upbringing. Luckily having…grandparents that lived to be very elderly I'm a very much a quality of life type person in my beliefs. But I know professionally it's not that easy and that sometimes as a family face to make those decisions for someone. Any movement or blink of the eye is a glimmer of hope. And I definitely can see how it would be challenging to make that black and white decision when just the world is not.

Stacy said EDM was revealing. She recalled having a series of moments where she was exposed to unethical situations for the first time. She believed these experiences were important to shaping her understanding of reality and the impact of ethical situations. Stacy stated:

> Growing up I had wonderful family and it's just that whole the idea that the world wasn't always what it was cracked up to be wasn't, I didn't know. As you are all getting older and you see some of that, just stuff that happens and you read a report from [a physician who sees at risk children], or two, or seven and you go, 'Oh my God, there's awful things that can happen to kids here.' As you get more exposed to that, your eyes open a little bit and go, 'That happens here, and that can happen to these kids that we work with.' It's awful to kind of have that naive blanket be lifted, but I think it's a good thing too.

Stacy acknowledged the contrast between her upbringing and working through ethical decisions. She believed having additional exposure was forming for herself and for future SLPs. In a future comment she noted the importance of student exposure to different values when developing their moral compass and ethical reasoning. Bea's internal morals and desire to serve her patients often drove her EDM actions. Bea recalled:

> Yeah. I guess for me, it's just, I always like to speak up. Whether they [medical teams] listen or not, that's up to them. I can't influence that, but just knowing that I need to advocate for those patients, what's the right thing, and just respectfully speak up and if they take it or not, that's out of my hands, but at least I've done my job when there was an ethical situation. I advocated, documented, and then it's out of my hands.

Throughout her interviews, Bea reiterated her desire to put the patient desires first during EDM. This goal was innate to her values and morals. Each of these supervisors connected the impact of values, morals, upbringing, and experiences to their personal ethical reasoning. These internal elements were essential to their ethical foundations and development. The supervisors

were confident in their ability to determine right from wrong. They hoped to impress these professional standards on future SLPs.

Impact of Supervisor Values on Students. As with other experiences, supervisor backgrounds and values were shared with their student clinicians. Students discussed the impact of supervisor professionalism on student development. The supervisor participants also described how personal values may influence student EDM. Bea acknowledged the impact of her patient advocacy when supervising students:

> And I do try and instill that in my students. We're the patient's advocate, so we do need to, if something isn't right, we need to speak up and make sure that we're all on the same page. And you can't go wrong with that, if you do it respectfully.

Bea clearly desired to instill patient advocacy in student clinicians. However, Emelia discussed the potential flip side to the impact of supervisor morals and values. She highlighted ways where students may be misled into unethical practices:

> And also, I think that as a student...It's your understanding that you're coming into this setting and going to have an appropriate, ethical, well-educated supervisor that is there for your benefit to teach you and help you progress. So, in that setting I think they'd be guided, and they'd be able to learn how to make those educated decisions. Realistically, is everyone a great supervisor? Is everyone a great therapist? No. And so I think you can get into a tricky situation. But I really, really would like to see more of those, how am I trying to say this… I guess more accountability for those…supervisors that, you know sometimes I think that in the past it's been looked at as 'Yay, I get some assistance' versus what it should really be. And that it's, you should be taking on more work because you're guiding and shaping and teaching a new SLP. So, I like this that the more

> development of tools…and more accountability for them [supervising SLPs] is a good thing.

Emelia had witnessed unethical behavior surrounding some supervisors and the potential for negative influence on student EDM development. Collectively, supervisors saw their personal values as a positive influence on the student clinician. A few had witnessed negative influences from other professionals and believed there needed to be more accountability in SLP clinical supervision. While supervisors acknowledged the positive and negative impact of student values, both participant groups detailed the impact of experience in the development of EDM.

Experience gave supervisors the freedom to complete EDM with less effort when compared to student participants. As the result of experience, supervisors had established professional networks and patient education scripts readily available for EDM. Ethical experiences had also shifted the supervisors' philosophy on EDM. They were less concerned about enforcing healthcare recommendations and more passionate about patient rights and balancing self-determination.

When it came to the role of the student in EDM, supervisors attempted to protect all parties by taking ownership of the ethical situation. Students saw their role as a learner and took less ownership of the patients. Supervisors both promoted, and limited, student EDM development. Resolute in their personal values, supervisors also desired to impart their ethical standards to student clinicians. Students became the next influencing texture in the participants' descriptions of EDM.

Students

The following sections outline student influences on EDM and are divided into three sections: (1) making patients feel heard (student horizon), (2) a learner role (student horizon), and (3) ethical decision-making readiness (supervisor horizon). Similar to the influences of

supervisors, the participants' stories provided insights into the internal and external student ethical decision-making (EDM) experience. The voices of the student participants agreed and disagreed with the impressions that supervisors had of student clinicians. The students and supervisors each spoke about the impact of student perceptions on EDM. Collectively, the participants engaged in conversations about student personality traits, perceived roles in EDM, influences of experience, student strengths and limitations. The next two sections detail the students' self-perspectives during EDM.

Making Patients Feel Heard

Students identified with their patients. They believed they had strengths in building patient rapport and advocation. They applied their personal histories in work, school, and family to relate to the patients and their caregivers. When discussing personal traits, Erica disclosed:

> I think that I'm really compassionate with patients and so whenever we had something come up with maybe it was let's say a diet and telling somebody that we were…recommending changing their diet I feel like I did play a role in that…I feel like I did well connecting with the patients and even if it was a hard scenario or something making them feel heard.

Erica believed this communication was important to the patient EDM experience. She valued placing the patient at the center of the ethical conversation. Other students also sympathized with the impact communication disorders across a variety of environments. As a second-year clinician, Sierra reflected on her ability to advocate for others during outside employment. She recalled:

> I guess I don't have a ton of experience from an SLP [speech-language pathology] standpoint, but I take a lot of what we learn into my position as a care provider for those with special needs. One of my clients…at our team meetings they'll often say things like,

> 'We need to continue to have a direct select because otherwise she's no longer going to be able to direct select,' and things like that. None of these people have a communication background, so then I'm able to come in and say, 'Well, communication shouldn't be as hard as possible. If it's really difficult for her to do it, she's not going to want to do it.' I guess I take most of my advocacy stuff for my clients at my personal job because I'm the one working with them for multiple hours out of the day and things like that. I feel like most of the advocacy that comes with my position so far, as my experience an SLP, is more just educating the family on things that they genuinely just didn't know was a thing. I feel like that's more education versus... Because they're not necessarily harming them on purpose, they're not trying to keep them back, they just don't realize that they could be doing things in a better way.

While Sierra did not consistently reflect patient ownership across her clinical experiences, she did use her professional knowledge to advocate for patient needs in her workplace. She was confident in her ability to identify with her clients and their communication needs. She felt the need to speak up on their behalf. In the other direction, Sarah's personal work history influenced her clinical decision-making. When asked about patient's refusing her healthcare advice, she stated:

> This isn't in my SLP world, but when I was a CNA I observed an SLP because I was a CNA and they would always come around mealtimes and we would always assist during mealtimes. She made her recommendations and this guy…he refused, and he signed a consent to not follow the recommendations and he was dead two months later. Died of aspiration pneumonia. Seeing that, I know how serious aspiration pneumonia can be, even in a healthy person. You know, I mean he was a little bit older, but he was pretty healthy, pretty mobile. When things are going to your lungs it doesn't matter how strong

you are. I mean some people can aspirate and never show a sign, but other people can die two months later. A lot of factors play into that, but quality of life. He decided that was not what he wanted to do. He wanted to have thin water and everything he wanted. And he knew the risks.

Sarah's experience as a nursing assistant had shaped her view of patient autonomy and quality of life diets. She recognized individual patient wishes. The textures of student backgrounds and experiences appeared in the students' statements; however, backgrounds were reflected more significantly in the clinical supervisor self-perspectives. Student perspectives focused more on the interplay of personal history with clinical practice versus experience relative to EDM.

Student participants did not readily address their personal upbringing and morals. Instead, they concentrated on personality characteristics and outside experiences. The students considered how their histories might be of benefit to their patients. The desire to help their patients was the most common self-reflection found in the student interviews. During discussions of their roles in EDM situations, students spoke more of observations as opposed to actions.

A Learner Role

Whether they believed they were limited by other ethical stakeholders, or their supervisors, students grappled with EDM. Overall, students had unclear views of what was to be their role in EDM as a student and future professional. When asked about her role, Erica stated:

> A learner…So yeah I don't feel like as a student in those situations that we talked about I didn't have to make the final call on anything. So, I feel like it was just good for me to be exposed to these scenarios and situations that might come up and I got to see how my supervisor, the decisions that she made regarding them so yeah.

Erica valued her observational role and exposure to EDM during clinical experiences. While she did not play a direct role, she hinted at generalization of her observational experiences.

A few weeks into her last student clinical placement, Sierra also had decreased understanding of her role. She stated:

> I think when you're working under somebody it's hard to know what your place is, being that technically, even though I'm treating the clients, they're still technically not my clients. Ultimately, everything still falls on someone else, it doesn't fall on me. Even if I make a mistake at this point, it's their mistake for not catching it, kind of a thing. Or vice versa, if something happens and you're under a supervisor it's the supervisor's responsibility, it's not my responsibility yet. I think that that's probably part of it, because I think once I'm on my own and everything is up to me, how I choose to do my therapy practices and things like that, then I will know why I'm doing certain things and it'll be easier to determine when to make those changes, I guess.

In this statement, Sierra had limited patient ownership and difficulty defining her role. She deferred to the clinical supervisor for patient responsibility. When asked why she had less ownership, Sierra partially conveyed:

> I think part of it is just our profession in general, it is very Type A personalities and so they need to have control over their case load. Even if they were to give you everybody in their case load, you don't really have... there's still a lot of times... I mean, you're still working under their goals, you're still doing their care plan, until a new care plan comes anyways.

Sierra continued this concept of limited engagement in direct EDM during clinical placements. Sierra and Erica appeared comfortable with their secondary role in EDM during

their initial and secondary interviews. While both expressed ideas on how to holistically solve certain ethical dilemmas, in the end they deferred to their supervisors. Hannah attributed her limited role to the patient population type and the start of a different placement:

> Right now, my supervisor is doing most of that I think. Especially now with the adult clients I'm with. It feels very different when I'm working with a child and parents are coming in. Because it's more the parents who are making those decisions for children versus the children themselves. Adults were not really in my realm, just not the opportunity yet for me to make those decisions.

Across the student experiences, all students had accounts of limited roles in EDM. These limited role definitions occurred because of reduced confidence, inadequate guidance, directive supervision-style, and/or adjusting to a completely new clinical placement.

In these supervisor-student relationships, the students had ideas for solving ethical situations but did not consistently feel comfortable speaking up. They had questions that went unasked. Charlene described her internal conflict when wanting to speak up about an ethical scenario:

> Yeah. And…I was like 'What if I'm wrong? What if I look stupid?' Kind of like getting over that stuff. Which that is my personality. I'm always afraid, I don't like to be wrong. Nobody likes to be wrong, but anyways. So that was kind of, those insecurities kind of came out a little bit more when I was with this other person who I didn't have as good of a relationship with. I mean I knew her and saw her every day, but we didn't work together as much. And so then, not that I wasn't supported, but I was like 'Oh, I'll just keep it to myself. I'll say it later, it's fine.

Charlene's thoughts about this case reflected a holistic view of the patients and their needs. However, she internalized these because of low confidence in her opinion.

Other students also internalized their thoughts that reflected holistic ethical reasoning. Occasionally, this was because students were not always present for all discussions with ethical stakeholders. In other stories, the student did not work with the supervisor to see the entire problem through to the end. When students did provide their opinions, they quickly recalled the supervisor's response and feedback during their personal interviews. The students who felt uncomfortable speaking up, looked to their supervisors for approval.

While some students struggled to find and define their roles, others had clear conversations with their supervisors on their part in EDM. Clarity in the student's role also resulted in increased patient ownership. Sarah recalled her student clinician role in an acute rehab setting:

> I feel like I was, because if they were my patient, I was taking on that responsibility and [my supervisor] and I would discuss it first and then go into the session kind of prepared. And then if they would ask any other questions or anything, then if I didn't know the answer, I would ask [her] and then [she] would kind of step in and answer that question. But for the most part, she didn't like take over and start answering questions or anything. Unless I asked her to specifically. '[Supervisor] what do you think about this?' Or something like that during your session.

