



*Reflective Practice in Speech-Language Pathology: Relevance for Practice and Education*



*La pratique réflexive en orthophonie : pertinence pour la pratique et l'enseignement*

#### KEY WORDS

REFLECTIVE PRACTICE

SPEECH-LANGUAGE  
PATHOLOGY

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#### Abstract

As a profession, speech-language pathology appears to have become interested in reflection and reflective practice as important components of clinical practice and education. However, little systematic consideration of the potential value of reflective practice within the field has been undertaken. The purpose of this paper seeks to consider how reflective practice is relevant to contemporary speech-language pathology practice. Drawing on comprehensive and diverse theoretical literature, we suggest that reflective practice is a framework worthy of consideration because of its potential to: (1) foster the generation of knowledge from practice, (2) balance and contextualize science with patient care, (3) facilitate the integration of theory and practice, (4) link evidence-based practice with clinical expertise, and finally, (5) contribute to the cultivation of ethical practice.

#### Abrégé

En tant que profession, l'orthophonie semble en être venue à s'intéresser à la réflexion et à la pratique réflexive comme composantes importantes de la pratique clinique et de l'enseignement. Toutefois, la valeur potentielle de la pratique réflexive a reçu peu de considération systématique dans le domaine. L'objectif de cette publication est de considérer la manière dont la pratique réflexive est pertinente à la pratique contemporaine de l'orthophonie. En nous appuyant sur une littérature théorique exhaustive et diverse, nous suggérons que la pratique réflexive est un cadre qui mérite d'être considéré étant donné son potentiel de : (1) promouvoir la génération de connaissances à partir de la pratique, (2) équilibrer et contextualiser les données scientifiques par rapport aux soins des patients, (3) faciliter l'intégration de la théorie et de la pratique, (4) lier la pratique basée sur les données probantes avec l'expertise clinique, et enfin, (5) contribuer à la culture d'une pratique éthique.

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## Introduction

The profession of Speech-Language Pathology (S-LP) has become interested in the concept of reflection and reflective practice as an important component of clinical practice and education. Yet to date, reflective practice has not been widely examined in the S-LP scholarly literature and it has only recently begun to be studied in any meaningful way (Coty, Kinsella, & Doyle, 2009; Hill, Davidson, & Theodoros, 2012). A reflective approach may be required as a standard for licensing and registration or can be adopted as a teaching strategy to facilitate clinical education. What remains unclear behind the call for the adoption of reflective practice is the essential question of 'why'? The rationale for integrating reflective practice into S-LP is difficult to elucidate given that the systematic consideration of its potential value is only beginning to occur in the field. This raises the question: What does reflective practice potentially offer to the field of S-LP, and more specifically, what can it offer to the contemporary practice of speech-language pathologists? Given the growth of interest in and the adoption of reflective practice in other disciplines (Mann, Gordon, & MacLeod, 2009), as well as increased calls for attention to reflective practice in the S-LP profession (Geller & Foley, 2009a; Geller & Foley, 2009b; Hersh, 2010; Horton, 2004), an examination of its value to S-LP is needed. In this paper, the relevance of reflective practice to contemporary S-LP practice is examined in an effort to provide justification for its adoption in clinical practice and education.

## Objective

The objective of this paper is to critically examine the potential relevance of reflective practice to the field of S-LP. In order to meet this objective, a brief portrait of contemporary S-LP, especially in health care settings, is provided. This is followed by a short overview and the central part of this paper - a critical analysis of reflective practice. Through this analysis we suggest that reflective practice has the potential to contribute to the S-LP field through its capacity to: (1) foster the generation of knowledge from practice, (2) balance and contextualize science and patient care, (3) facilitate the integration of theory and practice, (4) link evidence-based practice with clinical expertise, and finally, (5) contribute to the cultivation of ethical practice. As we explore these ideas, we believe that their relationship to the contemporary S-LP workplace and their inherent implications for clinical practice and education will become apparent.

