

Ethical and Legal Issues, Interprofessional Relations

Demands for services, Equipment and Ancillary services

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Pimps, Whores, Merchants and Bores

*This paper is presented as a philosophical perspective
of the field of audiology as practiced in a private set-
ting.*

The audiologist in private practice is a younger sibling of the institutionally based audiologist. Like his older brother, he comes from a family which is dedicated to helping, to serving the community, and to maintaining close ties with his academic and medical cousins. Unlike his brother who works in the university, the hospital, the schools, he has elected to perform his responsibilities in a smaller setting. In the past, his reasons for doing so have been primarily ego-oriented; he felt a need to provide audiologic services in a manner he felt to be appropriate; he wished to do so without the restrictions imposed upon him by chairmen, deans, chancellors, department heads, committees or colleagues with differing opinions, and he wished to do so with compensation that he felt reflected worth.

Because few of us were wealthy and had to provide for families, we usually became part-time practitioners still clinging to the security of the large institution. We became consultants to other large institutions, to industry, we worked in the evenings and on weekends as Saturday testers in physician's offices and we offered night school workshops.

Somewhere along the line we began to get disapproving feedback from our institutional colleagues. We were money grubbers without principle, we took audiologic shortcuts to grind out more

clients; most importantly, we were radicals who did not fit comfortably in the conservative mold. We began to believe our detractors. If one attended a meeting of audiologists in private practice he would hear presentations and papers which were defensive, self protecting and petty, self-serving resolutions made by audiologists more concerned about image than professional growth. As a group, we had not yet achieved any recognition by our colleagues nor more importantly any pride in ourselves. Most of the part-time private practitioners scurried back to the forgiving arms of the respectable institutional family. A few of us didn't go back but chose to fight it out in the public arena. It has been and still is a long battle with the outcome undecided. My concern as a private practitioner who intends to remain in the private sector is to identify those factors which will allow me to provide independent audiology services successfully and to be aware of those factors which might prevent me from doing so. The following appear to be primary areas of concern in developing and maintaining a private practice in audiology. (My apologies in the ensuing discussion for the use of "he" or "she" for convenience rather than any neuter term.)

Demand for Service

Although it sounds platitudinous to state that services which are to be provided must be recognized as needed by the community for which they are intended, it is far from it. The general public has been educated by non-audiologists, e.g., physicians and hearing aid dispensers, to expect cutting, painting or patching; as a next to last resort, hanging a crutch on the defective ear and, as the last procedure, getting lip reading lessons. In other words, the attitude held by the public is essentially based on expectations of a medical model for a disease process. If the audiologist also wishes to accept such a model, his difficulties will be magnificently reduced. He then can become a number generator who assists the physician in discovering who can or cannot be medically treated or he may be a number generator either assisting the hearing aid dispenser or replacing him in the art of hanging crutches on ears.

If the audiologist in private practice wishes to provide complete counseling and therapy services in addition to testing, he will typically find no ready-made market. Rather, he must create a need for these commodities by educating physicians, hearing aid dispensers, the hearing impaired and their families as to the nature of communication dysfunction and the alternative and/or additional avenues of remediation that can be traveled. If the larger institutions in the area have already managed to develop a public attitude which is more receptive, the private practitioner will have a somewhat easier market to reach.

Because the audiologist cannot advertise in the usual sense of paying money to hawk his wares, he must depend upon reaching the public through public announcements, articles of general in-

terest about communication, discussions with service organizations, workshops for health personnel; he must be prepared to mount any podium to describe what it is that audiology can offer and specifically, what it is that he can provide. The innocent, fresh from his academic program, is inculcated with an attitude that such advertising is bad form and that good works in and of themselves will shine brightly. Alas, too often he finds that hanging his shingle out will often be a sad experience of watching it rust in the inclement weather of public apathy.

