Audiology and Hearing Aids— Where We've Been, Where We Are, Where We Are Going

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Despite protestations to the contrary from many corners the history of audiology is strongly associated with hearing aids. If I may be permitted the luxury of reminiscence I can go back some 32 years to my first contact with the profession. As a hospital corpsman assigned to the Philadelphia Naval Hospital, I viewed my assignment to the aural rehabilitation ward as a stroke of rather good luck, because most patients there were not bedridden and were quite self-sufficient. That means they could make their own beds. They just couldn't hear too well. At the time I not only had no interest in audiology, I didn't even know what it was. Unfortunately, that is true for too many people even today. It was a number of years later that I was to learn who Hardy and Pauls were and, further that their aural rehabilitation program at the Philadelphia Naval Hospital was one of the cornerstones of the early structure of audiology.

It was out of the military based programs of this type that two basic audiologic functions evolved—one was the evaluation of functional hearing loss and the other was the hearing aid evaluation and its associated aural rehabilitation programs. In its postwar infancy these were the common referral requests received by the profession. The thrust and emphasis on differential diagnosis took a little longer to develop. As a matter of fact, that early concept of the hearing aid evaluation is something I have been trying to tone down for better than two decades. There are many, including some of my esteemed colleagues, who still believe the traditional hearing aid evaluation procedure was engraved in stone and to deviate from it is blasphemous. I, on the other hand, have held firm to the conviction that assessment of the hearing loss and its

associated communication impairment is my forte. Also, as an audiologist I am the most qualified professional to make sophisticated and knowledgeable judgments about such things as the ear to fit, the electroacoustic requirements of amplification and the like. I have never believed it worth either my time, or the patient's, to compare the patient's performance with a series of similar instruments with each other. Nor have I held the conviction that a clinical procedure has yet been developed which can single out that one instrument of devine creation that is singly suited for a specific patient. Hearing aids, unlike the traditional view of marriage, are not really made in heaven. A successful instrument-wearer union is rarely confined to a unique merger.

However, when we look at where we've been, we must remember that we have certainly left people with the impression that the hearing aid selection procedure is based upon more than a good professional evaluation of the hearing impairment and its associated ramifications. Unfortunately, we never really got the word across that the success of hallmark programs was probably more related to the counselling and aural rehabilitation components of the program than to the instrument selection procedure itself.

Where else do we come from? I'm spending some time on this because it's where we've been that accounts for a lot of our problems today. Audiology professes to be an independent health profession. I find this quite amazing when I consider the work environments we've grown up in. Fundamentally they are non-cost conscious, non-fee charging institutional facilities . . . typically university clinics and public schools. As we have begun to move into other settings we still tend to lean on others such as the Community Chest to support our deficit programs. I have often wondered why we should be embarrassed to charge a cost related fee for our services. If they are not worth the fee, we shouldn't be providing the services. Now, with escalating costs of todays world, even the traditional deficit environments are being forced to take a long hard look at the rationale behind "free" services. Even though we all cut our teeth on free or low fee services, we must be prepared, if we haven't yet, to move out into the real world where, if we cannot earn our keep, we just will cease to exist.

It is also important to look back at our interaction over the years with others involved in the hearing services and hearing aid delivery system. Traditionally we have viewed and placed ourselves as subservient to the physician and superior to the hearing aid dealer. Let us examine, for a moment, our past behavior first with respect to the physician and then the hearing aid dealer.

Audiology probably received a substantial boost in its professional development from the physician, albeit inadvertantly. Many of the time

consuming and financially unproductive test batteries were developed and performed by audiologists who often acted as an inexpensive consultant to the physician. The audiologist began to appear in otolaryngologic residency training programs, more often training the ENT resident in the meaning or interpretation of tests rather than the performance of them. The physician's involvement with hearing loss was directly proportional to the likelihood of surgical management of the problem. Consequently, as hearing aid technology became more sophisticated the physician actually began to be less informed about the communication impairment and aural rehabilitation. For example, I still hear some physicians make the statement that a hearing aid won't help a nerve loss. Patients with hearing losses who are desirous of a hearing aid and who sought out the physician were either directed to audiology clinics or sent directly to the hearing aid dealer. In my experience the more difficult cases tended to be referred to us but the majority went directly to the dealer.

For our part, we have generally considered the physician as essential members of the hearing health team. Our Minimum Requirements for Hearing Programs offering Guidance in Selection of Hearing Aids published annually in our directory and last revised in 1964, is a perfect example of our selective support of otolaryngology rather than just the medical profession itself. Before even consideration of audiologic prerequisites we abrogate all responsibility to the otolaryngologist. Even within medical circles there is not such support of the specialities. Our position has changed over the years, but we have not yet verbalized it in official documents. We still hold the belief that the patient will be best served when examined by both the audiologist and a physician knowledgeable in disease of the ear. However, we recognize that is not always possible and have stated publicly that *at the minimum* the patient should be examined by either an otolaryngologist or an audiologist prior to obtaining a hearing aid. This implies that as an independent profession we do not require physician participation as an absolute in this, as well as in other facets of our activity.

