



Ethical reflections

Readability of written speech pathology reports

Suze Leitão, Nerina Scarinci and Cheryl Koenig

Peter had been struggling at school since year 1. He was now in year 3 and his teacher suggested he be assessed by a speech pathologist as he was still not reading fluently. Peter's dad was keen for him to be assessed – he himself had left school early with limited education and did not want the same for his son. Peter's mum felt that he would grow out of it, as his older sister had “got the hang of reading in the end”, but she agreed to the testing.

The assessment was carried out by a speech pathologist employed by the school and the report arrived by post. It included the following:

A series of non-words were presented to Peter to assess his ability to apply letter-sound correspondence rules in reading. He scored 0/5 on this task. Peter used a top down approach when attempting these words, and tended to guess them as real words according to the first one or two phonemes.

On the phonemic decoding efficiency subtest from the Test of Word Reading Efficiency Peter's standard score was 60.

Working memory and semantic knowledge were tested using the Word Classes subtest from the CELF-4 which evaluates the ability to perceive the associative relationships between word concepts. Peter obtained a standard score of 6.

In summary, Peter has weak reading skills with a profile concomitant with a diagnosis of dyslexia. He will require support.

In this column of “Ethical reflections” we have chosen to focus on the topic of report writing. Why should we need to draw on our professional Code of Ethics (2000) when we have to write a client report? We know that the Competency Based Occupational Standards (CBOS, 2001) require us to record information objectively, effectively, accurately and in accordance with the requirements as stipulated by our workplace. We also know that on request, our documentation must be supplied for legal purposes. And, when we think about ethics and clinical reporting, it is clear we must adhere to confidentiality guidelines and obtain consent for distribution of information about a client. But what about ethical principles such as truth, fairness, autonomy and beneficence?

Let us start with *truth* (we tell the truth) and *fairness* (we provide accurate information, strive for equal access to services and deal fairly with all our clients). When working with speech pathology students in the early stages of their

training, academics focus their teaching on the difference between objective, factual observations (e.g., the child cried during the session) and subjective interpretations (e.g., the child was tired and unhappy today). We may argue that both of these observations are “true” but we must be clear about the difference.

While many of the tests we use in clinical practice allow us to gather numerical “objective” data, the interpretation of these data and the language we use to report our findings will be influenced by our own therapeutic philosophies and theoretical constructs. The choice of test itself may even be influenced by a service provider's policy about eligibility for services. When we come to gathering informal assessment data, it is even more important to understand how the underlying framework we draw on (consciously or unconsciously) dictates not only what we observe, but also how we interpret and understand our observations, i.e., our version of “the truth”.

Our Code of Ethics also talks about *beneficence* – seeking to benefit our clients and not knowingly causing harm. This balance can sometimes be hard to achieve. An example would be the tension we may feel when wishing to advocate for services for a client, but at the same time meeting our professional responsibility to accurately report the client's assessment results. How do we deal with the desire to have a child accepted into a service if their data don't exactly fit the eligibility criteria – do we downplay aspects of it, emphasise others? And if we do so, is this being truthful? Another situation may be when reporting information that we feel may be unexpected or distressing to a family – how do we strike a balance between accuracy/truth and beneficence/non-maleficence? How do we “word” a document such that the truth is told, but in the most sensitive way possible? The importance of showing sensitivity to parents' and carers' feelings and concerns must be acknowledged by speech pathologists. Research suggests that parents value reports which document both their child's strengths as well as weaknesses in order to portray a complete picture of their child (Donaldson, McDermott, Hollands, Copely & Davidson, 2004). Perhaps inclusion of such information may help speech pathologists to meet the ethical principle of beneficence.

In terms of competencies, CBOS element 2.5 is the most relevant to reporting: “Provides feedback on results of interpreted speech pathology assessments to the client and/or significant others, and referral sources, and discusses management.” This involves us determining the following:

- Who is to receive the feedback/report?
- How will we consult with the client and/or significant others, and/or the referral source about the content of the report?
- How is the report to be provided (oral and/or written)?

- How will we modify the language within our report to meet the needs of our client (and other readers)?

Reports often form the primary source of communication between speech pathologists and clients – they provide one way of facilitating communication and including the parent/carer in the assessment and intervention process. What happens however if the report cannot be understood? Are speech pathologists meeting their ethical obligations if reports are not accessible to the reader? Unfortunately it is common practice to see phrases such as the ones below included in paediatric speech pathology assessment reports:

On the phonemic decoding efficiency subtest from the Test of Word Reading Efficiency Stephen's standard score was 60.

The phonological processes: stopping, assimilation, final consonant deletion, and context-sensitive voicing indicate a phonological delay. The processes of initial consonant deletion, medial consonant deletion, and consonant cluster simplification are deviant processes.

Aidan achieved a standard score of 4 on the Formulating Sentences subtest. He was unable to use coordinating conjunctions and did not consistently use conjunctive adverbs in his discourse.

For practising speech pathologists, such terminology may be easy to understand; however for the parents and carers of our clients who come from varied educational backgrounds and occupations, these types of phrases are extremely difficult, if not impossible to understand. Research suggests that when parents are confronted with such terminology, they either completely disregard that section of the report, or attempt to guess the meaning of the unfamiliar terms (Donaldson et al., 2004).

