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Comparing the codes of ethics of the six signatory associations of the Mutual Recognition Agreement

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Abstract
Purpose: The Agreement for the Mutual Recognition of Professional Association Credentials (MRA) between six national associations provides a mutually negotiated expedited process for applying for certification in speech-language pathology by any of the signatory associations. Although the MRA recognizes common standards in academic and clinical practice and eases the process to have credentials recognized, an interesting concept is that SLPs who have membership in more than one association must adhere to the code of ethics in each association. Thus, as SLPs will need to abide by them the question then becomes, are the codes of ethics in the six national associations comparable?
Method: Using a content analysis procedure, the authors sought to identify similarities between the six codes of ethics.
Result: The results revealed similarities between the six codes in areas such as responsibility to clients, professional conduct and practitioner competence.
Conclusion: The findings should not to be interpreted to imply that one code of ethics was better or more comprehensive than another, as each code of ethics must be understood and interpreted in temporal, situational and local cultural contexts. Rather, the discussion includes a proposal to create a unified document.

Keywords: *Ethical issues, cross-cultural, speech-language pathologists, mutual recognition agreement*

Introduction

Speech-Language Pathology continues its growth internationally as a profession (Crowley & Baigorri, 2011). The global inter-connections of the world's population provide opportunities for speech-language pathologists (SLPs) to travel, research and work abroad. However, national credentials are not intended for international work. Where is credentialing reciprocity available for SLPs who work internationally? The Agreement for the Mutual Recognition of Professional Association Credentials (ASHA, 2008) between six national associations (hereafter referred to as the MRA) provides a mutually negotiated expedited process for certification in speech-language pathology by any of the signatory associations.

History of the MRA

In 1997, the American Speech-Language-Hearing Association (ASHA) and Speech-Language & Audiology Canada (formerly known as Canadian Association of Speech-Language Pathologists and Audiologists) entered into the first Mutual Recognition Agreement (MRA) (SAC, 2005a). The agreement went into effect on 1 January 1998 to recognize both professions; speech-language pathology and audiology. This agreement ended on 1 May 2009 as ASHA's audiology certification standards significantly changed (SAC, 2009) and a new agreement came into effect for speech-language pathology only.

The original agreement recognized that professionals in either profession who held certification by either ASHA or Speech-Language & Audiology Canada (SAC) were considered equal in that the academic course work, clinical practicum and examination requirements were similar (SAC, 1997). During this time, the Royal College of Speech and Language Therapists (RCSLT) and Speech Pathology Australia (SPA) requested to join the MRA. In August 2004, all four associations signed an agreement (Boswell, 2004).

On 20 November 2008, the Irish Association of Speech and Language Therapists (IASLT) and the New Zealand Speech-Language Therapists Association (NZSTA) joined the MRA (AMRA, 2008) and is valid today (SAC, 2009) for SLPs who have the full credentials of the association. For example, SAC members who have earned their clinical certification (C) may utilize the MRA. As stated earlier, the MRA

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is not valid for audiologists, as certification standards are different.

The MRA is an agreement between the associations. However, this mutual recognition process may not meet the licensing or registration requirements needed to practice, as it does not supersede licensing or registration requirements for practice (Tice & Moore, 2009). The SLP may have to meet other requirements to work in the country. For example, to work in the Canadian province of Saskatchewan, the SLP must apply for a registration to the licensing body, Saskatchewan Association of Speech-Language Pathologists and Audiologists (SASLPA), and obtain the appropriate visa to work in Canada (SASLPA, n.d.). In this scenario, the SLP must be a certified SAC member and pay an application and licensing fee before being eligible to practice in Saskatchewan.

Although the signatory associations of the MRA have agreed upon a set of negotiating principles, processes and terminology to examine the codes of ethics, an interesting concept is that SLPs who have membership in more than one association must adhere to each code of ethics. For example, in the above scenario if a member of the RCSLT applies to work in Saskatchewan they would adhere to a minimum of four codes of ethics: RCSLT, SAC, SASLPA and the Health Professions Council (a regulator of 15 professions in the UK). Although the MRA streamlines the process for practitioners to obtain their credentials, Bupp (2012a) notes that it is important for practitioners to be well versed with all sources of professional obligations and learn and apply sometimes inconsistent ethical rules, codes and standards. Thus, as SLPs will need to abide by more than one code of ethics, the question then becomes; are the codes of ethics in the MRA signatory associations comparable?

What are ethics?

