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ON THE COVER

Alfred M. Butts invented Scrabble® in 1948 and now it is estimated that one out of every three homes in America has a Scrabble® game on hand, so that there is no doubt that Scrabble® has become a household name. The American Academy of Audiology is working diligently to make “Audiology” a household word through the promotion of our slogan, “How’s Your Hearing – Ask An Audiologist.” As you can see from this month’s cover design, those words could score high enough to make us all winners!

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APPRECIATION IS EXTENDED TO STARKEY LABORATORIES FOR THEIR SPONSORSHIP OF COMPLIMENTARY SUBSCRIPTIONS TO AUDIOLOGY TODAY FOR FULL-TIME AUDIOLoGY GRADUATE STUDENTS.
Playing Well With Others

Gail M. Whitelaw, PhD, President, American Academy of Audiology

This President’s message is written as I am returning from the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) annual convention in Los Angeles and as I prepare to leave for the AAA Board of Directors meeting in Minneapolis, host city for AudiologyNOW! 2006. The timing of these trips in relationship to each other sets the stage for the topic of this message—partnership and collaboration.

We will be completing the update to the Academy’s strategic plan as part of our October Board meeting. The Board has been looking at the goals of the Academy; however, two are particularly relevant for this message: promoting a member-driven environment and partnering with other organizations to “advance hearing and balance” care. A frequent message received from members is related to promotion of the profession of audiology. Another message from members is the appeal to act in a collaborative manner with other organizations, the types of comments that our Board refers to as requests to “play well with others.” In some cases, these two messages may be at odds in the need for the Academy to be the voice of audiology while understanding agendas of other professional organizations that also address hearing and balance care.

I have written and spoken on the Academy’s “coming of age” as an 18-year-old organization. The analogy of evolving into adulthood can also be viewed as a maturing of the communication that occurs between the Academy and other organizations. As adolescents grow to adulthood, they are better able to effectively address differences of ideas, opinions and viewpoints, and in these interactions, compromise and collaboration become viable options. So, too, should be the case with evolving organizations.

Change is both inevitable and desirable in organizations. In their 2001 book Ten Tasks of Change: Demystifying Changing Organizations, authors Jeff Evans and Chuck Schaefer state that “changing is the continuous process of an organization attempting to align itself with shifts in its environment.” Bonnie Litch, in a 2005 article in Healthcare Executive, points out that change “is what organizations do, not what you do to them.” In this context, the Academy has matured and evolved in how we interact with other professions and organizations.

The Academy is the professional home of audiology and in that role has had opportunities and challenges to develop relationships with other organizations. Our previous experiences have helped to shape our current interactions, and the Academy has learned from previous successes and obstacles that have been encountered. The intent is to enhance the Academy’s ability to develop partnerships that benefit the profession and advance hearing and balance care. Poet Maya Angelou sums up this learning experience in her quote “You did what you knew how to do and when you knew better, you did better.” As the Academy matures, we are committed to “doing better” in a number of these types of relationships and I wanted to take this opportunity to share some of these interactions with you.

One of the partnerships that has been cultivated and venerated by the Academy over the years is that with the Academy of Dispensing Audiology (ADA). The Academy and ADA have been united in numerous activities to advocate for audiology and shape the future of the profession. Recently, leadership of the Academy and ADA had breakfast with Senator Tim Johnson and his staff, sponsor of Senate Bill 277 for direct access to audiology services for Medicare beneficiaries. We look forward to continuing to nurture the relationship with ADA, as well as nurturing relationships with other audiology organizations.

This year, the Academy has joined with the American Speech-Language-Hearing Association in a number of important initiatives that will help to shape the future of audiology. These initiatives have included addressing the prospect of decreased reimbursement for audiological services proposed under the Medicare fee schedule, participating in a joint meeting to discuss the future of program accreditation, and participating in the planning process for the second audiology summit meeting to be held in February, 2006 on the topic of clinical education.

The Academy continues to enjoy a mutually beneficial partnership with Self Help for Hard of Hearing (SHHH). For a number of years, the Academy worked to develop our own “consumer council” to understand the patient perspective and address joint advocacy efforts. In recent years, the Academy has enjoyed a strong relationship with SHHH, which has fulfilled the desired goals of the Academy’s own consumer council and has offered us much more. We have partnered in advocacy efforts for hearing and balance care and have enjoyed opportunities to share information and ideas that have advanced the goals of both organizations. In June, Past-President Richard Gans; the Academy’s Director of Health Care Policy Jodi Chappell; and I attended the SHHH Convention in Washington, DC as presenters and participants. A number of Academy members volunteered at the Academy booth and provided information about audiological services and consultation. More recently, the Academy has partnered with SHHH, the Texas
Academy of Audiology, and a number of industry partners in hurricane relief efforts.

Most recently, the Academy has been working to foster a stronger relationship with the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS). Many Academy members have commented on their positive collaborations with their otolaryngology colleagues, and this feedback is the backdrop for forging new ways for the Academy to work in partnership with AAO-HNS. Initial meetings between the Academy’s Executive Director, Laura Fleming Doyle, and AAO’s Executive Director, David Nielsen, provided a framework for addressing issues that help both professions advance hearing and balance care and establish common ground. Academy and AAO leadership enjoyed a meeting in August to discuss mutual interests and explore opportunities for collaboration. Richard Gans, President-Elect Paul Pessis, and I also had the opportunity to attend the AAO-HNS convention in Los Angeles and were able to talk with individual AAO-HNS members regarding audiology and to interact with Academy members that were in attendance. We are looking forward to ongoing meetings with the AAO-HNS leadership during the coming months and to host AAO leaders at AudiologyNOW! 2006.

The Academy’s commitment to promoting the mission and goals of the independent profession of audiology will be first and foremost. However, as the Academy has grown and matured, the value of collaborative relationships and developing alliances with other organizations has become more evident. In some cases, this will reflect a partnership with an organization on a specific issue or activity. In other cases, the Academy will work to seek common ground by understanding positions that may be in conflict with that of the Academy. The conclusion in these situations may be to “agree to disagree,” as compromising the profession and professionals in order to placate partner organizations is not an option. As with all relationships, disagreement can be a springboard to new ways of addressing problems and issues. Conflict does not have to mean the end of a relationship and we will strive to keep lines of communication open despite potential disagreements. In the end, these types of interactions are of mutual benefit in advancing hearing and balance care and in promoting the profession of audiology.

REFERENCES
I wasn’t sure there was much I could do for the victims of Katrina other than offer my prayers and make a donation to the Red Cross. I felt helpless and removed, as I am sure many of you did. I could see the pain and devastation but felt frustrated that there was nothing I could personally do to help.

That was soon to change. Within a week after Katrina hit, I received two emails almost simultaneously: one from Terry Portis of SHHH and the other from Academy Past-President Dave Fabry of Phonak. They both had the same idea. Let’s coordinate an effort through the audiologists of the Academy to help those evacuees who are in need of hearing aid repair or replacement. Phonak had located a mobile hearing van and was donating 500 hearing aids; SHHH had Dry-Aid kits and hearing aid batteries with new donations coming in daily. I contacted some of our exhibitors to see if they could donate additional materials and received a positive response from Mid-States Laboratories and Westone for impression materials and earmolds. Next, we needed audiologists to complete the equation. The Academy contacted Phil Allred, President of the Texas Academy of Audiology. The TAA agreed to coordinate a relief effort starting in Houston at the Astrodome. Local SHHH members assisted by not only cutting through some of the bureaucratic red tape, but by going through the crowd at Houston’s Astrodome and identifying those in need of hearing aid repair and replacement. Within 4 days of receiving those emails from Terry and Dave, the Academy received a generous offer from Barbara Cone-Wesson to accept PhD students displaced by Katrina at the University of Arizona. We decided to contact other universities to see if they could also accommodate displaced students. Within a matter of hours, we had 12 similar offers. We then sent a notice out to over 700 student members asking them to help us get the word out to fellow students who were displaced.

The day after I received those emails from Terry and Dave, the Academy received a generous offer from Barbara Cone-Wesson to accept PhD students displaced by Katrina at the University of Arizona. We decided to contact other universities to see if they could also accommodate displaced students. Within a matter of hours, we had 12 similar offers. We then sent a notice out to over 700 student members asking them to help us get the word out to fellow students who were displaced.

In addition to these efforts, Starkey Laboratories has also gone into the Astrodome and set up operations to test and fit hearing aids for those displaced by Katrina. My sister, who is an otolaryngologist in Houston, placed one of our members to work in her practice after Katrina forced our audiologist member out of New Orleans. And I am sure there are many other acts of kindness and generosity by the audiology community of which I am not aware.

One of the reasons I have always enjoyed my role as Executive Director of the American Academy of Audiology is because the members are so caring. This catastrophe has only confirmed what I already knew about your kindness, generosity and compassion. Thank you all for your kindness to those displaced by Katrina and for your generosity in supporting the Academy’s efforts to help in whatever small way we possibly can. (At this writing, 12 evacuees in need of assistance with their hearing aids have been connected with audiologists who have volunteered their time.)

In addition to providing assistance to those evacuated to Houston’s Astrodome, we have asked our members from around the country to help those who have relocated into their city as a result of Katrina. SHHH is working to get the word out to consumers that evacuees can contact the Academy to be paired with an audiologist in their new city. Your response has been heartwarming. Once a connection has been made between the relocated consumer and the Academy member, the Academy is working with them to secure the donated materials from Phonak, Westone or Mid-States Laboratories.

AudBlog

“I’m hopeful that one year audiology will be showcased at the fair and a seven foot tall butter ear will appear in that refrigerated showcase.”

Welcome to the Blogosphere. Be sure to read AudBlog — President Gail Whitelaw’s weekly musings on the state of audiology and the Academy.

www.audiology.org/blog
have been an audiologist or an audiologist in training for a quarter of a century. I studied audiology as an undergraduate student, graduate student, PhD student, and PhD candidate. I taught audiology as a teaching fellow, assistant professor and associate professor. I practiced audiology as a clinical fellow and university supervisor, and I am currently a full-time clinician. I love my profession. I can’t imagine doing anything else for a living.

Over the years I have been intrigued by the words and habits of audiologists, and I have noticed subtle changes in the seemingly small and insignificant things we say and do in our routine professional lives. However, I believe these words and habits are neither small nor insignificant. I believe they reflect our collective self-perception. In this paper I share some of my observations, beginning with the words and habits I have thought stifling, but ending with evidence of our maturation.

The topic of this paper first occurred to me, believe it or not, during my undergraduate studies in the early 1980s. I read a textbook passage that troubled me. I cannot recall the text or author(s), but the passage, as best I can now recall it, read in part: “As audiologists, we should not go flapping about in white coats.” I wondered; why couldn’t we wear white coats? And if we did, why would we be “flapping about” in our white coats while physicians, dentists and optometrists were doing their white coats? I do not know the beliefs or intent of that now forgotten author(s), and I can’t even be sure of how accurate my memory of that passage is. I only know that those words had an impact on at least one impressionable young student.

Later in that decade, I became acquainted with a professor who wore a white coat in the clinic, to the snickers of the students. I detected a similar resistance to medical garb in later years when wearing scrubs or having my own students wear scrubs. I also recall, in the 1990s, when a retired audiologist saw me wearing latex gloves and scoffed, “so audiologists wear gloves now.” But why wouldn’t I wear gloves when removing cerumen? Why must I touch cerumen-coated hearing aids with my bare hands? Why did medical garb look foreign on an audiologist?

Perhaps some of us worried about appearing pretentious. We were, after all, not doctors. Consider the tools we rejected, including stools and headlamps to use when examining ears, removing cerumen, or taking ear impressions. These are medical paraphernalia that, when used them, seemed out of place. But those of us who have tried them know their utility. On a stool, one can position oneself to view ear canals’ typical upward course. And with a headlamp, one’s hands are free to work. Yet many audiologists stood hunched over in an uncomfortable arc while they worked in patients’ ears in the dark.

We seemed not to want a lot of tools around, as if our jobs must be too simple for all that. Some of us had one syringe and one type of impression material to use on ears of all sizes, shapes and textures. And when we finished with the syringe, it could often be found on the counter with the hardened impression material in it when the next client arrived. In contrast, physicians and dentists have trays of various and cleaned tools at the ready. And when finished, the tools are placed in a container to be cleaned. I believe our habits were, in part, attributable to our training in universities rather than medical clinics, and to our lack of audiologic equivalents of nurses and dental assistants to do the preparation and clean up. Nevertheless, I noticed the habits.

Similarly, we often preferred not to add to our test repertoire; rather, we replaced old with new. With the advent of real-ear measures, sound-field testing immediately became archaic and was largely abandoned. A similar fate was reserved for Bekesy audiometry, synthetic sentence index, pitch pattern sequence, and many other tests some of my fellow old-timers may recall and occasionally use. I wonder if the tendency to throw out, and even ridicule, those old tests reflected doubt in the value of what we had been doing. Or perhaps we longed for the perfect test to make clinical skill and interpretation unnecessary.

But sometimes, our words can be the most self-limiting. We tested hearing, seemingly a technician’s job, while physicians conducted physical exams, dentists conducted oral exams, and optometrists conducted eye exams. We had clinical impressions and we rehabilitated, while doctors diagnosed and treated. We ordered hearing aids from a manufacturer or company, while dentists and optometrists ordered their prosthetics from a lab. We worked and held a job, while physicians, dentists and optometrists were in practice in a profession. Our words were not those of doctors.

But I have observed changes in our words and habits. We have declared that we are a doctoring profession. We have an Audiology Oath (Steiger, Saccone, and Freeman, 2002), and that oath has been recited at graduation ceremonies and at white-coat ceremonies for our doctoral students. Many of us wear white coats or scrubs, we see patients, and we use whatever tools will help us help our patients. Our clinical practices are varied and complex. We are even starting to diagnose and treat hearing loss, tinnitus and balance disorders. We are imposing fewer self-limitations through our words and habits. We are maturing.

Do you agree that words and habits matter as I have suggested? If you do, then take care. There may be an impressionable student reading thoughtfully what you write, watching carefully what you do, or listening intently to what you say. Consider letting them hear the words I wrote in the first paragraph of this paper: I love my profession.

REFERENCES

The opinions expressed in this Viewpoint are those of the author and in no way should be construed as representative of the Editor, officers or staff of the American Academy of Audiology.

Signs of a Maturing Profession

JAMES STEIGER, Ph.D. West Palm Beach VA Medical Center, FL
Auditory Processing Disorder (APD, sometimes called Central Auditory Processing Disorder, or CAPD) is generally defined as difficulty with listening that cannot be explained by peripheral auditory testing. (CAPD) has recently been examined by both ASHA and the British Society of Audiology. ASHA defines (CAPD) as “difficulties in the processing of auditory information in the central nervous system (CNS) as demonstrated by poor performance in one or more of the following skills: sound localization and lateralization; auditory discrimination; auditory pattern recognition; temporal aspects of audition, including temporal integration, temporal discrimination (e.g., temporal gap detection), temporal ordering, and temporal masking; auditory performance in competing acoustic signals (including dichotic listening); and auditory performance with degraded acoustic signals.” (ASHA, 2005)

APD is clearly a disorder that is difficult to diagnose and treat. Many scientists, educators and audiologists are studying methods of improving the communication of children and adults with APD. It appears that APD can be either acquired (as may be the case in some children with histories of chronic otitis media) or inherited, as some language disorders appear to be. Interestingly, the auditory processing problems of language impaired children may not be inherited (Bishop, 2002), pointing to the complexity of this interaction. How can we determine the causes of inherited APD?

