Ethics – Speech Language Pathology & Audiology

Course Information

Course Sponsor: Innovative Educational Services

Provider Approval: ASHA Approved Provider of Continuing Education. Provider Code: AAVE

Course Description

“Ethics – Speech Language Pathology & Audiology” is a web-based continuing education program that focuses on defining ethical behavior for speech and audiology professionals. Information presented includes sections on the theoretical basis for ethical decision-making, conflict of interest, confidentiality, informed consent, the ASHA Code of Ethics, legal standards of behavior, and hypothetical case scenarios.

Course Rationale

This course was developed to explain, promote, and facilitate ethical behavior among speech-language and audiology professionals.

Learner Outcomes

At the end of this course, the participants will be able to:

1. define the meaning of Ethics and explain the various theories that promote ethical behavior.
2. identify the theoretical basis for ethical decision-making
3. define the parameters of informed consent
4. identify components of effective provider-patient communication
5. differentiate between appropriate and inappropriate relationships
6. define conflict of interest and identify situations that demonstrate it
7. identify the principles of confidentiality as defined under HIPAA guidelines
8. identify and apply the principles of the ASHA Code of Ethics
9. analyze and interpret clinical situations to determine appropriate professional legal and ethical behavior.

Course Instructor: Michael Niss DPT, President, Innovative Educational Services

Instructor Conflict of Interest Disclosure - Dr. Niss receives compensation as an employee of Innovative Educational Services

Course Instructor: Niva Kilman MS, CCC-SLP, ASHA CE Administrator, Innovative Educational Services

Instructor Conflict of Interest Disclosure - Ms. Kilman receives compensation as an employee of Innovative Educational Services

Methods of Instruction – Asynchronous text-based online course

Target Audience – Speech-Language Pathologists, SLP Assts, Audiologists, Audiology Assts

Course Educational Level - This course is applicable for introductory learners.

Course Prerequisites - None

Criteria for Issuance of Continuing Education Credits - score of 70% or greater on the written post-test

Continuing Education Credits - Two (2) hours of continuing education credit

Course Price - $19.95

Refund Policy – 100% unrestricted refund upon request

Innovative Educational Services is approved by the Continuing Education Board of the American Speech-Language-Hearing Association (ASHA) to provide continuing education activities in speech-language pathology and audiology. See course information for number of ASHA CEUs, instructional level and content area. ASHA CE Provider approval does not imply endorsement of course content, specific products or clinical procedures.

This program is offered .2 CEUs (introductory level; related area).

INNOVATIVE EDUCATIONAL SERVICES

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# ethics – speech language pathology & audiology

## outline

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Ethics Overview

The word “ethics” is derived from the Greek word *ethos* (character), and from the Latin word *mores* (customs). Together, they combine to define how individuals choose to interact with one another. In philosophy, ethics defines what is good for the individual and for society and establishes the nature of duties that people owe themselves and one another. Ethics is also a field of human inquiry that examines the bases of human goals and the foundations of “right” and “wrong” human actions that further or hinder these goals.

Why Ethics are Important
Ethics are important on several levels.

- People feel better about themselves and their profession when they work in an ethical manner.
- Professions recognize that their credibility rests not only on technical competence, but also on public trust.
- At the organizational level, ethics is good business. Several studies have shown that, over the long run, ethical businesses perform better than unethical businesses.

Ethics vs. Morals
Although the terms “ethics” and “morals” are often used interchangeably, they are not identical. Morals usually refer to practices; ethics refers to the rationale that may or may not support such practices. Morals refer to actions, ethics to the reasoning behind such actions. Ethics is an examined and carefully considered structure that includes both practice and theory. Morals include ethically examined practices, but may also include practices that have not been ethically analyzed, such as social customs, emotional responses to breaches of socially accepted practices and social prejudices. Ethics is usually at a higher intellectual level, more universal, and more dispassionate than morals. Some philosophers, however, use the term “morals” to describe a publicly agreed-upon set of rules for responding to ethical problems.

Ethical Questions
Ethical questions involve 1) responsibilities to the welfare of others or to the human community; or 2) conflicts among loyalties to different persons or groups, among responsibilities associated with one’s role (e.g. as consumer or provider), or among principles. Ethical questions include (or imply) the words “ought” or “should”. 
Ethics Theories

Throughout history, mankind has attempted to determine the philosophical basis from which to define right and wrong. Here are some of the more commonly accepted theories that have been proposed.

Utilitarianism
This philosophical theory develops from the work of Jeremy Bentham and John Stewart Mill. Simply put, utilitarianism is the theory that right and wrong is determined by the consequences. The basic tool of measurement is pleasure (Bentham) or happiness (Mill). A morally correct rule is one that provides the greatest good to the greatest number of people.

Social Contract Theory
Social contract theory is attributed to Thomas Hobbes, John Locke, and from the twentieth century, John Rawls. Social contract theories believe that the moral code is created by the people who form societies. These people come together to create society for the purpose of protection and gaining other benefits of social cooperation. These persons agree to regulate and restrict their conduct to achieve this end.

Deontological or Duty Theory
Under this theory you determine if an act or rule is morally right or wrong if it meets a moral standard. The morally important thing is not consequences but the way choosers think while they make choices. One famous philosopher who developed such a theory was Immanuel Kant.

Ethical Intuitionism
Under this view an act or rule is determined to be right or wrong by appeal to the common intuition of a person. This intuition is sometimes referred to as your conscience. Anyone with a normal conscience will know that it is wrong to kill an innocent person.

Ethical Egoism
This view is based on the theory that each person should do whatever promotes their own best interests; this becomes the basis for moral choices.

