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Academy President Brad Stach welcomes new members elected to the Board of Directors (from left) Ted Glattke, Lisa Hunter, Sharon Kujawa and Helena Solodar.
One of the underlying principles of the formation of our Academy was the commitment to move the profession to the doctoral level by transforming our academic model, from the ill-fitting one that it was, to one more appropriately aligned with a professional education model. Although the journey over the ensuing years has not been easy or uneventful, reaching this goal now appears inexorable.

The early idea held by most audiologists was to change the Master’s level entry model by both expanding the classroom curriculum to match the expanding challenges of practice and, perhaps even more importantly, enhancing and gaining control over the quality and consistency of clinical education. Many programs have re-engineered their curriculum and the manner in which they educate students clinically. I am continually impressed with the way in which many of our educational institutions have attacked the challenge of creating a new model for the professional education of audiologists.

But the movement didn’t stop there. In addition to focusing on the next generation, some audiologists led the charge to help current practitioners upgrade their knowledge to the level of earning the AuD credential through additional education. I believe that, for the most part, the results have had a significantly positive impact on the quality of the practice of audiology in the United States.

Over the years the academic transformation of our programs has met with some significant, well-deserved cynicism, which has persisted due to practices engaged in on both ends of the academic spectrum. In designing models of education for current practitioners, some of our programs have chosen the risky notion of equating experience with academic achievement. In the absence of academic standards for such programs, we can only hope that such an approach is short-lived. In designing entry-level models of education, some of our educational institutions seem to have missed the point about transforming our model and appear to have instead chosen to simply repackage their Master’s degree programs and rename them. Disappointingly, such an approach can occur in the absence of academic standards that truly ensure practitioner competence. I doubt seriously that this approach will be embraced by those who seek a high-quality education, practice our profession, or hire those who do.

I want you to be aware of some of the steps the Academy is taking to assist in the conversion of our academic model. I spent time over the past two weeks with three groups of members who embrace the challenge of changing our professional model. I attended a recent board meeting of the Accreditation Commission on Audiology Education, a fledgling organization chaired by Angela Loavenbruck, created on the belief that a new model of education necessarily requires a new way of thinking about accreditation. In a most enlightening and positive way, this group is setting the stage for accreditation based on outcome rather than process. They see an end to the day when record-keeping skills of the institution are a more salient feature of the accreditation process than the quality and competence of the graduating students.

I am impressed with many of their ideas about how to focus standards on the single meaningful outcome of ensuring the development of a competent professional practitioner and how to help universities use outcome measures as diagnostic tools to help enhance learning opportunities for their students.

I also attended a meeting of the State Licensure Subcommittee of the Academy’s Government Relations Committee. Chaired by Barry Freeman, this subcommittee has as one of its major charges the integration of our new educational model into state licensure laws. That is no easy task. This group is working on model language that would change entry level to the AuD, permit portability of licensure for those current practitioners who choose not to earn an AuD, and address the issue of provisional licensure. The committee is making substantial progress in developing ways to make state laws and regulations match our evolving educational standards.

I also attended a meeting of our new Foundation Board, chaired by Barbara Packer. The movement of our profession to a doctoral level practitioner has left some to question the source of our future research base. Others argue that the differentiation of the doctorate earned by those seeking to be scientists (PhD) from those seeking to be practitioners (AuD) is only enhanced by redefining the educational model. The new American Academy of Audiology Foundation, launched recently by combining two corporate entities, met recently and re-invigorated the commitment of this Academy to supporting the profession’s research and scientific base. The new Foundation is committed to an aggressive program of fundraising to sponsor educational and research efforts.

A new accreditation commission, a new state-licensure initiative, and a new Foundation: all re-committed to ensuring that our new model of audiology education can live up to our lofty expectations.
Executive Update

Direct Access: Take a DIRECT role in your Profession
“You Can Make a Difference”

The Academy leadership is in full support of Rep. Ryun (R-KS) and Capps (D-CA) bill, the Hearing Health Accessibility Act (HR 2821). This legislation would allow for “Direct Access” to audiology services. This is an important first step towards audiologists being recognized as independent practitioners. Direct access will allow Medicare beneficiaries the option of going directly to a qualified audiologist for hearing and balance diagnostic tests. The Academy favors giving Medicare beneficiaries the option of seeing either a physician or an audiologist for hearing health care.

Academy leadership and staff are working to ensure this bill gathers the necessary support. Now is the time when you can actively participate in the future of your profession without too much time or money. You can make a difference. We need each member to participate in three ways. First, the Academy needs you to contact your Representative and ask them to support H.R. 2821. Second, ask your patients to support this bill by also writing their Representative. And finally, the Academy needs you to contribute to our Political Action Committee (PAC), thereby allowing the Academy to have direct access to legislators to encourage their support for this initiative.

We have made it easy for you and your patients to contact Congress:
1. FAX or EMAIL a letter to your Member of Congress and the two Members listed above encouraging them to cosponsor HR 2821. Please send a copy to Jodi Chappell for her files. A sample letter for audiologists is posted on www.audiology.org/professional/gov. To send an email, use the Academy Legislative Action Center at http://capwiz.com/audiology/home/
2. Encourage Medicare patients to send a letter to Congress on this issue. A sample letter for patients is posted on www.audiology.org/professional/gov. Print copies and make them available in your offices.

The Direct Access Fact Sheet (talking points), Sample Audiologist Co-sponsor Letter, Sample Patient Co-sponsor Letter, and a copy of HR 2821 have been posted to the Academy web site at www.audiology.org/professional/gov.

Academy members can also help by making personal donations to the American Academy of Audiology, PAC, Inc. It is through our PAC that the Academy is able to actually meet and have direct “face time” with the various lawmakers. It may not make sense to have a PAC to meet with your Member of Congress, but unfortunately that is the way Congress works. You, as an individual constituent, can come to town and meet with your Member of Congress without making a political contribution because you are directly involved with voting for him/her. For your professional organization to be allowed time to visit with a Member of Congress, the Academy often needs to contribute to their campaign fund. It is imperative to have a fund that allows the Academy to support candidates who are in the position to support important initiatives such as HR 2821. The Academy leadership, lobbyists and staff must be able to have access to Members of Congress to present our issues and request their support of the bill. If every member of the Academy gave $10 to the PAC, we would have over $80,000. Our fund needs to grow to allow for the Academy to represent your interests on Capitol Hill as they relate to direct access. You can make a difference.

Please send a personal check to the Academy for $10 or more to help the Academy do the job and actively educate Congress to move HR 2821 through the legislative process.

These are relatively easy areas of participation on your part: 1) send your Representative an email, 2) ask your patients to participate in the co-sponsorship campaign by writing letters of support, and Academy donations to the PAC. These simple steps can actually make a big difference in your professional future and the future of audiology.

Thank you in advance for taking the time to help the Academy help you with this important initiative.

Laura Fleming Doyle, CAE
Executive Director of The American Academy of Audiology

Consortium Conference
Issues & Concerns Related to Fourth Year AuD Students
Sponsored by the American Academy of Audiology with support from the American Academy of Audiology Foundation and the Veterans Administration
A conference for audiologists to establish standards and guidelines for the clinical experience of training AuD students

REGISTER NOW!
Saturday & Sunday, January 10-11, 2004
Hyatt Regency Reston
Reston, VA
LETTERS TO THE EDITOR

RESPONSE TO CARMEN

I read with interest an article in the July/August issue of Audiology Today by Richard Carmen, titled “Personality Type Among Audiologists as Measured by the Myers-Briggs Type Indicator.” As one of many clinicians and researchers that have looked at personal style over the past 5-6 years, I would like to commend Carmen on his consideration of the Myers-Briggs Type Indicator (MBTI) and the Keirsey Temperament Sorter (KTS) to look at personality type among audiologists. Personal style assessment can certainly facilitate a better understanding of our profession and increase the effectiveness of rehabilitative endeavors with our patients. I do have concerns, however, with his survey procedure and conclusions.

Carmen presents what is offered as a review of the literature; however, there is no mention of the numerous personal style articles that have focused on MBTI/KTS as well as other assessment tools.

The author reported on a sample of 217 audiologists given an online version of the MBTI/KTS. Although this is an adequate sample size, it is well known that online surveys do not reflect the general population. These surveys reflect only that portion of the population choosing to use a computer, sign-on to the site, and then take the assessment. Accordingly, this survey is not necessarily reflective of only audiologists since hearing scientists, academics, traditional hearing aid dealers, and industry representatives from all parts of the world may sign on and take the internet survey. From such a potentially biased sampling procedure, it is difficult, if not impossible, to reach substantive conclusions about the personality characteristics of the general audiologist population.

The stated goal of the study was to determine if audiology as a field tended to attract or repel a particular personality type. In my opinion, this study missed its goal.

—Robert Traynor, Greeley, CO

Audiology Today welcomes letters from readers. The AT Editorial Advisory Board offers the following guidelines: All letters are subject to editing for brevity and clarity. Letters should be limited to one subject or theme. Letters should not exceed 175 words. Invective and derogatory comments will not be published. Send letters to the Editorial by email at jnorth1111@aol.com.
Helena Solodar and Gyl Kasewurm, long time private practitioners, recently conducted a virtual seminar for the Academy entitled “Change Your Luck: A Fearless Approach to Getting and Keeping Patients Through Marketing and Customer Service.” This article and three subsequent articles will focus on the information provided in that virtual seminar. Readers who wish to purchase a copy of the complete seminar can do so at www.audiology.org.

The benefits of a planned marketing strategy are innumerable. Business owners or practice managers often rely solely on their intuition to make business decisions. While this informal knowledge is important in the decision making process, it may not provide you with all the facts you need to achieve improved marketing results. A marketing strategy will help you define business goals and develop activities to achieve them.

The audiology community has plenty of data to indicate that we are not achieving an increase in market penetration among the hearing impaired population. While the incidence of hearing loss is increasing, the amount of patients walking through our doors is not. These challenging times force audiologists in every practice setting to develop a creative marketing strategy to convince hearing impaired consumers to seek the services we offer.

DEFINE YOUR POSITION

One of the first steps in creating a marketing strategy is to define your position in the marketplace. What makes your business or practice setting unique? Put that pen and paper to work and make a list of the reasons why patients should choose you or your practice setting for their audiology services. The next step is to determine the types of services that you want to specialize in. Do you want to see everyone, or are you targeting a particular segment of the population, i.e., pediatrics, adults, dizzy patients, tinnitus sufferers, etc. Finally, compose a list of the benefits of the products and services you have to offer.

The essence of marketing is to understand your patients’ needs and subsequently develop a plan that surrounds those needs. Let’s face it. Audiologists who want to succeed and survive have a desire to grow the business.

INCREASING REVENUE

There are only four ways to increase revenues in any business. While the terminology may be offensive to some audiologists, the principles remain the same regardless of the type of business. The four ways to increase revenue include:

- Acquiring more customers
- Persuading each customer to purchase a product
- Persuading each customer to buy a more expensive product or “adding on” additional products
- Persuading each customer to purchase more profitable products

All four of these strategies should increase revenues and, if your pricing is appropriate, boost profits.

Most marketing experts encourage focus on the first, which is to acquire more patients. Why? Acquiring more patients will increase your patient base and, hopefully, your revenues. This seems especially pertinent to audiology since we know that only a small percentage of those who need our services choose to seek them out. How can marketing be used to acquire more patients? Try the following:

- Spend time doing your research and then create a strategic marketing plan. Carefully analyze your target market to determine an appropriate strategy.
- Determine goals and strategies that will help you reach out to patients that you are failing to attract now.
- Price your products and services competitively and then develop a budget for your marketing plan.
- Develop your message and materials for the marketing campaign.
- Constantly evaluate the effectiveness of the marketing materials and determine whether they are reaching and impacting your target market.

After you have developed a marketing plan, take care to follow it and review it often.

MISSION STATEMENT

A Mission Statement is the heart and soul of a good marketing plan. If you don’t know where you are going, how will you know which road to take to get there? Another way of looking at a Mission Statement is that it is part two of a two-part description of the overall business intent. The Vision Statement, part one, describes the future: where you are going or where you want to go. The Mission Statement, part two, describes why you exist today and/or what you are doing to pursue your vision for the future. Together these two valuable proclamations provide direction for the business by focusing on day-to-day goals that will help you accomplish your mission, while taking steps to pursue your vision of the future.

Once you determine how you want to grow your practice and have formulated a written plan for the practice, you are certain to be on your way to a more productive and profitable future.
Infection Control in Audiological Practice

The Importance of Infection Control

In the delivery of any health related service, it is the health professional’s responsibility to ensure the safety of all patients served. Toward this end, it is imperative that audiologists provide patients with diagnostic and treatment environments that are designed to minimize or eliminate the potential transmission of disease. Audiologists must be diligent in their efforts for controlling the spread of infectious disease within the context of the entire clinical setting for several main reasons.

Diagnostic and rehabilitative services provided by audiologists are sought by a wide range of patients varying in age, underlying disease, socioeconomic status, history of pharmacological interventions, and other factors that directly influence the integrity of the immune system’s ability to defend and protect the human body from a variety of potentially infectious microorganisms (Bankaitis & Kemp, 2002; Kemp & Bankaitis, 2000). These patients maintain a heightened susceptibility to those microorganisms commonly residing in many healthy persons or on various surfaces. While these microbes do not pose a threat to healthy individuals with intact immune systems, even mildly immuno-compromised patients maintain an increased risk of developing opportunistic infections. By definition, opportunistic infections originate from commonplace microbes that take the opportunity to infect a body with a weakened immune system (Bankaitis, 1996). These microorganisms may lead to a level of infection that ultimately results in serious, life-threatening complications.

Since the practice of audiology involves and requires a notable degree of patient contact, patients and clinicians are exposed to an environment in which a variety of contaminated objects may come into direct or indirect contact with multiple patients (e.g.: headphones, immittance or otoacoustic emissions probe tips, electrodes, otoscope specula, oto-lights, earmold impression syringes, probe tubes for real-ear measurement, earmolds and/or hearing aids).

Contact transmission remains the most common means of cross-contamination and possible disease transmission (Kemp & Bankaitis, 2000). Contact transmission may occur when a clinician or the patient touches another individual or object. Removing a hearing aid from a patient’s ear or accepting a hearing aid from a patient with bare hands are practices that may encourage inadvertent cross-infection via contact transmission. In the event transmission occurs, microbes naturally seek entry into the body by traditional routes including natural orifices (nose, eyes, and ears) or via the epithelial layer of the skin (Kemp, Rooser, Pearson, & Ballachanda, 1996).

The scope of practice in audiology has changed significantly over the last 20 years, and infection control has become a more important issue. Beyond advancements in hearing aid technology, immittance procedures, or discovery of otoacoustic emissions which often necessitate the use of probe tubes or tips in multiple patients, many audiologists are involved with procedures that may potentially result in exposure to body fluids. For example, monitoring of cranial nerves or somatosensory evoked potentials not only requires the presence of the audiologist in the operating room, but the handling, insertion, and removal of several pairs of needle electrodes. Many clinicians may be involved in the administration of a battery of vestibular procedures that, on occasion, cause patients to vomit. Cerumen management and the dispensing of hearing aids to vomit. Cerumen management and the dispensing of hearing aids potentially expose clinicians to infectious agents. While cerumen is not considered an infectious agent unless it is contaminated with blood or mucus, due to its color and viscosity, visual detection of blood or ear drainage contaminants may be difficult. Therefore, it should be treated as if it is a potentially infectious agent (Kemp et al., 1996). As more and more of these types of procedures are performed by audiologists, the incidence of exposure to blood and other bodily fluids and subsequent risk of exposure to blood-borne pathogens such as HIV or hepatitis substantially increases.

