The Hearing Aid in Rehabilitation Planning for Adults

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Rehabilitative audiology represents broad terminology including sub-areas as audiologic assessment, hearing aid evaluation, speech-reading, auditory training, counseling and pre- and post-hearing aid consultation. Consumers Report[1] has asked the question, "Why do so few of the estimated 6 to 15 million Americans with significant hearing loss use hearing aids?" People who need a hearing aid are sometimes not just awed by the cost, but would like not to acknowledge that they really do not hear as clearly as they once did. Holcomb[2] stated that the good audiologist or hearing aid consultant spends considerable time and effort in selecting and / or adjusting the hearing aid to the patient, but sometimes neglects a factor of equal or greater importance, i.e. the adjustment and conditioning of the patient to accept and utilize a hearing aid to the best advantage. Indications are that the general public has acquired the belief that a hard-of-hearing individual need simply wear a hearing aid to bring his hearing up to normal volume which will solve all of his problems. According to Patee and Cary, most persons who come to speech and hearing centers do not return for available rehabilitation or follow-up after a hearing aid has been selected. A survey of 119 adults by Alpiner, who underwent hearing aid evaluations at three different university speech and hearing centers, indicated that the majority of persons felt that they were not appropriately counseled by either the audiologist who recommended the aid or the hearing aid dealer who dispensed the aid. About three years ago at an ASHA convention, regarding the difficulty in getting clients to seek rehabilitative measures after hearing aid selection and fit, Harford stated, "We have tried everything but dancing girls." A concensus of opinion during that session was that hearing impaired adults who need help do not seek it. The point of the matter is that the hearing aid itself is only one factor involved in the rehabilitative audiology process and it may be incidental as to who actually dispenses hearing aids to clients if there is no follow-up.

We have, in part, come some distance from the old traditional days of rehabilitation that focused on the invalid procedures of Nitchie, Kinzie, Jena, and Mueller-Walle. Now we are seriously concerned whether or not we should get involved in the hearing aid dispensing business, in one form or another. I feel that the concern is justified, but that the interest in dispensing stems from

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another related issue, that being supportive personel, in which less than ASHA certified audiologists may be able to perform some of the audiologic techniques previously recognized as our realm of responsibility. The point here may be that we are continuing the search to justify the audiology profession. We no lònger are in the position of justifying the audiologist who is primarily concerned with audiologic assessment and hearing aid evaluation, leaving the remainder of rehabilitative audiology to someone else. The issue is a very complex one in which we really need to focus on our future directions.

Many hearing aid dealers are not averse to the principle of hiring audiologists to engage in rehabilitation, some physicians are not shy about hiring supportive personnel to perform certain audiologic tasks in their offices, and some clinical audiologists feel that there is a better future in engaging in the total process of rehabilitative audiology mentioned at the beginning of this paper. It almost appears that our concern for the dispensing of hearing aids has been brought about by a panic effect regarding the future of the ASHA certified audiologist. It is felt quite strongly that we must avoid a "band wagon approach" and not immediately rush into the dispensing of hearing aids without styding the logic of the process and all that it entails. We need to fully understand all of the ramifications involved in the dispensing of aids which includes the financing of the operation, the time expenditure necessary in order to fulfill the task efficiently, and somehow justify that the hearing aid dealer is not doing his job. If we decide that hearing aid dispensing fits into our domain, regardless of the many factors involved in the rehabilitative audiology process, then we must be prepared to assume the responsibility for total rehabilitation of the hearing impaired adult.

It was indicated earlier that it may be incidental as to who actually dispenses the hearing aid if the aid is considered only part of hearing rehabilitation. The reason for this statement is due to a subjective analysis regarding who actually refers hearing impaired clients to speech and hearing centers throughout the country for speechreading, counseling, hearing aid orientation sessions, and auditory training. I exclude Veterans Administration hospital programs based on the sub - fact that they are government controlled and that their financial responsibilities alone present a different situation. At an Academy of Rehabilitative Audiology conference held two years ago in Winter Park, Colorado, it was generally agreed that hearing aid dealers, physicians, and our own audiologists who confine themselves to audiologic assessment and hearing aid evaluations do not, as a rule, serve as primary referral sources. A sampling of hearing aid dealers and physicians in the Denver metropolitan area indicated that they have never been convinced that hearing rehabilitation is successful and that hard-of-hearing adults will learn to speechread and adjust to hearing aids without our help. These attitudes are depressing but not shocking to us; perhaps the weakest aspect of audiology and speech pathology is the shoddy and limited research done in areas such as speechreading. If one reviews the literature, we find that so much of the research has been accomplished with invalidated instruments--we need only to review the results of speechreading tests with emphasis on assessing lipreading ability with ridiculous sentence lists. One of the most recent new lipreading tests, within the past two years, is validated by using an existing non-valid test. It would appear

that we need to engage in public education with hearing aid dealers and physicians regarding the success of our accomplishments in aural rehabilitation. Unfortunately, we have little hard data in which to engage in this public education activity—we still meander in the unknown and contend that our services do help the hearing impaired.

We need to establish priorities in the profession. Regardless of whether or not we dispense hearing aids, we still continue to be delinquent in the total aspects of rehabilitative audiology for adults. It is felt that sometimes we devote so much of our energy to innovations, which can be positive, but perseverate in terms of our own feelings without regard to how hearing impaired clients view what we do. Much grass root work needs to be done; if we are realistic, it may be that we start with total rehabilitative audiology needs before considering the dispensing of hearing aids. Many years have been devoted to hearing aid research with a certain amount of sophistication, many years have been devoted to the other aspects of hearing rehabilitation, generally not sophisticated; very little attention has been devoted to the person who needs help and his relationships with clinical audiologists, hearing aid dealers (a la the present situation), and physicians. Why not establish priorities in terms of hearing impaired adults--and let us not do it from any kind of panic effect! A little foresight may be helpful--we *know* hindsight usually has been more revealing.

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