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As an example, the popular Clinical Practice articles offer evidence-based reviews of topics relevant to practicing physicians. This edition includes the April 25, 2024, article, “Age-Related Hearing Loss.” Or, you might also want to listen to one of our many podcasts, including Intention to Treat, which offers a behind-the-scenes look at some of the most complicated, perplexing, and fascinating issues facing medicine today, and Not Otherwise Specified, which features conversations with some of medicine’s most innovative thinkers about the challenges and promises in health care today.

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Sincerely,

Eric J. Rubin, MD, PhD

Preparing for the Virtual Physician-Job Interview

The interview has become a new world, for now, with the pandemic, and both prospective employers and physician candidates are adjusting

By Bonnie Darves, a Seattle-based freelance health care writer

Physicians and other health care professionals know well that functioning — and practicing medicine — in a pandemic is a very different and much altered experience from a year ago. Even though physicians and residents are often providing care in fraught and challenging environments, when it comes to looking for a new practice opportunity, they’re not likely to find themselves at the point of care but rather in their living rooms. Interviews have gone virtual in a big way as the risks and logistics of the traditional site interview have prompted employers and even candidates to forgo site visits.

What this means is that both parties are having to adjust. Employers are increasingly vetting candidates without ever shaking hands or watching physicians interact in live group settings. Physicians are trying to figure out how to put their best face forward over video platforms such as Zoom, Skype, GoToMeeting, or Cisco Webex, to name a few, and how to make the most of what can be an awkward exchange.

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The good news, for physicians, is that this is a new and evolving experience for all involved. As such, it’s important to keep in mind that many people, including employers and senior physicians on the call, might find the video virtual interview challenging. It’s not a technology-proficiency test, after all. However, on the technology front, physicians who find themselves in job-search mode during the coronavirus pandemic should do their best to prepare themselves, their environment, and their computers or devices for a successful meeting. This means “attending” the session as professionally as possible and ensuring that extraneous factors or technology don’t get in the way of a productive conversation.

Some of the prerequisites for virtual interviews are no different than they would be for a formal site-visit interview. First and foremost, look the part and dress professionally. It might feel awkward to don a suit or, for women, other formal business attire, but that’s a must. Physicians should be well dressed, well groomed, and reasonably refreshed when going to a video interview. In other words, treat the experience as if it were a formal site interview that you traveled to and prepared for in advance. Leave the casual demeanor behind, or at least in the other room.

It’s key to know exactly who will be on the video call and what their roles are so that candidates can read bios and prepare accordingly. It’s also appropriate to ask about the length of the interview and to request an agenda, if one will be prepared.

Following are some of the most important considerations in preparing for a video interview:

**Prepare and “professionalize” the immediate environment.** For starters, the room should be well and brightly lit and the background clean and free of clutter. That means ensuring that there isn’t an unsightly stove or a television or even a stack of books or laundered T-shirts in view. As a background, a blank wall, an embellished window, or a background cabinet with a non-disturbing decorative item all work well. Alternatively, many video platforms enable use of green-screen effects, which replace the actual background with a digital or virtual background. A word of caution is in order here: Candidates whose home environments are unsuitable and who want to use a background should be sure for something clean and simple, not a potentially distracting image of a tropical beach, an old-growth forest, or a fake wine cellar. Finally, make sure that the lighting in the room is unobtrusive and doesn’t interfere or produce visible glare.

Do a trial run and then take the time to record a hypothetical session with a friend or family member. In advance of a virtual interview, candidates should receive specific instructions on the technology that will be used, as well as a link for getting into the session. For those who haven’t used the technology that will host the meeting, it’s important to get a trial subscription and ensure they’re familiar with the way it works and any features that might be used. Many physicians in primary care and internal medicine subspecialties have already had their trial by fire conducting patient virtual visits, but for others, video-meeting platforms might be new turf.

