Vigo gives you all of this and more. With two full product lines at two distinct price points, Vigo and Vigo Pro totally redefine what you can offer patients looking for a mid-priced hearing solution.

For more information please call 1-800-526-3921 or visit www.oticonusa.com.
MORE of what you’re looking for in a mid-priced hearing solution.

MORE sound quality. MORE performance. MORE simplicity. Vigo gives you all of this and MORE. With two full product lines at two distinct price points, Vigo and Vigo Pro totally redefine what you can offer patients looking for a mid-priced hearing solution.

For more information please call 1-800-526-3921 or visit - www.oticonusa.com

Now for all degrees of significant hearing loss.
Get the power to change life: www.naida.phonak.com

New iView
Clear status information
at the push of a button
for parents and caregivers
The “D” Word: An Interview with Marlee Matlin
Actress Marlee Matlin sits down with AT to discuss a variety of topics, including her recent stint on the television show Dancing with the Stars, her role in the movie Sweet Nothing in My Ear, plus her status as a role model for the deaf and hard-of-hearing community.

BY DAVID FABRY, PHD

A Recommended Protocol for BAHA Assessment and Verification for Individuals with Single-Sided Deafness
While the BAHA has proved to be a promising form of treatment for single-sided deafness (SSD), its inception in 2002 resulted in a new dilemma: determining a way to evaluate, fit, and verify the instrument to ensure efficacy in the treatment of patients. This article describes a clinically feasible protocol for audiologists who provide evaluations of patients with SSD.

BY HILLARY SNAPP, AUD, AND FRED TELISCHI, MD

Enhancing Patient Care and Professional Relationships Through Personality Assessment
Learn more about adapting your personality style to situations and striving to respect and understand another’s point of view. For a clinical practitioner, this can play a major role in enhancing your relationship with colleagues, retaining your patients, increasing your career possibilities, and building a successful practice.

BY MICHAEL J. SIMPSON

Bioacoustics and Canine Audiology Clinic
AT managed to get Peter Scheifele, director of the Facility for the Education and Training of Canine Hearing and Laboratory for Animal Bioacoustics (FETCH LAB) at the University of Cincinnati, to “sit and stay” for a discussion on his vision for the program that links audiology to veterinary medicine.

BY DAVID FABRY, PHD

Remember, the first 20 Academy members to find the 20th Anniversary logo on the cover of this issue and e-mail the location to publications@audiology.org will receive a $20 gift certificate to the Academy Store.
Previous winners of this contest or any other 20th Anniversary contest are ineligible to win again. Entries must be received by August 1, 2008.
Why sell other batteries, when you can sell your own?

How do you make some of the most powerful batteries on the market even more powerful?

By putting your name on them. Once your customer tries our top-of-the-line Varta Micro Batteries, they'll settle for nothing less. And, with just a 10-carton order, we can imprint your logo, address and phone number on each package. So, when your customer needs a refill, you know where they'll be headed. Sell the two biggest names in batteries. Varta. And yours.
The American Academy of Audiology promotes quality hearing and balance care by advancing the profession of audiology through leadership, advocacy, education, public awareness, and support of research.

BOARD OF DIRECTORS

PRESIDENT
Patrick Feeney, PhD
University of Washington
pfeeney@uw.edu

PRESIDENT-ELECT
Kris English, PhD
University of Akron
ke3@uakron.edu

PAST PRESIDENT
Alison Grimes, AuD
UCLA Medical Center
agrimes@mednet.ucla.edu

BOARD MEMBERS-AT-LARGE

Bopanna B. Ballachanda, PhD
Premier Hearing Centers
b.ballachanda@comcast.net

E. Kimberly Barry, AuD
Department of Veterans Affairs Medical Center
kimbar@kology.net

Deborah L. Carlson, PhD
University of Texas
dlcarlso@utmb.edu

Lawrence M. Eng, AuD
Golden Gate Hearing Services
lauauid@ghhs.com

Karen A. Jacobs, AuD
AVA Hearing Center
mjacobs@iserv.net

Gary Jacobson, PhD
Vanderbilt University Medical Center
gary.jacobson@vanderbilt.edu

Patricia Kricos, PhD
University of Florida
pkricos@csd.ufl.edu

Thomas Littman, PhD
Factoria Hearing Center
tom@facthear.net

Georgine Ray, AuD
Affiliated Audiology Consultants
gray838144@aol.com

Audiology Today (ISSN 1535-2609) is published bimonthly by the American Academy of Audiology, 11730 Plaza America Drive, Suite 300, Reston, VA 20190; Phone: 703-790-8466. Periodicals postage paid at Herndon, VA, and additional mailing offices.

The annual subscription price is $105 for US institutions ($125 outside the US) and $50 for US individuals ($65 outside the US). For subscription inquiries, telephone 703-790-8466 or 800-AAA-2336. Claims for undelivered copies must be made within four (4) months of publication.

Publication of an advertisement or article in Audiology Today does not constitute a guarantee or endorsement of the quality, safety, value, or effectiveness of the products or services described therein or of any of the representations or claims made by the advertisers or authors with respect to such products and services.

AMERICAN ACADEMY OF AUDIOLOGY MANAGEMENT

EXECUTIVE DIRECTOR
Cheryl Kreider Carey, CAE | ccarey@audiology.org

ASSISTANT EXECUTIVE DIRECTOR
Edward A. M. Sullivan | esullivan@audiology.org

SENIOR DIRECTOR OF FINANCE AND ADMINISTRATION
Sandy Bishop, CPA | sbishop@audiology.org

SENIOR DIRECTOR OF GOVERNMENT RELATIONS
Phil Bongiorno | pbongiorno@audiology.org

SENIOR DIRECTOR OF EDUCATION
Victoria Keetay, PhD | vkeetay@audiology.org

SENIOR DIRECTOR OF MEETING SERVICES
Lisa Yonkers, CMP | lyonkers@audiology.org

DIRECTOR OF REIMBURSEMENT
Debra Abel, AuD | dabel@audiology.org

DIRECTOR OF INDUSTRY SERVICES
Shannon Kelley, CMP | skelley@audiology.org

DIRECTOR OF COMMUNICATIONS
Amy Miedema | amiedema@audiology.org

DIRECTOR OF EDUCATION AND STANDARDS
Megan Olek | molek@audiology.org

AAA FOUNDATION DIRECTOR OF DEVELOPMENT
Kathleen Devlin Culver, MPA | kc Culver@audiology.org

AMERICAN BOARD OF AUDIOLOGY MANAGING DIRECTOR
Sara Blair Lake, JD, CAE | slake@audiology.org

EDITORIAL MISSION
The American Academy of Audiology publishes Audiology Today (AT) as a means of communicating information among its members about all aspects of audiology and related topics.

AT provides comprehensive reporting on topics relevant to audiology, including clinical activities and hearing research, current events, news items, professional issues, individual-institutional-organizational announcements, and other areas within the scope of practice of audiology.

Send article ideas, submissions, questions, and concerns to amiedema@audiology.org.

Information and statements published in Audiology Today are not official policy of the American Academy of Audiology unless so indicated.

COPYRIGHT AND PERMISSIONS
Materials may not be reproduced or translated without written permission. For permission to photocopy or use material electronically from Audiology Today, visit www.copyright.com or contact the Copyright Clearance Center, Inc. (CCC) at 978-750-8400. CCC is a not-for-profit organization that provides licenses and registration for a variety of users.

© Copyright 2008 by the American Academy of Audiology. All rights reserved.
President’s Message

Charting a New Course for the Academy and Our Profession

THIS YEAR’S 20TH ANNIVERSARY OF THE AMERICAN Academy of Audiology is a wonderful opportunity to celebrate just how far we have come as a professional association and a profession. Twenty years ago James Jerger recognized that the time was right to launch an organization of, by, and for audiologists. As we reviewed our past at the general assembly at AudiologyNOW! in Charlotte, I was struck by the courage and wisdom of Dr. Jerger and his hearty band of founders. They recognized the unique opportunity presented to them when they acted to form the Academy. Over the last 20 years, the Academy has grown through its infancy and childhood and emerged as a dynamic association of approximately 11,000 members, served by an elected board of directors, an executive director, and a staff of over 30. During that time, the Academy has been a leader in the development of our doctoral-level profession on behalf of its members, the profession, and the patients we serve.

At our July meeting, your current board of directors, along with the Academy staff, will help the Academy take its first steps into our next 20 years. As is done in a three-year cycle, the board will review the current Academy strategic plan, take stock of what the Academy has accomplished over the past three years, sample the pulse of the membership with our membership survey, and chart a course for the future.

As we think about our future, one special interest of mine, which is an interest shared with many of our members, is that of research. We are a data-driven profession making clinical decisions based on the research evidence. It is critical for our profession to conduct research into better ways to diagnose, treat, and prevent hearing and balance disorders. This is not an exercise that we can leave to other professions, although we will clearly need to keep abreast of developments in related fields. Just as the Academy is of, by, and for audiologists, we must support research of, by, and for audiologists. To this end, Beth Prieve, chair of the Research Committee, is leading a discussion with her committee on ways in which the Academy may enhance its research focus. Examples of the ideas proposed include additional Academy research grant support, and increasing the interaction between researchers and clinicians to facilitate research collaboration.

The Academy Board of Directors has already started this process by approving the development of an Academy Research Conference (ARC), which will be an annual day-long conference on a given scientific theme that will emphasize translational research—taking research from the lab to the clinic. The Research Committee will select a theme for the annual ARC, recommend program chairs, and form an ARC Program Committee.

The theme of the inaugural ARC is “Otoacoustic Emissions: Improving Practice Through Science,” and will be held in Dallas, Texas, on Wednesday, April 1, 2009, the first day of AudiologyNOW! We are extremely pleased that Academy member Brenda Lonsbury-Martin, PhD, is serving as the program chair for the inaugural ARC. Brenda has formed a dedicated program committee that has recruited an amazing group of presenters. In addition to David Kemp, who discovered otoacoustic emissions, presenters will include Michael Gorga, John Guinan, Lynne Marshall, Beth Prieve, Christopher Shera, and Jonathan Siegel. Watch for information on registration and submissions for a poster session in a future issue of Audiology Today and at www.audiology.org.

As the Academy writes the next chapter in its history, I hope you will consider serving on an Academy committee. It is through the efforts of members like you that the Academy moves forward. Help us chart a course for the future of the Academy and our profession.
Passion – the deliciously small RIC hearing aid from Widex.
Staying Relevant for Audiologists
Like the Sands in an Hour Glass

THE PROFESSION OF AUDIOLOGY. THE AMERICAN Academy of Audiology. One exists because of the other. One is 50 years old. The other is 20. Approximately 11,000 audiologists choose one as their professional organization. How can the Academy remain relevant to this growing number of audiologists? With the beginning of a new fiscal year (July 1, 2008, FY09), it is especially timely to assess where the Academy is headed and how the Academy is serving audiology.

To answer this question, let’s begin with a brief overview of not-for-profit organizations. In the for-profit model, the owner, customer, and workforce are three separate populations. In an association, they are one and the same. For example, the Academy’s members are our Owners, Customers, and Workforce (Board/committees/task forces).

Unique to not-for-profits, governance (meaning “to steer” in Greek) maintains an effective balance among these three intertwined components. Therein lies the purpose of the 12 audiologists—the Board of Directors—elected by the Academy’s members: to steer, or set the strategic direction of the Academy. Among the duties of the Board of Directors is to select the co-leaders of the organization:

- Elect their representative—the president—to facilitate their meetings and speak on their behalf
- Hire an association professional—the executive director—to oversee the operations

Governance is further defined by the relationship of these two individuals. In essence, Patrick Feeney and I will co-pilot the Academy this year, each contributing a unique but necessary perspective to the leadership role. Given the time constraints of volunteering, the president changes annually. That means I have a new co-pilot each year, another factor inherent to not-for-profits.

The hourglass, I believe, is helpful in visualizing this governance structure. The professional needs and desires of audiologists are top and center. The board prioritizes them, setting the strategic direction of the organization on behalf of the profession. The staff lends their expertise while providing continuity and the association management base for the organization, as illustrated in the hour-glass model.

To gauge the Academy’s relevance for audiologists, we look to several measures and benchmarks for both the volunteers and staff.

STAFF—A recent survey of 600 associations (17% of which were health-care associations) indicated the following benchmarks when comparing the Academy with other associations of similar revenue:

- Our profitability and efficiency was equal to or higher
- We had fewer staff than others
- Our membership revenue was a smaller percentage of revenue
- Our educational revenue was significantly lower (a growth opportunity!)
CO-PILOTS—In June, President Patrick Feeney and I attended a symposium for the chief-elected officer and chief staff officer (offered by the American Society of Association Executives). This is helpful in differentiating the roles of governance from implementation.

BOARD OF DIRECTORS—Audiologists were invited to evaluate how the Academy is doing and share thoughts for the future by participating in a survey mid-May. The board will use that data when reviewing/updating the Academy’s Strategic Plan at the first board meeting in July to kick off the new fiscal year (Note: The strategic plan is systematically updated every three years).

The Academy’s leaders desire to govern effectively, so that the Academy is the voice of the profession of audiology. This is more readily realized when our members—the Academy’s owners, customers, and workforce—are engaged and fulfill their role by completing Academy surveys, serving on committees, etc. It is the delicate balance between volunteers and staff that will continue to keep the Academy’s programs and offerings to audiologists relevant...just as thousands of grains of sand sifting through an hourglass. AT

ENDNOTES

STRUCTURE

1,000 Audiologists/Members: vote for representation
12 Board of Directors: vote for one to speak for them
1 President (chief-elected officer)
1 Executive Director (chief staff officer): hires and directs staff
7 Senior Directors: lead clusters/program areas
34 Total Staff

FUNCTION

Audiology/professionals
Governance
Volunteer expertise/time
Serve 1–3 years and rotate off
Set vision, goals, and objectives
Committees process new ideas
Association management professionals
Operation/management
Paid for time/expertise
Provide continuity and foundation of organization
Strategic implementation to achieve goals
Staff manages new initiatives

A New Day, A New Way

LET’S PLAY A QUICK GAME OF WORD
association—what is the first thing that you think of when I say “baseball”? Many people might say “summer,” “ballpark,” “glove,” or “steroids” (at least these days). However, most audiologists will either say “hot dog” or “cowboy,” because we tend to view things in a different fashion than the rest of the population. If I say “frequency,” most will say “intensity,” or “bone conduction” follows “air conduction,” and so on.

