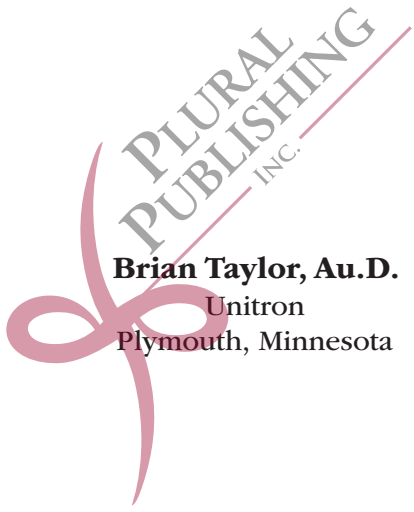
CONSULTATIVE SELLING SKILLS FOR AUDIOLOGISTS



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FOREWORD

It's often been said that the fitting and dispensing of hearing aids is "both an art and a science." What does this mean? Noted Stanford University author and scholar Donald Knuth probably summed it up best when he said, "The difference between art and science is that science is what we understand well enough to explain to a computer. Art is everything else."

I have to say that in most of my writings, I've focused on the "science part" of the fitting process. That's not because I'm a scientist—the science part is just a lot easier to write about. I'd much rather explain how to add the insert earphone RETSPLs to the patient's frequency-specific HL LDLs to obtain the 2-cc coupler output values for setting the AGCo kneepoints than to attempt to give you a useful strategy for counseling a patient who is not using his hearing aids because he believes it makes him look less attractive. But which of the two topics is the most important?

There only are a handful of audiologists who are willing to tackle both the art *and* the science aspects of fitting hearing aids, and you're holding a book written by one of them right now. Dr. Brian Taylor has nicely laid out the various skills needed to successfully "sell" better hearing and provide appropriate patient counseling. But never fear—he also includes some of the supplemental background science and clinical skills that make the overall process effective. It's difficult to think of an audiologist better suited to write a book of this type, as Dr. Taylor's varied experiences in teaching, dispensing, management, and industry give his writings the "been there, done that, and here's what works" flavor that this topic needs. Brian and I have worked together on many projects over the years, including some fun times writing the book *Fitting and Dispensing*

Hearing Aids, recently published by Plural Publishing. Although we sometimes disagree regarding the best professional football team, we almost always are in agreement concerning all things audiologic and the beverages from New Glarus.

For you younger readers, it's important to point out that there was a time when audiologists were not involved with the actual dispensing of hearing aids, and a book like this would have looked quite out of place on an audiologist's desk or the shelf of a university library. Because I'm old enough to have experienced those days first hand, here's a little history. Until the late 1970s, it was considered unethical by the American Speech-Language-Hearing Association (ASHA) for audiologists to sell hearing aids. Because at this time state licensure was not readily available for audiology, most clinical audiologists valued their ASHA certification, and did not want to jeopardize their standing as an ASHA member by selling hearing aids. For this reason, the role of the audiologist regarding the dispensing of hearing aids was poorly defined, and a bit peculiar. Although most patients simply went to a storefront hearing aid shop to purchase hearing aids from a traditional dispenser, some did go to the audiologist first. In these cases, the audiologist would test the patient with different stock hearing aids to determine what brand was "best" for that patient, send the patient out to a neighborhood dispenser who sold that brand, and then test the patient again after he had purchased the hearing aids, supposedly to give the fitting a "stamp of approval." As you might guess, there often was considerable disagreement between the dispenser and the audiologist concerning what fitting was truly best for the patient, and the patient was caught in the middle. Not a good way to provide appropriate amplification and follow-up care.

So in the '60s and most of the '70s, the audiologists' primary role in the hearing aid selling process was knowing how to conduct soundfield monosyllabic speech recognition. Fast-forward to 2012 and Dr. Taylor's current book, where you can read about consultative selling using the patient's primal brain and mirror neurons, transaction-based versus relationship-based selling, the persuasive communication stool, the loyalty loop, and the stepping stones of gaining a commitment. Things do change!

I often hear an AuD student say in their first or second year, "I'm really not interested in hearing aids, as I don't want

to have to *sell something*." But what are we selling, really? We know that properly fitted hearing aids and effective counseling will lead to long-term hearing aid use, benefit, and satisfaction. And we know that effective hearing aid usage is related to not only improved communication, but also increased earning power, emotional stability, improved family relationships, physical health, and increased social participation. So what we really are selling is our skills. Our skills to educate the patient regarding the benefits of hearing aid use, our skills to provide the patient with the optimum fitting through verification and validation, and our counseling skills to handle any bumps in the road that might occur throughout the process. In most cases, a better life for the patient is the result. Not a bad thing to *sell.*

So indeed, fitting and dispensing hearing aids is both an art and a science. Noted French physiologist Claude Bernard is known for the statement, "Art is I, science is we." "We" often get bogged down with the science, but there is a lot of "I" for you to glean from this excellent text.