Natural Law Theory
This is a moral theory which claims that just as there are physical laws of nature, there are moral laws of nature that are discoverable. This theory is largely associated with Thomas Aquinas, who advocated that each thing has its own inherent nature, i.e. characteristic ways of behavior that belong to all members of its species and are appropriate to it. This nature determines what is good or bad for that thing. In the case of human beings, the moral laws of nature stem from
our unique capacity for reason. When we act against our own reason, we are violating our nature, and therefore acting immorally.

**Virtue Ethics**
This ethics theory proposes that ethical behavior is a result of developed or inherent character traits or virtues. A person will do what is morally right because they are a virtuous person. Aristotle was a famous exponent of this view. Aristotle felt that virtue ethics was the way to attain true happiness. These are some of the commonly accepted virtues.

- **Autonomy**: the duty to maximize the individual’s right to make his or her own decisions.
- **Beneficence**: the duty to do good.
- **Confidentiality**: the duty to respect privacy of information.
- **Finality**: the duty to take action that may override the demands of law, religion, and social customs.
- **Justice**: the duty to treat all fairly, distributing the risks and benefits equally.
- **Nonmaleficence**: the duty to cause no harm.
- **Understanding/Tolerance**: the duty to understand and to accept other viewpoints if reason dictates.
- **Respect for persons**: the duty to honor others, their rights, and their responsibilities.
- **Universality**: the duty to take actions that hold for everyone, regardless of time, place, or people involved.
- **Veracity**: the duty to tell the truth.

**How to Make Right Decisions**

The foundation for making proper ethical decisions is rooted in an individual's ability to answer several fundamental questions concerning their actions.

1. **Are my actions legal?**
   Weighing the legality of one’s actions is a prudent way to begin the decision-making process. The laws of a geopolitical region are a written code of that region’s accepted rules of conduct. This code of conduct usually defines clearly which actions are considered acceptable and which actions are unacceptable. However, a legitimate argument can be made that sometimes what is legal is not always moral, and that sometimes
what is moral is not always legal. This idea is easily demonstrated by the following situation.

It is illegal for a pedestrian to cross a busy street anywhere other than at the designated crosswalk (jaywalking). A man is walking down a street and sees someone fall and injure themselves on the other side of the street. He immediately crosses the street outside of the crosswalk to attend to the injured person. Are his actions legal? Are they moral? What if by stepping into the street he causes a car to swerve and to strike another vehicle?

Admittedly, with the exception of law enforcement officers and attorneys, most people do not know all of the specific laws that govern their lives. However, it is assumed that most people are familiar with the fundamental virtues from which these laws are based, and that they will live their lives in accordance with these virtues.

2. **Are my actions ethical?**
   Professional ethical behavior as it is defined in this context relates to actions that are consistent with the normative standards established or practiced by others in the same profession. For speech and audiology professionals, these ethical standards are documented in the ASHA Code of Ethics. All SLPs, SLP assistants, audiologists, and audiology assistants, even those who are not members of ASHA, are bound to these guidelines. This is because the ASHA Code of Ethics is the accepted and de facto standard of practice throughout the profession.

3. **Are my actions fair?**
   I think most people would agree that the concept of fairness is often highly subjective. However, for these purposes, we will define fairness as meaning deserved, equitable and unbiased. Fairness requires the decision-maker to have a complete understanding of benefits and liabilities to all parties affected by the decision. Decisions that result in capricious harm or arbitrary benefit cannot be considered fair. The goal of every decision should be an outcome of relative equity that reflects insightful thought and soundness of intent.

4. **Would my actions be the same if they were transparent to others?**
   This question presents as a true reflection of the other three. Legal, ethical, and fair are defined quite differently by most people when judged in the comfort of anonymity versus when it is examined before the forum of public opinion. Most often it is the incorrect assumption that “no one will ever find out about this” that leads people to commit acts of impropriety. How would your decisions change, if prior to taking any actions, you
assumed just the opposite; “other people will definitely know what I have done”. One sure sign of a poor decision is debating the possible exposure of an action instead of examining the appropriateness of it.

Informed Consent

Patients have a fundamental right to direct what happens to their bodies, grounded in the principles of autonomy and respect for persons. In turn, health care professionals have an ethical obligation to involve patients in a process of shared decision making and to seek patients’ informed consent for treatments and procedures. Good informed consent practices, thus, are an essential component of ethics quality in health care. And that means more than getting a patient’s signature on a consent form.

The goal of the informed consent process is to ensure that patients have an opportunity to be informed participants in decisions about their health care. To achieve that goal practitioners must inform the patient (or authorized surrogate) about treatment options and alternatives, including the risks and benefits of each, providing the information that a “reasonable person” in similar circumstances would want to know in making the treatment decision. A key element of the process is that the practitioner must explain why he or she believes recommended treatments or procedures will be more beneficial than alternatives in the context of the patient’s diagnosis.

Informed consent must always be specific: to the individual patient, the clinical situation, and the recommended plan of care or recommended treatment(s) or procedure(s).

Consent for Multiple Treatments

Although consent is always specific, it is not the same as saying that separate consent is always required for every episode of repeated treatment. When the plan of care for a given diagnosis involves repeated treatments or procedures—for example, a course of diagnostic tests or ongoing therapy—practitioners do not need to obtain consent for each individual episode.

Blanket Consent

Informed consent for a planned course of multiple repeated treatments based on a specific diagnosis is very different from practices sometimes referred to as “routine” or “blanket” consent. Asking a patient to agree at the outset of care to “any treatment your doctors think is necessary,” or “routine procedures as needed,” is ethically problematic in several ways.
Such practices fail to meet the requirement that consent be specific. This is the case even when common procedures are identified. For example, asking a patient entering the ICU to consent to the use of a ventilator, performance of thoracentesis, or other common critical care interventions, “if needed.” Such individual procedures are not part of a plan of care because they are not anticipated to be clinically indicated or recommended for that individual patient at the time consent is obtained.

