# Interprofessional Relationships

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Ladies and Gentlemen:

I wish to take this opportunity to thank you for this asking me to come here and speak to the Academy.

I have been asked to speak to the topic of Interprofessional relationships. When the original request was made and accepted I decided that in order to add validity to the paper I would discuss the paper and topic with a range of colleagues, soliciting their input at all stages. The resultant paper then represents the final winnowing of those ideas and inputs.

While the final form and language are mine, I would like to take this opportunity to thank my co-authors, Kenneth M. Stevens, M.D., and Armin B. Olsen, M.D., not only for their assistance in the preparation of this document but, more pertinently, for exemplifying the kind of positive potential for cooperation about which I intend to speak.

**by Jay B. McSpaden, Ph.D., Kenneth M. Stevens, M.D., Armin B. Olsen, M.D.**

Any of you who read your mail and/or the literatures, newspapers and magazines of your own and other professions lately, should be aware that Audiology, as a profession, is in trouble. I am here today to reinforce to you that, "we are in trouble, and that we have earned it." It is my considered opinion that (as a profession) Audiology delivers some of the most expensive 1957 service money can buy. In addition to that, the majority of clinics in this country perform services that border upon almost all of the requirements for "malpractice". This terrible state of affairs, we have brought upon ourselves, through carelessness, ineptitude and a feeling that "Oh well, hell, nobody can do anything about it anyway". Pogo, unfortunately, was right. "We have seen the enemy, and he is us."

Worse, and much more ultimately destructive to our profession, is our cavalier disregard for our interprofessional relationship. Here, too, large segments of our professional population are in serious trouble. Sometimes those troubles are caused by the situations in which audiologists find themselves, but, the vast ma-

jority of cases in which true adversary relationships exist are caused, it seems to me, by an appalling lack of communication, sensitivity and insight. These (almost without exception) are accompanied, I believe, by enormous egos and equivocally supported illusions of adequacy re professional abilities, duties, and competence.

We are the profession of supposed "communication experts" who commit, on a daily basis, sematic "atrocities" capable of lifting the most placid professional (whether physician, hearing aid dispenser or other) to a true "Red Alert" status. Perhaps the saddest thing of all is that this is done, not out of deliberation and malice aforethought, but rather, because **no** thought is given, **no** care is extended, **no** awareness present, of the other people with whom we work. I am convinced that people who can be found in this situation, are by and large, a party to a relationship in which judgements have been made that the fundamental purpose of the relationship is **not** the delivery of patient care, but rather the enrichment and self-aggrandizement of the individual involved.

I am frankly sick of PhDs in ours and other professions, who **demand** respect, **not** based on their ability to earn it, or upon their ability to demonstrate their competence, but by virtue of the letters after their name. I am equally fed up with those physicians who demand respect solely on the same basis.

Do not misunderstand me. My purposes today are to lay out for you my impression of the interprofessional relationships that exist between audiologists and physicians, audiologists and hearing aid dispensers, audiologists and other professions. So far, it should not be beyond the limits of wit for you to have gathered that I think that there have been some mistakes made, but the picture is not totally black.

In hundreds of centers around this country, good, nurturing, substantial interprofessional relationships occur, strengthen, and develop, which contribute materially to the highest quality of patient care. It is unfortunate to me that the numbers of such centers are less (in my perception) than half of those centers in which multiple professions work together. I do see change, however, and I see that change moving in a positive direction in spite of the rather loud, long and malicious publicity that the relationships between the professions have been getting in the last couple of years. I think we should look at these relationships and see how they are built, why they succeed, why they can fail and at some of the reasons for the present problems.

Just to take, perhaps, the most blatant example of the last group, let's discuss for just a moment a furor over the use of the word "diagnostic". First of all, "diagnostic" is a word, just like any other word. It has no meaning except for the meaning that we give it. It was Lewis Carroll in "Alice, Through the Looking Glass" who told us that, "A word means what I want it to mean".

When the Audiologist uses the words "differential diagnosis" or "diagnosis", he means **where** the lesion is. However, when the physician uses the word "diagnosis" or "differential diagnosis", he means **what** the lesion is. Not a terribly earth-shattering difference, and yet, an unbelievable amount of difficulty is caused by the mutual lack of understanding of the different definitions of that shared word.

