AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Professional Liability and Risk Management for the Audiology and Speech-Language Pathology Professions

Ad Hoc Committee on Professional Liability and Risk Management

Reference this material as: American Speech-Language-Hearing Association. (1994). *Professional Liability and Risk Management for the Audiology and Speech-Language Pathology Professions* [Technical Report]. Available from www.asha.org/policy.

Index terms: risk management, private practice

DOI: 10.1044/policy.TR1994-00250

About This Document

The following report was developed by the American Speech-Language-Hearing Association (ASHA) Ad Hoc Committee on Professional Liability and Risk Management and approved by the Executive Board (EB 181-93) in December 1993. Members of the committee include Elca Swigart, current chair; Marc Kramer, past chair; Charlene Zand; John Ferraro; and Evelyn Cherow, ex officio. The report was completed under the guidance of Jean Lovrinic, vice president for governmental and social policies.

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Introduction

The ASHA Ad Hoc Committee on Professional Liability and Risk Management was charged with developing a report on (a) the professional claims history of the professions and (b) risk management procedures to minimize liability exposure for speech-language pathologists and audiologists and maximize service to clients/patients, hereafter referred to as clients throughout this report.

This report is designed to increase the awareness of speech-language pathologists and audiologists concerning issues in risk management. It is not intended to serve as a standard or as a substitute for legal advice.

I. Background

An individual who causes injury to another either intentionally or unintentionally can be held liable for the action. By virtue of advanced knowledge, training, and skill, a professional has a responsibility to conform to certain standards of conduct to protect the public from unreasonable risks. A professional standard of care is traditionally established by codes of ethics, scopes of practice, preferred practice patterns of professional associations, and state licensure laws. The responsibility of licensed and/or certified professionals to conform to those standards may be referred to collectively as professional liability.

As professionals, practicing speech-language pathologists and audiologists are vulnerable to liability claims. Risk exposure may be increased if services are provided for invasive procedures, specific disorders, in certain physical settings, or for special populations. Complaints of unethical practice and unprofessional conduct for the professions in various work settings have been reported (Miller, 1983). Therefore, it is prudent for all members of the profession to develop an awareness and knowledge base about professional liability and to maintain responsible professional standards for risk management within their own scope of practice and practice setting.

Although legal claims against speech-language pathologists and audiologists and reports of unprofessional or unethical practice have been relatively few (Miller & Lubinski, 1986), their incidence may increase in the future as a result of a variety of factors:

- increase in the number of practitioners in the speech-language pathology and audiology professions;
- increase in the number of individuals who receive services;
- expanding scope of practice and responsibilities of speech-language pathologists and audiologists;

- enhanced professional autonomy within institutions or organizations and through private practice, which encompasses approximately one-third of the speech-language pathology and audiology professions;
- staff shortages and institutional policies requiring cross-training and use of support personnel and temporary employees;
- development of new technologies and diagnostic and treatment modalities, including invasive procedures;
- lack of standards of care for nontraditional sites (e.g., home care);
- media reports of "innovative treatments" that may lead to unrealistic expectations of outcome;
- high cost of medical care that may affect traditionally accepted standards of care;
- heightened public awareness of clients' rights and the potential to recover costs and damages when the injury is deemed serious; and
- increase in prosecutions of personal injury cases due to specialization of attorneys.

The two most important factors influencing a practitioner's ability to reduce exposure to liability are awareness and education. Therefore, this report gives a broad overview of the legal process as related to professional liability, summarizes data related to liability claims and sanctions for unethical conduct in the speech-language pathology and audiology professions, discusses standards of care, and suggests risk management strategies to reduce situations that may result in liability exposure. The report is designed to increase the awareness of speech-language pathologists and audiologists concerning issues in risk management. As stated earlier, this is not intended to serve as a standard or to substitute for legal advice.

II. Overview of the Legal Process and Ethical Practices

When through private practice audiologists and speech-language pathologists "establish themselves as legal entities in their own right and not mere agents, servants, or employees of another" (Muraski, 1982), they may find themselves named as defendants in legal action or as respondents to ethical complaints. They may also be drawn into lawsuits in conjunction with others, such as employees or manufacturers. Consequently, it is important that professionals be able to recognize types of situations out of which claims and lawsuits are likely to arise. For this reason, a brief discussion of the various types of liability and unprofessional or unethical practice follows.

A. Theories of Liability

1. Civil Professional Liability. When a lawsuit is filed, the theory of liability under which damages may be recovered must be set forth. When bringing an action against a health care provider, the two theories that are generally pursued are action in tort or action in contract.

a. *Action in Tort.* Professional liability (erroneously but commonly called "malpractice" by the lay public) stems primarily from actions in tort, which are private legal actions in which one person (the plaintiff seeks a remedy

(usually monetary) for damages to health, physical integrity, property, peace of mind, or reputation caused by another person (the defendant). Tort derives from two bases:

- *unintentional tort*—actions that were unintentional and during which the practitioner failed to exercise the degree of care that a professional of ordinary prudence would exercise under the same circumstances, such as negligence, misdiagnosis, incorrect or inadequate treatment, injuries from equipment or premises, or harmful effects from human subject research.
- *intentional tort*—illegal actions that were intentional and from which a reasonable person would believe that a particular result was substantially certain to follow, such as assault (an attempt to do violence to another person), battery (unauthorized physical contact), false imprisonment, or defamation of character.