## Contemporary S-LP

The contemporary workplace for speech-language pathologists (S-LPs) is an ever-changing one that is driven by political, economical, social, and technological forces (Lubinski & Hudson, 2013). For example, within Canada's evolving health care system, there are current demands for increased efficiency, cost-effectiveness, and quality improvement (Health Council of Canada, 2013). With current cost-cutting measures, S-LPs find themselves with fewer resources to respond efficiently to increasingly growing demands. In other words, they are being asked to 'do more with less'. This calls for innovative approaches. Further, S-LP practitioners are facing increasing requirements related to accountability for their service and the need to prove to third-party payers, employers, and clients that their services are measurable and cost-effective. This means that there are increasing demands for S-LPs to use methods that are derived from evidence-based studies and to document functional outcomes. As interprofessional collaborative patient-centred practice is recognized as necessary for improving the quality of patient care in Canada (Barrett, Curran, Glynn, & Godwin, 2007), another important issue facing today's S-LPs is the need to work effectively with other professionals across different settings. All clinicians must develop strategies for working collaboratively in multi-professional and multi-specialty teams. These expanded collaborations and their additionally increasing demands, often driven by politico-economical forces, not only affect S-LPs' professional practice, but also the preparation of S-LP graduates.

Socio-demographic trends also contribute to the changing landscape of S-LPs' clinical work (Lubinski & Hudson, 2013). For example, as the composition of the Canadian population is changing steadily (Statistic Canada, 2014), S-LPs are required to provide responsive and sensitive services to caseloads from more culturally and linguistically diverse populations. Moreover, an aging population (Statistic Canada, 2015) demands increased levels of service delivery and escalating healthcare costs, putting pressure on S-LPs to change the manner in which they deliver services (Lubinski & Hudson, 2013). With older individuals presenting with a variety of chronic health conditions affecting their communication, cognition, and swallowing, S-LPs also face an increase in the complexity of needs for this population. Confronted with these socio-demographic changes, S-LPs must examine their own education and experience, and seek to upgrade their knowledge and skills as needed, in order to provide competent care to these growing populations.

As for advances in technology, access to the Internet, particularly telepractice, offer S-LPs the opportunity to provide assessment and intervention services to rural areas, but also to various parts of the world (Dudding, 2013). There is also greater use of online and distance continuing education for working S-LPs and similar online and distance support for students who are on placements in remote areas. Such uses of technology extend the transfer of clinical knowledge and have the potential to improve access and quality of S-LP services. These technological advances inevitably call for the development of new skill sets and expanded capabilities from S-LPs and graduates alike, in order to facilitate appropriate and high quality services to individuals with communication, cognitive, and swallowing disorders.

In sum, the clinical workplace for S-LPs is a complex, dynamic, and rapidly changing environment, necessitating the ability of students and practitioners to learn new skills quickly. Many of these skills must be learned independently through a process of constantly reflecting on one's practice and seeking new opportunities for learning. In such changing conditions, ethical issues also may arise as clinicians are faced with conflicting demands and contradictory situations. This may require negotiating with an existing institutional work ethic and environment that may be conflicting with one's professional and personal values (Kummer & Turner, 2011). Thus, clinicians and student entering the field of S-LP require even greater "preparation, tools, and awareness" (Rose & Best, 2005, p.348) in order to successfully cope with this changing workplace. We propose that such "preparation, tools, and awareness" (Rose & Best, 2005, p.348) may lie in the understanding and recognition of the importance of reflective practice to achieve effectiveness in a complex work environment. In the following section, reflective practice will be briefly presented.