Sarah and her supervisor took, or had, additional time to have conversations before EDM meetings. They were purposeful about the roles of the student and clinician. Sarah reflected on the time and purposeful conversations as a forming EDM moment.

Charlene eventually had her inner, ethical reasoning thoughts supported by a supervisor. That made a difference in her approach to other ethical situations. Charlene described:

> Especially because once I said what I was thinking out loud then I heard that yeah my supervisor was thinking that same thing…So it kind of affirmed that I wasn't off the

mark. I think I was afraid of being wrong and so I didn't say anything. I think moving forward, just like trusting myself more and then also like kind of getting over that and like, 'it's alright if you don't have the answers all the time, talking through the situation is helpful in itself' so yeah.

In the student experiences, when they had open, honest conversations with their supervisors, they perceived increased readiness for future EDM. The bulk, though, of the students either readily or reluctantly took a secondary role in the EDM process.

The shift to higher-level EDM development was uncomfortable. When students were given a limited role in EDM, they reflected less patient ownership during their first and second interviews. Students who had scaffolded ethical situations demonstrated more ownership and reflective reasoning during secondary interviews. Student growth and development into EDM is vital to their success as future professionals. In this way, student EDM development can be self- and/or supervisor limited.

Supervisors also remarked on the influences of students in the development of EDM. They reflected on student strengths and limitations during EDM. The student influence that supervisors spoke of the most was effective, critical thinking skills. The following sections cover the supervisors' perspectives of student clinicians during EDM. They include an evaluation of student EDM readiness, strengths, and limitations from the supervisor participant narratives.

Ethical Decision-Making Readiness

Supervisors looked to student behavior for indications of readiness for EDM. One of the first markers of student readiness was the ability to reason through a difficult situation. Emelia clarified how she determines a student's readiness for tough situations:

> Honestly, depends on their where their starting out with me. So, we're end of their, let's say they are doing an internship there and they've had a lot of experience with patient

care, with going to care conferences with, having some of these hard questions thrown at them through their treatment sessions and evals and discharges anyways or care conferences, tough care conferences with families. If I've seen that some of their experiences warrants that they can field something like that, I would obviously be right there with them. We would have conversations prior to them educating family and having talks like that. And again, individual basis with students, either they can, or they can't.

While Emelia valued experience, she also saw naturalness for EDM in some students. She saw it as a does or does not have skill. In a later interview she described how she worked to scaffold this reasoning for students who struggled.

Bea also summarized her experiences with student growth in ethical reasoning:

Well, again, it's students, their thinking is typically very concrete. You know? It's hard to make a recommendation like that for students. I feel like it comes with experience and time, being able to think a little bit more open like that. So, my student is only in her third week currently. She pretty much needs direct guidance on how to make a recommendation like that where if this then that. So just encouraging her to think a little bit outside the box…Maybe towards the end of their internships. But right now, no. I mean, ideally that is the goal. And, yeah, I would say towards the end, I am more willing to step back and let them take the lead. But it's hard for me because we're dealing with real patients and their families who are sick and have multiple things going on. It's hard as a student to know what to say and to say the right thing. You know?

Bea also saw students as either reflecting or not reflecting the problem-solving skills for EDM. When asked about student growth in critical thinking over the course of a semester, Bea responded:

> Usually when they have that base knowledge of what they've learned, and then now they're actually seeing real patients and not everything fits into a mold and usually students grow and they're able to see that we have to be open minded and forward thinking with those cases.

In the preceding quote, Bea described some characteristics that may precede student strengths in EDM. She allowed that while students come to their clinical experiences with a foundational knowledge in normal and disordered functions, they often lack the ability to account for individualized nuances. Throwing back to the concepts of holistic thinking, Bea described students as struggling to see the whole picture and not just a textbook example. The time needed to develop this level of decision-making was almost an entire clinical experience for most students.

Similar to Emelia, Bea generally waited until later in a clinical placement to give the student additional EDM independence. "I think I could work on letting some control go. But it's a skill that would be more advanced towards the end of a 10- or 12-week internship."

The readiness and amount of student growth needed to take on these advanced decisions varied between settings and supervisors. As discussed previously, Heather had students in the acute and rehabilitation settings start by observing her during ethical discussions. She monitored patient rapport and student experiences before asking them to direct a difficult session.

In the outpatient setting, Laura had a tense family conference fairly early on in the student's experience. Laura outlined their respective roles during this ethical scenario:

> Yup, so she [student clinician], actually what I had her do was she shared the results of the testing that we had done. And what I had her actually do, is review, prior to those results a reminder with them that we had copies of releases just to reiterate that we did have…I had her reiterate that…I had her kind of do more of those portions. I handled

more of the confrontation, I guess, between us and parents. More so because I wanted, and I let her know that ahead of time, because I more so wanted to provide a model, it was kind of her first real like questionable type of situation and she was very nervous about that. So, I said that I'll provide the model if you take in information. But I wanted her to be a part of it, so I had her kind of go over the results of the testing, the goals, and reminders.

Collectively viewed, supervisors had strong patient ownership during EDM and did not allow for students to immediately jump into complex ethical situations. They also monitored student development to define the roles of the student and supervisor during EDM. Hallmarks of student readiness of EDM included holistic and in-the-moment critical thinking skills.

Supervisors watched for students to realize the individual nuances of each ethical situation and respond appropriately. However, many student clinicians did not reflect these skills until late into their clinical placements. Again, with their jobs and licensures potentially on the line, supervisors were slow when allowing the students freedom during EDM. The supervisors also highlighted student strengths during EDM.

Strengths in EDM. Extending the voices of the student participants during EDM stories, supervisors also found that students related well to patients and were compassionate. Heather recalled strengths she had observed in student clinicians over the years:

> I just think as students we're very compassionate. We just have that; I feel it's the personality of us wanting to be a therapist. We want to support others. We want to have a listening ear. I feel like they can build a rapport with patients and family fairly easily. I think could also be spun as a negative as well that sometimes too compassionate or worrying too much about their feelings. But I would just say, that listening ear and compassion towards their patients.

Similar to the student participants, Sarah, Sierra, Hannah, and Erica, Heather identified listening, compassion, and rapport as the largest student strengths during EDM. Bea added to the picture with her positive student experiences:

> I think students do really well at knowing what the recent research is and what they're being taught in class. They're really good at referencing that when trying to make a decision. But trying to apply it towards the whole picture, like taking into account all of the different aspects of this person and what's going on, it's difficult to synthesize all of that as a student, obviously. But they're really good at knowing the textbook things and what they've learned and how things should go.

Bea also recognized student skills in understanding recent research, knowledge of evidence-base practice. When discussing this she saw it as an initial foundation to eventual complex decision-making. Laura was also asked about student strengths, she added:

> They do well, I think they start asking questions a lot. They ask good questions and I think they maybe reflect a little more and maybe realize like 'oh this is real; this isn't just school anymore. This is a real thing, and this could really mean something.

Collectively, supervisors found students to be compassionate, listening, interactive and caring toward their patients. They had strengths in knowing the latest best-practice research and asking questions to understand content beyond the classroom. While students were compassionate and patient-centered, supervisors also suggested areas for student development building upon these initial strengths.

Big Medical Picture. As reviewed prior, supervisors monitored student critical thinking when making decisions about EDM roles. During interviews, supervisors noted decreased holistic thinking in student clinicians. Bea detailed a common conversation in her supervisory sessions:

> Well, we talk about, 'This is what we know from the speech pathology end of things and what research says and what we've learned in our classes and continuing ed stuff. But we also need to take into account what the patient's wishes are, the family's, the big medical picture what all they have going on medically to make our recommendations and assist with the decision-making.' I feel like I spend a lot of time just encouraging them to just not look directly in the speech little bubble. We have to look at everything and take into consideration all the different perspectives when making decisions.

Bea reported frustrations with students using concrete thinking, only textbook knowledge, and not making individualized ethical decisions. She saw students grappling with synthesizing information from multiple places to make a decision. Along these same developmental lines, Bea observed student at an absolute-knowing level and struggled with the work needed to move them forward.

Laura also reflected that while students asked questions they were not independently searching for answers on their own. Supervisors saw students as wanting to be told, instructed on the right EDM path. Katie observed concrete student behavior during in-session decisions and ethical, appropriate treatment.

> Sometimes I'm a little bit disappointed with the students that, even with a hard patient, they just take what I'm doing and keep doing the same thing. No, I expect you to come up with your own ideas. Yes, I get that this is hard, but you're going to have these harder patients. So, come up with even your own activities even if you're doing the same thing, the carrier to getting that done needs to be different. So that's something going forward [with future students] I want to be clear about. I know you're learning from me, and that's great, so take what I have shown you as far as a technique or treatment practice. But I want to see what you can come up with in that same area. It's not always like that.

> And maybe I'm just getting old. So, I have these generation Z students and I'm like no, do better. They are, they're just different.

When it came to complex ethical decisions, supervisors found student clinicians taking the safe, predictable route. Supervisors looked for student readiness for EDM. They often noted, though, student weakness across other tasks that would prepare them for ethical reasoning. Laura tied experience to the ability to prepare for holistic EDM:

> That's kind of a struggle because you have some students that can do that [plan] really well and then others that don't and it's one of those skills that comes with experience or practice and sometimes doesn't come. Honestly! I would say they don't necessarily do that well and I feel like without the experience, having some of those experiences, I feel like they don't quite understand the big picture of that…once they've had that situation I feel like they flip into like 'okay, I need to be more prepared for this, or what if this were to happen?' But until then I feel like they, I don't know that they make that connection as to like this is, again, real. Like this is my job.

Supervisors believed that students lacked holistic, critical thinking. While Baxter Magolda's Epistemological Development (BMED) stages will be discussed in detail later, these supervisor stories warrant comment on student development within the influence of "Big Medical Picture" thinking.

The bulk of supervisor descriptions of student clinicians are linked to the early stages of the BMED model. The supervisors encountered students who wanted direct answers. When students stepped into EDM, they relied heavily on supervisor feedback and approval; however, the dynamics of EDM created limited student opportunities to attempt and experience EDM.

Supervisors did not feel comfortable having students engage in EDM without markers for holistic reasoning because of possible the ethical, legal, and professional repercussions. Students

had restricted opportunities for holistic reasoning and improved EDM. The participant stories highlighted a shortfall in the challenges and support required for student clinicians to reach appropriate skills with EDM during clinical practicums. Students needed experiences to develop EDM readiness. Occasionally, 13 weeks was not enough time to move through four stages of epistemological development toward independent, complex problem-solving. Consequently, the gap in experience continued to permeate EDM and limit student development.

When discussing student EDM challenges, all supervisors returned to the role of experience. Bea stated, “But I think just not having any experience yet or being more in the classroom, it’s a harder concept to grasp coming right out of grad school.” Heather also discussed the impact of experience on holistic, on the spot thinking.

> I would say as students they are just afraid to hurt feelings or if the family disagrees. I’m just kind of trying to still stay strong in your recommendation despite what they’re questioning or asking. Can’t they just have a little sip or can’t they just…still sticking to your grounds and your education and what you know was right because family does get a little pushy and they are strong in their wants as well. I just think that takes real life practice and we’re not always equipped with those situations, I think takes as any profession, just kind of experience and exposure to it.

Continuing the experience horizon, supervisors linked their own and student EDM development to experience. They also detailed the development of student information gather behaviors prior to facilitating an ethical decision.

Quick Decisions. When asked about student challenges with EDM, three supervisors detailed the impact of student preparedness on development of EDM. Laura stated:

> Oh gosh… they do not always think things through really. They want to make quick; I think they make quick decisions. So, I feel like they don’t, they sometimes rush that.

They do not really thoughtfully plan out how it's going to best be handled, you know maybe that think on the spot kind of thing.

Emelia also noted:

I think that goes back to really under preparation. So, when we're going into care conferences or we're doing something that side with the family, it is a lot of conversations about every which way this can go. I think prep is the key always for students to be prepared to go into a situation and field hard questions.

Katie also noticed poor student preparation:

I know that they've had a lot of practice in grad school, but I think just whether it's a test that I have in my clinic that they haven't had lots of experience with, so I say 'Okay, you're going to get this test, read up on it,' and they clearly haven't read up on it enough. So, they're giving to many cues or they're not doing the ceilings and basals right, or they're just helping the child out a little too much. Then the results are instantly skewed.

