ThinkingEthically About Professional Practice in Adapted Physical Activity

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There has been little critical exploration of the ethical issues that arise in professional practice common to adapted physical activity. We cannot avoid moral issues as we inevitably will act in ways that will negatively affect the well-being of others. We will make choices, which in our efforts to support others, may hurt by violating dignity or infringing on rights. The aim of this paper is to open a dialogue on what constitutes ethical practice in adapted physical activity. Ethical theories including principlism, virtue ethics, ethics of care, and relational ethics provide a platform for addressing questions of right and good and wrong and bad in the field of adapted physical activity. Unpacking of stories of professional practice (including sacred, secret, and cover stories) against the lived experiences of persons experiencing disability will create a knowledge landscape in adapted physical activity that is sensitive to ethical reflection.

Keywords: teacher preparation, research methodology, qualitative inquiry, professional development, philosophy of science, pedagogy

To date there has been little critical exploration of the ethical issues that arise in professional practice common to adapted physical activity. The importance of bringing an ethical lens to practice in adapted physical activity was awakened when the first author assumed the role of Executive Director of The Steadward Centre for Personal & Physical Achievement. The mission of the Steadward Centre is to advance knowledge, provide applied learning opportunities for students, and offer adapted physical activity, fitness, and sport programs for kids, teens, and adults with impairments.1 As the scope of the role became clear over time, discomfort with professional practices observed and policies implemented at the Centre increased. One hundred and fifty people were on a waiting list to join the Centre and begin exercising. People were observed waiting for long periods of time in the hallway.
for the adult transportation buses to arrive. Waiting also occurred at the bottom of the ramp into the building until someone took notice and offered assistance to traverse a difficult ramp system. A great deal of time was spent waiting—waiting that was imposed by the range of program offerings, policy, and the built environment. Increasing moral discomfort resulted in an awakening to the taken-for-granted reality of waiting at The Steadward Centre.

Reflection on the observed taken-for-granted professional practices and many discussions held within a graduate level course in adapted physical activity precipitated the writing of this paper. We were motivated in part by our need to acknowledge the paucity of ethical writing in our field while also recognizing our positions within university settings to create an ethical agenda for professional practice in adapted physical activity. The aim of this paper is to open a dialogue on “What constitutes ethical practice” in adapted physical activity (Goodwin, 2008, p. 181). Noddings (1984) suggests there are four means of nurturing the ethical ideal—dialogue, modeling, practice and confirmation. This commentary focuses on dialogue as a means to begin thinking ethically about the vast subject matter in adapted physical activity. The paper opens by highlighting the need for ethical thinking, followed by descriptions of four ethical theories that may be useful tools for framing ethical thinking in our field. Finally, the ethical theories will be linked to two broad themes in adapted physical activity practice—disability as subject and reflective instruction.

Why Be Concerned About Ethics in Adapted Physical Activity?

For the purposes of this paper, professional practice is being defined as “a coherent, socially organized activity with notions of good practice within the practitioners’ understanding and skillful comportment. A practice has shared understandings about goals, skills, and equipment and is continually being worked out in new contexts” (Benner, 1997, p. 50). The call to ethical thinking in adapted physical activity practice is not new. More than a decade ago, Reid (2000) called for the careful study of ethics:

There are few scholarly philosophical papers in adapted physical activity and even fewer adapted physical activity specialists educated in philosophical inquiry. This is troublesome since adapted physical activity is often based on ideological, rather than exclusive empiricism. . . . A careful study of ethics will assist adapted physical activity to critically evaluate accepted rules and practice. (p. 370)

DePauw (2009) further reinforced the need for educational programs that embrace a culture of personal integrity. She highlighted the important role of universities in understanding ethical dilemmas that might contribute to professional misbehavior and our social responsibility to bring “attention to professional ethics” (DePauw, 2009, p. 54). As educators, one or our greatest obligations may be that of nurturing ethical ideals of those we mentor (Noddings, 1984).
Although a call to action in the preparation of ethically responsible leaders in adapted physical activity has been made, we appear reluctant to devote energy to thinking and writing about ethical issues. We cannot avoid moral issues as we inevitably will act in ways that will negatively affect the well-being of others; it is unavoidable. We will make choices, which in our efforts to support others, may hurt by violating dignity or infringing on rights (Hinman, 2008).