Ethics comes from the Greek root Ethos and "refers to the character of a particular community's way of life … and concerns human behaviour only within particular roles and contexts" (Hutchings, 2010, p. 7). Ethics refer to codes of behaviours or sets of values that state what is right or wrong within certain contexts (Hutchings, 2010; Pritchard, 2006). There are different branches of ethics. Professional ethics refers to the appropriate guidelines for practitioners to follow in order to fulfil the aims and goals of their profession, with a focus on protecting the interests of the clients and patients served (Horner, 2003). Bioethics is the "systematic study of human conduct in the area of life sciences and healthcare, insofar as this conduct is examined in the light of moral values and principles" (Reich, 1978, p. xix). Bioethicists examine the ethics and philosophical implications of certain biological and medical procedures, technologies and treatments (Pellegrino, 1999).

The following bioethical principles underlie ethical guidelines of many healthcare organizations: Freedom of action and choice, justice and fairness, doing good for others, preventing or avoiding harm and fidelity and loyalty (Bupp, 2012b). Freedom of action and choice includes "respecting the rights of others to make autonomous choices, even when we believe they are mistaken, as long as their choices do not infringe on the rights of others" (Kitchener, 1984, p. 46). According to Kitchener, the right to privacy is part of freedom of action and choice as the assumption is that individuals have the right to make autonomous decisions about their own lives and information relevant to it. Competency must be considered when determining the ability to make autonomous choices. For example, someone may be considered totally incompetent (e.g., a 12 month old), intermittently competent (e.g., a person with Alzheimer's disease) or limited in competence (e.g., a 12 year old). Clearly, a 12 month old cannot make an autonomous choice, thereby making informed consent unobtainable. Alternatives must be considered such as obtaining parent/guardian or judicial consent.

The principle of justice and fairness suggests that "equal persons have a right to be treated equally and non-equal persons have a right to be treated differently if the inequality is relevant to the issue in question" (Kitchener, 1984, p. 49). For example, gender and racial differences are not relevant for equal access to SLP services. This does not imply that the needs or communication disorders of these people are equal.

Doing good for others involves contributing to the health and welfare of others. Speech-language pathology is considered a helping profession and the word help is synonymous with benefit. As a result, the profession accepted the obligation to promote the health and welfare of clients through the services that are provided. The client must benefit from services.

Preventing or avoiding harm forbids certain kinds of actions and includes both "not inflicting intentional harm nor engaging in actions which risk harming others" (Kitchener, 1984, p. 47). SLPs have an obligation to not harm, maximize service benefits and minimize possible harms. The literature suggests that it is difficult to define harm (Kitchener, 1984), but one example would be gross negligence on the part of a clinician. A SLP who orally fed a client under strict orders not to be fed orally could be said to be harming that person.

The last principle that Bupp (2012b) states is fidelity and loyalty and involves faithfulness, promise keeping and dedication. This is important because, when individuals freely consent to participate in a voluntary relationship such as SLP–client or supervisor–supervisee, an ethical commitment is implied for both parties. For example, if a supervisor lies to a supervisee about the former's credentials

(e.g., certification status), the lying is disrespectful to autonomy, regardless of the intention, because in a vacuum of candor/honesty, the supervisee cannot choose freely to seek out another credentialed supervisor even if it means prolonging the supervisory process or experience.

Codes of ethics in professions allow members to organize ethical standards, rules and principles of professional conduct in a systematic fashion (Pritchard, 2006). As SLPs provide a service that profoundly affects the safety and welfare of others, they must be accountable to their clients, families, colleagues, communities and others. However, codes of ethics must consider a wide range of moral, cultural and religious differences to create the expression of shared commitments by diverse practitioners (Pritchard, 2006; Sullivan, 2005). It is through the code that a social partnership begins between the public and professionals where accountability and responsibility are served by the profession (Sullivan, 2005). Codes of ethics benefit SLPs (e.g., providing recourse if asked by an employer to do something unethical); clients (e.g., providing SLPs with specific guidance on how to end their professional relationship with clients without abandoning the client) and the community (e.g., helping an employer, supervisor, clients or families manage the impaired practitioner) (Bupp, 2012b).

Pritchard (2006) suggests that some think that, given the diverse background, beliefs and ambitions of practitioners, it is naïve to believe there is enough agreement to form the basis of a code of ethics, however minimal. However, there need not be agreement about everything and, at every level, in order for there to be substantial agreement at the level of professional practice. For example, the profession of psychology sought the convergence of international ethical discourse into a "universal declaration of ethical principals" or UDE (Gauthier, Pettifor, & Ferrero, 2010). The UDE purports to "provide a moral framework of universally acceptable ethical principles based on shared human values across cultures [that] guide psychologists in conducting their professional and scientific activities" (Gauthier et al., 2010, p. 180). Like the UDE, the MRA is not a code of ethics. However, perhaps one of the future aims of the signatory associations in the MRA could be to "encourage the development of codes of ethics across the globe that provides ethical support and guidance" (Gauthier et al., 2010, p. 180) for SLPs.

