While ongoing advancements in technology and treatment options provide patients with opportunities to receive more optimal care from health-care providers, patient-provider communication and patient satisfaction remain a critical component of high-quality health care. Patient satisfaction is influenced by a variety of internal and external factors such as patient-provider communication, insurance, an individual’s personal life, and general anxiety related to health. These were areas that I gained personal, first-hand experience with balancing and navigating during my recent journey to receiving a cochlear implant (CI). This article will highlight some of these moments from which I gained particular growth and insight for my future as a practicing audiologist.

A goal of sharing my experience is to demonstrate the importance of, and the interaction between, a health-care provider’s responsibilities and communication exchanges with patients and the patient’s right and responsibility to be an advocate for themselves and their health care.

As a clinical audiologist in training, I am working on my skills to be an effective and ethical health-care provider. In the summer of 2016, I received a cochlear implant. Undergoing the processes of receiving a CI allowed me the opportunity to see my future area of health care from the perspective of the individuals I will serve. Ultimately, this understanding demonstrated the important impact I will have on a person’s experience and, ultimately, on decisions related to success with hearing-assistive technology.

Background
First, a little background on my hearing history. I was diagnosed with a bilateral, sensorineural hearing loss at two years of age, though it is believed to be a congenital loss. I started wearing hearing aids shortly after my diagnosis and have been fortunate to have a very supportive family and education system. At age 14, a significant decrease in my hearing occurred; it was debilitating. It affected me mentally, academically, and socially. During this time, I underwent a CI candidacy evaluation and imaging studies, which deemed me a candidate, but I quickly declined the opportunity. After many years of success with a hearing aid, I did not see the point of pursuing a CI. The potential benefits of a cochlear implant were communicated to me but I was too stubborn to consider the benefits; thus, decisions were made based on my emotionally-charged desires rather than through an informed decision process.

When I enrolled in my AuD program in 2014, I did not anticipate having a desire to wear binaural amplification or pursue a CI because for nearly two decades, I was a...
monaural hearing aid user (left ear). As soon as my coursework began in my first year, the impact of auditory deprivation was discussed and I approached my professors regarding a hearing aid trial in my right ear. The hearing aid trial began in February 2015. The first two weeks were quite an adjustment because my right ear had lacked auditory stimulation. However, I pushed through the adjustment period because I was (newly) aware of the benefits provided by binaural amplification. I began to experience the auditory benefits and continued to use bilateral aids regularly.

At some point during my AuD program, I began to truly reflect on the information that I was given as a teenage patient with hearing loss. As an AuD student, I had been presented with additional information. I was now able to make informed decisions. I wanted to explore my options regarding a CI. One year following the initiation of binaural amplification, I underwent a CI candidacy evaluation. Unsurprisingly, I met the audiological criteria for a CI in both ears. After sifting through all the information and potential benefits for each ear, I approached my CI audiologist expressing my readiness. I called my parents to share the news; they were shocked by my decision due to my previous opinions. However, once they were given a full explanation, they supported my desire.

In February 2016, I spoke with my professor, a CI audiologist, about seeking approval from my insurance company for pre-authorization of CI surgery. My professor called the CI center, I called to schedule an MRI/CT. I was told the following instructions:

1. You must get an MRI and CT scan prior to meeting with the surgeon so they can determine your candidacy.
2. You cannot get an MRI or CT scan without having been examined by the surgeon first.
3. You cannot get an MRI or CT scan without a surgeon’s order for the scan, so you must see the surgeon first.

I was repeatedly told that I needed to have these tests done prior to meeting with the surgeon, but a surgeon’s order would not be given to me without being seen first. Three days prior to my appointment with the surgeon, an administrative staff member told me that it takes about two weeks to process the paperwork. After a month of no updates, I called my insurance provider and was informed that it takes seven to 10 days to process for authorization, but my paperwork had not been received. I called the CI center to follow up. It was discovered that my paperwork had accidentally been sent to the wrong insurance provider. This was frustrating because my goal was to be implanted by May and now the process had been delayed. It is natural to make mistakes; we knew we had to simply keep moving forward to achieve our goal.

Challenges
As an out-of-state student, it was imperative to see if my insurance company would permit surgery in the region of my university rather than in my home state. Eventually, my insurance company denied out-of-network benefits, thus my surgery was only permissible in my home state. This added additional stress to an already stressful situation. I knew that there were time constraints, travel expenses, and other factors that would influence my reactions to the surgery. It was with this high level of anxiety that I began the search for a center in my home state. I learned from this process that patients often come with pre-conceived notions and experiences that we, as clinicians, are unable to identify and over which we have no control.

After identifying a suitable CI center, I called to schedule an appointment to discuss my candidacy with a surgeon. My first call was answered by another employee notifying me that the CI scheduler was out of the office for three days; they left her a message and said she would call when she returned. After a week, I called again and left another message. I waited a few more days and still had not received a call. The lack of contact increased my frustration and I became more anxious to learn my candidacy status. I turned to my professors for advice. My professor called the CI center until she was able to speak to the surgeon’s nurse, who was responsive and professional. She was consistent in returning our calls.

One of the requirements for determining CI candidacy is undergoing an MRI and CT scan. In the numerous times that I had been on the phone with several receptionists at the CI center, I was given different instructions for obtaining these tests, resulting in confusion. I was unsure when, where, and who would do the MRI/CT.

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member called me to indicate that I needed an MRI/CT scan done the day before the consultation. The staff member then told me it would take two days for insurance to process the order for coverage, so it was too late to get the scans before my appointment.

Results
As I continue my journey in becoming a clinician, I learned that expectations are a critical component of health care. Patient and provider expectations should be established early to ensure congruence between the two parties’ expectations. A personal goal I have developed as a result of this experience is to ensure that patients I fit with hearing assistive devices have realistic expectations, but not just expectations for how to use the device. We also set expectations for interactions; I learned that the support staff also influence patient expectations and future interactions.

The day of surgery was an excellent experience due to the administrative staff and health-care providers. I was greeted by the receptionist, who was warm and welcoming: she wished me luck. The nurses, anesthesiologist, and surgeon were professional and executed their responsibilities with utmost care and kindness. I felt respected as an individual rather than just another patient. Having an operation may be daunting, but my comfort level increased as I interacted with each health-care provider that day. In sum, my surgery occurred without incident and I was impressed with the process from beginning to end.

Looking back on this experience, there were positive takeaways and opportunities for improvement in providing optimal health-care services. Ultimately, we all know the importance of patient–provider communication; but people tend to forget that patients are also responsible for facilitating effective communication. Although I was frustrated with the lack of communication to set up appointments, I realized that health-care facilities are working with many other patients daily. It is common sense that it takes two people to hold a conversation; this made me realize that patients may have to initiate communication to get their needs met. Patient satisfaction and quality of care does not solely depend on the responsibilities and performance of health-care providers. For the patient, the decisions he or she makes are largely dependent on the interactions with the entire health-care faculty. All employees influence a patient’s experience.

There is a litany of internal and external factors that may influence a patient’s interactions and reactions to their health care; only some of which we can control as providers. I hope that reading my experience can help you understand that within your practice, it is not just how you, as a provider, interact with patients; it is how all of these factors come together that influence a patient’s responses, experiences, and outcomes.

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