Another example is the tendency of audiologists to practice what I call "word medicine". Now, I don't want to bring up an old argument, but, audiologists, (at least in this country), are not trained physicians, and physicians, for the most part, are not trained audiologists, though there are some rare exceptions. Audiologists have a tendency to write reports that baldly infringe upon the territory of Medicine. Medicine, on the other hand, has a tendency to write consult sheets and reports that baldly infringe upon the territory of Audiology. Neither profession, it seems to me, is aware that it is doing this; nor, if it is aware of the behavior, feels that it is not within its professional province to do so.

Let me give you another example of what I mean. If an audiologist describes an auditory behavior of the middle ear consistent with some fixative process in that middle ear, in just the terms that I have given you, he is within this professional bounds of Audiology. If, on the other hand, he says to the physician, "this is a case of Ostosclerosis", he has clearly stepped beyond the pale. Conversely, when a physician says, "Ah hah, all I need is a SISI test and discrimination scores and I can tell VIIIth nerve lesions from cochlear pathologies", he is clearly stepping out of his area of expertise.

The best relationships that I have had the pleasure of observing, the ones in which I have been fortunate enough to work, that were the most successful, have been based, almost entirely, on an understanding by both professions that **I will not** practice Medicine and **they will not** practice Audiology. There is nothing wrong with that, and we share feelings that together we provide a better service for our patients than either of us is able to provide alone. As my friend, Dr. Ken Stevens says, "Together we are invincible".

I am firmly convinced that successful interprofessional relationships, are and of necessity, should be, both evolutionary and metabolic. They have all the aspects of metabolism. There is the anabolic building phases that cause strengthening, nurturing and growth, through education, shared communication and empathetic support. There is also the catabolic phase, this consists of the tearing down of old prejudices, the giving way of old ideas and the surplanting of old relationships that have been the foundation for the present stages of growth. In a philosophical sense, the growth of professional interrelationships recapitulates the dicta about ontogeny.

I think, also, that they are evolutionary. I see no reason to believe that there is an end point beyond which those relationships cannot go, certainly not in the long term. But, in order for these relationships to be positive, (not now just talking about physicians and audiologists, but audiologist and the whole spectrum of other professions) they must be carefully tended, assiduously maintained and strongly protected. They must be based on a mutuality of purpose, specifically, a commitment to the delivery of the highest possible quality of patient care.

They must have a sufficient amount of individual and shared ego in order to provide driving force toward the end of quality patient care, but not so much ego as to interfere with the abilities of the members of the group, to work, continuously, in harmony with each other. We must keep before us, at all times, that it is not the **patient** (that is a prize that) we are somehow competing for, but rather it is **patient care** that is the prize that we are striving for. The patient belongs to himself and competition that is destructive between the professions for his heart and mind leaves him cheated, misused and less than honorably served.

Good relationships between professions that contribute to improved quality of patient care are of necessity synergistic. In those cases, in those centers, in those groups, in which this synergy exists, strides are being made to close the enormous gap that has come to exist between the quality of deliverable care and the quality of delivered care. We are never going to get it completely closed, at least let's hope not. Because the ability to do so demands that those people in research who are driving forward the frontier of the quality of deliverable care would have to stop, unfortunately (I am afraid), for a considerable period of time. We are not, however, going to ever get there for a much more fundamental reason and that is that there are sufficiently swollen egos among members of all the professions to prevent the kind of positive synergy that we have been discussing here from happening in every instance. There are always going to be some people who simply cannot abide the idea that other people do their work well, too.

Part of the mistrust stems from the desire to claim exclusive use of the term "healer". And I am not speaking here just of physicians. There are an awful lot of audiologists around who think they contribute to healing. There are an awful lot of hearing aid dispensers around who believe they contribute to healing—maybe not healing the body necessarily but healing the person and his communication matrix and improving the quality of his life. Legitimate philosophical arguments can be made in behalf of this idea, but, if you fall in love with the word (healer) and you are infected with the generic nature of the word, it may become negative in that it begins to interfere with the ability of professionals to work with each other.

Exact terminology is important. For example, it is very important over the long haul that the physicians with whom we work refer to us in our particular setting as "the Audiologist" as opposed to "our Audiologist". It sounds like a little thing, but it isn't. It is important that they call me Dr. McSpaden just as I call them Dr. Olsen or Dr. Stevens, or Dr. Wilson. Or it's important that we all call each other by our first names.

