Sound Bites Podcast Transcript
Episode: Dr. Patricia Gaffney

Dave Fabry: Welcome to Starkey Sound Bites. I'm your host, Dave Fabry, Starkey's Chief Hearing Health Officer. This week, September 23rd through September 27th is Falls Prevention Awareness Week, and it's observed every September. You get the little double entendre. It's right around the beginning of fall because really the beginning of fall is already too late for many individuals, especially if they break a limb like my mother did. And although falls don't necessarily kill people, there are non-fatal falls, but if it's accompanied by a broken limb, it often begins a downward spiral. And so my guest on this episode of Starkey Sound Bites is someone I've known for longer than either of us probably care to admit, but I looked and it's probably well over 20 years now, Dr. Patricia Gaffney. Tish, if I may. Thank you for joining us here and I'm really excited to do this episode of Sound Bites with you.

Dr. Patricia Ga...: Thank you so much for having me, Dave. And yes, it has been quite a long time that we've known each other.

Dave Fabry: Well, it's really been a pleasure, and as I said, I was really looking forward to this episode because I have known you for more than 20 years when you were a student at Pitt at the time, and I had the opportunity to come out numerous times during your training program because Dr. Catherine Palmer is a longtime friend and colleague of mine. And so I began to get to know you there. And then certainly watching you blossom in your career, I mean the list of awards that you've received from various organizations and your participation in organizations dates back to really when you were a student. I'm a lifetime member of an organization that no longer exists thanks to you. I was given a lifetime membership of the National Association for Future Doctors of Audiology. Thank you for that.

Dr. Patricia Ga...: That's how much we like you is we gave you an award that's an organization that's disappeared.

Dave Fabry: Yes, I've begun to outlive organizations now, which is sad testimony to this point of my career. But in all seriousness with Fall Prevention Week, and we'll come to that in a minute, but this year it begins on my birthday, and this is my 65th birthday. So we know, and will come to this, but we know that falls in the aging population are a significant issue. We know, however, that falls can occur at any age with a variety of different comorbid conditions to hearing loss. But as Dr. Frank Lin published about a decade ago, an article really just looking at the prevalence and insolence and comorbidity between falls and hearing loss, and even a mild hearing loss places an individual at three times the risk of falling and that risk increases with increased hearing loss.

And so we'll come to that. But I want to begin with your journey. How did you find audiology and talk about the path that really brought you first to GW, George Washington University for your undergraduate, continued at Pitt, and then a couple shorter stops along the way. But you've been with Nova Southeastern where you're now a professor for quite a while, but talk a little bit about that journey, if you would.

Dr. Patricia Ga...: Sure. So I've always just loved science and anything science related. I thought I was going to be an astronaut or a marine biologist, all these things when you're little. And it really was my uncle who was an ENT in Delaware and I had the opportunities to work in some summer weeks help filing and things like that. But I was able to observe him, and more importantly, was actually able to observe his audiologist.

And as I was in undergrad at GW, thinking about where I wanted to go with my professional career, I really liked medicine, but I would look at my uncle's appointments and they would be 15 minutes and they'd be crammed and it would be, we got to do this, this, this, this in a very short period of time. But then when I watched his audiologist, there was that science medical component to it, but also the ability to just sit there and talk to your patients and have a little bit more time to help counsel them and give them that information that they were looking for. And you would see them be in the physician office have all these questions, but then they could ask the audiologist because there was a little bit more time. And that balance between those two was really what drew me to audiology was you have this healthcare component, but you have this ability to take a little bit more of a breath and talk to your patients.

And so in my undergrad, I was a speech and hearing student, the only audiology student that was planning to go to an audiology program. And then when I was applying to graduate school, it was just as the AuD was coming out and I ended up applying half AuD, half masters. My advisor to my undergrad was, "Well, we're not sure if the AuD is going to work out. And so just think about that as you're applying." And so I ended up getting into Pitt, which was a master's program when I started. In our first semester, they said to us, "We're going to change to an AuD so you can decide whether you want to stay or if you want to leave with the masters. And I ended up staying. And Pitt's such a great school, I felt so prepared for my career ahead of me. I ended up doing my externship at the VA in Miami, which is what brought me to South Florida. And I was there for about two years after graduation before I took the job at Nova.