These supervisors had students with quick, underprepared patient interactions leading to ethical concerns and unfortunate experiences. Again, reflecting lower levels of BMED, supervisors witnessed students short-cutting the information gathering stages of EDM. They saw students as desiring quick, black-and-white answers instead of holistic, individualized patient recommendations.

In summary, student work experiences and personality traits were an asset for patient connections. These characteristics aided the students during perspective taking and movement toward holistic, bioethical reasoning. However, students were often secondary members of the EDM team. They were kept in that position, in part, because of observed ineffective EDM skills. Supervisor narratives described student clinicians in the initial stages of BMED. Students had quick, incomplete problem-solving actions. Supervisors saw experience as a way to move

students toward increased EDM independence. Most students, though, did not take over during ethical cases until the last few weeks of a clinical placement.

The majority of the student strength areas outlined by supervisors also became key areas for growth. Students had strong textbook knowledge but struggled to understand how to use that knowledge during ethical dilemmas. Students made quick, underprepared decisions. Hasty choices resulted in inadequate patient education and treatment sessions.

Collectively, the student voices and supervisor views on student strengths and challenges created a textural description of the student clinician influences during EDM. Supervisors and students agreed that the students had strong foundations in knowledge-base and compassion for the patient. Overall, decreased confidence, holistic thinking, and thoughtful preparation were considered challenges to student EDM. Across the board, students needed more growth for EDM. The following section further defines the influence of other professionals on the development of EDM.

Other Professionals

The discussion of influences from other professionals was divided into two sections: (1) I needed support (student horizon) and (2) bounce it off colleagues (supervisor horizon). While outside resources such as ASHA were used to solve ethical dilemmas, the largest influencing resource on both the students' and supervisors' ethical decision-making (EDM) was other professionals. The participants discussed the impact of others on their EDM; however, these groups utilized other professionals in different ways.

I Needed Support

Students were influenced by their supervisors, supervisory relationships, peers, and other healthcare professionals. When asked what resources she used during an ethical situation regarding a communication board, Sierra responded:

> I relied on my supervisor a lot, I guess. And just her experiences and the hopes that she would guide me the right way, I guess. I didn't personally [speak with other professional], but she [other professional] would talk to my supervisor and then she would talk to other people in the building and bring up the concerns. So, then the concerns would somehow get back to my supervisor and then we would talk about them.

In this scenario, Sierra is using her supervisor's experiences and conversations to further understand the process of EDM. She refrained from making a statement about her thoughts, feelings on this ethical scenario and defaulted to her supervisor's perspective.

Hannah also used her supervisor as a primary ethical reasoning resource during her concerns with interpreter services, "I did go to my supervisor as well. Just to ask, like I feel uncomfortable with this. What do you think? And it didn't really change anything, until there were other people kinda backing it up." In this situation, Hannah used not only her supervisor, but when she wanted additional support for what she believed was the best course of action, she went to other professionals and peers. She looked for ethical reasoning reassurance from a variety of sources.

As discussed previously, supervisor experience, background, and professional approach were all influential during student EDM. Student's also utilized their peers as a sounding-board during EDM. During her second interview, Sierra clarified when and how she used her speech-language pathology classmates for EDM:

> Always. Always. I always-I'll always say something like, 'This happened today,' and just ask them, 'This is my reaction, this is what I'm thinking about that, am I thinking wrong?' Because I do know that everybody can take things out of context and things like that, and people can over-exaggerate things, and I'm kind of one of those people who

> over-exaggerates things sometimes. So, I'm like, 'I just need to make sure that I'm having an accurate feeling about this, what do you guys feel about the situation?

Sierra emphasized the importance of having others to support her during the process of EDM. She needed reassurance. Beyond their supervisors, Sierra and other students looked to their peers to either validate or counter their ethical actions. During her first interview, Hannah explained, "it was the support of trusted friends and also trusted colleagues that helped me understand better that maybe it wasn't expected of me. Or shouldn't be expected of me." In Hannah's second interview she clarified:

> I often reached out to people who I knew or like could tell me you're in the right or like you should keep fighting for this almost. Like friends or other professionals who have similar experiences that could tell me like keep working on it, like you're in the right and keep working towards it. So, I needed support, like I was searching for somebody to tell me this is right still. And kind of doubt, having some doubts in myself.

Hannah looked to others for to confirm ideas during ethical dilemmas. She and her clinical supervisor had conflicting views on an ethical situation. She lacked confidence in her ethical reasoning and looked for the support of others before discussing with her supervisor. Hannah went to other classmates and professionals to aid her in resolving this conflict.

Collectively, students looked to other professionals to assure them of the correctness of their ethical actions. The students lacked confidence across a variety of ethical situations and looked to others to confirm their ethical choices. The influence of other professionals became more specific to medical doctors in some student interviews.

Different Doctors. When working with their supervisors through EDM, students found other therapy professionals, such as physical therapists and occupational therapists, useful. Students also recalled the impact of SLP-physician relationships. These conversations became

one of the most-commonly described interactions during student interviews. Sarah was almost finished with her clinical fellowship by the time she completed her second interview. She noted the following about physician interactions:

> So, we've [clinical fellowship supervisor and Sarah] had multiple conversations about this person [physician] and not in a positive way just because she kind of downplays our whole profession and she doesn't really make any sense to me because she's a [physician in a highly related field]. So, you don't know anything about the swallowing and stuff and part of it. But yeah, so that's been kind of hard too, and it's an ethical thing, like where do I fit in here? So, working through that with [my CFY supervisor] has been helpful because she understands exactly where I was coming from. And then she helped me work through that a little bit too…multiple patients. And it's kind of like gossipy in the [hospital] like, 'Oh, that [patient] doesn't need to have a video swallow study.' Type thing. And then they question what I'm doing because I'm new, I'm a CFY, and all this stuff. And then it's kind of like them not trusting me, but I'm trying to build a rapport with all the providers…And so it's kind of disheartening for a couple of weeks there, where I was just like, really? This isn't how it's supposed to be. Like you're a [physician] and you're gossiping and yeah. You don't have to put all that in your report and stuff like that. Just like the staying in your lane, doing what's only in your scope of practice type thing, is very good to know.

It is apparent that Sarah felt frustration over the physician diminishing her role in the healthcare team. Sarah had concerns when trusting this physician with patient care and best-practices. She felt disheartened by the actions of the other provider. She detailed ethical scenarios as a result of violated professional boundaries. This impacted her confidence in EDM,

and she looked to her clinical fellowship year (CFY) supervisor to support her during the difficult exchanges with the medical provider.

Erica also observed the influence of physician practices on her medical internship,

> the doctors. That was very interesting to see the different doctors because, by the end of my time there, I knew these doctors always put in for swallowing orders even if we don't need them and these ones will give us pushback on diet recommendations or like that kind of thing. So, they, every doctor was different and had their opinion…And I think I really learned a lot the things that my supervisor would do or say to the doctors.

Erica learned to adjust her behavior and advocacy for patients based upon common behaviors of medical providers. She learned to adjust her EDM based upon the involved professionals. Across these accounts, students were looking toward other professionals to often support them during uncomfortable nature of EDM. They relied upon supervisors, peers, other therapists, and a knowledge of medical staff, as first-line resources to EDM. With limited EDM experience, students sought out others to validate their EDM. Student participants were not alone in their discussion of physician influences; supervisors also talked about physicians as well as a variety of other medical professionals as influential to EDM.

Bounce It Off Colleagues

While students needed support, supervisors looked to bounce ideas off other professionals. The overall reliance on others was different for experienced versus novice SLP clinicians. Supervisors discussed a spectrum of resources used during EDM including: ASHA webpages, ASHA scope of practice, billing guidelines, and professional webpages/blogs. Yet, similar to the student participants, other professionals were the number one resource in the supervisor's toolbox. Other SLPs topped the list of other professionals in the supervisor stories. Emelia found value in the opinions of other SLPs:

> Lots of conversations and myself, that's the truth. Another thing which I feel like actually this is what I do hands down the most. Bounce it off of colleagues, that is my go-to, and it's really interesting because, I will either get five of the same answers or you will get, it's funny, get really varied responses to your one situation. I specifically, I generally go to other SLPs, if it is specifically treatment related, then obviously I want someone like an SLP can help me with that.

Emelia used her own thoughts and opinions, as well as those of her colleagues, during EDM. She acknowledged that getting a spectrum of opinions was one issue tied to discussing an ethical situation with others. Yet, she still found the opinions of other SLPs helpful. Stacy added more positives to the role of coworker resources:

> Some of the biggest benefits that I have, if I have a really good team of coworkers and if I have a question that says, 'Hey, how do you think I should handle this situation?' Or you know, you kind of give them a run down on the situation and then you can have a social worker that I can talk to. We have OTs/PTs that I could talk to that work with the patients as well. So, it's nice to have somebody else, but you can run these things through other people.

Beyond SLP colleagues, supervisors looked to other members of the healthcare team. Stacy emphasized the importance of information gathering from a variety of team members before finalizing an ethical decision.

Bea suggested a large group of different professions she believed was needed during one of her ethical dilemmas, "Well, the attending physician, the resident, the case manager, the patient, and daughters, the nurse." Emelia described why she used other rehab professionals during EDM:

> But, as I've often referred to this more because that's my experience…OTs and PTs are generally facing the exact same thing you are, when it's not speech therapy, specific, how to give and I loop this back. I know it's like a broken record, but the whole patient centered care versus business corporate, so PTs and OTs experience the same darn thing.

In these accounts, supervisors are using many members of the healthcare team as EDM resources. From experience, they knew who they could trust, and when to use those interprofessional resources most effectively. In contrast to students, supervisors primarily used other providers as resources to gather information rather than direct, or support, their ethical decisions. Supervisors also had complex balanced relationships with healthcare providers.

Physicians. Three supervisors considered the impact of physicians on their ethical practices. When asked if there was something/someone who really influenced her ethical decisions, Bea replied, "I would say for sure the physicians, too. Yeah, the physicians." To this same question, Heather answered:

> Definitely, other doctors I would say working in the population of adults and aging and hospice palliative care those providers have played a large role. That depends heavily on patients wishes, but let's say, you make a recommendation for a feeding tube and they need to be NPO, but maybe that is not feasible with our other medical comorbidities. And that's when the physician has sat down and said, 'I know you're recommending NPO, but can we get them to eat something else, can you make them safer?' For example,…It definitely makes you realize that we each have a role and I feel we get very deep into just your recommendation that there, let's say dysphasia. That can they eat or not, but we each have a role into this patient's care, and you are all equally as important.

In this case, Heather sees the benefit that physicians have provided her when working as an interprofessional team. While Bea and Heather reflected on positive influences, Stacy had experienced a difficult situation with a healthcare provider. She recalled:

> Probably the biggest, not helpful experiences would be sometimes, sometimes you have a strong conviction like this is what's going on with this patient and you get, you get pushback from a different professional, not in your area but in a different area. So that can be frustrating sometimes. Like you were talking about the, what about the family that 'something blew up in your face' or so that that was an incident where the team of the therapy team that I work with, we had significant concerns that the child is autistic and so we brought that to this physician and told them our concerns and then what happened was that another professional not, not wise, who will communicate regularly with us. Told that family, that child is not autistic and so that, that's very frustrating when that happened. Even though we see these children on two times a week on a regular basis and somebody isn't going to take your information into consideration….There's sometimes we have, we'll keep running into like one provider that's not helpful or one provider that's not willing to, to listen to what we have to say and….sometimes there's not a whole lot you can do about that other than then document what you know to be true and look you see and that's all you can do.

Overall, the participants relied on conversations with others to work through EDM. They often looked to their peers and colleagues first, but also found influences in the rehab team. Physician influences were a horizon across both supervisor and student participants; however, they were not consistently found to be a resource toward solving an issue. Rather, physicians were often reported as an individual creating the ethical dilemma for the SLP clinicians.

Students and supervisors approached their resources differently. While students used others for support, direction, and reassurance, supervisors tended to use them as a resource toward solving a problem. These differences reflect the ongoing discrepancies between experienced and inexperienced clinicians. In general, the inexperienced clinicians looked to others to direct them, while the experienced looked to their resources to gather information. Because of the complexity of these decisions, ethical situations occasionally resulted in difficult emotions. All participants discussed the negative emotional impact of EDM and their coping mechanisms.