Scientists are working to develop mouse models of APD (Moore, 2005). How can something as complex as auditory processing be examined in a mouse? Several tests of auditory processing are under consideration for use in mice. For example, a classic test of hearing in mice is the acoustic startle reflex. The startle response in animals and humans is a reflexive twitch of facial and body muscles in response to a sudden, intense stimulus. This stimulus might be tactile, visual or acoustic (Koch, 1999). This response in mice is easily quantified by placing the mouse on a platform that will move and measuring the latency and amplitude of the motion in response to the stimulus. While the startle response is not a test of central auditory processing, it can become one when it is used to measure pre-pulse inhibition (PPI). PPI is the decrease in the magnitude of the startle response when the stimulus is preceded by another, less intense, sound. If the mouse hears (and processes) the pre-pulse sound, then the measured startle response after the second (louder) stimulus will be decreased relative to the classic startle response. PPI has the advantage over other tests that it can be conducted rapidly, without training, enabling screening of large numbers of mice.

A variant of the PPI paradigm that has already been used to measure auditory processing is gap detection. Gap detection is a classic test of central auditory processing (CAP) in humans. The test involves detection of a gap (silence) in a sustained noise. Children with APD frequently exhibit difficulty in the temporal processing required to detect small gaps in noise (reviewed by Phillips, 1999). In mice, a gap in noise can be used as a “pre-pulse.” That is, if a gap in continuous noise precedes a startle stimulus, the startle response will be decreased in a similar fashion as above for the pre-pulse sound (Ison et al., 1998). Since gap detection is a measure that is affected by central auditory processing, it can be used as a measure of CAP in mice. The ability to examine central auditory processing in an animal model will allow scientists to better understand the central processing of auditory signals, and it will allow for studies of genes that alter central auditory processing in mice and humans.

References:
I am always stunned that, regardless of what part of the world I am in, I am likely to see a hearing aid wearer stick his/her hearing aid in their mouth - apparently to lubricate the hearing aid shell - and then insert the hearing aid in their ear. Ugh! The intent of this informational piece is to provide audiologists with an arsenal of information that can be relayed to all hearing aid wearing patients about why sticking hearing aids in the mouth is not a good idea.

Since 2002, several studies have documented the presence of bacterial and fungal growth on hearing aid and earmold surfaces. While some of the recovered microorganisms were consistent with what would be expected to be found in the external auditory canal (i.e. Staphylococcus, diphtheroids, occasional fungal spores), the majority of the recovered microorganisms were not. Furthermore, several of the microorganisms were considered extremely virulent (i.e. Staphylococcus aureus, Pseudomonas aeruginosa) while others were considered exceptionally unhygienic; several hearing aids were contaminated with light to heavy amounts of bacteria (Enterococci) specifically found in feces and fecal matter. In other words, there are things growing on hearing aid surfaces that do not belong in the mouth, let alone the ear.

The mouth, as is the case of the ear, is an orifice of the body. Natural body orifices provide an easy portal for microorganisms to enter the body. When a hearing aid is inserted in the mouth (or in the ear), microorganisms residing on those surfaces gain access to a dark, warm, moist environment that is more conducive to microbial proliferation. In the event the patient exhibits any degree of immunocompromise either due to underlying disease (i.e. diabetes), age (pediatric or geriatric patient), or medical history (chemotherapy, pharmacological intervention), given the right conditions, even seemingly innocuous microorganisms can become very aggressive, causing localized or systemic infection and disease.

**ROLE OF THE AUDIOLOGIST**

As audiologists, it is our legal, ethical and clinical responsibility to consciously establish a health care environment designed to eliminate or reduce the potential for cross-contamination through the implementation of federally mandated infection control protocols. The Occupational Safety and Health Administration (OSHA) requires workplaces to develop written, profession-specific infection control plans and protocols addressing employer categorization, HBV vaccination procedures, infection control training plan and records, engineering and work practice controls, emergency procedures, and post-exposure evaluation with follow-up plans. Resources addressing audiology-specific infection control requirements and protocols are available and address these issues in more detail. As hearing health care providers, audiologists should also transfer infection control knowledge to their patients by doing the following:

**LEAD BY EXAMPLE: IMPLEMENT FEDERALLY-MANDATED INFECTION CONTROL PLANS AND PROTOCOLS**

Audiologists must implement federally-mandated infection control plans and protocols...
mandated infection control plans and practice associated protocols. There are many reasons why audiologists should implement an infection control plan which specifically addresses the audiology clinical environment. The most definitive justification stems from the fact that infection control represents a federally mandated requirement overseen and enforced by OSHA. Failure of compliance results in citations and significant fines. Beyond the legal obligations, the nature of audiology is inherently associated with a high degree of disease exposure. The services provided by an audiologist and the corresponding infection control principles that he or she chooses to either apply or ignore can influence not only their own health, but the overall health and well-being of their patients and co-workers. By putting infection control in the forefront, audiologists will be demonstrating best practices to their patients.

**TEACH YOUR PATIENTS WELL**

Educate patients on hearing aid hygiene by taking the necessary 2 to 3 minutes to tell your patients about the importance of cleaning and disinfecting their aids and show them the proper techniques for doing so. Free educational tools are available to audiologists to facilitate this process, including an 8.5” x 11” laminated counseling card and prescription pads. Both items have been designed specifically for educational purposes and do not promote specific products. The laminated counseling card is a two-sided educational tool. The front of the laminated card illustrates the three main steps involved in proper hearing aid hygiene. The back of the card provides a detailed explanation on the importance of hearing aid hygiene and may be used either as a script for the audiologist to use to relay important infection control information, or it may be given to the patient to take home with them as a reference and a reminder to clean and disinfect their hearing aids every evening.

**BECOME A GREATER RESOURCE TO YOUR PATIENTS**

Provide patients with access to appropriate products. For those patients who are in the habit of lubricating their hearing aids by placing the devices in their mouth, teach them why this technique is inappropriate and provide them with alternative methods of lubrication by making appropriate products available for resale at your office. In addition, provide patients with access to appropriate hearing aid disinfectants for use at home. For example, alcohol should not be routinely used to clean and disinfect hearing aids. Alcohol, although technically a disinfectant, chemically denatures, or breaks down, acrylic, plastic, rubber and silicone. Since hearing aid shells and earmolds are comprised of these materials, the use of alcohol will degrade surfaces, creating a greater need for instrument repair and maintenance. Furthermore, alcohol does not possess a broad spectrum of bacterial or fungal kill. Given the extent of reported microbial growth on hearing aid surfaces, patients should be made aware of the availability of disinfectants specifically designed for hearing aid surfaces. These disinfectants should be made readily available for resale within audiology clinical practices. This small convenience serves as a tremendous opportunity to let your patients know that you, as their audiologist, are a resource for all their hearing health care needs.

**REFERENCES:**

You can feel the excitement as the curtain rises, your senses heighten as the stage and the cast members come into view. Your heart beats in anticipation of the engaging event that you are about to experience. Capture that feeling and more when you attend AudiologyNOW! 2006. There you will be more than an enraptured audience member, rather you will experience AudiologyNOW! as a cast member with the play written around your experiences! Use our new, advanced Itinerary Builder to help you learn your lines and create your experiences at AudiologyNOW!

**ACT I**

Wednesday, April 5, explores the Learning Labs, which feature hands-on experiences. Samantha Lewis and her Learning Lab subcommittee have assembled diverse course options from VEMP to Marketing. Choose from three full-day or four half-day Learning Labs. Later in that act you can participate in the hot topics in Audiology with the 2-hour Focus Groups.

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**FULL DAY Learning Labs**

**Audiologic Tinnitus Management: What To Do & How To Do It**

This course will provide step-by-step guidelines for the management of tinnitus by audiologists. A “progressive intervention” approach is described, which addresses five hierarchical levels of clinical need: (1) rapid interview-screening to assess the need for intervention; (2) group educational counseling; (3) tinnitus intake assessment; (4) ongoing treatment (1-2 years); and (5) extended treatment (2+ years). Techniques for selecting ear-level and sound-enhancing devices will be described, as well as a specific counseling protocol.

*James A. Henry, PhD, Tara L. Zaugg, MA, Martin A. Schechter, PhD*

**Clinical Application of Auditory Evoked Response in Children**

There is unprecedented demand for diagnosis of hearing loss in infants and young children. This practical presentation reviews current strategies for confirmation and description of auditory dysfunction in children using electrophysiological measures. The focus will be primarily on ABR/ASSR techniques but will also provide attendees with guidance on the complete infant test battery. Main points will be supplemented with case reports, and equipment will be available from a variety of manufacturers for hands-on learning.

*James W. Hall, PhD, Roger A. Ruth, PhD, Barbara K. Cone-Wesson, PhD, and Todd B. Sauter, MA*

**Cracking the Reimbursement & Practice Management Code**

Reimbursement and practice management issues affect everyone, regardless of practice setting. In this session, we will examine audiologic reimbursement issues including Stark, Safe Harbor & Anti-Kickback regulations, the rationale behind obtaining a Provider Identification Number (PIN), the National Provider Identifier (NPI), the cessation of “incident-to” billing, the use of proper procedural and diagnostic coding, modifiers, Advance Beneficiary Notices and documentation. This in-depth review will enable participants to make valuable choices for their practices.

*Kadyn O. Williams, AuD, Paul M. Pessis, AuD, Alan Freint, MD*

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**HALF DAY Learning Labs**

**Cerumen Management**

Audiologists provide a variety of services necessitating patients’ ears to be relatively free of cerumen as significant amounts interfere with diagnostic and rehabilitative procedures. As such, cerumen removal has become an important practice management issue. This workshop will address core issues related to cerumen management including a review of ear canal anatomy and physiology, the pathophysiology of cerumen, instrumentation, equipment considerations, infection control considerations, and cerumen removal techniques. Video demonstrations will be presented and discussed.

*A.U. Bankaitis, PhD*

**Marketing for Audiologists in all Practice Settings**

This session will present ideas of how to make your patients “patient’s for life.” Interactive exercises will teach participants how to create a personal marketing strategy and customer service policy. Participants will learn how to utilize Negen’s proven marketing concepts to draft their own marketing plan. Learn how to motivate patients to come to YOU and discuss ways to position yourself and your organization as the BEST providers of quality hearing health care.

*Bob Negen*

**Utilization of Middle & Late Auditory Evoked Potentials**

There is a growing interest in middle and late auditory evoked potentials. These evoked responses appear to be underutilized by the audiology community. This presentation is one that will focus on the basis of middle and late potentials and their clinical application. Discussed and demonstrated will be generators, recording parameters and interpretation of the middle (MLR) and late N1, P2 potentials with ongoing emphasis on clinical utility.

*Frank E. Musiek, PhD, Gary P. Jacobson, PhD*

**Vestibular Evoked Myogenic Potentials (VEMP)**

The vestibular evoked myogenic potential (VEMP) is a simple, non-invasive test that may supplement the current vestibular test battery by providing diagnostic information about saccular and/or inferior vestibular nerve function. Topics will include the acoustic sensitivity of the vestibular apparatus, VEMP recording methods, effects of stimulus parameters and clinical applications for the VEMP. Case studies will be presented to demonstrate clinical utility and hands-on experience will be provided using several different recording techniques.

*Faith Wurm Akin, PhD, Owen D. Murnane, PhD*
Minneapolis is known for many things: more theater seats per capita than any city outside of New York, fine dining, jazz clubs, friendly people and beautiful scenery but the main reason for choosing Minneapolis for the site of AudiologyNOW! 2006 is the number of Hearing Aid manufacturers located in the area. As part of your AudiologyNOW! registration you have the opportunity to tour two randomly selected hearing aid manufacturing facilities the afternoon of Wednesday, April 5th. The tours also include virtual tours of hearing aid manufacturing facilities from around the country and a complimentary box lunch.

Finish the act by attending Celebrate Audiology where you will enjoy an enchanting evening of strolling performers, sophisticated acrobatics and pure entertainment in the classical sense. Munch on your favorite concession stand treats while mingling with friends, both old and know. The stage is set for an evening of fun. We hope you enjoy the show!

**ACT II**

On Thursday, April 6th, the curtain rises on the 90-minute NOW!Sessions that feature the state-of-the-art in audiology presented by top audiologists, hearing scientists and physicians. This year, Bob Margolis and the Featured Sessions subcommittee have lined up an impressive cast of invited guest speakers to educate attendees on the many complex issues and changes facing the profession.

Attendees will then gather at the General Assembly to hear Academy leaders and keynote speakers, led by President Gail Whitelaw with her state-of-the-profession address, kick-off the official welcome to AudiologyNOW!.

The next scene leads us to an “opening night,” so to speak, for Audiology Solutions (Formerly known as the Expo). The new name better describes the service this part of AudiologyNOW! provides. Here you will find over 200 exhibitors with solutions to the professional challenges.

**Revised program books: PreviewNOW! and ProgramNOW!**

PreviewNOW! offers you an overview of the events, registration and housing information. ProgramNOW! will be a complete compendium of all session abstracts with presenter information, room numbers and all the information you will need to have a successful time at AudiologyNOW!.

You should receive your PreviewNOW! in December. If not please send in your name and address to previewnow@audiology.org.

**Audiology Solutions**

Over 200 manufacturer and professional exhibitors’ representatives will be on hand to help you find solutions for your patients and your professional growth.

**Office Personnel**

Register your office personnel to attend AudiologyNOW! at a reduced fee. Choose from a series of courses in the Professional Issues and Practice Management Core such as the NOW!Session “Medicare 101+: A Blend of the Old and New Information.” Included in the Office Personnel package price is a ticket to attend the Learning Lab “Cracking the Reimbursement and Practice Management Code,” access to all educational sessions, Audiology Solutions and box lunches. CEUs are not available to Office Personnel registrants.

Register on-line at audiologyNOW.org. Save money by registering before January 21st, 2006!
facing audiology professionals and their patients.

CEUs are available that afternoon at Exhibitor Courses and Introductory Learning Modules (formerly Instructional Courses). These courses are selected from our call for innovative proposals to provide engaging and interactive learning sessions.

ACT III

The lights will come up on Friday featuring the WOW!Session, *Legends of Auditory Science* with William Brownell, Peter Dallos, Robert Galambos and Jozef Zwislocki discussing their groundbreaking work and the impact of hearing science on audiology.

There’s a two-hour intermission at noon to ready yourself for the upcoming scenes. Take a break and stretch your legs while visiting Audiology Solutions where you can enjoy your complimentary boxed lunch.

When the clock strikes 2:00pm it’s your cue to return for the afternoon sessions. Introductory (1-hour) and Advanced (2-hour) Learning Modules will bring you up to date on the latest concepts in one of 6 learning cores: Diagnostics, Disorders, Hearing and Balance Sciences, Hearing Conservation, Professional Issues and Practice Management, and Treatment. Later, join the festivities at the Foundation Research Awards and Poster Presentations to discuss research with the Poster presenters and also recognize the 2006 Research awardees.