For the past 17 years, Audiology Today has been synonymous with “Jerry Northern,” and he has served as editor, art director, Web site editor, unofficial Academy historian, and one of our greatest professional diplomats. In fact, no one in their right mind would ever attempt to follow in his footsteps. That said, no one has ever accused me of being rational, so it is with great enthusiasm that I begin my term as content editor of Audiology Today with this issue. It is testimony to Jerry’s capabilities and the Academy’s growth during the past two decades that it takes several people (a village, really) to fill his shoes, and in fact you will see that he will retain the role of editor emeritus, providing articles and input of historical perspective.

Amy Miedema serves as executive editor, and her team includes some new and some familiar names who will attempt to build on the legacy that Jerry has established for the magazine of providing something useful for every audiologist in each issue—regardless of whether you are a clinician, researcher, or teacher. We hope that you will continue to enjoy Audiology Today, and we invite you to submit your ideas and suggestions. Please e-mail me at dfabry@audiology.org with your thoughts—I look forward to hearing from you!
The Audiology Now! 2008
Reviews are in!

“A new day in Hearing Healthcare!”

“Truly amazing..... you have finally done it!”

“An invention of this magnitude does not happen overnight. Congratulations!”

“Now I can standardize all of my offices. Say hello to SpeechPro!”

“You have finally closed the loop. We have dreamt of this day for years.”

“This is certainly the end of the road for manufacturers first guess programs.”

“Soon, students will be learning SpeechPro, while RECD will be relegated to history.”

MAGNATONE
PERFECTION IS POSSIBLE!

800.789.6543  MAGNATONE.COM
U.S. & International Patents Pending
An Interview with
Marlee Matlin
BY DAVID FABRY
(AT) sat down with actress Marlee Matlin to discuss a variety of topics, including her recent stint on the television show *Dancing with the Stars*, her movie *Sweet Nothing in My Ear*, and her status as a role model for the deaf and hard-of-hearing community.
Many people are familiar with you from Dancing with the Stars, Law and Order, or West Wing, but some might be surprised to know that you are also the youngest recipient of the Academy Award for Best Actress in a Leading Role for Children of a Lesser God. What was it like to win such a prestigious award for your first major acting role? Did it subsequently place undue pressure on you for future roles?

At the time, I wasn’t really mindful of the importance of such a distinction. Being only 21 and having just moved away from home for the first time, I was so new to Hollywood. I think the importance of being honored in such a fashion struck me the following year when I was asked to present the award for Best Actor to Michael Douglas. It was as if I had entered a very exclusive club—people nodded in recognition and reporters asked me very serious questions. It was as if I was watching a movie of a Hollywood actress being welcomed back to the Oscars, but it was me! And I was under double the amount of pressure for future roles. First, because every Oscar winner seems to have the responsibility of following the Oscar-winning role with something as suitably prestigious (rarely happens!) and, second, the fact that critics proclaimed my victory as a result of a pity vote and that I wasn’t really worthy of the recognition because they thought I was a deaf person playing a deaf role so how could that be considered “acting?”

It was tough going for me, but fortunately I had the help of friends like Henry Winkler and Whoopi Goldberg, both of who defied expectations themselves and who went on to achieve success. It was a matter of just plowing forward despite what people thought I could and couldn’t do, just as when I was a kid. Thank goodness I was well prepared to “fight.”

In Children of a Lesser God, the character you played—Sarah Norman—was a rebellious and troubled young woman who experiences many changes after meeting an inspirational teacher, played by William Hurt. I know that your family and educational situation growing up in Illinois was entirely different, but did you draw on any of your own experiences for the movie?

Sarah and I couldn’t have been more different in terms of our upbringing or our approach to life. Whereas Sarah was rebellious, refused to speak, had a difficult relationship with her mother, and was distrustful of people who didn’t sign, I was not. I enjoyed speaking and signing growing up, had a normal childhood that wasn’t marred by too much rebelliousness (though like any teenager, I was a bit of a drama queen, but who isn’t in their teen years? Ha!), and I had a close and loving relationship with my family. What I did draw from my own upbringing and what I did use in the movie was the spirit of independence that my parents gave me. Sarah was as independent as they come and was never afraid to speak her mind. That was pretty much who I was growing up, so in that way, we were alike.

What inspired you to become an actress? Was there a signature moment when you realized that this was your destiny?

I got the bug when I was very young—7 years old! It was when my mother and camp counselors invited me to sign a song in sign language on stage at summer day camp. There I was doing my thing and people were smiling and applauding me! It was like the little stories I used to tell in front of the bathroom mirror but this time people were giving me praise! I was instantly hooked. As for the inspiration, I probably will say that it was the fact that I was deaf and had to create my own way of expressing myself that inspired me to act. Sitting at a mirror and telling stories to characters who mysteriously signed back was a great way to keep myself entertained. It eventually made sense since acting was the best way to express myself.
AT: I have to confess to being quite a fan of your work; I have seen most of your movies and television appearances, including your role as Joy Turner’s attorney in My Name Is Earl, the lip-reading Laura on Seinfeld, and the movie What the Bleep Do We Know. It really represents a wide range of dramatic and comedic roles—do you have a favorite?

MM: Children of a Lesser God is always my favorite because it was my first film, but I must say that every time I do something new, I proclaim it my “favorite.” I loved Seinfeld, I loved My Name Is Earl. I also loved Picket Fences and The West Wing. And I loved doing The L Word and Dancing with the Stars. Now ask me about the stuff I didn’t enjoy doing or that I’d rather you not see and there’s a small list there too. There were times when I just had to work and couldn’t be too choosy about the films that I did. Fortunately, they were films that didn’t get a great deal of exposure and which were relegated to the $2 DVD bins at Kmart! Haha!

AT: You are such an inspiration to many people with hearing loss—did you ever feel, however, that Hollywood wanted to compartmentalize you into the role of “deaf” or “hard-of-hearing” actress, rather than an Academy Award-winning actress who happens to have a hearing loss? If so, was it difficult to overcome this stereotype?

MM: Hollywood compartmentalizes all actors. It’s something that I’ve heard from my friends like Whoopi Goldberg and it happens to anyone who floats somewhere outside the mainstream. It’s a stereotype I have to work on overcoming every day, but I don’t let it consume me or identify me. I’ve been fighting stereotypes all my life and it’s just another part of who I am. The trick is balancing overcoming stereotypes and achieving success by putting yourself out there regardless of what people think. I believe people would rather see positive things from me than negative so I work on emphasizing what I can do despite what some think I cannot.

AT: In addition to achieving professional success, you are also mother to four children. I remember in Children of a Lesser God that your character wanted to have deaf children, and I have encountered patients over the years who felt the same way. At the time, this was quite a controversial element of the movie—that the mainstream views deafness as a “disability” to be avoided or “repaired.” Some people that I knew had a hard time understanding why anyone would prefer deaf over hearing. How do you deal with that kind of attitude and ignorance?

MM: Everyone has a right to his or her opinion and preference. It doesn’t mean that we have to like it or have to deal with it. There will always be this attitude about deaf people as long as...
hearing people are in the majority. It’s just the nature of majority/minority dynamics. All I can do, as an actor who happens to be deaf, is show people that whatever “handicap” they think I have or that somehow I am “disabled” in some way, my success and my work prove otherwise. Doing Dancing with the Stars was one way of doing that. Yes, I’m deaf and, yes, I can dance. I was glad to have the opportunity each week to show that to 22 million people. I couldn’t have asked for a better venue!

AT: I have noticed that in some roles, you have used ASL, and in others you use your voice in addition. Is this a conscious choice, or do you receive guidance from directors and producers regarding their preference for the role?

MM: It’s a matter of the script dictating what mode of communication I use. In Sweet Nothing in My Ear, it was very clear that the character I played only used ASL and did not speak or use hearing aids. In The L Word and The West Wing, I played quite a different character, someone who moved between hearing and deaf communities independently and sometimes on her own. That dictated that the characters would have to sign and speak. It just depends on the character and sometimes the assessment comes from me and sometimes it comes from the writers, directors, or producers.

AT: I know that you have been active with many philanthropic organizations, including the Starkey Hearing Foundation, which was featured on Dancing with the Stars. I know that you also serve on the Gallaudet University Board of Trustees. Do you find it difficult to find a balance between representing the “hearing” and “deaf” communities?

MM: I’ve always moved between both the hearing and deaf communities and have no problem supporting charities that have hearing and/or deaf perspectives. I know that some members of the deaf community might find this problematic and sometimes I’ve even been criticized from hearing people for being too deaf. But that’s who I am. As I told myself many years ago, I would never back down from what I believe in. If people have a problem with it, that’s unfortunate. I do my best to balance between the two. In the end, I think much more can be accomplished if we strive to bring the communities together rather than talk about how different we are. I am deaf; I cannot deny it. I love, embrace, and live deaf culture. But I live in a hearing world, too, and know that there are all sorts of perspectives out there that I must understand if any sort of progress toward mutual understanding is to be made.

AT: Which do you prefer: movies, television, or stage? Why?

MM: I prefer movies and television over stage only because at this point in my life, stage work in New York would be problematic having four kids and family in LA. As for movies and
TV, it all depends where! Working on a film for three months in South Africa would not be my idea of great job—too far and too long away from the family! At the end of the day, it’s really about the script and the work. If it’s good, I like it whether it’s TV or film. I enjoy working, period.

AT: OK, on to Dancing with the Stars (DWTS)—why did you decide to be on the show?

MM: Because it was there, as the cliché goes. No one in Hollywood was probably going to cast me in a musical, where I would dance, and yet I would have loved to had the chance. I love dancing. So why not accept the invitation to dance when it came in? It’s the second most popular show on TV these days behind “American Idol,” and you know I’d not soon be on that show! Ha!

I’ve always said work for me is about challenging myself, breaking through barriers but also about having a good time. And Dancing with the Stars was just that. It was also about having the chance to show a side of me that people probably would have never seen. In the end, my family loved that I did the show and my kids thought I was the coolest mom for having participated.

MM: The dancing I did in Children of a Lesser God was not really dancing. It was improvised movement in a small Italian restaurant. Hardly what I would call dancing. I’ve danced at weddings and Bar Mitzvahs and have done some grooving at clubs in my younger days. I’ve always had a good sense of rhythm. But I never had any professional dance training or experience. I was completely clueless when it came to ballroom and Latin dancing when I arrived at my first rehearsal on DWTS.

AT: I know that you did some dancing in Children of a Lesser God, but did you have any other professional dance experience prior to DWTS?

MM: The dancing I did in Children of a Lesser God was not really dancing. It was improvised movement in a small Italian restaurant. Hardly what I would call dancing. I’ve danced at weddings and Bar Mitzvahs and have done some grooving at clubs in my younger days. I’ve always had a good sense of rhythm. But I never had any professional dance training or experience. I was completely clueless when it came to ballroom and Latin dancing when I arrived at my first rehearsal on DWTS.

AT: Which was more of a challenge on the show— hearing the music or mastering the footwork?

MM: Well, hearing the music was never going to be a challenge because being deaf just made it too difficult to follow along. It was more about mastering the footwork in time with my partner. I never used the music to dance. I used it to know when I should start to dance; I can hear that much. But 99 times out of 100 the music was just background for me and I depended on Fabian to be my music. That’s why I would chuckle to myself when I didn’t catch my steps correctly on my last two dances and they said it was because I was deaf. Not true. I didn’t catch my steps because I just lost track of my own feet. I never used the music to time my steps. I used Fabian. But it was easier to label my errors on the dance floor as being deaf and not hearing the music for hearing people. That’s okay.

I get it. I understood eventually that it was what they needed to hear to be able to understand that what I did was because of my “disability” rather than say it was just simple human error on my part.
to get in touch with what’s happening. But let me emphasize that I cannot rely on them entirely. They only serve to augment what I can see and perceive with my eyes and what I can use to assist what I know with my signs and my speech. And in terms of audiologists working with deaf people, my best advice is patience and appreciation for their preferred communication mode. Whether they sign or speak, a deaf person should be allowed to follow what they prefer works best for them. Too many lives have been broken and too many dreams have been shattered because of personal communication modes that have been forced upon people that didn’t want or understand them. My perspective is that all means to communicate work best as long as that at the end of the day, the deaf person’s needs, wants, and desires are not compromised.

**AT:** To that end, can you talk about what motivated you to add “successful author” to your list of accomplishments? Why did you decide to write the book, *Deaf Child Crossing?*

**MM:** I told myself when I was 11 that I’d like to write a book and tell the world it was okay to be deaf. It probably grew out of my own parents’ desire that nothing should be denied to me and that I should be treated like any child should be treated—with love and respect. It might have been that I was having a bad day with kids in the neighborhood or at school. Perhaps someone was making fun of my speech or my signs. In any case, since I was a fan of books and loved reading Judy Blume books, where adversity was openly discussed, I thought I could do the same thing about myself. It wasn’t until I was a mom that I thought it was the perfect time to write a book so that I could share these experiences with my children.