### Reflective Practice: An Overview

There are many different conceptualizations and ideas about what constitutes the theory of reflective practice, as well as its purposes and applications. In their systematic review of reflective practice in health professional education, Mann et al. (2009) offer a useful way of conceptualizing the different reflective models by distinguishing between those focusing on the iterative process of reflection (i.e., Boud, Keogh, & Walker, 1985; Schön, 1983; 1987) and those that identify different levels of reflection (i.e., Dewey, 1933; Hatton & Smith, 1995; Mezirow, 1991; Moon, 1999). More importantly, Mann et al. (2009) point out a common premise to these models:

the examination of experience through deliberation resulting in learning, which guides future actions. In terms of purposes and applications, reflective practice has been described as having different roles. More directly, reflective practice may be viewed as a way to link theory and practice, generate theory about practice, better understand the conditions under which practitioners work, develop professional knowledge and expertise, and improve actions in professional practice (Bolton, 2005; Greenwood, 1998; Honor Society of Nursing, 2005; Johns & Freshwater, 2005; Kinsella, Caty, Ng, & Jenkins, 2012).

The origin of reflective practice lies in the seminal work of Donald Schön who was influenced by the earlier work of reflective theorists such as philosopher John Dewey (1933). Dewey (1933) defined reflection as "active, persistent, and careful consideration of any belief or supposed form of knowledge in light of the grounds that support it and further conclusions to which it tends" (p. 9). Schön (1983) introduced the 'reflective practitioner' as an individual who uses reflection to revisit experience in order to learn from it, and to frame the "messy and confusing problems" (Schön, 1987, p.3) found in professional practice (Kinsella, 2007; Schön, 1987). In his writings, Schön (1983; 1987) has explored the different sources of professional knowledge and inquired about the kind of 'knowing' with which competent practitioners engage. He describes reflective practice as a form of inquiry by which practitioners make connections between general knowledge and particular cases when faced with problematic situations (Schön, 1987). Essentially, Schön's (1983; 1987) theory of reflective practice draws attention to what practitioners learn through *reflection on* experience in the context of unique and complex professional practices and consequently, considers how knowledge relevant for practice is generated from this experience.

Schön posits that technical rationality (i.e. the application of scientific theory and technique to the instrumental problems of practice) is important for professional practice, but suggests that it has been overemphasized (Kinsella, 2007; 2010). He contends further that there is a complementary and different kind of knowledge embedded in competent professional practice. In Schön's view, there is an epistemology of practice<sup>1</sup> that is displayed "in the artistic, intuitive processes which some practitioners do bring to situations of uncertainty, instability, uniqueness, and value conflict" encountered in practice (Schön, 1983, p.49). In other words, when S-LPs reflect on "what to do" in such situations, they draw from a broad repertoire of knowledge built from experience that can lead to successful outcomes. Thus, reflective practice is

the process of surfacing, examining, testing, and refining the kind of practical knowledge that may yield effective professional interventions and learning (Argyris & Schön, 1992; Schön, 1983).

### Relevance of Reflective Practice for S-LP

Clearly many variables contribute to becoming an effective S-LP practitioner. Most S-LPs would agree that these include such things as a sound theoretical and scientific knowledge base across multiple disciplines and areas of study, as well as good technical skills. Moreover, no one would refute that being an effective practitioner also requires the capacity to successfully manage complex contextual situations that arise in practice and to exhibit the requisite interpersonal skills that will occur as part of therapeutic practice. Therefore, we propose that reflective practice is important for S-LPs, and for the S-LP profession, because it offers opportunities for enhancing effectiveness in professional practice. We contend that reflective practice has the potential to directly influence S-LP practice in at least five ways. The areas of practice that are influenced by reflection include the practitioner's ability to: generate knowledge from practice, balance and contextualize science with patient care, integrate theory and practice, link evidence-based practice and clinical expertise, and cultivate ethically guided practice. Each of these critical areas will be addressed in the sections to follow.

### Generating Knowledge from Practice

Reflective practice draws attention to the ways in which knowledge is generated through reflection on practice experience. For example, reflection on clinical situations, relationships, or organizational issues encountered in the workplace are potential sources of professional learning that become integrated into a practitioner's repertoire of knowledge, or 'practice-based evidence' (Gabbay & le May, 2011). Schön (1983, 1987) contends that the practitioner's everyday performance depends to a significant extent on knowledge derived from reflection on informal experiences in workplace. He posits an "epistemology of practice" in which professional knowledge is developed from the practitioner's process of "making sense of their professional experience" (Richardson, Higgs, & Abrandt Dahlgren, 2004, p.8). Further, one's epistemology is "revealed in the pragmatic competencies reflected in practitioner action" (Kinsella, 2007, p.105).