Near and Dear to My Heart

Ethical decision-making (EDM) impacted participant emotions and well-being. Students used words such as heartbreaking, frightening, trauma, frustrating, and guilty. In her first interview, Sierra discussed an ethical situation where she felt guilty about the possible outcome. When asked to further describe, she stated:

> I panic, I start to breathe really heavy and I get really anxious about it and I can't think of anything else until I know that that issue has been resolved, or whatever it might be. And I've been that way always. Like anytime I might get in trouble or something like that, like I can't focus on anything else until whatever it is gets ... if I get a response or something.

Sierra returned to this topic in her second interview:

> Part of it, for me, is that I do think that I'm an anxious person, but I'm not diagnosed or anything like that. I dwell on things a lot that I'm like, 'Okay, that didn't go how I wanted it to go.' I probably make a bigger deal out of conversations that other people probably just never think of again. But I'm like, 'Oh, they probably think I'm so mad at them…' Usually I'll think about it for a while after, and maybe for the rest of that day I'll

think about it. Then the next day I'm usually fine and I can continue to do things normally.

Sierra acknowledged concerns with anxiety and the impact of EDM on her well-being throughout the time following an ethical situation. Sierra's primary resource when dealing with these emotions was to seek peer support.

Erica described how the emotions of EDM impacted her clinical experiences:

> I think that may have been one of my biggest takeaways from this semester. I did not anticipate or think at all that I would be emotionally involved and there were times that I left my internship crying and I feel like we don't talk about that in school at all and we don't talk about how to deal with that. And so, I felt very, and even sharing with my husband like I absolutely love doing [working in] that setting but I don't want to feel like this for the rest of my career. I can't be coming home every day and feeling and can't stop thinking about my patients and stuff.

Like Sierra, Erica looked to her immediate support system to help process her emotional responses to EDM; however, Erica's circle was smaller and not as aware of the EDM nuances tied to speech-language pathology (SLP). When asked about her emotions surrounding EDM in her CFY, Hannah said:

> I'm glad you talked about the emotions too because I think that was as a big part of what I'm experiencing right now. I'm trying to express to other people like this is near and dear to my heart, and I need to almost tell them about these things that happened in grad school in order for them to understand where I'm coming from and where my emotions are along with these very, it's almost policy issues or like tiers of standard that we should unfold. And kind of those emotions bring so much into it in trying to have people who are coming from... Like there's also those emotions of other people saying like, 'Oh I've

been doing this for 15 years, and you're now coming in and telling me you want to do it a different way. And that makes me feel like I've been doing something wrong for 15 years, when I don't feel that way.

Hannah felt passionate about her ethical topic. Yet, she began to see how she was impacting other clinicians with her strong emotions, and past trauma, when it came to this same topic. She desired to make a change in her current position because of the impact of past EDM emotions.

In her first interview about supervision, Bea spoke about how she developed the ability to compartmentalize ethical situations.

> Most the time [I can compartmentalize] it's a skill that I've developed over the years. At first as a new therapist and stuff, I used to have tons of anxiety at night and sleeping... If there were things going on or wondering if I did the right thing or if I didn't do... Now, I can [sleep]. Now, I can. Yeah, for the most part. Yeah, because I try to act in a way that's ethical, so that I can sleep at night. You know?

When asked how she got to that point, Bea responded:

> I think it's a time and experience and confidence thing. When you're brand new and you're trying to find your ways at your job, you just question yourself, 'Am I doing the right things? Even though it feels like I am, I wouldn't intentionally not.' But it's just a lack of confidence. I think it just comes with the experience that I've had. Maybe I think definitely coworkers and things influence that and help with that.

While Bea believed experience and time were needed, Laura discussed working a clinical fellow (CF) through an emotional situation.

> I would say she [the CF] required a fair amount of guidance with it because in total layman's terms she was freaking out. She was like 'oh my gosh, are we going to get in

trouble?' and it was like well… So that was where I think for me, having experience and just having been in the field longer I was able to say, 'Look, let's look at what's being questioned.' I was able to kind of walk her through some of the pieces that I felt really strongly we have support of based on the ASHA code of ethics, based on just general policy of the department and the site that we were working at. But you know, I think that, if thinking back to that, if she would have been on her own, I'm not sure. There was an element of, I'm not going to say panic, but definitely an element of 'oh my gosh, this isn't good, I'm not going to…' I would bet to this day if we were to ask her, and I remain in touch with her a great amount, but I would be to this day if we were to ask her she would recall that and say that was one instance where…Yeah, very emotional, very much. So that's what I think it is. Those kinds of examples sticking in your head when you're looking at training graduate students to be prepared, 'what are you going to do if?'

Laura again pointed to the role of experience in the development of EDM and managing emotions. Across these student and supervisor discussions of emotions we see a disparity in student coping needs and appropriate tools. Students struggled with compartmentalizing the emotional impact of EDM. While some turned to their peers, others struggled with coping while preserving patient confidentiality.

Supervisors sought out others as needed; however, had learned to monitor their own and their supervisee's EDM emotions. Students lacked confidence across the essence of EDM development. This lack of confidence occasionally overflowed into emotional reactions, something not all students were prepared to experience. The following section opens the discussion of how supervisory and student personal experience shaped the forward, or backward, development of student EDM.

Student Development Reflections

The participant stories included a wide variety of learning experiences, settings, and instructional methods. While experiences in ethical decision-making (EDM) development were unique for each participant, the textural and structural descriptions established a group narrative and essences detailing the what and how of EDM. The students and supervisors also discussed student development and instructional methods. The following sections provide an overview of the initial challenges, instructional techniques, and independent EDM reflections from the student and supervisor participants.

Initial Challenges

Students remarked on the challenges related to EDM and influences that limited their independent EDM. The challenges and lack of experiences across EDM lead Sierra to the role as a receiver of decision-making knowledge. She said, "I relied on my supervisor…and the hopes that she would guide me the right way..." During this interview, Sierra was a second-year graduate student with many clinical experiences. However, she considered her EDM experience as a receiver of knowledge instead of a creator of knowledge.

Sarah had a similar experience when her supervisor negated her proposed EDM plan, and said, "Like [my second supervisor] would straight out tell me like, 'Nope, this is what I would do."' In this example, Sarah's EDM experience was met with limited options for critical thinking development. Sarah's supervisor directed her to the desired response instead of aiding her to find it on her own.

Charlene's self-doubting led to her taking a limited role in EDM. She spelled out her feelings during the ethical situation:

> I don't know. I think in this situation I probably would have went along with what she said or maybe asked, or maybe I would have phrased myself more in a question. Like what do you think about this? You know, kind of. And then umm I don't know. The

> easier way to walk it back I guess is probably, what I would have done. I think if I would have had then though a clear opinion about it, like this was where we were oh should we do this now or should we do it later. Is it within our scope? it was kind of on the fence. I think if it was something that I had like a real strong opinion about then I would have said something. I think the fact that it was a little bit more grey then also made me more nervous that I was wrong.

Charlene was in the initial stages of her clinical fellowship when she reflected on this student experience. In this account, Charlene acknowledged hiding her EDM skills because of lack of confidence. As a clinical fellow, she had developed beyond those skills and hinted at regrets for missed opportunities during her student experiences.

Supervisors also discovered black-and-white student reasoning during clinical experiences. Bea noted her students had strengths in knowing recent research but limitations in critical thinking. Other supervisors saw weaknesses in students' ability to think on their feet and knowing what to say, or do, during live patient counseling sessions. Supervisory behaviors also impacted this developmental pattern. As highlighted in the discussion of supervisor influences, students often played a secondary role in tough discussions and ethical decisions. This instructional technique restricted to the student's role in EDM and the full experience.

Instructional Techniques

The student participants emphasized the role of supervisor modeling during ethical dilemmas. Only one supervisor, though, labeled her instructor behavior as a modelling method during the interviews. When discussing her supervisory role in an ethical situation, Laura stated:

> …more so because I wanted, and I let her know that ahead of time, because I more so wanted to provide a model, it was kind of her first real like questionable type of situation

> and she was very nervous about that. So, I said that I'll provide the model if you take in information. But I wanted her to be a part of it.

In this description, Laura planted the seeds for her student to closely watch her model, yet still required actions from the student during the interaction. This is an example of an instructional option for increasing student engagement in the EDM process. Laura did not dictate the student actions; rather, she modeled the possible options and allowed the student opportunities to engage and critique the outcome. By scaffolding their observations, Laura embedded the beginnings of student shaped knowledge.

Questioning is another instructional method reflected in the participant interviews. A few supervisor interviews hinted at questioning approaches when working with student clinicians; however, the participants did not name questioning as a direct instructional method. Emelia provided an account of working a student through an inappropriate EDM counseling session:

> This [ethical decision] is not a decision that needs to be discussed right now [in front of patient and family] verses something that in a sense opens up a can of worms that possibly, maybe, is not the right time to discuss this. Also, just knowing correct verbiage to use, being able to discuss things in a layman's term, not promoting fear or confusion…if we're doing ethical decision-making in front of patients or family members [my response] is to always diffuse that situation and defer and when we are in private counsel to set and discuss correct verbiage, also discuss problem solve, problem solve, how that could have gone differently, how we could have handled that differently.

In Emelia's explanation, she faced an awkward situation with a student who was not prepared to handle the interpersonal nuances of EDM. Her instructional response was to remove the student to private counsel and ask the student problem solving questions. In this way, Emelia

promoted the student's role in EDM while supporting with appropriate questions and topics. She scaffolded the students reasoning but did not instruct her on the preferred behavior.

Other supervisors used words such as explaining, debriefing, and describing current and past ethical scenarios to aid students in EDM. This sharing of experience through supervisor storytelling has the potential to guide the student toward acceptance of the unclear decision-making paths taken during ethical scenarios. Supervisors recounting their ethical experiences adds to the student understanding the unclear nature of EDM. Laura described a situation where ethical training came full circle with a graduate student:

> Well she [the student clinician] questioned me right away, and my response to that was fairly simple because she was..[identified as needing support in ethical situations]…yeah she certainly challenged why she needed to do that [additional work with the code of ethics]. And some of that when she challenged was, really for me…I was like 'oh my gosh, what did I get myself into?' But on the flip side it really was a great experience because it certainly makes me always think, 'okay what if this scenario doesn't play out as well with a graduate student? What are some of the steps we can do'…new students come in and they're so green, and they're just doing what they're told …It's like okay I know what this is, I know what this disorder is…but they don't have a chance to really reflect and they don't understand that big picture until… it's like if my [student's] boss tells me I have to bill for this then I'm going to bill for this…I feel like it's our responsibility, or my responsibility, to make them understand that you're signing off on every one of these notes and you're putting a billing code in. It will come back to you, you need to understand what you're doing. You know, what you're billing for. So, I think in that regard…I do think that we do address a lot of those [ethical experiences], I try to address a lot of those ethical pieces so that we don't get to the point [of no return].

Laura described a student questioning her ethical practices after she assigned additional work to the student clinician. She reflected on her own ethical practices, and how that drove her to educate future students on the impact of ethical actions, such as billing for the correct services. Laura saw the need for student epistemic development and reflected on her own ethical situations to guide the students. She desired to encourage students to think for themselves, make ethical choices, and consider the gray areas related to clinical practice.

The student participants observed their supervisors closely and looked to their supervisors for approval during their EDM experiences. The students recognized the process of learning, yet still looked to their instructors for feedback on right and wrong. Many of the supervisory descriptions of student behaviors also matched concern for supervisor approval. The supervisors saw students attempting to solve complex issues; however, the students undershot the time and information needed to make sound ethical decisions. As they moved forward into more advanced practice, student participants reflected on their early limitations and newfound strengths in independent EDM.

EDM Confidence

In her second interview, as she was rounding out her clinical fellowship year (CFY), Sarah described how her supervisor aided her in independent EDM:

> …when we compare like grad school to CFY. I think whenever I had a dilemma where I thought, 'This is a decision we have to make, and we have to weigh the pros and cons.' I think that having that supervisor there to kind of guide you through that process was really important. And certainly, bringing that problem up to them. I feel like they almost waited for you to bring it up to them, to see how you would handle it by yourself. But I just always talked it through with [my adult rehab placement] supervisor…But I feel like if I ever had a dilemma or I needed guidance through something, I would bring it up to

them [supervisors] and they would kind of walk me through after I had already spelled out what the pros and cons were. So, you're critically thinking by yourself with some guidance.

In this example, Sarah grew in her ability to critique the gray areas related to EDM and make initial decisions. Her supervisors gave her room to problem solve, thus increasing Sarah's confidence in her EDM experiences. Sarah recognized the need to solve ethical problems on her own, yet, appreciated the supervisor's input during the decision-making process.

