COVID-19: Ethical Considerations for Audiologists and Speech-Language Pathologists

The COVID-19 pandemic is dramatically changing our daily practices. While ASHA cannot provide legal advice, we can provide some general guidance on navigating this public health crisis under the ASHA Code of Ethics (2016) (hereinafter, “the Code”).

Please remember that the facts and circumstances faced by each audiologist or speech language pathologist are different—as are the applicable state laws, practice settings, and workplace policies. Moreover, guidance about the COVID-19 pandemic is being constantly updated and refined. Therefore, it is critical that you take the below information as providing general ethics guidance only. Our goal is to flag at least some of the ethical issues you should consider as you navigate the COVID-19 pandemic.

Below we share questions raised by your peers and general ethics guidance provided by ASHA.

Plan for providing uninterrupted services.

I’m an audiologist at an outpatient/inpatient hospital clinic. Am I at risk of client abandonment if I refuse to treat patients to minimize my exposure to the virus that causes COVID-19?

Audiologists and speech-language pathologists are ethically obliged not to abandon a client. However, this obligation isn’t absolute. ASHA’s Issues in Ethics statement on client abandonment states, “no clinician is ever ethically required to work . . . in physical danger in order to offer client care.”

Guidance from the Centers for Disease Control and Prevention (CDC) recommends that employees who fall into the following three categories may be temporarily excluded from “direct patient care responsibilities for suspected and known positive COVID-19 patients:” pregnant women (and women who are breastfeeding), immunocompromised employees, and employees 65 years and older. If you fall into one of the three “temporarily excluded” employee categories, there is a strong basis to assert the hospital is putting you in “physical danger” by asking you to provide direct care to suspected and known positive COVID-19 patients. Therefore, you not treating clients under those circumstances likely wouldn’t be considered client abandonment by the Board of Ethics. (Code Principle I, Rule T) (Your hospital might still direct you to perform patient care responsibilities for other patients and/or alternative duties.)

You do still need to make reasonable efforts to continue uninterrupted care for your patients. If that isn’t feasible, work with your employer to ensure an appropriate transition for your patients. (Principle I, Rule B) Talk with your employer about transitioning to telepractice to continue working with your patients (if allowed in your state, if logistically feasible, if appropriate to the services you provide, and if reimbursable by the patient’s insurers). Should you assign home exercises or online programs to bridge the gap during a hiatus of in-person appointments? If not, work with your employer to find other clinic colleagues—who are not pregnant, immunocompromised, or over 65 years old—to provide your patients similar services, if possible.
Legal considerations are also involved in attempting to minimize health and safety risks in the workplace. For example, the Occupational Safety and Health Administration’s (OSHA) guidance on COVID-19 states, “existing OSHA standards may apply to protecting workers from exposure to and infection with” the virus. The guidance refers to the “General Duty Clause” of the Occupational Safety and Health Act, which imposes employer obligations to protect employees from “recognized hazards” in the workplace. Your state’s occupational safety and health law might also apply in this case.

**Ensure you have consent to deliver services using technology.**

Under the Code, Principle I, Rule H states, “Individuals shall obtain informed consent from the persons they serve about the nature and possible risks and effects of services provided.” Clients/patients might already have signed permission waivers. Check to make sure they cover providing services remotely. If they don’t, you need to get permission from your clients/patients or their families. Remember, informed consent must be voluntary. Generally, such permission should be in writing, but some families might not have computers and/or scanning technology (or access to them) to deliver signed written documents during the COVID-19 crisis. Check with your state licensing board to see whether any restrictions exist on the form of acceptable informed consent or waivers and, if yes, if the state board has modified those limitations under current circumstances. Alternatives states may allow including permission granted via written email or text or perhaps even voice mail, so long as you can save it in its original format, transcribe it (if appropriate), and print/copy it for files.

**Protect the health and safety of yourself and your clients/patients.**

*My home health agency is requiring me to continue in-home services after I reported I might have been exposed to someone with COVID-19. They are threatening to fire me if I refuse to provide services.*

Under the Code, individual practitioners have the ethical responsibility, “to hold paramount the welfare of the persons they serve professionally.” (Principle I) Under CDC guidance, you may have to self-quarantine for 14 days. The CDC listed “older adults” and “people of any age who have . . . serious underlying medical conditions” as at risk of getting “very sick” during the pandemic. These populations might make up a significant portion of the clients/patients you serve. The CDC also indicates many who might be sick with COVID-19 are asymptomatic and can still spread the virus to others.

If your employer demands you continue to provide services after possibly being exposed to COVID-19, and you do so, you are putting your clients/patients at risk. Continuing to practice might also violate state or federal laws and regulations, which almost always constitutes a violation of Principle IV, Rule R. For example, some governors declared a state of emergency, requiring those with possible exposure to self-quarantine, during the COVID-19 pandemic.