A number of scholars contend that professional knowledge gained through reflection on professional practice experience remains underutilized in the contemporary health care system (Beecham, 2004;

Gabbay & le May, 2011; Higgs, Titchen, & Neville, 2001; Kinsella, 2010). For instance, Gabbay and le May (2011) have called for greater attention to the ways in which practice-based knowledge is generated and how it ultimately contributes to professional practice. Others have suggested that it is important to make the tacit knowledge that informs professional practice explicit (Higgs, Richardson, & Dahlgren, 2004; Higgs & Titchen, 2001) and to contribute to disciplinary knowledge bases by sharing such knowledge in collective forms (Kinsella & Whiteford, 2009). In S-LP, such discussions are only beginning to occur. Beecham (2004) has directly suggested that it is urgent for S-LP as a profession to "understand what we do in practice; and that this needs to be theorized" (p.133). She argues that this is important because "without understanding, as a profession, what it is that we do, and why we do it, we will be subject to the enthusiasms and counter-enthusiasm of groups of therapists/academics owning different understandings of practice" (Beecham, 2004, p.133). In addition, the knowledge generated through reflection on practice is information that is important to explicitly share with students and less experienced practitioners; doing so serves as a potential contributor to effective decision-making in practice and supports the extension of students' knowledge (Dollaghan, 2007; Titchen & Ersser, 2001; van der Gaag & Anderson, 2005). Finally, attending to the significance of and making explicit the various forms of professional knowledge that inform clinical decision-making is important for interprofessional collaboration in that it enables communication amongst team members relative to the rationale for pursuing actions to meet the client's needs (van der Gaag & Anderson, 2005).

In sum, reflective practice has the potential to contribute to not only the individual practitioner's repertoire of knowledge relevant to practice, but to the profession. Indeed, if information gleaned from reflection is made explicit and considered collectively, it has the capacity to generate disciplinary knowledge that can continually serve the profession of S-LP. The knowledge generated through practice is also suggested to be of importance to efforts toward interprofessional collaboration in the context of clinical service provision.

### Balancing and Contextualizing Science with Patient Care

In writing about the crisis of care in the helping profession, Swaby-Ellis (1994), a paediatrician, writes that: "[b]alancing the responsibilities of effectiveness, efficiency, and empathy will never be an easy task" (p. 94). In the same vein, Beecham (2005) and, more recently, Roulstone (2011) remind us that the S-LP profession faces diverse challenges

from dual commitments of being a scientifically-based profession, as well as a helping one. As outlined in Speech-Language and Audiology Canada (SAC, formerly CASLPA) Code of Ethics (2005), S-LPs strive for high standards by providing professional services and information that are supported through current scientific and professional research. They also hold in esteem the values of caring and respect in their daily professional practice (SAC, 2005); thus, S-LPs place importance upon building a positive helping relationship within the clinical encounter (Beecham, 2004). Given the dual commitments as a 'scientist' profession and a 'helping' profession, balancing sound discipline-specific knowledge with the capacity to manage the contextual and interpersonal aspects of clinical service provision is required for effective day-to-day S-LP practice (Hinckley, 2010). Nonetheless, coursework in S-LP has not always reflected both commitments. Historically, the focus on discipline-specific knowledge about normal and disordered speech, language, voice, swallowing, and communication processes has resulted in little information being shared about the special characteristics and processes of working with individuals with communication disorders and their families (Shahmoon-Shanok & Geller, 2009). Within the discipline-specific education of S-LPs, knowledge that is more relational, reflective, and experiential in nature has typically not been directly addressed (Beecham, 2004; Cruice, 2005; McAllister, 2005; Shahmoon-Shanok & Geller, 2009). According to Beecham (2004) an emphasis on rules and the application of procedures derived from discipline-specific knowledge can result in a narrowed and somewhat circular gaze by the practitioner on the nature of a person's communication disorder. This gaze may not permit the practitioner to appreciate and balance the helping relationship formed between a practitioner and client and the measurable symptoms of communicative breakdowns exhibited by this client—both of which underlie the S-LP clinical encounter (Beecham, 2004; 2005).

