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In Conversation with Robyn Cox

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On the occasion of her retirement, eminent audiologist Robyn Cox took the time to speak with Sheila Douglas about her life and career.

SD: What lead you to the field of audiology? And, why did you choose to emigrate from Australia to the US?

RC: Through sheer luck I had the opportunity to go to a very good high school in Brisbane (Australia) and was able to win a scholarship to go to the university. I had absolutely no idea what I should do there. So basically I just decided to do at the university what my best friend was planning to do because she seemed to have some ideas. And she was going to do speech therapy which was a brand new program at the University of Queensland at the time. In the end she didn't go for one reason or another. So I went and, having no ideas of my own, I went into the speech therapy programme (there was no audiology programme at the time) which was a 3-year diploma not a 4-year bachelor's degree. Along the way we did get what would have been the equivalent of one semester credit of audiology classes, taught by Laurie Upfold who was one of the original audiologists in Australia and who has recently himself retired. I found audiology to be more interesting than speech therapy. But there was no place in Australia that you could study audiology at that time and there were very few "audiologists" around.

Then along the way I met this guy from the US while we were both studying at the library (if that's geeky enough for you). He was a political science student. We started dating. To put this into context it was the time of a big buildup in the Vietnam War and his US "minders" insisted that he return to the US so they could draft him and send him to Vietnam. So we decided to get married and I would come with him to the US and that is how I ended up emigrating from Australia. Why not have a new adventure? We were planning to go back to Australia, but that never happened.

I had a 3-year degree so I wasn't eligible to get hired as a speech therapist; I needed a 4-year degree. So I went to the local university (Ball State University in Muncie, IN) to deal with the 4th year. And, along the way I took a couple more classes in audiology because you needed a few credits in sudiology to get that speech pathology degree, and I thought "Well, you know, this audiology thing is really pretty interesting." So I just "kept on floatin.'" It was easy to just go on into the graduate programme and get a master's degree in audiology. And, it was pretty interesting. By the time that was over my husband was interested in getting his PhD in political science and the plan was to go to Bloomington (Indiana University) and I just floated along with him and thought "Well, they've got a PhD in audiology there, I'll just go do that." I know that this doesn't sound nearly as inspiring as people probably want, but this is actually what happened. When I finished that PhD it was time to get a job so I just got a job and started working as an audiologist. I was an

assistant professor. I'd only been one year in that job when I got some information about a research position that was available and I interviewed for that and I got it. I was one year out of my PhD. And, that was really what turned everything around, and I became a researcher after that. Everything from there was really about research. And, I stayed with the field of audiology; I never actually considered leaving it. I found it interesting. It was satisfying from the point of view of having enough science to be challenging and also involved working with real people and people with real problems. Gradually, as time went on, I became more and more interested in the people with real problems.

SD: What would you say is the thing with which your name is most closely associated?

RC: Anybody else would have a much better idea than I would! I would say that it's probably the APHAB Questionnaire; it's so widely used. The fact that the APHAB is so widely used makes it more valuable than it might otherwise be because there's a huge base of data. If you do a search you'll find lots and lots of research that's been done using it and research about it, and so it's arguably the most valuable contribution I've ever made even though it might not be the best one.

SD: What do you *hope* to be remembered for? As in "Robyn Cox? Isn't she the one who… ?"

RC: Until very recently it never occurred to me even to think about being remembered for anything because I know very well that people fade away pretty quickly. I do think I made a considerable contribution to the science of outcome quantification in different ways over the years. And, I think that that has been useful to the field. A lot of people have gone with that idea and made their own contributions, of course. None of it, taken by itself, amounts to the Theory of Relativity, that's for sure.

SD: At least it gives us something to do beyond "How does that sound, sir?"

RC: That's right! And it's a step in the direction of science. Since we began the journey of making science out of outcomes I think we've made good progress and achieved a huge amount of understanding of what it's like for people – I wouldn't say we know *everything* about what it's like for people, but we know better. I think we are less likely to *assume* we know when, in fact, we don't, what it's like for them to have a hearing problem and to *live* a hearing problem and still maintain their sense of personal worth and enjoy their life. This is really what our job is supposed to be about.

SD: What memories do you have about the writing of your earmould monograph?

RC: It was written very early on when I started on the research mode and it was really kind of an accident that I wrote that. Someone else was scheduled to write it but then they had to pull out, so I was sort of accepted as "Okay, well, nobody's ever heard of *her* but I guess she can write." I remember two things about it. One is that it was quite exciting, and I had the opportunity to interrogate myself about "So, what do you think happens if *this* happens?" and then I could go down into the laboratory and actually find out the answer to that. That was terrifically exciting and empowering! It helped me realize that I could find a way to overcome the practical obstacles that make it difficult to determine what's going on. Secondly, *every one* of those figures had to be hand drawn. Back in those days we didn't have any graphics programs and everyone who created an article for publication had to create their own figures by hand. It was a *huge* undertaking!