**AT:** Thank you for taking the time to talk with *Audiology Today*. It truly was a pleasure! **AT**

**ABOUT THE AUTHOR**

**DAVID FABRY, PhD,** is the content editor for *Audiology Today* and the chief of audiology at the University of Miami, in Miami, FL.
Join our team as an employee.
Help us achieve our mission: to make top quality hearing care accessible through our company-owned clinics in CA, FL, MA, MI, MO, NC, NJ, NY, OH and Ontario, Canada.

Flexible hours, high salaries and upward mobility make HearUSA a very rewarding company to work for. In fact, our employees rate us highest in job satisfaction & benefits.

So is working WITH us.

Or align yourself with a referral powerhouse.
Join the HearUSA Hearing Care Network – with over 1,600 participating independent audiology clinics. We contract with major managed care programs, health plans, employer groups & subscriber organizations to bring new patients into your practice.

With over 5 million covered lives, the HC Network represents significant growth potential for any independent operation.

TO LEARN MORE ABOUT EMPLOYMENT OPPORTUNITIES, CALL:
800.323.3277 x303
www.hearusa.com

TO LEARN MORE ABOUT NETWORK OPPORTUNITIES, CALL:
800.333.3389
www.hearusa.net

Working FOR us is great...
A Recommended Protocol for BAHA Assessment and Verification for Individuals with Single-Sided Deafness

BY HILLARY SNAPP AND FRED TELISCHI

The benefits of the BAHA over conventional amplification for individuals with SSD have been well established. However, the degree of benefit is individual-specific.
In recent years, there has been considerable anecdotal and clinical support for use of Bone Anchored Hearing Aids (BAHA) with patients who have single-sided sensorineural hearing loss. There is, however, no established protocol for determining candidacy, fitting methods, or expected outcomes for individual patients. We have established a clinically feasible protocol to assist in determining candidacy for BAHA implantation. The protocol is based on known auditory deficits experienced by individuals with single-sided deafness. Performance on speech-in-noise tasks (e.g., Quick SIN) are evaluated with and without the BAHA demonstration device in place. Performance is compared across varying conditions, and potential benefit is predicted by overall improvement in adverse listening conditions while wearing the demonstration device. Implications for the feasibility of using the BAHA protocol as a predictor of overall benefit prior to implantation will be discussed.

Rehabilitation of individuals with single-sided deafness (SSD) can be one of the most difficult challenges an audiologist encounters. For years, audiologists have struggled with helping their patients adapt to various assistive devices such as the CROS (Contralateral Routing of Signals) hearing aid. Despite persistent efforts, many find their patients rejecting treatment and resorting to relying entirely on the better hearing ear. Fortunately, in 2002 the implantable hearing device, BAHA, was approved for use in patients with SSD (U.S. Food and Drug Administration, 2002). While the BAHA has proved to be a promising form of treatment, its inception results in a new dilemma. Audiologists are now faced with the challenge of determining a way to evaluate, fit, and verify the instrument to ensure efficacy in the treatment of their patients.

Despite one normally functioning ear, individuals with SSD experience reduced ability to localize, reduced sound awareness, and difficulty communicating in adverse listening environments. These impairments result from the loss of subtle cues provided by binaural hearing (Palmer & Mueller, 2001). Since its approval by the FDA, the BAHA is increasingly becoming the standard form of treatment for people with SSD.

The BAHA uses bone conduction to transmit sound from the side of the non-functioning cochlea to the functioning cochlea, thereby attempting to restore the information obtained through binaural hearing. In recent years, there has been considerable anecdotal and clinical support for use of the BAHA with patients who have single-sided sensorineural hearing loss. Yet there is no established protocol for determining candidacy, fitting methods, or expected outcomes for individual patients. Further, the audiologist’s role should be to ensure that the appropriate treatment includes consideration of non-invasive amplification alternatives before surgery. Development of an appropriate evaluation to determine potential benefit in BAHA candidates is optimal.

In this article, we describe a clinically feasible protocol for audiologists who provide evaluations of patients with SSD. Evaluative measures, fitting methods, and validation procedures are described.

**CURRENT FITTING AND VERIFICATION MEASURES**

Establishing a clinically feasible protocol for predicting benefit with the BAHA before surgical intervention is highly desirable. Protocols are important for establishing standards of care and maintaining efficacy in patient treatment. Implementation of an effective protocol allows for: (1) determining needs and limitations of pre-operative evaluation, (2) ensuring consistency in patient care, (3) structure in evaluation and treatment, (4) evaluation of effectiveness of treatment, and (5) assessment of outcome data.

Currently, there are a wide range of methods being employed for evaluation of BAHA candidates. Of those audiologists performing evaluations, few are using any validation or verification measures post-operatively to ensure appropriate fit and function of the device. Evaluation methods include relying on the basic audiometric test battery, aided puretone threshold testing in the soundfield, aided word recognition ability in quiet, and subjective reports based on demonstrations of the device in office. While the patient may be able to get a sense of how the implant will function, these methods do not provide sufficient
information to determine if the patient is an appropriate candidate or to estimate potential benefit following surgery. Further, these methods cannot appropriately verify device performance (Seewald, 1992; Seewald et al., 1996). Outcome measures are an essential component of evidence-based practice, and are essential for determining the efficacy of treatment outcomes (Killion & Niquette, 2000).

Normal hearing in the ear contralateral to the deaf side results in ceiling effects on word recognition testing in quiet, making it an inappropriate evaluation method for SSD patients. Puretone threshold testing in the soundfield provides information at limited frequencies and only for very soft inputs (Seewald, 1992; Seewald et al., 1996). Communication in noise is the most common complaint of patients with SSD (Giolas & Wark, 1967). Listening in noise is a suprathreshold task that involves a complex noise signal. Binaural release of masking occurs much later in the auditory pathway than detection of simple pure tone stimuli, making it impossible to predict performance in noise based on the pure tone audiogram (Killion & Niquette, 2000). Therefore, a comprehensive protocol must include speech in noise measures.

THE QUICKSIN
Speech-in-noise testing has been recommended for the assessment of individuals with unilateral hearing loss since 1962 (Donaldson & Selters). Evidence based in hearing aid models suggests the use of such measures for pre-fitting and hearing aid verification (Cox, 2003, 2005). When choosing a speech-in-noise test, the type of background noise and the speech stimulus used are important elements to consider. The QuickSIN (Killion et al., 2004) was selected for this protocol based on its speech stimuli, background noise component, measuring strategy, sensitivity, and efficiency.

The target stimuli in the QuickSIN are sentences scored by keywords. The sentences are low in contextual cues, which require more reliance by the listener on acoustic performance thereby reducing the opportunity for ceiling effects (Killion & Niquette, 2000; Killion et al., 2004; Wilson et al., 2007). The target sentences are embedded in multi-talker babble. The multi-talker babble simulates a much more realistic “real world” listening environment over steady-state noise that doesn’t reflect the amplitude and temporal characteristics of real speech (Killion & Niquette, 2000). The QuickSIN measures SNR loss, which is the signal-to-noise ratio needed to obtain 50% correct recognition. Measuring SNR loss provides the clinician with a quantitative value in decibels of impaired performance compared to normal performance. The test is divided into degrees of impairment (normal to severe), so that the clinician can determine how much in dB the SNR needs to improve for the patient to obtain benefit when listening in noise. Additionally, the QuickSIN has been shown to be a sensitive measure (Killion & Niquette, 2000; Wilson et al., 2007) as compared with other speech-in-noise materials. It is also very easily adapted to the clinical setting, requiring only one to two minutes for estimation of SNR (Killion et al., 2004).

PROTOCOL
The protocol is based on known auditory deficits experienced by individuals with single-sided deafness. Performance on speech-in-noise tasks (e.g., QuickSIN) is evaluated with and without the BAHA demonstration device in place, using symmetric and asymmetric talker/jammer conditions. Performance is compared across varying conditions, and potential benefit is predicted by overall improvement in adverse listening conditions while wearing the demonstration device.

Candacy
- Patient must be at least 5 years of age
- Permanent unilateral profound sensorineural hearing loss
- Normal bone conduction threshold in the contralateral ear defined as a 20 dBHL puretone average (.5K, 1K, 2K, and 3K)
- Poor or absent word recognition ability in affected ear
**Diagnostic Evaluation**

- Complete audiometric evaluation including puretone air conduction and bone conduction thresholds, immittance, acoustic reflexes, and word recognition
- Confirm severe to profound hearing loss in affected ear and normal hearing in contralateral ear
- Patient referral to otologist for medical clearance and surgical consult

**BAHA Evaluation**

- Review SSD and potential auditory limitations
- Provide patient with written information on BAHA and non-surgical options (CROS–Contralateral Routing of Signals)
- Demonstrate BAHA and CROS devices to patient, review function
  - Report patient subjective benefit with demonstration devices
- Perform speech perception with competing noise task (QuickSIN) in unaided condition
  - Testing is conducted in the soundfield
  - Position patient in sound booth with speakers located at 90° azimuth
  - Using the QuickSIN, set audiometer so the multi-talker babble noise is being delivered through channel 1 and the speech stimulus is delivered through channel 2
  - Multi-talker noise should be directed toward the better-hearing ear and speech stimuli toward the affected ear
  - Establish SNR loss. Two lists should be administered and the scores averaged to improve level of confidence (Killion et al., 2004)
- Perform speech perception with competing noise task (QuickSIN) in aided condition using the BAHA
  - Place the BAHA demonstration device on patient’s affected ear with the microphone directed toward the speaker
  - Volume dial should be turned up to highest setting without causing feedback
A hearing solution you can believe in.

The new Zōn™ with BluWave™ Signal Processing features best-in-class feedback cancellation, superior directionality, seamless environmental adaptation, and built-in real ear measurement, all wrapped up in a small, beautifully designed exterior. You’ll be confident your patients will enjoy improved hearing, and they’ll feel confident wearing them. Experience more at zonhearingaids.com.
BAHA Assessment and Verification

- Establish SNR loss following the established protocol
- Compare performance and determine potential benefit

**We recommend using the Cordelle II for demonstrating the BAHA, as it provides the largest amount of gain. Because of the dampening of the signal through skin and muscular tissue, the added gain of the Cordelle may simulate post-surgical effect more accurately.**

- Perform speech perception with competing noise task (QuickSIN) in aided condition using the CROS hearing aid
  - Place the CROS demonstration device on patient with the microphone instrument on the affected ear and the receiver instrument on the opposite ear
  - The speaker and noise configuration remain the same as in the previous tasks
  - Volume dial should be turned up to highest setting without causing feedback
- Establish SNR loss following the established protocol
- Compare performance to unaided as well as to BAHA and determine potential benefit
- Administer benefit questionnaire

- Questionnaire should allow patient to report performance with and without the demonstration device
- Questionnaire should be relevant to the auditory difficulties specific to the patient population

**Fitting**

- Patient is fit with the BAHA device following a 6-week to 3-month osseointegration period of the implant
- Review BAHA implant and potential benefit (i.e., improved sound awareness and increased perception in presence of background noise)
- Review components of device and device function
- Review care and maintenance of device and implant site
- Review placement and removal of device

**Verification of Aided Auditory Function**

- Perform speech perception with competing noise task (QuickSIN) in unaided condition
  - Testing is conducted in the soundfield

---

**Table 1. Signal-to-Noise Ratio Loss Aided vs. Unaided Pa**

<table>
<thead>
<tr>
<th>Condition</th>
<th>SNR Loss</th>
<th>Degree of Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaided</td>
<td>9.5 dB</td>
<td>Moderate</td>
</tr>
<tr>
<td>Aided</td>
<td>0.5 dB</td>
<td>Normal</td>
</tr>
</tbody>
</table>

**Table 2. Signal-to-Noise Ratio Loss Aided vs. Unaided Pb**

<table>
<thead>
<tr>
<th>Condition</th>
<th>SNR Loss</th>
<th>Degree of Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaided</td>
<td>17.5 dB</td>
<td>Severe</td>
</tr>
<tr>
<td>Aided</td>
<td>17.5 dB</td>
<td>Severe</td>
</tr>
</tbody>
</table>
Position patient in sound booth with speakers located at 90° azimuth

Using the QuickSIN, set audiometer so the multi-talker babble noise is being delivered through channel 1 and the speech stimulus is delivered through channel 2

Multi-talker noise should be directed toward the better hearing ear and speech stimuli toward the affected ear

Establish SNR loss. Two lists should be administered and the scores averaged to improve level of confidence (Killion et al., 2004)

Perform speech perception with competing noise task (QuickSIN) in aided condition using the BAHA

Affix the patient’s external device to the implant with the microphone directed toward the speaker

Volume dial should be turned up to highest setting without causing feedback

Establish SNR loss following the established protocol

Compare performance and record post-surgical benefit

Re-administer benefit questionnaire as a follow-up. Allow patient at least 6 weeks of personal experience with the implant before reporting subjective benefit

CASE STUDIES

Patient A (Pa)

Pa is a 68-year-old white male who presented with right single-sided deafness resulting from Meniere’s disease.

The standard audiometric test battery revealed a pure tone average (PTA) of 75 dB in the affected ear and 27 dB in the contralateral ear. Word recognition testing in quiet results were poor (12%) in the affected ear, and normal (100%) in the contralateral ear.

The patient underwent pre-operative BAHA evaluation at the University of Miami. Results are listed in TABLE 1.

A questionnaire developed for use by our clinic with patients who have single-sided deafness was administered both pre- and post-operatively. The patient reported significant improvement in all listening conditions post-surgery.

Conclusion: The use of the BAHA protocol was successful in predicting patient benefit.

Patient B (Pb)

Pb is a 48-year-old white female who presented with left single-sided deafness resulting from acoustic neuroma resection.

The standard audiometric test battery revealed a PTA of 110+ dB in the affected ear and 27 dB in the contralateral ear. Patient was unable to perform word recognition testing in quiet in the affected ear, resulting in no response. Recognition abilities were normal (100%) in the contralateral ear.