**Get rid of noise and potential distractions.** The interview setting should be quiet and calm. That means ensuring that background noises, including pets and family members, aren’t a factor. Ideally, opt for a completely quiet room — and house or apartment — if possible, and close windows to minimize street noise. Even minor background sounds, such as someone starting a washing machine two rooms away, can be bothersome enough to be overheard or, worse, distract the interviewee. Of course, it goes without saying that cell phones should be silenced and that all computer notifications that might chime during the session are turned off.

**Ensure optimal body and face positioning.** Even virtual-meeting veterans have likely found out the hard way that having the face positioned too far up or down, and the computer screen below eye level, can affect the experience. The interviewee’s head should be looking straight ahead, not down or up or down, and the computer screen below eye level, can affect the experience. In other words, treat the experience as if it were a formal site-visit interview. Leave the casual demeanor behind, or at least in the other room.

Having the computer or device properly elevated before the interview begins is key, so that the physician doesn’t need to make adjustments during the session. And once the session is underway, it’s important to maintain focus by not moving the head too much or looking off to the side. Even if that feels somewhat stiff, it won’t come across that way to the interviewer. It’s OK to use some body language, when appropriate, but that should be kept to a minimum because there’s not a large room to “absorb” it. Finally, physicians who aren’t sure how best to position their devices should ask for help from someone with virtual-meeting experience before the interview. In any event, the interviewee and the equipment should be positioned to enable natural-seeming eye contact between all parties.

**Get the technology in order.** First and foremost, ensure that the Internet connection is solid, and that the computer or device is fully charged and updated, so that it’s not likely to interject with an “update-needed” message.
It's also a good idea to close out any applications and websites that might be running in the background, not only because of potential distraction but also to ensure that the call loads efficiently.

Second, although computers and devices have built-in speakers and some have microphones, the quality of that audio experience can vary considerably. Physicians who expect to attend multiple video interviews over a period of a few months should consider purchasing and installing high-quality USB audio technology. One of the frequent complaints that business people make these days about video meetings that involve potentially multiple attendees is that poor-quality audio from an attendee’s computer is distracting.

The same goes for the video quality. Most laptops have an integrated web camera, but some might not, and older desktop computers likely don’t have one. If the video quality on the computer is poor, it might be worthwhile to purchase a good-quality web camera. Then, ensure that it’s optimally positioned — ideally above the screen, and look at the camera, not the screen, while speaking.

Finally, if the physician candidate might be asked to share a document or other item onscreen, preparing in advance is crucially important. Spending a fretful minute or two trying to get the requested item in view can be nerve-wracking for the physician and possibly annoying for the interviewer.

Some aspects of interviews haven't changed

After physicians have prepared their environments and equipment to support a successful interview, they should remember that even with the pandemic, the expectation is that the proceedings will be business focused. Just because there's not a conference room in the mix, it doesn’t mean that casual behavior is okay. It isn’t. The session likely will be conducted formally and highly professionally. As such, interviewees should avoid chitchat or lengthy discussion about the pandemic unless the interviewer raises the topic and seeks their perspective.

One thing to watch for in the video interview is that people sometimes talk over each other more than they might in a room, when they’re anxious to make a point. That’s never okay in a face-to-face meeting, and it’s potentially more distracting (and apparent) within the confines of a video session. Because there is sometimes a brief lag after someone speaks, depending on the technology in use, it’s advisable to wait an extra second or two before speaking.

As with any interview, candidates should ask questions at the end of the interview — about culture, team makeup, and roles and responsibilities — and during proceedings if it’s appropriate. Those questions should be prepared ahead of time. Candidates should also spend extra time researching the organization and reviewing any information that's available online about both the practice and the community. Without the benefit of a facility walk-through, the physician candidate might need to elicit important information about the actual working environment, available equipment, and other factors that would affect daily practice. It also helps to keep the names of interview participants handy in any virtual roundtable interview involving more than three participants.