Cost Considerations in Opening and Maintaining an Office

It is an expensive proposition to open an independent audiology office; it is even more expensive to maintain it. Initial costs will include a booth for \$6000, clinical audiometer for \$5000, a bridge for \$2000; an electro-acoustic hearing aid analyzer for \$2500; a typewriter, file cabinet and minimal office furniture will be at least another \$2000; paper, report forms, service forms will add a minimum of \$1000 and obtaining liability insurance, malpractice insurance and initial accounting or billing system costs will be about \$1000. It will cost a minimum of \$20,000 to open the doors. Because the lag between date of service and payment for that service is typically two and one half months, plan on obtaining a loan for no less than \$25,000 to cover costs during that time. Be prepared to approach your friendly banker for a loan of that amount in order to start a very small, one-man office in which you will be all the Indians and chiefs there are.

Continuing costs will be rent of about \$500, phone bills averaging \$50, accounting and legal fees of \$100, loan repayment of \$600, office and postage supplies \$100 and miscellaneous of \$100 (subscriptions, utilities, parking fees, gasoline) and equipment costs (calibration, new items) of \$50 totaling at least \$1500 per month. Because you have value as a worker and need to live, add in the cost of your salary, about \$2000 per month, and you can anticipate ongoing costs of about \$3500 per month. And don't be too optimistic about getting rid of those loan payments three years down the line; by the time you have accomplished that, your rent will have escalated as will all of your other costs.

What is the reality involved in earning \$3500 per month? Because you will work about 21 days per month, you must plan on earning at least \$160 each day to meet costs and your salary. If you are instantly successful and have an average of five clients each day, you would like to charge about \$30-35 for each of them. You might like to charge that since that seems a fair amount but unfortunately about 10-13% of your clients will probably not pay their bills and, depending upon your socioeconomic spectrum, some of the others will not be able to afford all of your nominal charge. You will reduce their bills to what they can pay. To allow for those who won't pay and those who can't pay all of your charges, you will have to raise that minimum fee to

\$40-45 for each of the five wonderful souls who have somehow found their way to your office. Incidentally, you will have about one hour to spend with each of them if you keep your report writing to 15 minutes per client, take one half hour for lunch, and only spend one hour a day doing your record keeping.

Thus far, we have been concerned with the factors involved in creating a market and operating in a cost efficient manner. Because historically the private practitioner has functioned as a sub-rosa member of the larger society of health professionals, he has been viewed with varying shades of jaundice not only by his colleagues but by others who work from the secure base of the large institutions. To deny this is foolhardy and to operate without this slightly paranoid attitude is to invite bankruptcy. Let us turn our attention to the ethics and interprofessional relations involved.

Ethics and Interprofessional Relations

To exist in a medical, paramedical, educational and health profession community as a member of a large institution is simple; one merely follows the existing code of ethics of the appropriate professional association, comports oneself with dignity, abides by the dicta of the institution, never accepts money directly for services but accepts one's check at the end of the month. The private practitioner typically belongs to the same professional associations, follows the same code of ethics, comports himself with dignity but then takes money for services while abiding by the dicta of his own institution, his private office. The assumption, voiced or voiceless, is that he will bend his principles, sell his scruples to make a living. Because his principles have been evolved, not by democratic process, but in an autocratic manner, they are assumed to be self serving rather than client or community serving. To combat these attitudes, the private audiologist must maintain a scrupulously clean profile. There can be no bending of rules of good conduct, either professional or personal; there can be no evidence of fee gouging; there can be no question of partiality to one physician, one hearing aid dispenser, or to anyone. Despite these precautions, he will still be suspect. If he is to dispel the attitudes of mistrust on the part of the institutionally-based health and education personnel in the community, he would do well to outdo the comparable institutional provider of audiologic services in giving advice, free services, educational guidance, free screenings. Even so, he will be accused of advertising, pandering, underselling and all other manner of misconduct by those institutions with which he is in competition.

We have been concerned to this point with factors of cost, creating a market, and operating in an ethical manner. Perhaps the single most important area or factor however is that of competition. It is an axiom in any business that knowledge of the com-

petition allows one to challenge it successfully. Gimbels doesn't tell Macy's but Macy's does everything possible to find out what Gimbels is up to. Unfortunately, knowing the competition is often of very little help to the audiologist in private practice. However, it is better to know than to operate blindly and naively. Perhaps this discussion of the competition will discourage those of you who have thought of entering the arena. With no malice, particularly, I have chosen to title this section "Pimps, whores, merchants and bores."