Several authors, such as Taylor (2008), have begun to emphasize that a caring and empathetic practitioner responds effectively to the interpersonal needs of their clients and his/her family. Reflective practice and the learning that occurs through reflective processes have the potential to allow practitioners to attend to such affective and relational dimensions that frequently occur in clinical encounters and to develop a repertoire of appropriate ways to respond to challenging interpersonal situations. In the midst of delicate interpersonal interactions, such as in a context of cross-cultural communication or discussing the clinical diagnosis, the interpersonal knowledge base derived from reflection on the therapeutic relationship

can contribute to the artfulness of selecting appropriate attitudes, tone, and words. Taylor (2008) suggests that such ways of responding can reduce practitioner and patient anxiety, allow for the sharing of critical information, and support clients in feeling that they are both cared for and respected as individuals. Indeed, reflective practice encourages practitioners to continually learn through reflection on their relational encounters in practice. This would include those related to affective, emotional, and inter-subjective domains of one's practice, as well as those of more traditional domains such as speech, language, and general communication processes. In this way reflective practice may contribute to a more humanistic and flexible approach to care, and in doing so, assist practitioners to engage in a reflective dialogue with the patient and his/her family members to foster improved communication.

In sum, effective S-LP practice can potentially be strengthened by blending several types of knowledge. Bringing together scientific knowledge with knowledge derived from reflection on the care of the client, mitigates the risk of practitioners applying an approach that does not fit the unique needs of clients. This issue is of current relevance as the S-LP profession gives more attention to the 'clinician effects' such as their ability to create therapeutic alliances with clients (e.g., Bernstein Ratner, 2005; Manning, 2010), and to person-centeredness in determining outcomes of intervention (e.g., DiLollo & Favreau, 2010; O'Halloran, Hersh, Laplante-Lévesque, & Worrall, 2010). Reflective practice offers the practitioner the potential to consider the unique relational, contextual, and emotional needs of the client and family while simultaneously seeking to balance and contextualize these concerns with the scientific approaches to practice.

### Integrating Theory and Practice

Supervisees and supervisors alike often perceive a lack of coherence between the theoretical knowledge they learn as part of their professional education and what is expected from them in practice (Carozza, 2011). This has classically been described as the *theory-practice gap* (Allmark, 1995). This gap has been widely documented and referred to, most notably in the nursing professional education literature (e.g., de Swardt, du Toit, & Botha, 2012; Gallagher, 2004; Hatlevik, 2012; Rafferty, Allcock, & Lathlean, 1996). In S-LP, Ferguson (2007) has identified the theory-practice gap as one of the most prevalent challenges for professional education. The transfer of theoretical knowledge to a workplace setting is not a straightforward undertaking, in part because of differences in context, cultures, and modes of learning (Eraut, 1994), and in another, because of the different forms



of knowledge required for professional practice (Higgs et al., 2001). This gap is also confounded by the reality that no two patients are the same and that the most advanced clinical service requires the ability to adapt, adjust, and seize emergent therapeutic opportunities when they occur.

An underlying assumption of the theory-practice gap is that theory<sup>2</sup> can transfer into practice in a straightforward manner. More directly, this underlying premise assumes that the language of abstract theoretical knowledge articulates precisely with that of clinical experience (Gallagher, 2004; Rafferty et al., 1996). Such a view, however, underestimates the dynamic and contextually-bound nature of practice situations. While effective practice needs to be informed by formal theory, the complex and ever changing nature of practice also necessitates the development and understanding of other kinds of theories relevant for professional practice (Eraut, 1994; Higgs et al., 2001; Kinsella, 2007). For instance, through reflective practice, practitioners develop theories of action (Argyris & Schön, 1992), or private theories (Eraut, 1994), those derived from lived experience that can then inform professional practice.