But as you pointed out, I was on the NAFDA board, I was a national representative and then the national secretary. And I feel like that had such a big impact on my career as a whole. It gave me opportunities. I got my externship because one of the other NAFDA board members was going there for a job and it was like, "Hey, they're looking for externs." And I knew about the Nova position being open from another NAFDA person. And so that experience

of being on that board as a student gave me a real commitment to the profession as a whole. It let me see how beneficial it was to volunteer and to give back to my profession, even as a student. I had you as one of the great advisors to our organization and then developing that mentorship going forward.

And then in 2007, I took the job at Nova and I have been here since and it has been a great opportunity. I love working with students. I really enjoy teaching. I love talking to them. And as you mentioned, my area is dizziness and balance, and I've had the opportunity to really grow a really great dizziness and balance vestibular program here. And so it has been wonderful and I've continued to volunteer for various national organizations including the American Academy of Audiology where I'm definitely the most involved, but also the American Balance Society, Audiology Practice Standards Organization where we were on the board together, various organizations that have had different inputs into the profession.

Dave Fabry: Well, lots to unpack there and thank you for providing that background. I mean, first off, I think the majority of our listeners are either audiologists or hearing instrument specialists. And one thing I would ask you first is what lit that fire under you to become and recognize at an early stage the need for professional involvement?

Dr. Patricia Ga...: It was funny because I didn't volunteer a lot in high school and undergrad. I had a job in undergrad where I worked a lot, and so I didn't really have the flexibility of volunteering as much. And I went to my first AAA, which was in Philadelphia, which is my hometown. I was a first year student and Pitt was still in that transition period. And so we went to Philadelphia for the conference and we saw students walking around with the little NAFDA ribbons and we're like, "What is that?" And so they described it to us. I went back and I immediately was like, "We need a chapter. We need to start it." And I think part of it being that I saw audiology not just as a major, but as my career and as my professional home, this is who I'm going to be and if this is where I'm going to be for the rest of my life as a working individual, I need to participate in that and I need to provide work and time to it.

And then there's always benefits to that too. So when I was a NAFDA student, I got to meet students from all these other programs and I got to see, okay, well how are they doing it at this school and how are they doing it at that school? And how could I take that information and bring it back and how can we change things to make it better? And it was just this opportunity to give back. And I think that's so cliche to say that, but it's tough for professional organizations because you rely a lot on volunteers and it takes time and it takes commitment. And the more I did, the more I was rewarded internally for doing that. I got to meet other people. I have friends across the spectrum of audiology, and that was rewarding and getting to see things accomplished.

One of the early committees I was on was the public relations committee for AAA, and they wanted to start Audiology Awareness Month or something like it. And they're like, "We need somebody to work on this." And I'm like, "I'll do it." So I sat down and I compared different types of organizations and their months and from that created Audiology Awareness Month in October. And so that was something I'm like, "Okay, well this gives back and this is something that we can use going forward." So those things were just very internally motivating and it was beneficial to me as something that I accomplished, but it was also beneficial to the profession, patients, colleagues, future students. And that's what has propelled me to keep doing that.

Dave Fabry: And timing is everything. The other area that I'm interested in is you chose to focus on vestibular as an area of research and clinic, both when you were at the VA, I remember. And do you still see patients occasionally now, I believe?

Dr. Patricia Ga...: Oh, I see patients. I saw patients today. I had clinic today. Yeah, I do still see patients.

Dave Fabry: I think that's particularly important. I do as well, and I think it's a way to keep your saw sharp and patients will always challenge you to really challenge the assumptions of what it is that you're doing and why it is that you're doing that. But so many audiologists I think really take for granted that it's hearing and balance within our scope of profession. And I say it's a big capital H and a little B in many cases, but you've really embraced that. And I think looking at the way that falls impact and the opportunity for many audiologists to establish themselves in their area if they go into a clinical practice or in an academic center, vestibular is an area of great opportunity because I like to say it's one of the areas that audiologists get to do where we really get to treat patients if they have benign positional vertigo in a way that can resolve the issue. But when you got to Nova, how important was it to you that you really grow that vestibular area?