There are many ways for us to deal honorably with each other. Physicians are the only people in the world who can call themselves "physicians". A great many different people in the world may call themselves "doctor". The word "doctor" means teacher. Many of us have doctorates, (whether EdD, MD, PhD, etc.) and have earned that title. We have a right to use it when we want. However, it should not be allowed to become a ploy in a game of one-up-manship and in too many cases, that is precisely what happens. I once heard a very difficult conversation in which a very, very young first year resident, (first term out), was talking to a professor with a PhD who was a teacher at his medical school, and was "pushing" at the differences between "real doctors" and PhDs. The learned gentleman turned to him and pointed out that **his** "intellectual ancestors" had been called "Doctor" while the young man's "intellectual ancestors" had still been cutting hair.

At that time I was vastly amused by the exchange, feeling a little fragile with a brand new PhD after my own name, but I have since come to understand that both responses were wrong. We deserve and earn each other's respect by virtue of our shared professions of confidence in the competence of each other's work. On no other basis are we happy; on no other basis can these relationships prosper and on no other basis can the patient's needs best be served.

The old ways die hard, and our prejudices are as long lived as anyones. If the relationship between Medicine and Audiology have historically required statesmanship and diplomacy, then the relationship between Audiology and the Hearing Aid Industry can best be described, historically at least, as "warlike". The reasons for this mutual distrust and antagonism are steeped in history. They are, in most cases, no longer pertinent to the modern day history of health care. Nonetheless, there has been, up until the present moment, a level of suspicion, mutually shared between the Hearing Aid Industry and Audiology that has never served the public well.

It is time that Audiology, as a profession come to understand that a significant portion of the Hearing Aid Industry **does what it does better than we do what IT does.** It is time that a significant portion of the Hearing Aid Industry comes to understand that **we do what we do better than IT does what we do.** Only in that way, understanding that even this team is not totally sufficient, can the

patient's needs best be served. In the final analysis, we are all in this together. We all share a common goal, specifically, to improve the quality of life of the patients with whom we come in contact by providing them with the very best that the health care system has to offer. Each of us, (Medicine, Audiology, the Hearing Aid Industry) and many others are simply part of that health care delivery team. When we work together, the patient is well served. When we work against each other, the patient pays the price. In most cases, he is unaware that there is a price. He is cheated by the failure of those professionals in whose hands he has placed his care to work together in an equitable fashion.

Consider, please, the fact that for no other reason than because the explosion in the corpus of knowledge, it is no longer possible for an Audiologist, or a Hearing Aid Dispenser, or a Physician to do it all. The days of genericism are gone and the sooner we understand that, (and the sooner we stop making our patients pay for the lack of our understanding of that) the better off all of us will be.

No one person (no matter how dedicated, hard working or interested he may be) can even read all the literature that is pertinent to the delivery of generic care. It requires specialization. It requires special training. It requires longterm use in order that facility be developed with the tools, language and techniques necessary to deliver first quality care to those people who place their trust in us. The sooner all of us understand that the optimum structure is a professional coalition of truly competent specialists, dealing with their patient and with each other with respect and equanimity, the sooner our professional interrelationships will come of age.

I am convinced that intervention by governmental bodies may in some part, force these issues in a very short time. I am convinced for example, that the federal government will declare "as illegal and in conflict of interest" dispensing on the part of medical facilities such as hospitals and medical clinics. I am convinced that they will declare "as illegal" dispensing of hearing aids on the part of physicians, and probably also audiologists. I am convinced that these things ultimately may be in the best interest of the patient. I am also convinced that audiologic care except in the sense of widely based screening, does not belong in the Hearing Aid Dispensing Industry, but belongs in the hands of audiologists in medical centers.

In regard to positive, synergistic, interprofessional relationships, I hold the following truth to be self-evident: "No audiologist, hearing aid dispenser, physician, or other profession, ever (in my view) had a moment's difficulty, beginning 10 seconds after he demonstrated that he was competent and that he can provide a kind of quality service unavailable from any other source."

The future of our conjoint efforts is dictated by this "prime" factor.

I believe that the explosion in the amount of knowledge necessary to deliver first quality care in the 20th and 21st century clearly demands that divergent professions must work cooperatively together with mutual respect for themselves and each other as professionals in order that the patient's needs be served. There is neither selfishness nor altruism in this statement, merely a perception of the features on the face of the future and a projection of our relationships in it.