Regulatory Agencies

In the early 1980s HIV-1 was identified as the cause of AIDS and the concern over potential cross infection of health care professionals and patients became a catalyst for change across the health care field. This concern resulted in regulatory bodies, particularly the Occupational Safety and Health Administration (OSHA), enacting regulations that would provide health care employers and workers with guidelines for risk reduction by reducing exposure to potentially harmful infectious agents. It should be noted that while AIDS served as the catalyst of change, the concept of infection control is more comprehensive. Infection control deals with reducing the transmission and exposure of all infectious diseases (Table 1) from the common...
### TABLE 1: INFECTIOUS DISEASES IMPORTANT TO AUDIOLOGY

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>AGENT</th>
<th>POTENTIAL TRANSMISSION DANGER</th>
<th>INCUBATION PERIOD</th>
<th>POTENTIAL OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired Immune Deficiency Syndrome (AIDS)</td>
<td>Virus</td>
<td>Blood to Blood contact. Blood enters via something as simple as chapped hands.</td>
<td>Average 8 years</td>
<td>Death</td>
</tr>
<tr>
<td>Chicken pox</td>
<td>Virus</td>
<td>Blood, saliva or mucous (ear drainage); provide therapy for infected, sub-clinical child.</td>
<td>10-21 days</td>
<td>conjunctivitis, shingles, encephalitis</td>
</tr>
<tr>
<td>Common cold</td>
<td>Virus</td>
<td>Blood, saliva, mucous; infected patient sneezes on counter. Receptionist touches counter, touches nose, then breathes on others in the office.</td>
<td>48-72 hours</td>
<td>temporary disability</td>
</tr>
<tr>
<td>Cytomegalovirus</td>
<td>Virus</td>
<td>Blood, saliva, mucous; handling toys that infected child put in mouth.</td>
<td>2-8 weeks</td>
<td>Birth defects, death</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Virus</td>
<td>Oral, fecal; failure to wash hands after seeing infected patient.</td>
<td>2-7 weeks</td>
<td>Disability, liver damage</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Virus</td>
<td>Blood, saliva, mucous; handling cerumen containing dried blood or providing therapy to “carrier.”</td>
<td>6 weeks - 6 months</td>
<td>chronic carrier, chronic disability, death</td>
</tr>
<tr>
<td>Herpes simplex-1</td>
<td>Virus</td>
<td>Blood, saliva, mucous, exude from sores; Touch canker sore while providing therapy.</td>
<td>2-12 days</td>
<td>temporary discomfort, herpetic conjunctivitis, herpetic whitlow</td>
</tr>
<tr>
<td>Herpes zoster (Shingles)</td>
<td>Virus</td>
<td>Blood, saliva, mucous; Make contact with vesicle (blister).</td>
<td>6-10 weeks</td>
<td>disability</td>
</tr>
<tr>
<td>Infectious mononucleosis</td>
<td>Virus</td>
<td>Blood, saliva, mucous; contact with infected saliva during therapy.</td>
<td>4-7 weeks</td>
<td>temporary disability</td>
</tr>
<tr>
<td>Infectious meningitis</td>
<td>Virus or bacteria</td>
<td>Blood, saliva, mucous; contact with infected saliva during therapy, contact with infected mucous (ear drainage).</td>
<td>2-10 days</td>
<td>temporary disability</td>
</tr>
<tr>
<td>Influenza</td>
<td>Virus</td>
<td>Saliva, mucous, respiratory droplets (moisture particles from the lungs); provide service for infected patient.</td>
<td>1-3 days</td>
<td>temporary disability, death</td>
</tr>
<tr>
<td>Legionellosis</td>
<td>Bacteria</td>
<td>Respiratory droplets; therapy or otoscopic examination requires that practitioner’s face come close to patient’s face.</td>
<td>2-10 days</td>
<td>temporary disability, death</td>
</tr>
<tr>
<td>Measles (German)</td>
<td>Virus</td>
<td>Saliva, mucous; saliva of infected individual touches tongue depressor which is then handled by the practitioner who fails to wash hands prior to touching nose.</td>
<td>9-11 days</td>
<td>congenital defects, temporary disability, encephalitis</td>
</tr>
<tr>
<td>Measles (rubeola)</td>
<td>Virus</td>
<td>Saliva, mucous; saliva of infected individual touches tongue depressor which is then handled by the practitioner who fails to wash hands prior to touching nose.</td>
<td>9-11 days</td>
<td>congenital defects, temporary disability, encephalitis</td>
</tr>
<tr>
<td>Mumps</td>
<td>Virus</td>
<td>Respiratory droplets.</td>
<td>14-25 days</td>
<td>temporary disability, sterility (men)</td>
</tr>
<tr>
<td>Otitis externa</td>
<td>Bacteria fungus</td>
<td>Saliva, mucous, blood, contact with microbes; handles ITEs with bare hands, transferring fungus from one to the next.</td>
<td>7-10 days</td>
<td>itching, pain, swelling</td>
</tr>
<tr>
<td>Pediculosis (head lice)</td>
<td>Lice</td>
<td>Lice transported from scalp via combs and hats; head phones could potentially transfer lice from child to child.</td>
<td>eggs hatch in 7-10 days</td>
<td>temporary discomfort, itching and scratching</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Virus</td>
<td>Blood, respiratory droplets.</td>
<td>varies with organism</td>
<td>temporary disability, death</td>
</tr>
<tr>
<td>Staphylococcus infection</td>
<td>Bacteria</td>
<td>Saliva, mucous, contact with staph colony; Audiologist handles ear mold or speculum prior to disinfecting.</td>
<td>4-10 days</td>
<td>skin lesions, death</td>
</tr>
<tr>
<td>Streptococcus infection</td>
<td>Bacteria</td>
<td>Saliva, blood, mucous, respiratory droplets; practitioner touches instrument that enters mouth of infected patient.</td>
<td>1-3 days</td>
<td>heart and kidney problems, death</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Bacteria</td>
<td>Respiratory droplets, saliva.</td>
<td>up to 6 months</td>
<td>disability, death</td>
</tr>
</tbody>
</table>

Reprinted with Permission from Infection Control for the Professions of Audiology & Speech-Language Pathology (Kemp et al, 1996).
cold to Tuberculosis, Hepatitis B and the like. In other words, infection control policies do not encompass an isolated virus or a single disease; rather, infection control is an all-encompassing concept designed to minimize the transmission of and/or exposure to all potentially infectious diseases (Kemp & Bankaitis, 2000).

Several federal and state agencies are responsible for developing guidelines for the purpose of saving lives and preventing injury or illness in the work place. The mission of reducing disease transmission in the health care setting also falls within the scope of these agencies which base their guidelines on regulations set forth by OSHA (i.e., OSHA, 1991). As each state can require infection control practices that exceed OSHA’s minimum requirements, audiologists must become familiar with the guidelines of the state(s) in which they practice. It should be noted, however, that not all states have plans. In those states where a plan does not exist, federal OSHA guidelines should be followed.

In response to the concerns regarding potential exposure of HIV in the workplace, in August of 1987 OSHA announced the intent to develop guidelines for protecting health care workers from cross-infection of blood-borne diseases. In addition, OSHA proposed to extend the scope of their mission by monitoring worker safety of health care treatment personnel. In the past, monitoring of cross-infection pertained to many groups of workers; however, such precautions were not specifically developed with health care personnel in mind. Based on the recommended Universal Precautions issued by the Centers for Disease Control and Prevention (CDC), OSHA submitted a program that was outlined in the Federal Register on May 30, 1989, and published as a final standard in 1991 (see www.osha.gov). Universal precautions, as defined by CDC, represent a set of precautions designed to prevent transmission of HIV, Hepatitis B virus (HBV), and/or other blood-borne pathogens when providing first aid or health care. Under universal precautions blood and certain body fluids of all patients are considered potentially infectious for HIV, HBV and other blood-borne pathogens. With regard to the audiology clinic, this statement indicates that infection control procedures apply to every patient and not only selectively to those who may be identified or suspected as having a potentially infectious disease.

To fully comply with OSHA regulations employees must be trained on OSHA blood-borne and safety standards prior to employment with subsequent refresher training once a year. Through the power of federal law (or state law, where a federally approved state law exists) OSHA mandates, oversees, and enforces infection control programs. Field inspectors randomly visit and inspect health care settings to ensure that such settings are in compliance with current regulations. Failure of an institution to comply with regulations results in citations and fines.

In addition to OSHA, four other groups actively set guidelines that impact the audiologist’s implementation of infection control practices (Table 2) The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) sets general guidelines for infection control based on OSHA standards that may vary, depending on the facility. The facility then creates specific protocols for each department. It is important that audiologists affiliated with hospitals with JCAHO accreditation learn how the Joint Commission guidelines affect the audiology department. Many institutions now have an infection control coordinator that can be of great assistance.

The Commission on Accreditation of Rehabilitation Facilities

<table>
<thead>
<tr>
<th>TABLE 2: REGULATORY AGENCIES CONCERNED WITH INFECTION CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OSHA</strong> Occupational Safety and Health Administration. Regulates workplace to ensure safe conditions, including establishing infection control regulations.</td>
</tr>
<tr>
<td><strong>JCAHO</strong> Joint Commission for the Accreditation of Healthcare Organizations Establishes standards and conducts voluntary accreditation programs for health care organizations; sets infection control standards based on OSHA standards.</td>
</tr>
<tr>
<td><strong>CARF</strong> Commission on Accreditation of Rehabilitative Facilities Establishes standards for organizations providing services to persons with disabilities based on OSHA standards.</td>
</tr>
<tr>
<td><strong>EPA</strong> Environmental Protection Agency Protects public and environment from risks posed by pesticides, promotes safer means of pest control, and registers chemical disinfectants and sterilants.</td>
</tr>
<tr>
<td><strong>FDA</strong> Food and Drug Administration Ensures safety of foods, cosmetics, medicines, medical devices; collaborates with EPA to research and document biological effects of chemicals, including disinfectants and sterilants.</td>
</tr>
</tbody>
</table>
Infection control in any setting revolves around controlling exposure among people as well as among people and the environment in which they work. The regimen required to comply with needed infection control measures may range from a simple cleaning to disinfecting to sterilizing depending on the nature of the contact. It is each clinician’s responsibility to employ preventive measures to ensure a healthy and safe work environment for themselves, their colleagues and their patients.

Research has shown that ordinary objects touched by patients are often contaminated with potentially infectious organisms. For example, in a study assessing bacterial growth on physicians’ stethoscopes, Breathnach, Jenkins, and Pedler (1992) found that 26 of 29 stethoscopes were significantly contaminated with staphylococci, a bacterium that can cause serious infections in immuno-compromised individuals. More recently, Bankaitis (2002) assessed the microbial composition found on the surface of hearing aids that were swabbed from 10 patients. Light to moderate amounts of ten different bacteria and three fungi were isolated from the group of hearing aids with the predominant organism the staphylococcus bacterium. The general finding of light to heavy microbial growth on hearing aid surfaces is not necessarily an unusual finding. Because cerumen is physiologically designed to inhibit bacterial or fungal reproduction, the residual presence of the very microorganisms it is designed to combat is to be expected.

The recovered bacteria and fungi are ubiquitous or widely distributed throughout the environment, with staphylococcal flora typically thriving on skin surfaces such as the external auditory canal. Although the recovered microbes from hearing aid surfaces are ubiquitous in nature, the hallmark of immuno-suppression is characterized by susceptibility of disease-prone individuals to these very same organisms (Schountz & Bankaitis, 1998; Bankaitis, 1996). For instance, coagulase negative staphylococcus is a universal microbe of normal skin and nasopharyngeal flora. Because of its universal nature, shedding of this bacterium is very common; however, it also accounts for a high percentage of hospital-acquired infections by susceptible patients exhibiting varying degrees of immuno-suppression (Murray et al., 1994).

As further discussed by Bankaitis (2002), in addition to the presence of staphylococcus on most of the hearing aids, unique microbial compositions were observed for each of the hearing aids studied, creating a more compelling concern for cross-infection. For instance, the clinician handling one hearing aid with unwashed, bare hands who subsequently handles another hearing aid with the same unwashed, bare hands could cross-contaminate the latter hearing aid with the microbial content of the former hearing aid. Reinserting a contaminated hearing aid into a patient’s ear will expose the patient to a foreign microbial composition. If that patient is immuno-compromised, the otherwise innocuous microbes from one hearing aid can cause an opportunistic infection with potentially serious complications.

While Bankaitis (2002) indicates that this study was not designed to establish a cause and effect relationship, it provides a compelling rationale for the need to integrate infection control procedures in the audiology clinic. Protection against inadvertent transmission of disease from patient to patient, clinician to patient, and patient to clinician must be approached from a preventative standpoint. Infection control begins with a written plan that should be available in every practice. While there is no single correct infection control plan, the procedures presented here may serve as guidelines for audiologists to develop their own plans while keeping in mind the local and federal regulations for infection control (OSHA, 1991).

General Housekeeping Practices and Environmental Infection Control

Environmental infection control requires cleaning, disinfecting and sometimes sterilizing items or surfaces that are reused. These terms are not arbitrarily selected to describe products or procedures. Each has a very specific legal meaning as defined by the Environmental Protection Agency (EPA). For example, a product that only cleans cannot be called a disinfectant, and a disinfectant cannot be called a sterilant unless it has been demonstrated to meet the requirements of a sterilant. It is important to understand the differences between these terms.

Cleaning

To clean means to remove the gross contamination from an object or surface without regard to killing germs. Cleaning is an.

(CARF) sets standards for organizations providing services to persons with disabilities. Like JCAHO, CARF issues general standards based on universal precautions which are then customized by each department in a facility.

The mission of the United States Environmental Protection Agency (EPA) is to protect human health and to safeguard the natural environment. Under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), first promulgated in 1947, the EPA registers all chemical disinfectants and sterilants intended for use on inanimate objects and/or environmental surfaces. The registration procedures are exacting and, particularly in the case of sterilants, extremely demanding. While a product may meet the criteria of a sterilant, the EPA also has the responsibility of reviewing toxicology and hazards data, product literature, and other company information to determine the benefit versus risk ratio of a qualified product. The Food and Drug Administration (FDA), in addition to its other consumer protection duties, also ensures that product labels are accurate and specific enough so that the contents may be used properly. This agency has been authorized by Congress to enforce several public health laws, including the Federal Food, Drug, and Cosmetic Act, and monitors the manufacturing, importation, transportation, storage, and sale of over one trillion dollars worth of goods annually (FDA, 1998).

Infection Control Rationale

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Cleaning

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INFECTION CONTROL IN AUDIOLOGICAL PRACTICE

important precursor to disinfecting and sterilizing as gross contamination must first be removed before these procedures will be effective. Cleaning can be accomplished with a brush, a wipe, or an ultrasonic machine.

DISINFECTING

To disinfect means to kill a specific number of germs, the number of which is determined by the level of disinfectant used. Health care facilities, such as audiology practice settings, should use a hospital grade disinfectant (Rutala, 1990). Effective disinfectants may be in the form of a towelette, a spray or a soak used for a static soaking tray or ultrasonic machine. Disinfectant products are commercially available for audiologists’ use that will not chemically denature plastic, silicone, rubber and acrylic. Rubbing alcohol, although considered a disinfectant, is not recommended in the audiology clinic as its chemical composition denatures those materials and/or devices typically handled in the clinical setting. Before disinfecting, all items should be first cleaned of gross contamination.

Disinfection is acceptable on “non-critical” items, those items that do not touch blood or other potentially infectious substances or are not likely to break the skin. Non-critical items in an audiology setting might include earmolds, hearing aids worn in the ear or canal, supra-aural headphones, otoscope specula, probe tips and tubes, ABR and ENG electrodes or any object or surface that is not contaminated with blood, ear drainage or cerumen that contains such bodily fluids. All of these items should be disinfected before handling or re-use, but sterilization is not required. Hearing aid cleaning tools and listening stethoscope couplers should be cleaned and disinfected before re-use. After use, these tools and couplers should be either soaked in disinfectant or wiped thoroughly with a disinfectant towelette. Hearing aids should be disinfected prior to sterilizing and must be pre-cleaned and then that cerumen specimen is a potentially infectious substance.

Cerumen is not an infectious substance per se, but often contains blood, mucous or other bodily fluid or substance. Objects that are capable of breaking the skin (i.e. curettes, wax loops) must be sterilized prior to re-use regardless of contamination. As the preferred sterilization technique, heat under pressure in an autoclave, can melt many of the implements used by audiologists, “cold sterilization” with chemicals is the recommended procedure.

Cold sterilization is accomplished by soaking instruments in 2% glutaraldehyde for ten hours or in 7.5% hydrogen peroxide. Currently these are the only chemicals approved for sterilization. Due to its ease of use (no mixing) Wavicide™ is often the favored glutaraldehyde solution. This solution is only to be used for sterilizing and must be stored in a tightly covered soaking tray to control fumes. Glutaraldehyde must not touch skin so gloves should be worn when accessing the tray and objects sterilized should be rinsed thoroughly prior to re-use. Porous items must not be soaked in glutaraldehyde. Glutaraldehyde solutions are effective for use and re-use for 14 or 28 days, depending on the brand. Controversy exists on the potential biohazard of glutaraldehyde upon disposal with many believing that it can be safely disposed of by pouring down the drain with flowing tap water to ensure dilution.

It is hoped that hydrogen peroxide solutions such as Sporox will supplant the use of glutaraldehyde as it is significantly less hazardous to use clinically and is free of the controversy surrounding appropriate disposal. Sporox is good for use and re-use for 21 days and may be disposed of in a similar manner to that often recommended for glutaraldehyde. Hydrogen peroxide is only a sterilant in a concentration of 7.5% or greater. Because it is safer to use and dispose of than the glutaraldehyde products, it is the recommended cold sterilant for audiology practices.