  Unintentional tort of *negligence* is the most likely civil litigation to be brought against a speech-language pathologist or audiologist. In order for a cause of action of negligence to be pursued, four elements must be present:

  - A legal duty must exist between the practitioner and the plaintiff. That is, a provider/client relationship was established.
  - A breach of legal duty must exist (i.e., service was not adequately provided, an improper diagnosis was reached, there was a failure to diagnose, or a physical injury resulted from the diagnosis or treatment).
  - A proximate cause (i.e., cause and effect relationship) must exist between the breach of duty and the injury.
  - An actual loss or damage must result from the injury. Actual loss or damage includes physical, psychological or developmental damage, loss of wages or services, or additional incurred expense.

Professional liability presupposes the existence of an accepted standard of care when the practitioner possesses the degree of education, credentials, and skills ordinarily possessed by practitioners in that professional field. Although level of care need not be extraordinary, it must be reasonable and diligent and must reflect the practitioner's maintenance of current knowledge in the professional area of practice.

Negligence is committed when there is an injury to the client resulting from failure to exercise the accepted standard of care. Both statutory law (created by federal, state, or local legislative bodies acting according to constitutional power) and common law (the development of legal principles from previously decided cases) define negligence. Although common law standards for our professions are minimal, they could develop over time with increased adjudication and testimony of expert witnesses in our profession as to “acceptable standard of care” (Kooper & Sullivan, 1986). Potential areas for litigation, in addition to those cited previously under the theory of unintentional tort, include failure to refer, consult, or follow; failure to properly warn or instruct; failure to obtain informed consent; and failure to reveal alternatives.

Intentional torts that might be filed against audiology and speech-language pathology professionals include assault, battery, and violation of confidentiality. For example, failure to obtain requisite consent to perform evaluation or

therapeutic procedures may result in an allegation of battery. Unauthorized release of client information may result in a claim for damages as a result of the loss of privacy and confidentiality. In the cases of intentional or unintentional tort suits, the courts require payments from defendants only when the plaintiff can prove fault.

b. *Action in Contract.* Another form of civil litigation includes that related to representation and promises. Failure to fulfill promises and other obligations may result in litigation under contract law. Practitioners must never state or imply a guarantee of results of treatment (1993 ASHA Code of Ethics, Principle of Ethics I, Rules of Ethics F), even though they may become involved with guarantees of dispensed products.
c. *Product Liability.* As audiologists and speech-language pathologists continue to increase their role in the acquisition, distribution, and utilization of assistive and augmentative devices and diagnostic and therapeutic tools, they also increase their potential for litigation in the event of product misuse or failure. Practitioners may be party to a product liability suit if they can in any way be connected with a defective device (e.g., dispense, utilize, or prescribe).

One example of litigation in this area involved battery ingestion by a young child. Although the case centered around the failure of the hearing aid manufacturer to provide a child-proof battery compartment, the dispensing audiologist was also brought into the litigation for alleged failure to instruct the parent concerning proper care of the device. All who dispense instruments or who use them in their practice are subject to being named if there is a product failure or if the device is used incorrectly.

d. *Third Party Liability.* Additional defendants may be named in litigation if they are believed to have played a role in the matter in question. For example, if a practitioner is engaged to provide program consultation and the employer is subsequently named as a defendant, it is possible that the employer will seek to litigate the consultant, since the condition or situation for which the employer has been named occurred as a result of the consultant's recommendation.
e. *Employer Liability.* Employers are subject to vicarious responsibility (*respondeat superior*) for the acts of their employees and, in addition, are subject to corporate liability. The *respondeat superior* concept is based on the rationale that the employee is acting on behalf of the employer, that the employer exercises supervision and control over the conduct of the employee, and that the employer is frequently in a better financial position to pay damages awarded. Legal interpretations have included any licensed professional who does not adequately supervise unlicensed persons acting in the professional's behalf, and all members of an evaluation or treatment team being held liable for the actions of any team member.

2. Criminal Liability. Criminal liability includes commission of misdemeanors or felonies arising out of the conduct of professional activities (i.e., battery, fraud, or grand larceny). These behaviors can subject the practitioner to fines and incarceration. In many cases, professional activities that may result in these complaints reflect an ignorance of applied regulation, or direct violation with full

knowledge of applied regulations (i.e., Medicare and Medicaid law, state insurance codes, and other governmental regulation). Ignorance of the law does not release one from liability. Battery, previously described as being litigated under the legal theory of intentional tort, may also be pursued under criminal codes. Other areas that may be prosecuted under either theory include product liability, employee liability, and third-party liability.