Argyris and Schön (1992) have suggested that professional effectiveness involves practitioner theories of action, which are comprised of what they refer to as *theories-in-use* and *espoused theories*. They contend that the theories-in-use which practitioners use in everyday practice are revealed in practitioners' actions and behaviours- for the most part, these are tacit and unconscious. Espoused theories, on the other hand, are more explicit and represent what practitioners' say about what they believe about practice; they represent the conscious theories that practitioners hold.

Both theories-in-use and espoused theories may be seen to correspond with what Eraut (1994) has referred to as "private theories" (p.59). Eraut (1994) contrasts "private theories", or "ideas in people's minds which they use to interpret or explain experience" (p.59), with "publicly available theories" or "systems of ideas published in books, discussed in class, and accompanied by a critical literature which expands, interprets, and challenges their meaning and their validity." (p.59). According to Eraut (1994), putting public theories into use involves an interpretive effort that gives them a contextual and specific meaning; that is, it involves a process of theorizing on the part of the practitioner. This process of theorizing involves the practitioner reviewing, through reflection, his or her private theories in a dialectical manner with publicly available theories (Eraut, 1994). From this perspective, the reflective practitioner is viewed as a theorist of his/her own practice

and individual decision-making is a reality of practice based on experience and knowledge. But, when other levels of consideration and discussion through social reflection specific to decision making are possible, it will likely enhance future practice and the practitioner's private theories. This collective point of view further posits reflective practice as an important vehicle through which publicly available theories are mediated through practitioner's private theories to shape action in professional practice.

Along similar lines, Hartlevik (2012) noted that reflective skills act as a mediator between one's practical skills and theoretical knowledge, thus, contributing to practitioners' perception of coherence between the two. Similarly, de Swardt et al. (2012) noted that guided reflection appeared to assist in clarifying theoretical and practical experiences and subsequently facilitated understanding of the connection between the two. In other words, new clinical learning derived from guided reflection becomes assimilated into one's repertoire of active knowledge. The supervision process in S-LP offers many opportunities for engaging in such reflective learning.<sup>3</sup> In sum, by serving as a mediating vehicle between abstract theory and the particulars of unique clinical situations, reflective practice has the potential to facilitate integration between both the theoretical and practical components of clinical experiences and ultimately contributes to the development of professional expertise (Benner, Tanner, & Chesla, 2009; Dreyfus & Dreyfus, 1986a).

### Linking Evidence-Based Practice and Clinical Expertise

For over two decades, the evidence-based practice movement has devoted considerable effort to making research evidence accessible, available, and transferrable to clinical practitioners. Recently, a greater emphasis has been placed on the need to integrate practitioners' clinical expertise with research evidence (Graham et al., 2006; Greenhalgh & Wieringa, 2011). In S-LP, Roulstone (2011) has argued that research evidence and expertise are both required for evidence-based practice to occur. Reflective practice is essential in the development of expertise (Benner, 2001) and, therefore, may have direct implications for S-LPs in fostering the judicious use of research evidence.

Originating from a group of physicians and medical educators at McMaster University, the evidence-based practice movement arose from the need for physicians to easily access evidence for clinical decisions while caring for patients (Evidence-Based Medicine Working Group, 1992; Sackett & Rosenberg, 1995). Evidence-based health care was originally defined by its proponents as "the conscientious, explicit, and judicious use of current best

external evidence [i.e., from systematic research/clinically relevant research] in making decisions about the care of individual patients" (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p.71). A systematic approach to evidence-based care was articulated along the following lines: (1) transform information need into a question, (2) search relevant information, (3) critically appraise the information found, (4) apply the findings of the search, and (5) evaluate and assess the outcomes (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). A later description of evidence-based care integrated the best external evidence together with individual clinical expertise and consideration of patients' preferences and values (Guyatt, Meade, Jaeschke, Cook, & Haynes, 2000; Sackett et al., 2000).

