Relationship-Centered Consultation Skills for AUDIOLOGISTS

REMOTE AND IN-PERSON CARE

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PREFACE

Since the beginning of the digital hearing aid era, more than 20+ years ago, audiologists have come to expect that incrementally improving technology will address the unmet need of individuals with hearing loss. Spend any time in a clinic and you are likely to hear all the following reasons persons with hearing loss forego amplification—even in the face of an oftentimes debilitating condition.

- "I hear well enough"
- "Hearing aids don't work well in background noise"
- "Hearing aids cost too much"
- "I don't want to deal with the care and maintenance of hearing aids"
- "It's not bad enough yet"
- "I'm not old enough to wear hearing aids"
- "Insurance doesn't cover them"
- "It's a big inconvenience to make an appointment to see the audiologist"
- "I don't like the way they look"

Make no mistake, hearing aids have never had higher overall satisfaction ratings. According to the most recent MarkeTrak 10 survey, published in 2020, 83% of current hearing aid owners are either "highly satisfied" or "satisfied" with their hearing aids and the quality of care they are receiving from their service providers. The challenge, of course, is only about one-third of adults with hearing loss are hearing aid owners, while the other two-thirds who could benefit from various interventions, including but not limited to hearing aids, fail to recognize the magnitude of their hearing challenges and decide to simply live with the problem.

Low uptake of hearing aids is far from a simple problem. Barriers to hearing aid use run deeper than cost or other issues related to the transactional process of acquiring hearing aids. Several of these issues are linked to the individual's personality, perception of value, and locus of control; factors that require well-honed communication skills from the audiologist, not a cheaper price or easier way to buy hearing aids.

To compound the problem of low uptake of hearing aids, recent data suggest untreated hearing loss is linked to several other conditions that erode a person's overall quality of life, especially as they age. Depression, cognitive decline, and social isolation are among the most harmful conditions associated with untreated hearing loss, and although evidence indicates hearing aids effectively stop these conditions from declining, common sense tells us interventions, provided earlier when an individual tends to be younger, healthy, and with milder hearing loss, improve both daily communication as well as several health-related outcomes, including depressive symptoms, cognitive ability, physical mobility, and emotional well-being.

Clearly, the antidote to low hearing aid uptake and the perniciousness of untreated hearing loss is more than a newer technologically-advanced hearing aid platform. Instead of fixating on hearing aids, ironically, as this preface, so far, has done, to address the problem of unmet need, clinicians would be wise to incrementally develop their interpersonal counseling and communication skills. In short, audiologists must be committed to practicing in a more holistic and patient-centered manner. One popular approach geared to better meet the needs of persons with hearing loss is to practice patient-centered care. Something that is easy to talk about (ask any audiologist and they say that they do it) but challenging to implement.

Patient-centered care might seem like a recent advance, but the term has been around for more than 30 years. In the 1980s, out of the morass of top-down, paternalistic care, emerged the concept of patient-centered care. This new model of care shifted control of medical decisions away from the credentialed professional directly toward the person receiving the care. It's probably no coincidence that the first recipients of patient-centered care were baby boomers who tend to be more participatory and consumer-oriented in their approach to just about everything.

For virtually everyone, though, the movement away from paternalistic care was a welcome change. Research in several medical fields confirms the value of patient-centered care. People like it because it tends to give them some semblance of control over their own body and a range of possible choices on how they want to receive treatment. However, because patients have more control in the decision-making process doesn't mean they are always right. Most people still want help navigating their choices and insights from an expert who they trust.

Additionally, there is another reason patient-centered care, at least in the traditional sense of the term, might have some serious limitations in the audiology or hearing aid dispensing clinic: audiology, unlike most other health care professions, blends the medical and the retail in a way that some clinicians find problematic. In audiology's unique blend of medical and retail, where many individuals are paying for service out of pocket, they are more like customers, who have myriad choices on how to acquire services, and less like patients who are often captive to their insurance plan's network of providers. Even though the person with hearing loss is likely to benefit from the expertise and guidance of the highly trained audiologist, they still have a choice on how they want to seek help and spend their money— something that is especially apparent in the emerging age of self-fitting hearing aids and automated hearing testing. The emergence of more ways for the individual to engage in the process of hearing care, through either the provider-based or self-directed routes, reminds us that we work with *persons* not patients.