The purpose of this study is to compare the codes of ethics of the six signatory associations of the Mutual Recognition Agreement. The rationale for this investigation is to determine if there is substantial agreement among the six codes of ethics of the signatory associations in areas such as clinical practice, research, ethical behaviour, etc., given the globalization of the profession of speech-language pathology, for the exploration of creating a document that provides a foundation for aspirations and concerns for speech-language pathologists and professional associations. By doing so, with this single document, SLPs and associations can have a guideline to: assess the ethical and moral relevance of the codes they need to abide by in their home countries and abroad; serve as an effective teaching tool in a professional issues and ethics course in SLP; stimulate global thinking about ethics and develop solidarity around issues of ethical global concern; and excite and energize research on aspirations and concerns for the profession.

Methods

Procedure

A content analysis (Marshall & Rossman, 1999) of the six codes of ethics of the MRA was performed. The six signatories are the American Speech-Language and Hearing Association (ASHA), Speech-Language and Audiology of Canada (SAC), Irish Association of Speech and Language Therapists (IASLT), New Zealand Speech-Language Therapists' Association (NZSTA), Royal College of Speech and Language Therapists (RCSLT) and Speech Pathology Australia (SPA) (see Table I). The most current version of the codes of each association was analysed at the time of this study. Of course, codes of ethics are dynamic and change with time in response to community needs and professional concerns, etc.

Typical analytic procedures of qualitative research fall into different phases, three of which include: (1) Organizing the data; (2) Generating categories, themes and patterns; and (3) Coding the data and testing the emergent understandings (Marshall & Rossman, 1999). In the first phase of data analysis, the macrostructure (e.g., headings, sub-headings, introductory statements) and the microstructure (e.g., specific rules) of all of the codes were reviewed. The specific rules rather than the more general aspirational principle or standard were analysed because each association presents rules differently. Specifically, ASHA separates 44 specific rules under four different Principles of Ethics (ASHA, 2010), SAC

Table I. Associations' publication dates of the code of ethics.

Professional association	Year of publication
American Speech-Language and Hearing Association (ASHA)	2010
Speech-Language & Audiology Canada (SAC)	2005
Irish Association of Speech and Language Therapists (IASLT)	2006
New Zealand Speech-Language Therapists' Association Inc. (NZSLTA)	2008
Royal College of Speech and Language Therapists (RCSLT)	2006
Speech Pathology Australia (SPA)	2010

expresses rules under 22 Standards (SAC, 2005b), IASLT list their rules under seven headings and 28 sub-headings (IASLT, 2006), NZSTA has 38 specific rules under six Ethics (NZSTA, 2008), RCSLT partitions their rules into six sections (RCSLT, 2006) and SPA has four duties with sub-sections for their rules (SPA, 2010). These differences observed may not signify a difference in ethical practice but may better reflect how each association conveys the standards of ethical practice to their members.

In the second phase, general themes were identified in the codes and subsequently labelled as general standards (see the Supplementary Appendix to be found online at http://informahealthcare.com/doi/abs/10.3109/17549507.2014.979873). A theme is defined as a common topic that runs through the data (Marshall & Rossman, 1999; Richards & Morse, 2013). For example, each code had themes of responsibility towards clients and practitioner competency. During this phase, each rule in all six codes of ethics was assigned into a general standard that had a similar theme. For this research, eight general standards were established. A ninth general standard, "miscellaneous", was created to address the rules that did not meet the criteria of the other definitions but needed to be assigned to a standard (see the Supplementary Appendix to be found online at http://informahealthcare.com/doi/abs/10.3109/17549507.2014.979873). Inter-rater reliability was established through an independent review at 100% agreement at the general standard level. The independent reviewer rated the six codes of ethics and also found similar themes that occurred throughout the documents. The raters were professional who had many years of experience in the SLP profession.

The general standards were further defined into specific standards based on the themes within the rules. For example, within the general standard of responsibility to clients, all six codes of ethics had specific rules on avoiding discrimination towards clients and using all resources and appropriate referrals that are available for the client. In order for a specific standard to be created, there had to be more than two codes of ethics with the same theme. Inter-rater reliability was established in this phase at 86.15% with an independent reviewer. Prior to rating the codes of ethics, the second reviewer received training on the definitions of the general and specific standards. The second reviewer assigned each rule to a specific standard. Disagreements were resolved through discussion to achieve a 100% point-by-point agreement.

Intra-rater reliability was also established at this level in that the first reviewer re-assigned each rule in the codes of ethics to a specific standard. Intra-rater reliability was established at 90.77%. Disagreements were resolved through discussion with the second rater to achieve a 100% point-by-point agreement.

Results

Content analysis

Table II presents the comparison analysis of the six codes of ethics in the MRA. The presence of a rule within is denoted by an "X" in the table. Again, the absence of an "X" may reflect that the association has addressed the ethical practice in a different format or at the macro-level such as a general heading, principle, value statement or standard. This study only analysed the specific rules at the micro-level within each code of ethics.