Depending on the profession of your agency supervisor, the supervisor, too, might violate state law. If your agency supervisor is ASHA-certified, a violation of the state law governing professional practice would probably also constitute a Code violation under Principle IV, Rule R. In addition, under the Code, supervisors can’t “knowingly allow anyone under their supervision to engage in any practice violating the Code of Ethics.” (Principle IV, Rule I) If your supervisor is from another profession, such as nursing, and you believe them to be “compromising the welfare of patients,” then you might be ethically obligated to report them to their state licensing board and/or professional association. (Principle IV, Rule N)
Your agency might also consider some potential practical consequences of you continuing to practice. Do your employer’s insurance policies cover claims potentially arising from clients/patients and their families if services were knowingly provided to them by a potentially COVID-19-exposed employee? Is your employer prepared to deal with potential workers’ compensation claims from employees who were possibly exposed to COVID-19 at work? Some states may consider workers’ compensation claims from health care providers who’ve been exposed to COVID-19 in the workplace.

**Safeguard the privacy and confidentiality of your clients.**

*My direct supervisor has instructed all staff at our private agency to use a computer platform to provide remote speech-language services to our clients during our state’s shelter-in-place order. This platform is listed as not compliant with the Health Insurance Portability and Accountability Act (HIPAA). What should I do?*

Under the Code, individual practitioners must protect the confidentiality and privacy of their clients’/patients’ personal information and the professional services provided. *(Principle I, Rules O and P)* The exception to these rules says audiologists and SLPs “may disclose confidential information only when doing so is necessary to protect the welfare of the person or of the community, is legally authorized, or is otherwise required by law.”

During this pandemic, the U.S. Department of Health and Human Services Administration (HHS) relaxed requirements to comply with HIPAA. Specifically, HHS has announced: “[The Office of Civil Rights] will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately”

Therefore, under the Code the potential for inadvertent disclosure of confidential information by practicing remotely on a computer platform not HIPAA compliant qualifies as “legally authorized” and ethically “necessary” to protect your client and the community from potential COVID-19 infection. Bottomline, you may use non-HIPAA compliant platforms for telepractice without threat of penalty from HHS and the Board of Ethics during the COVID-19 pandemic.

Before proceeding, check with your state licensing board to make sure you follow your state’s law on telepractice.

Your employer might also want to consult third-party payers—insurance companies, Medicare—to make sure the services you’re asked to provide remotely are reimbursable.

**Exercise your independent professional judgment.**

*The special education services director is now telling me I must switch from seeing my speech students remotely one-on-one to providing group sessions during the COVID-19 period. Do I have to do this?*

Under the Code, audiologists and SLPs should “exercise their independent professional judgment . . . in providing services when an administrative mandate . . . prevents keeping the welfare of persons served paramount.” *(Principle IV, Rule B)* If your supervisor is also ASHA-certified, they are ethically obligated not to “require or permit” staff to “compromise [their] . . . independent and objective professional judgment.” *(Principle II, Rule F)*
In exercising your professional judgment, you need to consider your students’ Individualized Education Program (IEPs) and privacy concerns in the current COVID-19 landscape.

**IEPs:** The U.S. Department of Education (DOE) issued informal guidance about the delivery of special education services during the COVID-19 crisis. It states schools “must ensure that, to the greatest extent possible, each student with a disability can be provided the special education and related services identified in the student’s IEP developed under IDEA, or a plan developed under Section 504.” It further provides that “IEP teams may, but are not required to, include distance learning plans in a child’s IEP that could be triggered and implemented during a selective closure due to a COVID-19 outbreak.” See also Supplemental Fact Sheet Addressing the Risk of COVID-19 in Preschool, Elementary and Secondary Schools While Serving Children with Disabilities

In a Joint National Association of State Directors of Special Education/Council of Administrators of Special Education/Council of Chief State School Officers Webinar on COVID-19 Guidance for Students with Disabilities, the Director of the Office of Special Education Programs (OSEP) answered a question about whether IEPs need to be amended to provide remote services:

*If the move to online or virtual is part of the school closure recommendation, we are not requiring you to go back into the IEP to address it. This is going to be considered an alternate mode of instructional delivery. If you’re looking at virtual or online learning as part of the student’s daily instruction once they return to school, then the IEP team would have to take into consideration how they construct that within the IEP.*

However, the DOE has *not* provided guidance on whether IEPs need to be amended if you switch from one-on-one to group sessions.

So, if your IEPs provide for group sessions, is there a reason why you believe specific students shouldn’t be grouped together—different diagnoses, age groups, social skills—for remote sessions? If yes, might you suggest to your director grouping the students differently? If you’re opposed to providing *any* group sessions remotely, and your students’ IEPs allow for them, then you need an “independent and evidence-based clinical” reason that keeps “paramount the best interests” of your students. (Principle I, Rule M) Are one-on-one speech sessions necessary to meet particular individual speech needs?

