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The Case for Diagnostic Audiology: Is Anyone Listening?

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At the end of the hallway of the ENT and audiology departments at St. Paul's Hospital in Vancouver is a meeting room officially dubbed the ENT Library. These days the library collection has been whittled down to 20 or so ancient ENT texts and one sad-looking model of the larynx. The room itself, however, is a vibrant place: it is a teaching space for clinical rounds and academic sessions, a clinic space for patient groups, an overflow work area for clinicians and researchers needing a place to park their laptops, and a lunchroom for clinic staff and physicians.

Last week I walked into the ENT Library at lunchtime to find a group of neurotologists, vestibular audiologists, ENT residents and a UBC audiology student animatedly discussing a puzzling case: a patient that presented with the debilitating symptoms suggestive of superior canal dehiscence (SCD) along with many of the expected audiovestibular test results that come with SCD, with the exception of normal VEMPs. This sort of interaction is common in our department. We audiologists are fortunate to have an easy, collegial and mutually respectful relationship with our ENT colleagues.

We have what we need to do our jobs well at the hospital – schedules and equipment that allow us to perform a variety of tests, the chance to discuss difficult cases with one another, the means to access journal articles when we're stumped, clerical staff that understand our patient population and workload. I consider myself lucky to work in a place where the contribution of diagnostic audiology to patient care is valued, with colleagues that are curious and knowledgeable, and under a hospital administration that supports audiology outpatient care. Most importantly, I believe our patients benefit from the assessment and counselling we are able to provide… for now.

At the end of March, the Audiology Department at Mount Sinai Hospital in Toronto will close. This in the same year the WHO is poised to ratify a new resolution that recognizes the increasing disability that results from hearing loss worldwide. As an audiologist that has worked in a hospital audiology clinic for close to 20 years, I am concerned. Do patients and physicians know what the loss of diagnostic audiology centres like Mount Sinai might mean for hearing health care?

Quite possibly Mount Sinai feels that equivalent diagnostic services are available to patients in the community. Few community audiology clinics, however, have the required equipment to perform and fully assess both peripheral and central hearing and vestibular function. Then there is the question of cost-recovery of diagnostic services in a private clinic: provincial medical plans will not pay audiologists directly for diagnostic testing, and do not adequately cover audiologic or vestibular testing billed through ENT physicians. Most (if not all) extended health care plans do not reimburse for testing. Private clinics that offer hearing tests free of charge will have a difficult time being able to justify or perform a full diagnostic test battery within such a business model; the costs of such provided tests are usually recouped in the sale of hearing aids. And most importantly, there is the loss of expertise that clinicians acquire through regular assessment of unusual, even extraordinary hearing and vestibular disorders and from hallway chats with colleagues that happen daily in a hospital clinic.

While every audiologist is trained in diagnostics, not all community audiologists will feel that they have the time, experience or knowledge they need to be “experts” in diagnostic audiology, having focused their efforts in other areas of practice. Certainly, I am fortunate to have access to expert audiologist colleagues I can count on for any number of things I don’t do on a regular basis (amplification, for one).

At a time when audiology is facing an identity crisis, the loss of diagnostic services in public health should sound a warning bell to the audiology profession. As audiologists we know the value of our diagnostic skills but are we effectively informing patients and other health care providers? Do patients and providers understand the difference between a hearing screening and a full hearing evaluation? Do they understand the significance of a hearing health check-up at a time when the burden associated with hearing loss is at an all-time high? Are our reports written in such as way as to make our findings useful to other healthcare providers? With the loss of hospital diagnostic facilities, will our physician colleagues still be able to access appropriate audiovestibular assessment to assist in medical diagnosis and patient care? Will the education of otolaryngology residents suffer? Will they be adequately educated on when masking is required, when test results are inconsistent, or when more detailed audiologic assessment is warranted? What impact will the need to charge patients for diagnostic services have on time spent to analyzing results and determining the site of lesion? Will patients understand the importance of these assessments and be willing to pay? Should regulatory bodies play a role in defining the parameters of diagnostic testing and maintaining it as an area of restricted practice?

If diagnostics is to remain a defining aspect of audiology practice, we need to advocate for proper funding for our services. We need to interact with stakeholders to ensure that our tests and reports are meeting their needs. We need to liaise with provincial regulatory bodies about setting out guidelines, and insist that the provinces and statutory regulations define who can perform and interpret diagnostic assessment. We need to be active clinical and academic partners in the education of physicians and others working in the health sciences. Our professional survival depends on it.