Standal and Hemmestad (2010) were among the first to apply ethical theory to the roles of leaderships, specifically those of instructor and coach. They used the Aristotelian notion of phronesis (i.e., practical wisdom or formative knowing) to understand the activities of coaching as more than a focus on technical process of applied nature science but rather a context-dependent and ethically charged judgment-based endeavor. Standal (2008) also looked to ethical theory to critique a call for evidence-based practice (EBP) in adapted physical activity. He cautioned that EBP emphasizes the hegemony of traditional science and its medicalization of disability. He further questioned the disavowing of practical wisdom of professionals to guide physical activity interventions.

Thinking Ethically

Ethical thinking occurs all the time and is widely construed to underscore the structure of our engagements with others as we think about what to do, what to think, and how to react (Cote & Levine, 2002). The study of ethics occurs when we identify the need to make ethical issues explicit and articulate and defend our views (Bennett, 2010). Ethical practice then refers to “the use of ethical theory and methods of analysis to examine moral problems, practices, and policies in several areas, including professional and public policy” (Beauchamp & Childress, 2001, p. 4). In thinking deeply about ethics in adapted physical activity, it seems logical to look to disability ethics as a starting place. Disability ethics, however, is often aligned with “big issue” dilemmas such as euthanasia, sterilization, or genetic screening (Shakespeare, 2006). Hanford (1993) cautioned that a “big issue approach to ethics ignores the real ethical issues which are inherent in the daily indignities” (p. 979).

The connections across adapted physical activity, disability, and ethics are complex, as they are woven with ideological intentions of normalization, inclusion, advocacy, and care (Clapton, 2003). Although a detailed description of the ethical theories that could potentially guide our ethical thinking and actions is beyond the scope of this paper, we will highlight several theories that may provide tools for thinking ethically about professional practice in adapted physical activity.

Principlism. Many of the pedagogical practices promoted in our undergraduate adapted physical activity programs are taken for granted as being ethical due to their compliance with one or more of the four principles associated with bioethics, including nonmaleficence, beneficence, autonomy, and justice. These four principles were developed in the 1970s as a comprehensive starting point for normative standards of conduct in biomedical contexts (Beauchamp, 1995). Although never presented as a comprehensive ethical theory, the four principles were later adopted by other health professions (Beauchamp, 1994; Beauchamp & Childress, 2001) as well as law, social and behavioral sciences, politics and economics (Pellegrino, 2000).
Nonmaleficence refers to doing no harm and protecting others from harm. Beneficence expresses the obligation to help others and further interests of importance to them by providing benefits and balancing the benefits against risks. It involves doing “good” by promoting another’s welfare, acting in another’s best interests, and acting to balance benefits against risks. Respect for autonomy reflects the western liberal tradition of individual freedom and the right of people to make independent and informed decisions about their own lives in their own best interests. Autonomy is associated with not only choosing freely but also accepting responsibility for one’s choices. The principle of justice supposes that all persons are of equal moral worth and are to be treated with fairness in the distribution of benefits and risks (Beauchamp, 1994).

The normative and objective standards of what came to be termed “principlism” provide “moral compass points” in differentiating right from wrong (Pellegrino, 2000, p. 661). Rules of practice can be formulated from the four principles including not only the ideas of medical benefit but also truthfulness, confidentiality, fidelity, and privacy, which are then interpreted within specific contexts to further develop their meaning, limits, and implications (Beauchamp, 1994). The ethical question of a normative standards approach could be phrased in terms of duty, “What is the good and right thing for me to do?”

Principles that provide normative frameworks have also been criticized for being distant from the everyday ethical issues that practitioners and policymakers face, focusing rather on high-profile medical cases (Austin 2007). A principle-approach ethics has also been criticized for being little more than a checklist that once applied becomes a recipe book for all situations, neglecting interpersonal relationships (Clouser & Gert, 1990). Beauchamp (1995) argues, however, that judicious decisions require the proficient use of individual judgment based on personal characteristic such as integrity and personal responsibility.