Responsibility to the client

The six codes have many similarities in the 12 specific standards under *Responsibility to the Client.* For example, all codes make reference to not discriminating against the client, not engaging in improper relationships with or harassment of the client and not guaranteeing success in treatment outcome to clients. The SAC (2005b) code states, "Members shall not discriminate on the basis of race, national or ethnic origin, religion, sex, age or disability in their professional relationships with their colleagues or clients" (p. 2). Additionally, NZTA (2008) states, "Members shall respect the rights of and be sensitive to factors such as client's race, age, religion, culture, sexual orientation or gender" (p. 3).

Responsibility to professional conduct

Similarities also occur in the general standard of *Professional Conduct*. For example, the majority of the associations have in their code that members must report ethical violations to the association. For example, ASHA (2010) states, "Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics" (p. 4). SAC (2005b) notes, "Members shall co-operate with the SAC Ethics Committee regarding instances of alleged violations of this Code, SAC By-Laws or policies by reporting suspected violations to the SAC Ethics Committee" (p. 2).

Responsibility to practitioner competence

High agreement occurred in *Practitioner Competence*. For example, the IASLT (2006) code states, "A member must possess professional qualifications as recognized by the professional body" (p. 3). Elsewhere, RCSLT (2006) indicates, "Every member is personally responsible for their conduct and performance. RCSLT members must be engaged in a process of keeping personal professional knowledge and skills up to date" (p. 10).

Responsibility to research

All associations have specific rules for *research* in their codes. In the ASHA code, research is embedded

Table II. Content analysis of a comparison of six codes of ethics in the MRA.*

General standards	ASHA	SAC	IASLT	NZSLT	RCSLT	SPA
1. Responsibility to Client						
a. Avoid discriminatory practices	X	X	X	X	X	X
b. All resources and referrals	X	X	X	X	X	X
c. Client safety	X	X	X	X	X	X
d. Consider legal, social and moral norms of the client			X	X	X	X
e. Full disclosure	X	X		X	X	X
f. Professional–Client relationships/avoid harassment	X	X	X		X	X
g. Fee for service	X	X	X	X	X	X
h. Guarantee results	X	X	X	X	X	X
i. Consent to release information	X	X	X	X	X	X
j. Maintain records	X	X	X	X	X	X
k. Consent for services		X	X		X	X
l. Conflict of interest/exploitation/personal gain	X	X	X	X	X	X
m. Efficacy of treatment	X	X	X	X	X	X
n. Other	X					
Total general standard (out of 13)	12	12	12	11	13	13
2. Responsibility to Professional Conduct						
a. Report violations to the association	X	X		X	X	X
b. Professional conduct	X		X	X	X	X
c. Speaking on behalf of the association				X	X	X
Total general standard (out of 3)	2	1	1	3	3	3
3. Responsibility to Practitioner Competence						
a. Possess professional credentials	X	X	X	X	X	X
b. Personal health	X	X	X	X	X	
c. Continuing Education	X	X	X	X	X	X
d. Scope of practice	X	X	X	X	X	X
Total general standard (out of 4)	4	4	4	4	4	3
4. Responsibility to Research						
a. Release of information	X	X	X	X	X	X
b. Consent for services	X	X	X	X	X	X
c. Acknowledgement	X	X				X
d. Appropriate approval to conduct research		X		X	X	X
e. Withdraw from research		X	X			
f. Share research				X		X
g. Supervision/delegation of tasks	X	X		X		
h. Appropriate methodology		X		X	X	X
i. Other	X	X				X
Total general standard (out of 9)	5	8	3	6	4	7
5. Responsibility to Colleagues						
a. Educating the colleague				X	X	X
b. Delegation/supervision of tasks	X	X			X	X
c. Professional relationships/Avoid harassment	X	X	X		X	X
d. Sharing of information			X		X	X
e. Other	X			X		X
Total general standard (out of 5)	3	2	2	2	4	5
6. Responsibility to Support Personnel						
a. Delegation/supervision of tasks	X	X	X	X	X	X
b. Misrepresentation of credentials	X	X				X
c. Professional–Support Personnel relationships/Avoid harassment	X	X	X			X
d. Other			X			
Total general standard (out of 3)	3	3	3	1	1	3
7. Responsibility to Students						
a. Delegation/supervision of tasks	X	X	X	X	X	X
b. Professional–Student relationship/Avoid harassment	X	X				X
c. Misrepresentation of credentials	X	X				X
d. Educating the student			X		X	
e. Sharing information			X		X	
Total general standard (out of 5)	3	3	3	1	3	3
8. Responsibility to Public						
a. Educating about communication disorders			X		X	X
b. Advertising services	X	X	X	X	X	X
Total general standard (out of 2)	1	1	2	1	2	2
9. Responsibility to Miscellaneous						
a. Equipment	X	X	X	X		X
b. Telepractice	X	X				
c. Staff						X
d. Employer				X	X	X
Total general standard (out of 4)	2	2	1	2	1	3
Total Ethical standards (out of 48)	35	36	31	30	35	42

