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## **Reflections on Change, Fitting Protocols, Counseling, Audiograms, and More!**

By Douglas L. Beck, AuD

### **Introduction:**

I believe most of us would like to help more patients with hearing loss and most of us would like to create a more successful business. Unfortunately, the often repeated and shop-worn definition of “insanity” is doing the same thing over and over and expecting a different result. That is, we need to embrace changes that make sense and drive prosperity—or we may find ourselves doing the same thing over and over while expecting a different result!

I know we all hate change. I get it. However, in general, it seems we tend to practice using protocols which (more or less) reflect the practice of our mentors from very long ago and far, far away. It can be argued the intention and goal of our mentors was (and remains) to provide us a knowledge-based “starting point” from which to build. That is, the mentor’s task was to provide a starting point, not a “plateau” and certainly not a “finishing point.”

There are 34.25 million people in the USA with hearing loss (Kochkin, 2009). Of those 34.25 million, perhaps half have a significant and compelling need for hearing aid amplification (Amlani, 2010). However, only one of every four (or five) people with hearing loss will voluntarily walk through your (or my) door. Unfortunately, of the people that do walk in the door, about half leave without acquiring hearing aids (Taylor, 2009). Therefore, depending on how you do the math, it seems we’re really only helping about one in 8 to 10 people with hearing loss—not a very good batting average and not at all representative or reflective of our significant knowledge and professional skills. Nonetheless, these numbers do represent an opportunity to change, learn, and grow.

Therefore, with some serious reflection and some tongue-in-cheek rants, it seems 2013 may be the perfect time to re-evaluate, re-think, and try some new things and reinforce some old, proven things. In this article, I’ll address eight of the ideas, issues, and pet peeves I presented at the 61<sup>st</sup> Annual International Hearing Society Convention and Expo in Arizona, this past September, 2012.

### **Part One: Fitting Protocols**

OK, I just have to get this out, and then I promise I’ll move on. As professionals, we must change as knowledge emerges and technologies change. It is noteworthy that “the single most important benefit of technology-driven communication enhancement (i.e., hearing aids) is additional human connectivity” (Beck & Harvey, 2009). We must *increasingly* adjust to, and accommodate, patients who walk in the door (often) with an abundance of knowledge and curiosity, as well as hearing loss. We need to adapt, or be left behind. That’s how things work in today’s market, and that’s how they will increasingly work in hearing aid dispensing.

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Unfortunately, hearing professionals (audiologists and hearing aid specialists) sometimes confuse starting points and finishing points. The point of “first fit” software is to initiate basic hearing aid fitting parameters—from which the licensed professional is to apply their knowledge and experience to eventually create a “final fit.” The first fit is almost never the best fit and, to the best of my knowledge, was never intended to be the final fit. The first fit is simply the beginning of the journey. Likewise, using an analogy from martial arts, despite years of conditioning, training and sweating, obtaining a black belt is not the end of the journey - it's, actually, *only* the beginning.

Beck (2010) reported Hawkins (2010) significant, revealing, and insightful article in which Hawkins asked, "Are YOU ready for Mr. Smith?" The fictitious Mr. Smith was a 59-year-old, well-connected middle-aged bright guy with a mild-moderate sensorineural hearing loss. Just as you and I do, Mr. Smith researches issues and answers prior to making large financial decisions. As such, he did his due diligence and researched hearing aids and fitting protocols online before purchasing hearing aids. He visited many websites (ASHA, AAA, Consumer Reports, etc.) and quickly and easily learned the national associations "strongly support the use of real-ear measures...as the primary method of verifying the performance of hearing aids..." As you and I would have done, Mr. Smith formulated a few basic questions to ask his hearing healthcare professional with regard to his hearing aid fitting, such as:

“Is the entire speech signal audible to me?

Have you programmed my hearing aids such that the amplified sounds will be within my dynamic range?

Have you verified that loud sounds won't be uncomfortably loud for me?"

And when the answers to the above questions were not particularly revealing or forthcoming, Mr. Smith queried (before leaving empty-handed),

“Are you aware many professional organizations ‘best practice guidelines’ dictate probe microphone measures to appropriately adjust hearing aids?

Did you really *just* use a software simulator to set my hearing aids?

Are you aware it only takes ten minutes to make probe microphone measures?" And finally, Mr. Smith said, "Let me get this straight. You want me to pay \$5,000 for hearing aids, which if successful, I'll wear some 10 to 14 hours a day for five years or so—and you're *not* taking 10 minutes to measure and adjust them in my ears?"

**....when both verification and validation protocols are used, office visits decreased (on average) by 1.2 visits.**

Kochkin, Beck, Christensen, et al. (2010) reported over half of all dispensing offices own REM equipment, yet REM is routinely used in (approximately) one-quarter of all adult hearing aid fittings. Kochkin (2011) reported the lack of objective real ear measurement (REM) verification and the lack of behavioral validation (confirmation of performance while wearing hearing aids) increased the total number of office visits per patient. Further, Kochkin noted (based on 533 office visits) when *both* verification and validation protocols are used, office visits decreased (on average) by 1.2 visits.

