Canadian Audiologist

The Official Publication of the Canadian Academy of Audiology

The Wired Audiologist

Published September 3rd, 2014

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In the early part of my career, I worked as an educational audiologist at the Robarts School for the Deaf in London Ontario. I recall one of my first case conferences for a student with hearing loss and was asked to provide a report. My response was woefully inadequate. I described the student's hearing loss, provided a description of the real-ear-to-coupler difference, and boasted how well the selected hearing aid was meeting DSL targets. This was the 1990s and the use of RECDs and DSL was still in its infancy. I was feeling pretty smug for being an early adopter of an excellent clinical technique. The problem was this child was not talking despite the fact that I was making speech audible across most frequencies.

Fast forward a few years and I am now working with adult clients. I recall cases in which two adults with essentially similar audiograms can have vastly different outcomes. The typical clinical pathway in audiology involves case history, audiometric testing, hearing aid fitting, followed by fine tuning. Some patients needs were met using this approach while others required frequent and lengthy follow-up visits. Could these appointments been avoided?

These experiences led to a personal interest in understanding the differences between verification as opposed to validation. Moreover, I also became interested in better needs assessment tools to determine which of our vast array of treatment options should be used with this particular patient. Finally, I became a believer in performing outcome measurements as I wanted to know if the work I was doing as an audiologist (particularly as one who is personally living with a profound hearing loss) was actually making a difference in the lives of the patients and families that I served.

Much of the work of Dr. Robyn Cox has been dedicated to these very questions. From the various scales she has developed (e.g., APHAB) to research on evidence-based practice, Dr. Cox has dedicated her career not only to validation measures but also to a vision of the professional audiologist as rehabilitationists rather than mere diagnosticians.

I was reading an April 2014 Audiologyonline interview with Dr. Cox and just wanted to scream my approval of many the things she stated in the article. Here is one quote that really speaks to me:

"*As a general rule, our current professional identity (both how others see us and how we see ourselves) is that of diagnostic technicians and/or hearing aid sellers. This is despite our extensive graduate education, broad scope of practice guidelines, and the career aspirations of most new audiologists who are entering the field. I'm sure you know that audiology began as a rehabilitative profession. But over time, we turned away from and abandoned our rehab roots.*"

Yes indeed we have abandoned our rehab roots. As marvelous as some of the technological advancements in this field are, the technology is only one half of the coin. The other half is the human element. It involves truly understanding our patients' needs. For example, we should be doing needs assessments and speech in noise testing to select the appropriate technology for our patients. The latter can easily be done within 5 minutes with a test such as the Listening in Spatial

Noise test (LiSN-S PGA). Yet the number of audiologists that routinely assess a patient's ability to understand speech in noise is low, even though hearing in noise is one of the main reasons a person seeks our help.

It involves counseling and coaching to teach our clients how to maximize this technology in the various listening environments encountered. And, if the patient is not ready or capable of following our recommendations, it involves having the strength and courage to help our patients develop realistic expectations.