As previously outlined, Charlene had held back from sharing her concerns during an ethical decision because she feared "What if I'm wrong? What if I look stupid?" These internal doubts about ethical decision-making reflect lower levels of epistemological development with uncertainty about knowing and reasoning. As Charlene worked through that situation with her supervisor, she found that the supervisor was open to her opinion and valued her input when making a final decision. In this scenario, Charlene learned that ethical decisions are not clearly defined. She also understood that uncertainty was held by both Charlene and her supervisor.

> You know, so it was helpful I felt like it gave a lot of affirmation. And they [my supervisor's] weren't saying there's not like a clear answer, but you're [Charlene] asking the right questions, you're on the right track, I like how you're thinking critically about it. Once we started talking about it they affirmed a lot of those questions which was helpful too.

Charlene recalled her supervisors' feedback and was receptive to the uncertainty in EDM.

In her second interview, Katie self-examined her role as a clinical supervisor and what it meant toward student clinician growth. She summarized her perspective:

> I think because, and probably only because of this conversation we've been having…I would really try and help them [students] see that it's not black and white and these

> parents [of children seen in SLP services] must be hurting in some way. Just to be able to take all aspects into consideration and not just jumping to those conclusions but still guiding them to the right thing to do because it's their job. I mean obviously they can't just sit there and wallow in all of the alternatives. You still have to make a decision and do something about it. So, I guess I would just help them understand that there are so many things that could be happening, but it's still our job to protect these kids…even though nothing huge has come up, it's been a good eye opener in just how I can even bring this into...[supervision]…That's been helpful. So just I feel like I'm this year going to become a better supervisor of all the different things we've talked about. Which is really good. Especially with ASHA [mandated supervisor training] and all that stuff... it's your job and so you're just doing it one way but trying to be intentional about actually teaching these people. How to become not just good therapists but good people and good thoughtful.

Katie's outlook on student supervision indicated her desire to aid students in developing not only clinical skills, but skills for effective, holistic problem-solving. Students with contextual knowing can integrate information from a variety of sources to solve a problem, even if the answer is unclear.

When discussing students who were ready for the demands of complex EDM, Bea considered the impact of student information gathering behaviors.

> I think they both just went above and beyond with their learning. They were very resourceful and just wanted to learn more than maybe what was required in their classes and just were always seeking out answers. And they just had that foundation, maybe that you can't teach, just how to interact with people and have conversations…It [Bea's interaction with them on EDM] was probably different. Because I gave them a little more

independence with those conversations. So just laying out the different options, we could recommend this, if this is what they want, these are their options. Let's talk about this with the family and see what they think and allowing the student maybe to have more, to be able to interact a little more than I would have with some other students.

Bea observed a few students with strengths in information gathering and interpersonal skills. And when she did, she allowed for more independence during EDM.

Student readiness for independent EDM emerged as a topic across the participant interviews. Supervisors indicated that the CFY was really the point where new clinicians show the most growth and independence toward EDM. During her second interview, Heather was asked about her opinion of student readiness for EDM. She responded:

> I would say, I guess it always just depends on what their experience has been and how many times they've been exposed to a setting or a situation like that, but I would say that's why we have a CFY and further mentoring...I think it just takes time for students to just build their confidence out of school, just making recommendations, and this is very complex. And so, I usually, I guess, encourage them to get support. So, I wouldn't say they're not equipped, but I think it would be beneficial for them to reach out for a little support.

Heather's statement keyed in on the information gathering behaviors needed for effective EDM. In Heather's experience, students became ready for these complex recommendations as they worked through their CFY.

Laura also compared the supervision of CFY versus graduate students.

> I've had really good experiences. From a CFY standpoint, I've had really good experiences…I felt like supervising or guiding the, 'Oh, here's an easier way to do this,' or 'Here's a strategy that I've learned over the years,' that, more than ethical decisions. I

> felt like those CFY students I've supervised came out with a really good understanding on both expectations when they graduated from their program, and now I'm supervising students, I think they learn about it, but it's so over time, and I think until they have a chance to get those experiences and implement them in place, the ages a lot of students are and the lack of experiences, they just don't understand, sometimes, what we might mean, even. Or I think even for us, if we sat and read the ethics policy it would be like 'Yep, we know what those things mean,' but I think a lot of students just kind of, it's like, 'Oh yeah, yep, I know what the code of ethics is…'I think they seem to become more and more aware of it, though, the further they're into their programming, and then I really see it when they go off campus, I feel like, because again they have experiences to compare or match the code to. It's kind of like 'Oh yeah, I had this situation where,' and then they have something they can pull from.

Throwing back to the role of experience, Laura pointed out the impact of connections between reading a code of ethics and practicing ethically. She points out the student need for practice, exposure, and space to learn. She described the importance of practice and exposure toward student development. Students did automatically advance in their EDM development. They were impacted by internal and external forces along the path setting them ahead and behind.

Conclusion

Students' ethical learning did not occur in a steady, forward motion. The students and supervisors saw areas of progress, followed by missed actions or missteps, as reflected in an earlier quote from Katie, "if you mess up once you learn but you don't want to mess up again. So, it's good, but it'd be nice not to mess up the first time." Not all ethical decision-making (EDM) messes are avoidable, but there is room for thoughtful design of student EDM

experiences. The influences on the participants EDM development were somewhat predictable from the literature, yet those influences were not consistently harnessed for student growth.

Patients and families, supervisors, students, and other professionals were known influences on EDM (Payne, 2011). Patients, families, and other professionals either helped or hindered the EDM process; however, there were challenges that the students often felt ready to tackle and promoted student development. The impact of emotions and poor student coping mechanisms surrounding EDM was a new concept to speech-language pathology EDM. The point now turns to the promotion of SLP student ethical education.

Students and supervisors should work systematically together toward improved EDM. All participants put patient needs and bioethical rights at the forefront of EDM. They all had a common goal and compassion for the patient; however, supervisor nuances and student development impacted their ability to work as one force instead of two. Students should not be the silent partner during ethical decisions. The best way to know where the student stands in their development and understanding of complex decision-making is to include them in the process. Students needed increased ownership, confidence, and scaffolded guidance. The supervisors desired to guide the students to independent EDM but could not articulate exactly how their supervision impacted student development.

In the following chapter, the supervisor and student interviews are pulled together into a discussion of the participants' essences of EDM, compared with the literature on EDM development in SLP. Further guidance is offered on how to design best-practice ethical pedagogy for SLP. These interviews provided awareness of the influences on student EDM, something only superficially understood in the research. What follows is an analysis of those influences and ways to promote student EDM development across the ethical dilemmas and influencing factors from the participant stories.

CHAPTER V

DISCUSSION

The purpose of this study was to explore what influences speech-language pathology (SLP) students and clinical supervisors ascribed to the development of ethical decision-making (EDM). Further consideration was given to the epistemic assumptions illustrated by the participants when describing their EDM influences. The existing research on SLP voices during EDM was limited to professional-level experiences and did not guide the details of best-practice bioethical pedagogy for higher education (Flatley et al., 2014; Kenny et al., 2007, 2010). This study aimed to understand the nuances of student ethical development from the perspectives of student clinicians and clinical supervisor instructors through experiential narratives.

Five SLP graduate students and six clinical supervisors discussed their roles, influences, and experiences in healthcare EDM during two, semi-structured, one-on-one interviews. Following each interview, the audio recordings were transcribed, and initial analysis was completed to identify individual participant horizons. After all data was collected, the transcripts were analyzed applying the phenomenological methods outlined by Moustakas (1994), flowing from horizontalization of individual narratives toward the structural and textural descriptions unfolding the essence of developing ethical decision-making. What emerged included experiential settings with stories of ethical dilemmas faced by the participants. These dilemmas formed the structural context of their healthcare ethical decision-making. Textural descriptions outlined what influenced the participants during these contexts and in the development of EDM. The details of these conclusions respond to the three research questions:

(1) What do SLP graduate student clinicians, in the Upper Midwest, describe as influences on the essence of ethical decision-making development?
(2) What influences do SLP clinical supervisors, in the Upper Midwest, ascribe to the essence of ethical decision-making development?
(3) What epistemic assumptions do student clinicians and clinical supervisors, in the Upper Midwest, illustrate as influences on ethical decision-making development?

What follows is a summary of the research findings, paired with associated conclusions from the existing literature, suggested pedagogical practice changes, study limitations, and future research directions.

Summary of Findings and Discussion

The ethical dilemmas faced by the participants extended the picture of speech-language pathology (SLP) healthcare ethical reasoning. The existing literature on SLP ethical decision-making included known external conflicts between the stakeholders of the patient, family, and other healthcare providers (Kenny, et al., 2007; Flatley et al., 2014). The students and supervisors in this study also described these external influences when detailing ethical scenarios during clinical experiences.

The participants faced conflicts with physicians pushing against SLP recommendations and/or patient and family desires. Students found themselves in the middle of unknown cultural norms and inappropriate interpreter services. The supervisors modeled behaviors that the students largely found professional with some glances at the unprofessional. Altogether, their stories linked the two groups and created a picture of the internal and external forces on student development of ethical decision-making (EDM).

Internalization and Coping

Similar to the existing literature, participants faced internal struggles during ethical dilemmas (Chabon & Donaldson, 2011; Kenny et al., 2007). The need for patient advocacy and compassion were themes running through both the student and supervisor interviews. An added horizon of internalization during this study was the emotional weight of EDM for the student participants. Limited research exists on the personality characteristics of SLPs (Schurr, 2018) and there is a large gap in understanding the impact of EDM on student emotions and personal life. The participants hinted at the characteristic personality traits of healthcare-based SLPs as compassionate and goal-directed; they self-identified with these traits.

Previous reports outlined the overwhelming nature of EDM for new providers. In Kenny et al. (2007), new practitioners described feelings of isolation and frustration when solving ethical dilemmas. The student and supervisor participants in this study reported similar feelings. They were emotionally tied to patient complexities and the burden of making an ethical choice. The primary coping technique for students was to seek out peer approval and support. Students needed a sounding board for their concerns. In one case this debrief was facilitated through their place of clinical practice where a case debrief was held with all care providers after the passing of a long-term patient, but that was an exception. For most students, they sought conversations with friends and spouses outside of their normal working hours. They demonstrated inadequate coping mechanisms, venues, and people. The compassionate, engaged students brought emotions, concerns, and insecurities about ethical decision-making home. They felt anxious about their ethical decisions and some could not rest until they found validation from a trusted confidante. They felt emotional and insecure in their EDM. The students needed additional ways to debrief and further support networks appropriate to the confidentiality and intellectual demands of healthcare EDM.

Most supervisors had learned to deal with these emotions and set them aside before returning home. They used their work colleagues to aid them in reasoning through a situation and generally felt secure in their final decision. Their experiences promoted an ease with their positions as part of the healthcare team and patient advocate. Previous research on EDM also found that practicing SLPs used other professionals and their previous experiences to finalize ethical decisions (Kenny et al., 2010). The supervisors in this study also reflected on the importance of relationships with other professionals and experience.

While the supervisors used their experience and established relationships, the students needed more coping tools for the unexpected emotional impact of EDM. The emotional aspects of EDM is one area where higher education should look to support appropriate Health Insurance Portability and Accountability Act (HIPPA) coping mechanisms for SLP graduate clinicians. The students turned to peers, or their established support communities, for support during EDM. Consequently, graduate programs should look to interprofessional education models for designing student ethical pedagogy that centers around knowledgeable, collaborative communities of practice (COP). The students in this study were partially restricted in their COP membership and epistemic development by both internal and external influences. Students and supervisors described the internal and external student factors when re-counting their essence of student EDM development

Students

The goal of this study was to gain the perspectives of students within their graduate career or clinical fellowship year (CFY), before their first professional placement. However, data was collected at two interview points and most student participants entered their CFY by the second interview. As a result, the picture of student ethical development was extended with some

interviews occurring eight to nine months apart. While this was not the intended design, the results can now be compared to the findings of Kenny et al. (2007).

Completed in Australia, Kenny et al. (2007) found that entry-level clinicians had strengths in sensitivity and the need to problem-solve; however, they also had difficulty identifying an ethical problem and then effectively and efficiently seeing that problem through to completion. Aligning with Kenny et al. (2007), the student participants in this study felt compassionate and related to the needs of the patients and their families. Also comparable to Kenny et al. (2007) findings, student participants who struggled to identify ethical dilemmas happening around them often missed opportunities to speak-up and engage with others because of limited confidence, or as Kenny et al. (2007) termed it, "self-protection" in their critical thinking (p. 510). What differed between the students in this study and the existing, professional-level literature were the horizons of patient ownership, cultural competence, and perceived weaknesses in critical, holistic thinking.