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However, after personally advocating REMs for some two decades, I realize professionals aren't as interested as I would expect. (Yes, it took me twenty years to realize that!) So, I offer the above simply as a reminder and a rationale to re-evaluate, re-think, and try some new things and reinforce some proven, old things. Moving on....

### **Part Two: Speech-In-Noise**

I'd like to state the obvious. The number one complaint of all patients with regard to their hearing loss and their hearing aids is their inability to hear clearly in noise. However, despite this most common of all complaints, very few hearing healthcare professionals check the patient's ability to perform speech-in-noise tasks. I believe this omission is a critical error. For example, if I went to an auto mechanic and said I have a flat tire which I'd like changed, and he proceeded to lift the hood and look around the engine, I'd conclude that he clearly has no idea what I was talking about. Why then, is it acceptable for the majority of our patients to complain about speech-in-noise, yet most of us don't test (i.e., measure) it? One cannot assume that someone with this-or that audiogram hears in noise at this-or-that level. It simply doesn't work that way! I believe we'd be better off measuring speech in noise ability to validate the patient's complaint and to show them we really do understand their primary complaint. Further, when we successfully fit the patient with hearing aids, we should be able to measure the same ability (speech-in-noise) and show an improvement while using our recommended and fitted hearing aids.

### **Part Three: Counseling via "Motivational Influence"**

As hearing healthcare professionals, we engage in lengthy and necessary counseling sessions with our patients. All the counseling we do is well intentioned, there's no question about that. However, some of the things we do and say could be improved to deliver a more concise, more consistent, and more beneficial message to the patient. In fact, some of the typical things we say and do are comparable to shooting ourselves in the foot.

Motivational Interviewing (MI) (Miller and Rollnick, 2013) is an incredibly powerful tool which helps facilitate the desire for change within the individual. MI has been shown to successfully work in changing the behaviors of obese patients, smokers, alcoholics and drug addicts. The core concept of MI is that in order for successful change to occur, it must be internally driven. Beck (2011) noted, "One cannot help the person who does not want and does not seek help..." Specifically, for MI to work, the individual must recognize that a particular change would be beneficial for them, and therefore, the patient motivates him/herself to desire and seek the change. MI is focused, goal-directed, and patient centered. MI is an effective tool as it recognizes and helps resolve ambivalence manifested via uncertainty, fluctuation, an inability to choose a preferred route/alternative, or perhaps the simultaneous desire and ability to see both sides of an issue. The counselor (i.e., hearing healthcare provider) is tasked with "rolling with resistance" while enhancing the patient's intrinsic motivation to change and to help patients articulate and discuss *their* reasons to alter behaviors – all in a non-confrontational manner (Beck, Harvey & Schum, 2007).

"Influence" (Cialdini, 2008) helps us understand how to get people to comply with ideas, protocols, and processes which are truly in their own best interest. Cialdini reports six core principles which impact and direct human relationships. Specifically, human relationships are impacted and

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directed through the recognition and use of reciprocation, consistency, social proof, liking, authority, and scarcity.

As hearing healthcare professionals, we can facilitate counseling sessions which incorporate core concepts and ideas from motivational interviewing and influence (combined by Beck, 2011 into “Motivational Influence”) so the patient becomes the one seeking solutions for their hearing loss, rather than our common approach which is often to review and describe the audiogram in depth (see below), to relate the audiogram to the patient’s difficulties, to describe hearing aid features, processes and prices and to start a trial period.

#### **Part Four: Questions Not to Ask**

Sometimes, we ask questions of patients with regard to their history, thoughts, and opinions which are damaging to the professional relationship, and sometimes poorly thought out questions stand in the way of the patient following through and acquiring hearing aids. Many of the traditional questions we recite in the office came from our mentors, but that was a different day and those questions served a different purpose in a different health-care environment.

For example, if we ask something innocuous like, “Does your hearing loss cause problems?” We allow (indeed, we invite) the patient to say, “No, it’s really not a problem at all. The problem is actually my wife/husband speaks to me from two rooms away while the TV is on and I’m washing the dishes.”

Given this situation, the patient has just denied the hearing loss and, further, the patient has just told us it’s not a problem—and as Cialdini notes, the patient really wants to be consistent with their thoughts and words and they do not want to look silly. We can argue or persuade all we like, but as Cialdini indicated – we need to have a two-way amicable relationship with the patient and, frankly, they don’t really want to be corrected or coerced. So, everything they say and do (after their response) needs to be consistent with what they just said, as they (likely) want you to like, respect, and believe/trust them.