ACT IV

Before AudiologyNOW! ends its run, take advantage of the Saturday finale starting with one of the morning’s opening sessions such as the three-hour Symposium on *Electrophysiologic Evaluation of Infants* or perhaps the 90-minute Symposium on *Gene Therapy*. The NOW!Session *Real-World Hearing Aid Fitting: Managing Patients Expectations*, which will include an audience response system, is just one of nine different NOW!Sessions that you can choose from that morning.

After your lunch break, you will have one last opportunity to enjoy Audiology Solutions before it is time to strike the set. Select from one of the Advanced Learning Modules that afternoon to round out your educational experience at AudiologyNOW!. Next, it’s on to everyone’s favorite way to bring down the house — Trivia Bowl; may the best team win!

Cast members will come away from AudiologyNOW! with rave reviews. We’ll have your souvenir “wardrobe” t-shirt for the first annual AudiologyNOW! waiting for you at registration.

Enjoy AudiologyNOW!, enjoy Minneapolis, and enjoy the variety of musical venues and Tony Award-winning productions the city is known for. Now, “lets all go to the lobby...”
**Schedule of Events**

**Wednesday, April 5**
- 8:00am – 7:00pm – Registration
- 8:30am – 5:30pm – Learning Labs
- 9:00am – 3:00pm – State Leaders Workshop
- 11:00am – 5:00pm – Reg Express at Minneapolis Hilton & Hyatt Regency
- 12:30pm – 5:00pm – Manufacturer Tours
- 3:00pm – 5:00pm – Focus Groups
- 5:15pm – 6:00pm – Student Volunteer Orientation
- 5:30pm – 7:00pm – AAA Foundation “Happy Hour and a Half”
- 7:00pm – 9:00pm – Celebrate Audiology

**Thursday, April 6**
- 7:00am – 5:00pm – Registration
- 8:00am – 10:30am – NOW! Sessions
- 10:00am – 11:30am – General Assembly
- 12:00pm – 6:00pm – Audiology Solutions 2006
- 3:00pm – 4:00pm – Exhibitor Courses
- 4:30pm – 5:30pm – Learning Modules, Research Pods, Exhibitor Courses
- 6:00pm – 7:30pm – Academy Awards Reception
- 7:30pm – 8:30pm – International Reception

**Friday, April 7**
- 7:00am – 5:00pm – Registration
- 7:00am – 7:50am – Academy Business Meeting Breakfast
- 8:00am – 11:30am – WOW! Session, NOW! Sessions and Symposia
- 9:30am – 5:00pm – Audiology Solutions 2006
- 12:00am – 1:30pm – Student Research Forum & Luncheon
- 2:00pm – 4:00pm – Learning Modules
- 4:30pm – 5:30pm – Learning Modules, Research Pods, Exhibitor Courses
- 5:00pm – 6:30pm – Foundation Research Reception & Poster Presentations

**Saturday, April 8**
- 7:00am – 5:00pm – Registration Open
- 8:00pm – 11:30am – WOW! Sessions and Symposia
- 9:30am – 2:00pm – Audiology Solutions 2006
- 12:00pm – 1:00pm – Discussion Groups
- 2:00pm – 4:00pm – Learning Modules
- 4:30pm – 6:30pm – Trivia Bowl
- 6:30pm – 8:30pm – Open Houses

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**Members in November**

As a benefit of membership, Academy members are able to register in November to get their first choice of housing! Take advantage of the reasonable rates and rooms we have secured by registering early. General registration and housing open for all attendees on December 1, 2005.

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**Save Time & Money: Why “Booking in the Block” Is So Important**

- The economic impact of AudiologyNOW!, which is largely based on room nights, allows us to negotiate reduced rental rates for the Convention Center – which in turn saves attendees money by keeping registration rates lower.
- Every room night we lose to a hotel outside our hotel block dilutes our future buying power and the ability to negotiate the best dates and rates.
- The fast and convenient shuttle services only the official convention hotels; you could incur additional expenses, such as cab fare, and lose valuable time.
- We contract, inspect and have strong relationships with our selected hotels.
- Your deposits are secure, your rooms are guaranteed, your safety and security kept in mind, and most importantly we can assist you if something goes wrong.

**Book Inside the Block!**

If you have comments or would like additional information please contact Lisa Yonkers at 703-226-1038, lyonkers@audiology.org

For session abstracts, schedule of events, registration and housing information and more go to audiologyNOW.org
Minneapolis is looking forward to seeing you at AudiologyNOW! 2006. In preparation for your trip to our City of Lakes, there are a few things you should know. First, we do not always speak of Minneapolis/St. Paul by their given names. Instead, we may say the “Twin Cities,” or “the Cities,” for short.

While it is wise to be prepared for either a cold spell or a heat wave in the Twin Cities in early April, for the most part you won’t be lugging coats to sessions at AudiologyNOW! 2006. The skyway system is practically a city within a city, completely climate controlled. If your hotel is too far away to walk to the Convention Center, shuttle buses will be running as they have at past conventions.

We do speak English up here in the Cities, but you might want to brush up on the local dialect. How to Talk Minnesotan by Howard Mohr is a good reference. A few examples:

“Uff Da” Pronounced oof duh, this term defies precise definition as it denotes anything from disappointment, sudden pain, surprised reactions to unexpected conditions. It is also a philosophy that one doesn’t have to swear or fly off the handle – just uttering the expression helps you let off some steam and then you can surmount the problem at hand.

“Not too bad/Could be worse/Can’t complain” Not ones to toot their own horns, Minnesotans might use any of these phrases to answer the question “How are you?” even after they just won the Pulitzer.

“You bet” Another multipurpose term, “You bet” works well in lieu of thank you, but is also great to use as a response when you really don’t know what else to say. It is meant to be pleasant and agreeable, without actually committing yourself to a strong opinion. Further north you’re likely to hear the “Yah, sure, you betcha” of Fargo fame, but in the Cities, a simple “You bet” will suffice.

Stroll along Nicollet Mall This mall is a pedestrian-only thoroughfare, with plenty of our favorite watering holes, sidewalk dining, and countless shops. You can even take a photo with Mary Tyler Moore – her statue adorns the corner just across the street from where the hat-tossing scene at the end of the Mary Tyler Moore Show credits was filmed.

Visit Spoonbridge and Cherry You knew you’d seen photos of it before, now you know its name. A Minneapolis icon since its completion in 1988, Spoonbridge and Cherry is one of the features of the Minneapolis Sculpture Garden at the Walker Art Center. The sculpture garden is one of the largest of its kind and includes more than 40 works of art.

Travel by skyway The skyway system is one of the features that make Minneapolis unique. The seven miles of enclosed walkways link together over 60 blocks of downtown hotels, restaurants, theaters, and merchants, connecting most of the downtown in climate-controlled bliss.

Experience the rich river history Along the Mississippi, you can tour St. Anthony Falls Lock and Dam and walk across the pedestrian Stone Arch Bridge. The upper St. Anthony Falls Lock offers nearly a 50 foot lift to vessels “locking through.” Originally built for rail use in 1883, the 2,100 foot long Stone Arch Bridge is a riverfront icon.

If you find yourself with some free time or you plan to make time to sightsee, you won’t be disappointed. Here are some things you should add to your To Do list:

...the Sights & Sounds

JOCelyn Martin, AuD, Convention program Committee, subhead for Community Support

A Standing Ovation for Minneapolis
Walk the lakes Lake Calhoun, Lake Harriet, and Lake of the Isles together are known as the Chain of Lakes and offer a great way to get away from it all while still in the city. Enjoy more than three miles of trails for walking, jogging, biking and in-line skating—all with the Minneapolis skyline as your urban backdrop.

Tour Mill Ruins Park Located on the banks of the Mississippi River, this area of mills, canals and other historic resources made up the largest water-powered facility in the world and was the birthplace of General Mills and Pillsbury. Today, you can visit the recent excavation of this historical site to get a glimpse into an era when Minneapolis was number one in flour milling.

Shop at Mall of America Or if shopping isn’t your thing, eat, drink, see a movie, visit an aquarium or ride a rollercoaster. You can do it all under one roof at the largest mall in the country.

Live it up in the Warehouse District The Warehouse District is a 30 block area that was added to the National Register of Historic Places in 1989. Historically a center of retail and commerce, it is now home to innovative arts, sidewalk cafes and a vibrant nightlife.

Learn some of the history of greater Minnesota If you’d like to spend a few days touring, there are many wonderful places to visit. You can spend a few hours at the Minnesota Historic Society, or you can venture out and experience it yourself. From Split Rock Lighthouse on the North Shore of Lake Superior to the headwaters of the Mississippi at Lake Itasca to the Historic Bluff Country that is Southeast Minnesota, the outlying areas of the state have a great deal to offer. Most of these sites are within a two hour drive from the Twin Cities.

These features and more make Minneapolis, Minnesota a great venue for the first incarnation of AudiologyNOW!. Minnesotans are thrilled to welcome you to our neck of the woods. Looking forward to seeing you in April! Until then, here is some random local trivia that shouldn’t steal any of Gus Mueller’s Trivia Bowl thunder:

- Known as the City of Lakes, Minneapolis is home to 22 lakes within city limits
- These products were all invented in Minnesota: Post-it notes, sandpaper, VCRs, synthetic rubber, Thinsulate, Masking Tape, Scotch Tape, Cream of Wheat, Wheaties, Cheerios, the pacemaker and Rollerblades
- Minneapolis was named Cleanest City in the Country by Travel+Leisure
- Minnesota led the nation in voter turnout in 2004
- Minnesota has more shoreline than California, Florida and Hawaii combined

Our new light rail’s Hiawatha line connects the entertainment packed Warehouse District in downtown Minneapolis with the Mall of America. The Mall has more than 520 stores, an entire level of restaurants and bars, and an amusement park. The best part? No sales tax on clothing in Minnesota.

April 5-8, 2006
THE YEAR IN EARS

15-MONTH DESK CALENDAR

You’ll find interesting ears for every month of the year in the Academy’s provocative new “The Year in Ears” 15-month desk calendar. The full-color Year in Ears calendar was cleverly designed to fit into a plastic CD jewel case so it can sit smartly on your desk. Innovative ear ideas are showcased each and every month taking you from January 2006 through March 2007. Perfect for the audiologist or ear enthusiast on your holiday shopping list! $15 for members; $20 for non-members. Shipping is extra.

Order today at www.audiology.org/store or call 1-800-222-2336, ext. 1039.

IT’S EAR-ESISTIBLE!
Insert Earphones for Occupational Hearing Conservation Testing

Since their introduction in the late 1980’s, the multiple advantages of insert earphones in clinical testing have been well documented (Clemis et al, 1986; Killion et al, 1985; Mueller, 1993). Both hearing health care providers and audiometric equipment manufacturers have steadily increased their use and acceptance of these devices during the intervening years. However, the application of insert earphones for audiometric testing in occupational hearing conservation programs (HCPs) has unfortunately been limited by the regulatory restrictions imposed by the Occupational Health and Safety Administration (OSHA), and by certain practical considerations. This article will review the basis and implications of the regulatory issues, and argue that some of the restrictions imposed by OSHA on the use of insert earphones in HCPs are not appropriate. The practical issues will also be addressed, showing that the small cost and time constraints of using insert earphones in HCP testing, as well as in the clinic, are outweighed by the advantages provided by this technology.

From the regulatory perspective, the problems for those who wish to use insert earphones in HCP testing are primarily the result of explicit reference to an outdated consensus standard by the current OSHA Occupational Noise Exposure; Hearing Conservation Amendment; Final Rule of March, 1983. To the exclusion of all else, the amendment mandates compliance with ANSI S.3.6-1969, Specifications for Audiometers, with regard to audiometric testing. While the ANSI Specification for Audiometers has evolved to include new information and technological advances (ANSI S.3.6-1989, 1996, and currently 2004), the 1983 OSHA amendment itself remains inexorably linked to a consensus standard that predates the introduction of commercially available insert earphones. Any audiometric technology, regardless of its potential contribution, not consistent with the requirements sections of the 1969 ANSI Standard, is also subject to comparable restriction.

Specifically, paragraph (h) (2) of 29 CFR 1910.95, Occupational Noise Exposure; Hearing Conservation Amendment; Final Rule states, “Audiometric tests shall be conducted with audiometers (including microprocessor audiometers) that meet the specifications of, and are maintained and used in accordance with, American National Standard Specification for Audiometers, S3.6-1969” The General Requirements section of that document, in paragraph 3.2, “Earphones” final sentence, states: “Each earphone shall be equipped with an earphone cushion for contact with the head of the subject.” Paragraph 3.3, “Headbands” states: “There shall be provided a spring headband which is adequate to hold the earphones against the ears to provide a satisfactory seal.”

Because an insert earphone has neither an “earphone cushion” nor a “spring headband,” it cannot meet the above requirements. The 1989 revision of ANSI S3.6 included Reference equivalent threshold sound pressure levels (RETSPLs) for insert earphones, without any references to cushions or a headband, in its Appendix G. Each subsequent ANSI S3.6 revision included a section within the body of the standard devoted exclusively to the use and calibration of insert phones. All of that recognition and guidance has no effect, however, with regard to OSHA’s Final Rule because it is, from an audiometric standpoint, frozen in time in 1969. While OSHA has recently considered updating regulations in general to resolve problems related to outdated consensus standards, no action has been taken.

OSHA citations inform the employer and employees of the regulations and standards alleged to have been violated and the proposed length of time set for their abatement. Penalties may be imposed in accordance with the seriousness of the alleged violation, employer willfulness, and failure to abate. The least serious category is a “De Minimis” Violation. Under an OSHA policy for de minimis violations, employers are allowed to comply with the most current consensus standard applicable to their operations, rather than with the standard in effect at the time of inspection, when the employer’s action provides equal or greater employee protection. De minimis violations are contraventions of standards which have no direct or immediate relationship to safety or health. Whenever de minimis conditions are found during an inspection, they are documented in the same way as any other violation, but are not included on the citation. De minimis violations do not have to be abated.

On August 31, 1993, Mr. Roger A. Clark, then Director, Directorate of Compliance Programs for OSHA, responded to a request from the manufacturer of insert earphones, regarding the limitations imposed on the use of insert earphones for HCP audiometric testing. The complete text of this letter of interpretation is available on the OSHA web site: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=21245. A background narrative and nine bulleted paragraphs outline specific conditions that must be implemented by employers who intend to use insert earphones for HCP audiometric testing in order to meet the criteria of a de minimis violation. If the nine conditions are met, only a de minimis violation exists. Failure to meet the requirements of each of the conditions, however, could result in the issuance of a citation.