In Kenny et al. (2007), some entry-level SLPs handed over complex ethical cases to other professionals. The student and supervisor participants in my study often placed the student in an observer role during ethical decision-making, with patient ownership for EDM occurring either in the last few weeks of a clinical placement or not at all. The reasoning for this limited role, which was provided by the participants, included the need for SLP control secondary to licensure demands, issues with patient relationships and trust in their provider/student, and perceived limited proficiency with holistic thinking.

Supervisors and students had conflicting views on student readiness for holistic thinking. During their interviews, the student reflections on EDM contained glances at holistic thinking; however, their reported lack of patient ownership, insecurities, and/or emotions stopped them from sharing their holistic ideas during student clinical practicums. The literature supports the

need for holistic thinking to effectively solve ethical dilemmas (Sharp, 2006). Speech-language pathologists must balance a variety of stakeholders and bioethical standards when solving an ethical problem (Chabon & Donaldson, 2011).

The supervisors discussed students making quick, unsuccessful decisions during ethical scenarios. Those ineffective reasoning patterns did not promote supervisor trust or student independence during complex clinical cases. The complexities of EDM tie to the high-level management of critical thinking, information gathering, and reasoning behaviors in contextual knowing and self-authorship (Baxter Magolda & King, 2004).

Student readiness for this type of reasoning varied across individual interview points as well as within student groups. Students interviewed during their final year of graduate school exhibited less patient ownership, difficulty identifying the complexities of EDM, and more internal struggles with their role as an ethical clinician. Those students looked to their supervisors to guide them and for approval of their ethical reasoning. In some statements they deferred ethical choices to their supervisors, even in situations where they insinuated they felt differently than the supervisor.

The students interviewed during their CF placement had increased self-reflection and information gathering ideas within their interviews in their reports as well as within analysis of their interviews. They reflected a solid foundation for understanding where they stood in the scope of practice, importance as a healthcare professional, and personal, ethical standards. They acknowledged their previous insecurities and desired to not make those types of choices again. They also critically reflected on the influence of supervisory behaviors toward limiting, or promoting, their ethical development. This self-awareness and ethical readiness matched the supervisor reports of students not truly reaching the level of independence with EDM until they

are placed in a clinical fellowship position. This view of student independence was highlighted by the varying levels of epistemological development across the student participants.

Student Participant Epistemological Development

Collectively, the student participants reflected all stages of BMED during their interviews. Differences, though, in complex reasoning, confidence, and value convictions set Hannah and Charlene apart from the other students. Hannah and Charlene each participated in interviews at the end of their graduate schooling and within the initial stages of their clinical fellowship year. During each of their interviews, Hannah and Charlene discussed high-level reflections on their ethical development and understanding of the intricacies of information gathering and reasoning during EDM. Statements from Hannah such as those discussing power differences and ethical convictions are consistent with Baxter Magolda's contextual knowing and into the self-authorship stages.

These interviews contrasted with the accounts of Erica and Sierra across both interview points. Erica and Sierra were interviewed in the fall of their second year of graduate school and again as they neared spring graduation. Erica and Sierra had less confidence in their abilities as ethical decision-makers and independent clinicians. Erica had strong empathy for her patients; however, remarked on her place as a learner during her clinical practicum. She had limited self-assurance in her reflections on ethical reasoning and deferred back to her clinical supervisor for right/wrong ethical decisions. Sierra was strong in her passion for patient rights; however, passive in her ownership of clients. These patterns were consistent with Baxter Magolda's transitional and independent knowing stages, and even some absolute knowing where students are beginning to question authority but have not emerged into full independent knowledge-making.

Sarah reflected a clear picture of the impact of a clinical fellowship and independent case

management on EDM skills. Sarah was interviewed at the end of her graduate programming and again within her CFY. In her initial interview, Sarah discussed some uncertain moments when defining her role as the SLP and looked to others for assistance. Her narratives at that time reflected the hesitancies of independent knowers, still looking to others to clarify her role in EDM. By the time of her second interview, Sarah's narratives echoed confidence in her ability to tackle difficult physician interactions, conviction in her effectiveness as a member of the healthcare team and critical evaluation of previous supervisory methods. Sarah displayed further characteristics of contextual knowing during her second interview. Meaningful, first-hand experience was key to the epistemological development of the students. Thus, experience and effective EDM cannot be separated. Baxter Magolda (1999) also argued for the role of situating learning in meaningful experiences. Consequently, SLP higher education should create ongoing opportunities for students to engage in ethical experiences. These opportunities should be presented in a variety of ways across meaningful, contextual communities and experiences.

Experience

The study participants' stories paralleled the literature on EDM in experienced SLPs (Kenny, 2010). Experienced clinicians use their established, professional relationships and holistic knowledge to solve ethical dilemmas (Kenny, 2010). The student participants' experiences detailed challenges and support with difficulty balancing these two notions. While some participant encounters arose as strong learning opportunities, not all stories reflected supported, yet challenged student experiences. The role of experience in student development is well-established in higher-education literature (Dewey, 1963; Kolb, 2014). Baxter Magolda's epistemological development model (BMED) also highlights the importance of interpersonal and contextual experiences toward higher-level ways of knowing (Bock, 1999; Baxter Magolda & King, 2004). Borrowing from concepts of BMED and Learning Partnerships, students should be

encouraged to engage in ethical decision-making experiences. Baxter Magolda provided three principles for learning experiences that promote self-authorship: (1) “validating learner’s capacity as knowledge constructors”, (2) “situating learning in learners’ experience”, and (3) “defining learning as mutually constructing meaning” (Baxter Magolda & King, 2004, p. xix). The student stories did not reflect the principles of validation and mutual construction during the ethically situated learning experiences. Students detailed limited learning autonomy during ethical experiences.

Students were often left out during EDM opportunities and felt insecure in their EDM perspectives. Supervisors looked for students to take a holistic view and an active learning role, but they did not readily hand over the EDM reins to students because of the associated risks. Students were not consistently embedded in the clinical community of practice (COP). They were not consistently engaged in increasing membership within their healthcare placement COP. They had limited independence during conversations with other members of the healthcare team (e.g. OT, PT, physicians). The student stories reflected peripheral and initial stages of legitimate peripheral membership during their student clinical experiences (Lave & Wenger, 1991). While in “a learning avenue” students were maintained on the periphery. They became more legitimized and core members when they began their professional, clinical fellowship positions. Consequently, this is an area for students to expand membership in their peer and professional COPs.

Students who are provided orientation and meaningful situation into a COP show increased collaboration and growth toward mastery (Atttrill et al., 2018). Student clinicians should be situated into the COP initially through low-stakes activities and legitimate peripheral participation, yet, scaffolded and encouraged toward core membership. Supervisors also found students wanting to shortcut the EDM process rather than using thoughtful consideration for their

ethical decisions. An ongoing need to steadily move the students through the EDM development process emerged from the participants' experiences. Students needed to be challenged earlier on in their clinical education; they needed increased engagement in the healthcare COP. This challenge would start with preparation in a structured classroom and move toward instructional techniques for mentoring within the clinical setting. Part of this instructional design would also incorporate establishment of working relationships with other professionals in the COP.

Other Professionals

Authors, such as Kenny et al. (2010), emphasized the role of other professionals in SLP EDM. Experienced SLPs utilized other professionals for complex EDM and management of internal and external issues. Existing literature points to established professional networks and relationships with other professionals as key resources to EDM (Kenny et al., 2010). The supervisor participants in this study also relied upon other professionals such as SLPs, social workers, occupational and physical therapists, and physicians to support them during EDM. The supervisors had established, collaborative communities of practice. Their experiences drew them to a few trusted professionals and resources that they relied upon as they worked through EDM. Viewing these stories through the elements of self-authorship, the supervisors were demonstrating characteristics of effective citizenship (Baxter Magolda, 2004). They understood the roles of relationships, collaboration, and perspective taking as integral to effective EDM. Supervisors respectfully spoke up when their reasoning conflicted with other professionals. They had mature decision-making and confidence in their personal integrity.

Drawing from the model for contemporary college outcomes provided by Baxter Magolda (2004), the areas of mature relationships, integrated identity, and cognitive maturity serve as a steppingstone to enhanced self-authorship. The learning partnerships between supervisors and students have the potential to promote student roles as effective citizens with

"coherent, ethical actions" for the "good of all" (Baxter Magolda, 2004, p. 7). With effective citizenship as the goal, higher education instructors are called to be attentive to enhancing student experiences with consideration of the intra- and interpersonal foundations of self-authorship.

Experiences with physicians and other SLPs stood out as two prominent influences within the professional influences' horizon. The SLPs were a resource for reassurance or direction in EDM and physicians took on that role as well. Yet, physicians also took on a role of adversary or creator of an ethical dilemma in the participants' ethical stories. These physician-to-SLP relationships were complex. Supervisors remarked on the intricacies of understanding the physicians and knowing how to approach them when working through an ethical problem. They, again, focused on the role of experience in these interpersonal foundations. The supervisors even attempted to protect students from difficult physician interactions by taking on the bulk of conversations with difficult providers during clinical practicums, thus limiting students' potentially negative experiences.

As the students entered their CFY some ran into direct conflicts with physicians and looked to their CFY supervisors or managers for support in dealing with a difficult physician interaction. Therefore, understanding and collaborative work are necessary across the healthcare team. This knowledge should start during formal education and extend into student clinical experiences. Interprofessional education and practice (IPE/IPP) concepts offer student learning scaffolding "when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (World Health Organization, 2010, p. 7). Interprofessional education also focuses the team toward the patient needs and wishes (IPEC, 2011).

Ethical Dilemmas

The routine, ethical dilemmas described by the participants centered on patient wishes and bioethical principles. Fitting with the existing literature, the most common ethical dilemmas discussed by the supervisors and student participants related to dysphagia, or swallowing disorder, services (Sharp & Genesen, 1996). However, the participant stories provided further understanding of the breadth and depth of ethical concerns.

Dysphagia issues occurred across the spectrum of healthcare placements. Students and supervisors were empathetic to patient and family needs and considered patient desires when making final dysphagia recommendations. The participants desired to build rapport with, and advocate for, their patients. They ran into concerns with ineffective advanced directives, administrators going above the heads of SLPs for diet waivers, and conflicts with other professionals overriding patient desires and/or SLP recommendations. The clinicians accounted for age, quality of life, and patient decision-making capacities when working through dysphagia scenarios.

Mandated reporting of abuse and neglect, and working within the SLP scope of practice were two further structural descriptions defining how the participants experienced the development of EDM. Related to the SLP scope of practice are concerns for administration override and billing issues. These practice standards did not emerge as structural descriptions from the collective participant stories. Some participants described the impact of management and facilities on their EDM. These concepts were part of some participant horizons; however, they were not found to be an essence of this groups' EDM development.

Practice Standards

While billing, management, organization, and facility influences were mentioned in some participant interviews, those horizons did not surface in the common EDM experiences. The ethical issues are highlighted in the existing literature related to professional-level EDM

(Atherton & McAllister, 2015). Pressure for inappropriate billing practices and appropriation of services are two of the most-common ethical concerns reported by healthcare-based SLPs (ASHA, 2019). One consideration for the absence of these items in the shared story essence was the duration of clinical placements (e.g. 13 weeks). It may be that the timing of these clinical experiences did not allow for students to become actively engaged in the organizational and legal policies related to the practice of the SLP. This would be an area of future research to evaluate if and how students experience administrative considerations during EDM.

Instructional Design for Ethical Decision-Making

The participant experiences demonstrated the importance of student voice in pedagogical design. Students struggled with their readiness for EDM. Supervisors were reluctant to engage the students in direct ethical reasoning. Consequently, EDM should be an early focus in SLP clinical education. Drawing from the andrological models of learning partnerships, Baxter Magolda's epistemological development model (BMED), communities of practice, and interprofessional education, the following section provides suggested instructional patterns for the ethical education of SLP student clinicians (Baxter Magolda, 1999; Baxter Magolda, 2002; Baxter Magolda & King, 2004; Knight et al., 2017; Lave & Wenger, 1991).