Competition

Historically, the largest competitor in the past has been the physician, specifically the ENT man who either performed his own tests with tuning forks or had his nurse run air conduction audiograms on his patients. He was a formidable competitor because he didn't charge for his audiologic offerings, such as they were. True, he didn't offer counseling, hearing aid advisement, or therapy but then again, his clients were seldom led to expect it. Why spend \$40-45 for something that could be obtained gratis.

The second largest competitor was the large institution such as the university, the hospital or the hearing and speech center supported by public funds. By working with the medical community, they were gradually able to provide more comprehensive services, usually at a price below that which the private audiologist could afford. Since the institutions could utilize student interns, graduate students, and trainees and were often allowed to operate in the red, it was feasible to provide cut-rate services. Because of nationwide cutbacks on support monies for such positions and because more institutions are requiring fiscal accountability of our departments, their role as competitor has diminished in importance.

The universities are now providing the private practitioner with his greatest challenge to solvency. They are preparing hundreds and hundreds of new audiologists each year for the job market. Well trained, young, with glowing mien and great expectations, they find a constricted field outside the walls of their universities. Many of them are now entering the world only to find that the glorious days of the past exist only in their mentor's memories. There are few jobs available and usually not in the large cities where many of them would like to live. By default, a good number of them become the competitors to the private audiologist with an independent office.

Audiologic whores:

The audiologist who sells her body to the physician replacing his nurse has actually been with us for many years. It is her proliferation that is of concern now. Because of the availability of the young audiologist, the physician can be assured of an endless supply of highly trained technicians who will grind out eight to ten sets of numbers each day for him. She sells her services by the

hour or the day, is given little opportunity to counsel patients or to interpret results and is seldom asked to provide any continuity of service.

Because she is available in such grand numbers now, a new market appears to be in the offing for her. Hearing aid dispensers, wishing to avail themselves of well qualified, moral, young audiologists, are beginning to look with interest.

Pimps:

The audiologic pimp is a somewhat better business person than our audiologic whore and is more experienced in the ways of the market place. He finds spots in the offices of busy physicians for a number of audiologists, collects a percentage of their earnings and supposedly supervises their work. The pimp is a newcomer to our field of private practice and perhaps the most frightening. In the guise of supervisor, he becomes the clinical mentor of recent graduates satisfying their CFY requirements for ASHA or their registered professional year for licensing. One shudders not only at the lack of supervision provided but more convulsively at the attitudes and principles that are transmitted from the pimp to his whore.

Merchants:

The audiologic merchant is frankly in the business to get as good a return on his educational investment as he can. Finding a glutted market, he discovers that a new sub-field is beginning to emerge, that of hearing aid dispensing. Whether selling services for fees or selling aids directly, he is a threat both to the audiologist in private practice who still clings to his tattered dignity and shreds of principle and to the hearing aid dispenser. Under the guise of providing comprehensive services, he is selling his educational credentials. I do not mean to belittle the honest audiologist who wishes to dispense aids as part of a complete audiology program. The audiologic merchant is to be distinguished from the audiologist by his lack of concern for other remediation approaches and from the hearing aid dispenser by his lack of concern for effective follow-up.

Bores:

This last grouping, that of audiologic bore, is the term I find useful to describe the young graduate who attempts private practice and finds that he lacks the audiologic expertise, the business acumen and/or personal presence necessary to stimulate business. Because the audiologist in private practice will only remain solvent with a continuing flow of clients, he is dependent upon establishing and maintaining referral sources. He fails and cries that the world is to blame rather than recognizing his inadequacies.

By being aware of the financial aspects of operating a sound

business and by recognizing the standards of audiology as universal no matter what the setting, it is possible to provide audiologic services independently and to achieve fair compensation for your efforts.