“Critical items,” those that may contact blood or mucus, or those items that are likely to break the skin, require sterilization. Cerumen is not an infectious substance per se, but often contains dried blood or mucus. If there is visible blood in or on cerumen, then that cerumen specimen is a potentially infectious substance and the instruments contacting it must be pre-cleaned and then sterilized. One difficulty is that the nature of cerumen, its color and viscosity, make it very difficult for the clinician to determine whether blood, particularly dried blood, is present. For this reason, instruments like curettes used in cerumen removal, immittance and
Ototoxic acoustic emissions probe tips, and otoscopic specula should be sterilized after use when visibly contaminated with cerumen, ear drainage or blood.

**Disposables**

Many items that have the potential for serving as cross-contaminants may be purchased as disposables including otoscope specula, immittance and OAE probe tips, earmold impression syringe tips, insert receivers, infection control earphone covers, and probe-microphone tube. The increased hygiene provided by the use of insert earphone receivers is one more advantage to the preferred use of these receivers over the continued use of supra-aural earphones. From an infection control standpoint, the use of products or items marked as disposable or one-time-use should be used as directed.

**Controlling the Human Source of Infection**

**Medical Case History**

If feasible, a full medical history of a patient can assist in reducing potential exposure. For example, identifying a case of shingles (Herpes zoster) while taking a medical history would alert the clinician to question an unusual looking sore. Identifying a patient taking an anticoagulant (e.g. Cumadin [the generic name is warfarin]) would warn the practitioner of a greater potential for excessive bleeding. It may be impractical to ascertain case histories in group settings like schools or industry. When possible, however, a medical case history should be taken.

**Hand Hygiene**

As previously mentioned, proper hand hygiene is critical to any infection control program. The Centers for Disease Control and Prevention (2002) has recommended that the use of fast-drying rub-on alcohol gels replace the traditional soap and water hand washing that is recommended to be done routinely before and after each patient. The alcohol-based gels are readily available, kill more microbes than traditional hand washing and are more convenient.

**Gloves**

All audiometric procedures, including hearing and immittance screenings performed by audiologists, should begin with a thorough inspection of the ear, surrounding facial area, and scalp. An otoscopic inspection of the circumaural region and ear canal should be conducted, confirming that the skin is intact and that there is no blood or ear drainage present. After completing this inspection, reviewing the medical history and considering the procedure to be performed, a determination of the necessity of gloves can be made. Gloves should be worn prophylactically when the risk of encountering infectious substances is high. It is recommended that gloves be worn during cerumen management procedures including irrigation of the ear. In addition, gloves should be worn whenever the patient has a draining ear, when blood is present, when sores or lesions are evident on the ear or scalp or when a medical history indicates an infectious disease. At a minimum, gloves should be worn when cleaning up spills of infectious waste and while disinfecting a contaminated area. Professionals are responsible for applying their discretion in the extent for which protective measures must be taken when cleaning spills. Additional protective measures may include a disposable cover for clothing and the use of safety glasses, the use of which would be dependent on the extent of the spill, the context of the situation, and the clinical environment.

Latex gloves should not be worn during impression taking as a chemical interaction between the material and the gloves keeps impression material from setting up. Gloves made from nitrile can be used safely with impression material. Latex gloves can be used when impression techniques use a pad (spread) and spatula thereby avoiding touching impression material with the hands. To avoid latex allergies, non-latex vinyl or nitrile gloves are preferred.

After use, gloves should be properly disposed of and hands should be washed immediately after removing gloves. Unless grossly contaminated with blood or other bodily fluids gloves should be disposed of in the regular trash (see Waste Disposal which follows).

**Protective Apparel**

Safety glasses and disposable masks are necessary when there is risk of splash or splatter of potentially infectious material, or when the audiologist or patient is at risk of airborne contamination. Cerumen removal by irrigation may require safety glasses or masks if the splash of the irrigation is significant. Also, safety glasses and a mask should be worn when working with a grinding or buffing wheel to reduce the chance of microorganisms and particles of plastic being inhaled or landing in eyes. Masks should be worn in the presence of immuno-compromised individuals who may be at risk from droplet contact. Tuberculosis patients are to be treated using OSHA TB guidelines which include a higher grade mask than the standard. In the absence of the use of insert receivers, disposable headphone covers should be considered to reduce the risk of cross contamination. These can be particularly important for mass screenings.

**Waste Disposal**

Glutaraldehyde is toxic and should be handled with gloves with consideration given toward eye protection. Although glutaraldehyde begins to neutralize when in contact with organic material, controversy exists toward the common practice of disposal down the drain while flushing with large quantities of water to dilute it and promote more rapid neutralization. It is because of this controversy and other health concerns with the use of glutaraldehyde that hydrogen peroxide (in a 7.5% concentration of higher) is recommended for cold sterilization in audiology practices. Certainly disposal of sterils must be made in accordance with local or federal regulations. Disposal methods are generally stated in the manufacturer’s specifications. Further information on hazards associated with disinfectant and
sterilization chemical product use, and corresponding poison control measures to be employed in the event a product is swallowed or comes in contact with the skin or eyes, is outlined in the manufacturer’s Materials Safety and Data Sheet (MSDS) and is available from the manufacturer upon request. The MSDS for all potentially harmful substances should be readily accessible in the clinic.

In the typical audiology clinic, waste (gloves, wipes, paper towels, etc.) that is contaminated with blood, ear drainage, or cerumen containing blood or ear drainage can be placed in regular trash receptacles unless the amount of blood or mucus is significant. Materials containing significant amounts of blood should be disposed of in impermeable bags labeled with the symbol for biohazardous waste. This would include gross amounts of material; that is, there is no need for biohazard bags for a little earwax. Rather, biohazard bags should be used for large amounts of visible blood and the materials used to clean it up. This waste should be picked up by a waste hauler licensed for medical waste disposal. When placing less contaminated waste in the regular trash, it is recommended that it be separated from the regular trash by sealing it in a separate bag or wrapping it in paper to minimize the chance of maintenance or cleaning personnel making casual contact with it.

Vaccination

One of the most effective forms of controlling infection is through vaccination. Measles, mumps, rubella, tetanus, influenza, tuberculosis, small pox, polio, pertussis (whooping cough), diphtheria, hepatitis A and hepatitis B are all preventable through vaccination. Vaccinations should be seriously considered for all health care professionals.

The Audiologist’s Responsibility

The Code of Ethics of the American Academy of Audiology states that “Individuals shall exercise all reasonable precautions to avoid injury to persons in the delivery of professional services or execution of research” (Part 1, Principle 2, Rule 2B). Toward this end, the development and vigilant execution of a comprehensive program for infection control, and the reporting and follow-up of exposure to potentially hazardous materials should be an integral component of any audiologic practice, regardless of setting. All necessary precautions should be taken to ensure the safety of the patients served, as well as the safety of the professionals and support personnel serving those patients. It is every audiologist’s responsibility to ensure that infection control protocols are established for their work setting and that the guidelines recommended within such protocols are adhered to routinely.

References


HIPAA Virtual Seminar CD
(originally recorded 2.28.03)

NOW AVAILABLE!

Cost is $50 for members.

.2 CEUs are available per individual, per CD to those on the Academy’s CE Registry.

This CD does not include the HIPAA manual. Contact molek@audiology.org for more information or an order form.
I have been an audiologist for 28 years and in private practice for 17. I have always been excited by what I do and proud to be an audiologist. Recently, however, I have witnessed audiological practices that make me uncomfortable. Many audiologists are in clinical situations where other professional groups determine what service is provided and how it is delivered. Who is it that will most affect how this growing field will evolve?

The field of audiology is changing rapidly. Evolutionary principles suggest the most adaptable audiologists, those best prepared for change, will be those that survive and are most successful. Audiologists have the opportunity to be in the position to influence how the profession develops. Will we become a large group of low paid technicians? Will we adopt the role of high-paid dispensers of expensive products? Or will we choose to become independent professional providers of hearing health, appropriately compensated based on the value of the services we deliver?

It has been clear for some time that to achieve our goal of independence, audiology must become a doctoring profession. This process begins with a professional — level education, matures through mentored clinical experience, and evolves finally into a fulfilling clinical practice. At this point audiologists have the opportunity to follow specialty interests while staying abreast of new ideas and research in our field.

The American Academy of Audiology (AAA) has been reviewing the scope of practice for audiology and has been examining the coursework that supports a doctoral level degree. The number of hours of mentored practice and who should supervise these hours is under consideration. The AAA Ethics Committee has studied current clinical practices in our field and, as we have a history of inadequately addressing ethical issues in our training programs, has identified many tough problems that require attention. The American Board of Audiology (ABA) has concentrated its efforts on encouraging audiologists to continue their education beyond minimum standards and rewarding those who demonstrate a commitment to delivering high-quality hearing health care.

The issue of achieving independence within our field may be more important than many of us think. AAA and ABA have helped provide leadership in moving toward this goal. It is paramount that individual audiologists commit themselves to achieving high standards of practice and to promoting the autonomy of our profession whenever and wherever possible.

ABA certification is one step in helping consumers, health insurance carriers, government agencies and others in the medical field recognize our standards of professionalism. The ABA will continue to develop certification programs and continuing education opportunities that best fit the needs of the audiologist of today and of the future.

Certification is important to this profession for purposes of establishing a standard of practice controlled by the profession, and not by state licensure boards. The fee paid to maintain ABA “Board Certification in Audiology” tells the world that no one can take away our status, our experiences, and our future. Participation in this endeavor will help build a nationally recognized body representing the best in hearing health care.
Countless people struggle to accept the reality of hearing loss, so it behooves us to ask, why is it so hard? Why do some individuals flatly deny that their hearing has changed? Why do others acknowledge a change in their hearing, but do nothing to improve their situation?

ASKING FOR HELP

Asking for help with any upsetting problem involves a process of psychological adjustments. Individuals who are in need of help must work their way through five stages of the “help-seeking process” (Hill & O’Brien, 1999):

1. I don’t have a problem (denial).
2. I do have a problem but I don’t need help (resistant to help).
3. I have a problem, I need help, but I don’t want help (reluctant toward help).
4. I have a problem, I need help, I want help, but I’m not ready to accept it (nearly accepting of help).
5. I have a problem, I need help, I want help, and I am ready to accept it (fully accepting of help).

Each stage represents a change in one’s concept of “self as a person with normal hearing” - and that is why it is hard to ask for help. For adults whose hearing has changed, “letting go” of who they are means a redefinition of self (now I am a person with hearing problems). The prospect of changing one’s hard-fought-for self-concept can be almost more than some patients can face, at least for the short term, if not always.

WHICH STAGE? WHAT DO WE DO NEXT?

Typically, we do not know in which of these five stages a patient is operating. It may seem too simplistic to say, “The patient will tell us” - but in fact that is the case. In so many words, patients will tell us, “My hearing is fine” (stage 1), “My hearing is bad but it doesn’t bother me” (stage 2), “My hearing is bad and it bothers me but I don’t want hearing aids” (stage 3), “My hearing is bad, it bothers me, I’m considering hearing aids but I have lingering doubts” (stage 4), or “I am fully ready to get the most out of hearing aids” (stage 5).

Once we determine what stage a patient is in, we can help by matching our responses accordingly. Below we address the most challenging stage: denial. When patients insist they do not have a hearing loss, the last thing they need is a professional who appears to be yet one more person siding against them. A more supportive relationship can be developed by asking patients what concerns have been expressed by family, and then, noting their reactions to those concerns. Providing an opportunity to “vent” and acknowledging the stress associated with the situation, without taking sides, gives patients support at a time when they are feeling none. For example:

Audiologist: Good to meet you, Mr. Jones. How can I help you today?

Mr. Jones: I’m only here because I promised my kids I’d get a hearing test.

Audiologist: [nods head, as in “tell me more”]

Mr. Jones: I mean, it’s like a screaming match these days when they come over, I’m starting to dread their visits. All they can do is complain about how I keep misunderstanding them - as if I’m doing it on purpose!

Audiologist: That sounds pretty stressful.

Mr. Jones: That’s the word for it, stress. I just want to get this over with.

Audiologist: Understood. Then let’s get started....

If the patient steadfastly holds the position that his hearing is fine, even after test results are conveyed, a recommendation for amplification will not be well received. A patient must be much further along in the help-seeking process before he will decide on amplification as being in his best interests, and right now, this patient has clearly told us he is not there. Rather than adding more pressure to the situation, we should consider backing away from a hearing aid recommendation. Many may feel that such action fails patients as it does not help them to recognize their problem. The reality, of course, is that this patient does recognize his problem. Deep down, he knows his hearing is changing; he just is not ready to deal with it. It may help here to consider the axiom, “Help is defined by the recipient.” This axiom acknowledges the fact that helping professionals cannot coerce adults to do anything they have not committed to doing on their own. Here, the patient only wanted to reduce family pressure, and that was accomplished. Our task is to enhance motivation for the resisting patient. This allows the patient to leave with valuable information and no reason to resent the audiologist. A set six-month follow-up appointment allows the patient the opportunity to revisit his position later with perhaps a much different outcome.

“TAKE HOME MESSAGE”

It is hard to ask for hearing help because it involves accepting a difficult change, adjusting one’s valued self-concept, and depending on others for support. This is challenging for many patients.

REFERENCE

NOMINATION PROCESS
Nominations will be considered and reviewed by the Academy Honors Committee and awards to selected recipients will be presented at the 16th Annual Convention & Exposition in Salt Lake City, March 31-April 3, 2004. Nominations must be submitted by October 24, 2003.

Nominations may be submitted by any Academy Fellow and must provide sufficient documentation as to how the nominee meets the specified criteria. An up-to-date resume of the nominee must be included with a letter of nomination addressed to the Committee Chair. Additional letters in support of the nomination and any other documentation that will assist the Honors Committee in their decision will be helpful. Not all awards may be given each year.

Address the nomination package to:
Sharon Sandridge, Chair, Awards and Honors Committee, c/o American Academy of Audiology, 11730 Plaza America Drive, Suite 300, Reston, VA 20190-4798

CAREER AWARD IN HEARING
This award is given for significant pioneering accomplishments (research, clinical or teaching) within the field of hearing. This award is not restricted to audiologists, but may be given to any individual with a distinguished career in hearing. Candidates should have at least 20 years experience in a field related to hearing. Candidates should have devoted his/her life to clinical or laboratory research, teaching, and mentoring young people in the fields related to hearing and/or clinical service in hearing-related endeavors.

CLINICAL EDUCATOR AWARD
This award is presented to an audiologist in recognition of major contributions in a career as a clinical educator. Candidates can be currently active in the profession or retired. They must have had a significant impact on the training of student audiologists in the capacity of teacher/instructor and/or clinical supervisor. Candidates for this award must have demonstrated exceptional insight into the diagnostic and remediation clinical process, and in their ability to establish and maintain caring patient relationships in their service to persons with hearing impairment. Most importantly, they must have demonstrated the ability to convey those insights to their students.

JERGER CAREER AWARD FOR RESEARCH IN AUDIOLOGY
This award is given to a senior level audiologist with a distinguished career in audiology. Candidates must have at least 20 years of research productivity in audiology (not in related field), and must have made significant contributions to the practice and/or teaching of audiology.

RESEARCH ACHIEVEMENT AWARD
This award is presented to an audiologist in recognition of a recent major research accomplishment in audiology. Research must provide new insights into the mechanisms of normal or abnormal hearing and have a significant impact on clinical practice. The accomplishments for which the candidate is recognized must be original and provide important new information on a facet of audiology.

PROFESSIONAL ACHIEVEMENT AWARD
This award is given for recent major professional activity such as the development of a significant clinical program or other type of professional achievement. Candidates must have created, developed, implemented, and/or directed a new program of highest caliber for the primary purpose of providing clinical service, clinical research, or teaching of audiology.

SAMUEL F. LYBARGER AWARD FOR ACHIEVEMENTS IN INDUSTRY
This award is given for significant pioneering activity (research, engineering, or teaching) within the field of hearing. This award is restricted to individuals whose achievements occurred while employed by a company or corporation in the hearing health care fields but whose contributions extended beyond their contributions to their company’s services or product and served to have a significant impact on the understanding of normal or disordered auditory systems.

HUMANITARIAN AWARD
This award is given to an individual who has made a direct humanitarian contribution to society in the realm of hearing. This award could fit a broad category of significant service-oriented activities. Candidates should have demonstrated direct and outstanding service to humanity in some way related to hearing, hearing disability, or deafness. Candidates should have demonstrated significant and consistent humanitarian contributions, preferably in matters related to hearing.

INTERNATIONAL AWARD IN HEARING
The American Academy of Audiology has established an annual international award to honor and recognize achievements of international significance in audiology by an audiologist, hearing scientist or audiological physician. Nominees should be nonresidents of the US who have provided outstanding service to the profession of audiology in a clinical, academic, research or professional capacity, and be in good standing in their country.