For audiologists, a potential downside to being more "person-centered" is the term implies the clinician is ceding too much control to the patient. Testing, diagnosis, treatment, and rehabilitation, in most cases, should not be solely placed on the shoulders of the person with hearing difficulties; after all, hearing loss is often a complex problem requiring the expertise of the clinician. Taken to its logical extreme, automated hearing assessments, self-fitting hearing aids, and AI-driven bots that provide counseling services are also "person-centered." Yes, some individuals might choose to self-direct their care, and for those who can "do-it-themselves" successfully, they should be encouraged to do so. The quandary, of course, is most persons with

hearing loss, at some point in their journey to improved communication, benefit from the personal interaction of an empathic, expert professional; someone who cannot be replaced by artificial intelligence, machine learning or neural networks.

For these reasons, audiologists need to focus on the *space* between the patient and the clinician: the relationship. The interaction, collaboration, and communication that takes place between two people—a sharing of ideas between two people, each with vested interests. That's why the term relationship-centered communication (RCC) is preferred and used throughout this book. Relationship-centered communication acknowledges the clinician's expertise and judgment, while respecting the person's preferences, perspectives, and ultimately his or her ability to decide what intervention is best.

Recently, Wallhagen, Strawbridge, and Tremblay (2021) proposed that audiologists should work within the 4M's framework (the 4M's framework is a termed coined by the Age-Friendly Health Systems movement). Chapter 2 of this book summarizes several frameworks used to streamline or better understand the sometimes messy and unpredictable nature of the interaction between a person with hearing loss and a clinician. The 4M's framework suggests that what Matters is relationship-centered communication, and it needs to be combined with being mindful of Medication that might impact the individual's overall well-being and communication ability, along with Mobility (maintaining overall daily physical functioning) and Mentation (sustaining good cognitive and emotional health). The 4M's framework reminds us that hearing loss is not independent of other health conditions and the ability to capture the full totality of the individual's situation is built on a foundation of holistic, empathic communication.

This book intends to provide some practical guidance, based on scientific principles, around this foundation of holistic communication. Furthermore, this book tries to show that relationship-centered communication is not confined to in-person visits; that strong professional relationships can be forged in the virtual world—something that should interest all stakeholders as we move into the post-COVID era of tele-audiology and remote care. Finally, as Chapter 5 tries to explain, audiologists do not have to sacrifice income to practice relationship-centered care; that

regardless of how you might price your products and services (bundled or unbundled), you do not have to abandon profit to practice in a relationship-centered manner. After all, best practice equals good business.

Most agree something magical happens in the interaction between the provider, who demonstrates a keen interest in the person's challenges, and the person with hearing loss begins to actively engage in the process of exploring and planning *how* they can communicate more effectively. This is something that cannot be replicated or replaced by AI-driven bots or a neural network. To paraphrase Kevin Roose, author of *Futureproof,* AI is everywhere, and algorithms run your life. Indeed, automation *is* everywhere, in hearing aids, on your smartphone, even inside your test booth, but there remains a place for relationship-centered communication and holistic care. It starts by freeing oneself from the clutches of incrementally-improving hearing aid technology, automated hearing testing, and your addicting smartphone, and focusing on the needs of the person in front of you —either in-person or on a screen—at this moment.

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THE CORNERSTONES OF RELATIONSHIP-CENTERED COMMUNICATION

Marlo, who recently graduated with her AuD, is finishing her first week of work as a clinical audiologist. It is late on a Friday afternoon, the end of an exhausting week, and Marlo is frustrated. After 4 years of immersion in the academic world of audiology and discovering a passion for working with adults who need hearing aids, Marlo is discouraged because in her first work week five adults who needed hearing aids declined her recommendation. Yes, she was busy completing a slew of diagnostic hearing tests for the otolaryngologist in the adjoining practice, but she spent at least an hour with each of the five patients—all of whom were hearing aid candidates. Yet all five patients said they needed to think about it, explore other options, and talk to their family before they decided to acquire hearing aids.

Marlo spent her past two summers interning at a leading hearing aid manufacturer. She learned so much about the latest technological advances in hearing aids that she was able to assist the technical support specialists at the manufacturer with troubleshooting problems in their current products. In fact, it was Marlo's technological prowess with modern hearing aids that enabled her to land her first job as a clinical audiologist. Marlo knew more about hearing aids than the other two audiologists on staff, including her boss, the director of the clinic. All that knowledge about hearing aids and an unbridled passion for helping people somehow did not translate into immediate success; that is, if success is measured by the number of hearing aids that were ordered at the end of the week—something she knew the clinical director, her boss, carefully monitored.