Dr. Patricia Ga...: So vestibular has interested me since my first year at Pitt. And Pitt's actually really well known in the vestibular world, but not in audiology. In medicine, in PT, but not in audiology. But the thing I liked about it the most was this puzzle format. You have all these pieces and you're trying to put it all together to create this answer to why they're dizzy, and it takes a lot more parts to it. And I just liked that puzzle component. And so my entire time when I was a student, any project that I could possibly make about dizziness or vestibular or balance, I did it.

And when I went to the VA for my externship and I was like, "Oh, I really like vestibular." When I was a student, there wasn't as many people who were truly specialized in vestibular. I can think of handful of people out there, but that was a very small number. And so a lot of the people who are my generation or older were really self-taught or had limited information and we had to really grow the

rest of it. And vestibular testing has changed dramatically since I was a student. cVEMP was just coming out. oVEMP didn't exist, I mean it wasn't a test, VHIT wasn't a test. There was all these things that we didn't know.

And so when I got to Nova and I told them that this is my area of interest, and as I developed, I was given half of an advanced course right up front, and as I progressed in my tenure here, I really was showing them the benefit of teaching this to our students and growing a whole new generation of audiologists who know that vestibular is a specialty. It's not just tacked on somewhere. It's not half of an electrophys course. It's not by the wayside. That this really is something that's really important and it's place where you can specialize and do things a little differently. And I'm looking at eyeballs all day instead of ears. So it really was important for me to really focus on that. And I will say that the people who are my generation who are also vestibular audiologists who are placed throughout the country, over time we've really seen this influx of students being interested in vestibular because there's people for them to look up to who do it and do it well.

Dave Fabry: Yeah, I love that, and I think you've really led by example in that regard. Now, I would say that it's not just audiology where we push balance away a little bit just because many people like myself, grew up in the era where we simply did caloric testing, and that usually ended with someone getting sick or maybe multiple people getting sick. But I would say ENTs as well. It's hard in many cases to find otorhinolaryngologists that are keenly interested in working with dizzy patients or patients who have their ears ringing. In your dad's practice, did he see dizzy patients? Did he embrace it? Did he tolerate it? Or was that a model for you as well that kindled that interest early on?

Dr. Patricia Ga...: Yeah. So with my uncle's practice, he-

Dave Fabry: Oh, it was uncle, sorry.

Dr. Patricia Ga...: Yeah, it's okay. With my uncle's practice, it's a rural part of Delaware, so he did see pretty much everything, but dizziness was certainly not his expertise. And so if he did have more significant dizzy issues where he couldn't figure them out, he would refer them either up to Wilmington or to Baltimore, to Johns Hopkins. And so that's a significant drive to either one. And so that is a hardship. So he tried to do as much as he could as a more small town rural area, but it certainly was not his favorite type of patient. And as you mentioned, that's true amongst ENTs. I mean they're just as specialized between the nose people and the throat people, and even just the ear people don't always want to see the dizzy people.

Dave Fabry: Well, and not the least of which is the equipment necessary to do state-of-the-art testing is expensive, and now if you establish yourself as the expert in that area, it can be very profitable as well. But it is an investment in equipment that goes beyond an audiometer in a test booth in many cases.

Dr. Patricia Ga...: I mean, he had VNG and when VEMPs came along, he had electrophys so he could do VEMPs. But yeah, I mean the equipment is expensive and when you're looking at physician time where they may have multiple patients scheduled for a short increment, a vestibular history is a long period of time. And so taking up this much time to get it a dizzy history is also problematic for a lot of their revenue streams to try and keep up with how many patients they need to see to make a profit.

Dave Fabry: Well, and even in the audiology training programs, I've seen your program and your facility at Nova and it's beautiful, but it is and probably took some arm twisting to sort of commit to the investment necessary. And I think this is really, in many ways, a large part of in a lot of programs, given that we have many smaller programs that then making that investment for the vestibular equipment to educate the next generation and provide the clinical expertise in-house is really challenging.

Dr. Patricia Ga...: Yeah, and if that's your expertise, you can talk about the benefits to that equipment, but a lot of programs don't have somebody where it's their expertise. So not only do you have expensive equipment, but you don't have somebody who wants to maybe deal with that equipment on a regular basis. They're teaching that class because it's necessary, but that may not be their area of expertise. So that makes it even a harder sell when you're looking at a bunch of different pieces of equipment that are all expensive and take up space.