HONOREES IN 2002
Jerger Career Award for Research in Audiology
Gary Jacobson
Humanitarian Award
Gregory Spirakis
Humanitarian Award
Julia Roskamp
Career Award in Hearing
Paul Kileny
Clinical Educator Award
Jane Baran
Research Achievement Award
Linda Hood
Professional Achievement Award
Anna Nabelek

HONOREES IN 2003
Jerger Career Award for Research in Audiology
Fred Bess
Humanitarian Award
Janis Wolfe Gasch
Career Award in Hearing
Jerry Northern
Clinical Educator Award
Rieko Darling
Research Achievement Award
Brenda Ryals
Research Achievement Award
Harvey Dillon
Samuel F. Lybarger Award for Achievements in Industry
Mead Killion

SEPTEMBER/OCTOBER 2003
Sam Lybarger was a giant in the hearing aid industry and known to all who had the good fortune to know and work with him as a true “gentleman’s gentleman.” Lybarger was born on April 19, 1909, in Wilkinsburg, PA. After graduate studies at the Carnegie-Mellon Institute, he accepted a position at E.A. Myers and Sons that produced hearing aids. At this time, radios were the main source of communication and entertainment for Americans, and since the hearing aids resembled large floor-model radio consoles, it was almost natural that the company’s brand name for their hearing aids became “Radioear.” (Figure 1.) Sam was such a visionary in the hearing aid field that among his many other accomplishments, he designed the first in-the-canal hearing aid.

Over the course of his long and distinguished career as chief engineer of E.A. Myers, Sam was granted 22 patents on various acoustical devices, including the first wideband hearing aid microphone, a superior hearing aid receiver, and the bone vibrator designs that became the international standard transducer for bone-conduction audiological testing. Lybarger noted that when a patient’s conductive hearing loss exceeded 40 dB, the bone vibrator becomes the most efficient method of coupling to the cochlea for the transmission of sound.

In 1947, before tape recorders were readily available, Lybarger made the first A-B hearing aid comparison recordings on a 16” 33 1/3 rpm transcription disc with help of his engineering friends at WKBB, our country’s first radio station. The recordings made by Lybarger illustrated the difference between real-ear and 2cc coupler responses.

I was honored to count Sam Lybarger among my friends. When the 1999 Acoustical Society of America met in State College, Pennsylvania, Sam was nearly 90 years old. He agreed to take a car ride with me to that meeting, where everyone there greeted him with enormous warmth and delight. Figure 2, taken when we stopped for lunch on that trip, shows the same friendly, inquisitive outlook he had shown all his life.

Sam was always gentle in pointing out the errors of his colleagues. As chairman of the prestigious National Institute of Standards hearing aid committee for

**Figure 1.** Fifty years of hearing aid progress

**Figure 2.** Lybarger and Killion at lunch on the way to the Acoustical Society Meeting

**A typical drawing in one of Sam’s notebooks.**

**A brand-new, out-of-the-box 1930’s Radioear B50 (it still works), shown with a bone vibrator output.**

**Sam the student:** From boxes full of similar papers

**Calculating the magnetic flux density in an air gap.**
many years, he would listen to everyone, try to reach a resolution through open discussions, and finally offer his own viewpoint. His insights, research, and gentle handling of committee members, including those who disagreed or simply did not understand, made him extraordinarily respected and admired.

In the eight boxes of personal and professional effects given to me by his son, Ed Lybarger, following Sam’s passing, there is the equivalent of two file drawers of standards activities, including records and documentation from the classic and successful fight with the telephone companies to make telephones compatible with hearing aid telecoil use.

Sam was active in numerous professional organizations including the Acoustical Society of America, the American Standards Institute, and various hearing aid specialist organizations. He served as president of the American Auditory Society and was president of the Hearing Aid Foundation from 1975 to 1977.

Lybarger was a sought after lecturer and traveled extensively to appear on numerous state, national, and international programs. He published many pioneering articles and chapters for books on hearing aid and related subjects. His chapters in the Handbook of Clinical Audiology and Interpreting Hearing Aid Technology are definitive. Sam presented the prestigious Carhart Lecture to the American Auditory Society in 1985, and he received their Distinguished Service Award in 1990.

Sam Lybarger passed away in Canonsburg, PA on Nov. 1, 2000. He was married to Alberta Myers for 64 years before her death in 1998. Their son, Edward, his wife and 4 grandchildren, survive them. During his funeral ceremony, a lifelong minister friend recounted not only many instances of Sam’s integrity and gentlemanly conduct, but added that Sam was always, first and foremost, an engineer. The minister described a canoe trip that he and Sam took down the Monongahela River in Pittsburgh. Sam, always the engineer, brought along a set of blueprints for each of the locks they would be going through.

Sam Lybarger made the world a better place, and I am honored to receive the Honors Award from the American Academy of Audiology established in his memory.
In the early 1990s two California audiologists set out to address the source of their frustration over the inadequacy of hearing aid fitting prescriptions designed for linear hearing aids in view of the current market of the emerging array of non-linear instruments. Michael Marion and I contacted a number of leading clinicians and researchers about the need for a comprehensive procedure for the selection and fitting of compression hearing aids.

As a result of these concerns for hearing aid fittings the new group, to be known as IHAFF (the Independent Hearing Aid Fitting Forum), held a series of meetings beginning in 1993. The IHAFF fitting protocol was developed as the principal outcome of these efforts, and was unveiled at the August, 1994 Jackson Hole Rendezvous meeting. The principles of the IHAFF protocol, such as the concept that successful fitting of hearing aids involves a process entailing far more than a prescription and a set of targets, have endured in the ensuing decade. The APHAB and elements of the VIOLA procedures have influenced many of the current hearing aid fitting methods.

The IHAFF group has met informally to discuss contemporary professional issues periodically in the years following the 1994 Jackson Hole Rendezvous. At the urging of Mead Killion and Gail Gudmundsen, the group met again in February of 2003 for several days on St. John Island in the US Virgin Islands.

Ten IHAFF members — Van Vliet, Ruth Bentler, Robyn Cox, David Fabry, Alison Grimes, Gail Gudmundsen, David Hawkins, Mead Killion, Catherine Palmer, and Robert Sweetow — met daily in an intensive open discussion format to investigate perceived problem areas in hearing health care, and to develop approaches for research or remediation of the problems. Other original IHAFF members — Marion, Lucille Beck, Gus Mueller, Larry Revit, and Michael Valente — participated in a summary teleconference at the end of the meeting.

The original IHAFF focused on very technical issues of the process of selecting and fitting hearing aids. The problem areas discussed by the current group included broader aspects of the entire process, and the stakeholders involved. The overall goal was identified as centering all of the group’s activities on promoting evidence-based evaluation and practice. Specifically, the focus of research and development will be on the service component of what audiologists bring to hearing aid delivery. This goal is focused on establishing audiologists as rehabilitation providers with regard to amplification through evidence-based investigation and practice.

In a practical sense, working toward this goal may help the group identify and find ways to address the problems that have resulted in the prevailing situation in which only 20% of Americans who are candidates for hearing aids have them and only 60% of these are satisfied with them. Remediation may require changes in many areas, including not only the selection and fitting of hearing aids, but also audiologic rehabilitation and, perhaps, changes in the service-delivery model.

In the coming months, the IHAFF team has set an ambitious schedule involving research, publications, and meetings focusing on specific elements supporting the overall goal. Next year, the September 2004 Jackson Hole Rendezvous program in Wyoming will be devoted to the presentation of IHAFF’s findings.
WAIT UNTIL YOU SEE THE NEW ADDITION TO THE ACADEMY’S WEB SITE

Now it’s even easier to promote audiology issues and make the Academy’s voice heard!

http://www.audiology.org/professional/gov
(link found on Government Relations web page)

It is important to get the Academy’s message out, especially to those who have the power to make a difference. Whether it’s Congress, the White House, Government Agencies, or the Media – with the Academy web site’s new Legislative Action Center you will be able to contact these key individuals about issues of importance to audiologists with a few simple clicks of a mouse.

It’s right at your fingertips on the Academy Government Relations web page. Here are just a few things you can do with the new Legislative Action tool:

- Send your elected officials a message asking them to support or vote against a specific issue. Current priority issues appear under “Action Alert” and link directly to a sample letter that can be sent as an email or that you may print and fax. All of this can be done by simply typing in your zip code and a few simple clicks of the mouse.

CURRENT ACTION ITEMS:

- Support EHDI and Hearing Health Research
- Direct Access to Audiology Services
- Encourage your Legislators to Become Members of the Congressional Hearing Health Caucus
- CMS Projects 4.2% cut in 2004 in Medicare Payments
- Be informed about how Members of Congress voted on key legislation important to audiology and top priority policy issues.
- Search Congressional and committee schedules for the U.S. House of Representatives and U.S. Senate.
- Prepare yourself to meet with your elected officials and/or their staff with Capitol Hill Basics. Get tips on calling your elected officials, how to best communicate with Congressional staff, how to make the most of your meetings, and MUCH MORE!
On July 22, 2003, Reps. Jim Ryun (R-KS) and Lois Capps (D-CA) introduced legislation that would give Medicare beneficiaries the option of seeing an audiologist directly, without a physician referral, for audiologic diagnostic testing. The bipartisan bill, the “Hearing Health Accessibility Act” (H.R. 2821), has been referred to the House Committee on Energy and Commerce and the Committee on Ways and Means for consideration. To access a copy of the bill, go to the Academy’s Government Relations web page at www.audiology.org/professional/gov/.

H.R. 2821 would allow Medicare beneficiaries to go directly to an audiologist for hearing and balance tests. That is, it would eliminate the Medicare program’s physician referral requirement for audiologic diagnostic tests. It would not require Medicare beneficiaries to see an audiologist first; patients who want to could still see their physician first. The bill would not expand the number of audiology services covered by Medicare. The bill would do one thing and one thing only: give Medicare patients the option of “direct access” to audiologists.

Other federal health care programs (including those run by the Department of Veterans Affairs and the Office of Personnel Management) already allow their enrollees to see audiologists directly.

BACKGROUND

The introduction of H.R. 2821 is a triumph for the Academy and the culmination of years of preparatory work. Before going to Congress it was necessary to first request this change from the Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare program. The Academy and the Academy of Dispensing Audiologists (ADA) urged CMS to give Medicare beneficiaries direct access to audiologists. After several years of meetings, correspondence, and studies, CMS ultimately refused to make the change in its regulations and suggested that the Academy go to Congress. While not the answer the Academy had hoped for, this rejection made it possible for us to request that Congress make the change legislatively.

WHY DIRECT ACCESS?

Direct access would be a major step in the direction of autonomy for the audiology profession. The Academy also believes that direct access would be a win-win situation for Medicare beneficiaries, audiologists, and the Medicare program:

• Direct access would save Medicare money.

The initial physician visit is costly to the Medicare program, and often unnecessary. Audiologists perform a number of steps to screen for medical conditions (i.e., taking a case history and performing an otoscopic exam and immittance testing) and refer patients with medical conditions to a physician. Entry into the hearing health care system can be made safely without a perfunctory physician visit.

• Direct access is an innovation that other health plans use successfully.

The Department of Veterans Affairs has allowed veterans to see audiologists directly for the past 10 years, and the Federal Employees Health Benefits Program encourages participating health plans to give federal employees direct access to audiologists. Many private health plans also allow their enrollees direct access to audiologists. If Medicare is to provide its beneficiaries the best possible care and remain financially
solvent, it needs to be more flexible and adopt innovations that have been used successfully by other health insurers.

**WE NEED YOUR HELP!!**

Grassroots support for H.R. 2821 is critical. If direct access legislation is to become law, Members of Congress must hear from their constituents that this change is needed and in the best interest of their constituents. Here is what you can do:

- Write to your Representative asking them to co-sponsor H.R. 2821. (A model letter for this purpose can be found on the Academy’s Government Relations web page at www.audiology.org/professional/gov/ under “Sample Audiologist Cosponsor Letter to House”).
- If you work or live in the district of any of the sponsors of H.R. 2821 (Reps. Ryun, or Capps), please send them a brief letter thanking them for sponsoring this bill. In addition, the Academy will be requesting that members send thank you letters to other Members of Congress who cosponsor this legislation. To keep track of co-sponsors as they are added, go to http://thomas.loc.gov, enter H.R. 2821 as the bill number, click on Bill Summary and Status, then click on Co-sponsors.
- Ask your Medicare patients to write Congress in support of H.R. 2821. (A model letter for patients can be found on the Government Relations web page at www.audiology.org/professional/gov/ under “Sample Consumer Co-sponsor Letter to House.” Copies of the model letter can be left in your waiting room.)

While these may seem like small gestures, please do no underestimate the impact of such constituent letters on Members of Congress. Congress recently passed a bill on drug reimportation over the objections of the pharmaceutical industry and the Bush administration, so Congress does respond to strong public support.

The next step for the Academy is to seek additional cosponsors for H.R. 2821 in the House. Stay tuned for updates from the Academy on progress being made. Be an advocate and make sure the voice of audiology is heard on Capitol Hill!
Feast Your Senses

All your senses will be delighted by Salt Lake City. The city is nestled in a valley surrounded by mountains visible from nearly every location within the city. The sun rises over the Wasatch Mountains and sets over the Oquirrh mountain range. The streets are wide, clean and well laid out, clearly well planned for modern transportation. To whisk you here and there effortlessly, TRAX, Salt Lake’s clean and efficient light rail system gives you a free ride in the downtown zone, which includes the convention center and surrounding hotels. The metropolitan area stretches north and south along the Wasatch mountains and includes about one million residents. Salt Lake combines unparalleled access to natural recreation, a bustling economy, dynamic nightlife, remarkable history and warm hospitality.

The end of March is the perfect time of year to visit Salt Lake City. Those from northern latitudes will need to remember that SLC is located at the same latitude as Northern California. For the outdoors enthusiast, the weather will be good for golfing, biking, touring the scenery, and just being outside. When you arrive you will find the grass is green, leaves are sprouting, and spring flowers are blooming. Snow is visible on the mountains all around you, the sky is an intense blue, and crisp, dry weather is typical, with average daytime temperatures of 62 degrees. The dry weather is responsible for the fluffy, light snow unique to Utah, known as “the Greatest Snow on Earth.” If snow flurries occur, it only adds to the beauty of the blooming spring and melts quickly in the city.

Salt Lake City was the location of the 2002 Winter Olympics. If you attended AAA in 1996 when it was last in SLC, you will be impressed with the improvements that have taken place since then. The Salt Palace Convention Center has expanded and there is a new, yet quaint, outdoor shopping mall, the Gateway Center, just a two-block walk away. The surrounding hotels have also been extensively remodeled, and new hotels have been added, including the luxurious 5-Star Grand America.
Few, if any, other cities can give you such easy access to cosmopolitan culture while being so close to the beautiful Rocky Mountains. Awaken at your hotel near the convention center, 30 minutes away from some of the best skiing in the country. In March and April, it’s possible to ski in the morning and golf or play tennis in the afternoon. Salt Lake has more golf courses per capita than any other US city, and golfing will be in full swing at the time of AAA, so don’t forget your clubs! If sports aren’t your thing, thrill your senses at a practice session of the Mormon Tabernacle Choir. Admire the size and height of the Olympic Ski Jumps or make a visit to Antelope Island on Great Salt Lake, the largest site for migratory sea birds in the Western U.S. Historic Main Street Park City is only 30 minutes away. For great indoor entertainment, visit the Clarke Planetarium or the Pioneer Memorial Museum or visit one of more than a dozen museums.

**FEAST YOUR EYES.**

Salt Lake’s city center is only 15 minutes from the great outdoors. City Creek Canyon offers walking and running trails close to downtown at Temple Square. In the spring the canyon is adorned with blooming wild flowers and impromptu waterfalls. The elevation of the valley is 4,372 feet with mountain peaks up to 11,500 on the east side of the valley, where the ski resorts are located. On the west side of the valley, where copper, silver and gold mines are located, the elevation reaches 9,500 feet. Views from the summits of the mountain peaks are simply awe-inspiring. Many ski areas will allow you to buy a ticket to the top just to enjoy the view and return to the base. Taking in dinner at a ski resort gives you the chance to view the city from higher up in the canyons, as twinkling city lights blanket the valley on your drive back to the city.

Five national parks are within a few hours of Salt Lake City, including Arches, Bryce Canyon, Capitol Reef, Canyonlands and Zion. More national parks are located within an additional few hours, including Grand Canyon, Mesa Verde, Rocky Mountain, Yellowstone and Grand Tetons. Additional national monuments and forests make it a perfect playground for outdoor enthusiasts.

**CULTURE FOR YOUR EARS.**

From Salt Lake’s earliest days a high priority has been placed on the arts. No other US city of similar size boasts so many high-quality offerings. The city is home to one of the nation’s finest regional symphony orchestras, Ballet West, world-class opera, dance, and theater companies, the University of Utah, and of course the illustrious Mormon Tabernacle Choir. Monthly gallery strolls showcase the city’s many galleries, including Artspace, and the Leftbank, areas that have become Salt Lake’s own “SoHo.” For a different kind of culture, try these nightspots: just walking distance from the heart of downtown is the Tabernacle, Salt Lake’s Newest and Only Dueling Piano Bar. You can be a part of the interactive live piano show. The Port O’ Call in the Heart of Downtown is Salt Lake

“Some say Salt Lake is a dry town.
Not so fast, partner…
Luckily, there are over 300 watering holes.”
City’s largest sports bar, with four floors of state-of-the-art sound system, stage and dance floor, Patio Room and Club Room. Murphy’s cozy Irish pub, with rich wood and soft lighting is a favorite with the Downtown neighborhood locals as well as Salt Lake’s many visitors. Murphy’s is close to the downtown hotels, and is the kind of place where locals greet new arrivals with genuine Utah hospitality and friendliness.