Goodwin (2008) explored the ethical implications of the goal of functional independence for persons with impairments and its impact on recreational pursuits. She pondered whether autonomy, a central principle of bioethics, overlooks the socially rich context of interdependence. As we also value friendship, family, and intimate relationships that are defined by their very interdependent nature, a deeper level of knowing is required to guide our thinking about independence as attainable and desirable (Cardol, De Jong, & Ward, 2002; Macklin, 1998).

**Virtue ethics.** As moral professionals and researchers, those working in the field of adapted physical activity advance opportunities for persons with impairment to engage fully in society. According to the school of virtue ethics “good people will make good decisions” and ethical behavior is what good or virtuous people practice (Oberle & Raffin Bouchal, 2009, p. 11). Virtue ethics suggests that actions are right when they stem from good character, or the disposition to be just, benevolent, or courageous in situations where someone is in need of help. Our motivation to help is the desire for others to lead good or proper lives. Proponents of virtue ethics suggest that the complexities of life defy the formulation of or adherence to externally imposed principles (Bennett, 2010). Within this ethical framework, the accumulation and synthesis of experiences, maturity, practical wisdom, and the influence of exemplars guide action (Begley, 2006). Rules are therefore, not part of virtue ethics; rather, it is about the virtuous agent and personal

Although being kind is a well entrenched virtue, it is only virtuous if benefits received by the person being kind are also enjoyed by the person being helped. When helping behavior is offered through genuine kindness, it is for the advantage of the other and therefore altruistic (virtuous). When the consequence of the help has a negative outcome for the person (e.g., denies independence), or if the help is to the benefit of oneself only (I’m a good person because I helped someone less fortunate without ascertaining if the help was desired), helping behavior is no longer virtuous and its ethical merit falls into question. Therefore, virtue ethics focuses on moral traditions that may become corrupted if not debated and reconceptualized so as to foster authentic relationships between service providers and those in our service (Begley, 2006; Clegg, 2000). Goodwin and Watkinson (2000) found in their study of the experiences of children with mobility impairments in physical education that undesired interference from classmates restricted their participation and caused them to question their perceived competence. In a further study, Goodwin (2001) reported that peer interactions within a physical education context could be supportive if it was instrumental in its outcome, caring in its intent, and consensual. Help from peers could, however, also be threatening if it decreased perceptions of independence by others and decreased self-esteem. The professional practice of utilizing peer support for children with impairments or the more structured implementation of peer tutor program, when viewed through a virtue ethics lens, illuminates the good or right along with the less visible bad or wrong implications of its use. Benner (1997) suggests that focusing on inner character; in this case, that of the helper can create an ego-centric self-involvement that inhibits a person from a respectful meeting of the other.

A further critique of virtue ethics lies with its emphasis on one’s character and the kind of person one ought to be—both of which are culturally and socially embedded. For this reason, virtue ethics has been criticized for being too be vague with little ability to guide actions across cultural communities (Begley, 2006; Holland, 2011).

**Ethics of care.** Many adapted physical activity professionals would see themselves as connected to others and emotionally responsive to their well-being (Oberle & Raffin Bouchal, 2009). “A care ethic is relational and focuses on meeting the other with respect characterized by recognition, support for growth or self-acceptance, and/or allowing the other to be” (Benner, 1997, p. 48.). The ethics of care, often associated with nursing, emerged as a feminist alternative to the male dominated principle-based biomedical ethics (Gilligan, 1982). There are two conditions of caring: engrossment or giving full attention to the person who is the recipient of the care, and displacement whereby the carer waives personal motivations to the act of caring. Care ethics has much in common with virtue ethics, including a focus on phronesis or practical judgment that is learned by practice. A point of departure is a shift in care ethics from inner character (virtues) to relational qualities such as attunement when responding to a particular context. A good practitioner is attuned to the context and skillful in intervening in ways that are responsive to a person’s interests and needs. Further, care ethics portray caring and interdependence as the ultimate goal of practitioner development over that of autonomy (Allmark, 1995). The
care ethics approach is also situation based and intertwined with emotion and cognition. Emotion is more than “noise” that troubles our cognitive processing; it creates the possibility for responding to others through caring practice (Benner, 1997). An ethics of care asks, “How am I to meet the other morally?” (Noddings, 1984, p. 4).