Insert earphones can be substituted for supra-aural earphones for HCP testing.
without concern about any tangible penalty if one follows each of the points addressed in the 1993 compliance letter. The nine points, somewhat redundant in relation to the Final Rule itself, are not particularly burdensome, with one exception that reads as follows:

“\textit{At the time of conversion from supra-aural to insert earphones, testing must be performed with both types of earphones. The test subject must have a quiet period of at least 14 hours before testing. Hearing protectors may be used as a substitute for this requirement. The supra-aural earphone audiogram shall be compared to the baseline audiogram, or the revised baseline audiogram if appropriate, to check for a Standard Threshold Shift (STS). In accordance with 29 CFR 1910.95 (g) (7) (ii), if the audiogram shows an STS, re-testing with supra-aural earphones may be performed within 30 days and the resulting audiogram adopted instead of the prior one. If retesting with supra-aural earphones is performed, then re-testing with insert earphones must be performed in conjunction.}”

If, in compliance with the above, subsequent annual testing can be accomplished by relying solely on insert earphones, with the original insert-earphone test designated as the “new reference audiogram for all future hearing tests performed with insert earphones.” If no baseline testing with a supra-aural earphone exists, i.e., a new program is initiated, insert earphones could be employed without concern for the above section, as long the other conditions are met. The other conditions, for the most part, amount to precautions that any prudent examiner normally would follow, e.g., technician training, (foam) eartip fit, equipment calibration, ambient noise levels, and appropriate record keeping. It is hoped that OSHA will eventually eliminate the double testing requirement, but for now it remains a formidable, but not insurmountable, barrier to insert earphone use in HCPs.

It is odd that OSHA views threshold differences that could result from different types of earphones on a single audiometer as problematic, when little or no regard is attached to an arguably greater potential for variability with different audiometers, or between one valid audiometric method and another. As long as calibration is performed appropriately and checked as required, with all other conditions equal, hearing thresholds obtained in the HCP will be valid and reliable regardless of the transducer employed.

In spite of the existing constraints, there are several reasons why employers and HCP service providers might consider using insert earphones. All of the clinical testing advantages of coupling the earphone directly to the earcanal generalize to the threshold testing performed for baseline and monitoring hearing conservation audiometry. Since most routine HCP testing is performed by technically competent personnel, but generally not by audiologists, insert earphone use may actually provide certain fail-safe advantages where procedures that may be routine in clinical work are not initially available in the HCP.

The advantages of insert earphone use include:

- **Reduction of Background Noise**
  The ambient noise attenuation of a supra-aural earphone with an MX-41/AR cushion is weak in the low frequencies, with values in the 4-6 dB range below 1 kHz, where problems related to high ambient noise levels attenuation will typically exceed 30 dB in the 125-8,000 Hz region. The greatest difference in ambient attenuation between inserts and supra-aural earphones is in the frequency range below 1 kHz, where the effect is most needed. Although one must use the OSHA “Maximum Allowable Octave-Band Sound Pressure Levels For Audiometric Test Rooms” (Table D-1) that are less restrictive than the ANSI Standards now specify for ears-covered testing, the added margin of safety insert earphones provide can be a valuable advantage, particularly if the measured ambient levels are borderline relative to the guidelines, or if the sound environment is not stable. Table 1 illustrates the difference between the ears-covered ambient attenuation for supra-aural and insert earphones.

- **Greater Interaural Attenuation**
  In subjects with large threshold differences between the right and left ears there is a chance when testing the poorer ear that the pure-tone signal will

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**TABLE 1. MEAN EARPHONE ATTENUATION VALUES FOR SUPRA-URAL EARPHONES (SAE) AND INSERT EARPHONES (IE) FROM ANSI S3.1-1999 TABLE A.1**

<table>
<thead>
<tr>
<th>Frequency in Hertz</th>
<th>Earphone Type</th>
<th>SAE</th>
<th>IE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>125</td>
<td>250</td>
<td>500</td>
</tr>
<tr>
<td></td>
<td>Earphone</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SAE</td>
<td>6.0</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td>IE</td>
<td>29.9</td>
<td>31.4</td>
</tr>
</tbody>
</table>

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Audiometry Today
Elimination of Collapsed-Canal Artifact and Greater Subject Comfort

The lateral pressure that supra-aural earphones exert on the test subject’s external ear may result in a collapsed canal artifact. This closure of the external canal in some subjects may cause a false threshold shift that may not always be identified as such initially. Audiological follow-up testing would employ one of several methods (including the use of insert earphones) to resolve the problem and establish true air conduction thresholds. With an insert earphone’s foam tip properly seated in the external canal, canal collapse artifact is eliminated. Most test subjects also report greater comfort with a lightweight soft foam tip in their ear compared to the heavier feel and clamping sensation of a supra-aural earphone.

Infection Control and Maintenance

Insert earphones, used as directed, provide increased hygiene (Bankaitis, 2003). When discarded after a single use as recommended by the manufacturer, E-A-RLINK™ foam eartips prevent any cross contamination between subjects. The tips contain no latex and have undergone independent testing to confirm that the risk of contact sensitization is extremely low. Cleaning the tips for re-use can, however, create a sensitization risk from residual chemicals that fail to rinse from the surface of these non-porous tips.

Insert phones have no headband to adjust, or cushions to clean and periodically replace. Most subjects are more comfortable with a foam tip in their ear canals than they are with a supra-aural setup. The foam tips are not unlike the hearing protective devices that many noise-exposed workers wear for much longer periods of time than the monitoring audiogram requires.

Concluding Remarks

The practical constraints of using insert earphones involve a marginally increased cost per test, i.e., two foam eartips at about $0.35 each, and the need to examine the subject’s ear canals, select the appropriate size tip, and properly roll it down for insertion. In the clinical setting these time and material costs have a negligible impact, and insert phone use is widespread. For HCP programs, where testing is limited to the pure tone audiogram at six or seven frequencies, and multiple subject testing is common, the ‘so much for so little’ premise is less dramatic but still valid. Insert earphones can provide a significant contribution to our efforts in the prevention of occupational hearing loss. HCP managers who may be interested in them as an alternative to the supra-aural earphone can consider whether the advantages gained with their use outweigh the barriers involved for their own programs.

This article was adapted from an item that appeared in the July, 2005 issue of the National Hearing Conservation Association’s “Spectrum.”

References


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How many audiologists could pass a state licensing exam or national certification test if it were required every few years to stay in practice? It may well be that the length of time between finishing grad school and taking the licensing test would be indirectly related to the number of persons passing the exam. All professional fields move forward with respect to philosophies, protocols, methods, equipment and instruments, as well as even some of the fundamental concepts underlying all of the above. Somewhere in the not-so-distant past, licensing boards, certifying agencies, and professional organizations determined that, in order to assure the integrity of the profession, it would be in the best interest of all, especially the consumer, to require continuing professional education. The American Academy of Audiology is no different. Principle 2 of the Code of Ethics states that Academy members will maintain high professional standards. Rule 2g pertaining to this precept requires members to participate in continuing education.

Rule 2g: “Individuals shall maintain professional competence including participation in continuing education.”

In concept, continuing education (CE) is terrific. Requiring people to keep abreast of new developments in their area of expertise is good for everyone. The problems arise when specific details of the requirements are left undefined. The vagueness in more codified requirements was intentional so as not to limit professionals from evaluating their own limitations and acting to minimize their own shortcomings. In audiology, if one judged him-or-herself to be in need of, say, updating in the area of neonatal techniques, one would pursue that CE avenue to “balance” their professional growth.

The “balance” of professional knowledge, breadth and depth, was the center focus in establishing the CE requirement. Even though there are clinicians who specialize, the intent of CE was to help assure that all members of the profession maintained a minimal degree of clinical competence as the profession moved forward.

A large portion of the American Academy of Audiology membership is involved in the dispensing of hearing aids. As instrument technology advanced, the need for product-specific training arose. Instrument manufacturers, in an effort to promote use of their products, began offering CE credit for training specific to their hearing aid. A significant number of Academy members obtain the required CE every year with nothing more than product specific training. Many hearing instrument manufacturers report that, if CE is not offered as a part of their programming training, attendance at these sessions is difficult to assure.

The necessity of being able to manipulate hearing aid software is not the point under discussion, but rather, whether this training alone satisfies the intentions of continuing education. And, it is not the educational intentions of the clinician that must be met, but rather the intentions of the licensing, certifying, and/or professional organizations which have set the CE requirements in place, including the American Academy of Audiology and its Code of Ethics.

The opinions expressed in this Viewpoint are those of the author and in no way should be construed as representative of the Editor, officers or staff of the American Academy of Audiology.
Did you ever see that scene in the movie *10* when Bo Derek and Dudley Moore are on the beach running toward each other? He is leaping through the air in anticipation of finally connecting with his vision of the perfect match. This concept is the service that HearCareers hopes to provide to employers and job seekers who post their job openings or resumes on our website. It is our intention to help those looking to hire or be hired find that perfect 10 person or position.

At the American Academy of Audiology, we are always in search of ways to provide efficient services that help our members streamline the everyday tasks necessary to function successfully. One of our greatest Academy resources is our employment service called HearCareers, which provides a place for employers and job seekers to interact.

Employers who post their available positions on our website can do so knowing that they are getting the lowest rates available. For members of the Academy, these rates are offered at an even greater discount.

What we offer employers that many conventional job posting sites can’t (aside from the phenomenal pricing) is a targeted audience. Have you ever received an application and wondered if the candidate even read the job profile before they applied? That is not a problem when you search through the growing database of resumes the Academy has available. Those posting their resumes with HearCareers have gone to the largest organization of, by and for audiologists for a reason; they want a job in the field of audiology.

HearCareers also gives employers the ability to keep tabs on how many applicants have viewed their job posting. Again, unlike many other job posting options, you can be assured that those viewing your posting are looking for positions within the profession. Why else would they be going to the American Academy of Audiology to search for a job rather than one of those mass job-posting sites? Employers have the option to contacting job seekers directly through the site, or they can have job seekers contact them.

Job seekers also stand to benefit by using HearCareers for their employment searching needs. We provide tools to help them not only search for a job, but get a job. Look through the HearCareers page of the website in the section titled “Resume & Interviewing Tips & Techniques” for assistance in creating a resume that gets noticed. Find out what questions you may want to be prepared for when you go in for an interview. Job seekers also have the option of using the Notify Me! service provided through HearCareers. When a person signs up for Notify Me! they receive weekly emails alerting them that a job matching their search criteria has been posted. Let Notify Me! bring the jobs to you.

It is our job at the American Academy of Audiology to advance the profession. It is our hope that by helping to make the connection between audiologist and employer we are one step closer to achieving that goal.

Get the connection going today at www.audiology.org/hearcareers

You kiss your loved ones good-bye, take a look at the world outside, and inhale the last breath of fresh air you will be breathing for a long time to come. You are either about to clean out your basement storage or are on the verge of the arduous task of research, research, and more research. One would think that with all of the available resources out there, it would be an easy task to undertake, but sometimes all of that information can work against you. There is either too much information that isn’t relevant to your question, unreliable sources, or web links that lead to other links, which lead to other links…and the cycle goes on. So what the Academy proposes is that you go to one place for your information needs, the Dome.

The Dome is an information service specifically designed for audiologists, speech-language pathologists and students. No more weeding through material that has absolutely nothing to do with your field of study. With constantly updated listings of multiple sources, the Dome is designed with researchers, clinicians, students and educators in mind. Academy members can save 53% off the regular price ($119.95) of an annual Dome subscription. The special member price is $63.95. Academy student members save too! Student members subscribe for $35 (regular student price is $49.95), a 30% savings. For more information, check out the Academy’s benefits page at www.audiology.org/professional/members/benefits/ or contact the National office at (800) 222-2336, x1044.
As we approach the closing of a year as busy as 2005, there are so many things I could write about to fill this page; but I would be remiss if I didn’t begin by stating my appreciation to the many who work on behalf of ABA. This would not only include our seemingly tireless Director, Sara Lake, but the entire ABA Board with whom I have had the pleasure to work and grow professionally for several years now.

Each year two members of the ABA Board rotate off and are replaced by two new members eager to carry on the board’s important work. These new ABA Board members are elected by those who hold Board Certification following a typical nomination process. I would encourage all ABA Board Certified audiologists to consider what they can give back to their profession through work with the Board, either in service within one of a variety of committees or on the Board itself. Anyone interested in working with the ABA Board need only contact Sara Lake at aba@audiology.org for further information.

“So what has the ABA Board been up to?”

2005 was the roll-out year for our first, and highly successful, specialty certification. As of this date, we have had four administrations of the examination for Specialty Certification in Cochlear Implants. Both the quantity and quality of candidates exceeded the ABA’s high expectations. The entire ABA Board of governors is thankful for the hard work and leadership put forth by Patricia Chute and Cheryl DeConde Johnson along with their committee members in bringing this certification program to fruition.

2005 has been the planning year for a second, eagerly awaited, specialty certification program. A focus group which met at the American Academy of Audiology Convention this year and a survey of the audiology community revealed a strong desire for a Specialty Certification in Pediatric Audiology. An impressive 78% of responding audiologists believed pediatric audiology had progressed to the point that it should be considered a specialty area. Jim Beauchamp and a tight working group of nationally recognized pediatric audiologists have been charged with making this specialty certification a reality.

2005 was also the year that brought increased recognition that, as audiology moves staunchly forward toward greater autonomy as a doctorate-level health-care profession, there is need for a new national examination: An examination not only reflective of our new entry degree but also an examination which would better test future audiologists’ application of newly learned and developed clinical skills.

“If I don’t have time to serve on committees or on the Board, how might I help ABA change the profession for the better as they continue their work?”

Well, as you might suspect, significant costs will be accrued when working with a testing consultant to guide ABA through the requisite job analysis, examination item writing and test construction, and subsequent test delivery, scoring and reporting which will be integral to the development of a new national audiology examination. The ABA is not new to this process and our experiences in the development and implementation of the Specialty Certification in Cochlear Implants will serve us well.

To make the new national examination a reality, the ABA is working with the American Academy of Audiology Foundation (AAAF) in a fundraising campaign aimed at interested individuals and organizations in support of this initiative. Our alliance with AAAF in our fundraising efforts makes your donations 100% tax deductible. Regardless of whether you are Board Certified, we need your help to build this portion of the road to autonomy and strength as a profession. To donate toward the development of a new national examination in audiology you may send your check to: The American Academy of Audiology Foundation (AAAF), 11730 Plaza America Drive, Suite 300, Reston, VA 20190.

To ensure that your donation goes to this ABA initiative, please enclose a note indicating that the donation is restricted to the ABA National Examination in Audiology. Please make a similar notation on the check. And once you have joined this part of audiology’s future, we will add your name to the ever-growing list of people to thank.
Join the AAA Foundation Board of Trustees as they recognize the recipients of the 2006 Research Awards, the James Jerger Awards for Excellence in Student Research and other Foundation funded research grants at the Poster Presentation and Foundation Research Reception. Posters will be available for viewing, and researchers will discuss their current projects at this wine and cheese reception (cash bar). The Board will also acknowledge the work of the 2006 Research Award recipients during this special event at 5:00-6:30pm on Friday, April 7, 2006.

Five top students will present their research projects at the always-interesting Student Research Forum at 12:00 noon-1:30pm on Friday, April 7, 2006. The AAA Foundation will recognize these outstanding students as they discuss their most recent research. Boxed lunches will be available in the meeting room.

The Marion Downs Lecture in Pediatric Audiology will once again feature a cutting-edge presentation on issues relating to the screening, diagnosis and management of infant and childhood hearing problems. The 2006 Lecture will be presented by Albert Mehl, MD, the appointee from the American Academy of Pediatrics in Newborn Hearing Screening. Look for more details on this special presentation in Audiology Today and other AudiologyNOW! materials.

