Letters to the Editor

IMPLICATIONS OF AUDIOLOGIC SUCCESS?

To the Editor:

I read with dismay Dr. Mark Ross's article, "Implications of Audiologic Success," in the latest JAAA. It is neither scientific in its arguments nor its conclusions. While there can be no doubt Dr. Ross conveys the truism that we audiologists have major responsibilities in the habilitation of hearing-impaired and deaf children, Ross concludes that all habilitation should be based upon the aural-oral methodology in providing linguistic development for deaf children. Unfortunately Dr. Ross begins his discussion in a most non-scientific manner by creating a hypothetical example, that of a child with what appears to be a profound hearing loss whose success he assures by the very fiction he has created. For those of us in educational audiology who are regularly and constantly faced with the tragedy of picking up the pieces of a failed aural-oral methodology provided to children with severe and profound hearing loss, it would seem to have been far more honest of Dr. Ross to have used not a concocted example, but real data on populations of severely and profoundly impaired children who have been brought up on the system he advocates. Then his conclusions might be more reasonably appraised. It is very easy, but hardly valid, to recommend a methodology when it is based upon fictitious example.

In terms of Dr. Ross's rationale for an early auditory approach (page 3 of the article), I agree that the auditory channel is the normal biologic route for learning speech and language, if by normal Dr. Ross means the most common. However, if by normal he means the exclusive route, he is quite mistaken. There is ample evidence that the human brain has no uncompromising linguistic preference for auditory input and acoustic output (see for instance Petitto and Marentette, 1991). As for Ross's statement that we typically do not know the specifics of a young child's hearing loss, that is true in those cases, for example, where a child's residual hearing lies somewhere outside the limits of our tests using auditory evoked potentials (i.e., cortical and brainstem test protocols). Does Dr. Ross mean that because we don't have precise measures on a child's hearing that we should default into the auditory method? Interestingly, he provides a rather precise description of the hearing loss for the child in his fictitious example, helping him justify the auditory method.

I should very much like to see from the proponents of the auditory method some carefully designed and controlled studies on the value of their method in the habilitation and education of severely and profoundly hearing-impaired children, particularly the latter. Those studies should be based not on just one or two exceptional children, but on an honestly representative number who are compared to children who have been educated with the help of sign language. No more fiction, self-justification, or sententious pronouncements please; just real data.

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Response to Riedner

To the Editor:

Dr. Riedner faults me for being insufficiently "scientific." Frankly, I had no idea I was writing a "scientific" article at all (Ross, 1992). I thought I was simply expressing some ruminations about an issue that has troubled me since I first came into the field: how do I reconcile my aggressive audiologic efforts with hearing-impaired children with the reality and choices they will ultimately confront. It is a dilemma faced by any audiologist who works with young profoundly hearing-impaired children—including, I'm sure, Dr. Riedner. The more effectively we are able to exploit the residual hearing of such children, the wider the range of options and difficult choices they and their parents will eventually have to make. Why is this such a difficult point to comprehend? Is Dr. Riedner suggesting that in our management procedures, we ignore the children's residual hearing?
I selected a hypothetical child as the basis for my non-scientific article to keep the discussion from being confounded with the particularities of a specific child. (It would have been more accurate, perhaps, if I had stated that the child was a "composite" example and not purely fictional.) I did refer to "real" children, such as those testifying in the chapter by Green (1990). I also showed some data, collected by my colleague Dr. Diane Brackett in 1990, which demonstrate a high order of auditory phoneme recognition by profoundly hearing-impaired children, some of whom were wearing cochlear implants. These children, those using FM systems as well as those employing cochlear implants, have continued to improve their auditory perceptual skills. They are already effective auditory and auditory/visual communicators, but, as I pointed out in the article, they are still audiometrically "deaf" and face some hard choices, in addition to increased opportunities, in the years ahead.

I tried not to frame my article in the traditional "oral vs. manual" dichotomy which has bedeviled the field of deaf education since Heinicke's and De l'Epee's time. I am well aware of (and, for a time, was personally involved in) the arguments on both sides of the issue. More often than not, they took on the coloration of a religious disputation rather than a clinical or educational debate. Dr. Riedner defines my intent as lauding an auditory-oral approach at the expense of a manual approach. I would ask him to please read my article again, this time a little more agnostically.

To respond to several of his specific points: I do think that if "we don't have precise measures on a child's hearing that we should default into the auditory method." I don't know how he defines "auditory method," but I think of it as making every effort to fully exploit a child's residual hearing with a rich pattern of appropriate oral language inputs. Why, as an audiologist, does he find this practice objectionable? On occasion there may be a down side to this decision for some children, much as we would like to avoid it. But to be fair, Dr. Riedner should also acknowledge the possible consequences of de-emphasizing an optimal auditory exposure in a child's early years. Moreover, I thought I was being explicit (bottom of page 3) about ensuring an early alternative to an auditory-oral approach when necessary. Perhaps someday we'll learn that, for some children, an alternated (not simultaneous, as with TC) auditory-verbal and sign language input can be accomplished without affecting either mode negatively.

One difference between us, I suppose, pertains to the input mode to emphasize initially. For children with definitely no residual hearing, I would agree that an early sign mode is desirable, perhaps vital. However, with the increasingly successful use of cochlear implants this decision, too, becomes less well defined. Clearly, continued developments in technology, both in wearable hearing aids and implanted devices, are going to continue to have an impact upon all hearing-impaired people. It would be a better use of both our energies and time if we could look at the implications of these developments and try to frame some new debates for the twenty-first century.

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