DELIGHT YOUR TASTE BUDS.
Enjoy dining experiences that range from mountain rustic to upscale city. Dining in Salt Lake is a culinary adventure, with hundreds of restaurants offering a remarkable variety of cuisine and atmosphere. Some of the best restaurants in the West are located in Salt Lake. Restaurants you try might include: ABSOLUTE!, where a blend of Swedish specialties, fresh fish seafood, pasta, steaks, wild meats and vegetables, exotic fruits, and luscious desserts can be enjoyed. Martine’s Mediterranean Restaurant has become essential to downtown nightlife and the city’s culinary scene. Martine’s specializes in tapas (small Spanish appetizers) and consistently draws a hip, pre-event crowd. Located in the heart of downtown is Red Rock Restaurant and Brew Pub — Utah’s icon since 1994 for impeccable food and a rich array of award-winning ales brewed on site. The Rio Grande Café, serving great Mexican food, is a Salt Lake City institution housed in the historic Rio Grande Train Station. To add to the history and ambiance the legend of the Purple Lady, a ghostly apparition with a purple aura continues to haunt the Rio Grande Depot. Stories tell of a jilted woman who jumped in front of a passing train, trying to retrieve a ring thrown by her lover. Her presence is most often felt in the spacious marble walls and high ceilings of the women’s restroom.

QUENCH YOUR THIRST!
Have you heard a rumor that Salt Lake City is “dry”? This outdated reputation only discourages those who haven’t been enlightened to the true Salt Lake City. In fact, alcoholic beverages can be ordered with a meal in most restaurants after 12 noon. Just ask your server for a liquor menu. Salt Lake’s many microbrew pubs offer some of the best food in town and are definitely worth visiting. Many also offer specialty coffees. A private club is a “bar” that sells every type of liquor available. Some only offer traditional bar snacks, but these days savvy club owners have the insight to offer extensive food menus. A three-week temporary membership is only $4, which enables you and your guests to enter and enjoy. Most private clubs do not charge a cover charge unless there is something big going on, like a hot local or national band. Most private clubs have pool tables, dancing, cigars and allow smoking. Utah’s clean air act prohibits smoking in restaurants and other indoor facilities.

“IT ONCE TOOK 140 PIONEERS 90 DAYS TO GET TO SALT LAKE CITY.
Now, you can be there in a few hours!”

SHOP TILL YOU ROCK!
If “shop till you drop” is your motto, Salt Lake City is your town. Did you know the first department store to open in the US was located in Salt Lake in 1868? A myriad of terrific shopping excursions await you, including the new Gateway Center. The Gateway is a unique, open-air shopping, eating and entertainment district that features over 90 shops and restaurants, the Olympic Legacy Plaza and historic Union Depot. Trolley Square is another shopping venue a short TRAX ride away, in a renovated trolley barn with both nationally familiar shops and unique local shops. Salt Lake has unique, historic downtown neighborhoods with Craftsman style bungalows and Victorian mansions housing local shops and art galleries.
Did you know:

- You can still submit abstracts for Research Posters (deadline: December 5) at www.audiology.org.
- Free, boxed lunches will be available daily in the exhibit hall on Thursday, Friday and Saturday.
- You can participate in a Focus Group (free) on Wednesday, March 31 (3:00pm-5:00pm) to discuss either a) clinical faculty issues, b) telehealth in audiology or c) working in an ENT office.
- There will be additional CEU opportunities on Thursday, April 1.
- A special Research Poster viewing Wine & Cheese Reception (cash bar) will be held on Fri, April 2nd (4:00-5:30pm).
- The Academy has contracted with a variety of affordable hotels, ranging in price from $108 to $172, including...
  - 5-Diamond Grand America Hotel ($172) as co-headquarters hotel with its sister property Little America Hotel ($147)
  - Historic, boutique Peery Hotel ($145)
  - Traditional hotels, including Hilton ($143), Marriott ($145), Red Lion ($108), and Sheraton ($135)
- Utah Jazz will host the NBA reigning champs San Antonio Spurs on Friday, April 2nd (7:00pm).

GETTING THERE. Salt Lake City can easily be accessed by highway, rail and air. Half of the US population is within 2-1/2 hours air travel from SLC. Furthermore, the SLC International Airport is closer to the city it serves than nearly any other airport. This means that the shuttle or taxi ride into town is relatively inexpensive.

Great fun, great atmosphere, great educational programs and great colleagues. Come and Rock Your Senses in Salt Lake City. We’ll be looking for you there!

Pre-Convention Workshops for 2004!

Nine workshops, with subjects ranging from Code Blue: How to Resuscitate Your Practice to a hands-on workshop on Auditory Steady-State Response will be offered on Wednesday, March 31, prior to Convention 2004. Start planning with your colleagues today to determine which of these fabulous educational sessions each will attend. Stay tuned for the next issue of Audiology Today for more details about the 2004 Pre-Convention Workshops.

FULL-DAY WORKSHOPS

1. Auditory Steady-State Responses (ASSR): a Hands-On Workshop is in the final planning stages and will offer expert instruction on the ASSR as well as hands-on time with the equipment from the 4 manufacturers of this equipment.

2. Current Issues in Pharmacology, Ototoxicity and Patient Management will be led by Kathy Campbell of the Southern Illinois University School of Medicine, Jose Rey of Nova Southeastern University, and Robert DiSogra of Audiology Associates of Freehold, NJ.

HALF-DAY WORKSHOPS


4. Code Blue: How to Resuscitate Your Practice organized by the Reimbursement Committee to answer all the coding questions introduced by changing federal law and the ever popular HIPAA regulations. Paul Pessis of North Shore Audiovestibular Lab, Chicago, IL and Kadyn Williams of Audiology Consultants of Atlanta, GA will share their expertise and welcome questions.

5. Current Perspectives on Minimal Hearing Loss by Fred Bess and Ann Marie Tharpe of Vanderbilt University, Nashville, TN.

6. New Views of Auditory Processing Disorders from Basic and Clinical Science by internationally renowned auditory neuroanatomist Kent Morest of the University of Connecticut, and Teri James Bellis of the University of South Dakota will detail the amazing connection between neuroanatomy and auditory processing disorders.

7. Practical Audiologic Rehabilitation in Busy Dispensing Practices by Patricia Kricos of the University of Florida and Sharon Lesner of the University of Akron.

8. Sound Field Amplification: Theory and Practical Applications by Carl Crandell of the University of Florida, Carol Flexer of the University of Akron, and Joseph Smaldino of the University of Northern Iowa.

9. YOUR Clinical Research Study: From Soup to Nuts will feature Ron Marks of the University of Florida to teach research design and a panel of clinical researchers that will explain how they produce their research. The panel will include Sherri Jones of East Carolina University, Patrick Feeney of the University of Washington, Vishakha Rawool of Southwest Missouri State University, Carole Johnson of the University of Auburn, Gyl Kasewurm of Professional Hearing Services, Catherine Palmer of the University of Pittsburgh, and Elaine Mormer

Pre-Convention Workshops are subject to change.
“A Day in the Rockies” at Solitude Mountain Resort

How about enjoying a great day in the beautiful Rocky Mountains just before the annual convention begins? To help you take advantage of the Utah experience, a pre-convention “Day in the Rockies” has been planned on Tuesday, March 30 at Solitude Mountain Resort. The Solitude Mountain Resort is only 30 minutes from downtown Salt Lake and easy to reach. If you are looking for more than one day of relaxation and skiing, discounted accommodations can be arranged for convention attendees for the weekend prior to convention which begins Wednesday, March 31, 2004. This is a grand opportunity to enjoy the splendor of the Rockies that you should not pass up!

Help us plan! We need to gauge interest in this event so we can tailor-make discounted recreational packages for your enjoyment. Activities at Solitude Mountain Resort include fantastic downhill or Nordic skiing, ski lessons (remember the state slogan - Utah is Ski Country!), “Backtracks” (expert backcountry skiing), snowshoeing, ice skating, sledding, Mongolian Yurt dining and everything else you can think of to enjoy the mountains. This could be a great opportunity to bring your spouse and children for a winter holiday! Rental equipment is available at discount prices for all activities. Ample opportunities for lodging exist at every price level. You can stay in Salt Lake City and take a day shuttle bus or stay at the resort. Just let us know your interests and we will help you plan a splendid recreational package. Skiing in Utah is very affordable and lift tickets are as low as $35 per day, and resort lodging begins at $128 per night.

Now is the time to plan so take a few moments to fantasize you winter holiday in Utah. Visit the Solitude Mountain Resort website at www.skisolitude.com, then send us an e-mail at Resortday@audiology.org and let us know if you are interested in joining us or if you would like more information. We do need to hear from you to help with our pre-convention “Day in the Rockies” holiday.

Salt Lake City Quick Facts:

- More than 740 daily flights (78,000 passenger seats)
- Airport is only 10 minutes from downtown
- 2 mountain ranges (Wasatch and Oquirrh)
- 10 world-famous ski resorts

Make New Friends at Best Friends

Add some extra time to Convention 2004 and visit a joyous spot in southern Utah named Best Friends Animal Sanctuary. Roughly the size of Manhattan, the Sanctuary is nestled in the heart of the Golden Circle of National Parks, which includes Grand Canyon, Zion, Bryce Canyon, the Grand Staircase/Escalante National Monument and Lake Powell. In this spectacularly beautiful setting, Best Friends cares for at least 1500 unwanted and abused animals who will live out their lives in comfort or be adopted into good new homes. Volunteers help the dedicated staff with everything from poop scooping to taking walks to simply giving companionship and love to the cats and dogs, pigs and rabbits, goats and burros, horses and birds and various other gentle creatures (even an abandoned goldfish)!

The Welcome Center is open daily with hour and a half free tours of the Sanctuary. Be sure to call ahead to book your tour at 435-644-2001 ext. 1. The delightful little town of Kanab offers lodging close by Best Friends and within 90 minutes drive of each of the natural wonders of this incredible Golden Circle of National Parks. Reach Best Friends at info@bestfriends.org or 435-644-2001 or visit them at www.bestfriends.org.
AAA Foundation Trustees Hold “New Beginning” Meeting

The reorganized Board of Trustees of the American Academy of Audiology Foundation recently met in Reston, VA to define mission and goals statements and to develop policies and programs for the coming years. The new Foundation structure incorporates two successfully merged non-profit entities, the former AAA Foundation and the Academy’s 501 (c)(3) corporation. Although the new non-profit organization temporarily carried the cumbersome name of “Foundation for the Advancement of Audiology & Hearing Science”, one of the first orders of business of the new Board of Trustees was to return the organization’s name to American Academy of Audiology Foundation or, as it is likely to be called, the “AAA Foundation.”

Under the terms of the new Foundation structure, the twelve members of the Foundation Board of Trustees were derived from both non-profit entities, with half of the Board selected by the Academy Board of Directors and the remaining Trustees carried over from the previous Foundation Board. Barbara Packer was installed as Chair and governed the initial new beginnings meeting. The reorganization meeting featured an interactive presentation by William McGinley of McGinly & Associates of Annapolis, to facilitate the Foundation’s Trustees’ discussions of how an association should best function. The Foundation Trustees committed to a long-range plan for fundraising, agreed to provide financial support for the Academy’s Scientific Research Programs, and reviewed numerous proposals for funding support.

Audiology Today editorial staff member and AAA Foundation Trustee Gyl Kasewurm, sat down with AAA Foundation Chair Barbara Packer to discuss the Foundation’s new beginnings:

AT: What is the goal of the ‘new’ Foundation?
BP: The Foundation will work to create and sustain resources to improve hearing health care. Our mission is to raise funds and support programs of excellence in education, promising research and public awareness in audiology and hearing science.

What projects will the Foundation support with funds?

At our first Foundation meeting, the Foundation Trustees considered several requests for project funding. The Trustees carefully considered and discussed all requests, and in consonance with our newly created mission statement, committed funds to the several projects. The Foundation Trustees agreed to take over funding of the Academy’s Scientific Research Programs that includes the Summer Research Fellowship Awards, the Student Investigator Award, the New Investigator Award, and the Student Research Forum Awards presented at our annual conventions through 2006.

In addition, we agreed to support the important Issues and Concerns for the AuD 4th Year Student Conference sponsored by the Academy in January 2004. This crucial conference will be held in Reston, VA and all interested parties and stakeholders are invited to attend and participate in the conference discussions. The Trustees also voted to support the ABA Cochlear Implant Specialty Certification by directing restricted grant funds to this program. Clearly, the types of projects that will continue to be considered for funding must be associated with our mission statement toward research, education, and public awareness in audiology and hearing science.

The AAA Foundation has undergone reorganization. Why was this necessary?

In a nutshell there were a number of financial, legal and historical reasons for reorganization and, more importantly, a revitalization of the American Academy of Audiology Foundation Board. We are now at a point in our lives as members of a profession that can turn its attention to our collective commitment to support hearing health care through philanthropic efforts. The Board of Trustees is enthusiastic about its goals, plans and strategies for the short and long-term.

How much money does the AAA Foundation hope to raise?

Our first fundraising effort in this fiscal year will be a campaign directed at the current Academy leadership, our former Academy Presidents and former Board of Directors. We are pleased to report that 100% of the current Academy Board of Directors and 100% of the Foundation Board of Trustees have pledged donations for our initial campaign. We are committed to raising $30,000 by the end of the
year to support the Academy Scientific Research Programs for 2003!

Can anyone contribute to the campaign and how are contributions made?
Absolutely! We encourage and welcome contributions of sizes large and small to the 2003 campaign. Contributions should be mailed to the American Academy of Audiology Foundation, 11730 Plaza America Drive, Suite 300, Reston, VA 20190, with checks payable to the AAA Foundation. If so desired, contributors may also use a credit card for contributions. For further information, look at the Foundation website www.audiologyfoundation.org.

Fred Bess serves as chief note taker during the AAA Foundation meeting.

Facilitator Bill McGinley discusses the role of non-profit foundations in support of professional associations.

AAA Foundation Board of Trustee members (standing from left) Fred Bess, Jeff Danhauer, Sandy Gordon-Salant, Linda Hood, Robert Traynor, Deborah Hayes, Creig Dunckel, Gyl Kasewurm; (seated from left) Lina Kubli, Barbara Packer (Chair), Melanie Driscoll, and Jerry Northern. Not pictured: David Fabry and Patti McCarthy.

Linda Hood (left) discusses Foundation business with Laura Fleming Doyle and Marilyn Weissman of the Academy National Office staff while Barbara Packer (right) looks on.

The new American Academy of Audiology Foundation Board of Directors is comprised of the following members: Barbara Packer - Chair, Fred Bess, Jeff Danhauer, Melanie Driscoll, D. Creig Dunckel, David Fabry, Sandra Gordon-Salant, Deborah Hayes, Linda Hood, Gyl Kasewurm, Lina Kubli, Patricia McCarthy, Jerry Northern and Robert Traynor.
CONSENSUS CONFERENCE

Issues & Concerns Related to Fourth Year AuD Students

Sponsored by the American Academy of Audiology with support from the American Academy of Audiology Foundation and the Veterans Administration

A conference for audiologists to establish guidelines for the clinical experience of training AuD students

Saturday & Sunday, January 10-11, 2004
Hyatt Regency Reston
Reston, VA

Conference Co-Chairs: Jerry Northern and Ted Glattke
Steering Committee: Lucille Beck, Gerald Church, Angela Loavenbruck, Gyl Kasewurm, Helena Solodar, Gil Herrer, Barry Freeman, Dianne Meyer, Catherine Palmer, Therese Walden, Ian Windmill

Details on the program and registration will be forthcoming

REGISTRATION FEES:
Early: $295 (before December 19)
Full: $350 (after December 19)

LODGING:
$107 + tax per night

Space will be limited and this important conference promises to fill up early.
For additional information or to request registration materials telephone 1-800-AAA-2336, ext. 1050 or e-mail consensusconference@audiology.org
Training the Fourth Year AuD Student

The Rush University AuD Advisory Board: Lucille Beck, Carmen Brewer, Kathleen Campbell, Laurel Christensen, David Fabry, Gail Gudmundsen, Linda Hood, Gyl Kasewurm, Mead Killion, Gus Mueller, Barbara Murphy, Jerry Northern, Tom Thunder, Mary Bacon, Marcie Mervis

As members of the Rush University AuD Advisory Board, we have gained special insight into some of the challenges that face all AuD programs. We are especially concerned, however, with the critically important issue of providing high-quality clinical experiences to AuD students. This is a challenge facing not only university training programs but also the entire profession. Wilson (2003) recently described problems related to the training of fourth year AuD students and urged that more careful thought be given to the design of the students’ clinical training. We fully agree and would like to expand the discussion with additional areas of concern and a recommendation.