B. Ethical Practice Complaints

Most professional organizations hold their members to a code of ethical conduct, and violation of ethical codes subjects the respondent to jurisdictions of administrative tribunals, such as ethical practice committees of state and national associations and state licensing boards. Although these organizations do not bring suit against the respondent, the actions and sanctions are sometimes admitted into evidence in support of any litigation being pursued. Professionals should be knowledgeable about professional association policies, such as codes of ethics, scope of practice statements, preferred practice documents, guidelines, or other "best practices" statements that form the basis of an expected standard of care.

III. History of Unprofessional Conduct, Unethical Practice, and Malpractice Insurance Claims

The reported incidence of unprofessional conduct and/or unethical practice leading to malpractice claims appears comparatively small for the audiology and speech-language pathology professions, as stated earlier. For purposes of this report, data from three primary sources were used to track trends:

- a study of state licensing boards presented at the 1992 ASHA Convention, "Speech-Language Pathologists and Audiologists: Professional Liability" (Graff, 1992);
- published actions by ASHA's Ethical Practice Board; and
- claims records from ASHA's liability insurance broker, Albert H. Wohlers and Co.

A. Study of State Licensing Boards

In this study, the state licensing boards of the 39 states that had licensure were contacted to provide detailed information regarding complaints of unprofessional conduct and unprofessional practice for audiologists and speech-language pathologists. Although 24 of the 39 states responded (62%), 19 provided "vague" data and 5 had no records to report. The total number of complaints reported was 134, 72 of which were undefined. The remaining 62 were broadly defined under the following categories:

- advertising complaints (29 complaints reported by 4 states),
- license fraud (20 complaints reported by 3 states),
- fraud (5 complaints reported by 2 states),
- unprofessional conduct (4 complaints reported by 1 state),
- standard of care (1 complaint reported by 1 state),
- unethical practice (1 complaint reported by 1 state),
- refusal of service (1 complaint reported by 1 state), and
- record keeping (1 complaint reported by 1 state).

These data must be interpreted with caution, since it cannot be determined whether the limited number of cases reflects the true incidence or results from poor record keeping, obscure mechanisms for reporting complaints within the state, or government agencies' reluctance to release information.

Table 1. Sanctions of ASHA's Ethical Practice Board Reported In *Asha* from February 1985 through August 1993

	Certification			*Total*	
	SLP	*A*	*Unknown*	*Number*	*Percent*
Unqualified to practice or supervise services and/ or misrepresented credentials	8	4	26	38	(72)
Charging for services not rendered	4	0	2	6	(11)
Rape/sexual assault	3		1	4	(8)
Fraud (mail, Medicare)		1		1	(2)
Petty larceny/possession of stolen property	1			1	(2)
Photocopy national exam			1	1	(2)
Improper clinical conduct/ judgment			1	1	(2)
Exaggerated claims/ promises of cure		1		1	(2)
TOTAL	16	6	31	53*	(101)

*One individual listed in two categories

Table 2. Sanctions by ASHA's Ethical Practice Board Reported In *Asha* by Year from February 1985 through August 1993

Year	**85**	**86**	**'87**	**88**	**'89**	**'90**	**'91**	**'92**	**'93**
No. of Cases	11	13	2	7	5	—	5	1	9

B. Reported Sanctions by ASHA's Ethical Practice Board

The Ethical Practice Board of ASHA publishes in *Asha* magazine the names of individuals found in violation of the Code of Ethics when the sanction is censure or revocation of membership or certification, or when publication of other sanctions is mandated by the Board. Table 1 is a summary of the numbers and types of violations resulting in published sanctions by the Board from February, 1985 through August, 1993. Table 2 illustrates the number of published sanctions by year. As seen from these tables, the number of publishedsanctions is small and has remained relatively stable over the past 8 years.

C. Claims Summary From ASHA's Liability Insurance Broker

Group malpractice insurance from the Chicago Insurance Company (brokered through Albert H. Wholes and Co.) has been available to the ASHA membership since January 1, 1982. Although the speech-language pathology and audiology professions are not considered “catastrophic exposure” industries by the insurer, all claims require investigation, whether initially appearing serious or frivolous.

Data from this insurance broker reveal that 129 incidents were reported between January 1982 and June 1993. Listed below are general categories under which the claims fell, along with the number of incidents reported within each category. The categories are listed in order of most-to least-frequent number of claims. It should be noted that malpractice insurance through Albert H. Wohlers and Co. is maintained by approximately one-third of the ASHA membership, and the committee did not have access to claims information from other insurance providers. Any trends extracted from these data, therefore, must be interpreted with caution.