What about the hearing aid dealer? My earliest recollections of a hearing aid salesman is when I was in high school and a neighbor who was a salesman opened a hearing aid office. He is still selling hearing aids today, the difference being 30 plus years of experience. I could understand then, when in graduate school, the hearing aid dealer was generally described as untrained, often unethical and totally unqualified to sell hearing aids. Early in my professional life I found it somewhat confusing, therefore, when some colleagues who were well trained and of good moral character—one who had been in graduate school with me and another with whose training I had partially been involved, opted to sell

hearing aids. Our rigid self image dictated they must choose *between* audiology or hearing aid sales. It was indeed remarkable to me that these well trained, ethical and otherwise qualified gentlemen suddenly became the reverse in the eyes of my peers. This suggested to me that the training of other criteria really had nothing to do with how we classified that scoundrel who sold hearing aids. It simply was a matter of whether or how he made money. Our history here is that of the fairly traditional professional purist, and we have a good example in recent Supreme Court decisions about the longevity of that posture. The advertising of professional fees is a good example of how sacred the old standards may be.

Where have we been then? We are a profession whose early history stressed the evaluation of hearing loss and its impact on communication. We also emphasized aural rehabilitation as part of the improvement of communication skills. For the most part we attach little monetary value to our services and fostered agency or institutional programs rather than individual initiative. We have described our profession as independent but we behave in a very dependent manner. We work for others rather than others working for us. We have become enamored with the glamor of diagnostic evaluations and abrogated our rehabilitation interests either to the speech pathologist or the hearing aid dealer. We consider any venture which generates profit with askance . . . often equating profit with unethical behavior. In our relationship with physicians we have been generally supportive because we truly hold quality health care for the patient to be a desirable goal. However, at the same time we have begun to struggle for true professional autonomy. Perhaps we have recognized that it has not been a two way street. Yes, we have sent the patient to the physician, but the patient is often sent by the physician to the hearing aid dealer.

Enough of history—Where has all this led us? Today we have reidentified the hearing aid as a component of aural rehabilitation and staked out audiology's claim to this total area. As one might imagine we have not been received with open arms. It should surprise no one that the physician and the hearing aid dealer are not grateful for attacking their livelihood. In our zeal to protect the consumer we have moved head on into economic confrontation with the others in the hearing health and hearing aid delivery system. To many our motivation is more self serving than simply consumer protectionist. Everyone doesn't believe that what's good for audiology is good for the consumer is just coincidental. Can you blame them? Our vociferous criticism of the hearing aid sales industry has had much to do with licensing legislation of hearing aid dealers. Unfortunately, this has backfired in almost every instance. For the most part licensure afforded a legal basis for their doing what we were opposed to in the first place.

Rather than licensure, the lobbying should have been, as it was in some states and at the Federal level, a plea for professional intervention. However, that also has its problems. When we demand either equal or exclusive rights to the professional evaluation of the patient we appear to declare war with otolaryngology. The choice no longer rests with the physician whether or not our services are to be included. The physician is placed in a dilemma. Physicians themselves do not like to see specialty stipulations legislated. They prefer "physician" rather than "specialist" be mandated. Thus it is hard to get broad *medical* support for referral to an otolaryngologist. Furthermore, the otologist probably does not wish to be required to refer to an audiologist. Were the legislation one which allowed for an option, i.e. *either* the audiologist or the otolaryngologist, the patient might never see the ENT physician. Truly to support such consumer protection legislation places the physician on the horns of a dilemma. The first removes professional supremacy and the second hits the pocketbook. No wonder we have problems today.

To me, of even greater significance is our paranoic position about hearing aid dispensing. It should be obvious that whether we hide the profit in a moral or ethical shroud entitled "overhead" or openly dispense at a profit has little bearing on our relationship with the hearing aid salesman. Either approach has the potential for generating the economic destruction of the traditional hearing aid dealer. Consequently, we make no friends when we advocate dispensing by the professional. As a matter of fact, we probably have generated almost as much internal as external conflict with our guidelines for dispensing hearing aids. I know of no professional issue which has been more divisive. Even among audiologists, alone, the issue is often one of violent disagreement. Among 20 members of an audiology task force meeting last year no issue was more evenly split or without compromise. Our traditional professional ethical standards have dictated that the primary inviolable principle is that attaching a profit to the dispensing of a product is sinful (unethical). Even newly developed New York State Licensure regulations specifying unprofessional conduct for all the professions reject the concept that there must be no profit. They define unprofessional conduct in this sphere as "exercising undue influence on the patient or client including the promotion of the sales of services, goods, appliances or drugs *in such a manner as to exploit the client or patient for the financial gain of the practitioner or of a third party.*" Mature professional associations are also more satisfied to admonish their members to behave in a manner consonant with the best interests of their patients. This latter approach is deemed unenforceable by our Ethical Practices Board but the former is presently being investigated as a violation of restraint of trade. Furthermore, I am well aware of a number of dispensing audiologists who have