The patient underwent pre-operative BAHA evaluation at the University of Miami. Results are listed in TABLE 2.

A questionnaire developed for use by our clinic with patients who have single-sided deafness was administered at the time of the evaluation. The patient denied significant improvement in all listening conditions post-surgery. The patient denied benefit in all listening conditions.

Conclusion: The use of the BAHA protocol was successful in identifying a patient who would receive minimal benefit from the BAHA implant.

CONCLUSIONS

The benefits of the BAHA over conventional amplification for individuals with SSD have been well established (Vaneecloo et al., 2001; Bosman et al., 2003; Niparko et al., 2003; Wazen et al. 2003; Lin et al. 2006). However, the degree of benefit is individual-specific (Sargent et al., 2001). Speech-in-noise testing is a viable means of evaluating potential benefit with the BAHA device in patients who have SSD prior to surgery. The QuickSIN can be easily adapted in the clinic to adequately predict benefit in patients with SSD. Further, use of pre-operative objective measures provides the patient and the clinician with the information necessary to make appropriate decisions about treatment. Objective measures combined with subjective measures should be the standard of care whenever possible in the diagnosis and treatment of patients. This clinically feasible protocol provides such measures and, as a result, ensures quality in patient care.

ABOUT THE AUTHORS

HILLARY SNAPP, AuD, is an audiologist with the University of Miami, in Miami, FL.

FRED TELISCHI, MD, is an otolaryngologist with the University of Miami, in Miami, FL.
REFERENCES


**BAHA Assessment and Verification**

**REFERENCE**


Siemens Vibe. It’s all about self-expression.

It's the first hearing instrument that fits personalities — and ears — in a radical new way. Not only will your patients be able to hear more clearly, they'll look good doing it. With an expanding selection of snap-on covers, Siemens Vibe can change to match their style or anything else. And, with its revolutionary in-the-crest fit, it goes where no hearing instrument has gone before. Tuck it in and they're set. Siemens Vibe. It's time to live out loud. Call your Siemens Sales Representative at (800) 766-4500 or visit www.itsyourvibe.com/info.

Answers for life.
Enhancing Patient Care and Professional Relationships Through Personality Assessment

BY MICHAEL J. SIMPSON

Personality assessment has united sparring co-workers, built strong teams, assisted leaders in getting the most from their people, seen increased patient/clinician satisfaction, and even improved marriages!
Teresa is an experienced audiologist and a well-regarded clinician. She has been practicing audiology for eight years and finds that she gets along quite well with most of her patients. She finds, however, that she does not feel this way about all of her patients. She reports that she “hates” the patients that appear to be serious and aloof. She reports that they are too reserved, they challenge everything she says, and they openly question her age and credentials. She finds that they don’t react to her warm personality and jokes like the rest of her patients. Because of her frustration with these patients, she often finds that she tries to “pass off” these patients to other audiologists as she despises working with them. She also reports similar feelings about her colleague, Jason, as he seems to have the same attributes. Concerned about her inability to relate to these patients and her colleague, she decided to research the role that personality types play in her unsatisfying professional interactions.

The study of personality and personality types can be traced to the time of Hippocrates (400 BC), who identified four basic personality types (phlegmatic, choleric, melancholic, and sanguine). Through time, many theorists including Jung, Myers/Briggs, Keirsey, and Bender have remained true to the four main personality types. Although there are nuances that distinguish one system from another, and for the most part, mirror Jung’s initial (feeling, thinking, sensing, and intuitive) personality styles. While Myers/Briggs is most recognized by professionals, many report that it is too complex and difficult to apply in a professional setting. That need for simplicity spurred similar recent creations including the Disc™ system (Marston), and True Colors® (Lowry). The Internet brought the next wave where there are literally hundreds of fee-based and free assessments similar to the four basic personality types that Jung created. There is even a personality test that tells you which Star Trek character matches your personality type! (Intergalactic Explorer Type by Rosmore).

For the purposes of this article, I will focus on the personality types as described by the DI Personality Inventory and the associated training program. The DI assessment and training program was developed by the Development Institute to be a conduit to deeper understanding of self, and of how to manage conflict, have more successful interactions with colleagues, and develop deeper trusting relationships with patients. For those in clinical practice involved with the sale of medical devices/durables, there is additional benefit in applying these concepts in sales and marketing scenarios.

The DI Personality system recognizes four primary personality types. Each personality type is defined by descriptive statements. These statements provide a summary of the strengths, weaknesses, and typical behaviors associated with each personality type. (See TABLES 1-4.)

A significant challenge facing audiologists in practice is the development of interpersonal skills to meet the needs of an increasingly demanding patient base. Like Teresa, many of us simply do not like some (hopefully no more than a small proportion) of the people we work with in practice. Instead of giving up, we need to find new ways of connecting. The most effective route toward these new ways is to examine your personality and become better at relating to others with different personality styles. By studying personality types, clinicians can develop executable ideas to enhance their professional relationships and improve personal effectiveness.

It is important to understand ourselves and to examine relationships with people with whom we have the greatest success (likely people like us) as well as those with whom we struggle to relate (likely those who are less like us). What most theorists and personality systems do not recognize is that the benefit of understanding your personality type is just the beginning. While it is great to understand your own personality type, it does nothing to help you to understand the other personality types and develop strategies to get better results. The greatest value comes with the realization that understanding others is the key to developing approaches to getting better results with patients.

By understanding your style as well as other styles, the clinician can identify personality types that are naturally in conflict and find strategies to find successful common ground. The Improvisor and the Stabilizer are typically in conflict as the Improvisor sees structure as confining, and
The following statements define the Improvisor:
- I like ambiguity
- Work is enjoyable if I have fun
- I am often the life of the party
- I like to take risks
- I am good at making decisions
- I crave success and accomplishment
- I have a good “gut” and make decisions easily
- I hate to plan my day
- I have a great day when I accomplish something big
- I am not very organized
- I am not detail-oriented
- I hate routine
- I can be misperceived as pushy and aggressive

The following statements define the Innovator:
- I love an intellectual challenge
- I need data to solve problems
- I do not respect those who do not contribute
- Emotion has no place at work
- I love a good intellectual debate
- I love solving problems others cannot
- I respect intelligence
- Being respected is more important than being liked
- New knowledge is exciting
- I can be misperceived as arrogant and stoic

The following statements define the Stabilizer:
- Perfection is the standard
- I am prompt
- I am organized
- I plan things well
- I hate when others waste time
- I like things to be stable and consistent
- I am efficient
- I work hard
- I can be misperceived as inflexible

The following statements define the Partner:
- I bring out the best in others
- I enjoy working with others
- I can tell when others are upset
- I have a hard time following someone I do not respect
- I am a great friend and can be trusted
- I do not like it when a team is in conflict
- I like people that are warm and empathetic
- It is fun to help others achieve their potential
- It is easy to not like those whom I do not trust
- I can be indecisive until I determine the right way forward
the Stabilizer sees it as necessary. The Improvisor also is more spontaneous and the Stabilizer a planner. I often see the Partner and Innovator in conflict as the Partner creates collaborative teams where the innovator will create disharmony at times if necessary to bring about better results. The true value of understanding the personality types is to have these natural antagonists look at the conflict from the point of view of the other person’s personality style. In any professional setting or interaction with others, it is important to work together and leverage differences. The strongest teams and clinical patient relationships I have ever witnessed create an environment where the clinician recognizes these conflicts and changes her approach to match the other person’s style.

Many struggle with the notion of changing our approach to match the other person. It is very important to realize up front that this is very difficult. Typically, we have strong elements of most personality types. Most people can relate well to three of the four types, and some struggle with more than one. In Carnegie’s book, How to Win Friends and Influence People (1936), two of the elements critical to influencing people are being genuinely interested in others and speaking in terms of the other person’s interest. Like Teresa, most of us do not have all personality types mastered. The personality type least like ours is often the one that gives us the most trouble. In fact, like Teresa, we may find people of this personality type so irritating that we hate working with them. Our biases convince us that we will never be successful, but there is nothing further from the truth. Our personality types can and do change over time, especially if we make an effort to incorporate some of the desirable traits of all personality types. If we do this, we will find that not only do we relate more effectively with those we struggled with in the past, but we increase our effectiveness with all personality types.

Many ask, “Do I need to change my personality to get better results with all personality types?” While you are not expected to change your personality, you should work intentionally to understand the lens that person is using to view the world. When we try to see the world through the other person’s perspective, we are more likely to gain that person’s trust and commitment to work with us. To do this, we may need to become more decisive like the Improvisor, more people-focused like the Partner, more logical and detached like the Innovator, or more pragmatic and structured like the Stabilizer. While adopting situation-appropriate skills from the other personality types, we can get better results but not need to change our personality.

It is important to consider application of these skills within the clinical setting. I believe that the most critical time to learn about your patient is the walk from the reception area to your office. The patient will provide many cues to their personality type in casual conversation. A simple question like, “tell me about what you are looking for in a hearing device” can reveal a considerable amount about the person. A more extroverted Improvisor may want to hear well in a crowded casino, or at a rock concert. The Partner will want to hear their spouse better or hear their grandchildren. The Innovator may be seeking cutting-edge technology, and the Stabilizer will seek a device that is practical and effective.

With a general idea of the patient’s personality type, the clinician then must determine the best way to build a strong professional rapport. The Improvisor may want the clinician to joke with him and focus on the things important to him. The Partner patient may want the clinician to ask about his family, remember his hobbies, and may want to feel that the clinician genuinely likes him. The Innovator may want the clinician to tolerate his attempts to test the clinician to see if that person is qualified, and may ask numerous questions about technology and procedures. The Stabilizer will want the clinician to conduct an efficient appointment and understand that the patient may be value and price sensitive.

Rapport leads to building trust, which is critical for a successful patient/clinician relationship. In the book, The Trusted Advisor, (Maister, Green & Galford, 2000) note...
that the greatest detractor of trust is self-orientation. While clinicians focus on credibility, reliability, and intimacy, they lose the game by focusing on their clinical goals and less on understanding the patient’s goals. By not considering the personality type and associated goals/expectations of the client, they may provide excellent clinical service, but unsatisfying professional interaction. With the increased competition from dispensers and other audiologists, we cannot afford to give a patient a reason to consider another practice. In the book *7 Habits of Highly Effective People* (1989), Stephen Covey notes that we should, “seek first to understand, then to be understood.” By focusing on the personality preferences of the patient, the clinician will have a significant head start in reducing his or her self-orientation and earn the trust of the patient.

In a sales and marketing context, the clinician can use personality assessment to her advantage. In a sales context, buyers will buy from someone they trust and respect. The profile of the individual will provide cues to a successful sale. The Improvisor wants options and wants to be sure his purchase will generate impact. The Improvisor will typically make decisions quickly and will be direct about his feelings and buying intentions. The Partner will want to be sure that the seller is genuinely interested in his goals and satisfaction. The Innovator wants a convincing argument with data to show that the buying decision will be a good one. The Innovator is definitely not one for “small talk” and will typically need time to deliberate before making a decision. The Stabilizer will want to ensure that he receives proper value, and is not interested in wasting time or off-topic discussions. For marketing purposes, a clinician may consider advertising to segments based on personality types. The Improvisor will likely be interested in advertising that is results oriented. The Partner will be interested in advertising that is focused on the relationship between clinician and patient. The Innovator will likely prefer advertising that stresses technology or innovation. The Stabilizer will likely respond to advertising that focuses on value for the money.

In many settings, I have witnessed the potency of personality assessment. Personality assessment has united sparring co-workers, built strong teams, assisted leaders in getting the most from their people, seen increased patient/clinician satisfaction, and even improved marriages! In many ways, the concept is quite simple. You can get better results by adapting your personality style to situations and striving to respect and understand another’s point of view. For a clinical practitioner, this can play a major role in enhancing your relationship with colleagues, retaining your patients, increasing your career possibilities, and building a successful practice. AT

### ABOUT THE AUTHOR

**MICHAEL J. SIMPSON** is a founder and executive vice president of the Development Institute, LLC, in Park Ridge, IL.

### REFERENCES


---

Looking for direction with your career, then call Newport

Call Newport Audiology Centers@ 1-800-600-7118,
Where you can focus on quality of patient care.
Visit our Website: www.newportaudiology.com,
send your resume to careers@newaud.com, or fax to 1-866-383-9627
Going to the Dogs

An Interview with Peter Scheifele

BY DAVID FABRY

Audiology Today managed to get Scheifele to “sit and stay” to discuss his vision for the program that links audiology to veterinary medicine.
Going to the Dogs

Shortly after moving from Dartmouth-Hitchcock Medical Center to the University of Connecticut a few years ago, Frank Musiek recalls meeting a graduate student with an unusual request: to assist with explaining an interesting phenomenon related to the communication patterns of beluga whales. Peter Scheifele, who was working on a PhD in animal bioacoustics, had observed that vocalization intensity between the belugas within a pod increased whenever passing ships approached them. Together, Musiek and Scheifele were able to form the basis of a hypothesis that would lead to Scheifele’s dissertation on the Lombard effect in whales—essentially an underwater cocktail party effect that is similar to the one in humans. In addition, a bond was formed between the two colleagues that ultimately served as the catalyst for development of the Bioacoustics and Canine Audiology Clinic at the University of Cincinnati.

The clinic provides in-depth diagnostic hearing testing for dogs while also researching ways to improve treatment options by investigating and developing hearing aids that are less expensive and more conducive to canine use. *Audiology Today* (AT) managed to get Scheifele to “sit and stay” to discuss his vision for the program that links audiology to veterinary medicine.

