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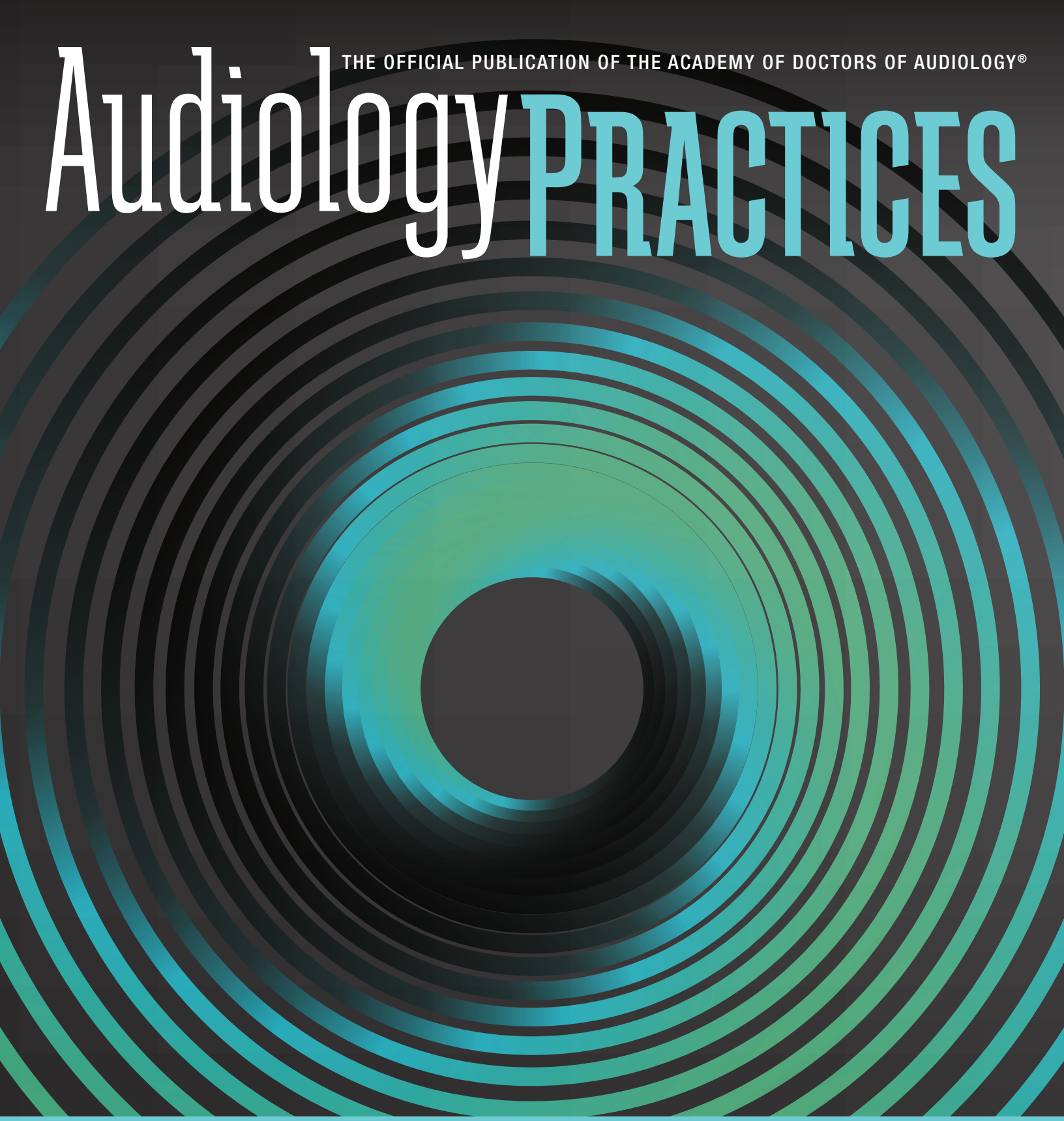

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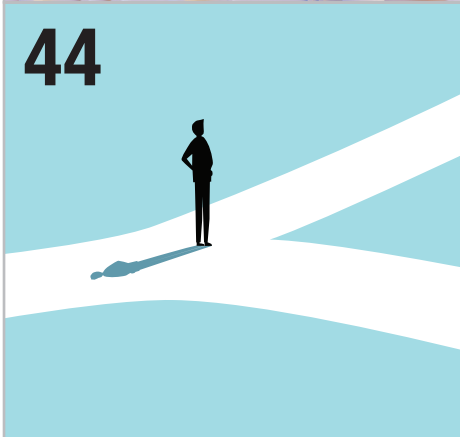

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Jill Davis, Au.D.

Audiology 2050: A Clear Direction

When I stepped into the role of ADA President this January, I knew the year would move quickly, but even I didn't anticipate just how much momentum we would have in the first few months. In many ways, that pace reflects where audiology is today. We are at a moment of both challenge and opportunity. The difference for ADA members is that we are not simply reacting to change, we have a clear direction for where we want the profession to go. That direction is Audiology 2050.

ADA has something powerful: a shared vision for the future of audiology and a roadmap to help us get there. That clarity gives us confidence as leaders and as members of this organization. It allows us to focus our energy not just on maintaining the profession, but on actively shaping it.

Starting the Year Strong

One of the most valuable decisions we made this year was to hold our ADA Board of Directors meeting in February, earlier than usual. Bringing the board together so early in the year allowed us to build strong connections right away, align our priorities, and begin working toward a cohesive message for 2026.

We were fortunate to host the meeting at ADA's headquarters in Frankfort, Kentucky, and it was a true pleasure to see firsthand where so much of the work supporting our members takes place. Being in the space where the "magic happens" gave the meeting an added sense of purpose.

During the meeting, the board focused heavily on translating the Audiology 2050 vision into tangible action. Rather than discussing the vision in broad terms, we broke the framework down into its individual "spokes" and evaluated them based on two key factors: importance to the profession and achievability in the near term.

Board Survey Results Audiology 2050 Element Rankings

Name of Audiology 2050 Initiative	Importance (Avg. Score)	Achievability (Avg. Score)	Total Score
Scope of Practice Consistent with other Clinical Doctors	5.75	3.25	9
Standardized, Evidence Based Practice	3.75	6.5	10.25
Professional Workforce Including Extenders	2.88	3.88	6.76
Audiologists Advance Professional Socialization Initiatives	3	4.13	7.13
Audiologists Are Advocates and Activists for the Profession	4.13	4.63	8.76
Achieve Medicare LLP Status	4.5	2.25	6.75
Primary Care Entry Point for Auditory & Vestibular Conditions	4	3.38	7.38

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Brian Taylor, Au.D.

Fewer Brands, Better Hearing? The Paradox of Rising Satisfaction in a Consolidating Market

In most healthy commercial markets, more consumer choice is equated with higher levels of satisfaction. After all, what consumer doesn't want a plethora of options? Going back to 1989, however, MarkeTrak surveys have noted an intriguing inverse relationship between overall hearing aid satisfaction and the number of brands available to consumers — meaning that as satisfaction has risen over time, the number of distinct brands in the market has actually shrunk. This is illustrated below. This counterintuitive trend is a product of industry consolidation, technological maturation, and evolving consumer expectations, and it carries, I think, important implications for both audiologists and hearing aid wearers.

Survey Year	% Overall Satisfied	Number of Hearing Aids Brands
1989	58% (initial MarkeTrak)	12+
2000	63% (MarkeTrak VI)	8-10
2008	74% (MarkeTrak VIII)	"Big 6"
2015	81% (MarkeTrak 9)	
2019	83% (MarkeTrak 10)	"Big 5"
2022	83% (MT2022)	
2025	82% (MT25)	

As the number of brands has decreased, patient satisfaction with hearing aids has increased.

In the late 1980s and early 1990s, the market was populated by a wide array of manufacturers offering relatively simple analog devices. Satisfaction levels were generally modest and constrained by fundamental technological limitations. Over three or four decades, however, digital signal processing, advanced noise management, directional microphones, wireless connectivity, and now artificial intelligence–based features have incrementally improved the wearer's experience. These technological advances — and the research and development investments required to bring them to market — have favored larger companies with scale, deep engineering resources, and global distribution channels.

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Friction and Forward Motion: Scope of Practice Modernization Isn't Meant to Be Comfortable

Audiology scope of practice modernization creates necessary tension. When policy proposals emerge to update or expand what audiologists are authorized to do under their licensing acts, debates quickly follow between professions, regulators, policymakers, and sometimes even within different factions of audiology. The friction that results can feel uncomfortable, contentious, and at times exhausting. But friction, by its nature, is not always a sign that something is going wrong. In fact, it may be evidence that meaningful progress is underway.

As a runner, I've experienced this lesson quite literally. When you run long distances, friction between your foot and your shoe often leads to blisters. Blisters are painful and inconvenient, but they are also part of the body's adaptive process. Over time, those blisters become callouses, protective layers that allow runners to go farther distances and endure more challenging environments. Without the initial friction, the body never builds the resilience it needs.

The friction that stems from change, growth, and adaptation, including the sometimes spirited debate around scope modernization for audiologists is building a more resilient profession that can achieve its full potential as a clinical doctoring profession.

Modernizing audiology's scope of practice reflects the reality that hearing and balance health care has evolved, education and training have advanced, and patient needs are rapidly shifting. Workforce shortages and technological advances have emerged. Statutes and regulations have not kept pace with these realities, making scope modernization necessary.

Still, updating long-standing professional boundaries naturally raises questions about safety, quality, accountability, and professional identity. Stakeholders often have competing concerns and this creates friction. Patient protection pushes up against patient access and workforce disruption results in both the erosion of traditional roles and the instinct to protect the status quo. Emotions can run high because the issues at stake: patient care, professional standards, and access to services are deeply important.

But the friction that stems from scope modernization also forces clarity. It compels professions to articulate their training and competencies. It encourages policymakers to scrutinize evidence and patient outcomes. It invites thoughtful examination of how interdisciplinary teams deliver care and how patients access services. Without this pressure, outdated structures can persist long after they stop serving patients well.

Friction, after all, is also what creates sparks. Sparks ignite fires, and fires drive transformation.

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The Regret Gap

How Tiered Counseling Disconnects Clinical Need from Intervention

PART 1

Bill Miller, Au.D., Hearing Insights, San Jose, California

INTRODUCTION

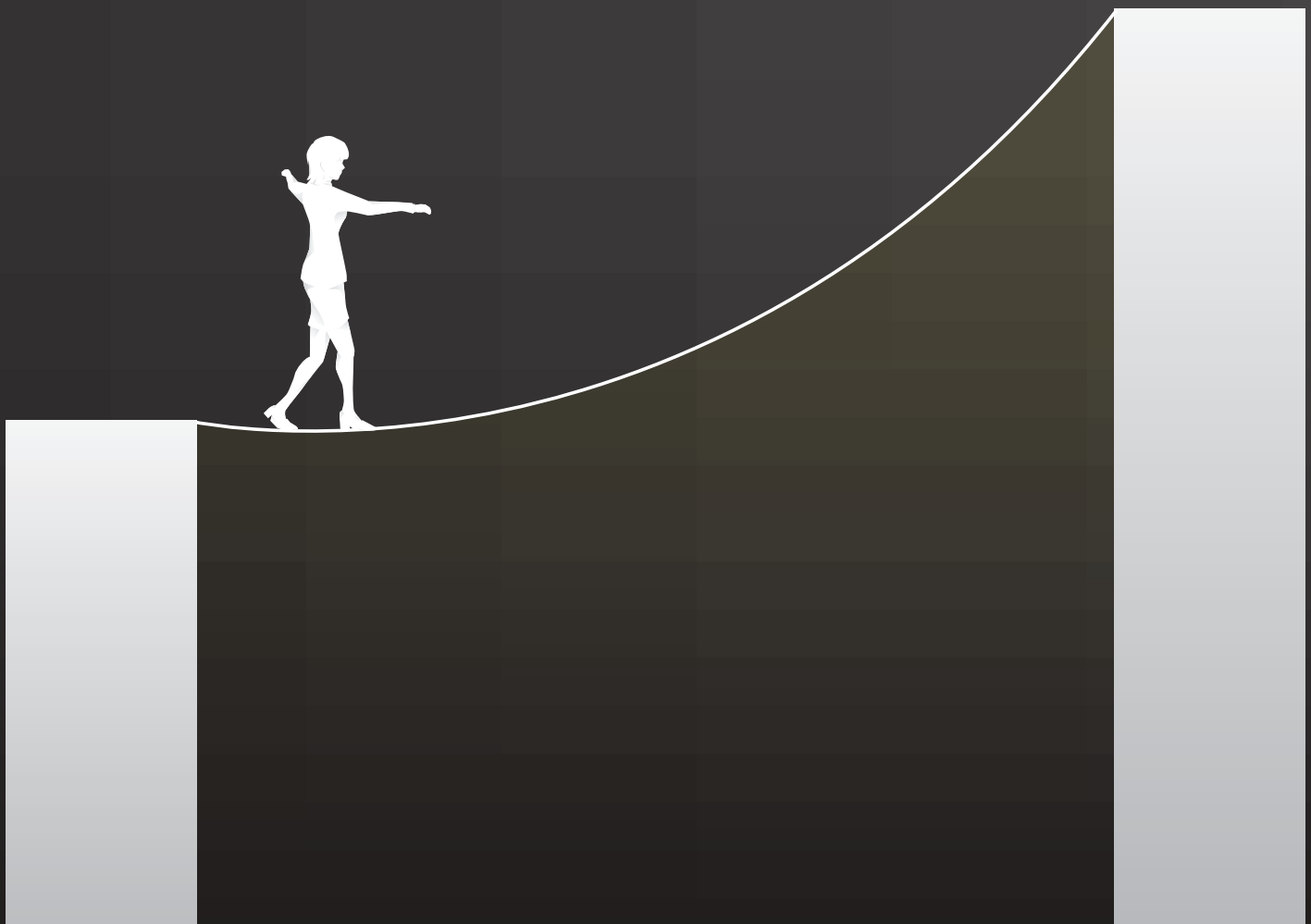
Clinical decision-making in adult hearing care is often shaped by commercial technology tiers (basic, advanced and premium) rather than diagnostic indicators linked to measurable outcomes. Patients believe they are selecting a clinical pathway. Often, they are navigating a pricing structure.

Hearing is not peripheral. It is how the brain stays connected to the world. When we treat hearing loss, we support the systems that keep patients engaged, alert and present.

Yet the current tiered model may inadvertently disconnect clinical need from intervention. Patients choose based on budget. Clinicians present options without clear diagnostic anchors. And satisfaction metrics can mask functional gaps.

We call this the Regret Gap: the distance between what a patient needs for long-term auditory health and the choice they felt compelled to make.

This article explores the evidence for that gap and proposes a framework to close it.



Margaret's Story

(Composite Case)

Margaret, 68, a retired teacher, sat across from her audiologist as three brochures lay neatly in front of her like a restaurant menu. Her WIN (Words-in-Noise) revealed a 13 dB signal-to-noise ratio (SNR) deficit, a clear struggle in noise. Her listening goals for the Client-Oriented Scale of Improvement (COSI) were straightforward: "I want to hear my grandchildren. I want to follow conversations at book club meetings."

The audiologist, with 15 years of experience, had a clear clinical understanding of what Margaret likely needed.

Still, the familiar script unfolded:

BASIC

$2,000

- ✓ Quiet environments

ADVANCED

$4,000

- ✓ Better speech clarity in small groups

PREMIUM

$6,000

- ✓ Most advanced processing in complex noise

"Which one fits your lifestyle?"

Margaret hesitated. Her book club met in a noisy coffee shop. Her grandchildren were loud and chaotic. She thought about compromising but heard herself say,

"I'll take the Premium. I don't want to wonder if I should have done more."

Six months later, Margaret stopped wearing her $6,000 hearing aids in social settings and avoided the environments where she needed them most. She still used them intermittently, just enough to justify the cost. At her next appointment, her audiologist noted she was "satisfied" because she was using the hearing aids. But satisfaction masked withdrawal. Her participation in book clubs and family gatherings had quietly shrunk. Margaret had the vague sense that she could be doing better, but no framework for understanding why she wasn't.

Consider what happened: Margaret didn't choose the "basic" or "middle" option. She invested in premium technology. If the tier system worked as intended, the top tier should have addressed her 13 dB SNR deficit. But it didn't.

The tier system failed even when the patient chose the "best" option. The technology didn't fail because it was ineffective. It failed because it didn't match her condition. When a device isn't linked to specific clinical findings, even the most advanced option can fall short.

Premium technology works when it matches a patient's specific diagnostic profile. Margaret's deficit required processing capabilities tied to her test results. But no one connected those results to the features she needed. She wasn't given a prescription. She was given a pricing menu.

This exposes a structural limitation: technology tiers are marketing constructs, not clinical categories. Margaret received what looked like a choice: three options at three price points. Functionally, she was being asked to select her own level of clinical intervention based on budget.

This is the paradox at the heart of hearing care: We present choices where prescription should exist.

The Illusion of Choice

The illusion of choice occurs when patients are presented with technology options that appear to represent clinical alternatives but actually represent price points. The patient's diagnostic need doesn't change between options. The clinical requirement doesn't change. Only the cost changes. Yet patients believe they are making a clinical decision.

When Margaret was asked "Which one fits your lifestyle?" (Basic for quiet, Advanced for groups, Premium for complexity) she was offered what appeared to be clinical autonomy. Functionally, she was being asked to select her own level of clinical intervention based on budget, without clinical guidance connecting her specific diagnostic findings to a recommended solution.