*The absence of an "X" may mean that the associations may have chosen to convey the ethical standard in a different format than at the level of specific rules.

throughout the document. In the other codes (SAC, RCSLT, IASLT, SPA, NZSTA) there is a separate section for research and RCSLT, SPA and SAC utilize both options in that they refer to research throughout the document *and* have a separate section. For example, the RCSLT (2006) code states under the section "In relation to individuals using speech and language therapy services" (p. 12) that members must obtain written consent for research. The RCSLT code also has a section regarding research with specific rules for research practices.

Three codes (i.e., ASHA, SAC and SPA) specify a rule to acknowledge a researcher's contribution to research. For example, in the SPA (2010) code it states, "recognize and, where appropriate, formally acknowledge their contributions to clinical practice, teaching, research or administration" (p. 4).

Four associations provide a rule that researchers must obtain approval from a governing body or oversight committee (e.g., Institutional Review Board) prior to conducting RESEARCH. For example, the SPA (2010) states, "the research protocols comply with the 'Health and Research Guidelines' of the National Health and Medical Research Council (2007)" (p. 3). The guidelines are available online and require all research using human participants having prior approval from a Human Research Ethics Committee.

Two codes (i.e., SAC and IASLT) specify that participants have the right to withdraw from research. In the SAC (2005b) code, it states that, "Members shall use protocols that are in compliance with standards acceptable by the scientific community by obtaining informed consent from research subjects prior to their participation in research studies and respecting the subject's research to withdraw from studies" (p. 4). In the IASLT (2006) code it states that, "The subject always has the right to withdraw from the research at any time" (p. 8).

NZSTA and SPA write that members share results and educate others through research. In the NZSTA (2008) code, it states, "members shall strive to increase knowledge within the profession and share research with colleagues" (p. 6).

When conducting research, sometimes supervision and delegation of tasks must occur. These issues are addressed in ASHA, NZSTA and RCSLT codes. For example, in the NZSLT (2008) code of ethics it is written that, "Members have the responsibility to ensure that research carried out by others under their supervision conforms to this Code of Ethics" (p. 6).

Four associations, SAC, NZSTA, RCSLT and SPA, state in their codes that members must use appropriate research methodology. For example, the RCSLT (2006) code states that "members must engage in audit and research using agreed and well-structured methodology" (p. 12). SAC (2005b) states, "Members shall use protocols that are in compliance with standards accepted by the scientific community" (p. 6).

Three associations' rules were not coded into the above-mentioned specific standards. First, ASHA has several rules that were coded into the "other" category of research because they have embedded research into the document over many sections. As a result, ASHA specifically refers to research more often. For example, ASHA (2010) states, "Individuals shall not misrepresent research, diagnostic information, services rendered, results of services rendered, products dispensed, or the effects of products dispensed" (p. 4). Second, SAC (2005b) states,

> Members shall use protocols that are in compliance with standards accepted by the scientific community by: d) ensuring that participation in research augments rather than delays or interferes with scientifically accepted methods of diagnosis or treatment; e) using peer review processes to evaluate research before presentation to the public. (p. 6)

No other code specifically addresses client's participation in research, helping the client's assessment or treatment, or that research is subject to the peer review process *before* public presentation. As stated previously, the codes that have a general statement to refer to other governing bodies may cover these issues.

Finally, under section 3.3.6 in the SPA (2010) code it states, "We contribute to the knowledge and expertise of our profession by creating and maintaining research opportunities and supporting research" (p. 3). This is unique because other codes do not refer to creating, maintaining and supporting research opportunities.

Responsibility to colleagues

Great variability occurs in *Responsibility to Colleagues*. Half of the codes refer to educating colleagues, (NSLT, RCSLT and SPA). With respect to delegation and supervision of tasks, ASHA, SAC, SPA and IASLT reference the need to supervise tasks delegated to colleagues. In the category of sharing of information, three codes, IASLT, RCSLT and SPA, have such a rule.

In the "other" category pertaining to colleagues, three associations have a rule that was not assigned to a standard. The first is ASHA rules that misrepresenting statements to colleagues are not ethical. Specifically, the rule states "Individuals' statements to colleagues about professional services, research results and products shall adhere to prevailing professional standards and shall contain no misrepresentations" (ASHA, 2010, p. 4). Second, NZSTA (2008) states, "Members shall acknowledge the professional contribution of other Speech-Language Therapists" (p. 7). Finally, the SPA (2010), in referring to independent debate, states "We defend and

promote our own rights and the rights of colleagues to participate fully and openly in public debate" (p. 4). No other association refers to public debates.

