Audiologists Should Not Dispense Hearing Aids

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Although the two papers on this program were specifically requested by our program chairman not to be presented as a debate, inevitably a degree of debate-like flavor creeps in. When contrasting papers are presented back to back, each author attempts to present his side of the issue in a most effective way. Thus I found myself, as I presume Dr. Harford did, tempted to press my argument from the narrow rather than from the more broad viewpoint. I hope I have resisted the temptation somewhat.

Our professional literature and the literature of the hearing aid industry is well stocked with technically correct and proficiently written papers of related significance. In one of several papers written about twenty years ago, Carhart (1950) described what has continued to be the usual mode of operation of most audiology clinics regarding hearing aids. The basic concepts are that there needs to be an impartial person dealing with the client, that the primary work of the audiology clinic is to assess the client's needs and to advise him regarding probable benefits from acoustic amplification, and that formal audiological testing procedures are valid.

While it is true that Shore, Bilger, and Hirsh (1960) concluded that tests for hearing aid evaluation are not sufficiently valid, and that differences among hearing aids are not adequately measured by the usual audiology clinic tests, in the same year McConnel, Silber, and McDonald (1960) reported opposite findings, namely that the clinical testing of hearing aids is an adequately reliable procedure.

That the audiological community has continued to search for valid hearing aid rating and advisory procedures is exemplified by papers by Jeffers (1960) on quality judgement in hearing aid selection; by Resnick and Becker (1963) who described the audiology clinic function as one of testing, and with hearing aid selections delegated entirely to the dealer; by Shore and Kramer (1963) who evaluated clinical testing and hearing aid advisement procedures, and who recommended that the hearing aid purchase be in the hands of the dealer; and more recently Jerger, Speaks, and Malmquist (1968) who demonstrated that the development of more sensitive and valid tests for hearing aid ratings are feasible.

While we may severely criticize our own professional literature for not being complete, comprehensive, nor definitive, it is clearly differentiated from what is seen in the hearing aid trade journals, with their emphasis on moving a product off the shelves, increasing the profit margin, and the concept of the hearing aid industry. In the trade journals there are professional articles about some technical aspects of audiology, but all are written by professional audiologists, and are at a relatively lesser level of technical complexity.

Typically, these articles are summaries of the state of the art, written for consumers of audiological research.

Other articles in the trade journals are exemplified by the items which describe a program of branch offices and a buying cooperative arrangement. In both of these cases, hearing aid dealers, franchised by hearing aid companies, have developed what appear to be professionally responsible and competent hearing testing and hearing aid advisement operations (Natl. Hrng. Aid J., 1971). However, even in these descriptions of exemplary programs, concern for the commercial operation is primary.

Obviously, my first argument against audiologists selling hearing aids is with respect to the temptations of the commercial market.

The person with a hearing loss (or his family) is vulnerable. He rarely is in a position to evaluate independently either the status of his problem, or the effectiveness of remedial measures, such as hearing aids. It is fairly easy for a hearing aid salesman to demonstrate benefits from at least one of his instruments when worn by a client.

But the demonstration of some small, albeit convincing, benefit from a hearing aid is not the equivalent of leading the client through a program of impartial clinical procedures to evaluate his acoustic, educational, vocational, and social handicaps and realistic evaluation of the results obtained through a hearing aid or other measures of remediation. I hold that the clinical audiologist, who is free from maintaining his income by the sale of hearing aids, is in a proper position to offer such services to the hearing handicapped, while another group more properly should dispense hearing aids to clients on the basis of independent determination of the advisability of a hearing aid (by the audiologist).

It is appropriate to comment about the role of codes of ethics in this matter. I presume the two that pertain are the Code of Ethical Trade Practices for the Hearing Aid Industry, and the Code of Ethics of the American Speech and Hearing Association. I do not intend to rest my argument upon the point that the American Speech and Hearing Association's code of Ethics at present prohibits the sale of hearing aids by audiologists. This would be a nonsequitor, for a code of ethics is made by a group of individuals to represent the ideals of their group at any one time. The ASHA Code of Ethics can be changed to reflect revised viewpoint regarding ethical practices.

The Code of Ethics of the Hearing Aid Industry, prepared by the Hearing Aid Conference and the Society of Hearing Aid Audiologists, is entirely concerned with trade practices. That code was developed by hearing aid dealers as a protective device against what they consider to be unscrupulous trade practices by members of their industry. It says nothing regarding the auditory welfare of the client.

This leads to my second point, and to what is always a dangerous practice, namely, predicting the future. One such fearless soul, apparently, is Dr. Williams (1971) from the University of Texas Speech and Hearing Center. He predicted the demise of the hearing aid dealers as well as of the audiologist. He based his argument on the premise that, in the past, audiologists have been heavily subsidized by university and governmental agencies, and therefore, in times of contracting government support, they will not be able to continue as before. Meanwhile, the hearing aid dealers will lose their business because

audiologists will go into private practice with physicians and eventually dispense hearing aids from their offices. I am sure that possibilities Dr. Williams describes will provide us all with anxious moments in the years ahead.