So how do you make a report “readable” for our clients? Perhaps the best way to address this is to use a working example. Consider: “Sarah’s phonological awareness, assessed by the SPAT, demonstrated her difficulties with phonemic segmentation, especially clusters, identification of coda, and phoneme deletion.” This sentence is not accessible to Sarah’s parents because professional jargon and acronyms have been used. A more accessible version of this report could read:

Phonological awareness refers to the ability to rhyme, break words into parts and blend sounds in words – these skills are important when learning to read and spell. Sarah's phonological awareness was tested using the Sutherland Phonological Awareness Test. This test is commonly used to assess children's reading skills. Results of this test showed Sarah is able to identify the sounds at the beginning of words (e.g., what is the first sound in “bike”?). However, she had difficulties identifying sounds in longer words when there were two sounds together, such as “dr” (e.g., tell me the sounds in “dream”) and in identifying the final sounds in words (e.g., what is the last sound in “knife”?). Sarah also had difficulty removing one of the sounds from a word and then saying the word that remained (e.g., say “farm” without the “f”).

In order to foster respectful and effective relationships between families and clinicians, speech pathology reports must be accessible. Research into professional reports consistently indicates that the usefulness of reports to

consumers is limited. Studies suggest that reports are often poorly written, poorly organised and easily misunderstood (Cranwell & Miller, 1987; Donaldson et al., 2004; Flynn & Parsons, 1994). Reports from speech pathologists tend to be ambiguous, contain excessive jargon, and are frequently written at a level that requires high level language skills (Tallent & Reiss, 1959; Weddig, 1984). This results in poor understanding and misinterpretation by parents, which in turn prevents effective communication and excludes the reader from the therapeutic process (Weddig, 1984).

To overcome issues of readability and access, reports should wherever possible not contain jargon, abbreviations or ambiguous language. In addition, reports should use short sentences, and should explain and interpret the assessment results in functional terms (Cranwell & Miller, 1987; Donaldson et al., 2004; Flynn & Parsons, 1994; Grime, 1990). Recommendations should be concrete, and test scores should be clearly interpreted with reference to the referral question.

The ethical principle most relevant to issues of readability and clarity is that of *autonomy*. Speech pathologists must respect clients’ rights to self-determination and autonomy, by providing written material that allows them to make informed decisions and to be active in a meaningful way in the therapeutic process. After all, parents will be central to affecting change in their child’s communication ability, and therefore, as specialists in communication, we have an ethical obligation to ensure that parents have access to the information they require. Parents have a legal right to be properly informed – failure by a clinician to provide information that is understandable to a parent may mean that informed consent has not been obtained.

Consumer response

Surviving the initial stages of shock and often denial following a child’s diagnosis of speech and/or language difficulties is challenging for any parent. Families may be confused and overwhelmed, and these emotions can destroy a family’s confidence and trust in their own judgment.

Compassion and empathy for this upheaval to family life is greatly appreciated by families. Most families respect and understand the need for professionals to adhere to their clinical training, but a “softening” of fixed and scientific views of humans as “statistical” beings is also greatly appreciated by consumers. Of course science has its important role to play, but human development cannot always be accurately determined by science, nor can potential be predicted, or spirit measured.

At times parents may feel bombarded with so much information that any information conveyed, especially verbal, has the potential to be forgotten, mislaid, or not understood. Sometimes parents may be so overwhelmed with the situation they won’t always ask the “right” questions, and communication lines between therapist and parent may become blurred. Clear, concisely written reports are required. Further to this, information regarding services to be provided and fees payable, especially any additional fees for written reports and assessments, must be preferably produced in written format, must be openly discussed and formally agreed to, prior to intervention commencing.

Also worth noting is that when parents and families are meaningfully engaged as part of a “team”, better outcomes will ultimately be achieved! As stated by Dr Lisa V. Rubinstein, president of the US Society of General Internal Medicine, “Sharing in decision-making will help raise the

quality of care given by any clinician, because it will sharpen the focus on the key decision points and help the clinician put a plan in place that the client understands and agrees with" (Chen, 2009).

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Cheryl Koenig is a consumer and carer representative on seven different government and NGO committees, including the Speech Pathology Australia Ethics Board. She is the author of two publications for NSW Health (2006, 2007) and has recently published her third book, *Paper Cranes* (Exisle, 2008). Cheryl is passionate about improving policy and services for consumers in all areas of health and is inspired by the increasing voice and credibility now being afforded consumers in relation to health issues.

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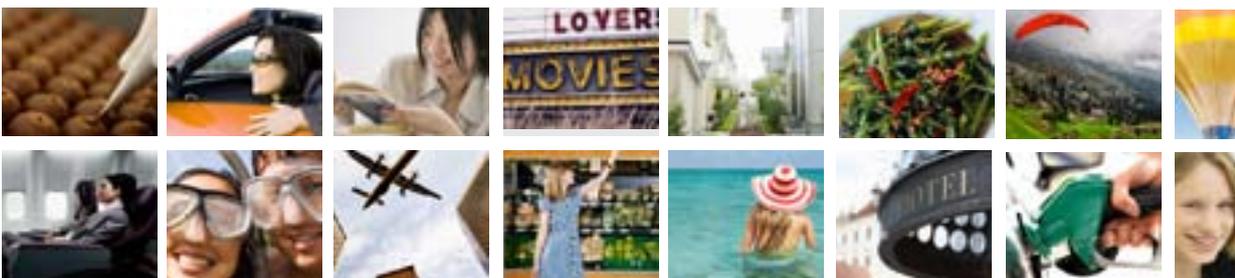
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