This is what I call the illusion of tiered counseling. We present multiple technology levels as though they represent different patient preferences. In truth, tiers often represent a spectrum of performance where the clinical differentiation between levels may be marginal for a given patient's diagnostic profile. Margaret's diagnostic need (a 13 dB SNR deficit) didn't change between tiers. Her clinical requirement for processing power didn't change. What changed was the price.

The message Margaret received: "You can choose your level of clinical benefit based on what you can afford."

Patient choice is not the problem. Informed patients should participate in decisions about their care. The problem arises when choice *replaces* clinical guidance rather than *following* it. When patients select technology without understanding how options relate to their diagnostic needs, choice becomes a burden rather than a benefit.

This structure, however, unintentionally, functions as cost-based rationing. Patients with fewer resources select lower tiers not because those tiers match their clinical needs, but because they cannot afford the alternative.

In other medical contexts, treatment recommendations are driven by clinical indicators rather than cost. An oncologist doesn't say, "Chemotherapy is indicated. Here are three options: Basic (low-cost), Advanced (mid-cost), or Premium (high-cost). Which one fits your budget?" They prescribe based on diagnostic evidence.

The prescription is non-negotiable. The clinical recommendation comes first. Then the conversation shifts to access: insurance, payment plans, assistance programs.

In audiology, the structure often reverses this sequence. The clinical recommendation becomes negotiable, attached to price. The system calls it patient choice. But when patients lack the clinical context to evaluate their options, it is a choice without understanding.

Why This System Breaks: A Behavioral Science Perspective

Understanding why tiered counseling fails requires looking beyond audiology to behavioral science.

In 2011, a team of behavioral scientists at University College London asked a simple question: why do some interventions change behavior while others fail? Susan Michie and her colleagues reviewed decades of research and distilled it to three requirements. They called the framework COM-B:

- **Capability:**
  knowledge to evaluate options and understand potential outcomes
- **Opportunity:**
  structural and systemic support to act on that knowledge
- **Motivation:**
  the desire or drive to achieve the outcome

For behavior change to succeed, all three must be present.

Current tiered hearing aid counseling addresses one factor: **motivation**. Patients generally have strong motivation: they want to hear significant others and participate in conversations. Where the system falls short is on the other two factors: **capability** and **opportunity**.

With Margaret, we see this clearly. She had motivation (she wanted to hear at book club and wanted to hear her grandchildren). She lacked capability: she didn't understand what a 13 dB SNR deficit means, what directional microphones do, or why she needed them. She lacked opportunity: no clinical structure guided her toward the right choice, only "which fits your lifestyle?"

This distinction matters. The tiered system was designed to present choice, not to build capability or create opportunity for optimal decision-making. When motivation exists but capability and opportunity are absent, patients make decisions without understanding. They select options they later regret. Or worse, they stop using the devices altogether.

The failure is not patient effort. The failure is structural.

The Evidence Gap

The failure of the tier model extends beyond patient confusion; it reveals a fundamental gap in our clinical evidence base. Currently, the profession operates on the assumption that commercial price points correlate linearly with clinical benefit.

However, there is limited peer-reviewed evidence demonstrating that the commercial classification of "Basic," "Advanced," or "Premium" corresponds to statistically significant differences in functional patient outcomes.

Cox, Johnson, and Xu (2016) found no consistent advantage of premium features on patient-reported outcomes in their analysis of hearing aid technology. Similarly, systematic reviews indicate that premium digital noise reduction features tend to improve listening comfort, reduce effort and enhance noise tolerance rather than improve speech intelligibility in isolation (Lakshmi, Rout, & O'Donoghue, 2019).

If premium technology provides distinct clinical benefits for patients with specific SNR deficits or cognitive loads, a validated evidence chain should exist:

Diagnostic indicator → Required processing capability → Measurable outcome.

However, this chain is currently absent from the literature. Consequently, patients often make substantial financial decisions based on presumed clinical efficacy; an assumption that current evidence does not consistently support.

When Margaret chose "Premium," she believed she was investing in maximum speech understanding. However, she made this decision based on a framework that conflates price with performance.

Despite purchasing the highest tier, she still struggled at book club. This occurred not because premium technology is ineffective, but because the tier structure disconnects clinical need from intervention.

Where Premium Technology Fits

It is critical to distinguish the technology from the tier model. The limitations discussed here do not imply that premium technology is unnecessary. Advanced features developed by manufacturers, such as binaural beamforming, deep neural network processing and transient noise reduction, can be clinically essential.

Premium processing offers genuine value when it serves as the minimum required intervention for a specific diagnostic profile:

- **Severe Speech-in-Noise Deficits:**

  Patients with poor SNR thresholds require aggressive noise reduction to reduce listening effort and prevent fatigue.

- **Cognitive Vulnerabilities:**

  For patients with reduced working memory, "premium" features that clean the signal are not a luxury. They act as a neural support mechanism that preserves mental resources for sustained attention.

- **Complex Acoustic Needs:**

  Advanced scene analysis provides stability in dynamic environments that basic processing cannot replicate.

The issue is not the existence of premium technology. The issue is the classification of these clinical features as "lifestyle or Tier upgrades."

This distinction has significant implications. When advanced processing is prescribed based on a diagnostic deficit, it is a medical necessity. When it is sold based on a lifestyle questionnaire, it is perceived as a luxury. The same technology, framed in two different ways, carries entirely different clinical and economic weight.

Currently, the tier model obscures this distinction. The result is a system where clinically essential features are vulnerable to being dismissed as optional upgrades by patients, payers, and the broader healthcare community. This undermines two things simultaneously. It undermines the value of advanced technology, and it undermines the clinical expertise required to prescribe it appropriately.

THE SATISFACTION PARADOX

Six months after Margaret's fitting, her audiologist noted she was "satisfied." Her satisfaction scores were high. By every metric the profession generally measures, she was a success.

However, Margaret had stopped wearing her hearing aids in the situations she bought them for. She avoided book club meetings. She became more selective with family gatherings. She reorganized her life around the device's limitations rather than using the device to expand her life.

This pattern reflects adaptive acceptance. Adaptive acceptance occurs when patients unconsciously adjust their expectations and behaviors to accommodate device limitations rather than receiving devices matched to their original goals. The outcome looks like satisfaction because the patient stops complaining. But the patient has not succeeded. The patient has settled for less than what was achievable.

Margaret is not alone. Adaptive acceptance is not a rare outcome. It is a predictable consequence of a system that asks patients to choose technology tiers rather than prescribing based on diagnostic need.

The question is not whether individual audiologists care about their patients or provide good service. They do. Audiologists enter this profession to help people hear better. The question is whether the tiered counseling structure we were trained to follow creates predictable failure patterns that clinical expertise alone cannot overcome.

If the system produces these outcomes by design, we should expect to see them consistently across practices, patients and geographies. Margaret's story illustrates what these patterns look like in a clinical encounter. But the critical question is whether her experience represents an isolated case or a systemic norm.

If these are systemic patterns rather than individual lapses, the solution is not better communication within the existing tier model. The solution is a fundamental shift from tiered options to clinical prescriptions.

The following section provides empirical evidence addressing this question directly.

The solution is a fundamental shift from tiered options to clinical prescriptions.

THE EVIDENCE:

EXPLORATORY PILOT ON UNDERSTANDING, REGRET, RESTRICTION, AND CONFIDENCE

The systemic problem described above rests on a structural argument: that tiered counseling disconnects clinical need from intervention, creates decision friction, and produces satisfied patients who unknowingly avoid the situations they purchased devices for.

But does this actually happen in practice?

To answer this question, we conducted an exploratory study examining how patients and audiologists make technology decisions, what patients understand about those choices, and how those choices shape satisfaction, regret, and real-world participation. The findings suggest that the structural problem is not hypothetical. It is observable, patterned, and consistent across patients and providers.

METHODS

Study Design

This was an observational study examining patient and audiologist perspectives on hearing aid technology selection. The aim was explicitly exploratory: to identify patterns, generate hypotheses, and inform future research.

Participants and Instruments

We surveyed 39 audiologists and 37 adult hearing aid users using custom electronic surveys. The instruments assessed technology selection practices, patient comprehension, decision regret and participation in listening environments.

Because this was exploratory research designed to identify patterns rather than confirm hypotheses, the surveys were not validated instruments.

Analytic Approach

We used descriptive statistics for quantitative responses and thematic analysis for open-ended responses. Exploratory correlation analysis examined relationships between variables, such as consultation confidence and patient satisfaction.

Limitations

Several limitations should be acknowledged. First, the sample skewed toward premium technology purchasers (51%), potentially biasing results toward higher-resourced, better-supported patients. Second, the sample size (n=37 patients, n=39 audiologists) was appropriate for exploratory pattern identification but not powered for subgroup analysis. Third, retrospective measurement introduces potential recall bias and precludes causal inference. Fourth, the instruments were custom-designed for this study and have not been validated. Finally, there was no experimental control; participants had different providers and manufacturer devices, meaning observed correlations are descriptive only.

These limitations are consistent with the study's explicitly exploratory purpose. The goal was not to establish definitive conclusions but to identify whether patterns consistent with the structural argument exist in practice and warrant further investigation.

RESULTS

Pattern 1: The Understanding Gap

Among the 37 patients surveyed, 76% demonstrated partial or poor understanding of hearing aid technology differences at the time of purchase. Thirty-five percent (n=13) reported poor understanding, 41% (n=15) reported partial understanding, and only 24% (n=9) reported good understanding.

Patients described their experience in their own words:

- **One noted, "They explained the differences, but I had no frame of reference for what it meant in real life."**
- **Another reported, "I feel like they understated my needs and tried to push lower options."**

These responses suggest that patients often navigate complex technology choices without adequate comprehension, despite strong motivation to make good decisions. This aligns with the COM-B framework discussed earlier: patients had motivation but lacked capability. The tier model provides options without providing the clinical context necessary to make those options meaningful.

Pattern 2: Decision Regret

Decision regret was reported by 43% of participants. Notably, regret was not distributed evenly across purchase tiers.

- **Among premium purchasers, 20% (2 of 10) expressed regret.**
- **Among non-premium purchasers, 60% (15 of 25) expressed regret.**

This disparity is significant. The stark increase in regret among those who compromised on technology tier suggests that the system creates a confidence gap. When patients feel forced to select a lower tier based on cost rather than clinical guidance, they are primed to doubt the efficacy of the device from day one. The decision framework itself undermines confidence before the hearing aid is ever worn.

Pattern 3: Behavioral Restriction

Three in four patients (73%, n=27) reported avoiding challenging listening environments, such as social gatherings or noisy restaurants, despite reporting satisfaction with their devices.

This finding confirms the satisfaction paradox described earlier. Patients reported satisfaction, yet they were not achieving the functional benefit they originally sought. This pattern supports the hypothesis that satisfaction often reflects adaptive acceptance rather than achievement of auditory goals.

Causality cannot be inferred from these data. However, the pattern is consistent with the structural argument: patients settle, stop complaining, and score as satisfied on standard measures while quietly contracting their lives around device limitations.

Pattern 4: The Confidence Predictor

Exploratory correlation analysis revealed a strong relationship between counseling confidence and outcomes. Among patients who felt confident during the selection process, 88% reported satisfaction. Among patients who lacked confidence, only 25% reported satisfaction.

This finding suggests that the quality of the counseling framework may be a stronger predictor of satisfaction than the technology tier itself.

This raises an important question. Are we measuring whether patients are satisfied with their choice, or satisfied with their outcomes? The data suggest these may be different constructs entirely. A patient can feel confident about a decision and satisfied with the process while still failing to achieve functional hearing goals. Current satisfaction measures may capture the former while missing the latter.

What the Patterns Show

These findings are exploratory and descriptive. They do not prove causation, nor do they establish that tiered counseling directly causes these outcomes. However, they are internally consistent and demonstrate that the patterns predicted by the structural argument are observable in practice.

Three mismatches emerge consistently:

1.

The comprehension mismatch:

the majority of patients lack adequate understanding of technology differences when making purchase decisions.

2.

The regret mismatch:

compromising on price leads to disproportionately high regret.

3.

The functional mismatch:

patients report satisfaction while avoiding the social environments they originally sought treatment for.

As Margaret's story illustrated, and as these data suggest, the problem is not isolated incidents of poor communication. It is a patterned outcome that emerges when the system asks patients to make clinical decisions based on cost and lifestyle rather than diagnostic need.

DISCUSSION

How did an entire profession come to ask patients to make technical decisions we cannot empirically justify?

We have diagnostics. We have outcome measures. We have decades of clinical experience. What we lack is the evidence that the "good, better, best" structure we present to patients actually maps onto their diagnostic profiles or predicted outcomes.

Consider what happens in practice. A patient walks in. The clinician recognizes that specific technology is needed to meet this patient's goals. Yet instead of prescribing that technology, the clinician presents three tiers without a clear recommendation. This is not informed choice. This is an illusion of choice.

The patterns observed in this study validate the concern that tiered counseling creates systematic gaps in understanding, decision regret, and behavioral restriction. The implications extend beyond individual practice. The problem is not that audiologists communicate poorly. The problem is structural. Audiologists have been trained to follow a framework that was never clinically validated.

The solution, therefore, lies not in refining communication within the existing tier system. The solution lies in replacing the system itself with one grounded in diagnostic prescription rather than cost-based choice.

These findings establish the empirical basis for a new clinical model. The specific mechanics of this proposed diagnostic-driven framework, and its integration with National Academies of Sciences, Engineering, and Medicine (NASEM) outcome measures, are detailed in Part 2 of this series, which will be published in the next issue of Audiology Practices.

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Table 1

Pattern	n / N	%	Summary Insight
Understanding Gap	28 / 37	76%	The majority showed partial or poor grasp of technology differences.
Decision Regret	16 / 37	43%	Concentrated among non-premium purchasers (15 / 25 = 60%)
Behavioral Restriction	27 / 37	73%	Avoided challenging environments; social withdrawal common.
Confidence–Satisfaction Correlation	15 / 17 vs. 2 / 8	88% (Confident & Satisfied) vs. 25% (Not Confident & Satisfied)	Confident consultations strongly associated with higher satisfaction exploratory correlation (descriptive).

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FROM KNOWN TO NOTICED

Rethinking Physician Marketing

Katie Armatoski, Au.D
Ascending Audiologists, LLC

The "Self-Promo Drop" and Its Profound Misalignment

It was 2019, and as I walked out of our local hospital, a single thought consumed me: Why do I find physician marketing so draining? I could talk enthusiastically for hours to my patients about the importance of hearing health. But educating physicians about it? It felt… superficial.

I had just completed the familiar ritual. The 15-stop tour. The office brochures. The contact cards. And of course, the assorted candies.

Let's call it: The 'Self-Promo Drop.'

As I sat in my car, I tried to diagnose the problem. It wasn't just the doubt that my brochures would be ignored. The entire process felt misaligned with my professional identity. There had to be a better, more efficient, and more authentic way to build physician referrals. Through that reflection, I diagnosed the core issue: a deep conflict between my identity as a clinician and the perceived commercialism of "marketing." I was driven by the reluctance to be misperceived as a "hearing aid salesperson." This led me to a critical new question: How could I engage physicians authentically, in a way they'd find valuable and exciting, without ever talking about the products I sell?

The First Clue: A Pinwheel and a New Perspective

The first part of this answer arrived unexpectedly. A manufacturer, Starkey, dropped off the most creative marketing piece I have ever seen: a tabletop pinwheel display, and it had *nothing* to do with hearing aids.

The pinwheel display referenced several different comorbidities and their relationship to hearing loss. My first reaction was shock. My second was a sharp sense of frustration. I had just finished four years of graduate school, and I couldn't recall a single lecture referencing these papers. I thought to myself, "If *I* didn't know this, it's almost certain the primary care physicians I'm trying to reach don't know it either."

This felt like a breakthrough. The insight was simple: lead with the *problem* (comorbidities), not the *solution* (products).

I started using this approach, and instead of the focus being on me, my materials highlighted the comorbidity facts: "people with mild hearing loss are 3x more likely to have a history of falling" (let's call it the Comorbidities Facts Drop). While the Comorbidities Fact Drop was a vast improvement, I couldn't shake the feeling that something was *still* missing.

The Investigation: What Do Physicians *Actually* Want?

That comorbidity pinwheel was a breakthrough; it gave me the what. I finally had a message and a stack of peer-reviewed articles that proved hearing health deserved more attention. I'd even summarize the articles for the clinicians to help improve the possibility that they would actually consume the materials. However, I still felt like I was talking to their head. To me, it felt like the clinical equivalent of telling a patient, 'I lowered the compression ratio at 2,000 Hz for you." It was accurate, but it wasn't relevant. I had the data, but I hadn't given them a reason to care.

To make things more challenging, the year 2020 had arrived, making it even more difficult to educate physicians in my area. I realized I didn't just need new materials, I also needed a new playbook.

In an effort to learn more about physicians and how they manage to find time to learn and get their materials, I began consuming webinars and white papers from the healthcare industry itself, specifically from online platforms like Doximity, which is used by over 80% of U.S. physicians.

The data I found painted a stark and immediate picture. According to Doximity:

Fact 1:

Physicians are drowning in information. Surveys show that "information overload is overwhelming an already stretched physician workforce," with 80% of specialists feeling "overwhelmed" by the amount of new information they must keep up with, often reviewing it "after their workday." This made me realize that my Comorbidities Fact Drop probably wasn't seen as helpful; it added to the overwhelm of a professional who was already running out of time.

