Q: Who needs Aural Rehabilitation? A: All those people we failed in the past!

What follows is a long explanation for the answer above. I have a reputation for promoting controversy, so here's hoping this stimulates (at least) polite discussion.

Familiar scene #1: Mr Smith comes in with a 60dB mid- to high-frequency hearing loss and a long list of listening difficulties - we recommend hearing aids. As a matter of interest, we ask why he has waited until this stage before "doing something about it". His reply might mention cost, didn't think loss was enough to justify h/a fitting, or that hearing aids don't work but he's desperate. After his hearing aid fitting he chews up hours of our time (and his money) getting retrained (Aural Rehabilitation) in how to listen again.

Familiar scene #2: Mrs Jones says that she can't hear in groups, needs the TV and phone turned up, and is in all sorts of trouble at work. The audiogram shows normal or near-normal hearing, so we tell her the loss isn't enough to warrant hearing aids. Her look conveys a mixture of relief (dodging the expense) and worry ("So how do I cope now?").

Please join the dots. (Hint : There's only two clients, and ignoring the gender and name change, the connection is obvious. With the passage of years," Mrs Jones" transforms into

"Mr Smith" "if we don't help her.)

Mrs Jones came in with a communication problem that we failed to treat. Now, don't go blaming the OHS 3FAHL rule to excuse your actions –she is still working, and gets the same (non)-treatment.

The NAL fitting protocol would generate zero gain if the thresholds were fed into it. And your colleagues would snigger when you passed by if you fit people who don't have a "real" hearing loss.

A recent posting by Gregory Frazer on the AAA General Audiology blog gives considerable scientific and anecdotal argument for fitting on the client's MCL rather than the audiogram. He points to the degree of nerve fibre loss (which can be as high as 90%) that can co-exist with normal thresholds. He suggests that "APD" might be (in some cases) purely due to damage in the cochlea.

An audiologist in New Zealand is using low gain hearing aids as a first approach for APD children with good results (personal communication).

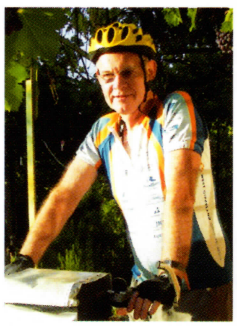
For anyone wanting to track down the research, there is a lot around. Let's move on to a business case for this approach.

Going back to Mrs Jones – we had a willing client that we failed. We left her worse than when she came in. She consulted an expert and was told nothing could be done. Before she entered our door, she had hope, but not now.

What would happen if we said "Yes, we can help"? It might be recommending LACE, or tactics, or low-gain hearing aids – or all three. We offer solutions and surely that is why we started practice in the first place. She will regard us as the people who treat communication problems. She will return every year for a review of her hearing needs, recalibration of the hearing aids, etc. One day she will be looking for "proper" hearing aids – higher priced probably, but she's stayed in touch with the hearing world, and doesn't need all that expensive Aural Rehabilitation. Let's split the cost saving with her – now, that's a good business advantage.

So our business model requires access to simple, cheap, reliable, cosmetically appealing hearing aids. Open fit, so no occlusion problems. Open fit wipes out the benefit of electronic directionality/noise reduction so complex processing is not required. Does this work? Some years ago we were fitting the ReSound Avance to clients with minimal loss on a trial basis. Nearly every client kept the aids because of the benefit they received ("You're not getting these back!" was usually their first comment when they were seen for review). They were upset when it was no longer available.

In the USA, there are personal amplification devices (you can't legally call them hearing aids) which are starting to have an impact. It's probably the same here but people aren't discussing it. What WE need to do is claim this ground – present ourselves as the communication experts who can do the testing to reveal possible health problems, appropriately treat the hearing problems, and provide a lifetime of care for that client. If we don't do it, some-one else will (not a hearing health care professional). Or even worse, no-one will help.



Any manufacturers out there – I'm looking for a device I can retail for under $500. I'm sure you can do it – but will you? Otherwise I'll just keep waiting until my clients' hearing deteriorates to the point where I have to do Aural Rehabilitation...

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"Neil abandoned a promising career in IT in the middle of last century and followed his wife, Sue, into Audiology. With her, he established and continues to run one of Victoria's earliest and most successful private Audiology practices. He has been an active Member of ACAud since its inception and has not abandoned his youthful dream of a united and client-centered profession.

Neil's interests include grand-parenting, fire fighting, cycling in the pretty parts of France, telling shaggy dog jokes and thinking outside the box."