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COMMENT

Professionalism in the context of providing elective services: reflecting on bias

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ABSTRACT

We examine the provision of elective pronunciation services, such as intelligibility enhancement, to non-native speakers by speech language pathologists (SLPs). Practices associated with the 'modification' of non-native accent raise significant professionalism questions about bias for SLPs and healthcare professionals. These questions arise partly due to the socio-cultural context in which SLPs practice and their clients live, and the relational nature of communication. We argue that due to the ambiguity inherent in accent modification practices, SLPs must weigh a variety of considerations before determining the circumstances in which such services are professionally acceptable. Our argument is rooted in consideration of the complex nature of professionalism related to communication. After surveying potentially relevant models from other healthcare professions and finding them wanting, we support our position in light of current literature on topics such as accounts of functionality. We conclude by generalizing our anti-bias recommendations to interprofessional healthcare professionalism.

KEYWORDS

Speech language pathology; professional ethics; professionalism; implicit bias

Speech-language pathologists (SLPs) are healthcare professionals who specialize in diagnosing and treating speech, language, and swallowing disorders across the lifespan. In the United States, these clinicians are regulated by the American Speech-Language-Hearing Association (ASHA) and its Code of Ethics [1]. Many SLPs also work in educational settings, and some offer elective services such as preventive vocal hygiene, gender-affirming communication, and 'accent/dialect modification' [2]. Not all certified SLPs are specifically trained or qualified to perform every role in their scope of practice, however, and it falls to the individual practitioner to seek extra-curricular education for practice areas in which they know or believe they need additional preparation. The SLP may find it personally, professionally, and financially beneficial to offer elective services, given their relevant knowledge of anatomy, physiology, cognition, language, and phonetics. Of the elective services mentioned in ASHA's Scope of Practice [2], however, 'accent/dialect modification' services elicit the most scrutiny from both within and outside of the profession. In this opinion, we offer a few ethical and professionalism-based arguments related to providing pronunciation services to non-native speakers (NNS),[1] and propose questions for SLPs to reflect on when considering offering such services. We also hope to motivate non-SLPs in healthcare to reflect on their own interactions with NNS and how they can improve communicative success with both colleagues and patients or clients.

Should SLPs provide elective pronunciation services?

The increasing globalization of healthcare workers and patient populations poses a challenge to successful patient-clinician (and clinician-clinician) communication in interprofessional settings. Foreign accent and dialect have been linked with shorter consultation times [5], lower quality of care [6], perceptions of lower clinical competency [7], and less trust for the clinician with a foreign accent [8]. The potential need for clarity of pronunciation is sizable.

SLPs are educated in most of the areas in which the ideal provider of pronunciation services would specialize. Even without specialized training in foreign or regional accents, they understand typical and disordered articulation, voice, fluency, and language. They have studied developmental and acquired aspects of communication, including the social determinants of health. One of their most basic functions is to assess speech and language; another is to modify the speech and language behaviors of individuals with communication disorders. SLPs are taught to listen to speech and to transcribe it phonetically (i.e. as it sounds as opposed to how it is spelled). They are also trained to create behavioral

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objectives tailored to the needs of their patients, clients, or students and to take data to demonstrate treatment outcomes.

One powerful argument for SLPs to provide these services is that requests come from clients in need of the very kind of assistance and support that SLPs are trained to offer. In light of the altruistic concerns built into the ASHA Code of Ethics [1] and the profession's self-conception of its dignity, as articulated in the same code, SLPs may feel professionally obligated to offer such services. In fact, one description of an SLP's actions in providing treatment is that in aiding clients to communicate better, they might also be aiding them in navigating unjust structures that exist in the world. However, there are at least two challenges to this positive reading of such services: first, SLPs have to reconcile how they conceptualize 'treatment,' given the nonpathological nature of accents and, second, a justification for a one-way response to a two-way communicative burden is needed.

Accents are not pathological

We say a person has an accent 'to mark difference from some unstated norm of non-accent, as though only some foreign few have accents' [9]. Everyone has an accent, regardless of what language they speak, when they learned to speak it, or who they are speaking to. It should go without saying that a foreign accent is not an indicator of pathology, but the continued use of terms such as 'accent reduction,' 'accent remediation,' 'accent elimination' – and even 'accent modification' – suggests a disproportionate focus on regulating and homogenizing a single 'standard' of English. Grover et al. [10] addressed the issue of undue pathologizing of accent differences specifically in a scoping review examining the evolution of terminology and research on accent services. They argued that terms such as 'reduction, elimination' and 'remediation' signify a view of accents as needing to be managed or improved, as one might view a communication impairment. Although they reported some satisfaction with the increasing use of 'intelligibility enhancement,' as it reflects an understanding that accents are not communication disorders, the authors ultimately rejected it as it

> … fails to convey that an accented speaker is fully intelligible in their L1 (if not English) and also intelligible in their accented English or World English to speakers who share their linguistic or cultural background or who have been previously exposed to their accent. [10,p.645]

They proposed the term 'accent expansion,' which is meant to illuminate the value of these services for those who seek them without suggesting a need to modify, reduce, or eliminate an established pattern of speaking or functional communication [10].