As with any type of interview, timely follow-up is important. Candidates should send an email thank-you note to key interviewers and any recruiter or staff member(s) who arranged the session, ideally within 24 hours. If the candidate is highly interested in the position, it’s appropriate to express that in the thank-you note and to inquire about possible next steps.

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How to Decline a Job Offer Tactfully

By Nisha Mehta, MD, a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine

The job search is hectic and stressful, and we put so much effort into finding the right job and trying to get the job offer that we rarely think about how to decline an offer. And yet, it is prudent to do this well.

Many people mistake dragging their feet on contracts while they entertain other offers, and then just letting the discussions fade away instead of formally telling a potential employer that they’re not interested. I’ve been guilty of this myself. In general, it’s always good to close the loop and make sure everyone is on good terms. We know how frustrating it can be when an employer doesn’t get back to us about the status of an application, and this goes both ways. Each side invests time and money into the process, and in many cases, other decisions are contingent on the hire.

Additionally, you never know if your paths with the people you interviewed will cross again. Maybe the job you took instead doesn’t work out, and this was a close second choice, and you want to approach them again. While you are looking in a particular job market, and the partners at the practice you turned down go to school with your children. Or perhaps you find yourself searching for a new job and someone you interviewed with is now associated with another practice you’re interviewing at or happens to have been a co-chief resident with members of the new practice.

In reality, the physician world can seem very small. Although there may be about 1 million practicing physicians in the United States, you’ll see that worlds often collide throughout your career. In today’s interconnected world, it’s more and more likely that someone you interact with in one context will turn up in another. Maybe your practices will be part of the same network, or maybe you’ll see people at a conference.

Consequently, it’s best to let the other party know as soon as you’re sure you’re not interested so that they can move on with the hiring process and adjust any related plans accordingly. Furthermore, how you do it matters. If this is a group you’ve spent a lot of time talking to who was recruiting you heavily, get on the phone with them and explain why you went in another direction instead of notifying them via an email or text. Take the time to reiterate that you appreciated the offer and their time, and hope to stay in touch. If there’s constructive feedback, you can give them about why the job ended up not being the most attractive offer, do so (tactfully). Maybe it’s just that your spouse couldn’t find a job in that town or you decided you wanted to move closer to family, but sometimes it is about the salary or the call structure or a vibe you got at the practice. Most groups will appreciate the feedback so that they know how to market themselves in the future.

The hiring process is very personal, and chances are, you’ve gotten to know multiple people on the other side of the process very well, and it likely warrants a few personalized messages to express appreciation, rather than one communication to the head of the group. Maybe there’s an HR director or realtor you’ve worked with extensively, or a partner who really took the time to answer all of your questions or host you at their home for dinner. Take the time to email them separately and let them know how much you appreciated their help. Ideally, don’t drag your feet on this because you’ll likely forget to do it later. As an added reason to do this, if you ever need to interact with or ask a favor from any of these people in the future, it’ll be a lot less awkward to reach out.

When in doubt, think about how you’d like to be treated if you were the one who was being declined in that particular situation. Who would you be guilty of this myself. In general, it’s always good to close the loop and make sure everyone is on good terms. We know how frustrating it can be when an employer doesn’t get back to us about the status of an application, and this goes both ways. Each side invests time and money into the process, and in many cases, other decisions are contingent on the hire.

Additionally, you never know if your paths with the people you interviewed will cross again. Maybe the job you took instead doesn’t work out, and this was a close second choice, and you want to approach them again. While you are looking in a particular job market, and the partners at the practice you turned down go to school with your children. Or perhaps you find yourself searching for a new job and someone you interviewed with is now associated with another practice you’re interviewing at or happens to have been a co-chief resident with members of the new practice.

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When in doubt, think about how you’d like to be treated if you were the one who was being declined in that particular situation. Who would you
Unusual Parts of Compensation Packages

By Nisha Mehta, MD, a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine

In speaking to so many about their job offers, I've realized that we're often myopic in terms of what we think can be negotiated when discussing a contract. There are the traditional things everyone asks about — salary, bonus structure, call responsibilities, vacation schedule, and signing bonuses, to name a few. However, when talking to people about what their ideal job looks like, there's often more random things on a wish list. What we fail to realize is that those are all things that can be asked for, but that nobody else would even think to offer them to sweeten the deal.