Moreover, seeking consent “in case” a patient should need some future intervention that is not related to that patient’s current clinical status violates the fundamental ethical norm that patients must make decisions about proposed treatments or procedures in the context of their present situation. As a “patient-centered action,” informed consent involves the contemporaneous bodily integrity, rights, dignity, intelligence, preferences, interests, goals, and welfare. If a patient’s condition changes enough to warrant a change in the plan of care, the practitioner must explain to the patient (or authorized surrogate) how the situation has changed, establish goals of care in light of the new situation, recommend a new plan of care, and obtain informed consent for the new plan or for specific treatment(s) or procedure(s) now recommended.

Notification versus Consent

Informed consent is also different from “notification,” that is, providing general information relevant to patients’ participation in health care. Notification informs patients not only about their rights, but also about organizational activities and processes that shape how care is delivered. Like informed consent, notification serves the goal of respecting patients as moral agents.

Refusing Treatment

The right to refuse unwanted treatment, even potentially life-saving treatment, is central to health care ethics. Health care professionals are understandably concerned when patients refuse recommended treatments. How should practitioners respond when a patient declines an intervention that practitioners believe is appropriate and needed? The answer to that question depends on both the patient’s decision-making capacity and the particular circumstances of the treatment decision.

Practitioners should take care not to assume that a patient who refuses recommended treatment lacks decision-making capacity. A capacity assessment is appropriate if the practitioner has reason to believe the patient might lack one or more of the components of decision-making capacity. When decision-making capacity is not in question, practitioners must respect the patient’s decision to decline an intervention, even if they believe the decision is not the best one that could have been made. However, this does not mean that health care professionals should never question the patient’s decision, or never try to
persuade the patient to accept treatment. For example, by exploring the reasons for refusal with the patient, a practitioner might learn that the patient simply needs more information before deciding to proceed.

The professional ethical ideal of shared decision making calls for active, respectful engagement with the patient or surrogate. As a prelude to exploring a patient’s refusal of recommended treatment, practitioners should clarify the patient’s (and/or surrogate’s) understanding of the clinical situation and elicit his or her expectations about the course of illness and care. Practitioners should clarify the goals of care with the patient or surrogate, address expectations for care that may be unrealistic, and work with the patient or surrogate to prioritize identified goals as the foundation for a plan of care.

Asking in a nonjudgmental way, “What leads you to this conclusion?” can then help the practitioner to understand the reasons for the patient’s decision to decline recommended treatment. It can also help to identify concerns or fears the patient may have about the specific treatment that practitioners can address. The aim should be to negotiate a plan of care that promotes agreed on goals of care.

**Resisting Treatment**

Health care professionals face different concerns when patients who lack decision-making capacity resist treatment for which their authorized surrogates have given consent. When a surrogate consents to treatment on behalf of a patient who lacks decision-making capacity, practitioners are authorized to carry out the treatment or procedure even if the patient actively resists. In such cases, treatment is not being administered over the patient’s refusal because the surrogate has taken the patient’s place in the process of shared decision making and exercised the patient’s decision-making rights. However, practitioners should still be sensitive to patients who resist treatment. They should try to understand the patient’s actions and their implications for treatment. Practitioners should ask themselves why, for example, a patient repeatedly tries to pull out a feeding tube. Is the tube causing physical discomfort? Is the patient distressed because he or she does not understand what is happening?

Resistance to treatment should prompt practitioners to reflect on whether the treatment is truly necessary in light of the established goals of care for the patient, or whether it could be modified to minimize the discomfort or distress it causes. For instance, a patient may resist treatment via one route of administration but not another.

Practitioners should also be alert to the implications of the patient’s resistance for the judgment that he or she lacks decision-making capacity. In some cases, resistance to treatment may be an expression of the patient’s authentic wishes. Decision-making capacity is not an “all or nothing” proposition. Rather, decision-
making capacity is task specific. It rests on being able to receive, evaluate, deliberate about and manipulate information, and communicate a decision, which can vary considerably with the decision to be made. A patient may have capacity to make a simple decision but not a more complex one.

When a patient resists, surrogates, family members, or friends may be able to shed light on the patient’s actions and help practitioners identify ways to provide treatment that are less upsetting for the patient. For patients with fluctuating capacity, it may be possible to explore concerns directly with the patient during lucid moments.

Patients who resist treatment present unique challenges for health care practitioners. The root cause of the resistance should be explored, as well as other clinically acceptable alternatives to the proposed treatment.

**Provider-Patient Communication**

Health care practitioners have an ethical responsibility to work with patients (or their surrogates) to negotiate treatment plans that respect the patient’s values, preferences, and goals for care. To meet that obligation, practitioners must ensure that they communicate effectively with patients and surrogates.

Communicating effectively is an important aspect of showing respect to patients. And it has practical benefits: Effective communication promotes greater satisfaction and helps ensure better adherence to treatment plans, with better health outcomes for patients. Good communication also reduces the likelihood of lawsuits even when patients don’t have good outcomes.

Yet poor communication remains a significant problem in health care. Many practitioners are not well trained in basic communication skills, such as asking open-ended questions to elicit information (“What brings you to the clinic this morning?”), reflecting patients’ comments back to them (“I hear you saying your new medication makes you sleepy”), or using other active listening techniques. And formal training rarely focuses on the communication tasks that must be completed in patient-provider encounters.

Moreover, practitioners tend to underestimate patients’ needs for information, and overestimate their own effectiveness in conveying information. Many patients aren’t comfortable disclosing that they don’t understand what practitioners are saying—asking point blank, “Do you understand?” puts them on the spot. And a nod in response doesn’t guarantee they’ve actually heard and understood what’s been said.
To make it easier for patients to understand health information, practitioners must establish conditions for effective communication. Among other things, they should provide a safe environment, in which patients feel comfortable asking questions. Practitioners should use plain language—e.g., “sore” or “wound” instead of “lesion”; “bad” instead of “adverse” reaction. And they should use the technique of “teach back,” asking the patient to recount what he or she has been told, to help gauge the level of understanding.