**AT:** Thanks for visiting with us, Dr. Scheifele. First of all, why did you decide to start this program?

**PS:** I have been working with animals for some time. I am a retired naval officer, and throughout my career have worked with marine animals (sea lions, dolphins, and beluga whales) and also with working dogs—counter narcotics and bomb dogs. Along the way, I had studied physics, acoustic oceanography, and animal science. I became interested in animal models of hearing while I was a graduate student at the University of Connecticut, and ended up with earning my PhD from both speech and hearing sciences and animal bioacoustics. That interest continued after I left Connecticut for Cincinnati, and we established the FETCH LAB. Our clinic is staffed by a veterinarian, audiologists, radiologists, a sonographer, animal trainer, and others in animal science involving animal hearing and communication.

**AT:** In addition to the lab, you are an assistant professor at the University of Cincinnati in the College of Allied Health Sciences—are you involved in teaching AuD students?

**PS:** Yes, I am, and this also served as motivation to establish the lab. Initially, I started teaching hearing science, specifically electrophysiology to AuD students, and I wanted to improve the experience for them while also continuing the work we began in Connecticut. We figured the canine was a good choice, because of the incidence of hearing loss in some breeds. We also thought in many ways it would be analogous to pediatric ABR evaluation, because we may not have a lot of information about their expected hearing thresholds, and we would like to establish electrophysiological normative data for them. Several AuD students are working in the FETCH LAB as part of their capstone projects to assist with this work.

**AT:** So, do normative data—analogue to “nHL” values—exist for dogs?

**PS:** No, not really. Because some dogs, such as Dalmatians, have a high incidence of deafness (approximately 20%), a suprathreshold presentation level (e.g., 70 dB SPL) may be used as stimulus to elicit a brain-evoked auditory response (BAER or ABR). Of course, that doesn’t provide us with any indication of the dog’s auditory thresholds, or tell us whether there are differences across breeds, but we really don’t know unless we complete a large population-based normative study.

**AT:** Which breeds have you tested already?

**PS:** Well, we have tested a lot of different dogs, but have the most data on Welsh Corgi, which we collected while I was in Connecticut. Word started getting around, and pretty soon a lot of people were asking us to test their dogs. This summer, we will test approximately one hundred Greyhound “rescue” dogs, so we will learn a lot more about whether “a dog is a dog” by comparing statistically normative data from the two breeds.
Delight in what’s Next™.

• The most advanced digital sound processing platform – no wonder it simply sounds better
• The world’s most sophisticated feedback management technology
• An exceptional set of purpose-driven innovations across four superb product lines that redefines excellence

next™
Success for your clients. Success for you.

Visit www.unitronhearing.com or call 800.888.8882
**AT:** What, no 101 Dalmatians?

**PS:** Funny, no, not yet, but we have tested a lot of Dalmatians, especially when the Disney movie came out and people’s interest in the breed was renewed.

**AT:** So, back to your students; why did you think that this was a good idea?

**PS:** One thing that I observed was that students only gain so much information from completing electrophysiological testing on each other, and I wanted them to gain more confidence in their clinical protocols, and place some additional pressures on them similar to what they would see with pediatric evaluations. That is, they may not always have a lot of time or a fully cooperative patient. And, they have to think about how they set up the equipment to do an ABR on a patient for which little is known about hearing and for which no norms exist.

**AT:** That does beg the question: Do you normally sedate canines for electrophysiological testing, or do you have them watch Scooby-Doo videos to relax them during the evaluation?

**PS:** Sometimes it is Scooby, and sometimes it is Acepromazine (an oral sedative), but the referring veterinarian makes that determination. Acepromazine is commonly used to control excited animals during examination, treatment, and grooming, and we used to use it with the counter narcotics dogs on ships when they got seasick and couldn’t work anymore. We only do anesthesia if the dog is undergoing other testing or surgery. Our attending veterinarian does a check of vitals before, during, and after testing. We only sedate about 40% of dogs, and we don’t sedate puppies.

**AT:** Wow, that is quite impressive, and suggests that the dogs feel comfortable with the test surroundings. I actually began my college career as an animal science major, and had worked for a veterinarian through junior high and high school. Dogs in particular can really sense stress, and to be able to complete this testing without sedatives is no small feat.

**PS:** Thanks—that brings to mind another point. One of the other benefits of establishing this clinic is that I think it represents yet another frontier for audiology; similar to the relationship that we have had in the past with otorhinolaryngologists, there is significant opportunity for a “veterinary audiology” sub-specialty.

**PS:** Of course—look at all of the other specialty areas that have emerged in veterinary medicine: orthopedics, ophthalmology, dermatology, and cardiology. Because of the incidence of hearing loss (both genetic and presbycusis) in dogs, we think that there is tremendous opportunity for both diagnosis and treatment, and audiology plays a role through our use of electrophysiological evaluation.

**AT:** Interesting. What stimuli are you using for diagnostic purposes?

**PS:** Right now, we are using insert earphones to deliver 100 microsecond clicks filtered from 300-3,000 Hz.

**AT:** Have you considered using high-frequencies to better match to the canine frequency response?

**PS:** Yes, but we are not presently using high-frequency transducers—just the typical ones used for audiometric testing that have been modified to fit canine ears. Eventually, we will want to use high-frequency transducers, but first we need to make certain that we can test reliably with the standard inserts. As you know, dog ear canals take a 90-degree bend, which is problematic for signal delivery. This is also a challenge for treatment of hearing loss.

**AT:** Ah, hearing aids for dogs—I have actually tried this a few times with admittedly poor results.

**PS:** This is probably because the device you fit was modified from one designed for use in humans, and didn’t take into consideration that dogs have the ability to move their ears, which will compromise the fit.

**AT:** Perhaps the new open-fit BTEs will work!

**PS:** Actually, we are investigating other designs that fit more deeply into the ear or are semi-implantable. The biggest issue with canine hearing aids is how to deliver and sustain or recharge the power. Stay tuned.

**AT:** What other diagnostic tests are you using?

**PS:** We also use distortion product otoacoustic emissions (DPOAE) testing, again with modified insert earphones, which provides us with a very good screening tool for hearing loss, as well as some frequency-specific information that we don’t get with click measures.
**AT:** That reminds me of the time some years ago when I was a graduate student at the University of Minnesota. I was working as a chinchilla tester in Dix Ward and David Nelson’s laboratory, and Mario Ruggero’s lab was right next door. One day, a veterinarian brought in a dog that had a spontaneous otocoustic tonal emission that was measured at something like 58 dB SPL. The poor dog had objective tinnitus, and it was driving him crazy.

**PS:** I haven’t seen that before.

**AT:** What about dogs that have external or middle ear otitis? I have two dogs that both suffer from ear infections, and it would be useful to know whether it was causing conductive hearing loss.

**PS:** Interestingly, veterinary dermatologists are the ones who are presently working the most with external otitis media. We have not yet tried bone-conducted ABR or immittance, but this may be something that could be done clinically as well to assist with diagnosis and treatment. We are starting to collaborate on a project with the Ohio State University to investigate this further.

**AT:** Can you estimate what percentage of canines you are working with that have congenital hearing loss versus presbycusis?

**PS:** About 60% of the dogs that we see have acquired hearing loss, and represent pets that are brought in by their owners because they wonder if there is anything that can be done to improve their quality of life.

**AT:** Forty percent is a pretty high rate of genetic hearing loss. Do you think that this is any way reflects the impact of “overbreeding” for physical attributes (e.g., “teacup” Poodles and Yorkies), rather than health?

**PS:** Hard to say, but I see your point, as it may seem like the opposite of evolution and contribute to genetic problems.

**AT:** Returning to the 60% with acquired hearing loss; any reason to believe that certain breeds are more susceptible to hearing loss, like hunting/working breeds, or if the dog listens to loud rock-and-roll music?

**PS:** Well, I know that you are kidding about the rock music, but there is some data to suggest that dogs that are frequently kenneled may be at greater risk for noise-induced hearing loss. We are collecting data now to determine whether damage risk criteria should be established for kennels (similar to OSHA) for the animals, as well as the workers.

**AT:** Having worked in kennels, I know that they can indeed be very noisy places, and it stands to reason that dogs that are routinely boarded may be at greater risk, so this is important work.

**PS:** We think so too.

**AT:** We have talked extensively about the FETCH LAB, which focuses on canine hearing, but do you also work with cats?

**PS:** Yes, we have tested cats and ferrets, and our intent is to eventually work with a wide range of animals in the clinic.

**AT:** I would imagine that while dogs have a higher rate of hearing problems, cats seem to have more trouble listening—at least when I speak to them!

**PS:** Yes, dogs may seem to be much better behaved, but have not found any difference yet. This reminds me of something I was thinking about when you said that you were a chinchilla tester; it is amazing to me, dating back to von Bekesy, that...
much of what we know about the human auditory system has been derived from animal research on guinea pigs, chinchillas, and in cats. It is, then, rather ironic that we are applying electrophysiological tests in this laboratory that have been optimized for use with humans to serve a clinical need for animals. It would appear that we have come full circle.

**AT:** Well said, and well-deserved, in my opinion, and I am glad that you have established this facility to serve that need. I would love to be an AuD student in Cincinnati’s program!

**PS:** It is never too late to start!

**AT:** Thank you so much for spending the time with us. **AT**

---

**ABOUT THE AUTHOR**

DAVID FABRY, PhD, is the content editor for *Audiology Today* and the chief of audiology at the University of Miami, in Miami, FL.

**ABOUT THE INTERVIEWEE**

PETER SCHEIFELE, PhD, is the director of the Facility for the Education and Training of Canine Hearing and Laboratory for Animal Bioacoustics (FETCH LAB) at the University of Cincinnati.

---

**CONVENIENCE FOR YOUR SUMMER ESCAPES**

**CALLING CARD**
Wherever your travels might take you, or your family, the Academy calling card offers members discounts on international calls, domestic calls, and more.

**CREDIT CARD**
A new world of rewards and privileges awaits you with the American Academy of Audiology MasterCard and American Express card. Earn points while you spend and have access to the MyConciergeSM service 24 hours a day for whatever special needs may arise.

**HERTZ RENTAL CAR**
If you must rent a car, use your member discount to receive special rates. Save yourself some money, or spring for the luxury sedan with heated and cooled seats.

**MEMBERSHIP HAS ITS BENEFITS**
Learn more about all of the benefits available to Academy members at www.audiology.org/membership/benefits.
Survey Says: Students Are in Need of More Information About Coding and Reimbursement

BY AMY AYLWARD AND MELISSA CAINE

THE Earliest Baby Boomers Are Entering their “golden years,” and as more infants are identified with hearing loss, there will be a greater need for audiology services. Audiologists are now doctorate-level professionals, on par with dentists and optometrists. AuD graduates are beginning their careers with more clinical preparation than those who entered the field with master’s-level training. But are they entering the field with the skills necessary to run a successful health-care practice? Certainly there are audiologists who will continue to seek employment in ear, nose, and throat (ENT) practices or hospital settings. Such work is attractive to many, as it allows for audiologists to practice audiology without the demands of business management and without the financial risk. That may seem the safe way to practice, but as Tom Northev’s 2000 article, “The AuD in Private Practice,” states, “The business of audiology still provides significant enough margins (profit per procedure) that allow and invite the prepared professional to open his or her own practice.” Preparation for private practice not only includes gaining the skills necessary to best serve the hearing health needs of patients, it also involves gaining the knowledge necessary to run a practice and code procedures in a manner which is both profitable and legal. Are the AuD graduates of today prepared to be involved in managing a successful health-care practice?

The American Academy of Audiology’s Coding and Reimbursement Committee conducted a survey to determine whether AuD students are receiving the necessary training in coding and reimbursement procedures. There were 267 students from 29 AuD programs who responded to the survey. Ninety-nine percent were enrolled in residential programs. Students in each year of study were polled, with 23% in their first year, 27% in their second year, 29% in their third year, and 21% in their fourth year.

Of these 267 students, only 19% completed a formal course in coding and reimbursement. Most who received this course did so in their second or third year of study (46% and 38%, respectively). Although it may not be expected for students in their first or even second years of study to have completed a course on coding and reimbursement, it was interesting to find that only 31% of third-year students and 30% of fourth-year students had taken such a class. Thirty-six percent of third-year students and 52% of fourth-year students reported that while they did not receive a course at their university, they did receive training through clinical experience. Eight percent of third-year students and 5% of fourth-year students obtained training through a professional meeting or conference.

Of the students who received a course on coding and reimbursement, 98% received resources on CPT codes typically used by audiologists, 88% on audiology ICD-9 codes often used by audiologists, 43% on HCPCS codes, and 67% on current Medicare reimbursement rates for audiology services. No students reported feeling extremely confident about their comfort level in coding and reimbursement skills. The majority (33%) felt neutral with 29% feeling somewhat confident and 25% feeling a little confident. Fourteen percent of those who took a coding and reimbursement course reported feeling “not confident” about coding and reimbursement skills.

Overwhelmingly, 75% of AuD students who responded to this survey reported that they don’t feel their program provides enough coursework and/or experience on coding and reimbursement. Twenty-five percent of responding students felt “not knowledgeable” on reimbursement for audiology codes, and only 24% felt somewhat knowledgeable. Less than 1% felt extremely knowledgeable. Students often know best what their program is lacking. Most of
them (44%) felt that they would benefit from receiving this information integrated into other coursework. Only 17% reported the desire for an entire course on the topic.

It is clear from these results that there is a lack of training in coding and reimbursement issues for current AuD students. If audiologists are to succeed as autonomous practitioners, they will need to be not only skilled clinicians, but also skilled business owners. A business, health care or otherwise, cannot be maintained without revenue. Proper coding practices are not only necessary to receive the maximum reimbursement available, improper coding practices can lead to investigations and hefty fines. Such fines have put health-care practitioners out of business. It isn’t always the dishonest practitioner accused of fraudulent billing, it is often the unknowing practitioner.