1. ***Improper ProcedureTreatment (25 claims).*** Performance of improper procedures was the most frequently reported cause of malpractice claims. It was impossible from the data received to identify the specific nature of these incidents, although the majority appeared to have involved audiologists and occurred in an "office" setting.
2. ***Hearing Aids (23 claims).*** Incidents relating to the testing, fitting, dispensing, and use of hearing aids were the second most frequent cause of malpractice claims. Eleven claims were made because of earmold impression material breaking off or being left in the ear canal; five incidents reported dispensing the "wrong aid." An incident of a child swallowing a hearing aid battery was included in this category.
3. ***Employment Conflict (15 claims).*** These claims involved such issues as breach of confidence, slander, employee vs. employer, workmen's compensation, and discrimination cases.
4. ***Physical Injury to the Ear/Hearing (13 claims).*** Claims that hearing testing damaged the ear canal or caused hearing loss and/or tinnitus to worsen were included in this category.
5. ***Physical Injury to Other Parts of the Body (11 claims).*** Burns to the face from solvents/electrodes were the most common incidents in this category. Eye damage was also claimed. One client filed a claim for suffering shortness of breath during an examination.
6. ***Improper Diagnosis (10 claims).*** These claims involved improper diagnosis and misdiagnosis of a speech or hearing problem.
7. ***Injuries Due to Falls (9 claims).*** Claims involving clients who fell from examining tables or wheelchairs comprised this category. Some of these falls occurred outside the testing area but within the clinical facility.
8. ***Client Death (8 claims).*** Although hearing/speech testing was not the cause of death, claims in this category involved the death of a client undergoing or being prepared for an examination (e.g., heart attack). One claim was made because of a fatal accident allegedly associated with obtaining repair for a defective hearing aid. The case of a distraught individual who killed her father after having her speech, hearing, and academic status evaluated was also included in this category.
9. ***Sexual Harassment (3 claims).*** Claims involving harassment by employers and misconduct toward clients comprised this category.
10. ***Property Damage (3 claims).*** These claims involved property damage by fire or water.
11. ***Failure to Provide Sufficient Information (2 claims).*** One client claimed that warning of medical risks was not provided. The other claim involved an ex-employer who tested HIV positive.

Table 3. Number of Claims by Category by Year from January 1982 through June 1983

Category	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	Total Claims/Category
Improper Procedure, etc.		2	3	2		4	1	2	4	5	1	1	25
Hearing Aids	1	1	1	3		1		1	1	2	10	2	23
Employment Conflicts	3			2	1	1		2		1	3	2	15
Physical Injury to Ear			1	2		5	1		1		2	1	13
Improper Diagnosis	1	3				1	1		1	1	2		10
Injuries Due to Falls				5	2	1		1		1	1		11
Physical Injuries to Body Parts		3	1	2		1		1				2	10
Death of a Patient		1			1	2	2	1		1			8
Sexual Harassment/ Misconduct		1	1					1					3
Property Damage								1	1		1		3
Failure to Provide Sufficient Information											2		2
Intraoperative Monitoring							1						1
False Claim											1		1
Other								1			3		4
Total Claims/Year	5	11	7	16	4	17	5	11	8	11	26	8	129

12. ***Intraoperative Monitoring (1 claim).*** The largest claim (more than $1,000,000) was paid because of the examiner's "failure to advise the surgeon." This occurred during an intraoperative procedure wherein an audiologist was monitoring somatosensory function.
13. ***False Guarantee of Results (1 claim).*** This claim was made because the clinician falsely claimed that the client's stuttering would be cured in 2 days.
14. ***Other (4 claims).*** One case involved mistaken identity; another was due to announcing a death of the wrong person; the third involved an unspecified criminal/fraudulent act; the fourth involved a fatality and the subpoena of the insured to serve as an expert witness.

Table 3 illustrates the number of claims by category and year. These ranged from an all-time low of 4 in 1986 to a high of 26 in 1992. Since the number of claims per year fluctuates widely, it may be more meaningful to note trends over 5-year periods. The average number of cases from 1983 through 1987, and 1988 to 1992, were 11 and 12 per year, respectively. Thus, the average number of claims per year has remained relatively stable over the past 10 years. Table 4 is a summary of the total dollars paid for claims from January 1982 through June 1993 for each general category. These amounts ranged from $0 for sexual harassment/misconduct to $1,025,392 for intraoperative monitoring. It should be noted that this latter amount was paid for a single claim.

Information regarding the number of claims per discipline and the settings where incidents leading to claims took place was available for 89 of the above cases. These data are presented in Tables 5 and 6, respectively. As shown in Table 5,

Table 4. Summary of Total Dollars Expended for Claims In Each Category from January 1982 through June 1993

Category	Total $
Improper Procedure	358,275.11
Hearing Aids	117,865.58
Employment Conflicts	25,711.00
Physical Injury to Ear/Hearing	51,711.00
Improper Diagnosis	154,523.00
Injuries Due to Fails	47,386.00
Physical Injury to Other Parts of the Body	30,844.00
Death of a Patient	16,760.00
Sexual Harassment/Misconduct	0
Property Damage	16,206.00
Failure to Provide Sufficient Information	7,009.00
Intraoperative Monitoring	1,025,392.00
False Claim	7,000.00
Other	6,500.00
Total	1,865,012.69

Table 5. Claims Filed According to Discipline from January 1982 through June 1993

Claims Filed Against	Number	Percent
Audiologists	52	(58)
Speech-Language Pathologists	18	(20)
Both—claims filed against Audiologists and Speech-Language Pathologists in the same setting	5	(6)
Unknown (as yet)	9	(10)
Neither	5	(6)

claims filed against audiologists were almost three times more prevalent than claims filed against speech-language pathologists. The most common setting where incidents leading to claims occurred was an “office” (Table 6).