Marlo's story is not new; it has been repeated by others on several occasions. Individuals have invested considerable money and time into becoming an audiologist, with a passion for helping people, only to be stymied by a bitter reality: You have to ask someone to buy something that costs a lot of money. By the time you've incurred several thousands of dollars in student loan debt and logged hundreds of hours learning about the human auditory system, diagnosis of hearing disorders, and a vast array of other pertinent details, it is a bitter pill to swallow when you come to grips with the fact that you have to convince people to buy something many of them do not want. After all, you have accomplished your goal of becoming an audiologist and you have a strong desire to share of all this knowledge with every patient who desires care, but the problem is most patients don't care how much you know.

The question is, why does a bright, academically trained, credentialed audiologist struggle with this?

This book is geared toward helping Marlo and others address this question. To effectively tackle this question, we must explore the multifaceted and somewhat peculiar role audiologists play in the health care system as both diagnosticians and rehabilitative specialists. Both these roles are equally important, but they require divergent skills. As this chapter addresses, the skills that are effective for disease detection are quite different from the skills required to be an effective rehabilitation specialist.

WHY RELATIONSHIP- AND NOT PATIENT-CENTERED COMMUNICATION?

The concept of patient-centered care emerged in the 1980s. This model of care shifted control of medical decisions away from the professional and toward the patient. For health care providers and patients alike, this was a welcome change. It meant that patients were assuming more control of their bodies and how they took care of them. Research in other medical fields has confirmed the value of patient-centered care. People like patient-centered care because it tends to give them some semblance of control over their body and how it is treated. However, just because patients have more control doesn't mean they are always right. After all, a patient's damaged auditory system, maladaptive coping strategies related to that hearing loss, and following a treatment plan within the context of the patient-clinician relationship is not the same as customer service in a retail business, in which it is said that the customer is always right.

Although it is certainly a debatable point, the term *patient centered* implies the professional is ceding too much control to the patient. When someone has a complex condition, a simple Google search and self-guided approach to care and treatment might be effective for some, but it is not appropriate for all. In the grocery store, the customer might always be right, but in the clinic, the patient is not always right or acting in their best interest. Testing, diagnosis, treatment, and rehabilitation should not be solely up to the patient to decide, because the clinician brings expertise that patients often need. When we place the relationship between the patient and the provider at the center, we strike a balance between helping the patient get what the patient believes he wants or needs, and what we, as expert professionals, believe to be in the patient's best interest.

Therefore, audiologists need to focus on the *space* between the patient and the clinician: the relationship, or the communication that takes place between two people. That's why the term *relationship-centered communication (RCC)* is used in this chapter and throughout this book. RCC acknowledges the clinician's expertise and the patient's preferences and perspectives. In most cases the final result of this relationship is a patient who has opti-

mized their ability to communicate with the guidance, insights, and persistence of the provider. Let's get started by learning what each party—the patient and the provider—brings to the table.

THE DUAL ROLE OF AUDIOLOGY

Audiology is a unique profession, and by most standards, it is a relatively young profession, blossoming in North America and western Europe following World War II. Cutting its teeth by managing the needs of soldiers returning from the war, audiology centered on two distinct practices. The first is diagnostics, particularly the identification of ear diseases using an evolving battery of site of lesion testing. This battery of tests included air and bone conduction pure-tone threshold testing, speech audiometry, tympanometry, and acoustic reflex thresholds. Eventually, electrophysiologic assessment of the auditory and balance system, including auditory brain stem response (ABR) and otoacoustic emissions (OAE) assessment, were added to the armamentarium of audiologists involved in diagnostic assessments. The second practice is treatment and rehabilitation; specifically, the selection and fitting of hearing aids for individuals with medically benign forms of hearing loss. Because medically benign hearing loss is not curable with surgery or medication, treatment and rehabilitation require the audiologist to interact with the patient over an extended time frame, usually several years. During the extended treatment and rehabilitation process, the audiologist needs a multifaceted approach involving periodic hearing checks, monitoring of any change in hearing that would necessitate a referral to an otolaryngologist, hearing aid cleaning and readjustments, and occasional counseling.

DIAGNOSTICS REQUIRES ACCURACY AND PRECISION

By virtue of their state license, audiologists have a responsibility to identify possible cases of medical pathology or ear dis-

ease and make the proper referral to an otolaryngologist for further workup. To fulfill this responsibility, audiologists must follow a prescribed test battery, including case history, air and bone conduction threshold tests, tympanometry, acoustic reflex thresholds, and speech recognition testing. The systematic administration of this test battery and the interpretation of the results require audiologists to apply their skills with accuracy and precision. "Accurate" in this sense means the test battery must be executed to rigorous clinical standards, and "precise" means the test must be executed in the same consistent and methodical manner every time. Essentially, audiologists use a set of standardized procedures to collect data about the functionality of an individual's auditory system. Based on the constellation or pattern of the results, the audiologist decides the next steps in patient care. The next step, for example, could be a medical referral for an individual who has a pattern on their test suggestive of an ear disease or medical pathology.