Audiologists entering the profession need to have confidence in and a sense of the importance of this knowledge. As reimbursement policies change, they need to have an understanding of the basics of coding and reimbursement to continue to thrive as practitioners. This is not only essential for the individual practitioners, but for the profession as a whole. Audiology and health care are in a time of change, with providers being heavily scrutinized for billing practices. If audiologists are to continue to grow in the public eye as highly trained health-care professionals, their knowledge of coding and reimbursement issues is essential. This knowledge, like clinical knowledge, begins with the curriculum of the doctoral program. AT

REFERENCE


ABOUT THE AUTHORS

AMY AYLWARD, AuD, is a technical support audiologist with GN ReSound.

MELISSA CAINE is a 4th year AuD student at Pennsylvania College of Optometry.

Survey of AuD Students’ Training in Coding and Reimbursement Procedures

How do you rate your knowledge on reimbursement for audiology codes?

Neutral | 16%  Slightly Knowledgeable | 35%
Somewhat Knowledgeable | 24%
Not Knowledgeable | 25%
Extremely Knowledgeable | <1%

What additions would you like to increase your knowledge on coding and reimbursement?

4% More resources provided by instructor
4% Other
6% More class time in an existing coding and/or reimbursement class
9% Resources provided by outside sources such as the AMA, Centers for Medicare and Medicaid Services, and other third-party payers
16% More experience in clinical placements
17% Adding an independent class on coding and/or reimbursement
44% Coding and/or reimbursement issues integrated into other coursework
Simply the best hearing system

Ultimate Performance – including SoundFlow, a completely new approach to real-time automatic adaptation.

Sophisticated Control – including ZoomControl, user selectable 360 degree directionality.

Unlimited Connectivity – including iCom, hands-free stereo connection to communication and entertainment devices.

www.exelia.phonak.com
Enlarged Cortical Maps Don’t Always Improve Perception

BY CHRISTOPHER CLINARD AND KELLY TREMBLAY

Changes to the Input of the Auditory

Pathways of the brain initiate changes that take place in the brain. One of the processes involved with these neural changes is “auditory plasticity,” which is how we sometimes describe the brain’s capacity to change. Over the course of our lives, the auditory cortex adapts to its input and changes how it processes certain aspects of incoming information (e.g., temporal or spectral). A lack of input, such as deprivation related to hearing loss, or a change in input from hearing aids or cochlear implants may result in changes to the processing of the auditory cortex. The central auditory system is highly organized. The tonotopic arrangement of the cochlea is preserved throughout the brainstem and cortex, and changes may only take place in parts of the cortex with altered input (e.g., high frequency hearing loss).

Cortical maps in the auditory cortex are map-like representations of which cortical areas respond best to a certain frequency. Much research is devoted to investigating the links between these cortical maps that have the capacity to change and how they relate to perception.

It might be intuitive to think that increased neural activity and enlarged cortical maps means better performance, right? Well, not necessarily.
Although there are studies that report enlarged areas of cortical representation that coincide with improved performance on behavioral tasks, there are also studies that report a lack of improvement on a perceptual task even though the cortical maps have been enlarged. When an area of auditory cortex has a larger representation of a particular frequency increased, it comes at the expense of surrounding areas. Since there is only so much cortex to work with, when the representation of one frequency grows, surrounding frequencies may become less represented. This relationship between perception and cortical maps is complex and not entirely understood.

Han et al (2007) recently examined the relationship between cortical map reorganization and perceptual effects by presenting acoustic stimuli to rats and examining effects on frequency discrimination performance and changes in cortical maps. They used two litters of newborn rats. One of these litters was raised in an anechoic chamber and was repeatedly exposed to a 7.1 kHz tone from the ages of day 9–30. A train of 100 ms tonebursts was presented at 60 dB SPL every two seconds for 24 hours a day. When the rats were two months old, they learned a frequency discrimination task. Rats that were exposed to the 7.1 kHz tones during development had significantly worse frequency discrimination at 7.1 kHz than at 5.9 and 8.4 kHz. Control animals had much better frequency discrimination at 7.1 kHz than the exposed group, but the exposed rats had better discrimination at 5.9 and 8.4 kHz than the controls.

Cortical maps in the control (unexposed) rats showed the typical continuum of low to high frequency representation, with each frequency being represented by approximately the same amount of cortex. In contrast, the cortical maps of the exposed group showed an enlargement of the cortical area responding to 7.1 kHz. In other words, continuous stimulation of specific areas of the auditory system resulted in a much larger area of cortex that responded to 7.1 kHz, relative to the control group. One interpretation of this study is that repeated presentation of these types of tones during early development coincides with a marked reorganization of the cortical frequency map, but having an over-represented frequency does not improve perception of that frequency. In addition, the cortical surface area representing the exposed frequency grew at the expense of having neighboring frequencies being under-represented.

Although the exposed group had marked changes in their cortical maps, it appears that reorganization related to stimulus exposure without behavioral relevance is not necessarily beneficial to perception. An important point about the Han et al study is that it wasn’t really a “training study.” That is, these animals were reared (exposed) to this acoustic event but there was no paired association or learned event that went with it. Other studies have reported that when an acoustic stimulus is paired with a behavioral task, cortical remapping is associated with improvement on a perceptual task.

We’re still learning if and how auditory training protocols and hearing loss modify the brain in humans. Auditory training protocols for humans can use the findings of basic science research to serve as evidence for the types of training that result in optimal changes in central auditory pathways. However, there is much work left to do before the links among stimulus exposure, perceptual tasks, and auditory plasticity are understood.

REFERENCE


ABOUT THE AUTHORS

CHRISTOPHER G. CLINARD, MA, and KELLY L. TREMBLAY, PhD, are with the Department of Speech and Hearing Services, University of Washington, Seattle, WA.
The National Temporal Bone, Hearing, and Balance Pathology Resource Registry

BY KEVIN WILLMANN

BECOMING AN ORGAN DONOR IS AN OPTION WE are always reminded of, especially when it comes time to fill out a driver’s license or a will.

But how many of us know that our temporal bones, which contain the organs of hearing and balance—the middle and inner ears—can also be donated upon death?

While the hearing organs cannot be transplanted to those suffering from ear disorders, the donation of the temporal bone upon death can assist in the study of deafness, dizziness, facial palsy, infection, tumor or other injury, as the inner ear is inaccessible for study during life.

Donations of temporal bones are accepted and sought after by the National Temporal Bone, Hearing, and Balance Pathology Resource Registry. Established in 1992 by the National Institute on Deafness and Other Communication Disorders, part of the National Institutes of Health, the Registry expands upon the activities of the former National Temporal Bone Banks Program, established in 1960 by the Deafness Research Foundation. Headquartered in Boston, the Registry has 26 temporal bone research laboratories nationwide.

Though major advances in understanding changes caused by ear diseases and improved treatments have resulted, more can be achieved through the continued study of the temporal region. Because of this, the Registry seeks individuals with ear disorders, including hearing loss or balance problems, as donors for temporal bones and associated brain structures. Those who don’t have any hearing or balance problems can also donate their temporal bones for study, if they choose. So far, at least 7,000 individuals have registered as temporal bone donors.

When a donor dies, a small portion of the temporal bone is surgically removed soon after death. This surgery does not
affect the appearance of the outer ear, head or face of the donor, allowing for open casket viewing if the family so desires. After donation, the structures of the inner ear are prepared for different research techniques, including microscopic study as well as procedures that allow identification of hearing defects at a molecular level. Each sample is studied to learn more about the ear structure and the causes of ear problems. These studies allow for new ways to diagnose and correct ear disorders.

In addition to the temporal bones, donors may also wish to donate the brain stem to the Registry. Such a donation is highly valuable to researchers, as the brain stem contains many of the brain pathways involved in hearing and balance. Study of these pathways provides information on disorders causing deafness and dizziness, including tumors, infections, as well as multiple sclerosis.

If the deceased is also an organ donor of transplantable organs, the donation of the temporal region is delayed until the time that the transplantables have been removed first. There is no charge to the donor’s family or estate for removal of the temporal bones. The professionals doing the removal are either paid by the laboratory designated to receive the bones or have donated their time. Though a potential donor may wish to make the donation of their temporal bones upon death, it is important to discuss these wishes to the next of kin. All final decisions about organ donations will be made by the next of kin, and they will be the ones who will notify the registry of a donor’s death.

Anyone interested in making a pledge to donate their temporal bones can call the Registry’s 24-hour hotline at 800-822-1327. This is also the number to call and notify the Registry of a donor’s death, so the arrangements can be made to retrieve the donor’s temporal bones. Potential donors will receive a donor packet, including a medical history questionnaire, as well as a donation and consent form. A wallet-size donor card will be sent upon receipt of the completed forms. A computerized record is kept for all donations, and donors are asked to keep the Registry informed of any changes in address or next of kin.

For more information, visit the Registry Web site at www.tbregistry.org.

REFERENCES


National Temporal Bone Donor Program, That Others May Hear, Boston: NIDCD National Temporal Bone Hearing & Balance Pathology Resource Registry (pamphlet).

EARN UP TO 11 HOURS OR 1.1 CEUs with the American Academy of Audiology’s Ethics in Audiology—The “Green Book”

CEU fees are $30 for first 0.3 CEUs and $25 for each additional 0.1 CEU

Visit www.audiology.org/education/eaudiology/ethics for more information on the Ethics “Green Book” CEU program.

The Ethics “Green Book” can be purchased online at the Academy Store. Cost $45
SOUND WARS

BY DAVID FABRY

IT READS LIKE A SCIENCE FICTION MOVIE TRILOGY—CONFLICT, REVENGE, AND THE EVENTUAL TRIUMPH, BUT THIS TIME AROUND, ACOUSTICS PLAYS THE STARRING ROLE IN A BATTLE OF YOUTH AGAINST WISDOM. BY NOW, YOU HAVE PROBABLY HEARD OF THE “MOSQUITO” (WWW.COMPOUNDSECURITY.CO.UK), AN ELECTRONIC DEVICE INVENTED IN 2005 BY A UNITED KINGDOM ENTREPRENEUR TO REPEL TEENAGERS WITH A HIGH-FREQUENCY STIMULUS (17.4 KHZ AT 85 DB SPL) THAT IS ANNOYING TO THEM BUT INAUDIBLE TO ADULTS. THE SAGA BEGINS.
**Sound Wars Episode IV:**
**A New Hope**

Howard Stapleton originally developed the Mosquito after his daughter had come home in tears from a store in their town in South Wales after being harassed by other teens. The store owner, when contacted, informed Stapleton that he wanted the hoodlums removed, but feared retribution if he called in the authorities. At this point, the security device inventor recalled from his own experience as a teenager when he heard the awful buzz of an ultrasound welding machine at his father's glue-plastics factory. His complaints about the noise literally fell upon deaf ears, as none of the workers (who were all older) could hear the sound. Thus, the basis for the Mosquito began on the principle that the annoying properties of sound will cause crowds to disperse, rather than congregate, in a specific location. Specifically, although teens can hear 17.4 kHz sounds, most adults will not. Actually, high-frequency and ultrasonic stimulation have more nefarious roots, having been promoted for years (with mostly equivocal results under controlled test conditions) as a repellent for rodents, mosquitoes, bats, dogs, goats, and mice, based on the principle of audiogenic seizures that are caused by frequency-specific sounds in some species. While the intent of the Mosquito is certainly to annoy—but not harm—teenagers, it nonetheless raises issues regarding the safety and efficacy of the device for crowd control.

The device has enjoyed initial success in the UK, with installations in approximately 4,000 public locations. Consumer backlash has occurred, however, over a number of issues, including whether the Mosquito (1) may cause permanent hearing loss in teenagers and young children; (2) is a violation of civil liberty, including the right to public assembly; or (3) unfairly discriminates against or persecutes children and young people without their knowledge or approval. At press time, the Mosquito is being marketed and sold with some success in the United States under the company name “Kids Be Gone” (www.kidsbegone.com).

**Sound Wars Episode V:**
**The Teenagers Strike Back**

Some teens have found a way to turn the tables on adults by reproducing the Mosquito as a cell phone ringtone to prevent disciplinary action that would normally accompany cell phone use during school hours. An abbreviated Mosquito tone, called the “Teen Buzz” (www.teenbuzz.org), has become one of the most downloaded ringtones on the Internet, and facilitates teens receiving audible confirmation of a phone call or text message surreptitiously in the classroom—provided the teacher is over the age of 25 years old. Some particularly industrious and devious teens have figured out how to use the ringtone to cheat on multiple-choice examinations, in a classic case of turning “lemons” into “lemonade,” but it has raised the ire of school administrators everywhere.

**Sound Wars Episode VI:**
**Return of the Ring Tone**

The escalation of the Sound Wars has led to the use of psychoacoustics; namely, combination or difference tones first credited to violinist Giuseppe Tartini may be used to assist with making the Teen Buzz ringtone to “reappear” at a lower frequency that is audible to more “mature” teachers who suffer from presbycusis or noise-induced hearing loss. These combination or “Tartini” tones are caused by intermodulation distortion products that develop in the ear in predictable fashion on the basis of the frequency difference between the primary tones. For example, if a continuous tone is presented in a classroom at 22.4 kHz, which is inaudible to all humans—young or old—several Tartini tones will be developed when the Teen Buzz ring tone is presented, the most significant at 12.4 kHz and 5 kHz, corresponding to 2f1-f2 and f2-f1, respectively. In essence, the use of this high-frequency “surveillance” tone will cause the Teen Buzz ring tone to be frequency-shifted and reappear within the audible frequency bandwidth of most adults, restoring order in the universe (until the kids figure out how to use frequency modulation or narrow-band noise to minimize standing waves and distortion products). As the confrontation escalates, the ultimate solution may be to use specialized frequency-lowering hearing aid devices with broad-band microphone inputs to detect the presence of high-frequency sounds and shift them into the teacher’s audible frequency bandwidth, further expanding the audiologists’ role from Guardians of hearing and balance to Sentinels of order in the classroom. AT
ABA Goes to Campus
BY JAMES W. HALL III

STUDENTS IN DOCTOR OF audiology (AuD) programs are the future of audiology. And, audiologists who are faculty members in universities with AuD programs—that is, the academic and initial clinical mentors for AuD students—have the most important influence on future audiologists. Unfortunately, few audiologists working in university settings are ABA certified. The University Committee of the ABA has as a major objective improved communication with faculty and students in AuD programs. The committee will strive to systematically and consistently inform university faculty members of ABA certification and initiatives, such as development of the National Examination, with the specific goal of increasing the proportion who are ABA certified. The committee has the related objective of disseminating information about the ABA to AuD students through faculty representatives.