Like virtue ethics, critics of ethics of care point out its unidirectional nature that can valorize professionals as caregivers (i.e., caring is always good), creating conflict in the need to protect and the desire for others to experience independence and self-determination (Austin, Bergum, & Dossetor, 2003; Hoagland, 1990). Ethics of care assumes that caring is good whereas the moral goodness of caring lies outside of the act of care itself and the outcome of care from the perspective of the recipient. Caring about the right things and care in the right way with sensitivity and skill is required of ethical caring (Allmark, 1995).

Relational ethics. Relational ethics places high regard on building relationships and contextually informing our actions (Benner, 2004; Bergum & Dossetor, 2005). Within a relational ethics framework, the traditional understanding of autonomy, or being free from interference, is reconceptualized to reflect the deeply interdependent existence of humans. A focus on individual autonomy is broadened to include social relationships and the power structures that give genuine opportunities for choice and the goal of achieving meaningful self-direction within the overall context of interdependence (MacDonald, 2002). Ethical moments, or the opportunities to build relationships and nurture ethical understanding become possible when people connect with one another and create a relational space of trust and become authentically receptive to the interface of the everyday existence of shared physical and social worlds (Austin et al., 2003; Marcellus, 2005). “The themes of mutual respect, engaged interaction, embodiment and creating an environment where freedom and choice are found . . . [are] necessary for a relational ethic to flourish” (Marcellus, 2005, p. 415).

Respect for self as well as others encompass the theme of mutual respect. Personal responsiveness, true presence, and empathy are required for authentic connections and engaged interactions with others. Embodiment acknowledges the interconnectedness of the feeling body and the thinking mind. Knowledge and compassion are of equal status with feeling and emotion in the embodiment of relational knowing. The theme of environment ties the relational space of the individuals to a network of relationships to community services and beyond. Taken together, through the four themes of relational ethics (i.e., mutual respect, engaged interaction, embodiment, and creating an environment characterized by freedom and choice), people come to an understanding of their obligations and responsibilities to others and themselves (Shaw, 2011) as they ask the question, “What should I do now?” (Bergum & Dossetor, 2005, p. 59).

From a relational ethics framework, the environment in which our professional practice occurs should encourage relational engagement with others and support the raising of ethical questions. Ethical failures within relational ethics then do not fall to the decision making of an individual who did not have a clear objective view of good or right. Rather, an individual’s ethical positioning is connected to the relationships held within her or his professional community. For this reason, relational ethics has been criticized for its potential to lead to responses that are too relativistic and lack impartiality (Austin et al., 2003).
In summary, ethical theory provides the conceptual space to pursue the plurality and diversity of different theoretical perspectives. Consideration of multiple perspectives for multiple situations can bring depth of interpretive possibilities (Sherwin, 1999; Wright & Brajtman, 2011). Each of the ethical approaches presented, for example, could be debated on the extent to which they reflect (a) autonomy and interdependence, (b) universality and particularistic context, and (c) reason and emotion (Paley, 2002). Not all approaches are equally helpful under all circumstances (Benner, 1997) nor is one approach necessarily more appropriate than another. Rather, the ethical approaches can be viewed as complementary to each other rather than contradictory.

The intent of this commentary is not to challenge the degree to which practice in adapted physical activity is ethically responsible but rather to bring fruitful discussions to bear on thinking ethically about professional practice in adapted physical activity. We would be remiss in bracketing our ethical thinking to professional practice alone. The second half of this commentary will highlight ethical sensitivities in two areas relevant to student preparation (preservice education) as well as postservice professional practice. The two areas are disability as subject and reflective instruction.