IV. Standard of Care

Risk occurs when a person who has advanced knowledge, training, or skill does not exercise the standard of care that would be exercised by the reasonable professional of like training and experience in similar circumstances. A professional standard of care traditionally is established by:

1. Publications of professional associations
    - Scope of Practice
    - Code of Ethics
    - Preferred Practice Patterns
    - Guidelines
    - Position Statements
    - Reports

Table 6. Settings of Incidents Leading to Claims from January 1982 through June 1993

Setting	Number	Percent
Office	53	(60)
Clinic	10	(11)
Hospital/Medical Center	9	(10)
Speech and/or Hearing Center	4	(5)
School	2	(2)
Nursing Home	2	(2)
Rehabilitation Center	1	(1)
Industrial Site	1	(1)
Home	1	(1)
Playground	1	(1)
Unknown	5	(6)

2. State licensure laws

Local practices (training and skills of other professionals in a similar locality) may be considered in some cases. However, with the development of modern communication techniques, this now has less influence on the determination of accepted standard of care than in earlier years.

A. Scope of Practice Statements

ASHA has adopted a scope of practice statement that (a) informs ASHA members and certificate holders of the activities for which certification in the appropriate area is required in accordance with the ASHA Code of Ethics, and (b) educates health care and educational professionals, consumers, and members of the general public about the services offered by audiologists and speech-language pathologists as qualified providers (ASHA, 1990b). From a risk-management perspective, it is critical for clinicians to be knowledgeable about the range of services outlined in the scope of practice and any additional policies that expand the scope, such as advanced areas recently recognized within the scope of the professions (ASHA, 1992a).

B. Code of Ethics

Members of the Association should also be familiar with the ASHA Code of Ethics, which was developed by the members of the Association for the members. Specifically, with regard to the interrelationship of the scope of practice definition and the ASHA Code of Ethics, the practitioner must adhere to Principle of Ethics II, which states that “individuals shall engage in only those aspects of the professions that are within the scope of their competence, considering their level of education, training, and experience” (ASHA, 1993e).

C. Preferred Practice Patterns

In 1993, ASHA adopted the Preferred Practice Patterns for the Professions of Speech-Language Pathology and Audiology (ASHA, 1993j). The preferred practice patterns were developed as a guide for speechlanguage pathologists and audiologists and as an educational tool for other professionals, members of the

general public, consumers, administrators, regulators, and third-party payors. These patterns define universally applicable characteristics of activities directed toward individual clients that address structural requisites of the practice, processes to be carried out, and expected outcomes. They provide a broad conceptual framework within which specific guidelines of practice apply.

D. Policy Guidelines, Position Statements, and Reports

Historically, ASHA has had a committee structure to develop policy guidelines, position statements, and reports that outline suggested "best practice" parameters. These policies may include protocols that summarize and reflect the state of the art in a particular area of practice, competencies for performing specific procedures, and cautions in the conduct of particular procedures. In litigation, "best practice" guidelines are often interpreted to represent a standard of practice. Guidelines, dynamic documents that are everchanging and require periodic updating based on evolving technologies and research findings, are useful to practitioners for comparing routine practice methods to those suggested by peers and experts in specific practice areas.

See the Appendix for a complete list of ASHA documents pertaining to standard of care. A compendium of ASHA policies is available that includes all current policies, reports, and tutorials relevant to the practice of audiology and speech-language pathology (ASHA, 1992b).

V. Risk Management Strategies

The objective of risk management is to protect the financial assets of the health care practitioner or institution by eliminating or reducing losses resulting from claims and lawsuits. By eliminating or reducing those situations that give rise to claims or lawsuits, the practitioner also protects customers of service. In this way, risk management and quality improvement are interrelated. Quality improvement concentrates on maintaining optimal levels of client care; risk management focuses on meeting acceptable levels of care from a legal perspective.

The Joint Commission of Accreditation of Healthcare Organizations (JCAHO) requires, as a standard of accreditation, that the risk management and quality improvement functions within the institution be closely integrated. JCAHO defines risk management as the "clinical and administrative activities that hospitals undertake to identify, evaluate, and reduce the risk of injury and loss to clients, personnel, visitors, and the institution itself. Standards are applied to evaluate a hospital's performance in conducting risk management activities designed to identify, evaluate, and reduce the risks of client injury associated with care and services" (Joint Commission on Accreditation of Healthcare Organizations, 1993).

Five steps in a risk management program are:

- identification of pure risks;
- analysis of those risks in terms of probable loss, frequency, and severity;
- development of alternative risk control and risk financing techniques and choice of the proper technique or combination thereof;
- improvement of chosen techniques; and
- monitoring the program's effectiveness and modifying it as risks change over time.

The individual practitioner can obtain maximum protection by reviewing potential areas of litigation, taking those steps necessary to reduce risks, and establishing a defensible record in the event that litigation does ensue. The four basic approaches to dealing with risks include risk avoidance, risk retention, risk transfer, and risk reduction.