Dave Fabry: It does, yeah. Well, and now turning to Fall Prevention Week beginning September 23rd, I know this year's theme is awareness to action. We've seen awareness for the importance of preventing falls increase in recent years, and this fall I think is no different. But now what are some of the goals for moving as somebody that, as you mentioned, was on the Balance Society Board and now you are president-elect of AAA and will begin your term as president October 1st. What would you say are some of the high-level awareness into action goals for this year's fall prevention week?

Dr. Patricia Ga...: Yeah, I think it's just really simple in one regard. I think one thing that every person can do is just ask about falls and fall history. In the past several presentations I've done to various groups, not everybody's going to be interested in doing vestibular testing, and not everybody's going to have the time or the resources to do that, but everybody takes some amount of case history and just asking have you had a fall or a near fall in the past several months or the past year can really make a big difference because if somebody has had a fall or a near fall, they are so much more likely to have a fall in the future. And there are injuries related to falls. We've talked about hip fractures. And I think a big one that I don't think gets talked about in enough is really traumatic brain injuries related to falls.

And so just very simply just asking and then having a place to refer them to, whether it's to a vestibular audiologist to do vestibular assessments. Or, if you don't have that in your area, because not... I live in a pretty metropolitan area, but if you're in a more rural area, you may not have access to that type of person. So referring them to physical therapy for a gait and balance assessment, just doing those two things can literally help save somebody's life in the future because there are deaths that are related to falls and that statistic, I think the CDC quotes it like every 20 minutes, somebody dies from a fall. And if you can just add that to your history, it can make a difference.

Dave Fabry: I'm glad you brought up the CDC because they did, as you said, they studied and said three questions that every clinician can ask is, do you feel unsteady while walking? Do you worry about falling? Or have you fallen in the past year? As you said, falling in the past year is a strong indicator. But those three questions, unsteady while walking, worry about falling and having fallen in the past year, if people address one of those three questions or more with a yes, that predicts 95% of the patients who are at elevated risk of falls. And then as we mentioned, the mere presence of untreated hearing loss, and it's thought to be for a variety of reasons, but cognitive load, if you will, the amount you have to concentrate on hearing and then navigating your visual environment to make sure that there isn't a trip hazard or some other hazard if the lighting is low, et cetera.

You don't have to immediately invest in a bunch of equipment, but if you're seeing patients with hearing loss, it's very likely that you're seeing patients who are at a risk and those three questions will address 95% of those at elevated risk. We, I think as you know, since 2019, have wanted to take that one step further as we became the industry's first and still only manufacturer to incorporate motion sensors, gyroscope that can detect a signature of a fall and then alert up to three contacts in the hopefully unlikely event that someone's wearing their devices and suffers a fall. And then even taking advantage of a smartphone world these days that if they're wearing their devices, they're connected to their smartphone and they fall. If they lose consciousness, as you said, or suffer a temporary or traumatic brain injury, the person that received the alert can actually see where that person was when they suffered the fall.

And we think we've heard a lot from the field, from patients, from their family members, from caregivers about the peace of mind that that provides. And I don't know whether you've ever had the opportunity to see it or see it in action. I think it's not designed as a 24/7/365 for someone who's at extreme risk like if they get up in the night and they're not wearing their hearing aids. But for patients who are at an elevated fall risk and they simply want to wear their hearing aids and have the confidence to know that if they suffer a fall, someone's going to know about it, and speaking as a baby boomer, they're not going to be the woman laying on the floor that said, "I've fallen and I can't get up."

Dr. Patricia Ga...: Yeah, and those situations of people falling and not getting up are absolutely true. I remember those commercials and everybody laughed because they were a little over the top, but I mean, I've had patients who have fallen and said they've laid on the floor for hours until somebody came to check on them, and that person just happened to come check on them.

Starkey's fall detection has been on my mind since I first saw it come out, and I have brought it up in presentations for those patients who we do think are a fall risk that this is another tool that can be used. Absolutely. And I was so glad because I remember Starkey in the beginning first had it in their premium level technology, and I was so glad to see it come down into all of the levels because we know that people who have a lower socioeconomic status have generally poorer health and therefore higher risk of a potential fall. So I was so glad that that technology was available across the spectrum of products. And yeah, it is something that I have brought up in presentations because it is such a great tool for this population that I see and patients who are being seen by other providers, the non-vestibular people may not necessarily think about it. And so if you're asking that question and they have some sort of concern about their balance, that may be one of those kind of features, hearing aid features that may drive you to that type of product.