**Disability as Subject**

The subject of adapted physical activity can be perceived as twofold. The subject on one hand is the purveyor of services, or the expert who engages in professional practice in service to those with disability. The subject on the other hand is an individual or group of individuals with impairment. Persons with impairments are seldom deemed experts in disability, even though they may experience disability as an outcome of the action or lack of action of those in professional practice. Those from within the disability community desire and arguably deserve equal status as experts of disability (Bredahl, 2007; Wendell, 1996).

**Purveyors of Service**

There has been a tendency to consider the expert in the area of disability to be the professional (Carlson, 2010). Adapted physical activity has been criticized for privileging the expert and in doing so further promote expertism (Shogan, 1998). Skrtic (1995) argued that the process of professionalization creates individuals who, on the basis of knowledge that they assume to be objective, share the belief that they are acting in the best interests of clients. “Professional disability parasites” has been used to describe those who acquire text book qualifications that lead to careers based out of the needs given perceptions of what is normative (Davis, 2004, p. 204). Shakespeare (2006) does not dismiss the need for specialist expertise and interventions in the lives of many people with impairments as those who devote their life’s work to disability may have insights that are important so the development of advocacy groups. Several key activities of professional practice neglected in adapted physical activity are the personal ethical work of deconstruction, criticism, and reflexivity, all of which will help to undermine the ideology of expertism (Skrtic, 1995).
The Steadward Centre, albeit a not-for-profit society with governance representation of current and past patrons of the Centre, could be viewed as complicit within the promotion of expertism and the creation of “disability business” (Albrecht, 1992). Through their professional practice, degreed adapted physical activity specialists hold paid positions to shape the experiences of people with impairments seeking to lead physically active lifestyles. The industry of disability fueled by physicians, health care professionals, and community service providers, including The Steadward Centre, are at risk for becoming self-righteous in carrying out their own missions and acceptance of government funding without addressing their true responsiveness to the needs of the communities on whose behalf they claim to advocate. The changes that occurred following the ethical thinking about the taken-for-granted culture of waiting in The Steadward Centre required a look at the degree to which virtue ethics was guiding its activities. To the credit of the team at The Steadward Centre, the culture of waiting was decreased by the implementation of new group programs that increased the number of people accommodated, a transition program that increased access to community-based fitness programs was initiated, a direct telephone line to the disability transportation system was installed so people could phone to inquire about their pick-ups, and a call button was mounted at the bottom of the ramp so that a call to request assistance to ascend the ramp could be made. Looking back, the “ethical work” required of everyday professional practice in the areas of empathy, entitlement, and equity was evolving at The Steadward Centre (Austin, 2007; Jespersen & McNamee, 2008).

Reflection on professional practices through a relational ethic lens brought a new level of understanding of the pervasiveness of some taken-for-granted practices. Reflexive thought resulted in a new level of responsiveness by the staff of the Centre to the needs of the communities it serves.

**Experiencing Disability**

Jespersen and McNamee (2008) recently asked, “… precisely how do we conceive ability and disability?” in the field of adapted physical activity (p. 92). Disability as subject of our professional practice is a value-laden and contested construct to the degree to which experts have medicalized impairment (person with disability). The social model of disability, first introduced through the UK disability movement of the 1980s, redefined disability as oppression resulting from prejudice, stereotyping, and discrimination and became known as the social constructionist model of disability (disabled person; Shakespeare, 2006). In North America, a social approach to disability was also taken up but was framed by a minority-group approach that recognized that disability was situated along a continuum rather than reflective of a dichotomy (Shakespeare, 2006). “Impairment is not tragic or pathological, but neither is it irrelevant, or ‘just another difference’” (Shakespeare 2006, p. 62). In American and Canadian accounts “disabled people” and “people with disabilities” are used interchangeably, in recognition that disability is both a biological condition and a social construct (Barnes, 1999).

