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# Striking the Right Balance

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Emma LeBlanc, AuD

*In this edition of "Striking the Right Balance", Emma LeBlanc, AuD writes a follow-up opinion piece to the article "Looking to the Future of Vestibular Practice in Canada" written by Carolyn Falls, MCISc, that was published in Canadian Audiologist (Volume 7, Issue 6, 2020).*

*Michael Vekasi, AuD, R.Aud, Aud(C), FAAA and Erica Zaia, MSc, RAUD are coordinating the "Striking the Right Balance," feature which will cover the latest information on 'all things vestibular.'*

*If you would like to be more involved in all things vestibular, please sign-up for the Vestibular Special Interest Group. Sign-up by simply by mailing CAAvestibular@gmail.com to let us know you want to be a part. Also, check out our Facebook page for a free list of online vestibular resources at the CAA National Vestibular Special Interest Group page.*

The idea of this article began when Carolyn Falls, MCISc, interviewed me about my experiences in a Doctor of Audiology program in the United States. She had asked me about my vestibular training, what the diagnostic privileges were in the U.S., whether audiologists could make direct referrals in the States and what my thoughts were on the differences between vestibular practice in Canada and the U.S. During this interview, she and I realized that this would become a much larger topic than what one article could cover. And so, the creation of this 2-part series began. As you saw in Carolyn's article, she covered what she labelled as key barriers to vestibular practice in Canada. I want to comment on those barriers from a U.S. perspective, which we thought would create a well-rounded analysis of the future of Canadian audiology practice. Could we look at vestibular practices in the U.S. to help us envision a better future for what practice in Canada could become?

I had assumed, and what I believe is a shared assumption amongst some of us in Canada, that audiologists south of the border have a more autonomous practice. Despite receiving my education

and doing several practicums in the States, I, for example, thought that all audiologists could make direct referrals to ENTs and make vestibular diagnoses. I have since learned that while I am not entirely wrong in my assumptions, it is much more complicated than a matter of yes or no. As I started my research for this article and began to interview a few of my colleagues who practice in the U.S. and/or went to school in the U.S., I discovered that this topic is, yet again, too large to encompass in one article. To be honest, I think you could spend an entire graduate course learning about the differences in vestibular practice between the two countries and still only begin to grasp the complexity.

I have identified what I believe are three primary areas of misconception among Canadian audiologists about vestibular practice in the U.S. They are making diagnoses, making direct referrals to other professionals, and practicing vestibular rehabilitation. In my opinion, one of the main reasons why it is so challenging to analyze audiology practice in the States, and why these misconceptions are so difficult to dispel, is that every state has different guidelines and often the insurer drives the practice.

There are two governing bodies for American audiologists (the American Speech-Language-Hearing Association (ASHA) and the American Academy of Audiology [AAA]), and they have similar position statements on the Scope of Practice of Audiologists. They both state that audiologists can diagnose and treat hearing and balance disorders; however, some states require additional licensure. When asking my audiology network if they make vestibular diagnoses, most report that they are more comfortable 'suggesting' a diagnosis even though making a diagnosis is well within their scope of practice. This is apparent in the billing processes and perhaps one reason why audiologists feel that it is safer not to make a firm diagnosis. During the billing process, audiologists must assign an International Classification of Diseases Clinical Modification Code (ICD) which, as the name implies, is a code that corresponds to the disease or diagnosis of a patient. Allocating the most appropriate ICD code is very important in the billing process as it is used for billing insurance and can affect a patient's medical coverage, especially when there is a disagreement between different professionals. To give you an example of how confusion in coding can arise, there is a code for "dizziness and giddiness," "vertigo, unspecified" as well as more specific diagnoses codes such as "Meniere Disease" and "vestibular migraine." How do you know which to choose? It is up to each professional to choose the most appropriate code, and perhaps it is the fear of clashing with other professionals such as family doctors and ENTs, which has led to audiologists shying away from making specific diagnoses.

This leads to the second area of misconception regarding the American audiology system: whether audiologists may make direct referrals to other professionals such as ENTs, neurologists, psychologists, etc. Many of my colleagues reported that it depends on the referring doctor, the clinic in which they work, and the type of insurance the patient has. Due to the many factors at play, often audiologists in the U.S. are not making direct referrals.

Lastly is the notion that vestibular rehabilitation is widely practiced among audiologists in the U.S. Vestibular rehabilitation falls within the scope of practice of audiologists according to ASHA and AAA, so why is it that only a few of my American colleagues practice vestibular rehabilitation? Most cite that reimbursement is difficult, and there is little infrastructure for audiologists to provide these services. Another barrier to vestibular rehabilitation is finding appropriate continuing education courses, as many of these courses and do not list audiologists as one of the professionals that the course is designed for. As you can see from these three

misconceptions, the U.S. audiology system is quite complex and difficult to analyze.

One area, however, that we can look to the States for some insight on how we can improve our practice in Canada is education. In Part One of this article, Carolyn Falls used six key pillars to discuss areas that can be improved upon in Canada's audiology practice, and I believe all these pillars are tied together by a straightforward mechanism – education. More education is needed to help gain diagnostic privileges throughout Canada and help open communication lines between audiologists and other professions such as ENTs. Education will also help foster the confidence of other professionals and ourselves to make these decisions, advocate for better funding for vestibular testing, and expand our vestibular practice to include services such as vestibular rehabilitation.

The switch to a Doctor of Audiology (AuD) degree from a Master's Degree has allowed programs in the U.S. to add more course work and labs to their curriculums. Most major doctoral audiology programs have at least two full vestibular courses (if not three or four courses), including approximately three hours per week of in-class and hands-on experience. Vestibular coursework is a much larger focus of AuD programs than it used to be. The longer doctoral format allows for more frequent and varied internship opportunities. Students are allowed to spend more time in the clinic, learning hands-on skills, which is an invaluable experience that helps ensure every student has the chance to practice and experience all types of audiology, vestibular audiology included. This is something that is sorely lacking in the Canadian system. One vestibular course (at most) is insufficient for students to learn anything more than the very basics of vestibular audiology. Hands-on experience is minimal despite being critical for the students' success. If students do not get one of the few highly coveted placements with a vestibular clinic, it falls to the individual audiologist to seek additional training post-graduation. Learning vestibular testing and interpretation is a skill that requires a lot of hands-on experience, and some tests, such as the Video Head Impulse Test (vHIT), take months to learn. Finding post-graduate training at this level is very difficult and, I fear, prevents many audiologists from working with vestibular patients.

Adding more vestibular courses to the audiology curriculum, having additional hands-on labs, and increasing the number of internship opportunities in Canadian schools will significantly improve our country's audiology field. We also need a way to encourage continuing education for practicing audiologists, especially in the field of vestibular practice. Perhaps, similar to how the AuD programs in the U.S. offered courses to upgrade audiologists with a Master's degree, we can create courses and diplomas that give audiologists the skills to test and interpret vestibular assessments confidently. Only once we have these resources in place can we begin to tackle some of the six key pillars Carolyn identifies to begin to build a better, more integrated future of audiology in Canada. Let's look to our neighbours to the South for some tips on strengthening our education system and take this opportunity to improve the education we offer our students and fellow audiologists. Change often starts from the ground up, so let's begin with our students.