Some examples of these?

• An early start and end to the day
• Dedicated academic or administrative time
• Unique FTEs such as 0.7 or unique structuring of their FTEs, such as alternating four- and two-day weeks
• Bonuses for creation of alternative revenue streams for the practice
• Changes in the amount of allotted CME money or money for office furnishings or technology
• The ability to work from home a certain number of days a week (for example, doing telehealth)
• A specified patient population according to their area of academic interest/desired practice panel
• An increased number of support staff, such as scribes or medical assistants
• The speaker system that you will have in your operating room

Some of these may sound silly to you to ask for, but I know of physicians who have asked for and received these things as part of their contract negotiations. Remember, what brings happiness in your day-to-day life as a physician is very individualized, and therefore, asking for those things that will enhance your satisfaction (e.g., career longevity) at that job is not unreasonable.

Of course, asking for these things can be an art form. Understand that every institution has different flexibility or bandwidth for accommodating individual requests. You may want to look at what other accommodations have been made for other physicians on staff as precedent for what may be realistic prior to compiling your list of asks. Also, be careful about how many of these additional things you ask for. If you have 10 unusual requests, even if they are relatively minor, the message to the employer could be that this is a pattern of behavior where you will always be asking for exceptions to normal operating procedures.

Figure out which ones mean the most to you. Also figure out which ones are going to be harder to negotiate later, as your negotiating power is always greatest before you sign a contract. Be prepared to justify the asks so they understand why they would make accommodations. For example, if you are able to clearly articulate why something will lead to increased efficiency, better patient outcomes, or contribute to your career longevity and prevent burnout, this would help your case. It would also help them to explain to others who question why these special accommodations were granted.

As demographics in medicine change, unusual asks will become more frequent. The sustainability of our health care workforce requires out-of-the-box solutions, and for some of you, these may be part of them! If you don't ask, you won't get it.
AGE-RELATED HEARING LOSS

Age-related declines in hearing gradually and progressively affect every person during life, initially manifesting as difficulty understanding speech in background noise or other specific situations. The main mechanisms through which hearing loss has been hypothesized to increase the risks of cognitive decline and dementia include adverse effects of hearing loss and impoverished auditory encoding of sound on cognitive load, brain atrophy, and social isolation.6,7

STRATEGIES AND EVIDENCE

CLINICAL PRESENTATION

Age-related hearing loss manifests gradually and subtly over time in both ears without any clear initiating event. It affects the auditory and clarity of sounds and a person’s everyday communication experience. Persons with mild hearing loss are often not aware of hearing loss and are not aware of their hearing difficulties as being attributable to external reasons (e.g., others not speaking clearly or background noise). As greater levels of hearing loss, persons may increasingly notice trouble with speech clarity even in quiet settings and can find conversations in noisier settings exhausting, given the increased cognitive effort that is required for processing the degraded speech signal.8,9 Often, family members are most aware of patients’ hearing difficulties.