The various perspectives on disability (biological, social model, minority model) raises interesting perspectives on who the expert is and what role the expert plays in determining what is good and right or bad and wrong in contexts where services are needed. If we demonize the medical model because it devalues
(consciously or unconsciously) those with impairments and does not adhere to the standards that define a “healthy normal body,” are we negating the experience and impact of pain and fatigue on quality of life? Adherence to a social and political model of disability to address inequities in those labeled disabled contextualizes disability but masks meaningful differences that are important to achieving desired goals. Jespersen and McNamee and others challenge us to avoid the dichotomization of the medical and social models and address the dynamic interaction of the two models (Koch, 2001). Where a biomedical normative ethic or an ethic of care is suitable for guiding important and necessary short term medical interventions, maintaining a high quality of life that promotes choice, control over individual autonomy, and interdependence may be better guided by the ethical frameworks of relational or virtue ethics that gives privilege to the disability experience. In summary, the who of adapted physical activity, be it those experiencing disability (person with disability or disabled person) and how disability is understood/created, or the ethical comportment of the purveyor of professional practice (expert) is worthy of ethical reflection.

Reflective Instruction

Updale (2008) in her article titled “The Ethics of the Everyday: Problems the Professors Are too Posh to Ponder,” asked if the perceptions of “good practice” have replaced ethical discussion and whose responsibility is it to open the dialogue? Universities are shaped by, and have a responsibility to, the communities that founded them and by inference an obligation to engage in a shared critical consciousness of the preparation of our future professionals and researchers (DePauw, 2009). Classrooms are pedagogical spaces for discussions of historically invisible ethical issues in what has been called the “third space”—an environment in which to grapple with concepts not studied elsewhere (Anderson, 2006; Gutierrez, Rymes, & Larson, 1995). For example, the public debates regarding the eligibility of Oscar Pistorius, the South African Paralympic athlete with amputations, to run in the Beijing Olympics raised awareness of ethical issues related to justice, merit, ability, and accommodation (Edwards, 2008; van Hilvoorde, & Landeweerd, 2008). Although this was a rare and highly publicized case, it highlights the breadth and depth of ethical issues that may arise in adapted physical activity practice.

Watchful Waiting

Thinking critically about instruction “refers to the constellation of educational theories, teaching and learning practices that raise critical consciousness about progressive social conditions . . . [with] aims to reconfigure the “traditional” teacher-student relationship” (Anderson, 2006, p. 374). Hanford (1993) suggests that to determine the ethical questions before us, rather than doing as is implied in don’t just stand there, do something perhaps we should consider the merits of the opposite, don’t just do something, stand there (Hanford, 1993). Watchful waiting replaces the natural inclination to intervene and may contravene the power-over another scenario that often unfolds in professional practice settings. Stepping back
from professional practice that is based in virtuous character of the practitioner or
the desire to provide care may bring the comportment of a relational ethic forward
for consideration. In a study of recreational experiences of women living in two
group homes Rossow-Kimball and Goodwin (2009) found that staff who interpreted
their roles to be the provision of supervised care created recreational experiences
that were staff directed, supervised, structured, and lacking in connections with
friends and families. Staff who interpreted their roles to facilitate choice in recreation
created opportunities that were self-directed, supportive, flexible, and inclusive of
friends and family. The application of professional and practical knowledge in each
group home lead to vastly different recreational experiences for the women who
lived there. When the distinctions between being for (care ethics) and being with
(relational ethics) another person are made, awareness of that balance of safety,
protection, and care against autonomy, choice, and self-determination becomes
discernable (Hanford, 1993).

The Knowledge Landscape

In working alongside others in our professional practice, we come to learn about
the profession of adapted physical activity. Within this landscape, there is dynamic
interplay between professional and practical knowledge (Clandinin & Connelly,
1995). Professional knowledge is comprised of the stories and information that is
shared by other professionals as visions of what is right given theory driven views of
practice (e.g., policy makers, administrators, supervisors). The professional knowl-
edge landscape is a sacred story that tells us who to “be” and what to “do”—which
can be associated with normative ethical principles found in professional codes
of conduct. It is comprised of normative rules that guide our action. The practical
knowledge is comprised of stories created by those who work alongside and support
people with impairments. It is a place where people are generally free from scrutiny
and live stories of practice—a place of secret story (Clandinin & Connelly, 1996).