At American Academy of Audiology Foundation Focuses on:

RESEARCH
Join the AAA Foundation Board of Trustees as they recognize the recipients of the 2006 Research Awards, the James Jerger Awards for Excellence in Student Research and other Foundation funded research grants at the Poster Presentation and Foundation Research Reception. Posters will be available for viewing, and researchers will discuss their current projects at this wine and cheese reception (cash bar). The Board will also acknowledge the work of the 2006 Research Award recipients during this special event at 5:00-6:30pm on Friday, April 7, 2006.

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FUNDRAISING & FUN-RAISING
New at AudiologyNOW! 2006!! The AAA Foundation’s Happy Hour and a Half reception will be held on Wednesday, April 5th from 5:30-7:00pm. Enjoy drinks and hors d’oeuvres, listen to the sounds of “Hearing Aid” and catch up with old friends at this special cocktail hour event. In addition, the AAA Foundation Board will recognize donors who make the Foundation’s work possible through their contributions and support. All Foundation Leaders, Benefactors and Sponsors are invited as the Board’s special guests. Tickets are available for $25.00 per person ($10.00 for students).

The AAA Foundation is holding a special expanded Silent Auction at AudiologyNOW!2006. Look for special one-of-a-kind items at the Auction in Hall B Foyer of the Convention Center. The Silent Auction will be open from Thursday, April 6th through Saturday, April 8th midday, and all AudiologyNOW! attendees are invited at no charge.

Come and bid on the perfect treat for your family, your friends, your practice or even yourself. You won’t want to miss this opportunity to find a bargain and support the AAA Foundation at the same time! And don’t forget to stop by the AAA Foundation Booth in the Academy Center to find out what you can do to help make the Foundation vision a reality!

Proceeds from the Happy Hour and a Half and the Silent Auction support the AAA Foundation’s mission to raise funds for programs of excellence in education, promising research and public awareness in audiology and the hearing sciences. For more information on any of these events, contact Kathleen Devlin Culver at kculver@audiology.org.

Looking for the perfect Holiday gift for your staff, colleagues and favorite patients?

Tired of wandering around the mall and fighting the shopping crowds?

’Tis the season to purchase colorful AAAF Ear Bouquet Note cards!!!

These high quality, all occasion note cards are a gift everyone would love to receive! Each box of twelve comes in three assorted colors and is only $15.

And best of all, the proceeds from the sale of Foundation Notecards assists the AAF as it works to raise funds for research, education and public awareness in audiology and the hearing sciences.

We have elves working overtime in the Foundation office to make sure your order arrives before the holidays. Go to http://www.audiology.org/store/gifts/ or contact Kathleen Culver (kculver@audiology.org or 703.226.1049) in the Foundation office to place your order today.

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As the holidays approach, the AAAF Board of Trustees reflects on the valuable corporate and organizational support it has received over the past twelve months. It is with appreciation and gratitude that the Board thanks these corporations and organizations for their contributions to the AAA Foundation’s successes of the past year.

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**The Oticon Foundation**
Matches Member Gifts in 2005

Did you know your contribution to the AAA Foundation Annual Campaign went twice as far in 2005?

The first $20,000 that was contributed to the 2005 Annual Campaign from the membership of the American Academy of Audiology was matched dollar-for-dollar by The Oticon Foundation.

This generous contribution from The Oticon Foundation allows the AAA Foundation to double the dollars used to support its mission of funding research, education and public awareness in audiology and the hearing sciences.

Many thanks to The Oticon Foundation for making each member gift doubly valuable in 2005!!!
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Building Blocks to Successful Marketing

Gyl A. Kasewurm, Aud, Professional Hearing Services, St. Joseph, MI

Whether you work in a hospital, clinic or one-person office, to be successful, you must have a marketing strategy, and you must implement it consistently. While many find marketing intimidating, you don’t have to be a creative genius to develop and implement a plan that will grow the business that you own or work in.

The key is developing a marketing strategy that forms a solid foundation for your promotional efforts. Implementing promotional activities such as print ads, direct mail, educational seminars or even networking without a marketing strategy is like buying curtains for a house you are building before you have an architectural plan. How would you even know how many curtains to buy or what size they needed to be?

You can develop a strong marketing foundation by:

► Defining your product or service: What is it that your patients are really looking for? You may be offering balance testing, hearing assessments and many types of amplification, but your patients are purchasing better relationships, improved communication, increased productivity, enhanced self esteem and a less stressful life. Your marketing efforts should promote the benefits of better hearing. It’s not about who YOU are, but rather about who the PATIENT wants to become when he or she is able to hear better.

► Identifying your target market: Everyone or anybody might be potential patients. However, you probably don’t have the time or money to market to Everyone or Anybody. Who is your ideal patient? Who does it make sense for you to spend your time and money promoting your service to? You might define your ideal patient in terms of household income, age, sex, or geographic area. For example, an audiologist who is a balance specialist may decide her target market is men over the age of 70 who live in a geographical area within 10 miles from her office.

► Knowing your competition: Even if there are no direct competitors for your service, there is always competition of some kind. Someone besides you is competing for the potential patient’s money. Why should the potential patient spend his or her money with you? What is your competitive advantage or unique selling proposition?

► Finding a niche: Is there a market segment that is not currently being served or is not being served well? A niche strategy allows you to focus your marketing efforts and dominate your market. For instance, you may want to specialize in dispensing custom ear products, selling assistive devices, tinnitus management or in providing vestibular or auditory rehabilitation.

► Developing awareness: It is difficult for potential patients to seek the services and products you offer if they don’t even remember you or know your organization exists. Marketing analysts generally suggest that potential patients will have to be exposed to your practice or organization 5 to 15 times before they are likely to think of you when the need arises, which often happens unexpectedly. You must stay in front of your patients consistently if they are going to remember you when that need arises.

► Building credibility: Not only must patients be aware of you or your organization, they must also have a positive disposition toward you. Potential patients must trust that you will deliver what you say you will. Often, especially with large purchases such as hearing aids, you need to give patients the opportunity to “sample,” “touch,” or “taste” the benefits associated with the product. While some professionals reject this type of “try before you buy” offer, time and experience has proven that patients have often heard negative comments regarding hearing aids and they are hesitant to repeat what they feel will be a negative experience.

► Being Consistent: Be consistent in everything you do. This includes the look of your promotional materials, the message you deliver, the level of service you provide, and the quality of the products you dispense. Some experts suggest that being consistent is more important than offering the “best” products and services. This in part is the reason for the success of chains. Whether you’re going to Little Rock, Arkansas or New York City, if you reserve a room at a Courtyard Marriott you know exactly what you’re going to get.

Before you consider developing a brochure, running an ad, implementing a direct mail campaign, or presenting an educational seminar, begin by mapping a path to success through the development of a consistent, focused marketing strategy.

Welcome to the Blogosphere. Be sure to read AudBlog — President Gail Whitelaw’s weekly musings on the state of audiology and the Academy.

www.audiology.org/blog

“...there must be hundreds of utterances of the word ‘audiologist’ on the cutting room floor in New York...”
The Doctor of Audiology (AuD) degree has forever changed the landscape of audiology private practice. As a unique brand for the profession of Audiology, similar to Optometry (OD), Dentistry (DDS), Medicine (MD) and other well-known professions; consumers can generally feel more comfortable in the knowledge that an AuD audiologist is educated to a certain standard and offers skills commensurate with other doctoral level professions. In today’s competitive world, most professionals that provide products and services to the hearing impaired are audiologists. Current estimates suggest that approximately 25% of audiology professionals are now at the doctoral level and more are graduating every day. A tremendous benefit for the profession with a substantial upgrade of the skills, the AuD has been a successful and worthwhile undertaking by the whole profession. Although this new designator uniquely brands the profession to consumers, it makes it increasingly difficult to distinguish one competitive practice from another. This article considers the question, “When all audiology professionals are branded with the AuD, how does one practice stand out among the others?”

WHAT IS DIFFERENT ABOUT NOW?

Since audiology is on a mission to become a doctoring profession in a very short time, many new clinicians have chosen to enter private practice and compete with other audiologists that have been there for many years providing high-quality services to consumers. Additionally, the past 10 years has seen the rise of corporations or “networks” that consist of new practices and those that have been purchased by corporate conglomerates. These networks are mostly owned by hearing aid manufacturers that have a vested interest in obtaining outlets for their specific brand of products. Thus, as suggested by Smirga (2004), those from whom we purchase products to serve the hearing impaired use their profits to directly compete with us in the market place. As indicated recently by Taylor (2005), consumers now assume that all dispensing professionals have access to roughly the same technology, if not the same products. Further, most clinicians have access to essentially the same test equipment and processes for serving patients. It is easy to understand why some feel that the provision of hearing aids and general hearing health care are largely commodities. Commodity products are those defined as homogeneous with little or no definition and with little differentiation as to brand or place of purchase. Though a hearing aid product of a particular brand and model can be purchased from generic sources as a commodity, the services and personal touches and interactions, rehabilitative services and follow up that cloak them are not. These are products that require personal services that must be provided by a knowledgeable professional that can interact with the patient on a long-term basis. Therefore, the problem that faces the independent audiology private practitioner is a new generation of competition comprised of hearing aid manufacturers owned by major corporations, new AuDs, as well as the traditional hearing aid dispensers.

THE BRANDING OF A PRACTICE

All of these competitors are formidable, and it is essential that a practice differentiate their “brand of audiology” from “other brands of audiology” offered in the same marketplace. The “brand of audiology” must stand out in the consumer’s mind over all other possible “brands” such as the new clinics, corporate clinics, and possible Internet purchases. This involves “branding the prac-
“...airplanes are great places to discuss audiology...except when the passenger’s passion is clearly getting to Las Vegas on a Friday night.”

Welcome to the Blogosphere. Be sure to read AudBlog -- President Gail Whitelaw’s weekly musings on the state of audiology and the Academy.

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practice” with a marketing campaign that will establish in the consumers mind that they have chosen the correct place to receive hearing care.

Branding, according to D’Alessandro (2001), is an old business practice that can be described as whatever the consumer thinks of when he or she sees or hears your company’s name. For example, what comes to mind when one thinks of Mercedes-Benz, Sony, or Hewlett-Packard? Some of the best products worldwide have built strong brands so that in the consumer’s mind the thought is of quality, reliability, and customer service. If, for example, Acme Audiology, LLC is to be branded successfully as the place for hearing care in a particular market, communications to the community must be ethically directed toward generating in the minds of prospective patients and others that the Acme Audiology, LLC “brand of audiology” is the best brand of hearing care in the market area.

Consumers are bombarded by these market communications from the competition. It is difficult to brand a particular practice, as some corporations with huge marketing budgets use audiologists with similar credentials to facilitate sales of their products. Unless a clinic differentiates itself from others selling the same products, it will look the same to consumers who will simply look for the best price. Referring to the differentiation issue, Kasewurm (2004) indicates that audiologists understand the services they provide but often fail to promote the benefits of those services. It is just this creativity and aggressiveness that is instrumental in the branding of a specific practice in an intensely competitive market.

For a better perspective on the competition, D’Alessandro (2001) presents the nature of competitive branding into four distinct categories:

**BRAND COMPETITION – All competitors that are like me.**

This category, for example, would represent all AuD audiologists that offer hearing care in the same market area. These competitors look exactly alike to the consumer, as they have the same “brand” for their credentials. In the consumer’s mind, without proper market offerings, they would presume that products and services for their needs could be obtained from any AuD professional. Thus, it is not enough to brand the credential; branding of the particular clinic is necessary to insure success.

**INDUSTRY COMPETITION – All competitors that look like me offering hearing care.**

Pertaining to the field of audiology, this would include doctoral level audiologists (PhD, EdD, ScD) other than the AuD or otolaryngologists. Similar to “brand competition,” many professionals appear to have the same capability to provide products and services to the hearing impaired consumer. Additionally, many consumers already have an established relationship with a professional for their hearing care and it is necessary to demonstrate that a practice can offer a reason to sever that relationship and establish a new one. Again, it is the intensity and the direction of the market offerings that can insure the branding of the practice separating a particular clinic as the facility of choice.

**FORM COMPETITION – All those in the same business.**

This category would include audiologists, otolaryngologists, hearing aid dealers, drug stores, wholesale warehouse corporations, internet options and other establishments that offer hearing care or sell similar products. Form competitors are those where considerable diversity may exist in the capability to serve consumers. Branding a practice by a tasteful and ethical market offering that presents the type of hearing care offered, can provide the differentiation needed by consumers. Indeed, it may be an ethical responsibility to conduct market offerings that direct consumers to the most qualified professional.

**GENERIC COMPETITION – All products that cost the same as hearing care.**

Generic competition is experienced by all hearing care professionals. In this instance, patients weigh the costs of hearing care against other more desirable recreational activities, required services or products; such as, new cars, foreign vacations, cruises, appliances or other items. Since the majority of hearing-
impaired patients are retired, there is only a finite amount of disposable income which can be utilized for hearing care. Since many older patients are on a “fixed” income, a negative decision to obtain hearing care may simply be an application of basic economics — the principle of “opportunity cost.” This principle suggests that there is only a finite amount of money and if the money is utilized to purchase an item, then that money is not available to use for another purpose. It is a simple fact that the products we sell in our practices, especially hearing instruments, are expensive, often not funded by insurance and compete for the consumer’s attention with other products of similar value. Further, it is also well known that consumers want these other competitive products or services more than those offered in our clinics. It is more fun and, sometimes, of more benefit, to take a cruise, go on a foreign vacation, or purchase a car rather than obtain amplification. Thus, there are many products in competition for the same money, and it is the marketing campaign, and sometimes the specific market offering, that will convince the patient to make the more prudent decision.

While marketing is what builds your particular brand of audiology in the consumer’s minds, it is not easy to build a great brand. D’Alessandro indicates that it takes an artistic sense of proportion and timing as well as a ruthless willingness to distinguish yourself from the competing brands and, hopefully bury, them in the process.

**COMPETITIVE ADVANTAGE**

No matter which of D’Alessandro’s categories the practice is part of, generating an audiology brand requires building a competitive edge for the practice that will cause consumers to choose this clinic over the others. A competitive edge is something that this practice does better than any other in the market area. When building this competitive edge, questions to ask are “What do we do better than the competition?” or, “What unique proposition can we present to consumers?” The answers to these questions should consider how value is added to the products and services provided by a practice.

**REFERENCES**


Noise and Military Service: Implications for Hearing Loss and Tinnitus

BACKGROUND

Congress authorized a report by the National Academy of Sciences on noise-induced hearing loss and tinnitus associated with military service in Public Law 107-330. The study was sponsored by the Department of Veterans Affairs. Congress has expressed concern on the prevalence of hearing loss and tinnitus associated with military service and the cost of adjudicated claims for disability. Auditory disabilities (hearing loss and tinnitus) are the third most common disability by body system and represent ten percent of all compensated disabilities. According to the VBA Annual Benefits Report for 2004, all compensated disabilities. According to the VBA Annual Benefits Report for 2004, hearing loss is the most common individual disability and tinnitus is third most common individual disability. The annualized compensation for hearing loss as a major disability was $660 million and $190 million for tinnitus in 2004.