Practitioners can use this technique to identify patient-specific barriers to communication, for example, low health literacy, which includes more than just difficulty reading. Cognitive impairments, such as early stage dementia, and, especially, limited proficiency in English (possibly indicating the need for a medical interpreter), also contribute. There can be other barriers to effective communication as well, for example, when patients have hearing problems.

Asking patients to recount instructions or to describe a proposed procedure can alert practitioners to individuals’ particular needs and challenges and help clinicians tailor communication more effectively.

**Relationships**

Boundaries define the limits of appropriate behavior by a professional toward his or her clients. By establishing boundaries, a health care professional creates a safe space for the therapeutic relationship to occur. Health care professionals need guidance if they are to avoid engaging in interactions with their patients that may prove ethically problematic.

**Professionalism**

The notion of boundaries in the health care setting is rooted in the concept of a “profession”. While this concept is understood in several different ways in the medical and sociological literature, there is consensus regarding one of the defining characteristics of professions and professionals: commitment to serve the profession’s clients. That is, professionals are expected to make a fiduciary commitment to place their clients’ interests ahead of their own. In exchange for faithfully applying their unique knowledge and skills on behalf of their clients, members of a profession are granted the freedom to practice and to regulate themselves.

Patients who come to health care professionals when they are ill and vulnerable bring with them expectations about this interaction and how clinicians should behave toward them as health care professionals, though patients are not always able to articulate those expectations clearly. Patients should be able to trust that their interests and welfare will be placed above those of the health care
professional, just as they should be confident they will be treated with respect, and be informed so that they can make their own health care decisions to the greatest extent possible. Professionals, as such, are held to different standards of conduct from other persons. Relationships and interactions that may be ethically unproblematic among nonprofessionals may be unacceptable when one of the parties is a professional. An individual may have a personal interest that is perfectly acceptable in itself, but conflicts with an obligation the same individual has as a health care professional.

For example, under circumstances in which it would normally be acceptable for one person to ask another individual for a date, it may not be acceptable for a health care professional to ask a patient for a date, because doing so might compromise the professional’s fiduciary commitment to the patient’s welfare. The nature of professions is such that the human needs the professions address and the human relationships peculiar to them are sufficiently distinct to warrant, indeed to demand, expectations of a higher morality and a greater commitment to the good of others than in most other human activities.

**Boundaries**

Boundaries define the professional relationship as fundamentally respectful and protective of the patient and as dedicated to the patient’s well-being and best interests. A boundary violation occurs when a health care professional’s behavior goes beyond appropriate professional limits. Boundary violations generally arise when the interaction between parties blurs their roles vis-à-vis one another. This creates what is known as a “double bind situation”. That is a circumstance in which a personal interest displaces the professional’s primary commitment to the patient’s welfare in ways that harm—or appear to harm—the patient or the patient-clinician relationship, or might reasonably be expected to do so.

**Legal Aspects**

Various legal and regulatory requirements address boundaries in patient-professional interactions. Clinicians are subject to guidelines for professional conduct in health care promulgated by state licensing boards. Most state professional licensing boards have addressed specific boundary issues. For example, “engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual ... [or] behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient.”

Some state board guidelines offer specific guidance to help clinicians avoid inappropriate conduct, such as recommending that professionals restrict contact with patients to appropriate times and places for the therapy to be given. Violations of these guidelines could result in probation, limitation of practice, and suspension or revocation of licensure. Clinicians should be aware; moreover, that
inappropriate sexual or physical contact can result in patients suing clinicians for battery and malpractice, and in several states sexual exploitation of a patient is considered a felony.

**Other Problematic Relationships**

Many kinds of interaction potentially interfere with the primary clinical relationship between practitioner and patient and pose concerns about acceptable conduct for health care professionals. Becoming socially involved or entering into a business relationship with a patient, for example, can impair, or appear to impair, the professional’s objectivity. Accepting a gift is sometimes an appropriate way to allow a patient to express his or her gratitude, and at other times is problematic. Showing favoritism—by giving a particular patient extra attention, time, or priority in scheduling appointments, for example—can cross the boundary between action that is appropriate advocacy on behalf of a particular patient and action that is unfair to others.

Such interactions or activities are ethically problematic when they can reasonably be expected to affect the care received by the individual or by other patients or the practitioner’s relationships with his or her colleagues, or when they give the appearance of doing so. Yet not all behavior that might be considered inappropriate necessarily violates professional obligations.

Health care professionals should be alert to situations in which they may be likely to be motivated to behave in ways that violate accepted ethical standards. Ambiguous interactions and relationships, for example, have the potential both to impair the professional’s objectivity and compromise his or her judgment, and to give rise to conflicting expectations on the patient’s part, which can contaminate the therapeutic relationship and potentially undermine the patient’s trust.

**Recommendations**

Health care professionals should beware of interacting with any patient in ways that could reasonably be expected to create awkward situations for either party, compromise the professional’s primary commitment to patient welfare, or call the professional’s objectivity into question. While not every business or social interaction or relationship between a health care professional and a patient necessarily violates ethical professional boundaries, professionals should critically examine their own actions by considering the following:

- Is this activity a normal, expected part of practice for members of my profession? Might engaging in this activity compromise my relationship with this patient, other patients, colleagues, my employer, or with the public?
- Could this activity cause others to question my professional objectivity?
• Would I want my other patients, other professionals, or the public to know that I engage in such activities?