Ethical Decision-Making in SLP Clinical Education

Meaningful experiences advance independent EDM. Clinical, ethical reasoning foundations begin with students recognizing their internal beliefs and views of themselves as community members (Baxter Magolda & King, 2004). Through acknowledgment of their personal upbringings, morals, and belief systems, students work toward distinguishing the internal and external influences during ethical situations. The student participants in this study initially had limited reflections on their personal values and how they interacted with their EDM; however, their reflections grew stronger with experience and through the secondary interviews.

Intrapersonal foundations begin with individual, thoughtful reflection and move toward community identity and mutually constructed understanding (Baxter Magolda & King, 2004). Interprofessional education groups are one such way to create a community of practice around the SLP student. Within this peer group, students explore morals, ethics, and culture, launching their inter- and intrapersonal foundations. The goal of IPE is to create a collaborative, interprofessional team focusing on values/ethics, roles, communication, and teamwork across professional healthcare fields (IPEC, 2011). The establishment of an IPE curriculum is endorsed by national healthcare accrediting bodies and considered best-practice healthcare education (ASHA, 2016b; WHO, 2010).

Interprofessional education bridges the gap between the challenges and supports in structured classrooms versus clinical experiences (Barr et al., 2005). Within IPE, students learn with their peers in other professional programs. The IPE model forms a core community of practice by learning with, from, and about all team members. This group has the potential to support and challenge one another in the development of EDM.

The student participants struggled with the emotional impact of healthcare ethics. They needed a set of core professionals for brainstorming and collaboration. The IPE groups have further potential to serve as a secure and reliable source of validation and emotional coping. Further, having an established network of healthcare students initiates the process of relationship building with other providers to promote ongoing strength and comfort in EDM during independent, professional practice.

Further situation of these students into the professional communities of practice has the potential to foster stronger relationships with experienced professionals.

Learning Partnerships and Epistemological Theory

As discussed previously, Baxter Magolda and King (2004) argued for the role of higher education in creating students with "coherent, ethical action; for good of all; and intercultural maturity" (p. 7). The student participant stories reflected the fundamentals of attention to cultural competence, ethical, compassionate care and foundational knowledge of best-practice services. Where the student participants struggled was within the context of patient ownership and confidence in their complex decision-making skills. When they entered their clinical fellowships, students became the primary SLPs and growth, ownership, and elements of self-authorship were then reflected in their narratives.

Thoughtful instructional design is needed to equalize student challenges and support along the path to EDM and self-authorship (Baxter Magolda & King, 2004). The challenges-to-supports balance should include a series of learning opportunities situated in meaningful student experiences. The next step in internal understanding is the student working toward ownership of their own learning (Baxter Magolda & King, 2004). As a high-level epistemological assumption, ownership of learning will not be a natural, next step for many entry-level students. Still, it is possible through placement of engaging and reflective learning activities early in undergrad and graduate programs. It should begin with transparent, clear expectations and move toward increasingly complex concepts and problems. Questioning and modeling behaviors should be used to initially introduce the student to the EDM process and appropriately challenge them toward independence (Cook et al. 2019).

Previous expert opinion literature has supported step-by-step ethical reasoning frameworks (Chabon & Morris, 2004; McCarthy et al., 2004). Yet, the results of this study and others led to a flexible, dynamic pattern of student and novice clinician EDM development (Kenny et al., 2007). Tying to the concepts of the forward and backward movement found along the epistemological continuum, education for student ethical development should provide

frameworks that adapt with student development (Bock, 1999). Higher education should move from the prescriptive, stepwise EDM models toward holistic, reflective education. It is important to situate learning in the cognitive, social, and internal aspects of BMED to shift students toward contextual knowing, self-authorship, and (Baxter Magolda, 2002; Baxter Magolda & King, 2004).

Moving forward, the most prominent external influence on the student participants' epistemological development was the supervisors. The described student-supervisor conversations reflected a wide variety of instructional strategies. These strategies occasionally limited the students in their development of EDM by using authoritative, directive instruction. Suggested changes to this dynamic relationship include thoughtful instructional strategies adapting to the student's development level for each encountered ethical dilemma.

The participants experienced a wide variety of ethical decisions; consequently, students will not be consistently comfortable with all ethical dilemmas. Through the learning partnerships model, interpersonal foundations begin with mutual respect and the ability to account for other's opinions while still gathering information toward complex problem solving (Baxter Magolda & King, 2004). Supervisors can support students by engaging in conversations with students that follow the three principles of learning partnerships: "validating learners' capacity as knowledge constructors, situating learning in learners' experience, and defining learning as mutually constructing meaning" (Baxter Magolda & King, 2004, p. xix). These examples also highlight the progressive nature of community of practice models, moving students from peripheral, to legitimate, and core community members (Lave & Wenger, 1991).

Examples of community of practice and epistemologic mentoring include Emelia's response to her student after a poor interaction, "problem solve, how that could have gone differently, how we could have handled that differently." Through these questions, Emelia aided

the student in “connecting their own and others’ experience and ideas” (Baxter Magolda & King, 2004, p. xx). She guided the student in what they should consider and empowered the student to consider options toward improved actions for the next encounter. The supervisor participants also utilized modeling behaviors for student instruction during EDM.

In this study, student participants watched the supervisors closely. They made evaluations of professional and unprofessional behavior. Students were not consistently involved in active EDM, yet they were taking mental notes on what they may or may not do in their future careers. Within the learning partnership between supervisors and students there exists a greater space for thoughtful challenges and supports when modeling professional behavior. While modeling provides more guidance than challenge, there is opportunity for evaluation of modeled interactions. Supervisors might consider guiding students on areas to observe, self-evaluate, and clarify following an ethical interaction. They might also open the conversation to options of what went well, what did not go well, and what the student may desire to change in the future. There exists strong potential for situating students into learning opportunities and experiences.

Ethical decision-making is an exposing process. It requires both internal and external awareness of highly personal ideas and beliefs. It demands complex decision-making and holistic reasoning. As a result, it is a skill that involves experience and repetition. This study examined the experiences of five students and six supervisors during the development of EDM. Further research is needed to expand what is understood and extend the impact of best-practice ethical pedagogy for SLP graduate programs.

Limitations and Future Research

This study told the story of a small group of Upper Midwest SLP clinical supervisors and students during student EDM development. While it expanded what is understood in SLP

development of EDM, further research is needed. One area of future research is the emotional impact and coping mechanisms for healthcare, ethical decision-making.

Internally, the students struggled with emotions and coping skills. Supervisors reflected on the burden of EDM early in their careers. All the participants identified as female. Belenky et al. (1986) suggested that women rely upon their prior experiences and two approaches to subjective knowing—a logical, detached or subjective, empathetic approach. This is one area where further research could identify the approaches used by novice and experienced clinicians, comparing epistemic approaches. This may aid in understanding student emotions and further the support for appropriate EDM coping strategies. Further internal, student knowing pattern research might consider an in-depth review of student reflections either in written or verbal narratives as they are experiencing the phenomenon of clinical and ethical decision-making. This has the potential to expand the understanding of student epistemological assumptions and ways of knowing.

External to the student and supervisor study participants was the influence of patients, families, and other healthcare providers. Additional research in each of these influences would benefit the understanding of student EDM experiences and development and promote instructional design. Research might be extended through detailed analysis of ethical dilemma narratives and clinical decision-making. Future research may also consider specific student EDM experiences and supervisor reactions, linking the impact of various supervisory methods on epistemological development.

This study was conducted by gathering students and supervisors from accredited SLP programs in the Upper Midwest. The results of this study detailed the participant experiences and are not generalizable to the experiences of all students and supervisors. Additionally, possible bias exists for those who would respond to participate in a study about ethical decision-making.

All participants in this study identified as female. While the demographics of the SLP profession are largely female, this is not representative of the entire body of SLP students and clinical supervisors. According to membership data for the American Speech Language Hearing Association (ASHA, 2019), 95.4% of ASHA member SLPs are female, and 39.5% of SLPs work in the health care setting. Larger scale quantitative and/or mixed method studies would support more generalization of findings and the picture of EDM in the field of SLP.

Another study consideration was the elapsed time between two-point interviews. When initially designing this study, I desired to interview students while they were still enrolled in, or had just graduated from, an ASHA accredited SLP graduate program. However, the amount of time between interviews was longer than anticipated because of principal investigator circumstances at the time of data collection. Consequently, three students had entered their CFY position before completing the secondary interview. Future research may work to control for this progression and interview students only within their graduate career, and/or extend toward a longitudinal study moving from student to experienced professional status with the participants.

When completing data analysis after the individual interviews, it became apparent that there was a connection of one supervisor and one student, pairing. While this was not anticipated, some elements of each of the pairing's interviews were purposely not included in the final documentation. This was done to protect participant identities. This is one consideration for future research design to investigate pairings or control for these in the future.

Lastly, the COVID-19, Coronavirus global pandemic impacted the United States healthcare system starting in spring 2020. Consequently, my participants were impacted in various ways as they responded professionally to the pandemic. I finalized interviews with three participants during this time. While some participants discussed this impact on their ethical decision-making, their stories during this time did not all fit the essence of the participants'

collective responses. As a result, some topics related to ethical decisions, supervision, tele practice, and service delivery formats were discussed in interviews during the Coronavirus pandemic. The horizons, though, specifically addressing COVID-19 response and ethics, were excluded from final analysis during this study. While these topics did not fit within the overall essence of these participants' experiences, the impact of the COVID-19 pandemic on student development and EDM would be another area for future research consideration.

Conclusion

This study aimed to understand the influences on EDM development for the student clinicians and clinical supervisors. The participants described ethical dilemmas related to inter- and intrapersonal conflicts. Collective ethical horizons ran through the student and supervisor groups and created a picture of the extent of EDM within the SLP's daily work. Ethical decisions were routine in the healthcare experiences of these students and supervisors. Yet, students and supervisors agreed on the students' decreased ability to effectively identify and reason through EDM without support.

Internal and external influences arose from the participants' ethical stories. The ethical dilemmas linked to dysphagia services tied closely to the existing literature (Sharp & Genesen, 1996). However, other factors such as mandated reporting, cultural competence, and scope of practice concerns did not tie directly to primary ethical concerns in the current literature. These ethical characteristics were distinctive to this group of participants. Further, students did not detail the administrative-based ethical barriers often faced by healthcare SLPs (ASHA, 2019). No two ethical stories matched. Still, commonalities in participant narratives linked to form the essence of student EDM development.

Patients and their families highly influenced EDM. Students did not consistently have opportunities to act as the main decision-maker during patient and family conversations; yet,

they related to the thoughts and feelings of patients and their caregivers. All participants attempted to advance patient rights and advocacy during EDM. In this way, some students had strong reactions to inappropriate interpreter and culturally competent services. This provided another detail of the individual nuances tied to EDM experiences. The impact of personal history, supervisory approach, and student confidence surfaced from the participant reflections.

Supervisors and students learned from one another through the mentorship process. Students viewed the supervisors as role models and took on the learner identity during their clinical placements. Students advanced their knowledge of professional and unprofessional conduct by observing their supervisors. When engaging in EDM conversations, students experienced a variety of supervisory approaches and initially felt insecure about offering their opinions and ideas. Supervisors found reduced student readiness for complex problem-solving and desires to shortcut effective EDM. While supervisors relied upon experience and established professional networks, students struggled with effective tools and coping strategies during EDM.

Overall, experience was vital to student and supervisory development of EDM. From this understanding, IPE, BMED, community of practice, and learning partnership models were used as suggested pedagogical practices for providing appropriate student support and challenges toward EDM development. It is recommended to begin with establishing IPE teams to enhance both intra- and interpersonal foundations for moral, ethical reasoning. While the focus of this study was SLP graduate education, potentials exist across undergraduate and graduate academic courses as well as through academic and clinical communities of practice. Interprofessional teams should work collaboratively toward understandings of themselves as citizens, ethical healthcare providers, and self-directed learners. As students begin clinical practicums, supervisors should look to appropriately challenge and support students across the numerous,

meaningful experiences presented in a hands-on learning environment. Students should understand the importance of their voice and active engagement in their learning.

Ethical decision-making is part of the fabric of daily SLP healthcare services. Students and supervisors are called upon to develop sound ethical decision-making skills prior to independent clinical practice. Through the students' and supervisors' accounts in this study, there is increased understanding of the meaningful experiences and influences on their EDM. These stories promoted awareness of the ways the participants were able to progress, or setbacks found, during the development process. From these stories, students and educators can look toward understanding of best-practice healthcare services and andragogical practices including interprofessional education, communities of practice, learning partnerships, and scaffolded epistemological development to capitalize on real-time learning moments. The student and supervisor stories in this study promote student growth toward effective, efficient ethical decision-making.