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THE PATH TO UNDERSTANDING

You have just spent the last 45 minutes conducting an extensive battery of auditory tests on a patient. According to the test results, your 70-year-old patient has a bilateral, moderate to severe, sloping high-frequency hearing loss with above average word recognition ability in both quiet and noise, which is consistent with his history of workplace noise exposure. The combined results of immittance and bone conduction audiometry point to sensorineural hearing loss in both ears. As the case history and test results do not suggest any type of retrocochlear pathology, you begin discussing the patient's communication needs and amplification options.

Based on your observations, this patient seems to be motivated to be in your office. He has brought his wife along to the appointment and readily provided you with information and insights into his communication deficits. During the dialogue with the patient, you feel that you are not making a connection with him. He is no longer making eye contact with you and seems distracted. You have another patient waiting to see you, so you hurry through the next part of the appointment. After you spend another 15 minutes discussing lifestyle and amplification options, he decides he will investigate other options for remediating his hearing loss. On his way out, he says that after he compares technology he will likely schedule another appointment with you. You pat yourself on the back because it seems he

really was listening to you. Six weeks later you are still waiting for him to reschedule with you. A year later you are still waiting.

Scenarios like this are replayed over and over in hearing aid dispensing clinics around the globe. Hearing-impaired patients have taken years to gather enough courage and motivation to schedule an appointment and receive a hearing evaluation. Audiologists supply a comprehensive assessment of the patient's hearing, provide a detailed explanation of test results, but often fail to connect with the patient, and, eventually, the patient chooses not to pursue hearing aids. As this chapter will attest, the first step to gaining an agreement is to understand the motivations and concerns of every hearing-impaired patient. Chapter 1 is about the path to understanding how to be a more effective consultative selling professional. Better understanding of the patient, better understanding of your communication style, and, finally, better understanding of the business of dispensing hearing aids. Part one of this chapter provides an overview of many of the typical behaviors of adults with acquired hearing loss. The second part examines personal communication style and how our communication style contributes to more effective interactions with the patient. We end by reviewing some of the important facets of managing a hearing aid dispensing practice and how the pressures of managing the business side of things can affect communication between the patient and audiologist. Figure 1–1 describes the three areas addressed in this chapter. The "sweet spot" for the effective professional is achieved when skills and behaviors for all three dimensions come together.

Recent research from the Better Hearing Institute (http://www.betterhearing.org) suggests that hearing-impaired patients are twice as likely to agree to purchase hearing aids when they bring a companion (spouse, child, etc.) along with them to their hearing aid evaluation appointment. This finding means that your front office professionals must be trained and possibly incentivized to ask first-time patients to bring a companion (often referred to as a "familiar voice") with them to the first appointment.

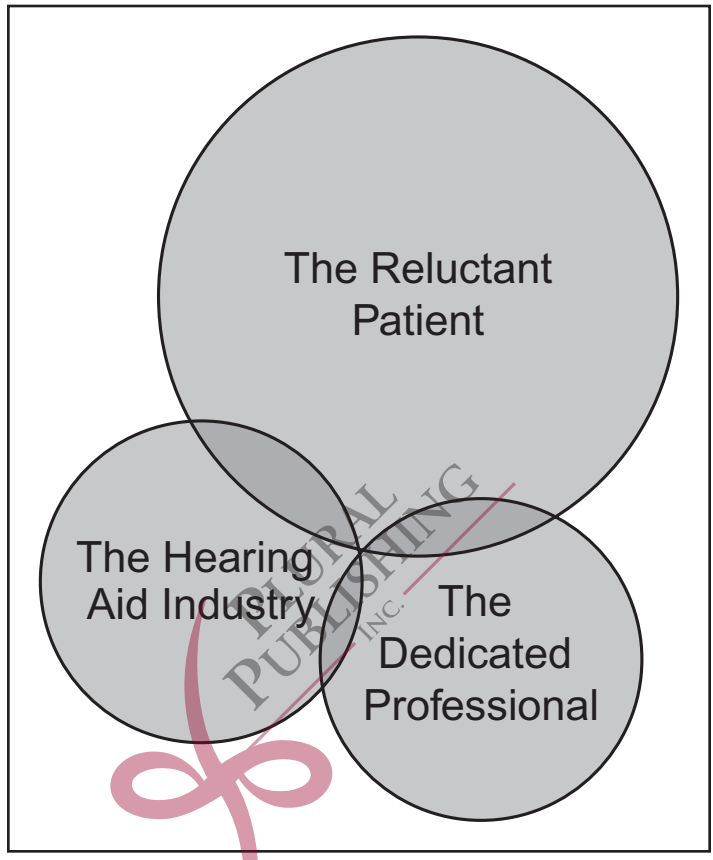

Figure 1–1. The three interconnected components of the consultative selling appointment.