If the answers to these questions indicate that an activity may violate professional ethical boundaries, the health care professional should:

• Determine if there are applicable standards.
• Consult a trusted and objective peer for a second opinion about the activity.
• Seek assistance from a supervisor or ethics committee.
• Communicate his or her concern to the individual involved.
• Transfer the patient to another clinician’s care if the professional relationship has been compromised, or if avoiding the violation will damage the relationship.

As well, it is imperative that health care professionals be familiar with:

• Relevant professional codes of ethics, standards of practice, guidelines, and position statements
• Applicable policies in their facilities; and
• Laws pertaining to relationships between patients and health care professionals.

Understanding and respecting professional boundaries is part of professional competence. Maintaining those boundaries is an essential part of compassionate, effective, and ethical health care practice.

**Gifts and Conflict of Interest**

Because gifts create relationships, health care professionals’ acceptance of gifts from commercial vendors can be ethically problematic in several ways. Accepting gifts risks undermining trust. It may bias clinicians’ judgments about the relative merits of different treatments. And it may affect treatment patterns in ways that increase costs and adversely affect access to care.

Health care professionals’ fiduciary, or trust-based, relationship with patients requires that practitioners explain the reasons for treatment decisions and disclose any potential conflicts of interest, including the influence of gifts.

Given the ways in which gift giving differs from entering into a contractual relationship, gifts to health care professionals can blur the distinction between formal business exchanges and informal, interpersonal exchanges.
Industry gifts to health care professionals create potential conflicts of interest that can affect practitioners’ judgment—without their knowledge and even contrary to their intent—thereby placing professional objectivity at risk and possibly compromising patient care.

If accepting gifts is ethically problematic in these ways, why do health care professionals continue to take the gifts they are offered? One explanation is that accepting a gift is a natural, socially expected reaction motivated by a combination of self-interest and politeness. But it is also argued that health care professionals have come to expect gifts as part of a “culture of entitlement” that has evolved over many years. Gifts have become a familiar part of many health care workplace cultures and established patterns of behavior often resist change. Other rationales are that inducements such as free lunches are needed to induce attendance at educational sessions (and may help offset the costs of such programs), and that they help boost employee morale. Some even claim that accepting gifts results in economic savings for health care institutions, because the industry provides for free items that the institutions would otherwise have to buy. Finally, apathy on the part of professional bodies allows the “tradition” of accepting gifts to continue.

Failure to enforce ethical standards consistently has made it easier simply not to notice, or not to be concerned about, the fact that accepting gifts creates ethical risks. None of these arguments, however, is compelling enough to allow an ethically problematic practice to continue. While habit and self-interest can be powerful motivators, ethical standards explicitly require health care professionals to place patient interests above their own.

In recent years, many prominent organizations and associations have established ethical guidelines for health care professionals about accepting gifts from industry representatives. These guidelines do not prohibit all gifts from industry, but there is general agreement that gifts from companies to health care professionals are acceptable only when the primary purpose is the enhancement of patient care and medical knowledge. The acceptance of individual gifts, hospitality, trips, and subsidies of all types from industry by an individual is strongly discouraged. Practitioners should not accept gifts, hospitality, services, and subsidies from industry if acceptance might diminish, or appear to others to diminish, the objectivity of professional judgment.

Professional guidelines seek to establish thresholds for what kinds of gifts and gift relationships are acceptable. In general, gifts to individual practitioners are discouraged unless they are of minimal value and related to the practitioner’s work—such as pads, pens, or calendars for office use.
The social dynamics of the gift relationship, the potential for gifts subtly to bias health care professionals' prescribing practices and clinical decisions, and the obligation of health care professionals to avoid acting in ways that might undermine public trust all argue for the adoption of clear, robust policies regarding the acceptance of gifts from companies. Creating a workplace in which professionals no longer routinely expect or accept gifts from industry is a challenging task that calls for professional role modeling and sustained, coordinated efforts on the part of clinical and administrative leaders, as well as development and careful implementation of clear, well-considered policy.

**Confidentiality**

The obligation to ensure patient privacy is rooted in the ethical principle of respect for persons. Health care providers convey that respect in a few ways with regard to privacy. They respect patient’s informational privacy by limiting access to patient information to those authorized health care providers who need it to perform their duties. The obligation to ensure patient privacy is also justified by the obligation of harm prevention. Sometimes maintaining patient privacy is a way of keeping the patient safe, for example, by minimizing the risk of identity theft.

Confidentiality is mandated by HIPAA laws, specifically the Privacy Rule. The Privacy Rule protects all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

“Individually identifiable health information” is information, including demographic data, that relates to:

- the individual’s past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.

Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

Health care providers must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. They must also develop and implement policies and procedures to reasonably limit uses and disclosures.
to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

**ASHA Code of Ethics**

**Preamble**

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose.

Every individual who is (a) a member of the American Speech-Language-Hearing Association, whether certified or not, (b) a nonmember holding the Certificate of Clinical Competence from the Association, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification shall abide by this Code of Ethics.

Any violation of the spirit and purpose of this Code shall be considered unethical. Failure to specify any particular responsibility or practice in this Code of Ethics shall not be construed as denial of the existence of such responsibilities or practices.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics as they relate to the responsibility to persons served, the public, speech-language pathologists, audiologists, and speech, language, and hearing scientists, and to the conduct of research and scholarly activities.

Principles of Ethics, aspirational and inspirational in nature, form the underlying moral basis for the Code of Ethics. Individuals shall observe these principles as affirmative obligations under all conditions of professional activity. Rules of Ethics are specific statements of minimally acceptable professional conduct or of prohibitions and are applicable to all individuals.

**Principle of Ethics I**

Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.
Rules of Ethics I

1. Individuals shall provide all services competently.

2. Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided.

3. Individuals shall not discriminate in the delivery of professional services or the conduct of research and scholarly activities on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.