Dave Fabry: Well, we've had more than a few providers who also have a hearing loss who thought, well, fall detection features just for old people, and then they suffer to fall. And now they are some of our biggest advocates in this space. And so thank you for bringing that up. I also agree completely that fall should know no budget or socioeconomic status, and that's why we did want to extend that because we believe that hearing care is healthcare and those highly comorbid conditions and falls in the aging population are right at the top is something that we really feel is important. Obviously the job one for any hearing aid is to help people hear better, but if we can tie along other features that all they have to do is just wear the devices and then know that they'll have some peace of mind for themselves, for their family, even professional caregivers, that's a win.

But one of the things we also know, and it's a fall detection feature, as good as it is, if it accompanies a broken limb, broken hip, broken leg in the aging population, it can almost be too late. And so we've been working aggressively towards moving from a fall detection or a fall alert feature into one that can also take advantage of those inertial measurement units and the elements of the STEADY protocol, the stopping elderly accidents, deaths and injuries, also developed by the CDC, the STEADY protocol. And we picked and isolated three categories of the subset of the STEADY exercises that were focused on gait, strength and balance.

And we completed a study with Stanford and are in the midst of rolling out a feature in a new product that will have the capability of providing comparison results to what would typically be done in a clinical environment where an

observer, typically a physician, audiologist, PT, would look and see how well a person can balance for 10 seconds with their feet next to each other, astride, one in front or with one foot up, and how they compare to the normative data.

And we found high correlation, and I think you came to my presentation with Matt Fitzgerald, we did at AAA this last year, and high correlation between the observer on the balance part of the thing, the strength test, how many times they can stand up and sit down in 30 seconds. And then the final one assessing gait is starting in a seated position in a chair, getting up, walking 10 feet, turning around and sitting back down again, it's a timed test, but it can also pick up sway. And then really the longer term goal will be to pair that with identifying which area specifically, balance, gait or strength where there is a weakness, and then allow the individual to partner that with using balance training tools that could ideally then reduce their risk and hopefully in the long, long goal, prevent a fall before it occurs. We're ways from that yet, but that's our really plan and we really share that with those who are interested in balance.

And so for me, vestibular has always been second or third on my list of priorities within the hearing space. Hearing aids has always been number one, cochlear implants and vestibular two and three, sometimes changing that order. But it's exciting to bring that to market, again, for those individuals who are at risk of falling and want to do something about it, want to do it in the convenience of their home to supplement what would be done with physical or occupational training, and therapy rather, and then visits to a vestibular audiologist for assessment. So we're excited about that.

Dr. Patricia Ga...: And that's exciting. Any of those tools are really helpful. And the next step is really bringing PT in so that they understand what hearing aids are capable of and what they can use. I mean, I could see a whole line of research looking at how that impacts assessment on the PT side as well and monitoring improvements in gait and balance training. So you have a long line of research ahead.

Dave Fabry: As usual, we're running out of time. I knew we would because you've got a lot to say. But I do want to transition a little bit. You'll begin your term as AAA, American Academy of Audiology, president in October. And you've been a part of that organization, as you said, since you were a student and you participated and received awards. So many, I can't even list, Outstanding Educator Award. You were in the future Leaders of Audiology Group, I believe, if not the inaugural one, one of the very early ones around 2010. And you have been on the ABS board of directors. But now with the AAA board and then coming back to serve as president, talk a little bit about what are the issues that are most concerning? You have one-year term, and that's always the challenge with AAA is that it's a very short term and about the time you're just getting going, you're passing the baton to the next leader.

Dr. Patricia Ga...: Yeah, I mean that one year is a short period of time, but it's all about collaborating with the president before you and the president after you. And so Bopanna Ballachanda has been the current president and his big focus was on increasing membership. And so that is still something that we'll continue to focus on. Members are so important to help drive, what are the goals? What do we need as far as advocacy? And those components of a healthy successful organization.