It would have been wiser to not ask that particular question. Indeed, just as a good attorney never asks a question he/she doesn’t know the answer to (in front of the judge or jury), a good hearing healthcare professional should avoid inviting comments and discussions which are not productive.

*...if we ask something innocuous like, “Does your hearing loss cause problems?” we allow (indeed, we invite) the patient to say, “No, it’s really not a problem at all.”*

Another question which invites non-productive answers from the patient would be, “Do you think you have hearing loss?” It seems to me if the patient is in the office of the hearing healthcare professional we can assume they have hearing loss until proven otherwise. That is, if we ask them, “Do you think you have hearing loss?” They might say, “Not really. Well, I know I have a little hearing loss, but I do fine most of the time when people look at me and they speak clearly. Besides, my doctor told me my hearing loss is normal for my age.” Why would we voluntarily go down that road? Now we have to correct the patient *and their doctor* and we have to prove to them we’re smarter (or better informed) than they (and their doctor) are while using our familiar sounds audiogram to prove our point and correct the patient (more on this below).

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## **Part Five: Questions to Ask:**

Based on Miller & Rollnick and Cialdini, I recommend asking questions specifically designed to get the patient to talk about their hearing loss. For example, I ask every adult patient, “Which is harder for you, understanding speech in a restaurant or a cocktail party?” Really the answer is irrelevant because the point is simply to get them to talk about their hearing loss. Virtually every patient will pick one or the other, and they’ll tell you why their chosen answer is difficult for them. And that means they’re talking about their hearing loss.

Another good question is, “Thanks for coming in today, Mrs Smith. It’s great to see you! Has your hearing loss gotten worse lately?” In general, there are only two answers to that question; “Yes, my hearing loss is worse.” or “No, my hearing loss is pretty much the same.” Either answer is fine as they are admitting and talking about their hearing loss—and that’s the immediate goal and the first step along the continuum.

## **Part Six: The Ultimate BAD QUESTION:**

Of course, for the people with mild-moderate-severe sensorineural hearing loss who do choose to walk in the door, we presume it took them, on average, seven years (on average) to seek our services. Arguably, they are quite used to the sounds they are hearing and can easily make the case that the most normal and natural sounds for them are the sounds they are accustomed to hearing. Nonetheless, I’ll bet that in most offices across the world, on a daily basis, most hearing healthcare professionals fit first time users with their binaural top-shelf hearing aids and ask, “How Does That Sound?”

It sounds crummy. They are not used to it. Amplified sound and perhaps circuit noise is not what they’ve heard previously and even excellent open fitting devices sound very different from their day-to-day baseline “normal” perception. Further, when we ask this ultimate bad question, the patient will respond, and in addition to their, often, negative perception of what \$5000 dollars worth of hearing aids sound like, they will likely notice and tell you their voice sounds funny, too! Now, we’ve invited them to say their brand new hearing aids sound weird or crummy and they’ve noted that they’re voice sounds funny, too. Furthermore, as Cialdini indicated, once they’ve said words and stated opinions that they (perhaps subconsciously) need to be consistent with, they will likely start to make additional negative observations—all of which we invited by innocently asking, “How does that sound?”

Why did we ask? Has a first time user ever responded with, “Oh my! This is FANTASTIC! I absolutely love these hearing aids! Where’s my checkbook! I should have bought these seven years ago!”

No, probably not.

The better thing would be to spend more time counseling and setting realistic expectations. Perhaps something like, “Mrs. Smith, this is going to be very exciting. I’ve checked your new hearing aids and they are performing exactly to specifications. So then, I’ll place them on your ears and then I’ll check to be sure the sounds you’re hearing are exactly what you need to hear and that they’re not too loud. After that, I’ll show you how to place them in and out of your ears, and we’ll change the battery and you’ll be all set to learn to listen. Now, the funny thing is, today is going to be a very unusual today. In fact, I know it’ll probably take the full 30 days, or so, for you to get accustomed to the sounds you’ve

been missing. Many of my patients also notice that at first, their voice sounds a little funny – sort of like the first time they heard themselves speak on a tape recorder! I assure you that in a few weeks the sounds you hear with the hearing aids will be very good, natural and normal, as will your voice. But again, you’re not going to be accustomed to the sound for a while, and it’ll be a fun experience as you learn to listen to the sounds you’ve been missing.”

The bottom line is, it’s better to counsel and prepare them ahead of time, and to help them develop reasonable expectations, and then verify and validate; than it is to apologize and continuously adjust the hearing aids to what the patient reports is “normal.” Again, the “normal” sound they are accustomed to is the sound they hear through their hearing loss, and the easiest way to achieve that sound is to remove the hearing aids – which is not the goal!