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

5. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, and judgment that are within the scope of their profession to assistants, technicians, support personnel, or any nonprofessionals over whom they have supervisory responsibility.

6. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services to assistants, technicians, support personnel, or any other persons only if those services are appropriately supervised, realizing that the responsibility for client welfare remains with the certified individual.

7. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession to students only if those services are appropriately supervised. The responsibility for client welfare remains with the certified individual.

8. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed, and they shall inform participants in research about the possible effects of their participation in research conducted.

9. Individuals shall evaluate the effectiveness of services rendered and of products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected.

10. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis.

11. Individuals shall not provide clinical services solely by correspondence.
12. Individuals may practice by telecommunication (e.g., telehealth/e-health), where not prohibited by law.

13. Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed, and they shall allow access to these records only when authorized or when required by law.

14. Individuals shall not reveal, without authorization, any professional or personal information about identified persons served professionally or identified participants involved in research and scholarly activities unless doing so is necessary to protect the welfare of the person or of the community or is otherwise required by law.

15. Individuals shall not charge for services not rendered, nor shall they misrepresent services rendered, products dispensed, or research and scholarly activities conducted.

16. Individuals shall enroll and include persons as participants in research or teaching demonstrations only if their participation is voluntary, without coercion, and with their informed consent.

17. Individuals whose professional services are adversely affected by substance abuse or other health-related conditions shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.

18. Individuals shall not discontinue service to those they are serving without providing reasonable notice.

Principle of Ethics II

Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.

Rules of Ethics II

1. Individuals shall engage in the provision of clinical services only when they hold the appropriate Certificate of Clinical Competence or when they are in the certification process and are supervised by an individual who holds the appropriate Certificate of Clinical Competence.

2. Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience.

3. Individuals shall engage in lifelong learning to maintain and enhance professional competence and performance.
4. Individuals shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's competence, level of education, training, and experience.

5. Individuals shall ensure that all equipment used to provide services or to conduct research and scholarly activities is in proper working order and is properly calibrated.

**Principle of Ethics III**

Individuals shall honor their responsibility to the public by promoting public understanding of the professions, by supporting the development of services designed to fulfill the unmet needs of the public, and by providing accurate information in all communications involving any aspect of the professions, including the dissemination of research findings and scholarly activities, and the promotion, marketing, and advertising of products and services.

**Rules of Ethics III**

1. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly or research contributions.

2. Individuals shall not participate in professional activities that constitute a conflict of interest.

3. Individuals shall refer those served professionally solely on the basis of the interest of those being referred and not on any personal interest, financial or otherwise.

4. Individuals shall not misrepresent research, diagnostic information, services rendered, results of services rendered, products dispensed, or the effects of products dispensed.

5. Individuals shall not defraud or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants for services rendered, research conducted, or products dispensed.

6. Individuals' statements to the public shall provide accurate information about the nature and management of communication disorders, about the professions, about professional services, about products for sale, and about research and scholarly activities.

7. Individuals' statements to the public when advertising, announcing, and marketing their professional services; reporting research results; and promoting products shall adhere to professional standards and shall not contain misrepresentations.
Principle of Ethics IV

Individuals shall honor their responsibilities to the professions and their relationships with colleagues, students, and members of other professions and disciplines.

Rules of Ethics IV

1. Individuals shall uphold the dignity and autonomy of the professions, maintain harmonious interprofessional and intraprofessional relationships, and accept the professions’ self-imposed standards.

2. Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.

3. Individuals shall not engage in dishonesty, fraud, deceit, or misrepresentation.

4. Individuals shall not engage in any form of unlawful harassment, including sexual harassment or power abuse.

5. Individuals shall not engage in any other form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally.

6. Individuals shall not engage in sexual activities with clients, students, or research participants over whom they exercise professional authority or power.

7. Individuals shall assign credit only to those who have contributed to a publication, presentation, or product. Credit shall be assigned in proportion to the contribution and only with the contributor's consent.

8. Individuals shall reference the source when using other persons' ideas, research, presentations, or products in written, oral, or any other media presentation or summary.

9. Individuals' statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.

10. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.

11. Individuals shall not discriminate in their relationships with colleagues, students, and members of other professions and disciplines on the basis of race or ethnicity, gender, gender identity/gender expression, age, religion, national origin, sexual orientation, or disability.
12. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation, nor should the Code of Ethics be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.

13. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics.

14. Individuals shall comply fully with the policies of the Board of Ethics in its consideration and adjudication of complaints of violations of the Code of Ethics.

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Ethics Case Studies

Case Study #1 - Confidentiality

John Jones, CCC-SLP, Sue Brown (receptionist), and Mary Smith (Director of Managed Care Contracting), are in a private office discussing the fact that they are treating a celebrity following a stroke. John says, “I can’t believe that I’m actually treating actress Jennifer Morrison.” Mary asks, “Do you think that she will fully recover and be able to act again?” John replies, “I’m not sure. I saw her MRI report, and it shows that she has a significant left side lesion on her brain.”

Is this a breach in confidentiality?

The information contained in each patient’s medical record must be safeguarded against disclosure or exposure to nonproprietary individuals. The right to know any medical information about another is always predicated on a sound demonstration of need. Frequently, many individuals require access to information contained in a patient’s medical record. Their right to access this information is limited to only that information which is deemed necessary for them perform their job in a safe, effective, and responsible manner.

The first questions we must ask are “What information is being disclosed and do the three individuals engaged in the conversation have a need to know this information?”