Fact 2:

The old "sales rep" model is dead. The data on "Attitudes About Engaging with Industry Sales Representatives" was the final nail in the coffin. Only 26% of physicians still prefer a traditional in-person visit. A full 1 in 5 (21%) flat-out "Don't Want to Engage with Sales Reps" at all, and the majority prefer a hybrid or "as needed via text, phone, or email" approach. This made me realize it probably isn't best to randomly drop by and ask for a minute of their time

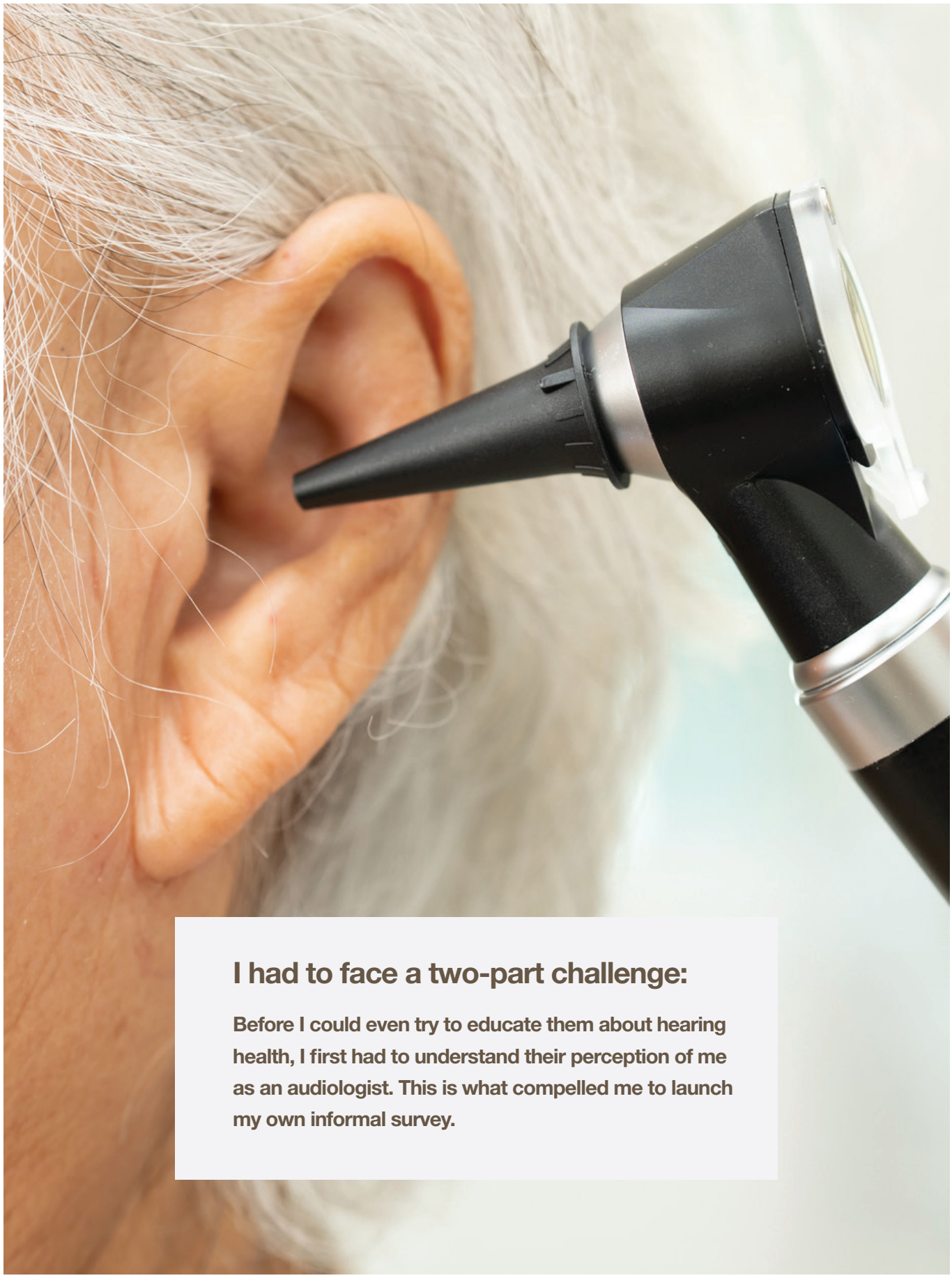
Fact 3:

They are actively looking for what we have. This was the most crucial finding. When asked about the topics they're interested in, 74% of physicians reported an interest in "Resources for my Patients."

This high-level data was the validation I needed. My old methods weren't just inauthentic to *me*; they were inefficient and unwelcome to *them*.

This discovery was fascinating, but it didn't highlight hearing health, a topic we all know is often seen as 'important, but not urgent' in a physician's overloaded schedule. This led me to a critical, and honestly, a much scarier question: Are they interested in receiving these materials at all?

I realized that if the answer was 'no,' then all the other questions about what format they prefer, how often to send it, were irrelevant. I had to address a much bigger problem first: a core awareness and perception problem.



I had to face a two-part challenge:

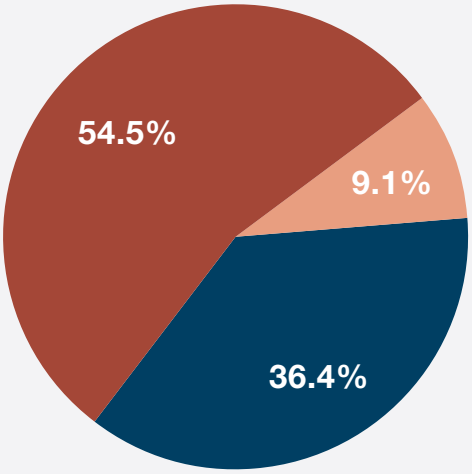
Before I could even try to educate them about hearing health, I first had to understand their perception of me as an audiologist. This is what compelled me to launch my own informal survey.

Testing the Theory: What Physicians *Really* Think

Key Finding 1:

THE PERCEPTION GAP

The question: When you think of an audiologist, which of the following best describes your primary perception? My theory that physicians misperceived our role as audiologists was valid. When asked about their primary perception of an audiologist, there was a notable lack of consensus; however, this perception varied depending on the specialty.



When you think of an audiologist, which of the following best describes your primary perception?

11 RESPONSES

- A collaborative healthcare partner
- A diagnostic specialist for hearing and balance disorders
- A provider primarily focused on fitting and selling hearing aids
- An ancillary or technical service provider

The responses revealed four distinct "types" of perception:

1. The Allies ("Collaborative Partners"): This view was held almost exclusively by the Otolaryngologists (ENTs) and one Primary Care Physician.
2. The Neutral Ground ("Diagnostic Specialists"): This was the most common default for Primary Care, Geriatrics, Emergency, Orthopedic Surgeons, and Vascular Surgeons. I see this view as passive. It positions audiologists as a technical testing service, not an active partner in patient management. One can argue that, given the role of a Vascular Surgeon, this is the most appropriate answer.
3. The Stereotype ("Hearing Aid Sellers"): My exact fear was confirmed; however, I remain hopeful, as out of four primary care physicians, only one held this precise perception, proving that this stereotype is still active in the medical community.
4. The fourth "type," an ancillary or technical service provider, has not been selected yet (*thank goodness*).

One interesting finding is that the two physicians who rated us the highest as a collaborative healthcare partner were both diagnosed with hearing loss and wore hearing aids (and neither was an otolaryngologist).

Key Finding 2:

HOW TIME-PRESSED PHYSICIANS WANT HEARING HEALTH UPDATES DELIVERED

Now, as audiologists, if we know who to target with our information, we also need to know in what format and how often they want it delivered. My preliminary results, as well as Doximity's, confirmed that the central barrier for physicians is, unequivocally, time. According to Doximity, "information overload is overwhelming in an already stretched physician workforce," who are often forced to review information after their workday."

This single barrier dictates their preferences for everything else.

As you can imagine, my old format, the "drop-in" strategy, is now the least effective method. The clear winners were high-value, low-friction formats: "Email Newsletter (summary, quick reference)" and "Lunch-and-learn session / CME opportunities." This move to a digital, brief format is powerfully validated by Doximity's data, which shows:

- 91% of physicians rate short-form articles as "Efficient" (vs. 66% who find long-form "Not Efficient").
- 85% of their learning engagement is online and via smartphone.
- The "drop-in" model is actively unwelcome; Doximity data shows only 26% of physicians prefer traditional in-person visits, while 1 in 5 "Don't Want to Engage" with reps at all.

This data, both local and national, reframes our entire role. We must stop being a quarterly interruption and start being an on-demand clinical resource.

The New Framework: Becoming the Collaborative Healthcare Partner

Through the research, I identified who, when, and where for this new playbook, but I was still missing the *why*. Hearing health isn't some exciting new medication that will make their patients feel better, so how can I motivate them to think differently about hearing health?

I first found the scientific framework, one grounded in the science of motivation, for this "why" on Masterclass (an online subscription where you can watch courses taught by experts). Daniel Pink's class, titled "Sales and Persuasion," discussed a study by Adam Grant and David Hoffmann on how to motivate healthcare professionals to improve their hand hygiene practices. The researchers tested two simple signs above a hand-washing station. One sign read, "Hand hygiene prevents **you** from catching diseases." The other read, "Hand hygiene prevents patients from catching diseases." The first, self-focused sign had no measurable effect. The second, patient-focused sign led to a 45% increase in hand washing.

Reminding clinicians of their purpose and the impact they have on others, protecting their patients, is a far more powerful motivator than appealing to their own self-interest or convenience.

This was the "a-ha" moment I had been looking for. My comorbidities drop had been misaligned. It wasn't worded to actually motivate clinicians to care more about their patients' hearing health. Grant's work highlights a critical point: reminding clinicians of their purpose and the impact they have on others, protecting their patients, is a far more powerful motivator than appealing to their own self-interest or convenience.

Pink's own research helps explain why. For complex, cognitive work such as medicine, motivation does not primarily come from external rewards ("candy") but from three intrinsic drivers: *autonomy, mastery,* and *purpose*.

- Autonomy is the ability to control how one spends time and attention.
- Mastery is the opportunity to grow in one's expertise.
- Purpose is the sense that one's work is meaningful and directly tied to important outcomes.

When I looked back at my old approach through this lens, I could see why it had caused so much internal dissonance for me and, likely, seemed misaligned to the physicians I was trying to reach. Let's break it down:

Self-Promo Drop

"Hi, my name is Katie Armatoski, and I am an audiologist in Oshkosh. I wanted to drop off some materials about us and our practice. We are committed to increasing public awareness to identify, treat, and rehabilitate hearing loss early. We also participate in best practices, meaning we use only evidence and research-based forms of treatment."

This model violates all three of Daniel Pink's drivers of professional motivation. First, it undermines autonomy, because it interrupts a clinician's workflow by demanding unexpected time and attention. Second, it doesn't support mastery, because the message is about my practice rather than providing clinicians with clinically relevant insights. And most importantly, it misses purpose. Instead of clearly showing how hearing health protects their patients, the script centers on me, which does nothing to strengthen the clinician's sense of impact.

Comorbidities Drop

"Hi, my name is Katie Armatoski, and I am an audiologist in Oshkosh. I have here a printed peer-reviewed article that I summarized for you. It reports that, compared to adults with normal hearing, those with mild hearing loss had about 1.9 times the risk of incident dementia, 3.0 times the risk with moderate loss, and 4.9 times the risk with severe loss."

This model also violates all three of Daniel Pink's drivers. First, it undermines autonomy, because I'm still interrupting a clinician's workflow. Second, it doesn't truly support mastery, because I'm reciting a complex statistic without translating it into simple clinical actions that would actually help them care for patients better. And most importantly, it misses purpose. Instead of clearly connecting the dementia data to how they can better protect their own patients, the script is framed around what I brought and what I summarized, which does little to reinforce their sense of meaningful impact.

A Collaborative Healthcare Partner Discussion (Purpose-focused message)

Now contrast the previous methods with this brief scheduled meeting. The focus is on respecting the clinician's autonomy, supporting their mastery, and reinforcing their purpose.

Autonomy:

I begin by acknowledging their limited time and offering one concise, evidence-based insight, such as the link between hearing loss and dementia:

> *Hi, I understand you are busy, so I'll keep this brief. My name is Katie Armatoski, and I'm an audiologist in Oshkosh. I'm here to share one concise insight from a study by Lin that impacts your patients.*
>
> *The key finding is that untreated hearing loss significantly increases the risk of dementia, but early intervention may slow or prevent decline. I've taken that complex data and distilled it into two simple clinical cues that make identifying these patients easier for you.*

Clinical Mastery:

Then, instead of promoting my practice, I translate the findings into practical clinical cues: the early complaints that appear *before* a hearing screening fails and the simple triggers that signal when to refer.

> *You're seeing the early signs already, often before a screening fails. Here are some early clinical cues:*
>
> - *"I can hear fine, but people mumble"*
> - *They keep mixing up medication times*
> - *Any patient who has an unexplained social withdrawal*

I offer an optional one-page evidence summary or a quick digital link they can review on their own schedule, reinforcing their autonomy.

> *I've summarized the actionable takeaways from the Lin study onto this one-page evidence based summary.*

Purpose:

Finally, I emphasize how clarifying hearing status enables them to protect their most vulnerable patients, those with cognitive concerns, communication challenges, or caregiver frustration, thereby aligning hearing health with their core purpose as clinicians.

> *The goal is improving communication for your patients who already have cognitive concerns. Addressing hearing loss allows them to better follow complex instructions for their other chronic conditions.*

The entire exchange positions audiology not as an interruption, but as an on-demand clinical partner who supports better patient outcomes.

> *My goal is simple: I want to be your partner for hearing health. If you ever have a patient whose communication needs are impacting their overall care, please use me as a direct resource.*

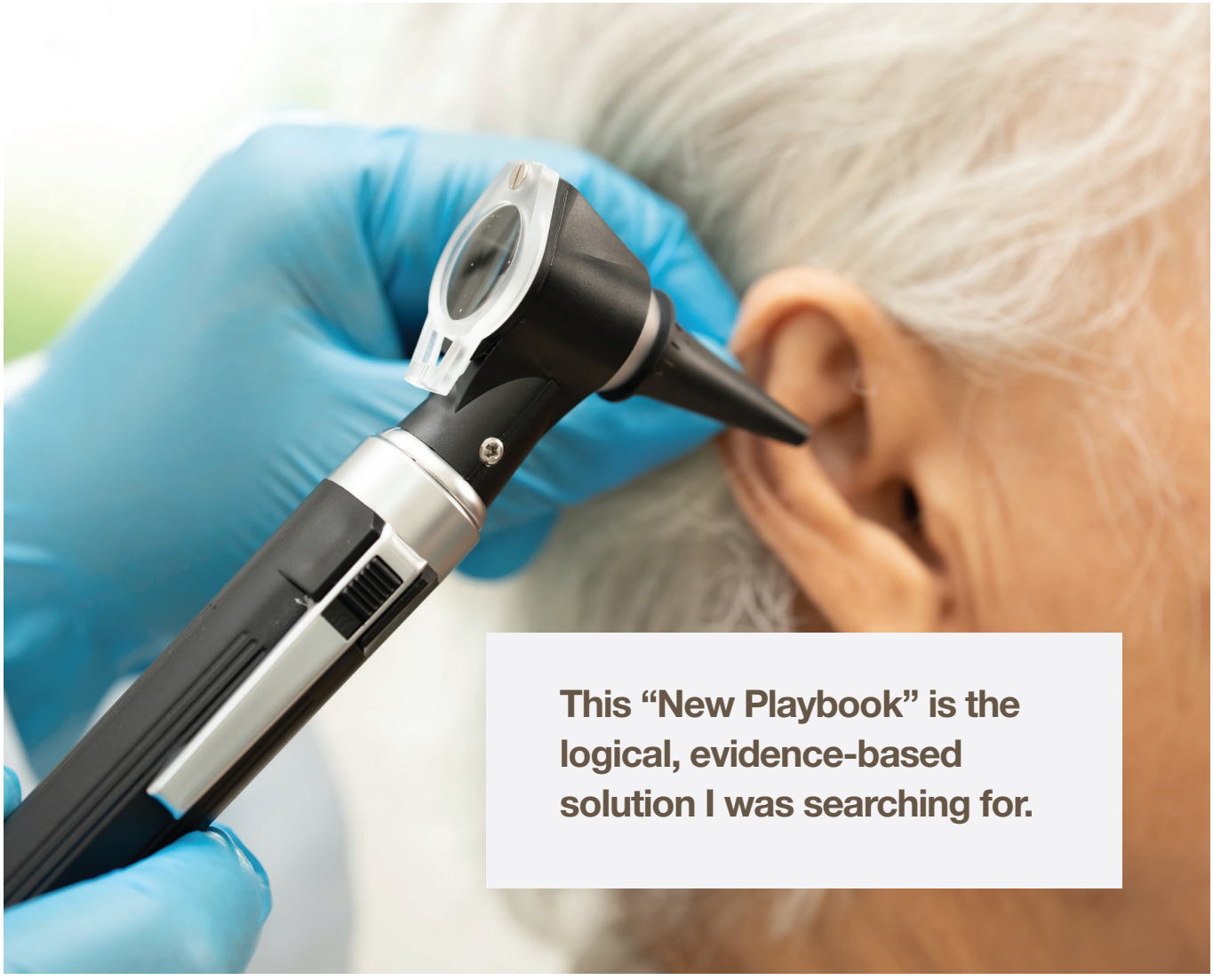
This is where it finally became clear. The way I communicate with clinicians must shift from being self-focused and driven solely by facts to being driven by a shared purpose.