In practice however, this new description notwithstanding, the emphasis in "evidence-based" approaches remains primarily on scientific research evidence that focuses on levels of evidence, research literacy, and the critical appraisal of scientific literature. Yet as Sackett, one of the originators of the term points out, "even excellent external evidence may be inapplicable to or inappropriate for an individual patient" (Sackett et al., 2000, p.72). In the context of S-LP, a primary focus on external evidence without *reflection in and on practice* might be seen to entail risks. In this vein, Dollaghan (2007) contends that the emphasis on scientific or external evidence has overshadowed the consideration of clinical expertise. Sackett et al. (1996) have cautioned that "neither alone is enough" (p.72). Without current best evidence "practice risks becoming rapidly out of date", and without clinical expertise "practice risks becoming tyrannized by external research evidence" (Sackett et al., 1996, p.72). A lack of balance between evidence and reflection on clinical experience (which informs clinical expertise) has the potential to result in ineffective and inappropriate care for patients.

Sackett et al. (1996) state that "[e]xternal clinical evidence can inform, but never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into clinical decisions" (p.72). This point is consistent with the rigour versus relevance dilemma which Schön (1983) notes practitioners face in their everyday work lives. Should practitioners rigorously apply external evidence in practice, even when it appears not to be working, or should they be concerned with relevant and useful actions in context, by reflecting on the situation in order to respond in creative and relevant ways? Despite the emphasis by Sackett et al. (1996), Dollaghan (2007) and others (e.g., Benner, 2001; Schön,

1987) on incorporating clinical expertise into evidence-based decision-making, this dimension of the evidence-based care movement has received little attention in the literature to date in S-LP.

In terms of discussions relating to clinical expertise, both Benner (2001) and Schön (1987) point out that practitioners require a capacity for reflection in order to develop their clinical expertise. Through such reflective effort, clinicians enhance their ability to respond in relevant ways in the midst of complex professional practices. The capacity to engage in reflection can contribute to S-LPs' professional expertise, inform their capacities to integrate external evidence into practice and respond to the complexities of practice and the needs of the clients. As a consequence of these actions, reflection may then serve to assist practitioners in negotiating the indeterminate zones of practice for which no clear trajectory of evidence-based outcomes exist (Dreyfus & Dreyfus, 1986b; Mamede, Schmidt, & Penaforte, 2008; Moulton, Regehr, Mylopoulos, & MacRae, 2007; Schön, 1987).

### Cultivating Ethical Practice

Reflective practice also has a role to play in the cultivation of ethical practice in S-LP. Ethical practice has been defined as 'conscious consideration' of daily activities that enable practitioners to identify the values that lead to their decisions and further actions (Chabon & Morris, 2005). Ethical questions and opportunities for reflection about them occur in S-LP practice on an everyday basis (Chabon & Morris, 2005; Stewart, 2007). Therapists often reflect on questions such as: "What should I do?", "What is the right thing to do?", "Is this fair?". Unfortunately, choosing the 'right thing' or the 'fair thing' to do is not always easily achievable. Ethical codes of conduct, such as SAC's (2005), can provide guidance to help solve ethical issues, though such codes cannot and do not provide specific guidance for those 'grey' or complex ethical issues that occur in everyday practice (Eadie & Charland, 2005). Eadie and Charland (2005) state that "ethical decisions require consideration of a number of factors" and that "speech-language pathologists must not only follow their professional codes of ethics, but they must look beyond the rules and regulations and identify ethical elements within daily practice" (p.27). Ethical situations in clinical practice are complex and involve many layers that the process of reflection can presumably help to unveil.