Some have taken a stronger stance against pronunciation services altogether. Yu and colleagues [11] pointed out that the so-called 'accented speaker' is a perceptual construct that arises only in relationship to listeners and their judgments. Their argument is that accent services are generally directed at speakers of varieties of English stigmatized by class and race. Even the use of 'accent expansion' sustains the practice of expecting minoritized speakers to 'keep expanding while more privileged others can simply be themselves' [11]. We prefer the term *intelligibility enhancement* (IE), which we use in the remainder of this opinion, as it focuses on the goal of improving intelligibility; justly recognizing that improvement of intelligibility might affect both native and NN speakers, as well as highlighting the two-way nature of communication.

Provision of IE services by SLPs is controversial even among individuals who agree that NNS should have access to pronunciation services [12]. SLPs are trained to situate communication disorders within a medical model; that is, the framework for 'diagnosis' and 'treatment' of a disorder. It is not appropriate to refer to pronunciation instruction as 'therapy' or 'treatment.' A clinician whose job title contains 'pathologist' may unwittingly send a message that their services are directed at treating pathology, reinforcing the impression that foreign accent is a negative trait to their clients (i.e. not patients). At the very least, IE should be framed as educational, and referred to as 'instruction' or 'training.'

Mutuality: communication is a two-way street

Successful communication is a collaborative effort, but the burden is not always equally shared by speaker and listener. Communication breakdowns can occur because of disruptions in the speech signal (e.g. disordered or different speech), receiver (e.g. impaired hearing) or environment (e.g. noise; [13]). Equally importantly, however, they may emerge from failure to correctly predict a communication partner's viewpoint and adapt to it constructively and in a manner consistent with communicative goals [14]. Motivated listeners who encounter difficulty understanding a speaker will consciously or unconsciously expend more effort into doing so (e.g. [15]). This communicative empathy or *mutuality* is essential for successful communication [16]. If a listening partner is unwilling or unable to extend the effort required to understand a speaker, they may give up altogether (e.g. [17,18]). There are numerous reasons that a listening partner might suspend a conversation with an individual who is hard to understand, some of which have nothing to do with the speaker (i.e. hearing

impairment, environmental noise, inattention, or lack of interest).

Thus, NNS may be perfectly intelligible to some listeners and not to others who are unwilling to put in the effort to understand them. In a perfect world, we could train every potential listener to avoid their own biases and to listen with intention, to recognize that hearing an unfamiliar accent should not cause them to 'shut their ears.' Ultimately, however, we are pragmatists. In this world, we know that bias against speakers with unfamiliar accents is prevalent and harmful to NNS [19].[2] For example, consider the potential embarrassment of a NNS assigned an interpreter when they have every reason to believe they speak adequate English.

SLPs who provide intelligibility enhancement services need to reflect on their own biases

Reflective practice involves continuing, intentional, and critical consideration of one's clinical experiences. Clinicians who engage in reflective practice are able to identify areas in which they need further education and training; they also necessarily interrogate their own beliefs, values and attitudes as they relate to the professional context in which they practice [20]. The degree to which SLPs engage in reflective practice is unclear, but the ASHA Code of Ethics requires that clinicians evaluate the effectiveness of their services and a commitment to lifelong learning in the profession [1,21]. For many clinicians, this means reviewing clinical data to ensure patients or clients are making progress and attending workshops to earn CEUs. We believe it is incumbent on SLPs to periodically examine their implicit biases as well, particularly when providing elective services for which no pathology has been identified. Because of their obligations to patients and clients, and the ASHA code's account of the SLP profession as dignified, SLPs need to consider how their individual, particular practices might reflect on the profession.

There are no firm guidelines for SLPs wishing to provide pronunciation services apart from ASHA's requirement to 'engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience' [1]. Few graduate programs in speech-language pathology offer coursework or experiences in pronunciation for NNS, but there are numerous continuing education opportunities for SLPs who wish to provide them. Despite this, 44% of respondents in a survey of SLPs providing pronunciation services indicated that they wished they had more training in teaching pronunciation [12]. Many of the respondents also had questionable ideas about accents in general and appropriate goals for pronunciation serves in particular (e.g. 33% believed that 'Errors in pronunciation result from not having speech muscles that are properly toned for English sounds,' [12]; p.255).

Further, in the US, 'American English' is the standard to which accent is taught, but we are not completely clear about what that is. That dialectal differences among native speakers of American English allow a listener to guess whether they are from the northeast or south or Midwest is suggestive. Is it professionally appropriate to teach to the dialect of the local population, of the hyperlocalized group or groups of which a client is a part, to some general 'standard' of American English, or to something else?