It is not simply a more polished script. It is a shift from marketing *at* physicians to collaborating *with* them, using what we know about intrinsic motivation to design outreach that feels aligned with both of our professional identities and our own.

The New Playbook

This entire journey, from that frustrating day in the hospital parking lot to analyzing the Doximity data and my own survey results, wasn't just an investigation. It was a search for an answer. The data clearly shows *why* my old "Self-Promo Drop" felt misaligned and *why* it was unwelcome. More importantly, the research provides a clear blueprint for a new model.

This "New Playbook" is the logical, evidence-based solution I was searching for. It is the framework for how *we* can finally operationalize this shift from "salesperson" to "collaborative partner," in a way that is sustainable for us and respectful of physicians' time constraints. The goal is to stop behaving like quarterly interruptions and instead become an on-demand clinical resource. This new playbook is a strategic, three-part sequence:



Play 1: The Reimagined Drop-Off (The Primary Touchpoint)

This component is the new cornerstone, designed to bridge the gap between digital efficiency and in-person presence. Rather than abandoning physical visits, we change their purpose. Instead of stopping by to hand out self-focused brochures, we stop by to leave a tangible clinical tool.

This new approach is the physical application of the Adam Grant hand-washing study. The old, self-promo drop was like the ineffective, self-focused sign ("Here are *my* materials"); it was misaligned with the physician's core motivation. This new drop-off *is* the effective, purpose-focused sign. The entire tool is themed around a shared, patient-centric mission, "Protecting Your Patient's Cognition," which provides tangible evidence that you are aligning with *their* core purpose: to protect their patients.

The visit is measured in seconds, not minutes. It does not demand anything of the physician's schedule, yet it reinforces the idea that audiology is a source of valuable, patient-centered information. Over time, this pattern of small, respectful, clinically focused touches builds familiarity without eroding goodwill.

Play 2: The Digital Foundation (Supporting the Drop-Off)

This component supports the primary drop-off, acknowledging that physicians are overwhelmed and often engage with new information after hours. This brief, clinical primer, not a traditional newsletter, is designed to align with their intrinsic motivators.

It introduces the *same* purpose-focused topic as your physical drop-off (e.g., "Protecting Your Patient's Cognition"). By being mobile-friendly and brief, it respects their Autonomy, allowing them to engage on their own terms and schedule. It supports Mastery by delivering a concise "short summary" of high-yield data (a format my survey data confirmed they prefer). It also reinforces Purpose by priming them to recognize the patient-centric physical tool when it arrives. This hybrid model delivers on their preferences for both short summaries and printable handouts.

Play 3: The Purpose-Focused Consultation

This final component is the goal. It is the proactive opportunity our consistent, high-value drop-offs earn you over time.

After establishing a pattern of trust through strategic touchpoints and drop-offs, we are no longer a cold interruption. We have earned the right to offer a brief in-person consultation. This can be a simple "call to action" on our quarterly drop-off note, such as: *"This kit is a brief summary. To better support your team in identifying at-risk patients, I have a 15-minute clinical briefing on 'Protecting Patient Cognition' ready for your next staff meeting. Please let me know who the best person is to coordinate scheduling, and I'll send the details right over."*

When we create this opportunity, we step fully into the role of collaborative partner. Here, the same principles apply. The conversation is short, focused on patient outcomes, and structured around a small number of high-impact data points. The tone is collegial and consultative, not promotional.

A Necessary Evolution

Taken together, these three elements, the digital foundation, the reimagined drop-off, and the purpose-focused consultation, constitute a new playbook grounded in what motivates physicians and what our own data show they want. We transition from a model where we periodically appear, hoping to be remembered, to one where we are consistently available as a trusted, on-demand resource for patient-centered information.

It's time to stop marketing *to* physicians and start leading *with* them.

In doing so, we not only improve our referral patterns but also begin to narrow the perception gap that first prompted my survey. We found compelling evidence that our approach works on a personal level: the two physicians in our survey who rated us highest as a collaborative healthcare partner (both non-ENTs) were themselves diagnosed with hearing loss and prescribed hearing aids. This demonstrates that through repeated, respectful actions, we show that audiologists can be essential partners.

This is, I would argue, the work we were trained to do. This isn't just a new playbook; it's a necessary evolution.

It's time to stop marketing *to* physicians and start *leading with* them.

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The Doctor of Audiology:

A HISTORICAL JOURNEY

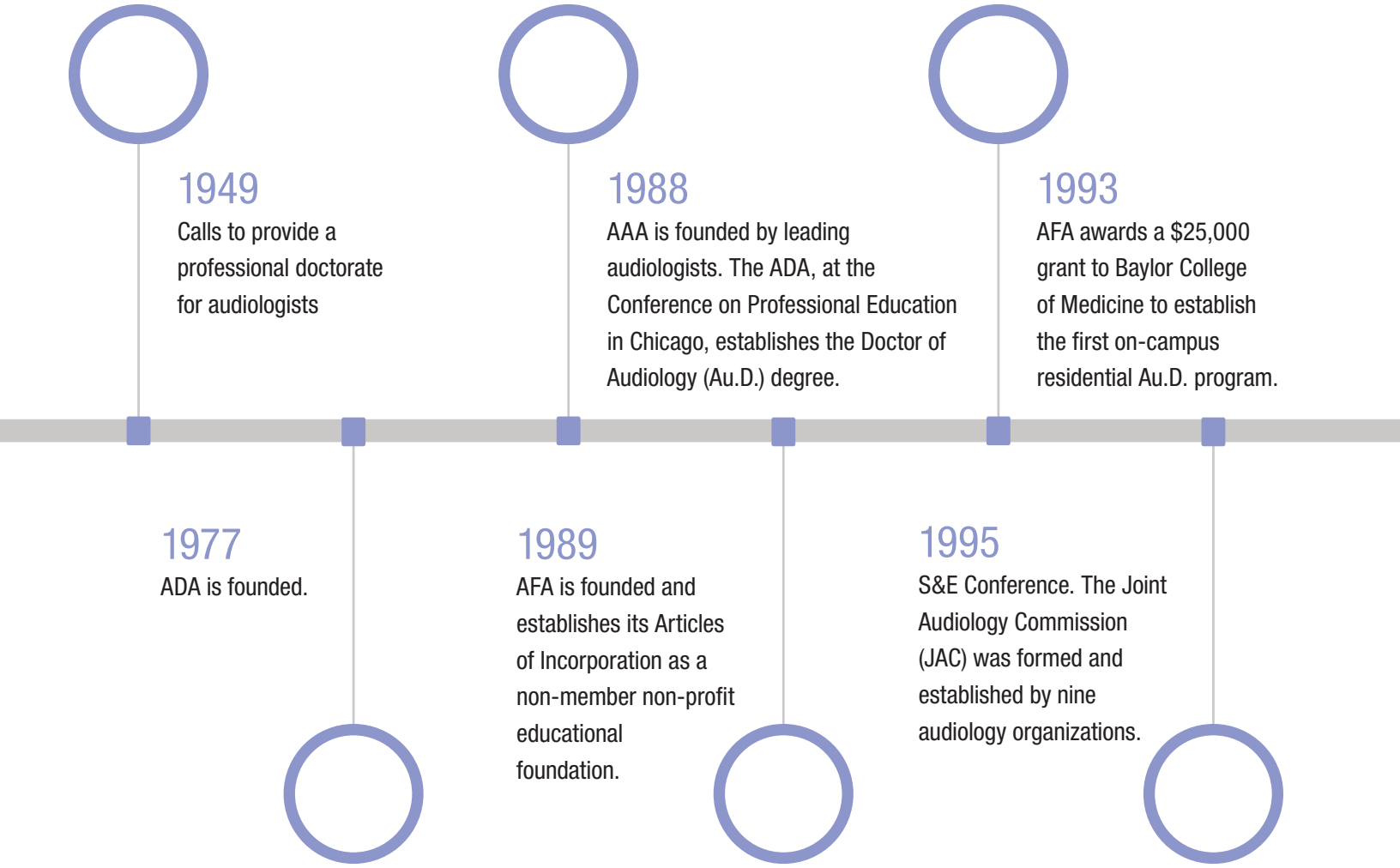
Larry Engelmann, M.S., Au.D.

INTRODUCTION

It is healthy for a profession to be reminded periodically of its beginnings. History can guide us on constructing and reforming our future. Dr. Ken Smith (a friend, colleague, and former president of the Academy of Dispensing Audiologists) encouraged me to write this nostalgic look at our Doctor of Audiology (Au.D.) journey, affectionately known as the "Au.D. Movement".

But first, let us recognize and acknowledge our appreciation for Dr. David Goldstein (Father of the Au.D.) and the thousands of practitioners, students, academics, and industry leaders who championed the Au.D. Movement. They selflessly and generously contributed thousands of volunteer hours, their unlimited energy, their visionary leadership, and millions of dollars in support of this once-in-a-lifetime transition. The transition was from an allied health care profession (requiring a master's degree from a graduate school to enter practice) to a healing arts doctoring profession (requiring a doctoral degree from a professional school to enter practice). Without them, audiology would still be a master's degree profession with 22-degree designations instead of our unifying Au.D. degree.

The Au.D. Movement was a protracted battle; occasionally quite embittered, frustrating, disappointing, contentious, unifying, and often exhilarating. I say this with a smile and from a unique perspective: Retired after 50+ years of involvement in audiology and as a former ADA president, I look back with great appreciation of being smack in the middle of the Au.D. Movement. I had the pleasure and honor of serving on the Boards of the Audiology Foundation of America (AFA) for eight years (1993-2001) and the Academy of Dispensing Audiologists, now the Academy of Doctors of Audiology (ADA) for seven years (2002-2009). Now, 38 years after its inception, is the Au.D. journey complete? The short answer is: No – much work remains. Today, it is a relatively simple process to apply to a Doctor of Audiology program. That has not always been the case. Let's look back to the beginning of the journey.

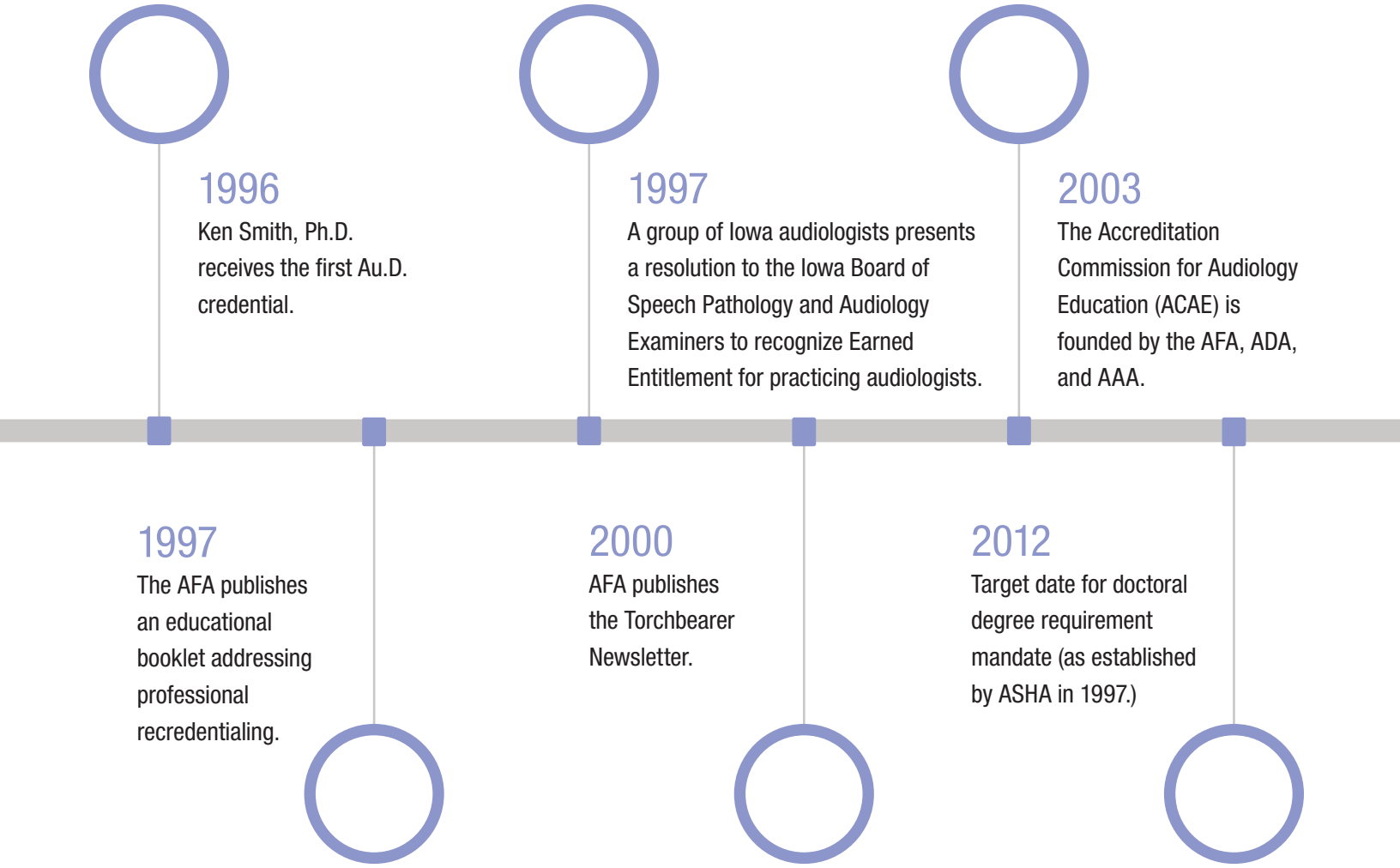


HOW DID WE GET HERE?

The profession of audiology was born in military aural rehabilitation centers during WWII (Goldstein, 1991-92). During the 20-year period from audiology's inception around 1945 until 1965, "… an undergraduate bachelor's degree was required for clinical audiologists in the United States. The entry-level academic credential for audiology was then upgraded to a master's degree followed by a nine-month period of supervised clinical experience." (Hall, 2019).

As early as 1949, there were calls to provide a professional doctorate for audiologists. Between 1963-1987, discussions in various forms and forums occurred about establishing a 'clinical doctorate' in audiology to no avail. "In 1963, the Highland Park Conference on Graduate Education rejected the professional doctorate in favor of the Ph.D." (Goldstein, 1991-92).

The American Speech-Language and Hearing Association (ASHA) took a position that eventually supported the concept of a doctoring profession; but they framed their rhetoric in a way that allowed for any doctorate degree, i.e., Ph.D., Sc.D., and Ed.D., not just the Au.D. degree, to be an acceptable degree to enter the practice of audiology. They referenced this approach as the "clinical doctorate" or, "clinical Ph.D.". It is essential to realize that the Ph.D. is a terminal scholarly degree designed to create new knowledge through research. Professional doctoral degrees are entry-level clinical practice degrees designed to apply existing knowledge to patient care. Windmill (1993) explained, "As far as can be discerned there is no formal recognition of a "clinical Ph.D." by a national agency, accrediting body, or academic organization." Continuing, he further remarks, "It is probably safe to conclude that a "clinical Ph.D." is a nonsensical entity, an oxymoron, and that utilization of the degree nomenclature following purely professional training may be called into question."



Indirectly, the Au.D. Movement germinated because of ASHA's former Code of Ethics (COE) precluding audiologists from incorporating the dispensing and sale of hearing aids to patients for profit within their clinical practice. This spurred the eventual establishment of the ADA which subsequently became the springboard for the Au.D. degree. In 1978, a Supreme Court ruled against the National Society of Professional Engineers (NSPE v. U.S., 1978) because the NSPE's COE precluded their members from engaging in areas of practice in which they were educated, trained, and licensed. This lawsuit and legal precedent forced ASHA leaders to change their position and Code of Ethics in order to also avoid Restraint of Trade violations.

The Academy of Dispensing Audiologists, now the Academy of Doctors of Audiology (ADA), was formed 48 years ago in October 1977. The ADA became the launching pad for the Au.D. Movement when it convened the 1988 Conference on Professional Education 38 years ago (ADA, 1988). Nine rabble-rousing visionary audiologists came together and said, "No more". They no longer accepted and settled for ASHA's leadership. These brave audiologists were the passionate movers and shakers of our profession. Instead of just talking about what needed to be done, they took action and did it. ADA was the first audiology-based organization formed for the sole purpose of incorporating hearing aid dispensing into audiology clinical practice as a viable, appropriate, and necessary means of treatment for hearing-impaired people. Consequently, hearing aid dispensing by audiologists is the standard of care for ameliorating hearing loss. The ADA continued to evolve and to advance the profession of audiology as one of doctoring care, requiring the Au.D. degree as the entry-level qualification for practice.

ROADMAP TO AUDIOLOGY'S FUTURE

Between 1986-1988, ADA conducted long-range as well as strategic planning meetings. They formed an Educational Planning Committee to address growing concerns over the state of audiology education and assess the feasibility of creating a professional doctorate. Twenty-five dedicated ADA members attended a conference with Dr. David Goldstein chairing the planning committee. During and following the meeting, an ad hoc committee completed the conference's proposed work outcome, and wrote its Proceedings, while a subcommittee developed an Au.D. degree program model. We will forever owe a debt of gratitude to this group of visionary leaders.