To facilitate this effort, I have organized a University/Student Task Force consisting of faculty members and AuD students from some of the leading AuD programs in the country. Faculty members serving on the task force hail from some of the leading university programs, among them Bob Keith of the University of Cincinnati, Linda Hood of Vanderbilt University, Lee Wilson of the University of Texas-Dallas, and Julie Manche of the University of Louisville. The task force, in partnership with a special ABA marketing team led by Angela Morris, is charged with developing educational materials about the ABA to include frequently asked questions (FAQs) about ABA certification and specialty certification, reasons for selecting ABA certification rather than alternative approaches for professional credentialing, and the value of ABA certification for meeting requirements for state licensure. The education efforts of the task force will continue and intensify within the next few years with the introduction of the ABA national examination.

The upcoming 10th anniversary of the American Board of Audiology is the perfect time to encourage AuD students, and their university mentors, to become active participants in the credentialing organization of, by, and for audiologists.

ABOUT THE AUTHOR
JAMES W. HALL III, PhD, is the associate chair and clinical professor with the University of Florida and a member of the ABA Board of Governors.

ABA Thanks Therese Walden
The ABA Board of Governors would like to thank Academy Liaison Therese Walden for her three years of dedicated board service to the ABA. With her visionary leadership, thoughtful collaboration, and outstanding contributions, Therese has played an integral role in the advancement of the ABA’s mission and will be greatly missed!

BOARD OF GOVERNORS
Bettie Champion Borton, AuD, Chair
James Beauchamp, AuD
James Hall III, PhD
Beth Longnecker, AuD
Jill Meltzer, AuD
Angela Morris, AuD
Steven Sederholm, AuD
American Academy of Audiology Board of Directors Liaison
Allison Grimes, AuD
Past Chair
Ex Officio Member
Bruce Edwards, AuD
Public Member
Ellis Rosenberg, MBA
Managing Director
Ex Officio Member
Sara Blair Lake, JD, CAE

For ABA information, contact:
American Board of Audiology®
11730 Plaza America Drive
Suite 300
Reston, VA 20190
800-881-5410
aba@audiology.org
Proposed Ethical Practice Policy on Financial Incentives from Industry

By Gloria Garner

In 2003, the American Academy of Audiology (Academy) and the American Academy of Dispensing Audiologists (ADA) jointly authored the “Ethical Practice Guidelines on Financial Incentives from Hearing Instrument Manufacturers.” Since then, a growing body of evidence from the social science literature about the impact of gifts has developed. With approval from the academy board of directors, the Ethical Practices Committee began the process of reviewing and revising these guidelines. In addition to review by the board of directors, the proposed policy is being reviewed by the Academy’s attorney, an ethicist hired by the Academy to review our Ethics Program, and key Academy staff members. The board values the involvement and input of our members in developing this policy. The board invites members to provide your feedback and questions after reading the social science literature on gifts and the DRAFT of the Proposed Ethical Practice Policy on Financial Incentives from Industry found at www.audiology.org; click on Membership & Benefits, Ethics, News. Please respond by August 31, 2008, to our dedicated list serve at ethicsdraftpolicydiscussion@lists.audiology.org. Instructions to subscribe to this list can be found on the Academy’s Web site at the same link listed above.

CALL FOR 2009 NOMINATIONS BOARD OF DIRECTORS

Nominations for three Board of Director positions of the American Academy of Audiology are now open and may be made by any member of the Academy.

Members-at-Large serve a three-year term in office beginning July 1, 2009. A job description for the Board of Directors can be found at www.audiology.org/aboutacademy/governance/directors/nominations.htm.

Submit your nominations in writing to:

Alison Grimes, AuD
Chair, Nominations Committee
American Academy of Audiology
11730 Plaza America Drive, Suite 300
Reston, VA 20190

OR E-MAIL NOMINATION TO:
agrimes@mednet.ucla.edu

Nominations must be received no later than 5:00 pm EDT, August 29, 2008.
AS THE ACADEMY MOVES INTO A NEW FISCAL year beginning July 1, 2008, the Government Relations Committee will take on a fresh look in form and function, while maintaining its primary objectives to advance the advocacy goals on behalf of the Academy. Earlier this year, the Academy’s Board of Directors approved a motion to modify the Academy’s governance policy that impacted the leadership and structure of the Government Relations Committee.

The board approved two primary changes. First, in a governance policy change, the chair of the Government Relations Committee will be appointed from the Academy membership and the president-elect will serve as the committee’s board liaison. The Academy’s policy previously directed the president-elect to serve as the chair while concurrently serving their president-elect term year. The intended purpose of the president-elect serving in this capacity is to prepare the individual to have a better understanding of the government relations advocacy position/statements taken by the Academy and to develop a familiarity with the political and government relations processes, in preparation for their term as president. While the benefit to the individual is worthwhile, the Government Relations Committee leadership has been challenged to maintain continuity from year to year as the chair changes annually with each new president-elect election cycle. The board-approved change will now provide the added degree of continuity needed to maintain a smooth transition annually from one president to the next. At the same time the president-elect, serving as board liaison, will be afforded the opportunity to become familiarized with the political and government relations processes, in preparation for his or her term as president.

The second change in policy will create a new configuration within the Government Relations Committee to better match the Academy’s advocacy objectives and existing management structure. The makeup of the Government Relations Committee membership had been previously arranged with the appointments from various other committees within the Academy, including the State Leaders Network, Coding and Reimbursement, and the Academy Political Action Committee (PAC) Board, as well as representatives from issue specific subcommittees including those addressing state licensure and pediatric audiology. The newly structured committee will consist of nine members not including the chair, per Academy policy. The chairs of the Coding & Reimbursement Committee and PAC Advisory Board will be included as members as well as the chairs of the newly formed Federal Affairs and State Affairs Subcommittees. The chair will appoint the chairs of the newly formed Federal Affairs and State Affairs Subcommittees from the committee members. The subcommittee members will be composed of committee members and other Academy members as designated by the chair. These new subcommittees will be responsible for identifying federal and state legislative and regulatory public policy impacting audiology, and support the committee’s objective to improve the effectiveness of the Academy’s federal and state advocacy efforts.

Erin Miller, AuD, coordinator, Hear Aid Dispensary and clinical instructor, University of Akron, will serve as the chair of the newly restructured committee. Kris English, PhD, incoming president-elect, is the board liaison. In addition to the Government Relations Committee, the president-elect will serve as board liaison to the PAC Advisory Board and Coding & Reimbursement Committee.

ABOUT THE AUTHOR

PHIL BONGIORNO is the senior director for government relations for the American Academy of Audiology.
GOVERNMENT RELATIONS COMMITTEE

Erin Miller, Chair; Kris English, Board Liaison; Phil Bongiorno, Staff Liaison

- Provide government relations leadership on behalf of the Academy.
- Identify federal and state legislative and regulatory public policy that impacts audiology, including advocacy strategies that advance the public policy interests of audiologists.
- Work to improve the effectiveness of the Academy’s federal and state advocacy efforts.
- Analyze and make recommendations on proposed legislative and regulatory public policy impacting the Academy and the profession of audiology.
- Make recommendations on Academy’s legislative and regulatory priorities.
- Develop strategies to implement Academy’s legislative and regulatory priorities.
- Initiate action on Academy legislative and regulatory priorities, including action alerts and other advocacy activities, as needed.
- Initiate and participate in the Academy’s public policy/position development process.
- Evaluate Academy’s public policy/position statements and work to ensure Academy public policies are developed in a timely manner; ensure relevancy and adherence to the state-of-the-art.

RESEARCH AWARDS PROGRAM

Now Accepting Applications!

- New Investigator Research Award | Up to $10,000
- Student Investigator Research Award | Up to $5,000
- Student Summer Research Fellowship | Up to $2,500

The deadline for receipt of all applications and related materials for funding is October 27, 2008.

Learn more at www.audiology.org, click on “Academia & Research.”
The Power of Recognition Is in Your Hands…

The Academy Honors Committee encourages all Academy Fellows to identify those colleagues they believe have made significant contributions to the audiology profession. If you know someone who should be recognized for his or her efforts, please take the time to submit a nomination packet to the committee for review.

All nominations must be received by October 20, 2008.

NOMINATION PROCESS
To nominate an individual, a nomination packet that includes a letter of nomination addressed to the committee chair and an up-to-date full curriculum vita of the nominated individual should be submitted by the deadline. Self-nominations will not be accepted. The nomination packet should include sufficient documentation as to how the nominee meets the specified criteria for the selected category. Additional letters (3-5) in support of the nomination and any other documentation that will assist the Honors Committee in their decision are required. All materials should be mailed to the Academy headquarters.

SELECTION OF HONOREES
The committee will consider all nominations, and awards will be made to qualified candidates who receive a majority vote of the voting members of the committee pending final approval of the Academy Board of Directors. Not all awards may be given each year. Selected recipients will be presented at AudiologyNOW! in Dallas, TX April 1-4, 2009.

GUIDELINES
Nominations should be made in a letter format with a full curriculum vita and 3-5 letters of recommendation of the candidate enclosed. The nomination and all supporting materials must be received at Academy headquarters by October 20, 2008.

SEND THE NOMINATION PACKAGE TO:
Brenda Ryals, Chair, Honors Committee
c/o American Academy of Audiology
11730 Plaza America Drive, Suite 300
Reston, VA 20190
Award Categories

JERGER CAREER AWARD FOR RESEARCH IN AUDIOLOGY
This award is given to a senior-level audiologist with a distinguished career in audiology. Candidates must be members of the Academy, have at least 25 years of research productivity in audiology (not in related field), and have made significant contributions to the practice and/or teaching of audiology.

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

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

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

DISTINGUISHED ACHIEVEMENT AWARD
Recipients of this award may include audiologists who are or have been exceptional educators in the classroom or clinic, have been innovative in program development, pioneering in areas of clinical service delivery, teaching, or research, or any combination of these areas. The contributions made by the recipients of the Distinguished Achievement Award must have an impact on the profession of audiology as a whole and not just at a state or local level. More than one Distinguished Achievement Award may be awarded per year. Recipients must be members of the Academy.

2007 AND 2008 ACADEMY HONORS RECIPIENTS

2008

Distinguished Achievement Award
Kristina English
Judy Gravel
Roger Ruth
Jon Shallop
Robert Sweetow

James Jerger Career Award for Research in Audiology
Larry Humes

Humanitarian Award
Howard Weinstein

2007

Distinguished Achievement Award
Kathryn Beauchaine
Theodore Glattke
David Goldstein
Gyl Kasewurm
Sharon Lesner

International Award in Hearing
Peter Blamey
Richard Seewald

James Jerger Career Award for Research in Audiology
Robert Margolis
Frank Musiek
AAA Foundation Announces New Leadership

BY KATHLEEN DEVLIN CULVER

THE AMERICAN ACADEMY OF AUDIOLOGY

Foundation (AAAFA) is pleased to announce that five distinguished members of the Academy have been appointed to serve as trustees on the AAA Foundation Board. Rieko Darling, Michael Santucci, Thomas Thunder, and Sue Windmill will begin three-year terms, and Karen Jacobs will serve a one-year term as the Academy Board Liaison to the AAA Foundation Board, commencing July 1, 2008.

In addition, Brad Stach, chair of the AAA Foundation Board, announced in June that Dianne Meyer has agreed to serve as chair-elect for the 2008-09 term, and will assume leadership as board chair on July 1, 2009.

“I look forward to working with Dianne to ensure a smooth transition in board leadership,” stated Stach. “The AAA Foundation continues to grow and thrive, and Dianne’s

Brad Stach and Kathleen Devlin Culver thank Linda Hood and Jerry Northern for their years of service on the Board of Trustees of the AAA Foundation at AudiologyNOW!
expertise and vision make her a perfect fit for the position of board chair. I am also excited about working with Rieko, Tom, Michael, Sue, and Karen; with their backgrounds and talents, I have every confidence that we can continue to move the AAA Foundation to the next level in fundraising for the Academy’s programs in research, education, and public awareness.”

Rieko Darling, a 2003 American Academy of Audiology Honors Award recipient, is currently an associate professor of audiology and director of the audiology clinic at Western Washington University. She earned her PhD from Florida State University in 1987 and has served on faculty at the University of Hawaii and Auburn University. Darling has also directed audiology and speech language pathology services at The Methodist Hospital in Houston, Texas, and has served as a consultant to the Department of Veteran Affairs Medical Center in Tuskegee, Alabama, and to the Area Agency on Aging for North Florida. Her teaching, research, and clinical interests are in the areas of diagnostic and geriatric audiology.

Michael Santucci is founder and president of Sensaphonics Hearing Conservation, Inc., a company dedicated to the research and development of technologies that control the damaging effects of loud music on musicians, sound engineers, and others in the music industry. He earned his master’s degree at Illinois State University, and regularly lectures on hearing protection at institutions such as Columbia School of Audio Engineering, University of Chicago, Northwestern University, the Audio Engineering Society and the GRAMMY® organization (NARAS). His articles on hearing health have been published in more than 40 periodicals, and he has served on the board of the National Hearing Conservation Association.