Responsibility to support personnel

In *Responsibility to Support Personnel*, three common themes were situated in the six codes. The first was delegation/supervision of tasks with 100% agreement. The second theme, misrepresentation of support personnel credentials, was supported in ASHA's, SAC's and SPA's codes. For example, the ASHA (2010) code states,

> Individuals shall not misrepresent the credentials of assistants, technicians, support personnel, students, Clinical Fellows or any others under their supervision, and they shall inform those they serve professionally of the name and professional credentials of persons providing services. (p. 1)

Relationships/harassment is mentioned in ASHA's, SAC's, SPA's and IASLT's codes of ethics. For example, the SAC (2005b) code states, "Members shall not condone nor engage in harassment of client's, colleagues or others" (p. 3). SPA (2010) asserts, "If we manage, supervise or employ staff we treat them fairly and without discrimination, bullying or harassment" (p. 3).

In the "other" standard, the IASLT (2006) refers to professional collaboration with support personnel. The IASLT code asserts, "A member must share information, knowledge and skills with fellow professionals, students and support staff as appropriate" (p. 7).

Responsibility to students

In the general standard of *students*, delegation and supervision of tasks from SLPs to students is in 100% acknowledgement. The other four have partial acknowledgement. ASHA, SAC and the SPA do not condone inappropriate relationships with or harassment of students. While SAC (2005b) does not specify students it states, "Members shall not condone nor engage in harassment of clients, colleagues or others" (p. 4). The word *others* is interpreted as including students. The second is that ASHA and SAC refer to misrepresentation of student credentials. The third and fourth are that IASLT and RCSLT members will educate and share information with students

Responsibility to the public

Variability also occurs in *Responsibility to the Public*. For example, IASLT, RCSLT and SPA have specific rules regarding educating the public. The RCSLT (2006) states, "in relation to individuals using speech and language therapy services, RCSLT members must, in association with the RCSLT, educate and inform the public regarding communication disability, ensuring the accuracy of such information" (p. 11).

All six associations have 100% agreement with advertising services in a truthful manner. For example, the SPA (2010) code of ethics states that "We ensure our promotional and advertising materials are accurate, based on evidence and do not misrepresent the profession" (p. 2). The SAC (2005b) code states, "Members may advertise their professional services" and "Members shall not advertise in a way that is false, misleads the public, misrepresents the professions, or disparages the skills of colleagues or other professions" (p. 5). These examples declare the need for truthful advertising.

Miscellaneous

The miscellaneous category captures those rules that do not meet the definitions in the above general standards. Four rules needed a separate category. The first is reference to the use of equipment. For example, ASHA and SPA refer to maintaining calibrating equipment properly.

The second is the use of telepractice as a service delivery model. ASHA and SAC codes state that telepractice as a service delivery model is acceptable, except where prohibited by law.

The third is that the SPA embeds the term "staff" throughout their code (i.e., under the subtitle of *supervision*) and has it as a standalone category. In the standalone standard, SPA (2010) lists additional rules such as "classify and remunerate them appropriately" (p. 4) and "make them aware of their rights if a dispute arises and give them access to counselling support and advice" (p. 4).

The final miscellaneous category is with the term "employer" that occurs in the NZSTA, SPA and the RCSLT codes. The NZSTA (2008) code uses the term "employer" twice, both of which are also captured previously under research (i.e., approval) and client (i.e., all resources). SPA (2010) also refers to "employer" and has a separate section titled "Duties to our Employers" (p. 2). Here, they specify rules such as "observing our employers' Codes of Ethics" (p. 4) and "We represent our employers' views fairly and do not put forward our personal views as being those of our employers" (p. 3). Many of the rules in this section are repeated elsewhere in their code and as a result are counted elsewhere in Table II.

Discussion

The current study compares the six codes of ethics in the MRA with the signatories of ASHA, SAC, IASLT, NZSLTA, RCSLT and SPA. The codes are analysed at the level of specific rules.

In summary, the codes are similar. The associations place similar emphasis on responsibility to the

client and practitioner competence. No complete consensus occurs in the standards of "Responsibilities to Professional Conduct", "Colleagues" and the category of "Miscellaneous". The other general standards agree in either one rule (e.g., Responsibility to the Public, Students and Support Personnel) or two rules (e.g., Research) and variability occurs elsewhere.

The nine general standards that we created for a basis of comparing the six codes of ethics are not to be viewed as comprehensive or exhaustive. As a result, the interpretation of this analysis is not to suggest that one code may be better or more comprehensive than others. Rather, this analysis demonstrates similarities occur in these codes of ethics. As stated earlier, this study and the table created reflect the themes that occur only at the level of specific rules and not at the more macro-level. The absence of an "X" in the table may simply indicate that the association chooses to convey an ethical standard to their members in a different format than the micro-level of rules.