The ADA, in October 1988, convened the Conference on Professional Education in Chicago and birthed the Doctor of Audiology (Au.D.) degree. The Conference was a "tell-all" snapshot of what was and what should be. It became the roadmap to audiology's future. Here is a synopsis:

- *…it has become conspicuously evident that a two-year training program is insufficient to assure the accumulation of current knowledge and technology necessary for independent clinical practice in audiology. Further, in order to function as a point-of-entry profession in the hearing care system and to be able to practice with relative autonomy, rather than as technicians under supervision, a rigorous doctoral level education is needed.*
- *After a minimum of two years of pre-audiology coursework, a student can apply to the professional audiology program.*
- *Application will be open to students who have completed specified coursework in mathematical, physical, and biological sciences, as well as other areas of undergraduate education* (Importantly, a pre-audiology curriculum was proposed to replace the undergraduate program in Communication Sciences and Disorders [CSD]).
- *Should specialty training in audiology be desired, a post-graduate education might be pursued. A small fraction of these audiologists may choose a career as a research scientist and pursue a Ph.D. degree.*
- *The advantages of this model are apparent. It allows a solid foundation in science to be laid before students undertake a professional education. This model also parallels the educational approach used in the three largest and most successful health care professions in this country – medicine, dentistry, and optometry.*
- *It will eliminate the need to introduce clinical/professional matters into undergraduate coursework* (unlike the curriculum in CSD).
- *The history of medicine and optometry makes it plain that each increase in educational standards was accompanied by a grandfathering mechanism designed to preserve the ability of existing practitioners to continue to serve the public. The ADA is committed to developing a mechanism whereby existing audiology practitioners with a Master's degree can earn the title of doctor (Doctor of Audiology) with the advanced knowledge and skill it represents. This mechanism must parallel the development of the doctoring degree for newly entering students in the profession. As has been the case in other professions, the mechanism would be available for a limited period of time. After this opportunity expires all audiologists will earn the Au.D. degree as full-time students in a recognized professional program. This plan must be implemented without forcing current practitioners to abandon their practices.*
- *The Au.D. degree program requires a clinical faculty whose members are vigorous practitioners of the art and science of audiology. They must provide clinical learning experiences in closely supervised settings in lieu of the research projects resulting in a thesis for an academic degree* (e.g., Capstone research).
- *In order to accomplish these goals, the ADA will establish a not-for-profit educational foundation which will be governed by its own independent board.*
- *It became apparent that, at least initially, it will be more advantageous to place such programs in already established learning institutions, rather than in free-standing professional schools* (with the eventuality of audiology programs shifting to their own professional schools).

This Conference created a: a) model pre-audiology curriculum, b) model admission standards and procedure (with a recommendation to establish an "Audiology Aptitude Test"), c) model doctoring curriculum, d) model clinical learning experience, e) model action plan to achieve the goals, and f) model public information program.

Almost immediately, there was unbelievable support and camaraderie from the practitioner community for the Au.D.

All audiologists will earn the Au.D. degree as full-time students in a recognized professional program.

(1988, ADA, Conference on Professional Education in Chicago)

Movement. However, there were plenty of naysayers, too -- mostly academics. Between 1988 and about 2010 there were a plethora of survey results, articles, opinion pieces, and editorials, etc. in professional journals and magazines (e.g., Hearing Journal, Hearing Review, Advance for Audiologists, Audiology Online, ADA's FEEDBACK, Audiology Today, ASHA Leader, etc.). Those articles were replete with support as well as dissension about the "Au.D. Movement". For example, a group of Big 10 academics and researchers ultimately proposed a plan to rescind the Au.D. degree and preserve the master's degree, largely by revamping the undergraduate degree in CSD (Humes and Diefendorf, 1993). Of course, this would have maintained the status quo and completely ignored the primary reason for transitioning to doctoral education; and that was a two-year master's degree no longer provided sufficient time to educate and completely prepare students for contemporary practice.

AAA FOUNDED

In 1988, the American Academy of Audiology (AAA) was founded by some 32 leading audiologists who had doctoral degrees. As the Au.D. Movement got underway, the AAA very much supported audiology's transition to a doctoring profession, and their leaders and members contributed greatly to audiology becoming a doctoring profession. However, the AAA Board was adamantly opposed to the "Au.D. Credential" developed by the Audiology Foundation of America (AFA). The AAA's support and contributions were for the Au.D. designation to represent only a professional degree – more later! Additionally, the late Dr. James Jerger (1988) noted early on that, "Audiology must serve as point-of-entry into the hearing care system and be able to function with relative autonomy."

AUDIOLOGY FOUNDATION OF AMERICA (AFA) FOUNDED

On April 13, 1989 (as guided by the ADA Conference on Professional Education) the AFA was founded and established its Articles of Incorporation as a non-member non-profit educational foundation. Its sole purpose and mission were to have a laser focus on transitioning audiology to a doctoring profession with the Au.D. as its distinctive designator. Professional organizations could not do this because they have multiple issues with which they deal and a variety of members to whom they cater. Dr. David Goldstein was the founding Chair. Without his energy and visionary guidance along with the AFA, the Doctor of Audiology [Au.D.] would not exist today. The AFA was the only entity devoting 100% of its time, efforts, and revenue to transitioning audiology to a doctoring profession. Thanks to the generosity of audiologists and industry, the AFA satisfied its purposes by providing millions of dollars to students in grants and scholarships and to universities with established Au.D. programs; among other activities. As an example, the AFA awarded a $25,000 grant to Baylor College of Medicine for establishing the first on-campus residential Au.D. program in 1993.

The AFA organized a national network of volunteer "Torchbearer Coordinator" audiologists. They coordinated and disseminated information to the audiology communities in their respective states. These Torchbearers and AFA Board members traveled across the country giving presentations at state and national conventions and meetings promoting the Au.D. The AFA sent out regular communications to the community and industry via its Torchbearer Newsletter as well as publishing journal articles about the Au.D. and the AFA's progress and accomplishments. They also developed two-tracks for practicing audiologists to be able transition; one was the short-lived Au.D. credential and the other was through distance education Au.D. degree programs. The AFA was instrumental, along with the ADA, in helping create two brand new Au.D. programs that first offered Au.D. distance education programs for practicing audiologists within medical schools, followed by the development of four-year residential programs. These programs were unveiled in 1999 at the Arizona School of Health Sciences – Kirksville College of Osteopathic Medicine (now A.T. Still University) and the Pennsylvania College of Optometry (now Salus at Drexel University). The AFA (2010) sent out a public notice to the audiology community: *After 21 years of work to transform audiology to a doctoring profession with a single, unifying designator, the Audiology Foundation of America (AFA) is declaring victory for the profession in upgrading to the Au.D. and closing its doors.*

1995 STANDARDS AND EQUIVALENCY CONFERENCE

The 1995 Standards and Equivalency Conference (S&E Conference) was organized by the AFA and sponsored by 12 audiology organizations referred to as "Team Audiology". There were 120 conference participants; 56% had master's degrees and 44% had doctoral degrees. The participants were divided into one of two-tracks: **Track 1** (43% of

participants) worked on "Standards" for Au.D. curricula. One of the areas covered was regarding the importance of developing a 'national examination' with predictive value for success in Au.D. programs, like the MCAT or the LSAT. Sixty-six percent (66%) of Track 1's participants agreed that this was Important or Very Important to pursue for program admissions. **Track 2** (57% of participants) worked on developing "Equivalency" mechanisms for practicing audiologists to utilize as a bridge to transition to the Au.D. **Option 1** was the right to an Au.D. Certificate/Credential (not a degree) issued by an institute (not a university) based upon the evaluation of qualifications. This option came to be known as Earned Entitlement (EE). **Option 2** was the right to an earned Au.D. degree (university granted professional degree) following a portfolio review and after meeting the standards established by that program. This was the distance education program, often referred to as Equivalency (E).

The consensus opinion statement from the S&E Conference agreed that by the year 2002 anyone entering the profession should be required to have attained a doctor of audiology degree (Au.D.) (S&E Conference, 1995; Engelmann and Micken, 1997). Instead, ASHA delayed the transition from an allied health care profession to a doctoring profession for over a quarter of a century. In 1986, an ASHA Audiology Task Force recommended that a professional doctorate become the entry-level degree for audiology by 1998 – a 12-year transition. In 1992, ASHA moved the implementation of the revised doctoral standards to the year 2001 – a 15-year transition. In 1997, ASHA finalized its revised standards for awarding the CCC-A. It concluded that the doctoral degree is mandated, to earn the CCC-A, as the minimum degree starting in 2012 – a 26-year transition. The consequences of ASHA's delay, delay, delay was the continued perpetuation of master's degree programs.

EARNED ENTITLEMENT (EE) PROFESSIONAL RECREDENTIALING PROGRAM:

The AFA published an educational booklet addressing professional recredentialing in general and specifically about EE (Engelmann and Micken, 1997). Below are some of the teachings provided:

Entitlements, sometimes referred to as "grandfathering", are recredentialing processes other than earned academic degrees used to establish uniformity, equality, and unity within professions during a period when educational requirements or standards of practice are transitioning. The professionals taking advantage of these honorable, ethical, and legal processes are intentionally indistinguishable from their peers in an effort to optimize a more seamless transition for the profession instead of prolonging the transition for years.

Professions, such as physicians, osteopaths, podiatrists, pharmacists, and lawyers have legitimately and honorably used various forms of entitlements during their respective transitions. Previously, optometrists adopted the "O.D." designator for all optometrists and entitled them to use the title "Doctor of Optometry" regardless of whether they had earned the O.D. degree. This was validated by their state licensing boards.

Psychometric science is used to develop and award credentials to various professionals. Discrete steps are followed in developing and implementing a statistically valid and reliable system which identifies and subjects' applicants to an evaluation of their professional capabilities and credentials. AFA contracted and partnered with a firm specializing in the psychometrics of credentialing and the development of professional examination processes leading to recredentialing. They created the innovative, contemporary version of entitlement processes utilizing a comprehensive portfolio review; often equated to what is known in academic circles as 'prior learning assessment' (PLA), a common and useful tool unfamiliar to the audiology profession. PLA is a process used by many universities to award college credit for non-traditional learning that occurs outside of a university classroom.

The design of the portfolio EE process incorporated information from existing university Au.D. degree programs, from 10 clinical content areas defined in the model Au.D. degree curriculum developed at the 1988 ADA Conference on Professional Education, elements of Prior Learning Assessment, and a comprehensive psychometric evaluation of formal education, continuing education, on the job training and professional capabilities. A standard of practice based on doctoral care was formed and validated on the reference group of approximately 100 doctoral audiologists whose primary practice responsibilities were direct patient care and whose average length of time practicing audiology was more than 15 years. The portfolio review process enabled audiologists to demonstrate that their knowledge, skills, and capabilities were commensurate with those of doctoral level audiologists. EE was voluntary and used scientifically sound and valid psychometric principles. It was a far more

"Earning my Au.D. degree has given me a new and heightened sense of responsibility to my profession and to the importance of recruiting as many other audiologists to earn their Au.D. as possible."

—Dr. Larry Engelmann
(Inaugural graduation of Au.D. students in 2000)

comprehensive process than any other entitlement process used by other professions to transition to doctoral status. The Au.D. credential was awarded when qualified, licensed, and experienced audiologists met the doctoral standard of care. The time-limited EE option was available for applications to be completed until January 1, 2007.

At the October 1996 ADA Convention, Ken Smith, Ph.D., immediate past president of ADA, received the first Au.D. credential. He said, *"Receipt of my Au.D. credential was the highlight of the meeting. For me to see this process become a reality was like seeing a dream come true, and I would hope that every qualified audiologist would consider this option for changing our profession."*

On March 14, 1997, a group of Iowa audiologists, with the support of the assistant attorney general, presented a resolution to the Iowa Board of Speech Pathology and Audiology Examiners to recognize Earned Entitlement for practicing audiologists. The resolution passed unanimously. The Academy of Dispensing Audiologists sent a supportive letter to all the state licensure boards in May 1997.

ASHA SUES AFA IN 1998 OVER THE AU.D. CREDENTIAL

ASHA's position, like AAA's, was that the Au.D. designation should represent only an earned degree, otherwise it would be misleading the public. A Press Release (April 2000) noted *"A successful settlement has been reached in the litigation between ASHA and AFA over the use of the Doctor of Audiology and Au.D. designations. Based on AFA's decision to cease issuing the credential, AFA's attorneys moved to dismiss as moot the lawsuit filed in July of 1998 by ASHA against AFA. The two organizations then followed the Judge's suggestion that they negotiate a settlement out of court."* The ending of this suit came at a time when the Au.D. credential was no longer needed as an assistive vehicle to transition audiology to a doctoring profession because there existed five universities that made available distance education Au.D. degree programs for practicing audiologists. The Au.D. credential, while controversial and now only part of our history, served its purpose for our profession. Despite ASHA, the transition pushed forward thanks to those who were dedicated to transforming audiology to a doctoring profession.

NATIONAL ASSOCIATION OF FUTURE DOCTORS OF AUDIOLOGY (NAFDA)

The NAFDA was founded in 1998 by an audiology student at the University of Louisville. The association was an autonomous student-run organization. NAFDA's corporate Bylaws stipulated that the organization's membership was open exclusively to Au.D. students. The new Au.D. student organization had chapters at universities across the country and was supported by ADA, AFA, AAA, and industry. NAFDA and faculty advisors were instrumental in establishing the velvet color for Au.D. graduate hoods as spruce green, aligning with medical degrees based on the Academic Costume Code. At AAA's 2008 convention, its leaders announced their plans to establish an AAA affiliated student organization, i.e., the Student Academy of Audiology (SAA). After numerous discussions between AAA and NAFDA leaders, NAFDA agreed to disband and merge its members into the new SAA.

AFA'S SPRING 2000 TORCHBEARER NEWSLETTER

The newsletter acknowledged and reported on the status of the five 'Distance Education Au.D. Programs' that became available for practicing audiologists. The first one was Nova Southeastern University (established in 1999). Soon to follow were Central Michigan University, University of Florida, Arizona School of Health Sciences – Kirksville College of Osteopathic Medicine (now A.T. Still University), and the Pennsylvania College of Optometry (now Salus at Drexel University).

AFA BOARD MEETING (AUGUST 21, 2000)

Dr. Larry Engelmann reported**,** "At the inaugural graduation of Au.D. students in 2000, Dr. James McGovern, President of the Kirksville College of Osteopathic Medicine explained to us that the black robes worn at graduation traditionally symbolize the 'death of self' while we accept the charge of reaching out to others. Earning my Au.D. degree has given me a new and heightened sense of responsibility to my profession and to the importance of recruiting as many other audiologists to earn their Au.D. as possible." After I earned my Au.D. degree in 2000, my friend, mentor, and former employer, Dr. Jack Hough, Otologist, one day looked up at me with a congratulatory smile and said, "Welcome to the club, Larry!"

LICENSING LAWS

State licensure defines an audiologist's right to practice. In 2002, ADA, followed by AFA and AAA, began separately working on a Model Licensing Law. After realizing the overlapping efforts, the three groups agreed to cooperatively form a liaison committee that worked between 2002-2004 in a collaborative effort to create one Model Licensing Statute (2004). The liaison committee was comprised of Ken Lowder, Au.D. (AFA Chair), Susan Paarlberg, M.S. (AFA Exec. Dir.), Bob Gippen (attorney and AFA board member), Barry Freeman Ph.D. (AAA rep. and professor at Nova SE's Au.D. program), and Larry Engelmann, M.S., Au.D. (Chaired the ADA Model Licensure Law Committee and ADA board member). Incorporating the Au.D. degree requirement as the entry-level degree to practice and updating state licensing laws one at a time was a long and arduous task, but not insurmountable.

ADA'S NAME CHANGE (2006): ACADEMY OF DOCTORS OF AUDIOLOGY

In November 2006, members of the Academy of Dispensing Audiologists (ADA) voted to change the association's name to the Academy of Doctors of Audiology (ADA) at the annual Business Meeting during ADA's 2006 Convention. This name change more accurately reflects the vision of the ADA and the future of the profession. Subsequently, ADA changed the name of its professional magazine from 'FEEDBACK' to 'Audiology Practices'.

OTHER IMPORTANT CONFERENCES

Periodically, there were other important conferences that helped shape the audiology profession and audiology education such as: a) the AAA Consensus Conference (2004) addressing student issues and b) the AFA Conference on Professional Education II (2008). Many topics were covered such as: professional doctoring and educational terminology vs. allied health and graduate school terminology, licensing for students – or not (e.g., provisional licensure), financial aid and other forms of assistance for students, clinical rotations, externships and preceptors, modeling audiology in relation to other doctoring professions, and looking at and solving obstacles for continuing to advance audiology to a doctoring profession.

ACCREDITATION

JAC

Out of the 1995 S&E Conference, the Joint Audiology Commission (JAC) was formed and established in 1995 by nine audiology organizations. Its Mission was to facilitate the establishment of an audiology-controlled accrediting body for Au.D. programs. It was suspended in 1997.

ACAE

The Accreditation Commission for Audiology Education (ACAE) was founded as an independent non-profit organization in 2003 by the AFA, ADA, and AAA. ACAE accreditation is focused solely on doctoral-level audiology programs, (ACAE, 2024). AFA provided support and financial grants to ACAE from ACAE's inception through most of 2005. Eventually, ACAE became and still remains a 'sister organization' to AAA.

Dr. Larry Engelmann (2002) (previous ADA president) said, "Audiologists are the professional minority group in ASHA by about a 10 to 1 ratio. I believe that audiology should be independent and free to develop and evolve on its own without any influence from an organization representing more than one profession."

Dr. Richard Gans (2005) said in a AAA Presidential Message, in part, "It is our belief that a new audiology accreditation body, free from the influence of another profession, is critical to the integrity of Au.D. education." and "We are confident that the ACAE will become the accreditation gold standard for Au.D. education."