The study project was assigned to the Institute of Medicine (IOM) and involved the following study tasks:

- Identify sources of hazardous noise exposure in military service
- Determine levels of noise necessary to cause hearing loss or tinnitus
- Review data on hearing loss and tinnitus among former service members
- Assess whether or not noise-induced hearing loss can have a delayed onset or can be progressive or cumulative
- Identify risk factors for noise-induced hearing loss and tinnitus
- Identify when military hearing conservation measures were adequate to protect hearing of service members
- Review service medical records for compliance with requirements for audiometric surveillance

IOM appointed thirteen experts and three IOM staff for the study. The committee had five meetings and multiple conference calls over 16 months. There were three public meetings with presentations from VHA, VBA, congressional staff, representatives of military services, and individual veterans. The committee reviewed published literature, data and reports from military services, analyzed published data on hearing, and collected and analyzed data on audiometric testing from veterans’ service medical records. The committee applied a hierarchy of evidence quality in judging studies on hearing and tinnitus.

STUDY FINDINGS

The most important findings of the IOM study were:

a. Military service members were exposed to hazardous levels of noise sufficient to cause hearing loss and tinnitus.

b. There was no scientific basis for delayed onset noise-induced hearing loss, i.e. hearing normal at discharge and causally attributable to military noise exposure 20-30 years later.

c. Without audiograms at beginning and end of service it was difficult or impossible to determine with certainty how much of a service member’s hearing loss was incurred in or aggravated by military service.

d. There was no scientific basis for presumption, i.e. predicting who will be exposed and who will suffer hearing loss or tinnitus by period of service or occupational specialty, which was the main reason for the IOM study.

e. Hearing tests were limited before 1970 and compliance with hearing testing and monitoring was poor even after 1970 when policies were in place.

f. Certain test frequencies (6000 Hz) were predictive of noise exposure.

g. Age adjustments and allocation formulae based on population data cannot be applied to individuals.

The committee found that hazardous noise levels are and have been present in military settings since WWII and included weapons systems, ground vehicles, ships, aircraft, communications equipment, and industrial-type activities. Noise exposure occurred during training, routine operations, and combat. Noise levels were sufficient to cause hearing loss and tinnitus. Exposure was unpredictable in onset and duration. The risk of noise exposure was consistent with OSHA regulations (85 dBA for a time-weighted eight hour day). With an exposure limit of 85 dBA, the risk of noise-induced hearing loss is 15%. In other words, 15% of service members would suffer material hearing loss. Material hearing loss is the average hearing thresholds at 500, 1000, and 2000 Hz. Significantly greater injury could occur at more susceptible frequencies (3000, 4000, and 6000 Hz) and might very likely be compensable under the VA schedule. Given the noise levels the committee found, there was a high probability of noise-induced hearing loss associated with military service. Hazard increased as the time-weighted average noise exposure increases. However, damage risk criteria were based on studies of industrial noise that were more constant and less intense than noise levels associated with military service. Many military noise sources are high intensity and impulsive. Many exceed permissible levels of impulse noise (140 dBA), even for one exposure. The committee found that there was no complete catalog of noise exposure (noise dose) for weapons systems and military settings.

The committee concluded that without audiograms at beginning and end of service it was difficult or impossible to determine with certainty how much of a service member’s hearing loss was incurred in or aggravated by military service. The committee found few no longitudinal studies on hearing in service members.

PRESCRIPTION

Congress' intent in ordering the study was to establish a basis for presumption. Presumption is mechanism whereby certain conditions are presumed to exist whether or evidence exists in service or medical records that condition were incurred in or aggravated by military service. Presumptive conditions include tropical diseases, chronic diseases, conditions associated with prisoners of war, and conditions associated with herbicide
exposure. The committee found that it was not possible to predict which service members, by period of service or by occupational specialty, will be exposed and which will suffer hearing loss or tinnitus. Data was not sufficient to determine susceptibility altered by exogenous factors such as solvents, carbon monoxide, or smoking, etc. or endogenous factors such as gender, race, or age, etc. The prevalence of hearing loss in military service warrants consideration of presumption, at least for certain veterans. VBA considers hearing loss to be presumptive if identified within one year of discharge. The committee found no studies on tinnitus in military personnel and virtually no monitoring or assessment of tinnitus. The study provided little scientific information or guidance on presumptive tinnitus.

**Late Onset Hearing Loss**

The committee did not find sufficient evidence to determine whether or not noise-induced hearing loss developed long after cessation of noise exposure. Essential longitudinal studies have not been done. However, anatomical and physiological data on recovery (animal studies) suggested that it was unlikely that delayed effects occur. The most pronounced effects on hearing were measurable immediately after noise exposure.

**Age-related Hearing Loss**

The committee found that few studies of cumulative noise exposure have been done. No studies of military tinnitus have been done. Studies of military hearing loss had a high degree of individual variability. The committee found significant limitations in population-based estimates of noise- and age-related hearing loss (ISO 1999 and ANSI S3.44 1996). The committee concluded that applying these population data to individuals was inappropriate. Therefore, applying age corrections or allocating the relative contributions of age-related and noise-induced hearing loss in disability claims was inappropriate.

**Military Testing**

The study found that hearing testing was limited before 1970. The reason that Congress was interested in the effective date of audiometry and hearing conservation was to establish a point before which presumption might apply. The assumption was that after this point, service members would have hearing tests to demonstrate they did or did not have hearing loss. As IOM found significant non-compliance even after 1970, this assumption does not appear to be correct. Nevertheless, more modern claims (after 1970) have a higher frequency of calibrated audiometry than older claims. The committee concluded that military hearing conservation programs were not adequate to protect hearing. The only way to diagnose hearing loss is by case history and diagnostic audiometry. The committee found limited effectiveness of hearing protection and hearing conservation programs. Noise-induced hearing loss was two to five times higher than acceptable standards in industry. There was poor compliance with audiometric testing and monitoring.

**Operational Needs for Department of Defense**

The committee recommended a number of improvements for Department of Defense:  
- Increase use of hearing protection  
- Monitor tinnitus  
- Audiograms for all new members at all basic training sites  
- Separation audiogram for all members  
- Explore VA participation (Benefits Delivery at Discharge)  
- Include 6000 Hz and 8000 Hz in all audiograms for detection of noise-induced hearing loss  
- Improve compliance with annual monitoring and follow-up  
- Improve data collection, reporting, tinnitus tracking, hygiene component (dosimetry)  
- Give VA access to hearing conservation data

**Implications for Audiology**

**Late Onset Hearing Loss.** The study found that there was no scientific basis for delayed or late onset noise-induced hearing loss, i.e. hearing normal at discharge and causally attributable to military noise exposure 20-30 years later. In cases where there were entrance and separation audiograms and such tests were normal, there was no scientific basis for concluding that hearing loss that develops 20 or 30 years later is causally related to military service. Therefore, audiologists have no scientific basis for concluding that delayed onset hearing losses exist.

**Age-Related Hearing Loss.** The IOM report found significant problems with applying age and noise exposure population data to individuals. It is not appropriate to make age adjustments or attempt to allocate the relative contributions of age or noise to hearing loss. While standards do exist for estimating age-related and noise-induced hearing loss, these standards will not be used in VA exams or opinions. It is also not appropriate to apply age adjustments in making decisions about eligibility for hearing aids.

**Compensation Exams and Opinions.** The poor compliance with military hearing testing and monitoring programs increases the likelihood that service members will not only suffer hearing loss or tinnitus but also may not have audiograms to demonstrate that hearing loss or tinnitus was incurred in or was aggravated by military service. A key finding of the study was that an audiogram and a case history were the only ways to diagnose hearing loss. It is difficult or impossible to determine with certainty how much of a veteran’s hearing loss was acquired during military service without audiograms at the beginning and end of military service. In the absence of such testing, VHA audiologists and physicians will be faced with increasing numbers of clinical opinions, c-file reviews, and appeals. In the absence of definitive evidence, such opinions must be based on probabilities and inference. Such opinions can only be made after a careful review of the evidence (medical and service records).

The IOM study also presents Audiology with an opportunity to review exam procedures for hearing loss and tinnitus in light of scientific findings. The IOM study found virtually no monitoring of tinnitus in the military. Because tinnitus is a subjective condition, it is adjudicated largely on patient report. Because of variances in exam procedures and clinical opinions, Audiology will identify ways to improve the quality of exams and clinical opinions. Guidelines already exist for conducting C&P exams and writing clinical opinions. We continue to receive complaints about variances in practice and non-compliance with national policy. In some
cases, the actions of audiologists have resulted in unnecessary appeals and concerns by high-ranking VBA and VHA officials and Congress. Over the next several months, we will issue additional guidance and training. This is perhaps a good time to review the Handbook on Standard Procedures and Best Practices for Audiology Compensation and Pension Examinations, particularly for describing tinnitus. Managers should ensure that all audiologists consistently apply the guidance and report exam findings using accepted formats using templates such as QUASAR, AMIE, or CAPRI. DoD Collaboration. The results of the IOM study present VHA and VBA with opportunities to collaborate with the Department of Defense. The Benefits Delivery at Discharge (BDD) Program is an excellent example of joint cooperation and seamless transition. In this program, service members receive VA benefits counseling and discharge physicals that conform to VA compensation exam protocols. Any condition noted during the physical is therefore service-connected. This program reduces the cost of adjudication, reduces redundant exams, establishes a definitive record of injuries or conditions while the service member is still in active service, and makes it easier for service members to receive compensation for service-related disabilities. Presumption. The study found no scientific or equitable basis for presumption. However, the study concluded that noise levels were sufficient to cause hearing loss and tinnitus. Military studies showed a high incidence of military noise exposure. VBA benefits data showed that hearing loss and tinnitus were among the most common service-connected disabilities and claims for these conditions were increasing rapidly. VBA noted that this demand was not driven by a desire for compensation (most hearing loss claims at rated at 0% or 10%) but by a desire for access to specialized VA services, including hearing aids. Congress indicated an interest in presumption by occupational specialty, but the IOM report concluded that this was not feasible. VBA or Congress may consider other ways to determine presumption based on certain occupations most likely to be noise exposed, evidence of combat or simulated combat, theaters of operation, service-connected disability for other combat-related injuries, instrumentalties of war, awards for combat, special operations, or valor, or enrollment in hearing conservation programs. Presumption would reduce costs of adjudication, reduce the number of appeals and opinions, and make it easier for veterans to seek compensation for disabling injuries incurred in service. A free searchable version of the report is available at the following website: http://www.iom.edu/project.asp?id=20024

Extend Your 15 Minutes of Fame with Members in the News!

HAVE YOU RECENTLY BEEN FEATURED IN A NEWSPAPER OR MAGAZINE ARTICLE, OR BEEN INTERVIEWED ON RADIO OR TELEVISION?

If so, we want to let the Audiology community know! The new Members in the News area of our web site (www.audiology.org/professional) is a growing archive of our members shining moments in the press. This is a great opportunity to let other audiologists know how what you are doing to promote audiology. To have a newsworthy tidbit included, please e-mail sdavis@audiology.org with the information you would like posted.
Washington can be a very complicated place. During this fall season, we are simultaneously dealing with the very technical questions raised by the proposed Medicare Physician Fee Schedule (MPFS) and, at the same time, the larger questions posed by health care reform. With regard to the MPFS, it is important, indeed vital, that we look behind the numbers of the CMS proposal to make sure that CMS understood the consequences of a 21% decrease in Medicare reimbursement over the next four years, as was proposed. On direct access, however, it is important that we paint the big picture with a broad brush to make sure that the Congress understands our position clearly. The American Academy of Audiology supports: (1) direct access, (2) lower costs, and (3) consistency.

Perhaps one of our most difficult challenges in Washington, DC is to coach a professional on how to reduce their entire life’s work into a five-minute statement that can be easily understood and comprehended by Congress and, thereby, impact federal policy. The Newsweek article can help us do that if we use it correctly, not withstanding our professional reservations. “We” were on the cover of Newsweek. That is a big deal in political terms, and we should feel free to use it whenever possible. Further, the Academy must begin to plan accordingly to provide hearing healthcare services for the oncoming 78 million Americans who will experience hearing loss in just a few years. Not only do we need to consider how to provide the necessary services, but we must plan our politically actions with equal care and concern. The number 78 million will help us find political leaders to support and carry forward our issues. That impressive number should also help us identify more co-sponsors for direct access to audiologists. Further, we need to think about who these 78 million people in the US are, where they live and their accessibility to reach qualified audiologists. How do we identify these constituents (without violating their privacy) and perhaps organize these consumers into political allies? This Newsweek cover story has opened some new doors for us and provided us increased entry to Congress and other federal agencies, but we all have much work ahead of us to take advantage of this unique opportunity.

A few months ago, “Hearing” made it as the main cover story in Newsweek magazine (June 2, 2005). Numerous American Academy of Audiology members expressed concern about issues and topics presented in the article and particularly noted that it did not mention the important and key role played by the profession of audiology. From our goals of political perspective, however, the article was a home run!

The very first sentence in the Newsweek article noted: “More than 28 million Americans have some degree of hearing loss, a number that could reach 78 million by 2030.” That’s 78 MILLION AMERICANS! Think about that number as a politician, not as an audiologist. That is the type of number, representing American citizens across the country, that demands respect. Any issue, especially a health issue, that affects 78 million people gets legislators’ attention.

Since the publication of that amazing Newsweek cover story, the Academy has been using the article in all of our lobbying visits on Capitol Hill. We are quick to point out to them that, “The goal of our proposed legislation, is to make it easier for those 78 million Americans to get access to qualified, licensed hearing care.” Newsweek provided us with a great opening sentence that really gets attention. Our goal is to keep Congress focused on the big picture. Legislators are in Congress because they (usually) understand the big picture. Members of Congress cannot be experts on all the specific subjects that come before them, but usually they understand the policy implications of the larger point.

We believe that Congress needs to understand that because 78 million Americans will be affected by hearing loss by 2030, the federal government should be leading the way in facilitating access to hearing care. At the moment, some federal agencies support direct access to audiologists; however, some agencies are not on board yet. That is a point Congress also understands. If the Department of Veterans Affairs and the Office of Personnel Management say that direct access to qualified audiologists works efficiently and makes sense economically, then direct access should also work in a beneficial manner for senior citizens dependent on Medicare.

WASHINGTON WATCH

HEARING: A NATIONAL NEWS MAGAZINE COVER STORY

MARSHALL L. MATZ, OLSSON, FRANK AND WEEDA, PC, WASHINGTON, DC

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Washington can be a very complicated place. During this fall season, we are simultaneously dealing with the very technical questions raised by the proposed Medicare Physician Fee Schedule (MPFS) and, at the same time, the larger questions posed by health care reform. With regard to the MPFS, it is important, indeed vital, that we look behind the numbers of the CMS proposal to make sure that CMS understood the consequences of a 21% decrease in Medicare reimbursement over the next four years, as was proposed. On direct access, however, it is important that we paint the big picture with a broad brush to make sure that the Congress understands our position clearly. The American Academy of Audiology supports: (1) direct access, (2) lower costs, and (3) consistency.