NOT JUST A CFY

It is important for all professionals to understand that the AuD student’s fourth or final year is NOT a Clinical Fellowship Year (CFY). In fact, attempts to equate the CFY year and the AuD clinical training experience will lead to unrealistic expectations of and from our students and could easily undermine AuD student education. Most audiologists are familiar with the CFY of the American Speech-Language-Hearing Association (ASHA) and understand that Clinical Fellows (CF) are individuals who have completed their university training, have actually been awarded their graduate degree, and are recognized in some way by state licensure or registration boards to practice with patients. Although we understand that CFs are not yet seasoned professionals, in most clinical settings CFs function with a great deal of independence. However, in direct contrast to the CFY individual, fourth year AuD students still are enrolled in a university program, have not yet completed their academic degree, and are not yet eligible for even temporary licensure from state regulatory agencies. The AuD trainees are students who still are learning and developing new skills and who still require close clinical supervision and guidance. As these AuD students begin to operate within their clinical training sites, it is crucial that audiology supervisors understand their responsibilities and shed the CFY mindset to ensure that the AuD fourth year experience is the rich learning pursuit that it is intended to be.

QUALITY OF CLINICAL SITES AND SUPERVISION

Most AuD education models require a fourth year of full-time clinical training and experience for each student. As such, this clinical component of the curriculum requires significant planning, coordination, and resources to accomplish the training goals. The AuD student’s fourth year should be a culminating period during which the student achieves competencies over a broad range of skills, encounters new viewpoints, and has opportunities for continued professional growth. Wilson (2003) states that sites selected for student clinical activities and training should meet appropriate education standards. We fully agree. To have 4th year AuD students simply return to clinical sites that they already experienced during their first three years is not likely to meet the need for broadening their education. We believe that multi-specialty sites or a combination of single-specialty sites are the most appropriate for the AuD clinical experience year. However, it is imperative to develop specific descriptions and criteria to identify suitable sites and qualified supervisors and to provide a national standardization to this process.

ENOUGH CLINICAL SITES?

Although it is our contention that the clinical experience sites and supervisors should meet specified criteria, this comment begs the question of whether there are enough qualified sites to accommodate the growing numbers of fourth year AuD students. While we cannot provide exact data and numbers, a few simple calculations suggest that this is potentially an enormous problem. There are 40+ residential AuD programs either already in existence or that will begin in Fall 2003. If each program enrolls 10 students per class, then approximately 380 fourth year sites will be
needed during 2006-07. Furthermore, extra sites will be needed in order to allow for the possibility that a site is not available for some reason at a particular time and for situations in which the fourth year experience may be split between two or more sites (i.e., a training experience in a VA Medical Center may not provide ample pediatric exposure, or another clinical site may not have sufficient diagnostic vestibular patients). Therefore, doubling the number of required clinical training sites to 760 is not unrealistic. And, as we already stated, ideally these sites should be in addition to those sites used during the students’ first three years. A more cursory way to look at the situation is that AuD programs are about twice as long as master’s programs and, on that basis alone, include more clinical placements. Either way, it is obvious that we soon will need a large number of qualified sites to provide extended clinical experiences for AuD students. University programs will need to convince clinical facilities that providing a fourth year experience is of value to all stakeholders. This situation presents a new and daunting challenge to university programs and to the profession. How we deal with this challenge will certainly influence the future of the AuD movement.

**Licensure Issues**

In most states students are exempt from licensure because they are not recognized as qualified providers and, therefore, cannot bill for services provided. Many states provide a provisional or interim license to individuals engaged in “supervised professional experience,” but that experience usually is described as post-graduate, i.e., to those already holding a graduate degree. Licensure in more than half the states requires or refers to the Certificate of Clinical Competence (CCC) of ASHA. The American Academy of Audiology (AAA) has a working group examining these and other issues, and audiologists in a few states are beginning to work on licensure modifications. Some have suggested that fourth year AuD students should have temporary licenses that would enable them to bill for services. Our Advisory Board cautions that such an option will undermine the credibility of the profession by implying that a degree is not necessary to practice audiology. We can think of no other profession that allows practitioners to be licensed before receiving a degree.

**The Matter of Payment**

Wilson (2003) described the issues and complications related to paying AuD students during their fourth year of clinical experience and training. In our opinion, the first priority of a clinical site should be to provide high-quality experiences. Compensation to the student is, by all means, a secondary consideration. The problem is that of sites providing salaries rather than stipends to fourth year AuD students. The practice of providing a salary likely comes from the aforementioned confusion between the fourth year AuD clinical training and the CFY position. Aside from the fact that the AuD student has neither a degree nor a license and cannot bill for services, a salary is clearly inappropriate because it changes the individual’s role from that of a student to that of an employee. The needs and expectations of students are very different from those of employees. Students need time to develop new skills and to learn how to assimilate clinical information. In contrast, employees are expected to function with a high degree of independence and often have productivity targets. Treating students as employees risks losing the careful guidance they need to be become capable young professionals. Other health professions, such as medicine, do not follow a practice of paying salaries to students during their clinical experiences.

Our Advisory Board strongly encourages training sites to offer stipends to the AuD students whenever possible. Audiology has a long tradition of students’ receiving stipends during clinical practicum, especially through the Department of Veterans Affairs. Stipends help students defray some of their educational and living expenses. Ideally, all fourth year students should receive stipends in one way or another, perhaps through some type of pooling of funds and equal redistribution.

**Recommendations**

We have used this forum to highlight some critical issues related to the clinical training of fourth year AuD students. It is clear that a national dialogue must be initiated so that a profession-wide consensus on these issues can be reached. We understand that a forum of academic faculty audiologists as well as clinical audiologists will convene on January 10-11, 2004 in Reston, VA to discuss the concerns and issues of the AuD student final clinical training year experience in a consensus meeting sponsored by the American Academy of Audiology. As the enrollment numbers of AuD students increases, it is important that our profession have open discussion forums to establish national standards and guidelines.

**References**


The opinions expressed in this Viewpoint are those of the author(s) and in no way should be construed as representative of the Editor, officers or staff of the American Academy of Audiology.
The Board of Directors of the Academy approved the Ethical Practice Guidelines on Financial Incentives from Hearing Instrument Manufacturers, (AT, 15:3, 2003). during their meeting in July 2003. We thank the members who took the time to provide their comments, both supportive and in opposition to the guidelines. Your comments were read by the Board of Directors, as well as by the members of the Ethical Practice Board. Among those expressing reservations was Robert Turner. Turner’s comments to the Ethical Practice Board contained many of the concerns articulated by other members, and he has graciously allowed us to publish and answer his comments as a way of providing an educational discussion forum.

Dear Committee:

R.T.: I would like to comment on the “Ethical Practice Guidelines on Financial Incentives from Hearing Instrument Manufacturers”. The relationship between manufacturer and audiologist is certainly appropriate for review. In addition, there are issues of potential ethical significance; however, I believe that parts of the guidelines are inappropriate and reflect an overreaction to ethical concerns. The Guidelines seem to take anything that benefits an audiologist and lumps it into the unethical category. Each practice needs to be evaluated on its own merit.

I do not maintain that there are no ethical issues that require consideration; however, each practice must be evaluated individually. There is always the possibility of an agreement between an audiologist and a manufacturer that violates our professional code of ethics. If that occurs, it should be addressed. However, efforts by a manufacturer to establish a business relationship with an audiologist are appropriate and, in general, do not have ethical implications. Efforts by a manufacturer to maintain a good relationship with an audiologist are perfectly appropriate. Most of the practices identified in the document as questionable or inappropriate, in fact, fall under establishing or maintaining a business relationship and are not ethical issues.

EPB: Audiology is a health care profession, not merely a business. One of the characteristics of a profession is its adherence to a publicly declared code of ethics; another is its willingness to self-regulate the profession, including defining appropriate and inappropriate business practices. Ethical standards of professional organizations are determined by the professional members of each organization. Professional ethics constitute an agreement on behavior which coincides with the expected behavior of the professional group. Ethics are subject to change as the group decides or situations dictate.

The Ethical Practice Board was asked by the Board of Directors to address concerns on conflict of interest as it relates to Principle 4 of the code of ethics that states, “Members shall provide only service and products that are in the best interest of those served.” As members strive to meet the challenge of this principle, they are governed by four specific rules. Rule 4c is pertinent; it states: “Individuals shall not participate in activities that constitute a conflict of professional interest.” In 1997, the Ethical Practice Board released a position statement that clarified:

“Conflicts of interest” includes all endeavors related to the practice of audiology in which professional advice, actions, or judgments may be compromised or appear to be compromised by financial or professional factors. When determining the potential for a conflict of interest, the individual should first consider Principle of Ethics 1: “Members shall provide professional services with honesty and compassion and shall respect the dignity, worth, and rights of those served.” This indicates that professional practice decisions must promote the well being of those served. Therefore, professional judgment and practice must not be biased by commercial ventures from which the audiologist may derive personal, professional, or financial benefit. This universal principle applies even to mundane office practices. The personally held belief that professional judgment or objectivity is unaffected by gifts or other economic benefits of significant value (greater than $100) is not, in and of itself, sufficient protection against conflict of interest.

We assume that you do not mean to imply that each audiologist member would be expected to judge his or her own behavior on its merits. Each member, upon joining the Academy, agrees to abide by the Code of Ethics. The recent statements are a clarification of the existing Code. The “Frequently Asked Questions” are taken more or less from “real life,” in order provide a basis upon which audiologists can judge their behavior as it relates to that proscribed by the Code of Ethics. Each practice or audiologist cannot be “evaluated on its own merit.” Doing so allows for each clinician to decide what professional behavior is to be. It prevents the profession from defining and regulating professional behavior.

Audiologists who participate in many of the practices promoted by hearing aid manufacturers not only present the appearance of a conflict in their choice of hearing aids for their patients, they may also be in violation of the legal codes of many states that
RESPONSE TO ETHICAL PRACTICE GUIDELINES ON FINANCIAL INCENTIVES
FROM HEARING INSTRUMENT MANUFACTURERS

disallow a de facto change in the invoice price provided to a third-party payer. It is the opinion of the Academy and the EPB that rewards for purchases of instruments, no matter what form these rewards may take, constitute at least the appearance of a conflict of interest, and in many cases pose a real conflict and may be illegal as well.

R.T.: Consider the half dozen major manufacturers since they provide most of the free stuff. All of these manufacturers produce a broad spectrum of high quality products. My decision as to the manufacturer(s) I dispense is of no practical consequence to my patient. I challenge anyone to provide research data that proves that Manufacturer A is the “ethical” choice and all other manufacturers are the “unethical” choice. Since my choice of manufacturer has no significant impact on the patient, how I make that decision has no ethical implications relative to the patient. Likewise, efforts by the manufacturer to entice my business have no ethical implications relative the patient, whether it is by discount prices, better training and support, better fitting software, registration fees, business development plans, free food and entertainment, cruises, or free backpacks. Thus, traditional practices that are designed to influence my choice of manufacturers are not unethical and should not be prohibited. It is an improper intrusion into the relationship between dispenser and manufacturer.

Efforts by manufacturers to reward their “best” customers are simply a variation on the issue discussed above. It is an effort to convince me to continue my relationship with that manufacturer. Since my choice of manufacturer is not an ethical issue, then these efforts are not inappropriate. If a manufacturer wants to have a “closed” event at AAA for their favored audiologists, that is perfectly appropriate.

EPB: Why do you decide to purchase from manufacturer A, while another audiologist uses manufacturer B? Consumers may have great difficulty deciding on the face of the professional behavior alone, whether each of you functioned without bias. Largely for this reason, the Code of Ethics expressly prohibits behaviors that may constitute such appearance of bias. We assume that audiologists will choose, for example, to dispense manufacturer A’s top of the line digital product for their patient based upon factors such as performance, cost effectiveness, reliability, customer support, warranty, and flexibility of programming. A different audiologist, evaluating these same factors through different eyes, may well make a different decision. We do not believe it is in the best interest of the patient for the purchase decision to potentially be clouded with factors such as the desire to provide reciprocity for the kindnesses of the manufacturer nor for the availability of other “perks”. Sometimes the perk can benefit patients, such as credit towards travel funding or equipment. However, then the question is balancing the needs of all patients against the need of the individual patient. A patient could question whether your practice’s need for a new piece of equipment justifies her being dispensed a product that is not optimal for her needs. Since equipment and business loans (repaid directly, not via credit for products dispensed) are acceptable, there are ethical ways in which the audiologist is able to utilize state-of-the-art equipment, without potentially compromising the individual patient’s interests.

R.T.: In the FAQ section of the guideline, it is suggested that the physician-pharmaceutical relation is “directly analogous” to the audiologist-manufacturer relationship. In fact, it is not an appropriate analogy, and using it as such can result in erroneous conclusions. The obvious difference is that audiologists and the hearing aid industry have a business relationship; physicians and the pharmaceutical industry do not.

Anytime anything is sold, whether it is expertise, testing, therapy, hardware, or even surgery, there is a potential conflict of interest. For most audiologists, there is a conflict of interest inherent in their employment even if they do not dispense hearing aids. We seem content to address these “other” conflicts of interest with the requirement that the interests of the patient must come first. We seem to obsess over hearing aids because they are things, not services, and because of the visibility of the manufacturers. With hearing aids, like any service or product, there is the issue of profit motive. Realistically, this is a bigger factor influencing conflict of interest than any incentive provided by a manufacturer. It is impossible to remove this conflict of interest based on profit motive. We either trust the audiologist to do the right thing, or ASHA was right 30 years ago when it said it was unethical for an audiologist to dispense a hearing aid for more than wholesale cost. If we can trust the audiologist to deal appropriately with all of the temptations that cannot be controlled, we can trust the audiologist to deal appropriately with manufacturers.

EPB: Principle 1 of the AAA Code of Ethics speaks to what is termed “beneficence” in the field of ethics – the concept that the duty of the health care professional is to benefit the patient, and that this is the primary role of the health care provider. You seem to be arguing that every practitioner has an inherent financial conflict of interest – seeing patients who pay for services allows...
the practitioner to earn an income. However, when the overriding concern is patient welfare and there is no reason to question the objectivity of the professional, and when the reason for seeing the patient is the belief that the services provided benefit the patient, then this is not considered a conflict of interest. In contrast, if the recommendation of the practitioner, whether for a repeat visit or for products or services, is viewed as not holding the patient’s best interest paramount, then the practice is considered a conflict of interest. Thus, patients do not question the ethics of an audiologist selling a recommended hearing aid at a fair price when the patient’s best interest is held paramount, but they may question the ethics of the audiologist if he or she received undisclosed incentives for recommending that particular brand of hearing aid.

Physician incentives are particularly nefarious because the patient is unaware that there is a financial implication to physician prescribing patterns. Other professions face this concern as well. Optometrists choose to have opticians dispense products to largely remove themselves from this situation and are required to bill for products and services separately. Dentists are required to make financial disclosure of gains from products, when those gains are not obvious.

The Ethical Practices Board considered recommending disclosure, rather than disallowing incentives. The decision to require members to avoid potential conflict of interest arose from consideration of what is in the profession’s best interest. We believe a delineation of the nature and extent of available incentives is a threat to the public trust in the profession. Consider the patient’s reaction to a physician disclosing that as top dispenser of this drug he earns $25,000 in speaking fees for the company, or to the audiologist’s disclosure that the manufacturer retains a portion of the sales price in a reserve account used to provide funds for manufacturer-sponsored trips.

While you contend that the physician-pharmaceutical relationship is not analogous to the audiologist-hearing aid manufacturer relationship, we might add that insofar as any relationship at all exists, both state and federal governments have taken a significant stance in the control of the physician-pharmaceutical situation, to the detriment of both. The Academy wishes to avoid such governmental intervention in our field.

R.T.: Hearing aids are critical to the future of audiology. Dispensing by audiologists has virtually saved the profession.

EPB: We agree. The importance of providing products that help patients hear better cannot be overstated. We believe that removing concerns about the professional’s conflict of interest is a step towards earning the right to practice autonomously, a goal of the profession.

R.T.: One of the positive aspects of audiology is the generally good relationship between audiologists and the hearing aid industry. As a university faculty member, the best free stuff is not available to me, so I have little personal investment in this issue. I do use the resources of the manufacturers to support the education of my students. Frankly, the free food and entertainment provided by the manufacturers at AAA give me a strong argument for convincing my students to attend.