CAA

ASHA's program accrediting arm is the CAA (Council on Academic Accreditation in Audiology and Speech-Language Pathology). A letter dated July 30, 2007, from then ASHA president Norma Anderson, Ph.D. to Dr. Celia Hooper, then president of the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD) noted, in part: "…ASHA's mission and values, which recognize the two autonomous professions of audiology and speech-language pathology within the singular discipline of communication sciences and disorders. ASHA is committed to representing both of these integrally related professions in governance, development, and delivery of programs, products, and services including continuing education,

advocacy, dissemination of practice policy documents, and the development and promulgation of professional standards."

Dr. David Berkey (then ADA president-elect) in a letter to the AAA Board of Directors in January 2007 noted, in part, "The responsibility for developing and maintaining professional standards and academic standards are core responsibilities of the audiology profession. We can no longer be satisfied to have this critical function under the control of another professional organization that represents audiology only as a 'minority interest'."

Dr. Angela Loavenbruck (previous AAA president) also noted in the same period that: "ACAE's standards are only for Au.D. programs, and are not tied to any requirement for certification."

CONCLUSION

This article presents a historical perspective on the Au.D. Movement's transition starting in 1988. Through a long-protracted roller coaster process, the Au.D. Movement transitioned our profession's education model from a graduate school master's degree for allied health professionals towards a professional school doctoral degree for healing arts doctors. Clinical practitioners garnered support almost immediately. Surprisingly, ASHA and many academics pushed-back hard against moving away from the two-year master's degree plus a 'clinical fellowship year' (CFY) after graduation. But eventually, all parties ended up working together for the betterment of audiology. Diverse topics were covered such as audiology's roadmap to the future; contributions from various professional organizations, foundations, and conferences; accreditation; and others. While our profession has made enormous strides, the journey is not over. There is much work to do to continue advancing audiology education and the profession. More on those topics next time.

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PART 1

AUTONOMY IS STRUCTURAL,

Not Technological

Amyn M. Amlani, Ph.D.

INTRODUCTION

Audiology frequently frames professional autonomy as a downstream consequence of innovation—through artificial intelligence, advanced diagnostics, and expanding treatment techniques. This narrative, while attractive, has failed to produce meaningful gains in authority, reimbursement, or workforce sustainability. Autonomy in US healthcare is not earned through technological sophistication; it is granted through structure—via licensure authority, statutory recognition, and reimbursement policy, particularly within Medicare.

This article identifies the structural gaps constraining audiology, examines their downstream effects on reimbursement, wages, workforce attrition, and quality of life, and outlines the bridge required for reform. It represents Part 1 of a two-part series reframing the autonomy conversation from aspiration to infrastructure.

Autonomy in US healthcare is granted through licensure authority, statutory recognition, and reimbursement policy.

INNOVATION HAS NOT DELIVERED AUTONOMY

Audiology is technologically advanced, clinically effective, and academically rigorous. Yet, despite decades of innovation and a transition to doctoral-level entry, the profession remains structurally constrained within the U.S. healthcare system.

Autonomy has not followed.

Instead, audiologists continue to face:

- limited reimbursement authority,
- inconsistent scope-of-practice recognition,
- wages that do not reflect doctoral training, and
- a fragile workforce marked by early-career attrition and professional dissatisfaction.

Equally telling is where audiology sits within the broader healthcare delivery landscape. Fully autonomous health professions—such as medicine and dentistry—are characterized by a substantial proportion of independently owned practices. Independent practice ownership is not incidental; it is a direct consequence of statutory authority, direct access, and reliable reimbursement. These structural conditions allow clinicians to control clinical decision-making, set sustainable business models, and capture the economic value of their expertise.

By contrast, audiology's constrained autonomy has limited the growth and stability of independent practices, reinforcing dependence on physician-owned systems, corporate employment models, and vertically integrated retail structures. This dependence is not a market failure—it is a predictable outcome of restricted authority and reimbursement.

The persistent belief that innovation alone will resolve these challenges has delayed necessary structural reform.

WHAT AUTONOMY MEANS IN PRACTICE

Professional autonomy is not symbolic; it is operational. In healthcare, autonomy is defined by three structural conditions:

1. Independent scope of practice, codified in state law
2. Direct access, without mandated physician referral or supervision
3. Full recognition as a reimbursable provider, particularly under Medicare

Audiology does not consistently meet these conditions. As a result, audiologists practice within a system that restricts professional authority while demanding doctoral-level expertise—without commensurate authority, reimbursement, or economic recognition.

This imbalance is the foundation of many of the profession's downstream barriers.

STRUCTURAL GAPS TO AUTONOMY

Gap #1: Medicare Recognition and Reimbursement Authority

Medicare as the Gatekeeper of Professional Legitimacy

The most consequential structural barrier to audiology autonomy lies within the Centers for Medicare and Medicaid Services.

Medicare is not merely a payer; it is the primary arbiter of legitimacy in US healthcare. Provider recognition under Medicare influences:

- private insurance coverage,
- health system credentialing, and
- participation in interdisciplinary and value-based care models.

Structural Consequences of Limited Medicare Recognition

Audiology's limited Medicare recognition—as a diagnostic supplier rather than an independent practitioner—has several cascading effects:

- constrained billing authority,
- artificially low reimbursement rates,
- continued dependence on physician-linked pathways, and
- exclusion from modern payment and care-delivery models.

These limitations are not accidental; they are statutory.

The Legislative Pathway: Medicare Audiology Access and Improvement Act

A clear legislative pathway exists to address this gap through the Medicare Audiology Access and Improvement Act (MAAIA), which seeks to modernize audiology's role within Medicare by recognizing audiologists as independent providers, expanding covered services, and aligning reimbursement authority with doctoral-level training. Passage of this legislation would represent a foundational step toward correcting the structural misalignment between audiology's educational preparation and its professional authority.

Advocacy as a Professional Obligation

However, legislation does not advance on merit alone. Progress requires sustained, visible advocacy.

Audiologists, therefore, face a professional obligation to support this effort—not only rhetorically, but materially—through advocacy funding, volunteer engagement, and direct communication with state and federal legislators. Absent broad-based engagement from the profession itself, Medicare reform is likely to remain aspirational.

Autonomy cannot be delegated to organizations alone; it must be demanded by the clinicians whose livelihoods, workforce stability, and professional futures are directly affected.

Why Innovation Alone Cannot Close this Gap

Fundamentally, Medicare policy does not respond to technological innovation. It responds to statute. Until audiology's role within Medicare is structurally modernized through legislative action, improvements in care delivery will *not* translate into professional authority, equitable reimbursement, or economic sustainability.

Gap #2: Reimbursement That Does Not Reflect Doctoral-Level Care

Low reimbursement is not incidental—it is structural.

Audiologic services are frequently reimbursed at levels that:

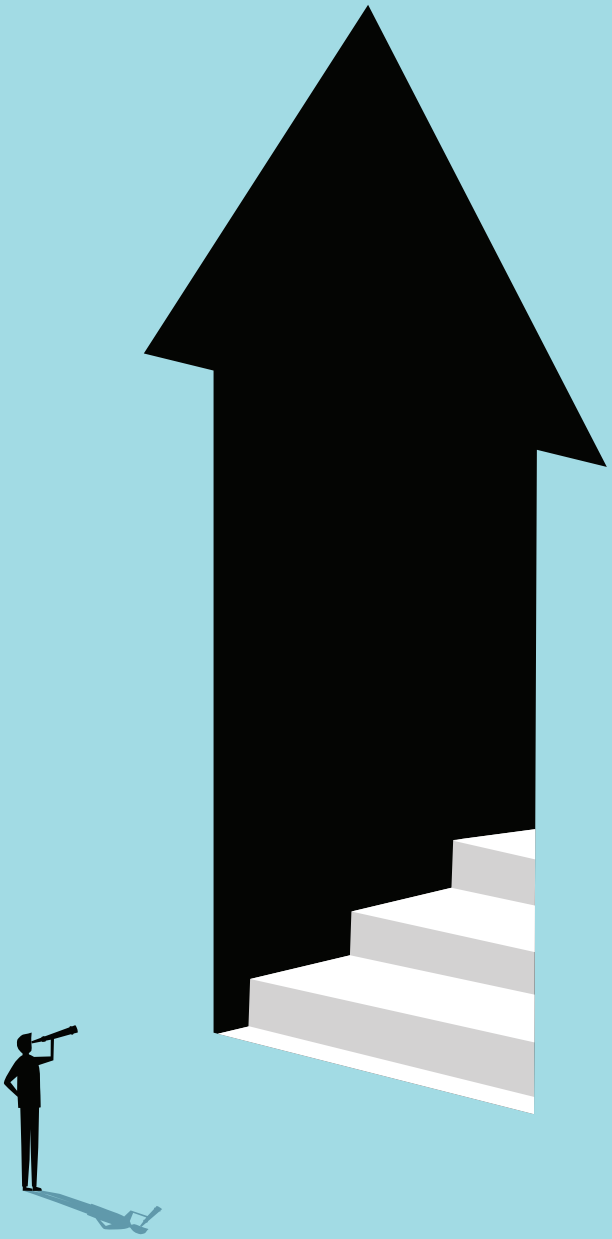
- fail to reflect clinical complexity,
- undervalue cognitive and counseling-intensive care, and
- incentivize volume over best practice.

This has produced a system where:

- time-intensive services are financially penalized,
- comprehensive care models are economically fragile, and
- clinical decision-making is distorted by reimbursement constraints.

The result is not merely dissatisfaction, but a profession structurally constrained from practicing at the level it is trained to deliver.

Autonomy cannot be delegated to organizations alone; it must be demanded by the clinicians whose livelihoods, workforce stability, and professional futures are directly affected.



Gap #3: Wages Decoupled from Educational Investment

Despite requiring a doctoral degree, audiology wages remain closely coupled to professions with lower terminal degree requirements. This wage stagnation reflects a structural decoupling between doctoral-level training and labor-market valuation, shaped by constrained pricing authority, limited-service differentiation, and institutional reimbursement structures.

An additional and often overlooked contributor to wage stagnation is audiology's constrained scalability of independent practice ownership. In autonomous health professions, independent practice serves as a primary mechanism for income growth, professional control, and long-term financial stability. Although independent audiology practices can be viable and often thrive, pathways to ownership are uneven and increasingly difficult to scale across the profession. Beyond reimbursement structures, ownership access is shaped by high educational debt, early-career risk tolerance, generational preferences for employment stability, and market realities such as payer mix and competition from vertically integrated models. Collectively, these factors contribute to many audiologists remaining in employed settings with compressed compensation bands, further decoupling doctoral-level training from long-term economic return.

The implications are clear:

- doctoral-level training is not rewarded economically,
- return on educational investment is poor, and
- salary trajectories fail to justify the cost and duration of training.

This disconnect undermines recruitment, retention, and long-term professional viability.

WORKFORCE CONSEQUENCES

Structural constraints manifest most visibly in the workforce. Audiology faces early-career attrition, migration to non-clinical roles, and abandonment of the profession altogether.

Many early-career audiologists report:

- lower-than-expected quality of life,
- limited upward mobility,
- and financial strain driven by student debt.

For many, this manifests as delayed home ownership, constrained geographic mobility, and prolonged reliance on employed models that offer limited income growth or schedule flexibility.

High educational debt—often accumulated during unpaid or minimally compensated clinical training—exacerbates these pressures. When combined with modest wages and limited autonomy, the result is predictable: dissatisfaction and exit.

These outcomes are not failures of resilience. They are rational responses to structural misalignment.

WHY INNOVATION HAS NOT SOLVED THESE PROBLEMS

Innovation has improved care—but it has not changed the rules of the system.

New tools have:

- enhanced diagnostic precision,
- expanded service delivery options, and
- improved patient outcomes.

They have not:

- increased reimbursement authority,
- altered Medicare recognition, or
- expanded statutory scope.

As a result, innovation has raised expectations without changing conditions—intensifying frustration rather than resolving it.

LIMITS—AND ADVANTAGES—OF PROFESSIONAL ORGANIZATIONS

Professional organizations play essential roles in education, advocacy, and standard-setting across healthcare. However, organizations such as the American Academy of Audiology (AAA) and the American Speech-Language-Hearing Association (ASHA) operate within governance structures designed to represent broad and diverse memberships, encompassing clinicians, researchers, educators, administrators, and—in the case of ASHA—multiple professions.

While this breadth confers strength in consensus-building and educational outreach, it also constrains the pace and scope of action on issues that fundamentally alter professional authority. Autonomy, reimbursement reform, and scope-of-practice expansion are inherently contentious topics that challenge existing interprofessional boundaries and legacy structures. Within large, consensus-driven organizations, progress on such issues is, therefore, often incremental, cautious, and framed to minimize internal conflict.

This reality does not diminish the value or importance of these organizations. Rather, it highlights a structural limitation: transformative change in professional authority rarely emerges from organizations designed to prioritize broad consensus over focused advocacy.

By contrast, the Academy of Doctors of Audiology occupies a distinct and complementary role within the profession. As an organization composed exclusively of doctoral-level audiologists and explicitly oriented toward clinical practice, healthcare policy, and professional autonomy,

ADA is structurally positioned to advance modernization efforts that are more difficult to pursue within broader umbrella organizations.

ADA's focused membership and governance model enable:

- direct engagement with healthcare policy and Medicare reform,
- sustained advocacy for scope-of-practice modernization,
- alignment between doctoral training and professional authority, and
- clear prioritization of independent practice viability and reimbursement reform.

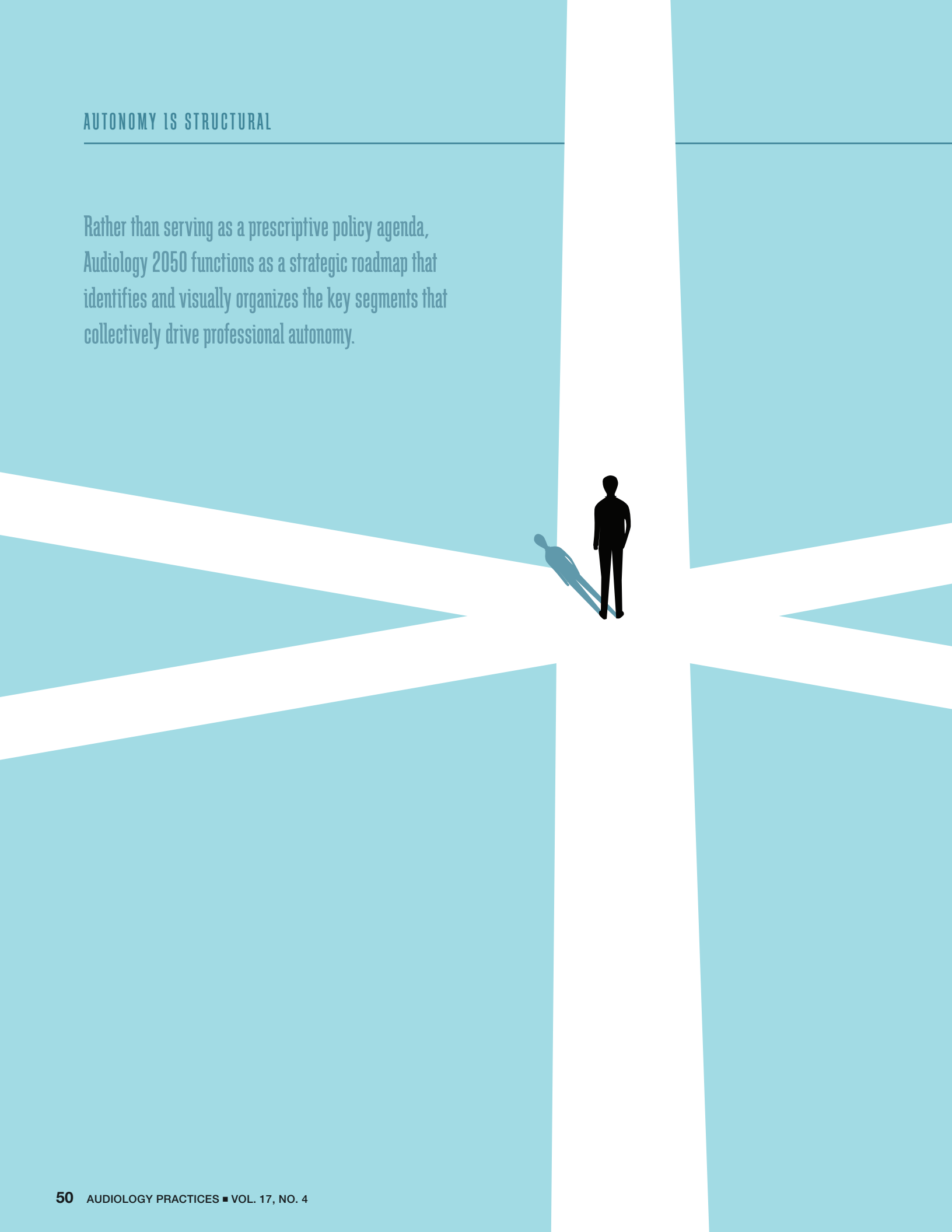
Autonomy, reimbursement reform, and scope-of-practice expansion are inherently contentious topics that challenge existing interprofessional boundaries and legacy structures.

As a result, ADA has emerged as the primary organizational leader in advancing audiology autonomy and practice modernization at the state and federal levels. This role is not competitive with other professional organizations, but complementary—reflecting the reality that different organizational structures are suited to different types of professional work.