One response to this question is that NNSs should determine whether they need or want to receive IE. However, what might an SLP's obligations be if they become aware that such requests are motivated by responses to unjust structures (e.g. to a communicative environment in which mutuality is not respected)? Consider, for example, cases of employers requiring pronunciation training for NNSs. If NNSs seek such training because they are required to, ethical considerations are raised relative to the power dynamics in play in employment spaces and within workforces, especially if the requested linguistic skills are not part of the employee's job description. Such an example places SLPs in a challenging position for both ethical and practical reasons. First, it raises the question of whether SLPs are assisting clients in navigating an unjust structural landscape (in line with their profession and their code of ethics) or reinforcing those structures by implicitly affirming a one-way response to a communicative breakdown, thus denying mutuality (and violating the altruistic nature of their profession). Second, bracketing the ethical issues, it raises practical questions about whether a given request for services is a proper request; that is, is the client seeking services a fit candidate for such services? These questions are concerning for SLPs on professionalism grounds, for at least two reasons. First, in this employment scenario, the client is requesting services in light of an employer's potentially unqualified assessment. Additionally, and, if true, more insidiously, this case indicates a desire for conformity or assimilation on the part of the employer. Requiring IE from a NNS reinforces any stigma attached to the accent of origin. Second, something as time-consuming and effortful as refining pronunciation in a second language requires a real desire for change on the part of the client. Even if the services were to be paid for by the client's employer, this motivation may be absent, given that the request is external to the client.

This reflection leads us to underline the need to evaluate our own biases. We affirm claims made in the SLP and health professions literature, but also dating back to treatments of broadly human concerns

in the work of philosophers such as Aristotle: as humans, we all have biases, of which we are not often aware [22]. It is the responsibility of any professional to reflect on their existing and potential biases. We can recognize and, in many cases, easily reject explicit bias, but implicit biases may lead to decisions and behaviors that negatively affect a particular SLP's clients or (considering the dignity of the profession and the potential reinforcement of unjust structures) the clients of SLPs generally. Thus, clinicians considering providing intelligibility enhancement to NNSs must ask themselves if they unknowingly act on their implicit biases against other languages or dialects in making this decision or in how they provide the service. What cultural and linguistic baggage might SLPs bring with them to IE services? How do they truly know when someone's pronunciation is 'correct?' What version of English should be taught? Answers to these questions do not appear to be available from professional associations – they have to be determined by SLPs themselves. An unscrupulous or simply unthoughtful clinician could do real damage to the client and to the SLP profession if they do not practice reflectively.

Recommendations for SLPs providing intelligibility enhancement services

We have provided some examples of how ethics and professionalism considerations should impact the provision of IE. SLPs must reflect on principles of justice as well as client autonomy in providing IE for NNSs. If an SLP decides to provide IE, they must think about how they can mitigate any cultural, linguistic, or ethnic biases that may assert themselves. If their rationale is rooted in client autonomy, are clients given the space to share their experience(s), so that the SLP can be present and avoid pushing a monolinguistic and ethnocentric narrative?

Further, we note that although ASHA does include 'accent modification' in its scope of practice documents for SLPs [2], there is no specific list of competencies required for an ASHA-certified SLP to provide IE. In light of this, SLPs without a solid background in phonetics, phonology, articulation and second language acquisition should not provide IE services. Certified professionals need to be confident in their abilities, but not at the risk of overestimating them. Further, we recommend that SLPs take a hard look at their knowledge of bilingualism and second language acquisition, and their skills in using appropriate resources and materials with NNS attempting to make themselves more easily understood. This may require research into current best practices.

Additionally, given that SLPs may serve as healthcare or educational providers (or both), they must reflect on which clinical 'hat' they should be wearing when considering an elective service. How does educational service delivery differ from healthcare? What outcomes are reasonable when working with a NNS on IE? To address questions such as these, we recommend that clinicians review their approach to service delivery before providing IE.

As professionals it is already incumbent upon SLPs to periodically reflect on their implicit biases. What are their initial expectations of a given client, and how do those expectations change over the course of instruction? What does the client expect of IE and is it reasonable? To what extent does a client need to be 'fluent' to benefit from IE, and who decides whether a NNS is fluent in English? To what degree should an SLP address any internalized stigma a client may reveal about their accent? Upon reflection, we recommend that SLPs take an honest look at their own behaviors and beliefs before (and during) the provision of IE services.[3]

Takeaways for clinicians providing elective services

In sum, our message to SLPs in particular, but also to clinicians more generally, is to consider their own implicit bias and how it might affect their professional practice. Unwarranted beliefs or perceptions may lead to unconsciously unprofessional behaviors, such as making assumptions about what a patient needs or prefers based on their name or appearance. Ethically- and professionally-based practice suggests additional scrutiny in elective cases, and practitioners must attend not only to requests for treatment and instruction but also to the just and unjust structures that lead to such requests.

Ethics

This opinion article did not involve human subjects and therefore did not require ethics review.

Notes

1. The term 'native speaker' has also been criticized as suggesting that intelligible English is spoken only by monolingual White individuals [3,4], but an acceptable alternative has not been suggested in this context.
2. One might object to this line of argument and suggest that modified accents can allow for similar success, as, in theory, they address the intelligibility concern we discuss. However, we do not argue that this is not an option, but rather that it is not an ethically acceptable one: this is due, generally, to the fact of mutuality in communication, and, professionally for SLPs, to their altruistic calling and their medical-scientific account of pathology.
3. One resource for doing so is the Harvard Implicit Association Test [23] available at https://implicit.harvard.edu/implicit/takeatest.html.

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Authors' contributions

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