Risk avoidance—refers to withdrawal from an activity (e.g., refrain from cerumen management). This approach should be followed when the professional lacks proper training or access to appropriate equipment.
Risk retention—refers to self-insurance, in which case an entity has the financial reserves to pay for any claims against it. This is usually accomplished by larger companies or corporations.
Risk transfer—refers to the purchase of insurance through an insurance agent, broker, or directly from an underwriting insurance company. Since defending oneself in a professional liability action can be costly, and since an unsatisfactory outcome is a possibility, it is incumbent on the prudent practitioner to obtain adequate liability insurance coverage.

Some professional associations, like ASHA, offer liability insurance as a member benefit. Some members purchase professional liability insurance from the Association's program; other members may obtain coverage from separate carriers or are covered by various forms of employer-provided insurance. Some members may remain uncovered.

Insurance policies fall into two basic categories: “occurrence” insurance or “claims made” insurance. Occurrence insurance covers incidents for injuries resulting from activities carried out during the policy period, regardless of when claims are filed. This is the type of insurance offered through ASHA to its members. Claims-made insurance provides coverage only for the claims made and reported during the policy period. Because the statute of limitations for filing personal liability claims may extend for many years after the evaluation or treatment was performed, professionals should determine carefully the type of coverage that is purchased privately, provided by employers, or purchased by employees.

Risk reduction—refers to the development of prevention programs and conformance with specific preventive techniques. This preventive approach is the focal point of the general strategies for audiologists and speech-language pathologists listed below. For clarification, these strategies are categorized into six areas:

1. Awareness and Education of Practitioner

- Identify potential risks.
- Eliminate or reduce risks by providing an accepted standard of care.
- Practice within the scope of your professional competence, license, and certification.
- Use only licensed or registered titles.
- Stay current with developments in your profession.
- Keep abreast of evolving standards of practice.
- Maintain professional competence through continuing education.
- Know state licensing laws.
- Know applicable codes of ethics.

- Know relevant scopes of practice.
- Know and use current preferred practice patterns, guidelines, and position statements.
- Know clients' Bill of Rights.
- Use only equipment or test materials with which you are trained or knowledgeable.
- Refer when you do not possess the knowledge, expertise, and credentials to provide a needed service.
- Be certain of licensure, certification, and other qualifications of all persons to whom referrals are made, as well as those of employers or employees.
- Know and use the policies and procedures of the hospital or organizations with which you are employed.

2. Effective Communication

- Establish a positive relationship with clients.
- Be a good listener.
- Explain test results, treatment goals, treatment plans, and procedures, as well as realistic outcomes.
- Take time to explain answers in lay terms.
- Avoid making statements that mislead clients into unreasonable expectations.
- Address both benefits and limitations of products or treatment.
- Encourage observation of procedures by caregivers.
- Make full disclosure of fees, billing schedules, and arrangements for missed sessions before treatment begins or equipment is dispensed.
- Provide written warranties and disclaimers of guarantees.
- Provide written warnings.
- Secure signature of client, caregiver, or significant other to acknowledge information transfer and indicate understanding of written warnings, warranties, and disclaimer of guarantees.
- Avoid criticizing colleagues in the presence of your clients.

3. Documentation—Record Keeping and Reporting

- Be aware that the care with which documents are kept will reflect the quality of care clients receive, and that these documents may be subpoenaed.
- Make all entries accurate, thorough, and legible.
- When corrections are necessary:
  - Never “white out” or obliterate;
  - Draw a line through incorrect information;
  - Initial and date the correction; and
  - Note why correction was necessary.
- Document all personal and telephone contacts with client and family.
- Keep copies of all correspondence with or about the client.
- Document all contacts with other professionals regarding the client.
- Document failure to show, cancellation, or rescheduling of appointments.
- Document noncompliant behavior by describing behavior that leads to that opinion, rather than making judgmental or opinionated statements.
- Document limitations of treatment process.
- Document recommendations.
- If team recommendations differ from your own, document your own recommendations and state rationale and conclusions.

- Keep records of all dispensed products.
- Keep records of equipment maintenance and calibration.
- Document warnings of dangers of products.
- Document informed consent for evaluation and treatment procedures.
- Document consent for dispensing or receiving client information.
- Document when and where all client information was sent.

4. Confidentiality

- Release to a specific entity only information that was requested in writing.
- Obtain a signed and witnessed release.
- Know who is authorized to view or receive records by awareness of:
  - state regulations;
  - policies and procedures of hospitals or organizations with which you are affiliated;
  - the client's rights of access to records;
  - provider's right of reasonable restrictions on access:
- Document does not have to be provided at any time or any place requested by the client, but must be provided at a mutually agreed-on time and place;
- Provider may need to be available to explain or interpret information; and
- Provider can charge reasonable fees for copies.
- Use fax or other forms of electronic mail cautiously to prevent disclosure to unauthorized individuals.