Historically, major shifts in professional authority have required *both* bottom-up pressure from clinicians and leadership from organizations structurally aligned with autonomy-focused advocacy. In audiology, that alignment has increasingly rested with ADA.

AUTONOMY IS STRUCTURAL

Rather than serving as a prescriptive policy agenda, Audiology 2050 functions as a strategic roadmap that identifies and visually organizes the key segments that collectively drive professional autonomy.



AUDIOLOGY 2050: A FRAMEWORK FOR STRUCTURAL ALIGNMENT

Addressing audiology's structural constraints requires more than isolated policy wins or organizational advocacy. It requires alignment—across professional organizations, educational models, workforce priorities, and healthcare policy. Historically, the absence of a shared strategic framework has contributed to fragmented efforts and misaligned incentives.

Audiology 2050 was developed as a profession-facing strategic framework, intended to support alignment across the audiology ecosystem rather than advance the priorities of any single organization.

Rather than serving as a prescriptive policy agenda, Audiology 2050 functions as a strategic roadmap that identifies and visually organizes the key segments that collectively drive professional autonomy. These include healthcare policy and reimbursement, scope-of-practice authority, workforce sustainability, educational alignment, and care-delivery models. By framing autonomy as the product of interconnected structural components—rather than a single legislative or technological outcome—the roadmap offers a common reference point for stakeholders across the profession.

Importantly, Audiology 2050 also provides a bridge for improved collaboration among professional organizations. By focusing on shared structural objectives rather than organizational roles, it creates space for complementary contributions—allowing consensus-oriented organizations to engage where appropriate, while enabling autonomy-focused entities to advance targeted reform. In this way, Audiology 2050 emphasizes coordination over competition and alignment over attribution.

As the profession confronts persistent challenges related to reimbursement, wages, workforce attrition, and quality of life, the value of a unifying strategic framework becomes increasingly clear. Audiology 2050 does not replace advocacy, legislation, or organizational leadership—but it helps ensure that these efforts move in the same direction.

THE BRIDGE TO REFORM: WHAT MUST CHANGE

If autonomy is structural, then reform must be structural.

The necessary bridge includes structural reforms already discussed, including:

- modernization of Medicare recognition and billing authority,
- alignment of reimbursement with doctoral-level cognitive care,
- scope-of-practice reform that reflects current training, and
- paid clinical training models that reduce student debt.

Absent these changes, workforce instability will persist—regardless of technological progress.

PART 1 OF A TWO-PART SERIES

This article has focused on identifying the structural gaps that constrain audiology autonomy and examining their downstream consequences for reimbursement, wages, independent practice viability, and workforce sustainability.

A follow-up article (Part 2) will examine why professional organizations have historically struggled to advance autonomy, with particular attention to governance structures, incentive alignment, and institutional constraints that shape organizational positions on healthcare policy and practice modernization. Together, these articles—Part 1 and 2—are intended to move the profession beyond aspirational narratives and toward structural solutions that align doctoral-level training with professional authority.

CONCLUSION

Autonomy delayed is workforce decline accelerated.

Audiology's challenges are not the result of insufficient innovation. They are the predictable outcomes of structural constraint. Low reimbursement, stagnant wages, workforce attrition, and declining quality of life are not isolated problems—they are interconnected symptoms of a profession operating without full autonomy.

Autonomy will not arrive through better tools alone. It will arrive only when the structures governing scope, access, and payment are reformed. Recognizing this reality is not pessimistic. It is necessary.

***Amyn M. Amlani, Ph.D.**, is an audiologist, researcher, and thought leader whose work spans clinical practice, health economics, and hearing-health policy. He serves as a clinical audiologist at the ENT & Allergy Centers of Texas, where he provides patient-centered diagnostic and rehabilitative care with a focus on tinnitus and hearing aid management. Dr. Amlani is the immediate past president of the Academy of Doctors of Audiology. Contact information: Amyn M. Amlani, PhD; Frisco, Texas, USA; (469) 834-2882; otolithic@outlook.com.* ■

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CLINICAL BULLETIN #7

Brian Taylor, Au.D.

Using The THS-H Survey to Identify and Treat Adults with Normal Audiograms and Self-Reported Hearing Difficulties

Description of the Condition

Individuals with a normal audiogram (≤20 dB HL from 250–8000 Hz, as illustrated in Figure 1) who nonetheless report communication difficulties—especially in noise, groups, or complex listening environments—are often described as having a functional hearing disorder or subclinical auditory dysfunction.

A Lack of Consensus *What's Normal?*

There is no clear consensus on how "normal hearing" should be defined. The routine audiogram has remained unchanged for 100 years. The results shown on the audiogram do not always reflect functional abilities of the individual.

250 to 8000Hz

A Lack of Consensus *What's It Called?*

The is no consensus on the name of this condition. It has several labels:

- Hearing difficulties despite normal audiograms (HDNHA)
- Subclinical hearing loss
- Hidden hearing loss
- Central auditory processing deficits (CAPD)
- Listening difficulties / communication difficulties
- Auditory processing disorder–like symptoms in adults
- Cochlear synaptopathy

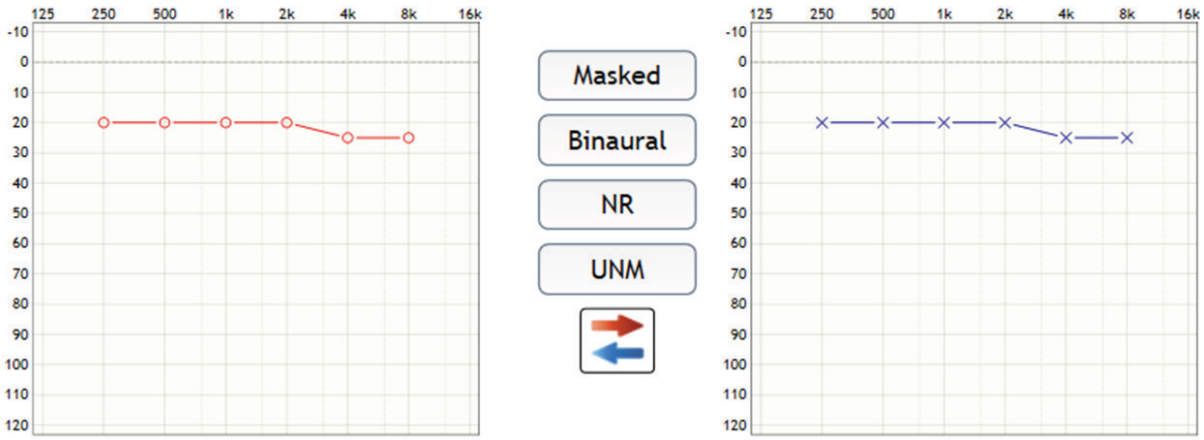

Figure 1. The typical audiogram of an individual with self-reported communication problems

Prevalence of the Condition

Research shows that approximately 10 to 15% of the general adult population has self-reported communication difficulties accompanied by a normal audiogram (Tremblay et al., 2015 Spankovich, et al 2018 and Curti et al 2019).

10 to 15%
of adults

45% of audiologists surveyed report seeing 1 to 3 individuals per month with this condition and 23% report seeing 4 or more individuals per month

(Koerner et al 2020).

Identification of the Condition

The original Tinnitus and Hearing Survey (THS) was developed in 2015 to provide a self-report option for US Veterans with hearing and tinnitus problems. In its initial form, the hearing subscale (four items) were scored on a five-point scale: 0 to 4, resulting in a maximum possible score of 16. The scale has been modified as the Tinnitus and Hearing Survey—Hearing (THS-H) using an 11-point scale, as shown in Figure 2. Davidson et al (2024) validated the THS-H on ~1,500 Veterans, many of whom presented with noise and blast injuries. **They determined a score of 27 or higher equates to the bottom 5th percentile of hearing performance.**

Tinnitus and Hearing Survey-Hearing Subscale

Hearing	No, **not** a problem										Yes, a **very big** problem
Over the last week, I couldn't understand what others were saying in noisy or crowded places.	0	1	2	3	4	5	6	7	8	9	10
Over the last week, I couldn't understand what people were saying on TV or in movies.	0	1	2	3	4	5	6	7	8	9	10
Over the last week, I couldn't understand people with soft voices.	0	1	2	3	4	5	6	7	8	9	10
Over the last week, I couldn't understand what was being said in group conversation.	0	1	2	3	4	5	6	7	8	9	10

Figure 2. The THS-H

Hearing Aid Outcomes

Davidson et al (2024) fitted 186 US Veterans with hearing aids.
Figure 3 illustrates wear time and Figure 4 illustrates global benefit for these 4 groups.

- Normal Hearing Test (NHT)/Significant Hearing Difficulty (SHD) = 13
- Normal Hearing Test (NHT)/No Hearing Difficulty (NHD) (tinnitus) = 36
- Hearing Impairment (HI)/Significant Hearing Difficulty (SHD) = 80
- Hearing Impairment (HI)/No Hearing Difficulty (NHD) (tinnitus) = 57

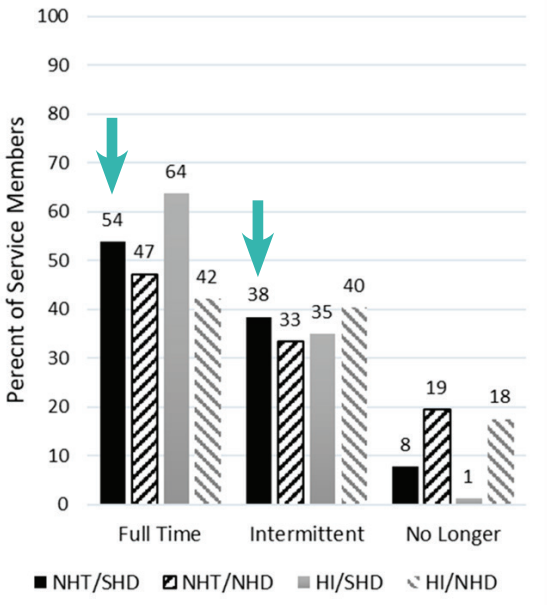

Figure 3. Percentage of participants reporting full-time use for 4 groups. (From Davidson, et al 2024). Blue arrows denote the normal audiogram/significant self-reported hearing difficulty group.

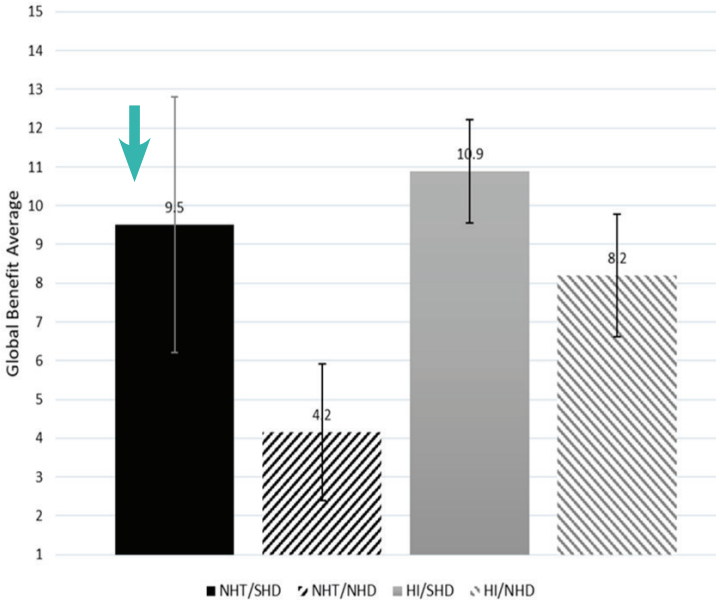

Figure 4. Global benefit average on the Hearing Aid Use and Benefit Questionnaire for 4 groups. (From Davidson, et al 2024). Blue arrow denotes the normal audiogram/significant self-reported hearing difficulty group.

Clinical Implications

1. The THS-H is a time-efficient and valid tool for identifying adults with normal audiograms who may benefit from hearing aids.
2. Both usage time and global benefit for those with normal audiograms and self-reported hearing difficulties are comparable to those with significantly greater hearing loss on the audiogram.
3. Low-gain hearing aids with minimal distortion, that provide sufficient audibility are practical solutions for this population.
4. Hearing aid outcomes shown here reflect VA service delivery in which patients incur no out of pocket costs. Thus, other low cost treatment options (e.g., high quality PSAPs, OTC and auditory training exercises) should be considered in a commercial clinic.

"Audiology must recognize our reliance on the audiogram now and aim to offer these services more routinely."

Expanding Our Scope of Practice

"The fact that our primary treatment for hearing loss == hearing aids -- is tied to the audiogram has effectively narrowed the audiologist's scope of practice. Only 7% of audiologists dispense PSAPs, 20% provide tinnitus evaluations, 20% provide auditory training, and 29% routinely perform speech-in-noise testing.

All these services could potentially benefit the "normal-hearing" population who self-report difficulties. Audiology must recognize our reliance on the audiogram now and aim to offer these services more routinely." - Gatlin and Dhar (2021)

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Advocacy 101:

Writing an Effective State Legislative Letter

Bryan Greenaway, Au.D. & Alicia D.D. Spoor, Au.D., ADA Advocacy Chairs

With state legislative sessions in full swing, the voices of audiology professionals are more critical than ever. Whether the need is urgent or part of a long-term strategy, a well-crafted letter that is thorough and direct can serve as a powerful tool to persuade elected officials.

While state associations provide the "talking points," the most effective letters are those tailored by individual practitioners. "Form letters," or letters with identical wording, are often valued lower when written testimony is weighed.

Use the following guide to ensure your letter hits the mark.

Formal Heading

Legislative and committee staff process hundreds of documents daily. If they can't identify the bill or your position in three seconds, your impact is diminished. Start with your department/practice/clinic's letterhead, if you are able to use it. Ensure the following are prominent:

- Recipient: Name of the Chairand the Committee
- Bill Information: Use the formal number and title
- Date: Use the hearing date, not the date the letter is written
- Your position: Use the specific terminology of your state (e.g., *Favorable, Favorable with Amendments, or Unfavorable*).
- Dear Mr./Madam Chair, Vice Chair, and Committee members:

Here's an example:

Chair Stephanie Smith
Senate Finance Committee
123 Main Street, Building C
Capitol, DC 55555

Date of Hearing

RE: SB 795- Health Occupations – Practice of Audiology – Definition
Position: SUPPORT

Madam Chair Smith, Vice Chair James, and Committee Members:

Introductory Paragraph

The first paragraph will be 1-2 sentences stating the position (e.g. favorable) and a very brief description of your position in the state. If you are a constituent (live or work in the legislator's district), state that immediately next to your name. Legislators prioritize their own voters above all else.

For example:

My name is Dr. Anne Thomas and I am a Doctor of Audiology at Great Hospital Center (GHC) in Brooklyn, NM. The audiology department at GHC provides comprehensive hearing and balance care to patients in a 200-mile radius. I am writing today to request a favorable report on SB 795.

More Detail

Use the second paragraph to make the letter unique to you. Write your elevator speech and explain any relevant connections to the legislation, committee, committee members, the community and more. This paragraph could be lengthy, but needs to be succinct, so the elected member continues reading the statement.

> I earned a Doctor of Audiology degree from Pacific University in Washington, NC and started my professional career at the Children's Hospital in San Diego, CO. After 10 years of providing pediatric care, I transitioned to a private practice clinic in the Westchester community and specialize in auditory processing disorders (APD). My daily schedule includes school-aged children and adults, as my specialty in APD is rare. Individuals and their families often travel more than 100-miles for APD services. The best part of my position is being able to care for individuals and see their growth in both educational and occupational settings.

The Legislative Issue

The next paragraphs are the substance of the letter. Outline how legislation affects your ability to practice and/or your patients' ability to receive care. Use evidence to back up your position and include references (endnotes) as much as possible.

> Contrary to the Oregon Medical Association's statement, audiologists recognize acute otologic conditions at the same rate as physicians and refer appropriately. (Zapala, 2010)

References should be up-to-date and fully support your statement. As necessary, reinforce the didactic and clinical foundations audiologists have, including any information on licensure that may be applicable.

If the legislation has multiple changes, make sure each topic is addressed. Modernization legislation, which is updating terminology and clearly defining an audiologist's scope of practice, may have a paragraph for each topic: evaluation, diagnosis, management, treatment, health screenings, cerumen removal, foreign body removal, ordering radiographic imaging, completing non-radiographic imaging, ordering cultures and bloodwork. Again, this is the essence of the letter and must be meticulous.

These paragraphs can also help defend against talking points raised by those opposing your position. Using citations can be very effective in this portion, essentially removing any doubt from an elected official's mind, and confirming the position that should be taken. When addressing opposition positions, keep your arguments professional and based in fact.

Each paragraph should only be 3-5 sentences, so the elected official can easily read it.

Show an Example

Before closing, audiologists should include an anecdote they have which exemplifies the need for the legislation. Anecdotes should be brief and factual without embellishment. A story about a patient who had delayed care or poor outcomes because they had to wait for radiographic imaging can be appropriate with scope modernization legislation. As would discussing the financial or quality of life implications of not being able to remove cerumen.

The Final Ask

The closing paragraph will be brief and respectful. This is the place to thank the members for their time and support of audiology, patients/constituents and drive home any critical information. The last sentence should reiterate the position.

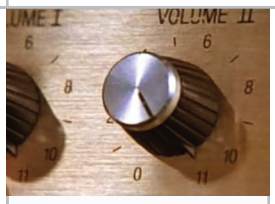
> Thank you for your time and continued commitment to thoughtful, evidence-based healthcare policy. I request an ***unfavorable*** report for SB 917.

