The Impending Spondee Crisis

Audiology has great potential in the age of the millennial. However, it will have to face new obstacles in how services are provided, what services are provided, and to whom. The TFCSL-1 and the test test won’t be enough to offset potential disruptions outside the test booth.

Say the word: hot dog. Yes ... SAY THE WORD: HOT DOG. In an age of blue-tooth connectivity, nano-technology, deep-brain stimulation, and robotic surgery, audiologists are asking their patients to say a word describing a food developed over a hundred years ago that is potentially composed of meat by-products. Regardless of how many vegans are in the waiting area, requesting the repetition of hot dog (or airplane or ice cream, for that matter) may not be an appropriate way for audiologists to introduce themselves to a new generation of patients. What message does “hot dog” send about professional knowledge and skills in what should be viewed as a highly technical field? Audiology is facing a spondee crisis. It can be averted if action is taken quickly, but responsibly.
The Impending Spondee Crisis: Audiology in the Age of the Millennial

The W-2 spondee list is a treasure dating from the early 1950s. Gratitude should be given to both the Harvard Psychoacoustics Lab and the Central Institute for the Deaf for developing the list and ensuring more than a half-century of usefulness. But that was over 60 years ago. Hard-wired rotary telephones, black and white television, and propeller aircraft were the norm. Hearing aids were mostly body-worn and audiologists did not dispense them. The spondee list of the 1950s worked well for “the greatest generation” and will probably do as well for baby boomers, but gen-xers and certainly millennials are going to expect much more.

Spondee word lists and test methodology have been analyzed, studied, discussed, modified, debated, and re-named (ASHA, 1988). Throughout these many years, it has always been stipulated that a critical characteristic of the spondee list was its familiarity to the general public. In addition, it was (and still is) recommended that the list be read to patients prior to testing to reinforce that familiarity (Tillman and Jerger, 1959). Regrettably, that part of the protocol is often omitted given time constraints in most clinical settings. Although the W-2 list remains familiar to most patients, when did you last hear a twenty-something use the words inkwell, padlock, or drawbridge in complete sentences? The familiarity of the W-2 list can no longer be assured. And, perhaps more importantly, the W-2 spondees date audiologists as relics of the past when they so desperately want to portray themselves as vibrant, current, and technically competent professionals. Simply put, are the W-2 spondees familiar enough to today’s patients and do they create the respect audiologists want?

Proposed Solution

What follows is a modest proposal for a new Twenty-First Century Spondee List (TFCSL-1). This modern list solves the problem of familiarity for millennials and will
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certainly impress, if not amuse, those new to an audiologist's office.

The proposed list solves the issue of familiarity, but undoubtedly will require some further analysis. Those with the requisite skills will need to evaluate the list for both phonetic dissimilarity and homogeneity of audibility (Olsen and Matkin, 1979). Even a well-constructed list could meet resistance when displacing something as sacred as the W-2. But modifications of test protocols to accommodate special populations are not unprecedented. Toddlers are asked to point to body parts and limited set picture cards are employed with those under five years of age. The millennials may also need to be viewed as a special population for whom accommodations must be made. At first, something as radical as the Twenty-First Century Spondee List may not be embraced by all. Why not implement the list with millennials? As their numbers increase, so will the use of the list. By the year 2065, the W-2 will be completely phased out (along with the boomers) and millennials, along with the TFCSL-1, will be firmly entrenched.

Adopting new test materials will not completely resolve all measurement issues when evaluating millennials. Although they will certainly be impressed with words like bitcoin and ringtone, they still may not offer the expected responses. The audiologist may be concerned when silence follows a request to say the word: hashtag (or any other word). What could the motivation be for not responding when the millennial should be able to hear the presentation? Could it be pseudohypacusis? Perhaps. But there is no need to panic. Reconnecting equipment for galvanic skin response testing or dusting off Swinging-Story Test materials should not be necessary. Although most boomers are perfectly willing to talk into microphones, millennials can occasionally appear non-verbal. They often prefer to communicate through texting. As audiologists, flexibility is paramount. When “say the word” does not get a response at any presentation level, the test procedure should be modified. Ask the millennial to text the word. Problem solved. This new procedure will require a new name and acronym: “Texting to Elicit Spondee Thresholds,” or more easily remembered as the “TEST” test.

The Future

Some readers who have come this far may now be considering whether best practices may indeed necessitate the need for a new, more contemporary, spondee list suited to a new segment of patients and their vocabulary. Of course, the TFCSL-1 is not a usable spondee list but merely a haphazard grouping of untested spondaic words generated by a misguided imagination to make the point that there is sometimes a need for change.

Similarly, the TEST test is not real nor could it be practically implemented. For one thing, it is hard to know if cellphone-service is even available in most test booths. Faced with the inability to administer the text version of the test, the same group of audiologists who want to use the TFCSL-1 would probably not be deterred. Instead of asking for responses via text, they might ask the millennial to take a selfie with the appropriate picture card that matches the spondee being presented. Once again, flexibility solves the problem but probably doesn’t improve upon best practices.

Those taking the TFCSL-1 and the TEST test a bit too seriously may now be thinking of other aspects of speech threshold or word-recognition testing that need modification. Everyone would agree that audiology in the twenty-first century is not the same as audiology in the 1950s. For those inclined to rethink best practices for speech threshold testing, the TFCSL-1 could be either be a starting point for a new list or the beginning of the realization that speech threshold measures aren’t needed at all. Perhaps the real merit of the TFCSL-1 is to show that even best practices need re-assessment. Clearly in 1959 and maybe even in 1999, testing with the W-2 list had to be one of the best of the best practices.