5. Informed Consent

- Obtain informed consent for evaluation and treatment procedures.
- Inform the client of the following elements to obtain a valid informed consent:
  - nature of ailment, proposed treatment, risk, consequences of treatment;
  - probability of success;
  - treatment alternatives; and
  - prognosis.
- Determine who has the authority to sign an informed consent by securing knowledge of:
  - state laws for determining minor status;
  - state and local laws for determining legal guardian for minors in the absence of a parent; and
  - policies and procedures of the hospital or organization with which you are affiliated.
- Treat minors only when accompanied by a parent or guardian or when written permission has been obtained to treat in their absence.

6. Client Safety—Make sure physical environment is free of hazards.

- Structure activities to reduce client injury.
- Follow universal infection control procedures.
- Ensure the availability of emergency services based on evaluation and treatment risks.

IV. Illustrations of Risk Management Strategies

Examples of related risk-management strategies are outlined here to provide sample approaches to handling practice risk. For purposes of this report, significant ASHA policies and related documents are listed below for several areas of practice. The development of risk management strategies may be procedure-, disorder-,

population-, and/or setting-specific. These suggestions are not intended to be all-inclusive, but are offered to stimulate thinking about approaches to risk management.

1. Hearing Aid Selection, Fitting, and Dispensing (Procedure-Specific)

a. ***Associated Policies***

- Vanderbilt/VA Hearing Aid Conference 1990 Consensus Statement (Hawkins et al., 1991)
- Amplification as a Remediation Technique for Children with Normal Peripheral Hearing (ASHA, 1991a)
- Definition of and Competencies for Aural Rehabilitation (ASHA, 1984)
- Hearing Aid Fitting (ASHA, 1993f)
- Assistive Listening System/Device Selection (ASHA, 1993a)
- Aural Rehabilitation Assessment (ASHA, 1993d)
- Product Dispensing (ASHA, 1993k)

b. ***Related Risk Management Strategies May Include:***

- Assessing status of external and middle ear structures prior to and immediately following preparation of an earmold impression
- Obtaining a "hold harmless" agreement with manufacturers of hearing aids and assistive listening devices that are evaluated and dispensed in order to prevent practitioner liability for "defective" products
- Advising clients about specific risks from possible battery ingestion and providing written instructions signed by practitioner and client
- Developing a checklist of related regulations (e.g., Food and Drug Administration, state licensure requirements) and steps for compliance for each client record

2. Intraoperative Monitoring (Procedure-Specific)

a. ***Associated Policies***

- Neurophysiologic Intraoperative Monitoring (ASHA, 1992c; 1993g)
- AIDS/HIV: Implications for Speech-Language Pathologists and Audiologists (ASHA, 1990a)

b. ***Related Risk Management Strategies May Include:***

- Obtaining written orders from the attending physician for evaluation and treatment services to the client
- Following universal precautions to prevent the risk of disease from blood- and/or air-borne pathogens
- Following infection control policies for materials and equipment
- Ascertaining that the informed consent of the client has been obtained for your services

3. External Auditory Canal Examination and Cerumen Management (Procedure-Specific)

a. ***Associated Policies***

- External Auditory Canal Examination and Cerumen Management (ASHA, 1992d)
- Cerumen Management Policy and Practice-A Continued Discussion on Two Fronts (ASHA, 1993c)
- AIDS/HIV: Implications for Speech-Language Pathologists and Audiologists (ASHA, 1990a)

b. ***Related Risk Management Strategies May Include:***

- Obtaining case history and inspecting ear canals to rule out signs of acute disease that contraindicate performing specific procedures
- Checking medical policy, institution insurance coverage, and delineation of practice privileges for the specific institution to ensure that there are no restrictions applicable to an audiologist performing these procedures, and becoming formally privileged if hospital or medical center has a mechanism to do this
- Following universal precautions to prevent the risk of disease from blood- or air-borne pathogens
- Having a specific contact and procedure for medical emergencies posted in a visible location
- Maintaining complete documentation of informed consent

4. Dysphagia Evaluation and Treatment (Disorder-Specific)

a. ***Associated Policies***

- Swallowing Screening (ASHA, 1993n)
- Swallowing Function Assessment (ASHA, 19931)
- Swallowing Function Treatment (ASHA, 1993m)
- Instrumental Diagnostic Procedures for Swallowing (ASHA, 1992e)
- Sedation and Topical Anesthetics in Audiology and Speech-Language Pathology (ASHA, 1992f)
- Knowledge and Skills Needed by Speech-Language Pathologists Providing Services to Dysphagic Patients/Clients (ASHA, 1990c)
- Ad Hoc Committee on Dysphasia Report (ASHA, 1987)
- Dysphagia position statements of state speech-language-hearing associations

b. ***Related Risk Management Strategies May Include:***

- Obtaining written orders from the attending physician for evaluation and treatment services to the client
- Checking the medical policy of the institution, as well as institution and self-insurance coverage, for use of diagnostic instrumentation
- Advising clients about the possibility of specific risks in the use of instruments in the evaluation process and during treatment
- Documenting informed consent of client and/or family for evaluation with instruments
- Following guidelines for specific instrumental diagnostic procedures and materials, including application of topical anesthetics (to be performed with a physician) and the use of associated suspension materials during videographic assessments
- Designating specific contact persons and procedures for handling of medical emergencies posted in a visible location
- Documenting instruction of direct caregivers in swallowing strategies and supervision of client eating
- Ensuring availability of emergency services