Signature

Sign the letter; an electronic signature is okay, but not a digital signature or different font type. Include credentials and license number.

> Taylor Mann, Au.D.
> Doctor of Audiology
> Idaho License #572693756

Letters, or lack of, sent to state members can significantly help or hurt legislative initiatives. A well-written letter can help reinforce or persuade an elected official to vote in the manner you request. State associations can help with the format and provide information; however, in most situations, each letter needs to be uniquely written by individual audiologists. ■



HAVE YOU HEARD?

Expanding Your Expertise in 2026:

On-Demand Webinar Access for ADA Members

The Academy of Doctors of Audiology (ADA) continues to deliver on its commitment to professional excellence by offering members exclusive access to a growing library of on-demand webinars in 2026. Designed to support clinical care, practice management, leadership, and advocacy, these sessions provide timely, practical insights that audiologists can immediately apply in their practices.

ADA members can access these recordings anytime through the webinar archive (scan the QR code to access), reinforcing the ADA's dedication to flexible, high-quality continuing education.

Below are four of the most recent 2026 webinar offerings available to members:

State Audiology Practice Act Modernization: The Who, What, Where, When, and Why

Description: Audiology is at a critical crossroads as outdated state practice acts struggle to keep pace with advancements in education and clinical care. This webinar explores the urgent need for modernization, addressing the impact on patient access, professional autonomy, and the future of the profession. Attendees gain insight into policy challenges and actionable strategies for advocacy at the state level.

Speakers: Alicia Spoor, Au.D.; Jana Brown, Au.D.; Kim Cavitt, Au.D.; Stephanie Czuhajewski, MPH

Team Dynamics That Work: A Practical Framework for Audiology Leaders

Description: This session provides a research-based framework for understanding team dynamics in audiology practices. Participants explore how motivation, mindset, and behavioral patterns influence collaboration, trust, and decision-making, equipping leaders with tools to build stronger, more effective teams.

Speakers: Amy Badstubner, Au.D. and Kari Morgenstein, Au.D.

Increase Patient Engagement & Acceptance of Care Using Video

Description: In today's digital-first healthcare environment, video plays an increasingly powerful role in patient communication. This webinar offers practical strategies for using short, authentic video to improve case acceptance, enhance patient engagement, and modernize practice marketing efforts.

Speaker: Brian Harris, D.D.S

ADA 2026 Coding and Reimbursement Update

Description: This comprehensive annual update reviews the most significant coding, reimbursement, and compliance changes impacting audiology practices in 2026. The session equips clinicians and practice leaders with essential knowledge to optimize revenue, navigate payer requirements, and ensure compliance in a shifting healthcare landscape.

Speaker: Kim Cavitt, Au.D.

Stay Connected, Stay Ahead

These webinars are just a snapshot of the available educational offerings. ADA members have ongoing access to resources that support lifelong learning, advocacy, and practice success. Be sure to log in to your ADA member account to access these webinars and earn CE where available—another valuable benefit of your ADA membership.

Attend ADA Advocacy Day at Capitol Hill

Wednesday, May 13th

Let's take action to turn Better Hearing Month into Better Hearing Policy Month!

Join audiologists from around the country on Capitol Hill on Wednesday, May 13, 2026, to AuDvocate to improve public policies governing the delivery of audiology services! Use the QR code to register to attend ADA Advocacy Day at Capitol Hill. During this important event, we will advocate for the following:

- Passage of the Medicare Audiology Access Improvement Act to enhance Medicare beneficiary access to audiology services
- Greater transparency and accountability for Medicare Advantage hearing benefit plans
- Parity in access to student loan funding for audiology students with students in other academic clinical doctoring training programs.

Advocacy Day Travel Recommendations and Hotel Accommodations

Flying in? We recommend flying to Ronald Reagan National Airport (DCA).

Legislative meetings will generally run from about 9:00 a.m. to 4:00 p.m. Eastern Time on Wednesday, May 13, 2026.

Please book travel to ensure departing flights are at 6:00 p.m. or later, on Wednesday, May 13th.

For attendees requiring hotel accommodations (either before advocacy day, after, or both), we have secured a block of rooms at Archer Hotel Alexandria. To book your room at the ADA group rate, please use the QR code, located to the right:

We will hold an informal (optional) dinner on Tuesday, May 12th near the hotel for interested attendees.

We look forward to seeing you in Washington, D.C. for ADA Advocacy Day, and working together to improve public policies related to the delivery of audiology care. Please contact Stephanie Czuhajewski at sczuhajewski@audiologist.org for more information. ■

New Hearing Aid Service Codes: Tips

BY KIM CAVITT, Au.D.

The 12 new hearing aid service codes were implemented on January 1, 2026. Here are some tips to consider:

1. Purchase and review the American Medical Association CPT Changes 2026 as it outlines the codes and their descriptions. This is the definitive authority on the code set and its use. This book can be purchased from Amazon.
2. Codes require performance by "qualified healthcare professional".
    a. Requires performance by "qualified healthcare professional"
        i. The American Medical Association defines "A physician or other qualified healthcare professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service".
    b. Payers can determine if these services can be provided and billed by legally established audiology assistants or technicians incident to an audiologist or hearing aid dispenser.
3. Determine what code to utilize by following these steps:
    a. What is allowed within my state scope of practice?
        i. Assessment of cognitive and communication status.
        ii. Assessment of visual and dexterity limitations.
            1. If not, lean into HCPCS codes.
    b. Did I meet the requirements of the new hearing aid service CPT code, including the minimum time requirement?
        i. If not, lean into HCPCS codes.
    c. Which codes (CPT and/or HCPCS) does the specific payer recognize and allow?
        i. Use the codes that are recognized and allowed by the payer and whose requirements you met.

d. Which code (CPT or HCPCS) has the higher allowable rate?

i. Use the codes with the higher allowable rate.

4. Must use a -52 modifier if only provide probe microphone (92639) or electroacoustic analysis (92641) on one ear/hearing aid.

5. Review coding edits:

Hearing Aid Service Coding Edits and Limitations

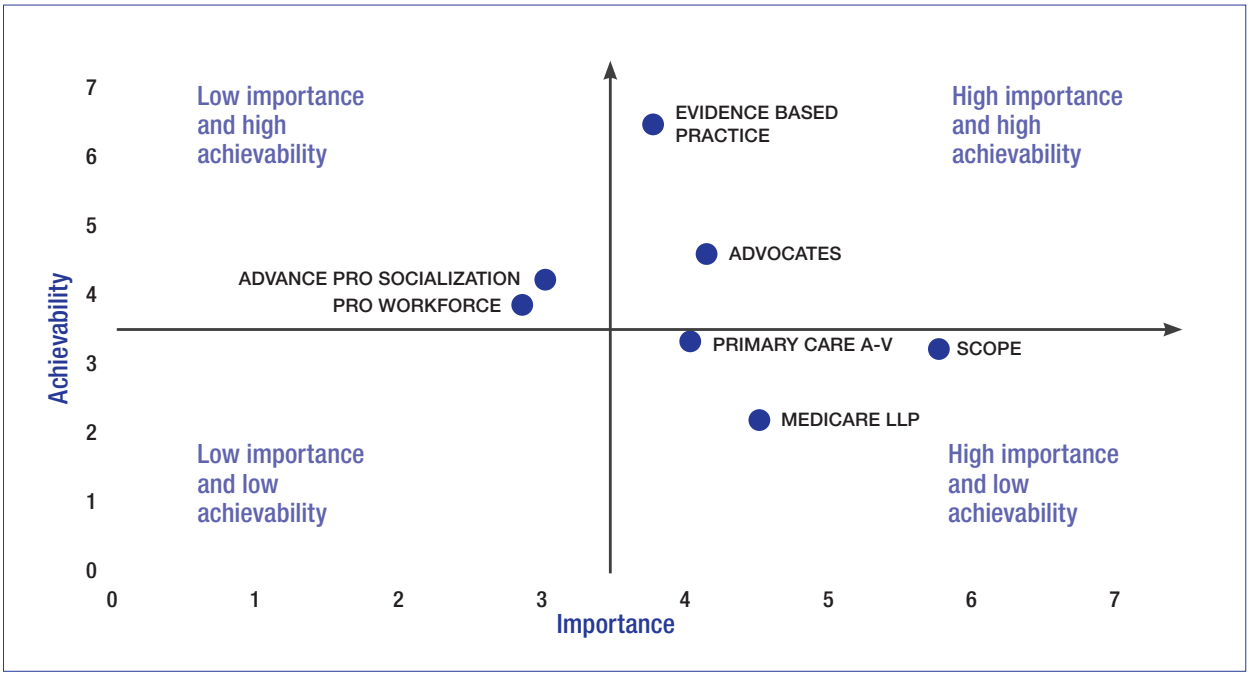
New Code	Coding edits and limitations
92628	Cannot bill with 92622, 92623, 92626, or 92627 on the same ear on the same date of service. Cannot report in conjunction with 92631, 92632, 92636, 92637, or 92642.
92629	Cannot bill with 92622, 92623, 92626, or 92627 on the same ear on the same date of service. Cannot report in conjunction with 92631, 92632, 92636, 92637, or 92642. Limited to two units of this code.
92631	Cannot bill with 92622, 92623, 92626, or 92627 on the same ear on the same date of service. Cannot report in conjunction with 92628, 92629, 92636, 92637, or 92642.
92632	Cannot bill with 92622, 92623, 92626, or 92627 on the same ear on the same date of service. Cannot report in conjunction with 92628, 92629, 92636, 92637, or 92642. Limited to two units of this code.
92634	Cannot report in conjunction with 92636, 92637, and 92642.
92635	Cannot report in conjunction with 92636, 92637, and 92642. Limited to two units of this code.
92636	Cannot report in conjunction with 92628, 92629, 92631, 92632, 92634, 92635, and 92642.
92637	Cannot report in conjunction with 92628, 92629, 92631, 92632, 92634, 92635, and 92642. Limited to two units of this code.
92638	Can add onto code 92634 and 92636; cannot be billed in isolation.
92639	Can add onto code 92634 and 92636; cannot be billed in isolation.

Please reach out to ADA if you have any questions, comments, or concerns. ■

Continued from page 3

This exercise helped us identify where we can make the most meaningful progress now, while continuing to advocate for the larger structural changes that will shape audiology's long-term future.

Audiology 2050 Ranked by Importance and Achievability



High Importance, High Achievability: Evidence-Based Clinical Practice

One of the most exciting developments is the launch of ADA Practice Accreditation. This initiative represents a significant step toward establishing clear standards for evidence-based care in private practice audiology.

We are currently working with the first 50+ clinics, guiding them through the accreditation process in manageable, bite-sized pieces. Their feedback will help refine the program before it is expanded to the broader ADA membership. This collaborative approach ensures the process is practical, valuable, and truly reflective of the realities of private practice.

Audiologists as Advocates

Another priority is strengthening our culture of professional advocacy.

We are encouraging every audiologist to be involved in their state audiology organization. For states that do not yet have one, ADA wants to help support the creation of those organizations, so every audiologist has a voice at the state level.

Advocacy does not always require large commitments from a small group. Instead, our goal is to create a culture where many professionals contribute in meaningful ways—through their time, talent, and treasure. When a large community participates, the collective impact is powerful.

High Importance, Lower Achievability

Some goals are unquestionably essential but require sustained effort and long-term collaboration.

These include advancing the role of audiologists as the primary care entry point for auditory and vestibular conditions, aligning our scope of practice with other clinical doctorate-level providers, and ultimately achieving Medicare Limited License Practitioner (LLP) status.

These priorities will not be solved overnight, but they remain central to the future of audiology. Through advocacy, partnerships, and consistent messaging, we will continue to move these goals forward.

Important Supporting Initiatives

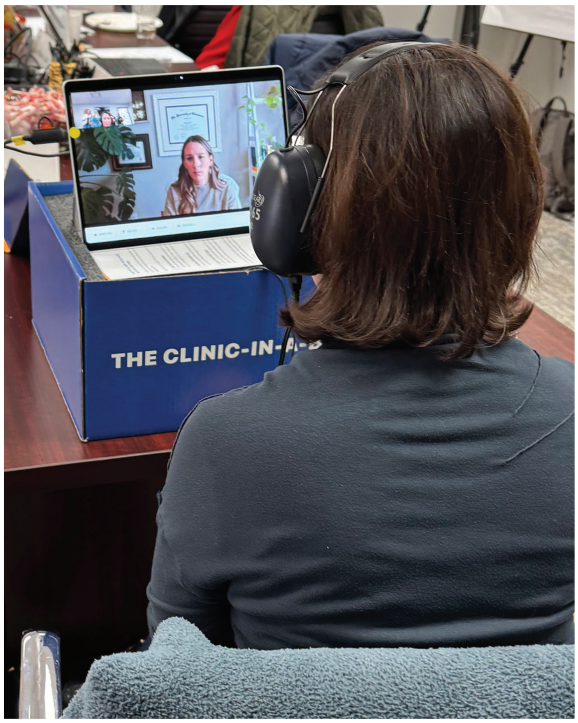
The board also identified initiatives that are achievable and supportive of the broader vision, including strengthening professional socialization within audiology and exploring models that support the professional workforce, including the appropriate use of extenders.

While these initiatives may not dominate headlines, they play an important role in building a sustainable and collaborative professional community.

Innovation in Practice

Our board meeting also included an exciting demonstration from WSA, who showcased the components of a remote patient visit using hear.com's Clinic-in-a-Box® teleaudiology solution. Seeing the technology in action provided a tangible look at how teleaudiology can expand access to care and create new opportunities for private practices.

Innovation continues to shape how we deliver hearing healthcare, and ADA remains committed to helping our members evaluate and adopt technologies that enhance patient care.



Building Relationships Along the Way

Of course, no board meeting would be complete without a little team building. Our group visited the Woodford Reserve Distillery for a bourbon tasting—arguably one of the best forms of professional bonding Kentucky has to offer.

Moments like these may seem lighthearted, but they serve an important purpose. Strong relationships among board members translate into stronger collaboration and more effective leadership for the profession.

AuDtonomy: The Future of Private Practice

Immediately following the board meeting, we hosted our annual AuDtonomy conference, an event designed for students and early-career audiologists who are exploring the possibility of private practice.

Each year, AuDtonomy brings together individuals who are curious, motivated, and eager to learn about ownership and entrepreneurship in audiology. The energy at this event is truly contagious. Time seems to fly as conversations spark new ideas and future practice owners begin to imagine what is possible.

It remains one of the most exciting and inspiring events we host, and it continues to reinforce ADA's commitment to supporting the next generation of leaders in private practice audiology.

Looking Ahead

Leaving the board meeting and moving into the rest of the year, three words kept coming to mind:

Excitement. Pride. Passion. Excitement about the work ahead. Pride in the strength and vision of this organization. And passion for the profession we all share.

Audiology is evolving, and the decisions we make today will shape the profession for decades to come. The work happening within ADA, from practice accreditation to advocacy to leadership development, is not just about the present. It is about building the profession we want to see in 2050 and beyond.

I am honored to serve as your president during such an important time for audiology, and I look forward to the progress we will make together in the months ahead. ■

EDITOR'S MESSAGE

Continued from page 5

As a result, many smaller brands were acquired, merged, or exited the market entirely, leaving a consolidated field of fewer, larger players. Paradoxically, this consolidation coincided with higher satisfaction ratings, likely because the dominant manufacturers have been able to push the performance, reliability, and feature sets of their products to places that were previously unattainable.

For consumers, higher satisfaction is clearly a net positive. Better sound quality, comfort, and usability are real wins. Yet fewer brands also mean less choice and less competitive pressure on price, service, and innovation. Even though OTC exists in theory to provide greater consumer choice, it yet has materialized as a competitor to prescriptive devices dispensed through professional channels. While the dominant players continue to innovate, the loss of smaller competitors can slow creative disruption and reduce options for wearers seeking alternatives to mainstream design.

For audiologists, this dynamic is a double-edged sword. On one hand, a smaller set of reliable, feature-rich brands simplifies decisions about which platforms to recommend (5 major brands might still be too much!) and may improve fitting outcomes because the technology is more robust and better supported. On the other hand, reduced brand diversity can mean less differentiation in approach or philosophy, fewer price points, and fewer niche offerings for unique patient needs. Clinicians must become deeply familiar with the subtleties of a narrower portfolio while advocating for patient needs that may fall outside mainstream technology paradigms.

Ultimately, the inverse relationship underscores a broader tension in healthcare technology: consolidation and maturity bring performance gains but can dampen market choice. Again, the availability of OTC has yet to fix this. Audiologists and consumers alike benefit from understanding that more brands doesn't necessarily mean better outcomes, but healthy competition and diverse perspectives remain valuable in driving both innovation and patient-centered care. ■

HEADQUARTER'S REPORT

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Of course, friction has limits. Too much of it—unproductive conflict, misinformation, or entrenched resistance—can stall progress and damage collaboration. Like gears in a machine, systems overloaded with friction can grind to a halt. The goal of policy discussions should never be conflict for its own sake. Instead, the goal is productive friction: the kind that sharpens ideas, strengthens policy, and ultimately improves patient care.

Health care has always evolved through dialogue, debate, and adaptation. Scope of practice modernization is simply the latest chapter in that ongoing story. If we approach the friction it generates with curiosity, respect, and a shared commitment to patient outcomes, it can serve the same function as those callouses formed by a runner's miles—protecting the system while allowing it to move forward with greater strength and endurance.

Progress is rarely frictionless. And perhaps that's why it requires steadfast commitment. ■

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