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An official grand opening ceremony for the Vanderbilt Bill Wilkerson Center for Otolaryngology and Communication Sciences was held on September 16, 2005 in Nashville, TN. An appreciative crowd composed of donors, university administrators, staff and faculty, current and former students and friends of the Bill Wilkerson Center were on hand to view the ribbon-cutting, listen to speakers and tour the new $65,000,000 state-of-the-art (and sciences) facility. The Bill Wilkerson Center became the Vanderbilt Department of Hearing and Speech Sciences and was partnered with the Vanderbilt Department of Otolaryngology in the early 1990s, and more recently joined forces to become partners in the new 45-story facility located in the south tower of the Vanderbilt Medical Center East building.

In contrast to Joni Mitchell’s well-known lyrics, “They paved paradise to put up a parking lot,” the new Center “paradise” consists of more than 160,000 square feet of space, and was constructed in a Vanderbilt medical center parking lot following ground breaking in 2001. The $65,000,000 facility will encourage interdisciplinary study, collaboration and experimentation in all of the speech, language and hearing sciences, and otolaryngology specialties, as well as the latest in teaching environments including flexible classroom and computer spaces. The new center includes 23 custom-designed sound-treated rooms that are fully equipped with the newest and latest scientific and clinical equipment, including a 3-story anechoic chamber and a high-tech reverberation room for research purposes. The extensive clinical facilities include a hearing aid dispensary featuring four spacious and fully-equipped fitting rooms, the National Center on Childhood Deafness and Family Communication, and a complete vestibular evaluation department including a Risk of Falls center. The new Center has 249 employees with 164 in the Department of Hearing and Speech Sciences and 105 in the Department of Otolaryngology. Of the 164 DHSS employees, there are 32 faculty/staff in audiology/hearing sciences with 17 PhDs, 4 AuDs, 11 hold master’s degrees.

Historically, the idea for a comprehensive community hearing and speech center originated in the mind of Dr. Wesley Wilkerson, an ENT specialist, in 1942 after hearing Louise (Spencer’s wife) Tracy speak about educational successes with her profoundly deaf son due to early intervention techniques. Dr. Wilkerson becomes determined to create a place where any child with hearing loss can come to learn to communicate through oral teaching methods. He realized the essential need for a to establish such a program in Nashville, as there existed no other referral facility than the state school for the deaf located 200 miles away. The Center was ultimately named in memory of Wesley’s son, Bill, who was lost his life during World War II in 1945. Wesley Wilkerson organized the “Tennessee Hearing and Speech Foundation” in 1949. The Foundation opened a clinic in an old fraternity house on the Vanderbilt campus in 1951, and named Freeman McConnell as the first director of the Bill Wilkerson Hearing and Speech Center. Dr. Wilkerson was also instrumental during these years to institute a training program for hearing and speech professionals with Vanderbilt University resulting in the first class of graduates in 1953.

From 1953 through 1956, the Center’s Board of Directors committed themselves to the establishment of a new center building. During 1956, ground was broken and a building project to construct a center of some 35,000 square feet was completed in 1958 at a cost of...
just under one million dollars. The Bill Wilkerson Center was considered the most state-of-the-art clinic of its kind in the world – in fact, it was the first building ever built as a speech and hearing center and featured in architectural journals for its research laboratories and anechoic chamber. In the 1960s the Center established a Parent-Infant Training program and housed the Nashville Public Schools Hearing Impaired Preschool.

In 1996, the Bill Wilkerson Center began a capital campaign to expand the existing building. During this period of time, the Center became the Vanderbilt Department of Hearing and Speech Sciences and was partnered with the Vanderbilt Department of Otolaryngology. The two departments subsequently became the Vanderbilt Bill Wilkerson Center for Otolaryngology and Communication Sciences and discussions began regarding the need for a new building. An aggressive capital campaign was undertaken, led primarily by the current Director, Fred Bess, Professor and Chair of the Department of Hearing and Speech Sciences, Vanderbilt University, who ultimately obtained more than approximately $15 million in gifts, donations, grants and pledges, to get the new center construction underway.

The story of the Vanderbilt Bill Wilkerson Center for Otolaryngology and Communication Sciences reflects the dedication of a vast number of outstanding professionals and lay Board members deeply involved since 1942. The professionalism established by Freeman McConnell, and continued by Fred Bess since 1976 through the present, has set the standard through the years for graduate training in hearing, speech and language, and serves even today as the model Center of Excellence in the provision of clinical communication services.

The main entrance of the Bill Wilkerson Center which served Nashville and Vanderbilt University from 1958 through 2005.

Freeman McConnel performs early vestibular balance test with a patient.

U.S. DEPARTMENT OF EDUCATION RELEASES NEW BROCHURE OUTLINING OPTIONS FOR DEAF AND HARD-OF-HEARING CHILDREN

The U.S. Department of Education has issued a new brochure for parents explaining the full range of options, including cochlear implants, for deaf and hard-of-hearing children. This marks the first time the Department has published guidance on cochlear implants, implanted devices for severe to profoundly deaf individuals.

“The brochure will improve the information provided to parents to help them make important decisions about their child’s hearing health,” said Donna L. Sorkin, Vice President, Consumer Affairs for Cochlear Americas, and an active advocate for early intervention in hearing health. “It addresses the full range of options, including the benefits of cochlear implants for appropriate children, so that more parents will become aware of this remarkable technology. This guidance is a milestone on the path to early intervention, universal newborn hearing screenings, and broader insurance coverage of cochlear implants.”

The brochure fulfills a policy directive from Congress issued as a result of the Congressional reauthorization of the Individuals With Disabilities Education Act (IDEA) in December 2004. IDEA provides access to services and education for families and children with special needs.

Entitled “Opening Doors: Technology and Communications Options for Children With Hearing Loss,” the brochure is distributed by state early intervention programs and is on the U.S. Department of Education Web site at: ww.ed.gov/about/offices/list/osers/products/opening_doors/index.html.
Members of the Independent Hearing Aid Fitting Forum (IHAFF) conducted a unique conference designed to “Teach the Teachers” as an aid to move graduate educational programs toward excellent amplification education.

A sub-group of IHAFF members presented “what” they teach and “how” they teach amplification in various AuD programs. The conference was conducted as an educational activity where expert teachers from around the country could listen to presentations and share their expert methods during discussions and poster sessions. The conference was held June 17-18 with more than 30 AuD programs sending faculty and clinical supervisors. Several manufacturers also sent individuals involved in education, and a number of recent graduates attended.

University of Pittsburgh faculty, Kris English and Elaine Mormer, dealt with the logistics, and several manufacturers (Phonak, Starkey Labs, Etymotic Research, Microsonic, and Qualitone) donated funds to assist in keeping the registration fee reasonable for our academic colleagues.

Patricia McCarthy opened the conference with a motivational keynote speech that set a challenging and cooperative tone for the meeting. IHAFFers Robyn Cox, Ruth Bentler, David Hawkins, Gus Mueller, Michael Valente and Catherine Palmer took turns discussing content areas along with the readings, class activities, homework, laboratory activities and evaluation procedures that might be used in amplification courses. Between talks, attendees were assigned topics to discuss and report back on to the group. This allowed for an exchange of ideas between attendees and conference faculty. Fifteen posters provided excellent lunch-time conversation. Harvey Abrams chaired the poster session submission process. Although attendees worked hard each day, time was carved out for the “Audiology Family Feud” event hosted by the conference moderator, Gus Mueller.

Attendees left the conference with a complete CD of all of the conference presentations as well as a compilation of all of the teaching materials used by the presenters. The University of Pittsburgh plans to continue the “Teach the Teachers” conference during alternate years. Each year will have a new focus with conferences related to content areas, teaching methods, evaluation methods, integrating didactic and clinical work, etc. The next conference will be in June 2007 and will focus on Aural Rehabilitation.

The IHAFF group includes Dennis VanVliet, Gail Gudmundsen, Gus Mueller, Ruth Bentler, Dave Fabry, Robyn Cox, David Hawkins, Michael Valente, Larry Revitt, Margo Skinner, Lucille Beck, Michael Marion, Robert Sweetow and Catherine Palmer.
TRICARE ANNOUNCES COVERAGE OF HEARING AIDS

As of September 1st, active duty military family members (ADFMs) who meet specific hearing-loss requirements, will be eligible to receive hearing aids (including services and supplies) as a TRICARE health benefit. This benefit is extended to ADFMs as part of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2002. Previously, hearing aids and services were only available to those beneficiaries who were in the Program for Persons with Disabilities (PFPWD). The FY 2002 NDAA provision allows for coverage of a hearing aid to ADFMs diagnosed with a “profound” hearing loss. With the assistance of service physicians and audiologists from both the Department of the Defense and Veterans Affairs, TRICARE established separate hearing-level thresholds or adults and children.

The criteria for an adult ADFM to qualify for hearing aids and services are:

- 40 decibel (dB) hearing loss (HL) or greater in one or both ears when tested at one of the following frequencies: 500, 1000, 1500, 2000, 3000 or 4000Hz; or
- 26dB HL or greater in one or both ears at any three or more of those frequencies (mentioned previously); or
- A speech recognition score less than 94 percent

The criterion for children of active duty service members to qualify for hearing aids and services is:

- 26dB HL or greater hearing threshold level in one or both ears when tested in one of the following frequency ranges: 500, 1000, 2000, 3000 or 4000Hz

Eligible TRICARE beneficiaries will receive all medically necessary and appropriate services and supplies, including hearing examinations administered by authorized providers that are required in connection with this benefit. The TRICARE Beneficiary Handbook indicates that eligible beneficiaries who suspect they or a family member may have a hearing loss should schedule an appointment with their primary care manager or medical provider for an examination. Beneficiaries will then be referred to an audiologist for any necessary tests.

New Health Benefit for Academy Members

The American Academy of Audiology has launched a brand new health program exclusively for members. As the cost of insurance continues to escalate for individuals and companies, it will be to your benefit to use the Academy’s health, life, long term care, disability and critical illness coverage for you, your family and your employees. By using our association health program, you can use the buying power of the Academy to receive lower rates, special underwriting consideration for pre-existing conditions, and to enroll in plans available only to members. Once you sign up for an Academy health or benefit program, your coverage cannot be canceled or rates increased due to medical conditions.

Contact the Academy’s health and benefit programs office and let them help you design better coverage and make cost cutting recommendations that will allow you, your family, and your employees to continue their coverage into the future. The Academy’s health programs will allow you to tailor a plan to meet your needs and budget without sacrificing quality insurance protection. For questions or more information please contact the Academy’s health and benefit programs office by emailing info@associationpros.com or calling (888) 450-3040. You can also check out their website at http://www.associationpros.com/assoc/AUDIO/.

PASSAGES

The Academy Board of Directors approved the following Fellows for Life Membership: Henry Tobin & Carolyn V. Young

Linda Hood, PhD, recently accepted a position at Vanderbilt University where she is Professor, Department of Hearing and Speech Services and Associate Director of Research at the National Center for Childhood Deafness and Family Communication. Hood, a past-president of the Academy, was a research audiologist at the Kresge Hearing Research Laboratory at LSU Health Sciences Center in New Orleans since 1982.

Tamala Bradham, PhD, has been appointed Assistant Professor in Clinical Research and Associate Director of Clinical Services at the National Center for Childhood Deafness and Family Communication at the Vanderbilt Bill Wilkerson Center in Nashville, TN. Bradham holds a PhD from the University of South Carolina.

William Dickenson, AuD, is the Hearing Aid Product Line Manager and Assistant Professor of Hearing and Speech Sciences at the Vanderbilt Bill Wilkerson Center in Nashville, TN. Dickenson completed his AuD at Central Michigan University in 2004.

Patrick Murphy, MA, Research Audiologist with Sonic Innovations in Salt Lake, UT, passed away suddenly in August from a heart attack. Murphy received his MA from SUNY in 1995. In addition to his passion for audiology, Murphy was a musician who played saxophone with several small group bands during recent Academy conventions.

Maurice “Ed” Popejoy, MA, passed away September 1, 2005 at his home in Yorba Linda, CA. Popejoy, a 1972 graduate of Cal State University Long Beach, was well known and respected in the Southern California audiology community. Ed worked in a variety of settings throughout his career, including Rancho Los Amigos National Rehabilitation Center; private practice; the House Ear Clinic in Los Angeles; and finally with HEARx in Fontana, CA.

Richard Krug, PhD, a retired professor of Audiology from the University of Colorado (Boulder), passed away in May 2005 at the age of 83. Krug received his MA in audiology at Northwestern University in 1951 and his PhD from the University of Oklahoma in 1960. In 1951, he was the first clinical audiologist of the newly formed Bill Wilkerson Hearing and Speech Center in Nashville, TN. Krug taught in the Department of Speech, Language and Hearing Sciences at the University of Colorado from 1963 until 1987 and served as chairperson for seven years. His areas of interest were in the provision of services for deaf individuals and forensic audiology to industries involved in hearing conservation.

Richard Dickerhoof, AuD, passed away at age 59 in September 2005 in Canton, OH. A graduate of Kent State University, Dickerhoof earned his AuD in the Pennsylvania College of Optometry Doctoral of audiology program. Dickerhoof worked for the past 20 years in an ENT office following a stint with the Stark County Department of Education.
NCRAR Hosts Aging Conference

The VA National Center for Rehabilitative Auditory Research (NCRAR) held their second international conference titled, “The Aging Auditory System: Considerations for Rehabilitation.” The meeting was held in Portland on September 22-23 with a focus on the necessary relationship between clinical research and clinical practice. A committee composed of Elizabeth Paffenroth-Leigh, Nancy Vaughan, James Jerger, Terry Wiley and Sandra Gordon-Salant helped select subject topics, speakers, scholarship winners and reviewed poster proposals. The meeting was organized by Gaby Saunders, Carolyn Landsverk, Nancy Vaughan and Elizabeth Leigh-Paffenroth with support from the Portland Veterans Affairs Medical Center, the VA’s Office of Research and Development and the Rehabilitation Research and Development Service.

The invited faculty included Moe Bergman, Emeritus Professor at the Sackler School of Medicine of Tel-Aviv University, who presented the keynote address, “The Oldest Old: New Responsibilities for Us?” Other featured speakers included Jack Mills, James Jerger, Sandra Gordon-Salant, Arthur Wingfield, Kathy Pichora-Fuller, Pamela Souza and Therese Walden. Some 200 registrants participated in the conference in which each session was followed by a lively question and answer panel discussion moderated by Stephen Fausti, Director of the NCRAR. The proceedings of the conference are to be published in a future issue of Seminars in Hearing.

Harry Levitt (left) provided the introduction for NCRAR Keynote Speaker, Moe Bergman.

Sandra Gordon-Salant described her research projects in speech perception and auditory temporal processing in elderly listeners.

A panel discussion featuring (from left) James Jerger, David Lilly, Sandra Gordon-Salant and Terry Wiley.
AuD Student Delivers Audiologic Services to Nigerian Armed Forces

An exemplary AuD student at Central Michigan University, Irene Okeke, takes classes online from her home in New Jersey, interrupted routinely by her travels to Nigeria to set up the country’s first audiology center. A native of Nigeria and a US citizen, she travels to spread the good news about hearing and health care. In addition, she has a private practice in Maplewood, New Jersey, is married and has five children. Since the Nigerian Army Audiological Center was commissioned in 1998, news about it has spread on national television and in newspapers. The center is the first one of its kind in the West African sub-region. Okeke serves as the Center’s director and has embarked on challenging projects to screen hearing within the Nigerian army, air force, navy and civilians as well as creating awareness about hearing health care. The center provides complete audiological evaluations, including ENGs, OAE, ABR measurements, ear mold fabrication and hearing aid fitting and repairs. She travels back and forth to Nigeria on a regular monthly basis. Her future plans include trying to improve newborn hearing screening, hearing conservation practices and developing curriculum to train audiologists in Nigeria. Although the word ‘audiology’ was alien to Nigerians, she is working to make it a common word, especially in the military environment. Audiology has transcended from the United States to a developing country like Nigeria and has changed the lives of many in hearing health care. Okeke holds an undergraduate degree in zoology from Rutgers University and a master’s degree in audiology from Montclair State University, both in New Jersey.