### Part Seven: Audiograms

Arguably, the most over-used and most misunderstood tool in our toolbox is the audiogram. In brief, the audiogram is a pivotal and important diagnostic tool. However, it does not need to be reviewed in detail with every patient, even though this is a common practice. Often, the audiogram is



the center-point of the counseling discussion. It shouldn’t be. The center point should be counseling and aural rehabilitation. I would argue most patients seen in the office have a mild-moderate-severe sensorineural hearing loss and, generally, they knew quite a bit about it before they walked in the door. Additionally, the majority of patients will forget 40 to 80 percent of everything we tell them immediately (Margolis, 2004). Therefore, I would argue that reviewing the audiogram in great detail with every patient is most often a waste of time. I

would recommend saying something like, “Yes, Mrs. Smith, indeed you do have a hearing loss which is consistent with your observations and experience and, fortunately, there is a great deal we can do to help.” Then, I suggest to move on to counseling and issues in aural rehabilitation.

Of course, if the patient asks specific questions about their audiogram, those questions should be answered, but lengthy discussions filled with medical and audiologic jargon addressing their pure-tone average, their type and degree of hearing loss, tympanograms, acoustic reflexes, word recognition scores, speech reception thresholds, and the like, are potentially overwhelming and very likely forgotten as soon as they are perceived. Specifically, hearing healthcare professionals must be truly and absolutely expert in conducting and interpreting audiograms, but the provision of a detailed “audiogramatic” explanation is most often a waste of time and generally unnecessary.

### Part Eight: Familiar Sounds Audiograms

Often, by the time one actually explains a familiar sounds audiogram, it has little “real world” meaning. The familiar sounds audiogram is so friendly, and so simple, and so horribly misleading that it has no real meaning at all. I believe our tools and explanations should be correct and meaningful. I can

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readily explain to a patient (or their parent) loud versus soft sounds and high versus low pitch without an incorrect and misleading tool, and I'm sure you can, too. If a patient (or parent) is really interested, it would be much more useful to have an honest and meaningful discussion. That is, the familiar sounds audiogram "dumbs it down" so much that it really is a waste of time more often than not. Again, I would recommend something like, "Yes, Mrs. Smith. Indeed you do have a hearing loss which is consistent with your observations and experience and fortunately, there is a great deal we can do to help." Of course, someone will write me and tell me they only use the familiar sounds audiogram with children. To which, I would say, you're not really explaining the audiogram to the child, you're explaining it to the parents/caregivers, and they are adults. Of course, the discussion should be tailored to the level of understanding of the involved people, and of course, if the patient has any of the warning signs indicative of a potentially more significant problem, further explanation and appropriate testing and referral are important, useful, and recommended. But in general, I advocate simple and accurate, not meaningless and messy.

**Conclusion:**

Hearing healthcare professionals are wonderful people. We do great things and we absolutely help lots of people. However, I believe we can help a lot more people by simply making a few course corrections and adaptations to successfully reach a much larger group of people with hearing loss and to better address the needs of those seeking our professional advice. As I close in on 30 years of being an audiologist, I've made some notes and observations along the way, and I suspect some of these same points have been noticed by you too. Therefore, it's my hope that by publishing some of these issues, we might facilitate changes which are beneficial to the profession, the professionals, and most importantly, to the patients we serve.

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1. **The familiar sounds audiogram is**
  - a) friendly and simple
  - b) horribly misleading
  - c) has no "real world" meaning
  - d) all of the above
2. **The majority of patients will forget**
  - a) 20-40% of everything we tell them
  - b) 40-80% of everything we tell them
  - c) 80-90% of everything we tell them
  - d) none of the above
3. **The most over-used and misunderstood tool in hearing aid dispensers' toolbox is**
  - a) the telephone
  - b) the audiogram
  - c) the ear mold injector
  - d) none of the above
4. **The center-point of a counseling session should be**
  - a) aural rehabilitation
  - b) the audiogram
  - c) counseling
  - d) a and c
5. **An effective question to ask after fitting a prospective hearing aid user is, "How does that sound?"**
  - a) True
  - b) False
6. **Which question(s) is/are good to ask during a patient consultation?**
  - a) Has your hearing gotten worse lately?
  - b) Does your hearing loss cause problems?
  - c) Do you think you have hearing loss?
  - d) b and c
7. **Checking the patient's ability to perform speech-in-noise tasks is an unessential task in an initial consultation.**
  - a) True
  - b) False
8. **The point of 'first fit' software is to**
  - a) initiate basic hearing aid parameters
  - b) give the wearer a perfect first and final fit
  - c) be utilized in conjunction with knowledge & experience to create the final fit
  - d) a and c
9. **The single most important benefit of technology-driven communication enhancement (i.e. hearing aids) is additional human connectivity.**
  - a) True
  - b) False
10. **The approximate number of people with hearing loss in the USA is:**
  - a) half of the population
  - b) 34.25 million people
  - c) 17.125 million people
  - d) none of the above

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