According to Chabon and Morris (2005) and Stewart (2007), an ethically guided practice consists of one in which consideration is given to the values at stake in decision-

making and professional judgment (Chabon & Morris, 2005; Stewart, 2007). Reflection has been depicted as a means for the practitioner to become aware of distortions and errors in assumptions, and to uncover the values, interests, and normative standards that underpin them (Brookfield, 1990; 1995; Kinsella, 2001). Confronting unsettling situations that provoke discomfort in practice are recognized as an opportunity for reflection and ethical exploration (Chabon & Morris, 2005; Kinsella, Park, Appiagyei, Chang, & Chow, 2008; Nisker, 2004). Thus, reflection may be seen as being essential to the cultivation of ethically guided practice (Chabon & Morris, 2005; Stewart, 2007). In contrast, missed opportunities to reflect on these dimensions may result in decreased awareness of practitioner values and assumptions and how these will shape practice. This failure can also lead to misreading of ethical issues or miscalculations in ethical judgments and may then prevent practitioners from adequately thinking about and justifying their decisions and actions (Chabon & Morris, 2005). Reflection is, therefore, a critical action that has the potential to inform competent practice and permit ethical decisions to be made within each given clinical encounter.

In summary, the cultivation of an ethically guided practice requires a reflective approach which involves, but is not limited to, the ability to examine one's personal values and beliefs and assess how they impact one's actions in the workplace (van der Gaag & Mowles, 2005). Further, reflection provides an intrinsic resource for the practitioner to develop their capacity to understand particular contexts and relationships and the ethical issues that may arise from them (Eadie & Charland, 2005). Consequently, a reflective approach not only offers the potential for practitioners to identify the values that guide their decisions in practice, but also to inform their capacity for ethical reasoning and decision-making in everyday S-LP practice (Chabon, Morris, & Lemoncello, 2011; Kenny, Lincoln, & Balandin, 2007; 2010).

### Conclusion

Reflective practice is a theory that attends to the centrality of practitioner experience in the generation of knowledge that is directly relevant to his or her practice. Although reflective practice has become recognized as an essential dimension in the development of professional expertise, and while research on it is beginning to emerge in other health care professions, it has yet to be integrated into the literature in any meaningful way in the field of S-LP. In this paper we have argued for the relevance and importance of reflective practice to contemporary S-LP practice. Today's S-LP workplace is a rapidly changing one, thus, necessitating the ability of practitioners to learn

new skills quickly. In this complex environment, ethical challenges also abound. Reflective practice offers a rich opportunity for learning in professional practice, as well as for developing knowledge that is essential to achieve effective and ethical practice in such a complex environment. In other words, reflective practice is critical to ensuring that the S-LP profession remains responsive to contemporary societal needs so as to ultimately achieve the best outcomes for the people it serves. In particular, it was argued that reflective practice has the potential to generate professional knowledge, balance and contextualize science with patient care, facilitate the integration of theory and practice, link evidence-based practice with expertise, and to cultivate ethical practice. Although further research is warranted, it is clear that reflective practice provide a rich framework that has the potential to advance professional practice and education in S-LP in a number of ways with benefits to not only the practitioner, but also to those whom the profession serves.

### End notes

<sup>1</sup>*Epistemology* is a term referring to how knowledge is constituted and which encompasses philosophical questioning about the origin, nature, and validity of knowledge (Finlay & Ballinger, 2006; Titchen & Ersser, 2001). Schön's *epistemology of practice* is a conception of knowledge that takes full account of the tacit knowledge or "knowing-in-action" making up the competence that practitioners sometimes display in complex clinical situations (Schön, 1995). In other words, this is critical knowledge that might not be captured in research results formulated in textbooks or published papers (Schön, 1995).

<sup>2</sup>For the purpose of this article, 'theory' refers to 'theoretical knowledge' which can be found in textbooks and which is typically taught through formal education activities.

<sup>3</sup>More details on how to facilitate reflection and the development of reflective skills in the context of supervision and clinical education can be found in the writings of Baird and Winter (2005), McAllister and Lincoln (2004), and Schaub-de Jong (2012), among others.



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