EVALUATION

Evaluation of a patient’s hearing issues requires understanding that a person’s perception of hearing depends on four components: the quality of the incoming sound (e.g., because the speech signal becomes degraded in rooms with background noise or reverberant acoustics), the mechanical conduction of sound through the middle ear to the cochlea (i.e., conductive hearing), transduction of the acoustic signal into a neuroelectric signal by the cochlea and transmission to the brain (i.e., sensorineural hearing), and decoding of the neural signal into meaning by the cortex (i.e., sensorineural hearing), and decoding of the neural signal into meaning by the cortex (i.e., sensorineural hearing). The goal of the initial clinical evaluation is to evaluate the patient for readily treatable forms of conductive hearing loss or other forms of hearing loss that may warrant further evaluation with an otolaryngologist. Conductive forms of hearing loss that are readily treatable by the primary care clinician include otitis media and cerumen impaction and can be apparent on the basis of history (e.g., acute onset with otalgia and aural fullness with upper respiratory tract infection) or otoscopy (e.g., evidence of complete cerumen impaction in the ear canal). Symptoms and signs accompanying hearing loss that require further evaluation or consultation with an otolaryngologist include ear drainage, abnormal otoscopic examination, unremitting tinnitus, vertigo, fluctuating or asymmetric hearing, or sudden onset of hearing loss without evidence of a conductive cause (e.g., middle-ear effusion). Sudden sensorineural hearing loss is one of the few forms of hearing loss that requires urgent evaluation with an otolaryngologist (ideally

THE CLINICAL PROBLEM

Age-related declines in hearing gradually affect every person during life. A person’s ability to hear depends on the inner ear (cochlea) precisely encoding sounds into neural signals, which are then processed and decoded into meaning at the cortical level. Pathologic processes that occur at any level of this pathway from the ear to the brain can adversely affect hearing, but age-related hearing loss involving the cochlea is the most common cause.1

Age-related hearing loss is characterized by the progressive loss of the sensory hair cells of the inner ear, which are responsible for encoding sound into neural signals.1,2 Unlike other cells throughout the body, sensory hair cells in the inner ear cannot regenerate, and these cells are progressively lost over the course of life owing to the cumulative effects of multiple etiologic processes. The strongest risk factors for age-related hearing loss include older age, lighter skin color as an indicator of pathologic processes that affect the hair cells, which are responsible for encoding sound into neural signals, and noise exposure.2 Other risk factors include cardiovascular disease risk factors such as diabetes, smoking, and hypertension, which can contribute to microvascular injury to cochlear blood vessels.1,2

Beginning in early adulthood, hearing begins to diminish gradually, particularly with regard to sounds at higher frequencies. The prevalence of clinically significant hearing loss increases across the life span, nearly doubling with every decade of life such that more than two thirds of all adults 60 years of age or older have some form of clinically significant hearing loss (Fig. 1).3 In the United States in 2019, approximately 72.9 million, or one in five, persons were estimated to have hearing loss.4 Epidemiologic studies have shown associations between hearing loss and impaired communication, cognitive decline,1 dementia,1 higher medical costs,1 and other adverse health outcomes.9 Research over the past decade has particularly focused on the effects of hearing loss on cognitive decline and dementia, and on the basis of this evidence, the Lancet Commission on Dementia concluded in 2020 that hearing loss in middle and late life was the single largest potentially modifiable risk factor for dementia, accounting for 8% of all dementia cases.5 The main mechanisms through which hearing loss has been hypothesized to increase the risks of cognitive decline and dementia include adverse effects of hearing loss and impoverished auditory encoding of sound on cognitive load, brain atrophy, and social isolation.6,7

CME CME CME CME
within 3 days after onset) because earlier diag-
nosis and intervention with glucocorticoids may improve the chances of hearing recovery. Sudden sensorineural hearing loss is a relatively uncom-
mon event, with an annual incidence of 1 in 10,000
people, and most commonly occurs in adults 40
years of age or older.13 As compared with a unilat-
eral hearing loss from a conductive cause, pa-
tients with sudden sensorineural hearing loss will
often report an acute, painless hearing loss in one
ear that results in a near-complete inability to hear
or understand speech in the affected ear.13

Multiple bedside screening methods for hear-
ing loss exist, including whispered-voice and fin-
ger-tap tests. However, these measures produce
widely varying levels of sensitivity and specificity13
and may be of limited usefulness depending on
the suspected probability of a patient having age-
related hearing loss. It is especially important to
note that, given the progressive decline in hearing
across the life span (Fig. 1), some degree of age-
related hearing loss can be inferred to be present
regardless of screening results on the basis of a
patient’s age, symptoms indicative of hearing
loss, and an absence of other clinical findings sug-
gestive of other causes.