If one is aware of, or anticipates dissension between the sacred story and the
secret story, one can live and tell a cover story. Moral discomfort may arise when
the sacred story, secret story, and cover story are different, more specifically the
sacred story we are told about how to best support people (i.e., the professional
knowledge we learn under the direction of academic instructors, executive directors,
agency, and government policies) and the secret stories we live (i.e., the practices we
engaged in that, at times, bumped against the sacred story) may be disharmonious.

The professional landscape is comprised of a dynamic interaction of pro-
fessional knowledge that includes codes of conduct learned through theory and
formal educational contexts (the normative rules and ethics of duty). Practical
knowledge of what is good or right or bad and wrong (the foundation of ethical
thought) is learned through practice (phronesis) in a space that is private and inte-
grates personal virtues with relational knowing. Unpacking stories of sacredness,
stories of secrecy, and stories used for “cover” is an essential part of the ethical
work required in adapted physical activity. Making visible the stories of instructors
and practitioners can bring tensions and synergies in experiences to light. Holding
the stories up against ethical theory can assist our moral knowing and subsequent
actions regarding the goodness and badness of intent, means, and consequences
of professional action.
Updale (2008) asked, “Is there a definable point at which practical problems become ethical concerns?” (p. 34). The ethical implications of some of our own work that reflects “best practices” in adapted physical activity have reported exclusion through practices such as use of peer tutors (Goodwin, Lieberman, Leo, & Johnston, 2011), limiting choice (Morphy & Goodwin, 2012), providing help (Goodwin, 2001; Goodwin & Peers, 2011), and supervising leisure (Rossow-Kimball & Goodwin, submitted). Allan (2005) went so far as to suggest that some professional practices in teaching have resulted in “special education damage” (p. 286). We are left with the sense that in some instances, our best practices may be inflicting unintentional harm that would become apparent by using ethical frameworks to determine what good practice entails, from not only the perspective of practitioners, but also people with impairments.

Ethical understanding of “counterstories” constructed from the lived experiences of persons with impairments “may offer both alternative understandings and a more appropriate ethical platform from which to engage in crucial discussions . . . . Counterstories are real lived and relational experiences with, and of, people with disability” (Clapton, 2003, p. 540 and 545). Hearing counterstories is arguably fundamental to our understanding of professional practice in adapted physical activity. The teller (i.e., individual with impairment) and the listener (i.e., practitioner) come together to begin “undermining a dominant story, undoing it and retelling it in such a way as to invite new interpretations and conclusions” (Lindemann Nelson, 1995, p. 23). We contend that more counterstories need to be heard in adapted physical activity. The phrase, “nothing about us without us” encapsulates the call for the voices of people with impairments to be integrated into our professional agendas (Shakespeare, 1998).

Summary and Conclusion

At the beginning of this commentary, we asked what constitutes ethical practice in adapted physical activity. The importance of counterstories as told by those who experience disability along with the unpacking of stories of professional practice (including sacred, secret, and cover stories) will create a knowledge landscape in adapted physical activity that is sensitive to ethical reflection. Contemporary ethical theory including principlism, virtue ethics, ethics of care, and relational ethics may provide tools for advancing our understanding of ethical comportment in adapted physical activity. One theory is not being advocated over another. A combination of ethical theories may be needed to address the wide expressions of professional practice in adapted physical activity.

In conclusion, we argued that there are two themes in adapted physical activity that are worthy of in-depth ethical thinking, disability as subject and reflective instruction. The degree to which our practices sustain us as experts has strong ethical implications specific to our professional motivation and the degree to which we are authentically supportive of the self-identified needs of the disability community without there being negative consequences to our support. Inclusion is not always good, help can hinder, and professionals can restrict autonomy. Our taken-for-granted pedagogical actions are often assumed to be beneficial—the grand narrative that permeates our field. A relational knowing within our pedagogical spaces
may provide a balanced understanding of needs and how to meet those needs. Our pedagogical spaces are dynamic landscapes where caring, virtue, relationships, and rules are contextually understood.

End Notes

1For more information please go to http://www.steadwardcentre.ualberta.ca/
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References