John’s first statement discloses the name of person receiving care, and his second statement reveals private patient medical information. Certainly, as the provider of speech therapy services, John would need to know the patient’s name and diagnosis in order to provide care. Sue, the receptionist, may also need this information to schedule appointments and perform other essential
clerical tasks. Mary, whose job it is to contract with managed care organizations, most likely has no compelling reason to know either the patient’s identity or any of her medical information. Therefore, the disclosure to Mary of the patient’s identity and medical information is a breach of patient confidentiality. (ASHA Code of Ethics: I-13, I-14)

Case Study #2 – Qualifications of Practice

Mary is a speech-language pathology assistant who has practiced for more than 20 years. Frequently, she is called upon to perform treatments that should be done by an SLP. The patients always give her compliments, and frequently request her to treat them. She demonstrates exceptional skills and achieves outstanding outcomes.

Is the clinic providing ethical care to its patients?

The practice of speech therapy is closely regulated throughout the United States. Each state, through legislation, establishes minimal licensure and practice standards. This is done to protect the general public against fraud and substandard care by under-qualified practitioners. It is each professional’s responsibility to adhere to the standards of care and licensure requirements specific to the state in which they practice. The licensee must also ensure that all care provided not directly by them, but under their supervision, also meets these standards.

In this situation, the assistant’s abilities and outcomes are considered irrelevant. The key sentence in the paragraph is: “perform treatments that should be done by an SLP”. The “should” in this case must not be interpreted as merely a casual suggestion but rather a legal definition regulated by the state’s Practice Act. Any treatment or procedure that should be performed by a licensed professional, must be performed only by a qualified licensed professional. (ASHA Code of Ethics: I-5, II-1, II-2, II-4)

Case Study #3 – Informed Consent

Sam is a SLP who works in a rehabilitation hospital. He has just received a referral to begin speech therapy with a 45-year-old woman who has had radical mandible reconstruction following cancer resection. He goes to her hospital room to evaluate her and begin therapy. She indicates to him that she does not want therapy today because she is in too much pain. Sam explains to her that the doctor has left orders for her to begin speech therapy. The patient refuses. Sam leaves and returns the next day to try again. Again, she declines treatment and he leaves.
Under the guidelines of informed consent, were Sam’s actions adequate?

Informed consent is the process by which a fully informed patient can participate in choices about their health care. It originates from the legal and ethical right the patient has to direct what happens to their body and from the ethical duty of the therapist to involve the patient in her health care.

The most important goal of informed consent is that the patient has an opportunity to be an informed participant in their health care decisions. It is generally accepted that complete informed consent includes a discussion of the following elements:

- the nature of the decision/procedure
- reasonable alternatives to the proposed intervention
- the relevant risks, benefits, and uncertainties related to each alternative
- the consequences on non-treatment
- the goals of treatment
- the prognosis for achieving the goals
- assessment of patient understanding
- the acceptance of the intervention by the patient

In order for the patient’s consent to be valid, they must be considered competent to make the decision at hand and their consent must be voluntary. It is easy for coercive situations to arise in medicine. Patients often feel powerless and vulnerable. Health care professionals should make clear to the patient that they are participating in a decision, not merely signing a form. With this understanding, the informed consent process should be seen as an invitation for them to participate in their health care decisions. The provider is also generally obligated to provide a recommendation and share their reasoning process with the patient. Comprehension on the part of the patient is equally as important as the information provided. Consequently, the discussion should be carried on in layperson’s terms and the patient’s understanding should be assessed along the way.

Sam’s actions in this case were not sufficient. None of the required information was offered to the patient. The most important thing he failed to explain to the patient was the consequences of non-treatment. The patient cannot make an informed decision regarding therapy without this information. It could be argued that her decision to refuse therapy may have changed had she known that one of the consequences of this decision could be the development of secondary complications. (i.e. increased risk of morbidity or mortality).

(ASHA Code of Ethics: I-8)
Case Study #4 - Medical Necessity

Steve is a speech-language pathologist who owns his own practice. He recently signed a contract with an HMO to provide speech therapy services. The contract stipulates that Steve will be compensated on a case rate basis. (A fixed amount of money per patient, based on diagnosis) Steve has performed a thorough cost analysis on this contract and has determined that the financial “break-even” point (revenue equals expenses) on each of these patients is 5 visits. He informs his staff that all patients covered by this insurance must be discharged by their fourth visit.

Is limiting care in this manner ethical?

Health care professionals are obligated to propose and provide care that is based on sound medical rationale, patient medical necessity, and treatment efficacy and efficiency. It is unethical to either alter or withhold care based on other extraneous factors without the patient’s knowledge and consent.

In this instance, the decision to limit care is not ethical. The quantity of care is not being determined by the medical necessity of the patient. A therapist must be able to justify all of their professional decisions (such as the discharging of a patient from clinical care) based on sound clinical rationale and practices. (ASHA Code of Ethics: I-8, I-18)

Case Study #5 – Conflicts of Interest

Debi Jones, Au.D., CCC-A is employed at an audiology clinic. She is meeting with a vendor whose company is introducing a new hearing aid onto the market. He offers her 3 free samples to “try out” on patients. The vendor states that if Debi continues to order more of these specific hearing aids, she will qualify to receive compensation from his company by automatically becoming a member of its National Clinical Assessment Panel.

Does this represent a conflict of interest?

Yes, there exists a conflict of interest in this situation. Debi has two primary obligations to fulfill. The first is to her patient. It is her professional duty to recommend devices to her patient that, in her judgment, will benefit them the most. The second obligation is to her employer, the clinic. As an employee of the clinic, it is her responsibility to manage expenses by thoroughly and objectively seeking effective products that also demonstrate economic efficiency. The conflict of interest occurs when she begins to accept compensation from the vendor in direct or indirect response for her orders. Even if she truly believes it is the best device for her patient, and it is the most cost effective device the clinic
could purchase, by accepting the money she has established at least an apparent conflict of interest. Under this situation she is obligated to disclose to all parties her financial interest in ordering the appliance. This disclosure is necessitated because the potential for personal gain would make others rightfully question whether her objectivity was being influenced.