Today, the W-2 list seems dated and the need for speech threshold measures have been questioned. Are they even necessary? Do they provide any useful information
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about the auditory system or could valuable time be better spent assessing other functions such as speech understanding in noise? Some believe that speech thresholds are still needed to confirm the accuracy of pure-tone testing. But how important is SRT-PTA agreement in most test settings? If you’re not routinely testing nine-year-olds feigning hearing loss or working with other populations where speech recognition threshold pure-tone average agreement may be important, perhaps speech threshold measures can be eliminated entirely.

Those who are overly concerned about the elimination of speech thresholds can still pivot to best practices as they relate to speech recognition measures. Single-word recognition tests in quiet, controlled environments provide a certain amount of useful information. However, they often don’t reflect the true impact of even a mild hearing loss in daily situations, especially in the presence of noise. Should time saved by eliminating the W-2 and/or TFCSL-1 be used to better assess auditory function in noise? Should single words be used or would continuous speech be more appropriate?

And what should the competing noise be:

- Street noise?
- Restaurant noise?
- Or, bowing to the needs of the millennial, perhaps a favorite iTunes track?

It has always been difficult to create controlled test environments and useful, noisy, “real-world” environments at the same time. That issue has plagued the assessment of hearing loss and hearing aid performance forever.

Most would agree that even if the TFCSL-1 and the TEST test were adopted, a change in spondee threshold measurement would not be a transformational event in the history of audiology. Certainly, any new spondee list reflecting current vocabulary would become obsolete in ten years or less as common vocabulary changes. Nothing should or can last forever, not even W-2 or the TFCSL-1. Limited longevity is part of the issue. Many procedures and products in the twentieth century had life-cycles much longer than we experience today. Audiology will need to adjust more quickly and continue to question methods and policies much more substantive than the measurement of spondee thresholds. Best practices will need to evolve along with audiology’s place in hearing health care. All industries and professions are subject to disruption if they cannot adapt. That is especially true when there is a tendency to dwell on the minutiae of everyday activities and lose sight of the bigger picture. One could argue that concerns over the W-2 list fall into the minutiae category.

Hearing health care is evolving more rapidly than ever in the age of the millennial. As audiologists continue to refine best practices, they will also be facing other new challenges. Those challenges go well beyond whether we need new spondees or any spondees at all.

Administrators look at audiology through the lens of time-management and the economics of insurance reimbursement. Audiologists will need to develop more efficient ways to generate the information obtained in a standard evaluation. Best practices must produce useful and valid information, but the time spent to obtain that information cannot be ignored.

Big-box retailers are probably not concerned about new spondee lists. With the help of the hearing aid industry, those retailers continue to become a larger force in hearing aid dispensing. Will opportunities for private

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practice audiology shrink? Even if some audiologists work for retailers, those jobs will be very different and not necessarily assured. There is no evidence that retailers care if audiologists or others dispense their hearing aids. In staff meetings, it is probably a safe guess that concern over best practices ranks far behind sales trends and return rates.

Consolidation in the hearing aid industry continues. History tells us that when consolidation reduces competition, it’s often not particularly good for customers. Audiologists are the customers of fewer and ever larger hearing aid companies. To think audiologists are in some way their “partners” is potentially naive. As hearing aid manufacturers vertically integrate, they will increase the dispensing of their products in company-owned outlets or funnel their hearing aids to big-box retailers. It would seem they prefer having audiologists (or others) as their employees rather than as independent, private practice entrepreneurs. That’s not a good trend.

Personal sound amplification products (PSAPs) are probably here to stay. The Food and Drug Administration may not be taking best practices in speech measures into account when examining the over-the-counter sales of PSAPs. And nobody knows yet the full extent of the PSAPs’ disruptive force. Audiologists are already faced with the dilemma of resisting them or embracing them. Time will tell what unexpected consequences develop.

If evolution does not come from within a field, then erosion may easily come from external forces. If the larger issues facing audiology are not addressed, other professions, as well as product manufacturers, will continue to influence the future direction of the field, and not always in a favorable way. Licensing and AuD battles may have been won, but too many other “practitioners” infringe upon or overlap with audiology. Although decades of Audiology Awareness Months and Better Hearing and Speech Months may have improved recognition of the audiologist’s role, that role is not completely understood by the public. And, unfortunately, when there is money to be made, others will take note and attempt to provide what the public wants in other ways.

Audiology has great potential in the age of the millennial. However, it will have to face new obstacles in how services are provided, what services are provided, and to whom. The TFCSL-1 and the TEST test won’t be enough to offset potential disruptions outside the test booth. Patient populations, technology, test protocols, insurance reimbursement, and the hearing aid industry are all evolving and so must audiology. Whether there is a spondee crisis is debatable. But, perhaps more than ever, audiology will have to subject itself, its best practices, and its place in hearing health care to ongoing evaluation. If audiologists do not initiate change, there is a greater risk that others will impose it.

Frank Bialostozky, MA, is semi-retired. He was in private practice in the Baltimore and Washington areas of Maryland for over 30 years. The views and opinions expressed in this article are those of the author and do not necessarily represent the official policy, position, or opinion of the American Academy of Audiology.

References