Deafness in Disguise: Concealed Hearing Devices of the 19th and 20th Centuries

The Washington University School of Medicine Bernard Becker Medical Library announce the release of a revised digital exhibit, Deafness in Disguise: Concealed Hearing Devices of the 19th and 20th Centuries, at www.beckerexhibits.wustl.edu/did/index.htm.

Deafness in Disguise features historic hearing devices that were hidden as everyday items during the 19th and 20th centuries, rare books on speech and hearing and related archival material. Created for viewers of all ages and backgrounds—from the layperson to the scholar—this revised exhibit combines images of hearing devices, rare books, photographs, illustrations, advertising literature and patents to provide a unique glimpse into the history of deafness and hearing impairment.

The Deafness in Disguise digital exhibit contains nearly 300 additional digital images of hearing devices and archival material, and includes new sections such as Marketing of Hearing Devices, a Timeline, an Image Gallery, and a Resource section. The Deafness in Disguise digital exhibit was executed through a retrospective metadata grant project funded from the federal Institute of Museum and Library Services through the Library Services and Technology Act administered through the Missouri State Library. In addition, a physical exhibit is located in the lobby of Washington University School of Medicine Bernard Becker Medical Library. For more information contact Barbara Halbrook at halbrookb@msnotes.wustl.edu or 314.362.2786.

POSITION STATEMENT ON AUDIOLoGY ASSISTANTS CURRENTLY UNDER REVIEW

The Academy’s newest Position Statement on the Audiologist’s Assistant has been posted in the Academy Documents area of www.audiology.org and is ready for review and comment. Please take time to read the statement and e-mail your comments to Craig Newman at newmanc@ccf.org or mail them to the national office: American Academy of Audiology, Attn: Sydney Davis, 11730 Plaza America Drive, #300, Reston, VA 20190.

If you would like to have this Position Statement mailed to you for review, please call Sydney Davis at the National Office at 1-800-222-2336, ext. 1033 or by e-mail at sdavis@audiology.org. All comments and suggestions must be received by December 15, 2005.
**THE TWELVE DAYS OF CHRISTMAS**

(As Seen Through The Eyes of an Audiologist)

**Monica Grant, AuD**

**Champaign, IL**

**ORIGINAL VERSION**

12 drummers drumming
11 pipers piping
10 lords a-leaping
9 ladies dancing
8 maids a-milking
7 swans a-swimming
6 geese a-laying
5 golden rings!
4 calling birds
3 French hens
2 turtle doves
And a partridge in a pear tree.

**AUDILOGISTS’ VERSION**

12 eardrums drumming
11 codes for typing
10 tones a-beeping
9 ladies dizzy
8 aids a-squealing
7 circuits dimming
6 geezers waiting
5 E-A-R rings!
4 spondee words
3-color pens
2 sterile gloves
And a cartridge in an HP.

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**Starkey Hearing Foundation’s Gala**

The Starkey Hearing Foundation held its annual “So the World May Hear” Awards Gala on August 20 in St. Paul, Minn., and raised a record $4.5 million. The event, which annually recognizes individuals for their significant humanitarian contributions, this year honored Garth Brooks’ Teammates for Kids Foundation, the late Olive Osmond, founder of the Children’s Miracle Network, the Wayne Gretzky Foundation, and the Richard Schulze Family Foundation. The spectacular evening included performances by Trisha Yearwood, singer/songwriter Michael Bolton, and pop and stage performer Donny Osmond. The Starkey Hearing Foundation graciously thanked the more than 1,500 attendees and the corporate sponsors that made the evening possible. Since 2000, the Foundation has provided more than 115,000 hearing aids throughout the world.

—Submitted by Sugata Bhattacharjee

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**“Phonak U”**

The second annual meeting of “Phonak U,” an educational conference held exclusively for students in residential AuD programs, was held at Phonak’s US Headquarters in Warrenville, Illinois. This year, 275 AuD and PhD students, representing 51 graduate programs from across the US. The program was designed to augment the experience gained in their educational programs and clinical rotations through a series of lectures, workshops, and “hands-on” experience with hearing aids, FM systems and real-ear measurement equipment.

Students were able to customize their experience by creating their own program schedule by selecting from the array of course offerings. The interactive format also included lectures given by a distinguished group of Phonak employees and guest faculty, including David Fabry, Barry Freeman, Alan Freint, Patricia Gans, Richard Gans, Ron Gleitman, Gyl Kasewurm, Sergei Kochkin, Catherine Palmer, Paul Pessis, Joseph Smaldino and Robert Sweetow.

A wide variety of educational topics were covered, including an extensive offering of adult and pediatric amplification topics, sessions on vestibular diagnosis and treatment, aural rehabilitation, cerumen management, forensic audiology, ethics and practice development. In addition, students participated in “role play” exercises designed to simulate real-world interactions, discussed interviewing skills, professional issues, and had the opportunity to improve their earmold impression and modification, hearing aid programming and clinical verification skills.

—Submitted by David Fabry
The International Evoked Response Audiometry Study Group (IERASG), founded by Hallowell Davis in 1967, held its 19th biennial symposium for the first time in the Caribbean, on the tropical island of Cuba. More than 140 clinicians, scientists, and students, from 24 different countries, working in the field of objective hearing assessment with brain physiological measures, met from June 12-16 in Havana. The 2005 Havana meeting combined advanced topics and cutting edge information in hearing science in a wide range of topics from basic research to more clinical and applied studies, with a number of social activities. The free running Mojito (rum-based) cocktails and the wonderful Cuban music contributed creating a warm and cordial atmosphere among participants to facilitate scientific interchange. The scientific program was supplemented with excursions to “Las Terrazas” coffee mill, the San Juan River and a visit to Old Havana.

The meeting opened with the Hallowell Davis Memorial Lecture delivered by R. Carlyon from the MRC Cognition and Brain Sciences Unit in the United Kingdom. It was followed by a number of original contributions and lively discussion on the topic of cochlear implants, brain plasticity in deaf and deaf-blind subjects, retrocochlear hearing losses, and auditory neuropathy. Other keynote presentations were delivered by T. Picton, of the Rotman Research Center in Toronto, “The Quest for an Objective Audiogram” and David Stapells, from the University of British Columbia, who spoke on “The Use of Auditory Evoked Potentials in Conductive Hearing Loss.” A hot topic for discussion was on the advantages and caveats of a new technique for objective hearing assessment: the fast rate (70-110 Hz) ASSR. There was much debate on technical aspects of evoked response audiometry, such as calibration and types of stimuli, AEP extraction methods, automatic detection and objective evaluation of hearing aids in the workshop presented by E. Laukli, R. Thornton, M. Don and S. Purdy.

The finale of the scientific program was a round table presentation, “Towards a comprehensive hearing screening protocol,” where speakers discussed many issues such as the measures of screening performance (M. Hyde, Canada), the challenge to get an appropriate evidence base (A. Davis, UK), the techniques used for the characterization of the residual hearing (B. Cone-Wesson, USA), the need to adapt screening protocols to local constraints as in the Middle East experience (H. Pratt, Israel) and the 20-year long term outcome of the Cuban hearing screening program (M.C. Perez Abalo, Cuba). The latter event was also an excellent opportunity to share with the scientific community the results of both clinical audiology and hearing research in Cuba, as well as the importance of technology (software and hardware) development.
Classified Ads

Illinois
Assistant Professor, Audiology: Tenure Track
Illinois State University • Normal/Bloomington

The Speech Pathology and Audiology Department invites applications for a nine-month Tenure Track Faculty Position beginning August 15, 2006. The department has a newly established Doctor of Audiology program that will begin Fall 2006. The position requires an earned Doctoral degree or the candidate to reasonably expect to complete their doctorate by August, 2006, CCC-A, and eligibility for Illinois licensure. Responsibilities include undergraduate and graduate teaching, research and service. All areas of expertise will be considered. Priority areas include electrophysiology, diagnostic evaluation, and amplification.

Initial Review of Applications will begin January 15th, 2006 and continue until the position is filled. To assure full consideration, please submit a letter of application, curriculum vita, graduate transcripts and three letters of recommendation by January 15, 2006 to: Walter J. Smoski, Ph.D., Department of Speech Pathology and Audiology, Campus Box 4720, Illinois State University, Normal, IL 61790-4720. Illinois State University is an equal opportunity/affirmative action university encouraging diversity.

Research Audiologist

Widex Office of Research in Clinical AmplificationWidex Office of Research in Clinical Amplification (Lisle, IL) has an immediate opening for a research audiologist / scientist. Reporting to the Director of Audiology, your responsibilities include providing audiological research for the benefit of hearing impaired individuals in addition to supporting the company’s product line.

This position would entail research and development of amplification systems; assisting in the design, data collection and documentation of research studies; and developing and refining rehabilitation and outcome measure protocols. A PhD in Audiology, Hearing Science, Engineering, Behavioral Science, or related field is required. Clinical experience is not required.

All responses will be viewed with the strictest of confidence. Kindly forward all resumes, cover letters with salary requirements to: Francis Kuk, PhD, Widex Office of Research in Clinical Amplification, 2300 Cabot Drive, STE 415, Lisle, IL, 60532. gsanti@widexmail.com

Widex is an equal opportunity employer. We are committed to providing equal opportunities for employment and advancement without regard to an individual’s race, religion, national origin, age, sex, sexual orientation, marital status, disability, or any characteristic protected by local, state, or federal law.

Ohio
Assistant/Associate Professor of Audiology

The University of Akron seeks qualified applicants for Assistant/Associate Professor of Audiology. Duties: teaching doctoral and undergraduate students in classroom, serving as a clinical preceptor for doctoral students, advising, providing institutional service, engaging in personal research, facilitating student research. Qualifications: earned doctorate in Audiology, eligibility for Ohio licensure; ASHA CCC; experience in classroom and clinical teaching; record of scholarly activity. To apply: Send letter of intent, resume, and three reference letters to Audiology Search, attn. Dr. Sharon Lesner, School of Speech-Language Pathology and Audiology, Akron, Ohio, 44325-5001. Information: Lesner@uakron.edu.

Review of applications begins Nov. 30, 2005, and continues until position is filled.

New Zealand
Audiologist Position in New Zealand

Audiology at ACH is fun! Our Cochlear Implant team is growing and we are seeking an experienced Audiologist to provide services to children who are deaf or hard of hearing. Our program uniquely incorporates child, family, audiologists, speech pathologists, social workers and physicians in a coordinated effort to help every child reach his or her full potential.

• Prior cochlear implant and pediatric experience required. Ph.D. or Au.D desired.
• Ability to work with multiple implant devices and various programming strategies needed.
• Primary focus on younger implant candidates and recipients.
• Secondary interest in Educational Audiology, Research or other compatible area preferred.

We are located at the top of the South Island, surrounded by mountains and the sea with a variety of opportunities available to those who enjoy outdoor activities. We are keen to work with an individual who displays enthusiasm for excellent service and who would enjoy playing a key role in our small team.

Applications from Full Members of an Audiological Society would be welcome.

Jill Beech MNZAS, Hearing Professionals Limited, 24 Nile Street, Nelson, NEW ZEALAND, Phone: (+64 3) 548 2323, Fax: (+64 3) 548 2324, Email: hearing@paradise.net.nz

For more info, visit our website at www.mayoclinic.org

Audiologist

Mayo Clinic in Rochester, MN, is looking for an experienced audiologist to join our large and expanding audiology practice. An exceptional career opportunity exists for the selected candidate to work in a clinical setting with children and adults. Applicants should have in-depth knowledge and clinical skills, excellent communication skills, and a strong desire to succeed. The audiologist will be part of a team of professionals who provide quality health care services in diagnostics, newborn hearing screening, vestibular/balance assessment, and hospital services. The audiologist will assume and manage a full and varied caseload of patients of all ages, participate in quality improvement programs, and continually update procedures to maintain a best practice program.

To qualify for this position, individuals must possess a graduate degree in Audiology and have a minimum of 1-2 years’ experience in audiology. Must meet requirements for Minnesota State Audiology Licensure. Mayo Clinic provides a competitive compensation package including salary, health benefits, vacation, professional travel, relocation, and tuition reimbursement.

To apply or for more information about Mayo Clinic and Rochester, MN, please visit http://www.mayoclinic.org/jobs-rst and reference job posting #52921. Please submit a cover letter and resume to be considered for the position.

Mayo Clinic
Becky Stolp - Human Resources
200 First Street SW, Rochester, MN 55905
E-mail: stolp.becky@mayo.edu

Imagine... Seeing smiles like this every day.
Imagine... Changing children’s lives
Imagine... A career at Arkansas Children’s Hospital

Audiologist (Cochlear Implant)

Audiology at ACH is fun! Our Cochlear Implant team is growing and we are seeking an experienced Audiologist to provide services to children who are deaf or hard of hearing. Our program uniquely incorporates child, family, audiologists, speech pathologists, social workers and physicians in a coordinated effort to help every child reach his or her full potential.

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• Secondary interest in Educational Audiology, Research or other compatible area preferred.
• Independent thinker who loves kids and is motivated by working with families.
• Offers incredible possibilities for professional growth in a fun, energetic clinical atmosphere with 24 speech and hearing professionals.

Arkansas Children’s Hospital
Audiology Department
800 Marshall Street, Little Rock, AR 72202
Patti Martin: email: martinp@archildrens.org

For information about our employment website, HearCareers, visit www.audiology.org/hearcareers. For information or to place a classified ad in Audiology Today, please contact Elizabeth Hargrove at ehargrove@audiology.org or 1-800-AAA.2336 ext. 1039.

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Audiology Today

The University of Akron seeks qualified applicants for Assistant/Associate Professor of Audiology. Duties: teaching doctoral and undergraduate students in classroom, serving as a clinical preceptor for doctoral students, advising, providing institutional service, engaging in personal research, facilitating student research. Qualifications: earned doctorate in Audiology, eligibility for Ohio licensure; ASHA CCC; experience in classroom and clinical teaching; record of scholarly activity. To apply: Send letter of intent, resume, and three reference letters to Audiology Search, attn. Dr. Sharon Lesner, School of Speech-Language Pathology and Audiology, Akron, Ohio, 44325-5001. Information: Lesner@uakron.edu.

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Arkansas Children's Hospital
Audiology Department
800 Marshall Street, Little Rock, AR 72202
Patti Martin: email: martinp@archildrens.org

For information about our employment website, HearCareers, visit www.audiology.org/hearcareers. For information or to place a classified ad in Audiology Today, please contact Elizabeth Hargrove at ehargrove@audiology.org or 1-800-AAA.2336 ext. 1039.
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