Thomas Thunder is both an audiologist and an acoustical engineer. He received his master’s degree in audiology from Northern Illinois University, followed by post-graduate training in acoustics at the Illinois Institute of Technology. He was awarded board certification in acoustical engineering from the Institute of Noise Control Engineering (INCE) and obtained his AuD from the Pennsylvania College of Optometry School of Audiology. Thunder is on the faculty at Northern Illinois University, and serves on the adjunct staffs at Rush University and the PCO School of Audiology. Previously in private practice, he now focuses on forensic audiology; consulting in hearing conservation, room acoustics, and environmental noise; and developing educational seminars. He is a member of numerous professional associations including the National Hearing Conservation Association, and the Acoustical Society of America, and is a past president of the Illinois Academy of Audiology and the Chicago Regional Chapter of the Acoustical Society.

Sue Windmill is the director of audiology at Kosair Children’s Hospital in Louisville, Kentucky, and is a member of the faculty of the University of Louisville School of Medicine. She completed a bachelor’s degree in early childhood education at
Foundation Update

the University of Kentucky and a master’s and AuD degree at the University of Louisville. She is coordinator of the student clinical program at the University of Louisville where she teaches the pediatrics and cochlear implant courses. She has been a member of the AAA Foundation Board, a member of the Academy Convention Committee, and the director of the audiology section of the International Service Learning Program from the University of Louisville. Her interest areas are identification and treatment of hearing loss in infants and children, including amplification and cochlear implants.

Karen Jacobs was awarded her AuD from the PCO School of Audiology. She is the owner operator of a private practice in Grand Rapids, Michigan, and is active on the Michigan Licensing Board and a member of LIONS International. Jacobs is beginning her fourth year as a member of the Academy Board of Directors, and is delighted that she will have the additional opportunity to serve the profession as the Academy Board liaison to the AAA Foundation.

Linda Hood, Barbara Packer-Muti, and Jerry Northern are completing their service on the AAA Foundation Board as of June 30, 2008. Blythe Holmes, a student at Rush University, also ends her one-year term as our student representative at that time. Packer-Muti served as chair of the board from 2003 to 2006, and annual giving grew dramatically under her leadership. Hood served the board as the “go-to” trustee in all matters research-focused, in addition to serving as chair of the Foundation’s Development Subcommittee. Northern has served on the AAA Foundation Board since its inception and has contributed in innumerable ways to its growth and success. Among many other contributions, he spearheaded efforts for the development of the Marion Downs Lecture; under his leadership the lecture has gained the reputation of offering cutting-edge presentations by world-renowned experts in the hearing sciences.

“The AAA Foundation is appreciative of the many contributions of Barbara, Linda, and Jerry. They have devoted their talents and expertise for many years to the Foundation, and they will be sorely missed,” Stach stated at their final board meeting in April. “I know I speak for the entire board in thanking them for all they have contributed.”

ABOUT THE AUTHOR

KATHLEEN DEVLIN CULVER, MPA, is the director of development for the AAA Foundation.

Ears to You!

Tribute Gift Fund

Do you have a colleague, co-worker, or family member who has a special occasion on the horizon? The AAA Foundation wants to help you celebrate!

A gift to the Ears to You! fund is a gift to the future of audiology. This fundraising effort is headed by Ross Roeser, the chair of the AAA Foundation Planned Giving Committee, and is a way for you and your friends and family to make a meaningful gift in honor of special milestones in the lives of your colleagues and loved ones. Your gift to Ears to You! will recognize graduations, retirements, promotions, award recipients, holidays, birthdays, anniversaries, personal accomplishments, or other occasions of note in the lives of those you care about. This is the perfect gift for someone who has everything...and best of all, the proceeds are used to fund research, education, and public awareness in audiology.

Special personalized gift cards are available for those who make a gift of $25 or more to the fund. Let us help you make your next celebration a little more special! Make your tribute gift to Ears to You! today. For more information, contact the AAA Foundation office at 703-226-1048.
Get the Latest Tools for Your Private Practice...

The BEST Guide to Marketing for Audiologists
Let this book help you successfully market your practice to consumers, employers, educators, physicians, and more.

The BEST Private Practice Start-Up Kit
An interactive CD-Rom with downloadable sample forms, templates, and information on how to start your practice.

Available August 2008 through the Academy Store.
www.audiology.org/academystore

Sample Practitioner’s Procedure

1. From time to time, the information included in this manual may provide consent, in writing, to distribute this information to a third party or entity.

2. Confidential information shall not be discussed in the presence of a third party or entity.

3. Confidential information shall not be discussed in a room with a door open.

4. Confidential information shall not be discussed in an airport or public area.

5. Confidential information shall not be discussed in the presence of a child or other individual who is not in the employ of the practice.

Sample Policies and Procedure Manual

Dear Employee:

Welcome to (business name). You have joined an organization that is committed to doing its part to ensure a safe workplace for all employees. This manual provides answers to most of the questions you may have about your work experience.

The following information contains one or more of the following topics:

• Confidential information related to (business name)
• Business policies and procedures
• Business operations
• Business procedures
• Business policies

Confidential information shall not be discussed in the presence of a third party or entity.

If the employee fails to follow any of the terms of this agreement, the employee will be responsible for all legal fees and costs associated with its enforcement. This agreement may only be enforced by the employee.

Sincerely,

(Appropriate contact names)

The BEST Guide to Marketing for Audiologists

Let this book help you successfully market your practice to consumers, employers, educators, physicians, and more.

Available August 2008 through the Academy Store.
www.audiology.org/academystore

The BEST Private Practice Start-Up Kit
An interactive CD-Rom with downloadable sample forms, templates, and information on how to start your practice.

Sample Policies and Procedure Manual

Dear Employee:

Welcome to (business name). You have joined an organization that is committed to doing its part to ensure a safe workplace for all employees. This manual provides answers to most of the questions you may have about your work experience.

The following information contains one or more of the following topics:

• Confidential information related to (business name)
• Business policies and procedures
• Business operations
• Business procedures
• Business policies

Confidential information shall not be discussed in the presence of a third party or entity.

If the employee fails to follow any of the terms of this agreement, the employee will be responsible for all legal fees and costs associated with its enforcement. This agreement may only be enforced by the employee.

Sincerely,

(Appropriate contact names)
BOARD OF DIRECTORS APPROVE SALARY SUPPLEMENT POLICY RESOLUTION

The Academy Board of Directors recently approved a policy resolution urging school districts providing for or considering salary supplements for school-based audiologists to recognize board certification by the American Board of Audiology (ABA) (“Board Certified in Audiology”) thus allowing those audiologists certified by the ABA to become eligible for such salary supplement programs.

Background: Academy leadership learned that some school districts around the country have salary supplement programs for audiologists, making eligible only those audiologists who hold a current ASHA-CCC certification. To date, numerous school districts have followed this model for these salary supplement programs. The resolution advocates for an alternative pathway for audiologists with board certification from the ABA to become eligible for such salary supplement programs. The policy resolution can be viewed at www.audiology.org; click on Government Relations then Policy Resolutions.

HEARING ASSISTANCE TECHNOLOGY: ACADEMY GUIDELINE RELEASED

The Academy has just released the guideline titled, “American Academy of Audiology Clinical Practice Guidelines: Remote Microphone Hearing Assistance Technologies for Children and Youth from Birth–21 Years.” The guideline has been prepared by the Hearing Assistance Technology Task Force: Cheryl D. Johnson, EdD (chair); Vicki Anderson, AuD; Arthur Boothroyd, PhD; Leisha Eiten, MA; Sandra Abbott Gabbard, PhD; Dawna Lewis, PhD; and Linda Thibodeau, PhD. The guideline can be viewed at www.audiology.org, click on Strategic Documents, then Standards, Guidelines, and Positions Statements.

ACADEMY RECOMMENDATIONS FOR AUDIOLOGIST STANDARD OCCUPATIONAL CLASSIFICATION MOVE FORWARD

In direct response to the Academy’s advocacy efforts to correctly categorize audiologists in the Standard Occupational Classification (SOC) manual, the Standard Occupational Classification Policy Committee (SOCPG) has proposed revision to the manual reflecting the Academy’s recommendation. For more information, visit www.audiology.org; click on Government Relations, then GR News.
ANNUAL REPORT

As we conclude our fiscal year (July 2007–June 2008), we have prepared the Annual Report to best illustrate our Academy accomplishments, committee accomplishments, and financials.

Over the past year, the Academy has worked to increase membership, maintain financial stability, enhance our public awareness initiatives and advocacy efforts, and develop our educational offerings. Here are some of the highlights from this year:

- Reached a record high membership of 10,673
- Implemented a new investment policy to better protect net assets
- Enhanced our public awareness initiatives and reached over 21 million consumers
  - Turn It to the Left™, reached over 20 million people (awarded 2008 Award of Excellence by Associations Advance America)
- Hearing Great in 2008, reached over 1.9 million viewers (thanks in part to a grant by Energizer through the AAA Foundation)
- Secured 90 co-sponsors on the Direct Access Bill to date
- Created a presence in Washington, DC, with the investment of our Capitol Hill office
- Increased our exposure to lawmakers and others resulting in enhanced advocacy efforts
- Audiology Solutions named one of the “50 Fastest Growing Trade Shows in 2007”
- Increased online education and on-demand Web seminar offerings

To review the financials and the committee accomplishments, visit www.audiology.org; click on About the Academy, then Annual Report.

CALL FOR PRESENTATIONS!

The AudiologyNOW!® 2009 Program Committee is looking for innovative session presentations. Help create an extraordinary educational experience for your colleagues.

Submit proposals online at www.audiologynow.org starting August 4, 2008.

FOCUS FOR 2009
Research and Clinical Practice: Integration Through Communication

AMERICAN ACADEMY OF AUDIOLOGY

April 1–4, 2009
Dallas, TX
**TEXAS**

**THE UNIVERSITY OF TEXAS AT DALLAS—CALLIER CENTER FOR COMMUNICATION DISORDERS**

Clinical Assistant Professor in Audiology: The University of Texas at Dallas seeks a Clinical Assistant/Associate Professor for the Doctorate of Audiology Program at the Caller Center for Communication Disorders, beginning August 1, 2008. Primary responsibilities include teaching graduate courses, coordinating AuD weekly labs and contributing to AuD program committees. Additional responsibilities may include supportive teaching roles in the AuD Program, such as clinical supervision and methods classes. Candidates must hold a doctoral degree, and possess the CCC-A and be eligible for the Texas Audiology License. Interested persons should submit a resume and two letters of recommendation by June 1, 2008, to: Academic Search #5086, The University of Texas at Dallas, 800 W. Campbell Road, AD 42, Richardson, TX 75080-3021. UTD is an EO/AA employer and strongly encourages application from candidates who would enhance the diversity of the University’s faculty and administration.

**UTAH**

**AUDIOLOGIST WANTED**

AuD or master’s level Audiologist wanted to dispense hearing aids in the Northern Utah region. Wages negotiable. Contact Sara Crookston at 801-713-0101 for information.

**WASHINGTON**

Full-time experienced Audiologist position available at Madigan Army Medical Center, Ft Lewis, Tacoma, WA. Hours are Monday–Friday, 7:30–4:00. No weekends, no holidays. Duties include EVOC, Cochlear, and some pediatrics patients. Applicants must have a 2 year degree, certification, and at least 1 year of applicable audiology experience. US residents only. Full Benefits include Health, Life, Dental, Vision, 401K, STD/LTD, paid holidays, paid vacations, and CME stipend. If interested please submit resumes on-line at www.godwincorp.com.

Bassett Healthcare is currently seeking a qualified Audiologist for this full-time, days opportunity.

**Residencies:**
- Performs patient Audiology testing with accuracy.
- Provides excellent customer service to internal and external customers.
- Maintains proper documentation and databases to ensure compliance with institutional, state and federal standards and requirements.
- Participates with department quality assurance, compliance and performance improvement plans.

**Requirements:**
- Doctorate or master’s degree in Audiology.
- CCC-A completed.
- Current New York licensure in Audiology and New York State Hearing Aid Dispenser License.
- New graduates considered.
- Must be able to communicate well with patients, Bassett providers and nursing staff, referring physicians and clinicians, schools or other agencies.

To learn more about our positions, please contact:

**Bassett Healthcare**
**Human Resources**
**One Atwell Road**
**Cooperstown, NY 13326**
**Call: 800-526-1271**
**Email: hr@bassett.org**
EOE M/F/D/V

**www.bassett.org**
Costco, one of the largest hearing aid retailers in the United States, is expanding and looking for dispensing audiologists. We discourage “pressure sales,” allowing you to focus on patient care, with the latest in digital technology at affordable prices. Costco Wholesale, a Fortune 50 company, also offers:

- Competitive wages based on experience, qualifications and market demand
- Outstanding benefits package, including medical, dental, vision, hearing, vacation/holiday pay, overtime pay and a 401(k) plan.
- Full-time and part-time hours
- Licensing and continuing education reimbursement
- Locations in most states
- Fully equipped sound room with computerized testing and programming equipment

If you or someone you know is interested in pursuing a career with Costco Hearing Aid Centers, please contact Tammy Clark by phone (425) 313-8787, fax (425) 313-6500 or e-mail audiologycareers@costco.com.

Costco is an equal employment opportunity employer and a drug- and alcohol-free workplace.
Summit 2009: Gold Standards in Audiology Education

Mark Your Calendars!
January 12-14, 2009
Orlando, Florida

To address today’s fundamental issues in PhD and AuD audiology education, including:

- Academic and clinical training models
- Combination PhD and AuD training programs
- The critical 4th-year AuD externship
- Accreditation standards
- Recruitment of diverse student populations