It is beyond the scope of this paper or our abilities to consider all the cultural, social, religious and moral differences (Pritchard, 2006; Sullivan, 2005) that influenced the creation of the six codes of ethics. Rather, we attempted to compare the themes of rules in each code to identify and present the similarities. Applying specific rules and standards or principles of ethics will naturally vary across countries and must be interpreted locally to safeguard the applicability to local culture, laws and beliefs.

Where to next?

The MRA presents "greater international employment opportunities and research collaborations" (Tice & Moore, 2009) and creates an opportunity for increased international relationships. Past president of ASHA, Kate Gottfred was quoted as saying that "[the MRA] facilitates the exchange of theoretical and clinical research and encourages the flow of information on best clinical practices" (Tice & Moore, 2009, p. 34). One area of international exchange of information and research can be shared aspirations and concerns, like those found in the six codes in the MRA. The profession of psychology did just that and looked at shared aspirations and concerns internationally and created such an international document. In 2008, the International Union of Psychological Science and the International Association of Applied Psychology adopted the *Universal Declaration of Ethical Principles for Psychologists* (International Union of Psychological Sciences, 2008). The *Universal Declaration of Ethical Principles for Psychologists* (UDE) was developed by an international Ad Hoc Joint Committee working under the auspices of the International Union of Psychological Science and the International Association of Applied Psychology (Gauthier et al., 2010). Gauthier et al. (2010) noted that, to develop the document, the process involved, "careful research, broad international consultation and numerous revisions in response to feedback and suggestions from the international psychology community" (p. 180). Furthermore, Gauthier et al. (2010) indicated that the result is not a code of ethics or a code of conduct but rather a, "moral framework of universally acceptable ethical principles based on shared human values across cultures" (p. 180). The document has four principles that articulate a common moral framework to guide and encourage psychology professionals globally towards the highest ethical ideas in professional work.

The adoption of the UDE "can help to keep psychologists dialogically focused on what they want and don't want for the profession and those it aims to help" (Strong, 2010, p. 248). The *Universal Declaration* does not provide universal assertions or expectations in an absolute sense. Rather, it is a resource for a specific profession that provides four principles that need to be interpreted within cultural contexts. The UDE can only be understood in temporal, situational and cultural contexts. Therefore, the meanings attached to the four principles will certainly vary between cultures and even within cultures dependent on the participants in the dialogue.

In the preamble, the objectives of the UDE are stated as follows:

> to provide a moral framework and generic set of ethical principles for psychology organizations worldwide: (a) to evaluate the ethical and moral relevance of their codes of ethics; (b) to use as a template to guide the development or evolution of their codes of ethics; (c) to encourage global thinking about ethics, while also encouraging action that is sensitive and responsive to local needs and values; and (d) to speak with a collective voice on matters of ethical concern. (International Union of Psychological Sciences, 2008, p. 1)

As the MRA paves the way for developing international relationships and opportunities for professionals to work abroad, perhaps the six associations could create a document so that SLPs could dialogue in shared concerns and aspirations. We are not suggesting replacing the current codes of ethics with one code that has certitude to enforce specific ethical standards across international boundaries. Rather, we are suggesting that the professional associations consider an initiative that would create an international dialogue in shared aspirations and concerns. Our rationale for this suggestion is 2-fold. First, this could potentially promote the profession worldwide and create a global understanding and co-operation in theoretical and clinical research while respecting the cultural differences. If an international document were created in similar fashion to the UDE then, by applying the same purposes, SLPs who work or research internationally could potentially achieve the following: (a) "evaluate the ethical and moral

relevance" (International Union of Psychological Sciences, 2008, p. 1) of the different codes of ethics that they must understand and abide; (b) assist with developing a code of ethics when providing a service or conducting research in a country without a code; (c) discuss aspirations and concerns on an international level while encouraging action that considers local cultural, religious, social and moral norms; and (d) promote speech, language, hearing and swallowing aspirations and concerns as part of a larger consortium to reach a larger consortium at the international level.

Second is that, if a code of ethics promotes mutual understanding, expectation and respect while considering a wide range of moral, cultural and religious differences then the MRA can include unification in ethics. Through this one document, a culturally sensitive model can be used for creating and reviewing codes of ethics. Thus, SLPs can make appropriate ethical responses in clinical and research practices throughout the world, regardless of culture. A unified document for SLPs may or may not be realistic "inasmuch as such codes suggest or prescribe specific behaviours that are influenced by and reflect the particular cultural, social and political beliefs of the cultures in which they are created" (Gauthier et al., 2010, p. 180) and interest in such an endeavour can wax and wane over time. However, perhaps the most important outcome will be ongoing international dialogues on ethical practice.

Building upon the UDE and five bioethical principles that underlie many health organizations (Bupp, 2012b) (i.e., freedom of action and choice, justice and fairness, doing good for others, preventing or avoiding harm and fidelity and loyalty), we propose the model shown in Figure 1 for consideration.