UNDERSTANDING THE RELUCTANT PATIENT

Before a review of why patients often display reluctance during the hearing aid consultation appointment, it is important to note that this section provides a cursory overview of the common behaviors associated with adult-onset hearing loss. For more in-depth information, the reader is encouraged to enroll in a graduate level psychology course or attend a lecture given by a recognized authority on behaviors associated with adult-onset hearing loss. Rather, the purpose here is to give a general overview of many of the common behaviors of adults with

long-standing hearing loss you are likely to encounter in a clinic, and briefly explain how to address these behaviors during the consultative appointment.

There is a lot of ambiguity surrounding adult hearing loss of gradual onset. Denial, anger, depression, and other emotions, are all part of the normal sequence of events related to acquired hearing loss. Considering all the psychosocial factors and negative stigma patients bring to an appointment, it is useful to spend some time exploring the mindset of a typical patient coming in for a hearing aid consultation. The basic psychology of hearing loss will help you to guide patients through the consultative appointment. (If you've been a practicing audiologist for more than a few years you might want to skip this part of Chapter 1.)

If there is one word that describes the typical hearing-impaired patient coming to a clinic for services, it is "reluctant." Given the strong stigma associated with hearing aid use and aging, it is not surprising that many patients are reluctant to use hearing instruments. Many patients will be reluctant to accept their hearing impairment or take action to improve their hearing ability. It is quite normal and expected for patients to be reluctant about using hearing aids. This fact transcends age, income bracket, and gender. Reluctant patients visit clinics looking for hope and help in overcoming their communication problems, but often leave without accepting a recommendation for hearing aids.

A recent study (Wallhagen, 2009) published in *The Gerontologist* explored various dimensions of stigma experienced by older adults with hearing loss and those with whom they frequently communicate. This longitudinal study conducted interviews over a one-year period in which one partner in a long-term relationship had hearing loss. Participants had not worn hearing aids in the past year. Results of the study indicated that stigma influenced decision-making processes at multiple points along the experiential continuum of hearing loss, such as initial acceptance of hearing loss, whether to be tested, type of hearing aid selected, and when and where hearing aids were worn. The author suggests these findings underscore the need to destigmatize hearing loss by promoting its assessment and treatment as well as emphasizing the importance of remaining actively engaged to support positive physical and cognitive functioning. Audiologists and other hearing care professionals are

encouraged to promote the concept of "healthy aging." Promoting the concept of "healthy aging" could mean you are educating patients about the benefits of improved communication, which is covered in Chapter 4 of this book.

For the person who experiences hearing difficulties, hearing loss is usually just the beginning of a series of social obstacles. In most cases, hearing loss is a communication disorder of gradual onset. This means that the hearing loss occurs slowly over many years. Typically, the hearing loss comes on so slowly that the individual may not be aware of the change as it occurs. In fact anecdotal data suggest it takes the average adult with hearing loss 7 to 10 years after they first notice the problem to visit an office for a hearing test. Unlike other health problems, hearing loss is not physically noticeable, and it does not hurt. Usually, it is a spouse, friend, or other loved one who first notices the hearing loss. All of us know someone who has trouble hearing conversations. Many times we notice the problem before they admit they have a problem. As you will read in this section, this is completely normal behavior.

Developing a relationship with your hearing-impaired client will ultimately increase your chance of successfully helping this person do something about his communication deficit. In addition, his ability to adapt to using hearing aids may be enhanced as a result of your ability to diagnose his hearing loss and his personality traits associated with it. You have an opportunity to have a profound and lasting influence on his life that goes beyond simply fitting him with hearing aids.

More than 34 million Americans, adults as well as children, suffer some degree of hearing loss. Because hearing loss is so strongly related to old age, and aging often is not a positive attribute in Western culture, the stigma can be quite powerful. This stigma has been called the "Hearing Aid Effect" and is present among both professionals and patients of all ages. Studies have shown that a substantial number of hearing-impaired patients refuse to wear hearing aids, even those with modern digital technology, because hearing aids appear to make them look old. As a professional you will encounter this stigma often. Let's review some of the hallmark behaviors of a reluctant hearing-impaired patient.

It is easy to generalize and say that all hearing-impaired individuals have similar personality traits. This assumption is