SD: Initially your research covered acoustics but then switched to patient satisfaction with amplification. What brought on this change of focus?

RC: My research covered acoustics because I was drawn to that. I was much more interested, in the beginning, in the more overtly "science" side of the field and less interested in the "people" side of the field, but the more I went into studying things like acoustics and adjusting and fitting

hearing aids, the more I realised that we didn't have any decent way of finding out whether we were doing a good job. The only thing that audiologists had in those days was monosyllabic word lists, and it was very clear in the research that they were not a useful predictor of the value of a particular hearing aid fitting. We kept on because we didn't have anything else. And, that's what made me think "I'm working on measuring down to the nth dB and I really don't have any idea what's important to people. I don't have any idea whether I'm helping them. I have a *fake* idea; I can do an aided monosyllabic word list and come up with an answer but it's not the *right* answer. So I'm going to drop all this 'acousticy' stuff and start studying what's involved in finding out whether we're *helping* people." And that made me immediately run in to the problem of "we have no way of measuring whether we're helping people." There was no clearly valid measure. Everybody was, at that time, absolutely married to the idea of measuring sounds, and it just seemed to me more and more that that was arrogant of us, to be thinking that we could measure sounds, that we didn't have to ask the human beings sitting in front of us.

My first funded research was *all* about developing outcome measures. To make the research interesting (for that time) and fundable I had to include the measurement of sounds (speech in different environments). But, I was essentially interested in finding out whether there was any usefulness in measuring speech understanding. I already knew that monosyllabic words were of no value so I needed to develop a more face-valid way of measuring aided speech understanding and to do that in environments that were outside sound-treated booths. And, then I also wanted to develop some ways of interrogating the human being in a systematic way about what their perception was and then see whether their perception and my measured "speech understanding things" actually agreed with each other. That was kind of the idea behind that earliest project. But, the business of questioning patients was of absolutely no interest to the scientific community at that time and remained completely of no interest for many years until we had basically a revolution in healthcare where customers demanded that their opinions be listened to. And, then, suddenly, outcomes became important to the healthcare field. Now we're asking people their opinion about every darned thing. So I definitely swam against the tide for a long time developing questionnaires, but I had a strong belief in the importance of them. Going back to your previous question I think that's probably the biggest contribution I've made to our field: helping to sensitise people to the importance of that. We have to talk to patients and find out what their problems are and see if we're addressing those problems, and it's rather arrogant of us to assume that we can help them without going there.

SD: What do you wish every newly graduated audiologist knew?

RC: Actually it goes to the same topic. During the time that I've been watching our field many of our students and our practitioners have become less interested in what *is* the most important thing in our field and that is focusing on the patient. Instead we have gone into making it all about hearing aids and technology, and that line has come almost to a full stop. I suspect that we have gone about as far as we can (at least for now) with hearing aid technology improvements *that really matter to people*. And, it's clear that it's not enough. It's not making people happy enough, it's not satisfying them, it's not solving their problems all by itself. Wearing hearing aids is not like putting on a pair of glasses, and it's never going to be. It's a lot more like strapping on a prosthetic leg. It's going to help you with your problems, but you've got a long way to go before you can get maximum benefit out of it. In my view audiologists have forgotten that their job is to help the person use the "prosthetic leg," so to speak. It's not just to give it to them. I have seen it happen so many times in the course of research that the human interactions between the knowledgeable audiologist and the hearing impaired adult (I never worked with children) is the big factor. It is THE thing. It's more important, frankly, than the technology in the hearing aid. So many people

who are subjects in our research will say “If only that audiologist I saw a couple of years ago had talked to me like you do it would have made a huge difference.” Or things like “Oh My God, you saved my marriage!” and we’re not doing counselling research; we’re fitting hearing aids and teaching people about them.

SD: If you could have the attention of every audiologist for 20 minutes what would you want to tell them?

RC: Years ago I attended Brad Stach’s president address at the AAA convention. I was struck by one thing he said: “Embrace the Inevitable.” I’ve remembered it ever since. I wish that audiologists would take that on board because I think that we are facing, quite frankly, the end of our field as we want it to be unless we remember who we are and begin to embrace the knowledge that our job is to use all the means at our disposal to help people solve their daily life problems that are caused by hearing loss. Few audiologists are doing that. We’re the ones who are *supposed* to do that, but mostly we’re not doing any more than providing hearing aids. As a field I don’t think that we’re living up to our promise. I wish that audiologists would embrace that idea and make some changes before it is too late. Eventually someone will figure out how to move beyond hearing aids and get paid for what they offer. I hope that will be audiology.