5. Pediatric Audiologic Testing (Population-Specific)

a. ***Associated Policies***

- Sedation and Topical Anesthetics in Audiology and Speech-Language Pathology (ASHA, 1992f)

- Joint Committee on Infant Hearing 1993 Position Statement (in progress)
- Guidelines for the Audiologic Assessment of Children from Birth through 36 Months of Age (ASHA, 1991c)
- Pediatric Audiologic Assessment (ASHA, 1993h)
- Auditory Evoked Potential Assessment (ASHA, 1993b)

b. ***Related Risk Management Strategies May Include:***

- Parent/caregiver observation/collaboration
- Documenting recommendations and compliance with recommendations
- Documenting attempts at recall efforts
- Maintaining a hard copy of recommendations, signed and dated by parent/caregiver when possible

6. Speech-Language Services to Geriatric Clients (Population-Specific)

a. ***Associated Policies***

- Guidelines for the Delivery of Speech-Language Pathology and Audiology Services in Home Care (ASHA, 1991d)
- Roles of Speech-Language Pathologists and Audiologists in Working with Older Persons (ASHA, 1988b)
- Provision of Audiology and Speech-Language Pathology Services to Older Persons in Nursing Homes (ASHA, 1988a)
- Conditions of Participation for Skilled Nursing Facilities (Office of the Federal Register, 1985)

b. ***Related Risk Management Strategies May Include:***

- Obtaining written orders from the attending physician for evaluation and treatment services to the client within hospital, skilled nursing home, or home health care agency for Medicare, Medicaid, and other insurance reimbursement
- Discussing the treatment plan with the family in lay terms to determine treatment rationales that are congruent with the client and family needs and environment to achieve the highest level of compliance
- Providing treatment at level of client's cognition
- Securing safe and adequate space and equipment for evaluation and therapeutic sessions with client
- Limiting the use of invasive oral-motor procedures in treatment to secure the trust of the client
- Maintaining current documentation for each home health care treatment session
- Obtaining written consent from client or family for their decision to withdraw treatment from the client and documenting reasons for their decision

7. Infection Control in School Setting (Setting-Specific)

a. ***Associated Policies***

- Chronic Communicable Diseases and Risk Management in the Schools (ASHA, 1991b)
- AIDS/HIV: Implications for Speech-Language Pathologists and Audiologists (ASHA, 1990a)
- Preamble to Preferred Practice Patterns for the Professions of Speech-Language Pathology and Audiology (ASHA, 1993i)

b. ***Related Risk-Management Strategies May Include:***

- Following universal precautions to prevent the risk of diseases from blood- and/or air-borne pathogens
- Checking medical history in student's records
- Checking federal, state, and local laws and regulations regarding the provision of services to children with communicable diseases
- Complying with ASHA Code of Ethics regarding confidentiality of a client's medical diagnosis and refusal to treat
- Referring questions regarding legal issues or confidentiality to local public health departments, ASHA's National Office, state attorney generals' offices, or state speech-language-hearing associations
- Following the infection control policies and procedures of local and state education agencies
- Working to establish school district policy on risk management
- Informing parents of procedures and policies

VII. Recommendations

The Ad Hoc Committee on Professional Liability and Risk Management recommends that ASHA's future involvement in risk management include:

- The development of a data collection system of complaints at state and national levels. This would require the cooperation of State Licensure Boards and ASHA's Ethical Practice Board;
- The development of an ongoing data collection system of claims statistics from insurance companies that cover both professions of speech-language pathology and audiology;
- The establishment of a committee with continuing status to develop a survey instrument for data collection and to:
  1. report circumstances surrounding professional liability cases and the reasons defendants won or lost,
  2. monitor and report trends,
  3. advise on risk-management guidelines and approaches, and
  4. monitor tort and health care reform;
- The provision of continuing education for members by identifying “high risk” areas of practice; and
- The encouragement of graduate programs to include professional liability and management for all future practitioners and program administrators.

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Electrodiagnostic Test Procedures, pp. 38–39

Auditory Evoked Potential Assessment, pp. 40–41

Neurophysiologic Intraoperative Monitoring, pp. 42–44

Balance System Assessment, pp. 45–46

Hearing Aid Assessment, pp. 47–48

Assistive Listening System/Device Selection, pp. 49–50

Sensory Aids Assessment, pp. 51–52

Hearing Aid Fitting/Orientation, pp. 53–54

Occupational Hearing Conservation, pp. 55–56

Speech-Language Pathology
Swallowing Screening, pp. 11–12

Spoken Language Assessment, pp. 57–58

Written Language Assessment, pp. 59–60

Augmentative and Alternative Communication (AAC) Assessment, pp. 61–62

Cognitive-Communication Assessment, pp. 63–64

Articulation/Phonology Assessment, pp. 65–66

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