Confirmatory evaluation of hearing loss is per-
formed with referral to an audiologist. During an
audiologic evaluation, a patient’s hearing is tested
with a calibrated audiometer in a sound-attenuat-
ing environment. The softest intensity of sound in deci-
bels that a patient can reliably detect (i.e., the hear-
ing threshold) is assessed across a range from 125 to 8000 Hz, with lower thresholds being in-
dicative of better hearing. In children and young
adults, thresholds across all frequencies will be
close to 0 dB, but with progressive age-related de-
cline in hearing, these thresholds will gradually
increase, particularly for sounds at higher frequen-
cies. The World Health Organization classifies
hearing according to the average of a person’s hearing thresholds at the frequencies of sound that are considered to be the most important for speech
(500, 1000, 2000, and 4000 Hz), termed the four-
frequency pure tone average (PTA4; also called the “hearing number”) and indicates in decibels the lowest level of speech sound that the person can hear. A
PTA4 in the better ear of 20 to 24 dB indicates mild hearing loss, 25 to 49 dB moderate hearing loss, 50 to 64 dB moderately severe hearing loss, and 65 dB or above severe or greater hearing loss. Prevalence data are from the Global Burden of Disease, Institute for Health Metrics and Evaluation, Uni-
versity of Washington (https://vizhub.healthdata.org/gbd-comapply/).

MANAGEMENT
The primary clinical rationale for addressing age-
related hearing loss is to enhance a person’s ac-
cess to speech and other sounds in the auditory
environment (e.g., music and audible alerts) in or-
er to promote effective communication, engage-
ment with daily activities, and safety. At present,
there are no restorative therapies for age-related
hearing loss, so the management of hearing loss is
focused on hearing protection, adoption of com-
munication strategies to optimize the quality of
the incoming auditory signal (over competing
sounds) and the use of hearing tech-
nologies such as hearing aids and cochlear im-
plants (Fig. 2). The prevalence of hearing aid use
or cochlear implantation among persons who
could benefit (as determined on the basis of their
audiologic hearing) remains very low. Among
persons with hearing impairment in the United
States, the prevalence of hearing aid use is below
20%14 and that of cochlear implantation is less
than 5%.15 Reasons for the low rate of adoption
are multifactorial and include such factors as
 stigma, poor accessibility to and affordability of
hearing interventions, and the inability of hearing
technologies to compensate fully for the degraded
peripheral encoding of sound caused by age-relat-
ed hearing loss.16

Hearing-protection strategies are focused on
reducing noise exposure by means of movement
away from or reduction in the volume of the sound
source and by the use of hearing-protection de-

Adapted from the World Health Organization (WHO) World Report on Hearing (Table 1.3). A person’s hearing can be summarized by an average of the hearing thresholds in each ear at the frequencies of sound that are most important for speech (500, 1000, 2000, and 4000 Hz). This summary measure of hearing that is used by the WHO is referred to as the four-frequency pure tone average (PTA4, also called the hearing number") and indicates in decibels the softest level of speech sound that the person can hear. The PTA4 can be used to understand a person’s hearing and communication experience in daily life. An audiometric report will typically provide this summary value, or this measure can be obtained by means of a hearing test on a smartphone (www.hearingnumber.org).