You must not only consider IEPs (and the DOE COVID-19 guidance), but also student privacy, when providing speech services remotely.

**Privacy:** Are you concerned that by providing remote group sessions you may violate the legal privacy rights of your students under the Family Educational Rights and Privacy Act (FERPA)? If your students’ parents signed waivers or gave informed consent to receive treatment, review those documents to see whether they cover the disclosure of identifying their student to other students and to other students’ families during remote group sessions, including disclosure of student email addresses. (See above). If such permissions don’t exist, next check the DOE’s recent guidance on FERPA and COVID-19, in effect only during the pandemic.
The guidance offers a somewhat “flexible” standard in letting schools determine whether FERPA’s “health or safety emergency exception” applies. The DOE clearly states the FERPA exception “does not allow for a blanket release of PII [personally identifiable information] from student education records,” and the disclosure without permission by a school is “typically” limited to “law enforcement officials, public health officials, trained medical personnel, and parents (including parents of an eligible student).”

However, the guidance also allows for educational institutions to disclose FERPA-protected information to “certain parties” without consent under limited circumstances, which may or may not apply to your situation:

If the educational agency or institution determines that there is an articulable and significant threat to the health or safety of the student or another individual and that certain parties need the PII from education records, to protect the health or safety of the student or another individual, it may disclose that information to such parties without consent.

Check with your school supervisor about the school’s interpretation of the FERPA guidance. The DOE has provided schools a sample FERPA “consent to disclose” document, which includes allowing the disclosure of personally identifiable information to other parents and household residents during telepractice instruction. In the end, you probably either need permission, such as the DOE FERPA disclosure form, to provide group sessions remotely to eligible students allowing for disclosure to other families, or documentation from your school that authorizes you to provide remote group sessions to eligible students under the FERPA exception.

Don’t forget to consider other privacy laws, such as the Children’s’ Online Privacy Protection Rule (COPPA) and the Protection of Pupil Rights Amendment (PPRA). COPPA is a federal law that imposes privacy requirements on websites and online services directed to children under 13 years old. PPRA is another federal law that allows parents of minor students to give or deny permission for their children to participate in DOE surveys that ask personal questions, such as religious affiliation.

**Become competent in telepractice.**

*My director tells me I need to provide our services remotely to both in-state and out-of-state clients, but I’m only licensed in one state. Plus, I’m not trained to deliver telepractice services. What should I do?*

The Code allows for telepractice. The only limitation is that such telepractice can’t be delivered by written (electronic and written) correspondence only. **Principle I, Rule N** also requires ASHA-certified individuals to “provide services via telepractice consistent with professional standards and state and federal regulations.”

Check with your state licensing board to determine if telepractice is allowed and, if so, under what circumstances. Some states activated existing emergency “temporary practice provisions” to enable out-of-state practitioners to practice in a state. As noted above, federal government agencies also issued recent guidance during the COVID-19 pandemic that provides some flexibility in terms of federal laws and rules, such as Medicaid, FERPA, and HIPAA. Don’t forget, you must also comply with various insurers’ requirements to ensure reimbursement.
If your permanent or emergency state laws enable you to deliver telepractice services to individuals both in and outside your home state, next consider whether the use of telepractice is appropriate for your clients. If not, discuss with your supervisor why—in your professional judgment—telepractice won’t meet specific clients’ needs. If telepractice fits for some clients, then consider if any professional standards exist that limit engaging in telepractice.

Under the Code, individuals may only provide clinical services in which they are competent. **(Principle I, Rule A)** To become competent, you should learn how to provide services via telepractice. **Principle II, Rule D** states practitioners should “enhance and refine their professional competence and expertise” by learning new professional skills. You need to decide how to balance your employer’s demands to deliver services remotely (and quickly) with your ethical obligation to engage in telepractice competently. Might your employer let you register for telepractice training—perhaps a continuing education on-demand webinar—you can take right away? Speak to your employer about how to work together to ensure the prompt delivery of quality telepractice services to meet the needs of clients.

**Legal Disclaimer:** The information provided in this posting/handout is for informational and educational purposes only. Nothing in this document should be construed as legal advice, and your use of the legal information provided is not a substitute for legal advice. ASHA has no knowledge of the specific or unique circumstances under which such information may be used by you. Your use of this posting/handout specifically or ASHA’s website generally does not create an attorney–client relationship between you and ASHA, or between you and any of ASHA’s employees or representatives. Each state has its own laws and they can vary widely, so you should obtain advice from an attorney regarding state laws that may be relevant.