EPB: Many hospitals and universities prohibit some of the current manufacturer incentives (“the best stuff”) because they do not conform to the institution’s policies on conflict of interest. We do not expect audiologists to decline all manufacturer incentives, only those that create a significant appearance of conflict of interest. Open parties at convention are considered acceptable, so your graduate students will still be able to graze the buffet at convention. Hopefully, they won’t be exposed to behavior such as invitation-only rewards parties, which we believe promotes the “what’s in it for me” mentality, rather than the “what product’s best for my patient” professional construct. Modest dinners with manufacturers are acceptable, manufacturer sponsorship of their educational seminars is ethical, with restrictions. You can accept pens and note pads.

R.T.: Let us be careful not to damage this important and valuable relationship by unfairly characterizing some of the manufacturers’ practices as improper and the manufacturers as unethical partners. Attempts to micromanage the relationship between audiologist and manufacturer will only harm the profession.

EPB: Ethical Practice Board agrees that good working relationships with manufacturers are important. The Academy hopes to partner with manufacturers as we raise our standards of professional behavior. Should members feel these efforts are misguided, the Academy’s Code of Ethics involving the manner in which AAA Audiologists deal with Hearing Aid Manufacturers may change in the future. If the majority of the members of the Academy wish to change these standards, it is within their power to do so. However, until the Code is changed, the Guidelines issued by the EPB represent the majority of the Academy members, at present, via the vote of their elected representatives.

To review the Guideline in its form, go to www.audiology.org/professional/positions/ethics.pdf.
The consensus statement was unanimously ratified by the faculties of Audiology and Speech-Language Pathology (Communicative Disorders) Programs at Arizona State University, Boston University, Howard University, Indiana University, Michigan State University, Ohio State University, Pennsylvania State University, Purdue University, San Diego State University/University of California San Diego, Seton Hall University, University of Arizona, University of Illinois, University of Iowa, University of Kansas Intercampus Program in Communicative Disorders, University of Massachusetts, University of Minnesota, University of Wisconsin, Washington State University and Wichita State University. Accepted unanimously July, 2003.

INTRODUCTION
The profession of audiology has experienced tremendous evolutionary changes as a result of at least four factors. These include:
• an expansion in the scope of audiology practice over the past two decades;
• an expansion of hard of hearing populations in need of audiologic services;
• the evolution of multiple organizations that have laid claim to the representation of the profession, with the disparity of their visions for the profession of audiology creating a significant and often divisive political environment;
• the adoption of a doctoral degree as the required degree for entry into clinical practice.

This has all occurred over a period of time characterized by wide fluctuations in the global economy, with a dramatic shift toward an emphasis on cost accountability and doing more with less in the delivery of health care services, and in meeting the missions of academic programs across the United States.

These changes have had serious repercussions on academic audiology programs resulting in the permanent closings of 33 long standing master’s programs over the past decade (Council of Academic Programs in Communication Sciences and Disorders 2000-2001 Demographics Survey). At least 29 new clinical doctoral programs (AAA July, 2003 website) currently exist. The majority of these are converted Master’s programs with the minority being new programs that were initiated primarily as distance education programs targeted toward practicing audiologists with their Master’s degrees. Several of the latter programs are now also developing residential post-bachelor’s AuD programs. The distance education programs emerged in the absence of any accreditation criteria that applied to them. The new clinical doctoral degree programs have various degree designators including: doctor of audiology, AuD; doctor of science, ScD; clinical PhD, etc.

As the cultures of Doctoral/Research-Intensive and Extensive universities are similar, with similar concerns and shared values, a seminal meeting of a convenience sample of programs from these universities, including representatives from the Big Ten universities and all Indiana universities with graduate audiology programs, was hosted at Purdue University October 4 and 5, 2002.

The purpose of this meeting was to:
• discuss issues and concerns that relate to the rapid evolution of the audiology profession in the context of the unique visions and values shared by audiology education programs in Doctoral/Research-Intensive and Extensive universities
• come to consensus on those issues/beliefs which are believed foundational to the maintenance of rigor in the preparation of clinical audiologists and to the development of the future of the audiology profession
• initiate a discussion of visions for the future evolution of the profession based on cross-disciplinary cooperation and the foundational principles of using the principles and precepts of good science to better understand the auditory system and serve the many populations of people with auditory disorders and
• create a mechanism for the continuation of the momentum of this group at an annual Audiology Summit meeting for all Doctoral/Research-Intensive and Extensive university programs held at future conference meetings of the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD).

SHARED VALUES:
The Big Ten universities, which gave birth to the field of audiology and have had strong programs in audiology and hearing science throughout the 50+ year history of the profession, share the mission of undergraduate and graduate education culminating in the preparation of clinical
practitioners and research scientists. These programs advocate using qualified faculty in adequate numbers with sufficient infrastructure support to effectively deliver a curriculum that represents the full scope of practice in the discipline. These universities also share the commitment to scholarship through the contributions of their faculty to the body of knowledge across disciplines via their research and the dissemination of research findings via appropriate juried venues.

The Big Ten universities advocate for the education of audiologists and hearing scientists by experts both from within the discipline and across academic disciplines whenever appropriate. This philosophy is consistent across both didactic and clinical education, emphasizing the relevance of clinical experiences supervised by the most qualified practitioner. It is also the shared belief that the most comprehensive preparation of clinical audiologists is accomplished when academic programs have consistent and reciprocal relationships with medical centers and other clinical venues such as schools and industry that provide access to experiences that both represent the full scope of audiology practice and are responsive to each program’s supervision requirements and desired student learning outcomes.

**CONSENSUS STATEMENTS:**

As these universities look to the current and future education of doctorally-prepared audiologists and hearing research scientists in academic programs across the United States we are in agreement on the fundamental and critical importance of the following statements:

1. We support the doctoral degree as the entry-level to the clinical practice of audiology and the freedom of university programs to select the doctoral degree designator (e.g. AuD, ScD, PhD, etc) that they deem most appropriate to the mission and culture of their institution.

2. We reaffirm that the depth and breadth of clinical preparation in audiology qualifies the audiologist to be the primary hearing health care provider.

3. We believe that the integrity of the discipline of audiology depends on a continuing and strong research base, which is synergistic with clinical practice and tended by appropriately educated PhD (or other research emphasis doctorate) research scientists and clinical scientists.

4. We agree that the PhD (or other research emphasis doctorate) is the degree that is necessary for the preparation of research scientists who have the knowledge and skills to maintain the research standards of the Academy and most rigorously contribute to the body of knowledge.

5. As unanimously resolved by the members in attendance at the CAPCSD April, 2002 conference in Palm Springs, California, and voted on and passed by the CAPCSD membership summer, 2002, we also are: “1)...opposed to the recognition by either the Office of Education or CHEA of any new accreditation entities for speech-language pathology or audiology programs...” and support the CAPCSD recommendation that, “... 2) the Council of Academic Programs in Communication Sciences and Disorders will entreat the Council of Academic Accreditation (CAA) to insure that all professional organizations with vested interests in the quality of professional education in either speech-language pathology or audiology are provided equitable opportunity for input to the standards review and implementation process, and the Council of Academic Programs in Communication Sciences and Disorders will exercise whatever influence and leadership opportunities it may have toward the goals articulated in (1) & (2) above.” Note: The CAA, as of 10/15/02, has already accredited 18 clinical doctoral programs (AuD, ScD and PhD) based on the new competency-based certification standards of the American Speech-Language-Hearing Association’s (ASHA) Council For Clinical Certification in Audiology and Speech-Language Pathology (CFCC ).

6. We believe that the profession of audiology will be best served through the cooperation of the organizations that have the representation of the audiology profession as part, or all, of their mission. The smooth and issue-focused trajectory of the future development of the audiology profession must not be compromised by the conflict created by disparate political agendas of these organizations.

7. We agree that there should be a single certifying body that should never link certification to a specific degree designator. We also acknowledge that with the advent of state licensure or title registration being mandatory for the practice of audiology in most states, certification is voluntary. For this reason, master audiologists may be licensed or have title registration without having certification. It is a concern shared by the group that under the current ASHA program accreditation guidelines, master audiologists who are able to legally practice the profession of audiology in their states but who do not have certification are unavailable to accredited programs as supervisors of our audiology students. There is need for resolution of this dilemma.
8. We believe that in response to the outcomes/learning-focused CFCC standards for competency in the knowledge and skills that represent the full scope of audiology practice, academic programs must establish levels of expected competency (e.g., taught, emerging/learning, mastered) with accompanying methods of formative assessment.

9. We agree that the areas of knowledge and skills identified in the certification standards (effective January 1, 2007) should be weighted according to their commonality across practice settings. Those that are judged to be more specialized or practice-setting specific should have a lesser weighting, allowing programs greater flexibility in defining the level of competency their students are expected to achieve and the alternative pathways that they may use to achieve those competencies.

10. We agree that although competence across the scope of audiology practice is the primary mission of clinical programs, exposure to research must be an integral part of the curriculum with the breadth and depth of this exposure defined by the mission and values of each program. We agree that at a minimum, graduates of accredited clinical doctoral programs in audiology must have a level of exposure to research methodology that is sufficient enough to allow them to be critical consumers of research. To this end we believe that clinical audiologists must have a level of research exposure that enables them to view their clinical practice as clinical science and to modify their delivery of clinical services based on the outcomes of their practice and evidence-based scientific research.

11. We agree that a doctoral program in audiology must have a core faculty that is sufficient in number, breadth and depth to present a curriculum that represents the majority of the scope of practice of the profession. Adequacy of the number of faculty is objectified through such metrics as accessibility to students, national visibility through publications and presentations, breadth of expertise recognized by members of peer institutions, and participation in activities that define “the cutting edge” in clinical practice. We agree that shared resources such as distance participation in clinical grand rounds, didactic lectures, virtual experiences, etc., should be used only to enhance the program being delivered by an adequate number of core faculty and never in place of them.

12. We recognize that in the current academic environment of Doctoral/Research-Intensive and Extensive universities, if an audiology program is to survive and flourish, the following activities must be well represented among the faculty: productive research (discovery) programs, active involvement in teaching (learning) with an expectation that these faculty, and all faculty within the academy, will be teaching at both the graduate and undergraduate levels, and productive service (engagement) activities which include the expectation for revenue generation through the delivery of clinical services, traditional department, college, university and community service activities including administration, and a new emphasis on development activities to address the fiscal needs of programs through the establishment of endowed scholarships, professorships/chairs, and named infrastructures. We agree that these expectations cannot be met using a model that defines full-time “faculty” using only the traditional tenure-track designation. We therefore encourage all audiology programs in Doctoral/Research-Intensive and Extensive universities to work with their university administrators and governing boards to establish a dual faculty track model that includes and equally values both tenure-track and clinical faculty (e.g., assistant through full professors).

13. We agree that the “12 months’ full-time equivalent of supervised clinical practicum sufficient in depth and breadth to achieve the knowledge and skills outcomes” (ASHA certification standards effective January 1, 2007) should be an integral part of the clinical education program and that clinical experiences can be acquired using a variety of models (e.g., fewer long-term or multiple short term experiences spaced throughout the program). The concept of a “clinical matching program in the final year of a clinical doctoral program” may be inconsistent with the letter and intent of these new certification standards.

14. We agree that specific guidelines for inclusion of practicum sites in a program must be created and address issues such as accreditation by appropriate bodies (e.g., Board of Health, JCAHO, etc.), number and adequacy of preparation of site supervisors, consistency of amount of supervision and willingness of supervisors to use university program-approved metrics for formative assessment of student competencies acquired at the site, responsiveness of the site to the needs of the academic program, scope of practice represented within the site, approval of site supervisors by the academic program, etc.
Recent Advances in How Hair Cells Work

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Hearing and balance functions rely on the hair cells of the inner ear. Mechanical stimuli such as sound or motion excite hair cells by deflecting the stereocilia bundles on the apical portion of the cell. The process by which hair cells convert these stereocilia deflections into electrical impulses is called “mechanotransduction” (Hudspeth, 1989). Mechanotransduction is thought to involve the tiny filaments called tip links that connect stereocilia to one another. Deflection of the stereocilia causes tension on the tip links, which are thought to directly open mechanosensitive ion channels (“transducer channels”). The result is that cations (primarily K+ ions) rush into the hair cell from the surrounding endolymph and depolarize the hair cell membrane. This depolarization causes release of neurotransmitter from the hair cell and thus activity in the nerve.

Scientists have known for over 20 years that hair cells must contain a transducer channel with very rapid response properties (Corey and Hudspeth, 1979). However, until last month, nobody had identified a vertebrate hair cell mechanotransducer channel. In the July 4 issue of Science, a group of scientists from the Max Planck Institute in Tübingen, Germany, and the Oregon Hearing Research Center in Portland reported the identification of a hair cell mechanotransducer channel in zebrafish (Sidi et al., 2003). The channel is similar to a channel identified in fruit flies as Drosophila no mechanoreceptor potential C, or nompC. In flies, this channel is expressed in touch-sensitive bristle neurons. In zebrafish, the channel is expressed in hair cells of the inner ear and lateral line.

The researchers used a technique called antisense morpholino injection to eliminate functional nompC channels in young zebrafish. They then tested hair cell responses to deflection of their stereocilia bundles, but hair cells of fish that lacked the nompC channel showed no electrical responses at all when their stereocilia were deflected. Normal zebrafish hair cells showed very robust electrical responses to deflection of their stereocilia bundles, and the resulting extracellular potentials were recorded. Normal zebrafish hair cells showed very robust electrical responses to deflection of their stereocilia bundles, but hair cells of fish that lacked the nompC channel showed no electrical responses at all when their stereocilia were deflected. When the nompC channels were restored in these same animals, the hair cells electrical activity also returned (Sidi et al., 2003).

These results indicate that nompC is a hair cell transducer channel in zebrafish. They also represent an important step in our understanding of vertebrate hair cell mechanotransduction. This is an exciting development not only from the perspective of the basic science of hearing function, but also from a clinical perspective, since advances in our understanding of hair cell function increase our chances of eventually designing therapies aimed at restoring hearing. The scientists that identified nompC as the zebrafish hair cell transduction channel are now searching for related channels in mice and humans.

BIBLIOGRAPHY

A STUDY OF SOCIAL AND EMOTIONAL FUNCTIONING OF CHILDREN WITH COCHLEAR IMPLANTS

The Child Development Lab at the University of Maryland, College Park, is conducting a research study to investigate the unique experience of children with cochlear implants. This information is of vital interest to the families of deaf children and many professionals who serve them, including implant teams, educators and mental health professionals. The project, taking place on the College Park campus of UMD, began in July 2003 and will run through July 2004. Nathan Fox and Froma Roth are the principal investigators. The study focuses on aspects of social and emotional functioning that are vital to developing healthy relationships and self-esteem. Interested volunteers spend the day at the Child Development Lab on the University of Maryland campus. Lunch is included and children will receive a $20 Blockbuster gift certificate. Information is available at www.cistudy.info or by contacting Efrat Schorr at 301-405-8315 or by email at cistudy@umail.umd.edu.

NATIONAL TEMPORAL BONE REGISTRY OFFERS FREE BROCHURES

The NIDCD National Temporal Bone Registry is dedicated to promoting research of hearing and balance disorders through the study of temporal bones and related brain structures. The Registry has two informational brochures available free of charge which encourage individuals with ear disorders to bequeath their temporal bones to scientific research. That Others May Hear is a short informational brochure which has a detachable postcard allowing interested individuals to request donor enrollment materials while The Gift of Hearing: Learning About Temporal Bone Donation is a larger, extended booklet written in non-technical language with colorful graphics to demystify the process for potential donors and their families. For additional information or to request free copies of either or both brochures, contact tbregistry@meei.harvard.edu or call 1-800-822-1327 at the Massachusetts Eye & Ear Infirmary, Boston, MA.

Auditory Processing Conference Scheduled in Dallas

The Bruton Conference will be held on October 11, 2003, at The Callier Center in Dallas, TX. Teri Bellis will present “Issues in the Diagnosis and Treatment of Auditory Processing Disorders in Children,” the keynote presentation. For further information about the program or registration, contact James Jerger at jjerger@utdallas.edu, or consult www.apd.org.

NCRAR INAUGURAL CONFERENCE

The National Center for Rehabilitative Auditory Research (NCRAR) has announced a national conference titled “Auditory Rehabilitation: A Multi-Dimensional Approach,” to be held October 9-10 in Portland, OR. Topics to be presented include issues related to telephone use and hearing aids, measurement of hearing aid outcomes, directional hearing aids, plasticity of the neural system for auditory rehabilitation. Speakers include Harvey Abrams, Robyn Cox, Harry Levitt, Michael Merzenich, Todd Ricketts, Mark Ross, Kelly Tremblay and Brian Walden. For conference information visit www.ncrar.org/conf.htm or contact Carolyn.Landsverk@med.va.gov. A one-day pre-conference tinnitus workshop will be held on October 8th, entitled “Clinical Management of Veterans with Tinnitus.”