A conflict of interest is a situation in which a person has a private or personal interest that influences the objective exercise of his or her professional duties. As a professional you take on certain responsibilities and obligations to patients, employers, and others. These obligations must take precedence over a therapist’s private or personal interests.

In addition to avoiding all real instances of conflict of interest, professionals must also avoid any apparent or potential conflicts as well. An apparent conflict of interest is one in which a reasonable person would think that the professional’s judgment is likely to be compromised, and a potential conflict of interest involves a situation that may develop into an actual conflict of interest.

How do you determine if you are in a conflict of interest, whether actual, apparent, or potential? The key is to determine whether the situation you are in interferes or is likely to interfere with your independent judgment. A good test is the ‘trust test’: Would relevant others (my employer, my patients, professional colleagues, or the general public) trust my judgment if they knew I was in this situation. Trust is at the ethical heart or core of this issue. Conflicts of interest involve the abuse, actual or potential, of the trust people have placed in professionals. This is why conflicts of interest not only injure particular patients and employers, but they also damage the whole profession by reducing the trust people generally have in audiology professionals.

(ASHA Code of Ethics: III-2, III-3, IV-10)

Case Study #6 – Relationships with Referral Sources

Larry Jones, CCC-SLP owns a private practice. Business has been poor. He decides to sublease half of his space to a maxillofacial surgeon. Larry’s current lease is at $20/sq ft. The doctor wants to pay $15/sq ft. They come to a compromise of $17/sq ft. Larry also agrees that if the doctor is his top referral source after 3 months, he’ll make him the Medical Director of the facility and pay him a salary of $500/month.

Is this an ethical arrangement?

No, this agreement is not ethical. The most notable infraction involves offering to designate (and compensate) the physician as the Medical Director contingent upon the number of referrals he sends. This is undeniably a direct offer of cash...
for patients. Another area of concern is the rent. At first glance, the rent amount of $17/sq ft seems fair because it was a compromise between the two parties. However, closer scrutiny reveals this to be unethical. The fair market value for rent has been established as $20/sqft. (Larry’s current rental agreement with his landlord). By discounting the doctor $3/sq ft on his rent, Larry is giving a referral source something of value.

It is unethical to offer anything of value to physicians or any other referral source in direct response for the referral of patients or services. This includes cash, rebates, gifts, discounts, reduced rent, services, equipment, employees, or marketing. Many mistakenly believe that it is a normal acceptable business practice to offer these things to referral sources. It is not. In most states, the practice is not only unethical, but it is also illegal. Exchanges of valued items or services between health care professionals and referral sources must never have any relationship to the referral of patients. Goodwill gifts of nominal value are acceptable provided that no correlation can be made between the magnitude or frequency of the gift giving and referral patterns. All business agreements and transactions should always be well documented and most importantly, reflect fair market value.

(ASHA Code of Ethics: IV-1)
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Ethics – Speech Language Pathology & Audiology

Post-Test

1. Which statement regarding ethics theories is INCORRECT?
   A. Utilitarianism is the theory that right and wrong is determined by consequence.
   B. Social Contract Theory proposes that moral code is created by the people who form societies.
   C. Ethical Egoism is based on the theory that each person should do whatever promotes their own best interests.
   D. Natural Law Theory proposes that ethical behavior is a result of inherent character traits.

2. Which of the following statements is TRUE?
   A. All actions that are legal are also morally right.
   B. All actions that are morally right are also legal.
   C. Speech / Audiology ethics vary state by state.
   D. The ASHA Code of Ethics establishes ethical behavior for all speech and audiology professionals; including those who are not members of ASHA.

3. Which of the following statements regarding informed consent is FALSE?
   A. Informed consent must always be specific to the individual patient.
   B. Blanket consent should be obtained from the patient if the care plan includes multiple treatments.
   C. Notification informs patients of their rights and how care is delivered.
   D. Patients have a right to refuse treatment; even those that could save their life.

4. Speech and audiology professionals can communicate more effectively with their patients by __________________________.
   A. asking primarily closed-end questions to elicit information
   B. reflecting patient’s comments back to them
   C. practicing passive listening techniques
   D. utilizing the teach forward method

5. A circumstance in which a personal interest displaces the professional’s primary commitment to the patient’s welfare is known as __________.
   A. fiduciary displacement
   B. blind egoism
   C. a double bind situation
   D. boundary neglect
6. Gifts from companies to health care professionals are acceptable only when
___________.
   A. the primary purpose is the enhancement of patient care and medical knowledge
   B. each professional in the field receives the same gift without regard to previous product usage
   C. the company is introducing a new product or service to the market.
   D. permission is received from the professional’s employer

7. Information relating to _____ is individually identifiable health information that is covered under the Privacy Rule of HIPAA
   A. an individual's past, present or future physical or mental health or condition
   B. the provision of health care to the individual
   C. the past, present, or future payment for the provision of health care to the individual
   D. All of the above

8. Which of the following is NOT included in the ASHA Code of Ethics?
   A. Individuals shall not discriminate in the delivery of professional services based on gender identity/gender expression.
   B. Individuals shall provide services or dispense products only when benefit to the patient can be guaranteed.
   C. Individuals shall engage in lifelong learning to maintain and enhance professional competence and performance.
   D. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.

9. A speech-language or audiology professional who has reason to believe that the Code of Ethics has been violated by a colleague shall __________.
   A. inform the ASHA Board of Ethics
   B. give the colleague the benefit of the doubt, and continue to monitor the situation.
   C. immediately report the colleague to the local police
   D. write an anonymous letter to the state licensing board

10. It is unethical for a speech-language professional to ________________.
    A. have a physician as a medical director
    B. sublease office space to a potential referral source
    C. waive the insurance co-pay for the spouse of a referring physician
    D. meet with a physician to educate them about new speech therapy techniques and interventions