APPENDIX A

Influences on Ethical Decisions

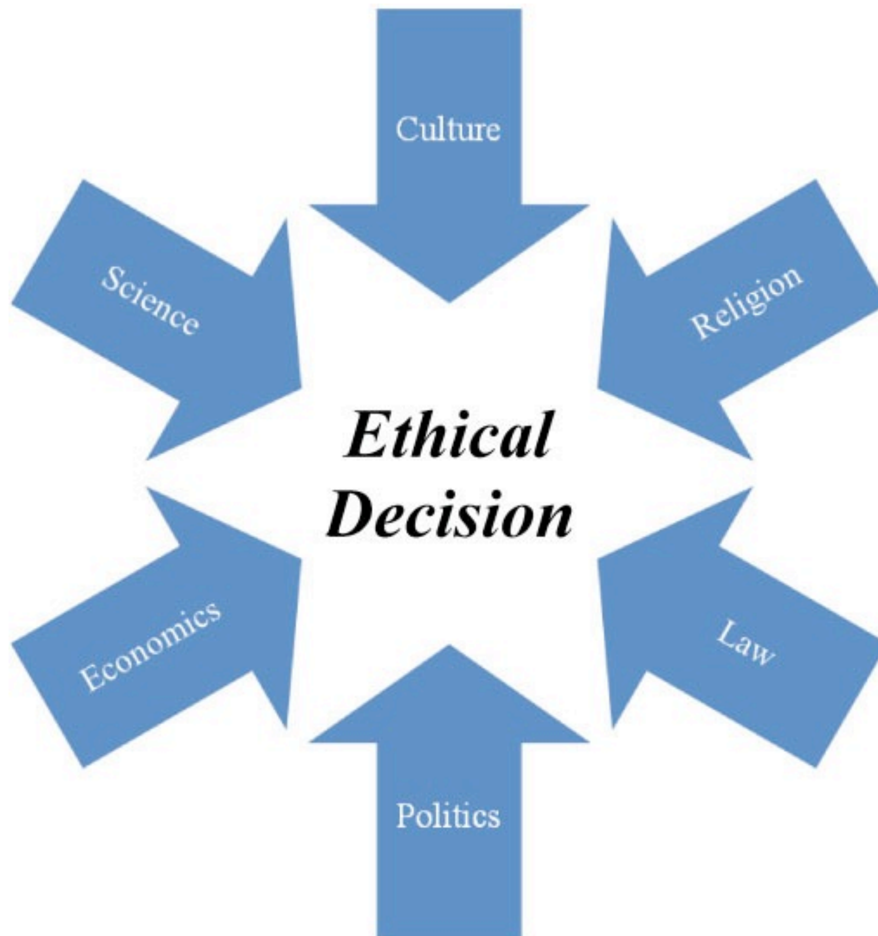

Figure 1. Influences on ethical decisions. Adapted from "Ethics of disability: Foundation of the profession of speech-language pathology," by K. T. Payne, 2011, S*eminars in Speech and Language*, 32(4), p. 281. Copyright 2011 by Thieme Medical Publishers, Inc.

APPENDIX B

Dynamic Model of Ethical Reasoning

Table 1

Dynamic Model of Ethical Reasoning

Awareness	**Independent problem solving**	**Supported problem solving**	**Decision**	**Outcome**
Early concerns	Initial reactions	Checking	Action for client	Positive
Conflict in practice	Accepting professional responsibility	Discussing	Action for professional	Negative
Critical incidents	Self-protection	Handing over	Action for team	Adequate
	Clinical reasoning		Action for organization	
	Rules			
	Beliefs and values			
	Lack of support			

Note: Adapted from “A Dynamic Model of Ethical Reasoning in Speech Pathology,” by B. Kenny, M. Lincoln, and S. Balandin, 2007, *Journal of Medical Ethics, 33*(9), p. 509. Copyright BMJ Publishing Group.

APPENDIX C

Learning Partnership Model

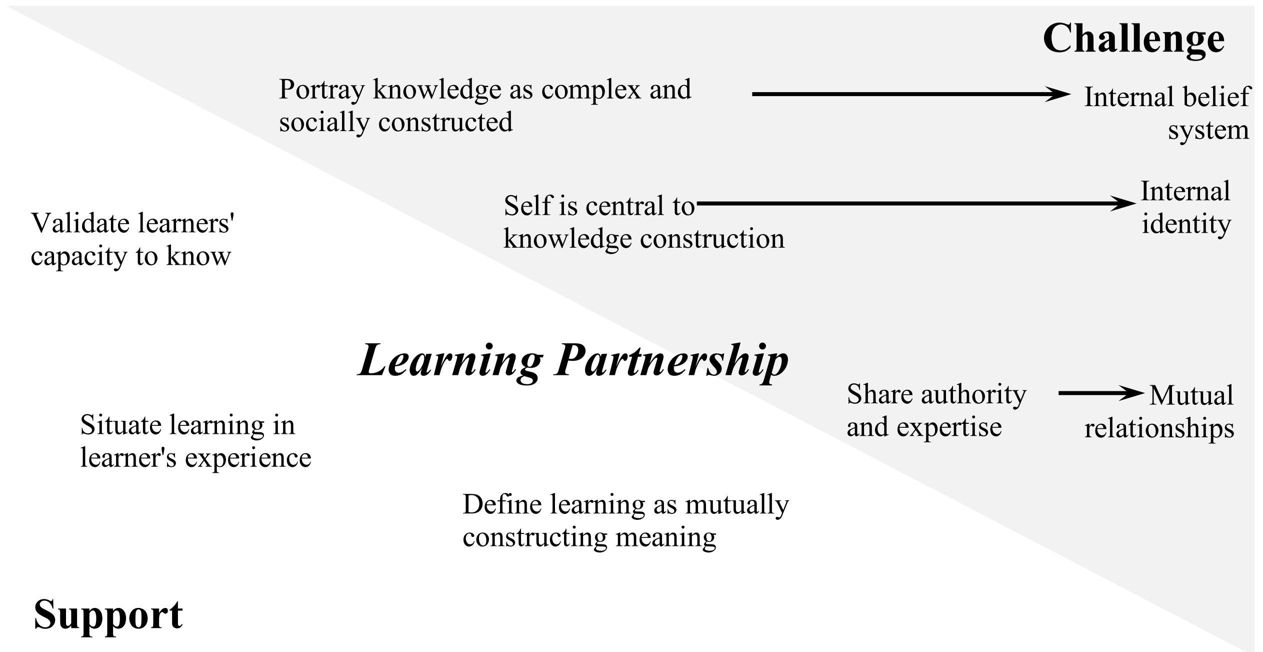

Figure 2. The learning partnership model. Adapted from: "Learning partnerships: Theory and models of practice to educate for self-authorship," by M.B. Baxter Magolda and P. M. King, 2004, p. 41. Copyright 2004 by Stylus Publishing, LLC.

APPENDIX D

Table 2

Participant Experiences

Role	Pseudonym	List of Healthcare Experiences
Supervisor	Emelia	Skilled nursing, rehabilitation unit, transitional care, home health
Supervisor	Katie	Outpatient; pediatrics
Supervisor	Stacy	Outpatient; pediatrics
Supervisor	Bea	Acute and rehabilitation hospitals
Supervisor	Laura	Skilled nursing, rehabilitation unit, outpatient, transitional care
Supervisor	Heather	Acute and rehabilitation hospitals, outpatient
Student	Charlene	Rehabilitation unit, outpatient
Student	Hannah	Outpatient, home-based services
Student	Sarah	Acute medical adult and pediatrics, rehabilitation unit, outpatient
Student	Sierra	Home-based services, early intervention, skilled nursing, outpatient
Student	Erica	Acute and rehabilitation hospital, outpatient

APPENDIX E

Research Study Participant Recruitment Letter

Hello,

I am a doctoral candidate in Teaching and Learning: Higher Education at the University of North Dakota. As part of my dissertation research, I am looking for SLP graduate student clinicians and clinical supervisors with experiences in healthcare placements who are willing to engage in one-on-one interview for an IRB approved research project on the topic of ethics in speech-language pathology. If you are interested in being a participant, or know of another graduate clinician or SLP clinical supervisor who may be interested, please contact me at:

Joni Mehrhoff at joni.mehrhoff@mnstate.edu or via phone at 406-231-8124.

Thank you,

Joni Mehrhoff, MS, CCC-SLP

APPENDIX F

Interview Protocol- Clinical Supervisors

1st Interview

1. Please tell me what you consider to be an ethical dilemma? What is your understanding of what makes something an ethical issue?
    a. Clarification in response to answer of uncertainty: An ethical dilemma occurs when an act has morally correct outcomes; however, it conflicts with an almost equivocal potential for wrong or negative results. It creates an area of uncertainty, a fuzzy line between right and wrong.
2. Please give me a tour of the experiences you have had learning about ethical decision-making in SLP.
    a. What do you recall learning about ethics from formal education?
    b. What informal education have you received in ethical problem-solving?
    c. What impact did other professionals or people involved have on your ethical decision-making?
    d. What resources have you used during ethical decision-making?
3. Ethical Dilemmas:
    a. Walk me through an example of a clinical ethical dilemma you have faced?

        OR

    b. In healthcare, one example of an ethical dilemma is when an SLP is asked to make a recommendations for a patient who's safest diet is NPO and alternative feeding options; however, the patient has late-stage dementia and is no longer their own decision maker and the family members disagree upon the patient's premorbid wishes for tube feedings.

4. Follow-up questions to ethical dilemma above:
    a. What was ethically challenging about that situation?
    b. What did/would you do? How did/would you resolve the dilemma?
    c. What resources did/would you use?
        i. Did/would you rely on others?
        ii. Where/Are there any resources you might provide to a student when working through the ethical problem?
5. What experiences have you had working with students during ethical decision-making in SLP?
    a. What role did the student(s) play?
    b. What did the student(s) do well?
        i. Why do you think that was?
        ii. What was your response to them at that time and for future ethical dilemmas?
    c. What did the student(s) not do well?
        i. Why do you think that was?
        ii. What was your response to them at that time and for future ethical dilemmas?
6. Please give me a tour of the experiences you have had with ethical decision-making in your work as an SLP?
    a. What impact did other professionals or people involved have on your ethical decision-making?
    b. What resources do you use during ethical decision-making?
    c. What actions do you take during ethical dilemmas?

2nd Interview

7. What about your experiences in ethical decision-making has been beneficial?
8. What about those experiences was not helpful?
9. What role did you take in those experiences?
10. Anything I did not ask you that you would like to share related to this whole topic?

APPENDIX G

Interview Protocol- Graduate Student Clinicians

1st interview

11. Please tell me what you consider to be an ethical dilemma? What is your understanding of what makes something an ethical issue?
    a. Clarification in response to answer of uncertainty: An ethical dilemma occurs when an act has morally correct outcomes; however, it conflicts with an almost equivocal potential for wrong or negative results. It creates an area of uncertainty, a fuzzy line between right and wrong.
12. Please give me a tour of the experiences you have had learning about ethical decision-making.
    a. What formal education have you had in ethics?
    b. What informal education have you had in ethics?
    c. What impact did other professionals or people involved have on your ethical decision-making?
    d. What resources have you used during ethical decision-making?
13. Ethical Dilemmas:
    a. Walk me through an example of a clinical ethical dilemma you have faced?

       OR

    b. In healthcare, one example of an ethical dilemma is when an SLP is asked to make a recommendations for a patient who's safest diet is NPO and alternative feeding options; however, the patient has late-stage dementia and is no longer their own decision maker and the family members disagree upon the patient's premorbid wishes for tube feedings.

14. Follow-up questions to ethical dilemma above:
    a. What was ethically challenging about that situation?
    b. What did/would you do? How did/would you resolve the dilemma?
    c. What resources did/would you use?
        i. Did/would you rely on others?
        ii. Where/Are there any resources you have been provided when working through the ethical problem?

2nd Interview

15. Reflecting on the experiences have you had during clinical placement related to ethical decision-making in SLP:
    a. What role did you play?
    b. What do you feel you did well?
        i. Why do you think that was?
        ii. What was your response to them at that time and for future ethical dilemmas?
    c. Was there anything that you did not do well?
        i. Why do you think that was?
        ii. What was your response to them at that time and for future ethical dilemmas?
    d. What happened that was helpful?
    e. What happened that was not helpful?
16. Anything I did not ask you that you would like to share related to this whole topic?

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