Vanderbilt Continuing Education Courses Scheduled

Vanderbilt University of Nashville, TN, has announced two new continuing education courses. A Pediatric Cochlear Implant Workshop is scheduled for September 18-20, 2003. The popular Vanderbilt Hearing Aid Selection and Fitting Hands-On Workshop -With Special Focus on the Pediatric Patient will be held November 6-8, 2003. For information and registration materials contact Kate Carney at kate.carney@vanderbilt.edu or telephone 615-936-5016 or visit www.vanderbiltbillwilkerscenter.com.
Providing hearing services to children in underserved Mayan communities was the primary goal of a recent mission trip by a group of University of Florida audiologists. Professor Alice Holmes at the UF College of Health Professions and AuD students Jennifer Bai Rossi, Christi Barbee, Christa Coore-Powell, Myriam De La Asuncion and Lori White traveled to the Mexican state of Yucatan during spring of 2003. The group observed audiologic care practices in schools serving children with hearing impairments in Yucatan’s capital, Merida, and tested the hearing of more than 80 children in special education schools in small Mayan villages. They also donated audiologic equipment to local clinics and 1,000 hearing aid batteries to children. The trip was coordinated by the local chapter of the National Association of Future Doctors of Audiology, the UF Office of Global Health and AYPRODA, a foundation serving children with hearing impairments in the Yucatan.

The group found a high incidence of hearing impairment due to maternal exposure to rubella among the children in the Mayan communities. “Because of the availability of vaccinations in the United States, I haven’t seen a case of rubella in clinic in 20 years,” Holmes said. With an average household monthly income of $125, the cost of a $200 rubella vaccination is an unreasonable expense for most families, Holmes said. The trip proved to be a valuable experience as the students gained experience evaluating children with significant auditory problems such as middle ear disease and problems with the external ear, and gave them the opportunity to work with children with multiple disabilities and limited or absent language skills. The UF plans to make the Yucatan trip an annual event with more faculty and student volunteers and to expand their testing beyond special education schools to mainstream schools to identify children with mild or moderate hearing loss.

Howard House, Pioneer in Otologic Surgery

Howard P. House, MD, founder of the internationally renowned House Ear Institute in Los Angeles, died on July 31, 2003 at the age of 95. Since its establishment in 1946 the House Ear Institute has grown from a one-person laboratory to a five-story building accommodating a staff of over 175 people dedicated to the advancement of hearing research. Howard House is well known to audiologists and otolaryngologists through his numerous lecture appearances and journal publications over the years. Specifically, he perfected the wire-loop technique to replace the stapes bone of the middle ear as well as other otologic surgical procedures. Howard House brought much attention to successful treatment of hearing loss through his contacts with many celebrity patients including former President Ronald Reagan and entertainer Bob Hope. The House Ear Institute has trained thousands of otologists from around the world and employed hundreds of audiologists.

Kappa Delta Alumnae Offer Hope For Babies with Hearing Loss

The Tallahassee Alumnae Association of Kappa Delta Sorority received a KiDs Grant of $5,000 from the National Kappa Delta Foundation for the Children’s Medical Services program of the Florida Department of Health. The grant funds were used to purchase educational videos and books for parents of newly identified children with hearing loss throughout the state of Florida. Audiologists Vicki Wiman and Karen Anderson were instrumental in obtaining the grant funds to support the SHINE (Serving Hearing Impaired Newborns Effectively) program.

Spirakis Receives Award

The US Agency for International Development, in conjunction with the city of Lakeland, FL, honored Gregory Spirakis with the Outstanding Citizen Achievement Award. The award is presented to Americans who have made exceptional contributions to international development through volunteerism. Spirakis was honored for his work to provide hearing services for deaf and hearing-impaired children in the City of Balti in the Republic of Moldova. Spirakis was previously recognized by the American Academy of Audiology with an Honors Humanitarian Award in 2002.

Ives Joins Audiology Faculty at Pennsylvania College of Optometry

Terri Ives has joined the faculty at the School of Audiology at the Pennsylvania College of Optometry (PCO). Ives was previously the manager of clinical research at Sound ID in Palo Alto, CA. She will be responsible for the integration of electro-diagnostic and balance courses into the PCO curriculum as well as conducting research in the areas of auditory electrophysiology and vestibular testing and rehabilitation.
SCOTT HAUG AUDIOLGY RETREAT
The 19th annual Scott Haug Audiology Retreat will be held on October 2-5, 2003, in Kerrville, Texas. The educational program will feature lectures from American Academy of Audiology President-elect Richard Gans, Robyn Cox, Paul Pessis, George Osborne, and Alan Frient. Topics will include discussions of vestibular assessment and diagnosis, current outcome measures, directional hearing aids’ benefit in noise, an update on HIPAA’s current implications on practices and profession, and the impact of non-prescription medications. Frient, an otolaryngologist, will address “Issues and Communications Between the ENT and the Audiologist.” The annual Retreat, held at the “Inn of The Hills” overlooking the Guadalupe River amid the beautiful Texas Hill Country, presents practical continuing education opportunities while allowing for relaxed fun and fellowship among the professionals who attend. For more information and registration materials, please visit www.scotthaug.org.

COCHLEAR IMPLANTS AND SENIORS: WHEN HEARING AIDS AREN’T ENOUGH
Self Help for Hard of Hearing People (SHHH) and Cochlear Americas collaborated to produce a new educational resource aimed at consumers entitled Cochlear Implants and Seniors: When Hearing Aids Aren’t Enough. This 16-page publication provides a clear and straightforward description of the cochlear implant (CI) process, and specifically addresses the concerns of seniors who are interested in cochlear implants.

While CI technology has long been a treatment for severe-to-profound sensorineural hearing loss in children and younger to middle-aged adults, hearing health care professionals were sometimes disinclined to recommend CIs for seniors. Historically, in our culture, there has been a widely accepted assumption that seniors do not need to hear as well as younger people and that to be hard-of-hearing when older is a normal and accepted part of life.

Today’s seniors are often highly involved in areas of life that benefit from hearing well — many people into their 60s and 70s still work, many seniors participate in community service, many travel extensively, and recent reports show that many seniors are raising grandchildren themselves. While it may once have been true that seniors led relatively “quiet” lives, the world has changed — and leading-edge assistive listening technology, including CIs, are appropriate for today’s seniors.

The Project Hope study of 1999 estimated the population of eligible candidates for CI technology by age. Of the total likely candidate population in the United States, 27% are between the ages of 65 to 79, and another 27% are over age 80. Reviewed by leading clinicians in the field, Cochlear Implants and Seniors references key studies demonstrating the value of CI’s for this demographic group, and addresses frequently voiced concerns by older consumers. Consumers may order a copy of the new booklet free of charge, or view it at www.hearingloss.org.

INTERNATIONAL CONGRESS OF AUDIOLOGY 2004 ISA-AMPLIFON STUDENT SCHOLARSHIP
The Executive Board of the International Society of Audiology will offer three (3) student scholarships sponsored by the Amplifon Foundation to attend the XXVII International Congress of Audiology, September 26-30, 2004 in Phoenix, Arizona. The scholarships include registration fees for the ICA International Congress as well as housing with local families during the meeting. The scholar is responsible for transportation from home country to the Phoenix Congress, food, local transportation and other incidental needs while attending the Congress.

Student applicants must be full-time graduate students taking courses in audiology and preferably working towards a degree in audiology or hearing science. Graduates who completed their degree in 2004 may also apply. The applicant must submit an abstract and written description of original research, either clinical or basic science, together with a letter of recommendation from their research advisor. The Scientific Committee of ISA will judge each entry and determine the final scholarship winners. The student’s research will be presented in poster format at the time of the Congress. Submission deadline is December 1, 2003, and scholar winners will be notified by February 1, 2004. For more information and applications, contact Sharon Fujikawa Brooks at sfujikawa@uci.edu or visit the ISA website at www.isaudiology.org.

CAOHC Invites AAA to Join Council
The American Academy of Audiology recently joined the Council for Accreditation in Occupational Hearing Conservation (CAOHC) as one of nine Component Professional Organizations with representation on the Council. Richard Danielson and Mark Stephenson serve as representatives for the American Academy of Audiology. CAOHC is an organization dedicated to the establishment and maintenance of training standards for those who safeguard hearing in the workplace. More than 21,000 certified occupational hearing conservationists have been trained through CAOHC courses since the organization was founded in 1973.
HIPAA: The October 16, 2003 HIPAA Transactions And Code Sets Standards Deadline Is Approaching!

The Health Insurance Portability and Accountability Act (HIPAA) is more than a privacy law. Congress also included a series of “administrative simplification” provisions that require the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions to improve the efficiency and effectiveness of the health care system. All covered entities must be in compliance with the electronic transactions and code sets standards by October 16, 2003.

The Administrative Simplification Compliance Act (ASCA) includes a provision that requires electronic submissions to Medicare effective October 16, 2003. However, one of the major exceptions to this requirement is for claims submitted by “a small provider of services or supplier.” A small provider is defined as a provider of services with fewer than 25 full-time equivalent employees: or a physician, practitioner, facility or supplier (other than provider of services) with fewer than 10 full-time equivalent employees. Small providers will not be required to file electronically with Medicare.

Testing with your carrier or fiscal intermediary is required to assure that you and your business partners can send and receive HIPAA compliant transactions. To schedule testing, contact your Medicare carrier or fiscal intermediary. For more information and helpful HIPAA resources, go to the Academy’s HIPAA web page at www.audiology.org/professional/members/hipaa/.

CMS is responsible for enforcing the electronic transactions and code sets provisions of the laws. CMS will focus on obtaining voluntary compliance and use a complaint-driven approach for enforcement of HIPAA’s electronic transactions and code sets provisions. When CMS receives a complaint about a covered entity it will notify the entity in writing that a complaint has been filed. Following notification from CMS the entity will have the opportunity to 1) demonstrate compliance, 2) document its good faith efforts to comply with the standards, and/or 3) submit a corrective action plan. For more information on CMS’s enforcement approach, see “Guidance on Compliance with HIPAA Transactions and Code Sets” released on July 24, 2003 at www.audiology.org/professional/members/hipaa/guidance20030724.pdf.

EDUCATIONAL AUDIOLOGY ASSOCIATION

Approximately 180 participants attended the 2003 Educational Audiology Association (EAA) Summer Conference was held July 12-16 in St. Louis, Missouri. Attendees listened to presentations by keynote speaker Kris English, and invited guest speaker Dave Fabry, among faculty members. A highlight of the conference was the presentation of the Fred Berg Award to Karen Anderson to recognize her accomplishments in the field of educational audiology and her contributions to the Educational Audiology Association. Her award included the gift of original artwork by EAA member Laurie Allen. This Fred Berg award is presented to an individual who has made notable contributions to the field of Educational Audiology on a national level. It is not automatically awarded every year. Past recipients have been: Frederick S. Berg (1991); Carol Flexer (1992); Julia Davis (1995); James Blair (1996); Noel Matkin (1997); Mark Ross (1998); Marion Downs (1999); Fred Bess (2000); Cheryl DeConde Johnson (2001); Kris English (2002).

Christine Jakubec, EAA Immediate Past-President, Karen Anderson holds the Fred Berg Award with Gail Whitelaw, representing the American Academy of Audiology Board of Directors.

The Past-Presidents of Educational Audiology Association gathered at the 2003 EAA Summer Conference in St. Louis. Pictured clockwise from the top left corner are: Johnnie Sexton, Laurie Allen, Karen Anderson, Peggy Benson, Christine Jakubec, Dorinne Davis, Cheryl Johnson, Barbara Murphy, Mary Ann Lyon Knittel. Inserted lower left is Kris English, and lower right is Mary Whitaker.
AMERICAN ACADEMY OF AUDIOLOGY MEMBERSHIP BENEFITS

ARE YOU TAKING ADVANTAGE OF YOUR MEMBERSHIP BENEFITS?

The American Academy of Audiology offers its members several benefits of membership. You may not even be aware of some of the advantages that come with being an Academy member. Not only are our members part of the world’s largest professional organization of, by and for audiologists, but they also benefit from discounts in a number of programs. Read on to find out more about the benefits of membership with the Academy.

PROFESSIONAL LIABILITY INSURANCE:
The Academy has endorsed the professional liability insurance program offered through Healthcare Providers Service Organization (HPSO). We selected this program because of the plans many benefits, the affordable rates, and their commitment to superior service. For more information, call 1-800-982-9491 or visit their web site at www.hpsos.com.

GEICO AUTO INSURANCE:
Academy members may qualify for an additional discount off GEICO’s already low rates. Call GEICO today for a free rate quote at 1-800-368-2734.

HEARCAREERS:
Whether you’re seeking a job or filling a position, the American Academy of Audiology’s HearCareers site has everything you need to achieve your hearing career goals. This online employment service allows job seekers to post their resume and view job postings for free. HearCareers offers discounted rates to our members who post positions. Go to www.audiology.org/hearcareers to make your next career connection with HearCareers.

MEMBERSHIP CARD/CALLING CARD:
This dual-purpose card can be used as a GlobalPhone domestic or international calling card. It is also your permanent membership card for easy reference to your membership number. U.S. rates are 5.9 cents per minute with no surcharges. To activate your card, call 1-800-866-895-5714 or go to www.audiology.org/callingcard.

COMPENSATION & BENEFITS SURVEY:
The American Academy of Audiology conducted its third annual Compensation and Benefits Survey in the Fall of 2002. A full report of the survey with detailed information will be available for Academy members online at www.audiology.org/hearcareers.

CAR RENTAL DISCOUNTS:
Members can get up to 15% off with Hertz and Alamo. Additionally, coupons are available for one car-class upgrade and $10 off a weekly rental with Hertz, and one free day and $15 off with Alamo. For Hertz use Discount Code (COPH 1299750) and/or call the Academy for member discount coupons. For Alamo be sure to request Rate Code BY and ID# 676435 and/or call the Academy for discount coupons.

ACADEMY CREDIT CARD:
With the Academy Credit Card, MBNA “gives a little something back” to the Academy every time you make a purchase, and you can earn points toward travel and brand-name merchandise. Apply online at www.audiology.org/professional/members/benefits or call 866-438-6262. Please mention priority code BUV7.

RESEARCH DOME:
The Dome online research subscription is the premier information service developed for clinicians, educators, researchers and students in the field of Audiology and Communication Sciences and Disorders. Save 42% off the regular price ($119.95) of an annual Dome subscription. The special member price is $69.95. Academy candidate members save too! Candidate members subscribe for $35 (regular student price is $49.95), a 30% savings. Go to www.audiology.org for a free trial or to subscribe.

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For more information on any of these benefits, contact Laura Franchi, Membership Benefits Manager, at 703-790-8466 x1039 or lfranchi@audiology.org.
By now you should be aware of the Hearing Health Accessibility Act, HR 2821, that was introduced in the House of Representatives recently. It is vital for you to send your letters to your Congressman urging his/her support in becoming co-sponsors of this bill that will allow patients direct access to our services. It is a good idea to have a stack of support letters at your office front desk for your patients to sign. By opening up the entryway with Medicare the road will be easier to navigate with other third party payors and eventually lead audiologists to secure Limited License Practitioner status. There are sample letters available on the Academy website at www.audiology.org. Take two minutes right now to “fill in the blanks” on the website letter and submit it electronically to your congressman for the good of the future of your profession and autonomy.

Before Direct Access becomes reality, it is important that you understand the physician referral process as it stands today. In order for you to bill Medicare for a diagnostic assessment, a physician referral needs to be in hand and/or documented in the patient’s chart. Equally important is that the “medical necessity” of this evaluation and the referral to the audiologists must be documented in the referring physician’s chart. In the case of a Medicare audit, physician referral documentation must be documented or paybacks will be required from audiologists.

In the case of no physician referral documented in the chart the patient, prior to receiving services, must sign an Advanced Beneficiary Notice. A copy must be given to the patient and a copy retained in their chart. An ABN must also be signed when treating or evaluating tinnitus, cochlear implant rehabilitation, vestibular rehabilitation and/or cerumen removal. ABNs are not required for hearing aids or if the audilogic assessment is being performed to assess the need of or for appropriate amplification. ABN forms and background information on the ABN are available at www.audiology.org/professional/members/medicare/abnfacts.php.

PROTESTING THE UNITED AUTO WORKERS CHANGE IN REIMBURSEMENT. The Academy sent a letter on behalf of the membership to the United Auto Workers in Detroit to protest the recent unannounced decreases in reimbursement. The letter attempts to educate the UAW as to what audiologists do in terms of fitting their members with amplification. The Academy has also received many reports of insurance companies denying reimbursement for 92569 independently of 92568 (especially in Texas) and has responded with letters to those insurance companies.

TELL US YOUR SIDE OF THE STORY. The Reimbursement Committee would like to hear of your success stories with audiology-friendly insurance companies and the other side of the continuum...any insurance companies that have been problematic. Please tell us about your exceptional and not-so-exceptional experiences in order for us to expand our insurance company base. E-mail your comments to audiology@neo.rr.com.

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