Now I ask your indulgence while making another prediction of the future, depending in part upon a definition of terms. My preference is that the audiologist of the future will be one who practices some aspect of the science of hearing. He will be in contrast to the audiologic technician, whose day will be spent routinely doing hearing tests, to be interpreted by a professional (such as an otologist or audiologist), and fitting hearing aids according to prescription, much in the way opticians fit eyeglasses or prosthetic supply houses fit artificial limbs.

As one proceeds through academic training and, especially through professional experience following the completion of the usual professional preparation requirements, one realizes that many of the hearing test procedures, which earlier appeared so intriguing and esoteric, in fact are mundane, routine, procedures. A high level of skill can be developed rather quickly on the administration of such audiological tests, and in fact the mark of a good procedure is the degree to which it can be carried out readily by technicians. The more routinely a test can be administered, the more general its applicability and reliability, the less its ambiguity, and the more objective its interpretations.

Thus it also becomes obvious that audiologic technicians can be trained to do very adequate testing; that a doctoral degree or even a master's degree is not a requirement, and that probably the only prerequisits are that the test technician be reasonably intelligent, have personal integrity, and exercise a high level of self evaluation so that he recognizes errors as he practices his techniques. This is the situation within fields such as the medical technician, the dental technician and much of nursing. While we professional audiologists may balk at the thought, the hard truth is that much of what we do can be accomplished, often even more effectively than by ourselves, by technician level individuals.

Thus the prediction that the future of audiology will involve at least two levels of practitioners.

The first level, and I am not sure whether it is the lower or the higher, is that of the audiology technician. This individual will administer routine audiology tests, report the test results on standard report forms, and submit these to a professional individual who will make the appropriate interpretations, make judgments about rehabilitative procedures, and assume responsibility for continued care of the patient.

We already have with us the vanguard of the audiological technician. The technicians' role is now being served by people who are known as audiologists, especially in some medical settings where the orientation is toward serving the diagnostic and other support needs of otolaryngologists. Many otolaryngologists train their nurses to test the hearing of office clients, and I have known of several instances where the receptionist or secretary in an office competently does the required testing. There currently is a grant from RSA to the National Association of Speech and Hearing Agencies to train former armed services medical corpsmen to be audiometric technicians.

Whether or not audiology technicians might also become franchised to sell hearing aids from a given manufacturer remains as a future development in the field, eventually probably to be determined by the interplay among vested interests as they attempt to influence our governmental agencies, and as audiologists further develop our ability to prescribe or recommend hearing aids accurately for individual clients. To say that the audiometric technician, whether or not he dispenses hearing aids, is an audiologist is a moot point and may rest upon a semantic definition. For the present, I would prefer not to apply the term audiologist to such people; I would prefer that they be allowed to to sell hearing aids.

Certainly, the level of academic training for audiology technicians can be far below the present master's level, probably below the four year baccalaureate degree, and may well be accomplished in no more than a one or two year technical training program comparable to the training presently offered for the medical or dental technician.

We also are seeing serious questions being raised regarding whether or not our present audiologist, holding the master's degree and the Certificate of Clinical Competence from the American Speech and Hearing Association, can be entrusted with the full level of responsibility, which the mature rehabilitative audiologists would prefer, and which the client deserves. Too often, the CCC audiologist has had only a one-year or so training program specifically in the field, with heavy emphasis upon administration of audiological tests, and one year of poorly directed professional experience. Typically his training has included little about the overall communication process, the psychological aspect of human behavior, the vocational and social readjustments, the counseling procedures, and the rehabilitative procedures other than hearing aids. Dissatisfaction with this type of audiologist led to the founding of this Academy. In addition, there has been at least one conversation among ASHA circles regarding the need for a higher level certification which would be granted for preparation and experience beyond the present CCC requirements.

Whether or not a traditional doctorate is required, or whether one year or two of training beyond the master's degree would be appropriate for the complete audiologist, is not the critical issue. What is clear is that audiologists, if they are to avoid becoming handmaidens of medical or other professions, or to become little more than over trained hearing aid salesmen, must support and develop a leadership cadre who practice as independent professionals, responsible for patient care. Such professionals may function within the academic sphere, or deliver services to the public. However, their services to the public should not be limited to the technical or testing level, nor should the services include direct provision of hearing aids. Rather, the services should emphasize making independent judgements, and assuming responsibility for the patient free from the demands of commercialism, the continued researching of the science of hearing and its rehabilitation and the teaching of persons to be audiologists or audiology technicians. A distinction between audiology technician and audiologist would, of course, result in fewer individuals being known as audiologists. On the other hand, what is proposed here not only would stimulate new methods for the effective delivery of services to the public, but also would be a progressive step toward solving a number of

problems in our field.

In summary, I proposed that we recognize on a formal basis, with whatever legal and academic trappings are appropriate, an individual to be known as an audiology technician. He may also have competencies and the facilities for the direct sale of hearing aids to the public, or he may continue to function only as a test technician. He would enjoy the benefits of and the limitations imposed by licensure, and would be directed by the professional audiologist. We would recognize the professional audiologist whose level of training and technical skills, self regulation by his professional organizations, and over-all level of activity would far exceed those of the licensed audiology technician, (and exceed the present CCC standards). This latter individual would properly be known as the audiologist. He would not dispense hearing aids.

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