Table 2. Functional Implications of Hearing on Communication Experience.14

<table>
<thead>
<tr>
<th>PTA4 (dB)</th>
<th>WHO Classification of Grade of Hearing Loss</th>
<th>Typical Hearing Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 dB</td>
<td>Normal hearing</td>
<td>No problem hearing sounds</td>
</tr>
<tr>
<td>20 to &lt;35 dB</td>
<td>Mild hearing loss</td>
<td>Does not have problems hearing conversational speech</td>
</tr>
<tr>
<td>35 to &lt;50 dB</td>
<td>Moderate hearing loss</td>
<td>May have difficulty hearing conversational speech</td>
</tr>
<tr>
<td>50 to &lt;65 dB</td>
<td>Moderately severe hearing loss</td>
<td>Difficulty hearing conversational speech</td>
</tr>
<tr>
<td>65 to &lt;80 dB</td>
<td>Severe hearing loss</td>
<td>Difficulty hearing most speech and taking part in conversation</td>
</tr>
<tr>
<td>80 to &lt;95 dB</td>
<td>Profound hearing loss</td>
<td>Difficulty hearing conversational speech</td>
</tr>
<tr>
<td>≥95 dB</td>
<td>Complete hearing loss</td>
<td>Cannot hear speech and most environmental sounds</td>
</tr>
</tbody>
</table>

- Poorer hearing benefits and throughput of speech as the PTA4 increases.
- The average PTA4 in aged adults without hearing aids is ≤40 dB.
- Many adult hearing impairments fall between 15 and 50 dB.

Figure 2. Management of Age-Related Hearing Loss.
Panel A shows the general PTA4 ranges at which various strategies and technologies may be useful, and Panel B provides details about the various strategies and technologies that are currently available. OTC denotes over-the-counter.
Area of Uncertainty

Age-related hearing loss results from the combined effects of multiple etiologic factors occurring over a patient’s lifetime.14 Whether pharmacologic or genetic therapies could be feasibly used to reduce the progression of age-related hearing loss or to restore hearing function is an active area of academic and industry research, but efforts have been largely unsuccessful to date.15 Although several mechanisms have been proposed through which age-related hearing loss could adversely affect health, one provocative mechanism suggests that impaired hearing and diminished auditory afferents may directly affect brain function and structure.16 Understanding whether existing hearing rehabilitative technologies could modify these effects and help support brain health will be important for optimizing future intervention strategies.

Guidelines

In 2021, the U.S. Preventive Services Task Force determined that there is insufficient evidence to assess the benefits and harms of screening for hearing impairment in asymptomatic adults 50 years of age and older.17 Clinicians were advised to use their own clinical judgment about conducting hearing tests in patients who have symptoms of hearing loss or who have raised concerns about their hearing. To my knowledge, no other clinical practice guidelines on age-related hearing loss are currently available.

Conclusions

The patient described in this vignette presents with a history consistent with age-related hearing loss. After evaluating for and ruling out a potential conductive cause or need for otolaryngology referral, I would presume that some degree of age-related hearing loss is present. I would counsel the patient and his wife about the ways in which age-related hearing loss as well as other factors can affect perceptions of hearing and how hearing technologies and improvements can contribute to improved communicative and social functioning and potentially have distal effects on supporting cognitive health. Depending on the patient’s preference, I would refer the patient to an audiologist for a formal diagnostic evaluation and counseling about treatment options or to a well-regarded retail center that sells hearing aids (e.g., Costco). If the patient is familiar with using technology, I would provide resources to help the patient learn how to do a self-test of hearing with a smartphone. I would also discuss the availability of over-the-counter hearing aids and explain that retail choices for over-the-counter hearing aids and support options for these technologies are expected to rapidly increase in the next 2 to 3 years as the market for over-the-counter hearing aids matures in the United States.

References


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- Teaching medical students, residents and fellows.
- Participation in research and scholarly activities within the Division of Rheumatology.
- Dissemination of research in peer-reviewed literature.
- Participation in service assignments in the Department, WSU and University.
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Michelle Maston or Cody Emond
Provider Recruitment, Berkshire Health Systems
(413) 447-2784 | mmaston@bhs1.org
cemond@bhs1.org

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Joseph Li, MD - Chief of Hospital Medicine
JLi2@bidmc.harvard.edu

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Robert Makar, MD, PhD
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Moro O. Salifu, MD, MNP, MBA, MACP
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Board certification in subspecialty is a requirement. Salary will be commensurate with rank and AAMC benchmarks.

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