successfully made a mockery of what is presumed to be an enforceable set of guidelines. It is truly a pity that we find it necessary to equate economics of a certain sort, product sales, with ethics while economics of another sort, professional services, are of little concern.

Many analogies have been made in recent years about audiology and optometry. I have been among those who have made such comparisons. There are important differences as well as similarities. I certainly like the fact that the bulk of optometrists are private practitioners. I know of none who work for opthalmologists and few who work for opticians. The bulk are in private practice where they examine eyes and fit and dispense lenses. I have received bills from optometrists which separately list the professional examination fee and the fee for the eyeglasses. However, the latter is not an unbundled cost plus overhead, and I know very well it is not being sold at cost.

Compare this with audiology. We are all aware of our current dispensing guidelines. But before discussing that lets consider a real difference. If there is anything that this profession needs it is an abrupt change from employee to employer status. I hope you share my chagrin when you and I hear about the number of audiologists accepting jobs with hearing aid dealers, not as salespeople but for the provision of audiologic services. *We should not be working for them, they should be working for us.* This independent profession of ours has so few independent private practitioners that we are almost unidentifiable. I have said before, and believe even more today, that our future depends on whether or not we can develop a corps of private practioners.

As well as similarities, there is an important distinction between the optometrist and the audiologist of which we should not lose sight. The diagnostic testing we perform does help to contribute to a medical diagnosis. Medical input also helps the audiologist arrive at a diagnosis. There is far more interaction between the physician and the audiologist than the physician and the optometrist. Consequently, the analogy is not a complete one by any means. It only holds in the prosthetic area, and in our zeal to achieve our independence we should not lose sight of the totality of our profession.

Where we are, then, is not far from where we have been. We are starting to assert ourselves and as a result we are embroiled in some political confrontations that are serious enough to pose a threat to our future existence. We have staked a claim to the total non-medical care from evaluation to rehabilitation of the patient with hearing impairment. If we really mean it we will have to fight for it, because our opposition is not willing to give in to us. We are still attemtping to cling to our pious ethical standards but are becoming more aware that today's society may distrust them and also consider them a restraint of trade. Our image of

ourselves does not always match up with how others view us and frankly, I feel we may be too impressed with our own purity. We have attempted to monitor local standards from a national level at a time when such authority is losing its public appeal. With the increasing dominance of state licensure and associated unprofessional conduct regulations, those at the national level will have less influence. Our national professional association should lend guidance, not control over behavior. Local regulations should be more influential in controlling our practices.

What does the crystal ball say about our future? This is difficult to assess with objectivity. Frankly, I see only two possible choices for us. Our current position regarding product dispensing, specifically hearing aids, is personally unacceptable to me, and I do not view it as a viable choice. It automatically presumes guilt and evil to be associated with profitable dispensing. It does not encourage private independent practice. It also implies that dispensing is not professional. If it is not, then I can see no way in which I should do it. Every moment of my time is cost accountable and I simply cannot see the need of differentiate professional from non-professional activities. Even if there is a difference, time in one activity costs just as much as in any other activity.

What *are* the choices then? One is to return to our previous prohibition against any kind of dispensing. This would be easy to enforce but, I hope, unacceptable to the profession. I believe it would be disastrous and would result in mass exodus of audiologists from ASHA. The other choice is to adopt a more general concept which admonishes against exploitation of the patient. Our standards should be consistent with the times as well as the nature and needs of the profession. How we are accepted by the public will to a large degree depend on how well we do our job. We should not be afraid to compete on the open market place with those who we deem educationally, technically and/or ethically inferior. Nor should we so hamper our ability to compete that we ruin our chances of success.

On the broader professional front I am optimistic that our relationship with the medical profession will improve. It is certainly my hope they do, because I view audiology-medical cooperation to be beneficial to each profession as well as advantageous to the patient.

It is time to select and chart the path which fosters the growth, not the death, of the profession. I view that path as one which broadens individual options and adopts a more mature posture by our national leadership. It must be one of independence, both professionally and financially.