Fortunately, the prevalence of ear disease or medical pathology involving the auditory system in adults with hearing loss is quite low. Zapala et al. (2017) estimated the odds are 20:1 of identifying an ear condition that needs medical referral to an otolaryngologist. This suggests that more than 95% of adults with hearing loss rely solely on the audiologist to be proficient at treatment and rehabilitation of their hearing condition. Even though the prevalence of ear disease or medical pathology is low, some of these conditions, if missed during a routine hearing assessment, could be catastrophic to the individual with the condition. Kleindienst et al. (2016) identified a handful of uncommon medical conditions, including fluctuating hearing loss, sudden hearing loss, and vestibular schwannoma that an audiologist must detect during a routine hearing assessment.

Accurate and precise execution of a hearing test battery, along with recognizing patterns in the results that necessitate a referral to an otolaryngologist, are firmly part of the medical model of care that audiologists learn during their academic training program and externship. Recall that the medical model requires the audiologist to identify possible ear disease through their case history and test battery, describe the results to the patient, and essentially tell the patient what to do next. That approach, which is a foundation of the medical model of care,

requires the clinician to carefully look for a cause–effect relationship, measure the extent of a potential problem, and tell the patient what to do about it. However, this constellation of skills is often ineffective for the chronic condition of medically benign hearing loss.

IMPROVING COMMUNICATION ABILITY REQUIRES SOMETHING DIFFERENT

Hearing loss is the third-most common chronic conditions of adults aged 65 years and older. According to Goman and Lin (2016), approximately one-third of all older adults experience some degree of self-reported hearing loss. In prevalence, just two other conditions—high blood pressure and high cholesterol—exceed it. There are dozens of conditions that are chronic in nature; some of these conditions, such as diabetes, chronic kidney disease, high blood pressure, and heart disease, are more deadly than others when left untreated. There are, however, three hallmarks of any chronic condition that make their treatment and management challenging for the practitioner. One, patients experience chronic conditions on a long-term and permanent basis; it is rare that they resolve without any intervention. Two, chronic conditions are controllable, but not curable. Patients who have a chronic condition need to do something to experience improvement. Three, chronic conditions require a multifaceted management approach over a long period of time, including a combination of medical intervention, rehabilitative services, and personal counseling. In the case of hearing aid use for the chronic condition of hearing loss, multifaceted management strategies often culminate in a person becoming a full-time consistent wearer of hearing aids. Many of the common characteristics associated with chronic conditions are summarized in Box 1–1.

There is an additional consideration about chronic conditions that makes the work of audiologists particularly challenging and that is often taken for granted: Many people with hearing loss of gradual onset can effortlessly delay treatment

Box 1–1. Hallmarks of Chronic Conditions

- Experienced by patients on a long-term and permanent basis
- Controllable, but not curable
- Require multifaceted management over a long period of time, including a combination of occasional medical intervention, education, rehabilitative services, and personal assistance
- It is common to delay treatment, minimize the consequences of the condition, and use maladaptive coping behaviors rather than seeking treatment or remediation
- Many individuals with the condition resist, avoid, and deny the need for help or advice from others, even close family members and trusted professionals
- Empathetic, forthright, caring, and knowledgeable providers can guide individuals with chronic conditions into taking action to improve the impact the condition has on daily living

because it is easy to develop coping strategies that enable them to function in a variety of listening situations. The list of coping strategies is long and diverse. It includes the cupping of the hand behind an ear, relying on a spouse or friend to rephrase what was missed during a conversation, constantly blaring the volume when watching TV, guessing at what others are saying, and avoiding noisy places. Many of these maladaptive coping strategies annoy or frustrate communication partners. Other maladaptive strategies place undue burden on the person with hearing loss, leading the person to become excessively tired or anxious at the end of the day. Perhaps, however, the biggest challenge associated with the chronic condition of hearing loss is that it is socially acceptable to minimize the ill effects of hearing loss and associate it with the natural progression of aging. As a society we believe hearing loss is normal in older people; that "Ole' Grandpa Joe" has to blast the TV and ask everyone to