The proposed unified ethical principles for SLPs model include four principles. These principles embrace the similarities found in the present study among the codes of ethics of the MRA signatories. All codes of ethics displayed respect for the dignity of persons and peoples (Principle I); competent caring for the well-being of persons and peoples (Principle II); integrity (Principle III) and professional and scientific responsibilities to society. By way of example, in Table II, items 1a, 1b and 1h under the general standard of "Responsibility to Clients" would be represented under Principles I and III of the proposed unified ethical principles model for SLPs. Also, in Table II, items 3a and 4a under "Responsibility to Practitioner" and "Responsibility to Research" would be represented under Principles III and IV of the proposed model.

Limitations

Some limitations are associated with the present study. The authors only analysed the rules. The principles and values that underpin the codes of the associations were not analysed. As a result, we acknowledge that the associations may have chosen to convey the ethical standard in a different format than at the level of specific rules (e.g., General principle or in a value statement). We recognize that some shared ethical understandings at this level helped us when we adapted the Unified Ethical Principles. Additionally, when the authors presented the idea of a universal document they drew upon the codes of ethics of six associations representing only Western societies. Perhaps these codes do not reflect those of other cultures, societies or countries.

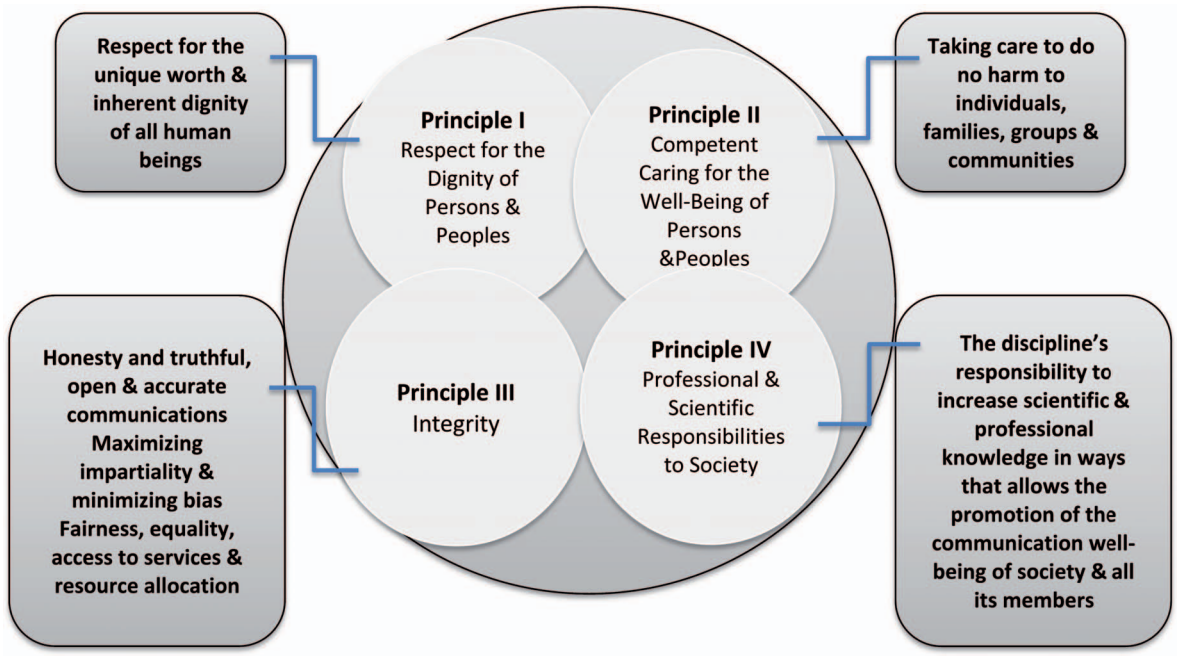

Figure 1. Unified ethical principles in speech-language pathology (adapted from UDE, 2008).

Conclusion

In the current study, we found many similarities across the six codes of ethics involved in the MRA. Again, the comparison made herein should not to be interpreted that one code of ethics was superior to another, as each code of ethics must be understood and interpreted in temporal, situational and local cultural contexts. The comparison was to highlight similarities so that a unified document could be considered. Although Table II also reflects some differences among the rules of the associations' codes, each organization may have chosen to convey ethical standards in a different format than at the level of specific rules.

The signatories involved in the MRA for SLPs have opened up many wonderful opportunities including the ability to work abroad, create international relationships and foster an exchange of information and ideas. We suggest that further dialogue with the associations could create a healthy discussion regarding the feasibility of a mutual recognition agreement for ethical standards in speech-language pathology.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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Supplementary material available online

Supplementary Appendix: Coding definitions.