But I think one of the things that is a crux of the profession is really our compensation. And throughout the years, I was on the board 10 years ago as a board of directors member at large and now coming back, some of the same issues are still here, and I'm sure they've been here for a very long period of time, but compensation and how we get paid is always such an issue. And really how do we go about improving that? And part of it may be legislative and coding related, but also part of it is just standing up for the services that we provide and having the ability to say, "Well, this is what it costs and this is what we're charging to do the things that we need to do to help successfully see patients and provide the care that we need to. So compensation is a background focus and thinking about where the organization is going and where can we help our membership. That's definitely one of them.

Another is looking at what really sets us apart and how does audiology really fit in the healthcare space going forward, and where are the areas where we have opportunity for growth? Where do we have opportunities for showing our excellence, showing our ability to provide high-level care, practicing at the top of our license? So we're really looking at what is the organization doing and how does it support our membership in these types of ways? So part of what we're going to be doing is looking in-house to see, okay, what are we doing? How can we fine-tune this a little bit better for what our membership needs and wants that will help project us into a better space for the future to common audiology?

Dave Fabry: I think, and as you said, some of these problems have been around and challenges have been around for a while and I'm back near the turn of the millennium when I was president of the academy, we were really on direct access. And really wrapped up in that is just really the ability for someone to come to an audiologist without needing to be referred. And then also I would say embedded in that is the value of service untethered from a device or a product. And I think that's a miss from my generation. I think we really need to harness that for the discipline moving forward to really have the perception of the benefit of service and also the value provided by the professional of that service. So I know you're on top of that.

I think also you mentioned compensation, and really embedded with that is the cost of tuition. When I was an undergrad and graduate student, it was a very different environment to when you graduated, and I know you did an excellent

paper several years ago now that you published an Audiology Today looking at generational debt load, if you will, cost of expense. And when you graduated back in 2005, 23% of the students surveyed who graduated that year had debt of less than $10,000. And then you fast forwarded in your examples to a decade later, and it was 15% had debt over $160,000. And in 2022, the last year that you had in your paper, it was nearly 17% had debt of more than $200,000. That's just mind-blowing for the baby boomers and thinking about all of the opportunities that we had to offset tuition is a burden that I think I worry about the students coming out now. I'm still as optimistic for the future as I was when I was a student, but how do you address that? Because I'm sure that's got to be top of mind for a lot of young professionals recently graduated or those still paying off tuition debt.

Dr. Patricia Ga...: And it is, I mean, and full disclosure, I graduated, between undergrad and graduate work, I graduated with about 160,000 in debt in 2005. So when you look at that graph, there was that small percentage, yeah, that was me because particularly my undergrad cost quite a bit. It's tough because I think that programs, they don't have as much say in how much they can charge within this gigantic institution of a university. And I think that's where I think a lot of programs, we would love to make our program so much less expensive to attract students, but the university is not going to allow us. And so I know some programs, including ours, have gone to a three-year model to try and get students out quicker.

But I think that part of the issue is that you're coming out with this debt, but then what's your salary on the back end? If you're looking at medicine and you say, "Okay, well you're going to take out 300,000 in student loans, but your salary is going to be several hundred thousand dollars," it's a lot easier to swallow that versus you're going to come out and the average audiologist is making $80,000. It makes it really hard to justify that. And I think it's that debt-to-income ratio that's really off. And so what can we do? Well, we can't say to X university, "Well, you need to charge less per credit." But we can say, "Okay, well from the professional side, how can we increase that income side so that we can make it more attractive?"

I feel like audiology has not been able to keep up with changes in salary over time. And I think that's really where that crux of that situation is. Yeah, the student loan debt is definitely a problem. And trying to address that across different institutions, scholarship availability, money availability, that's really hard. And the income side is hard too. It's always going to be hard, but I think that's where we have a lot more push or a lot more opportunity to change things.

So I do that survey every other year. So this fall I will be collecting 2024 data, and at one point I had to add, I was only going up to 150,000 to 200,000 and it got to a point where I had to add another category of student loan debt

amounts, and it's a tough pill to swallow considering that I'm still paying student loans.

Dave Fabry: I know if anyone's up to the task to really assess where the students are and considering with the board that you'll be working with, you've got this. But the last thing, and we really are out of time, but I know as well equity has been an issue for you as well. You mentioned equity. We're a profession that is nearly 80% female, yet in many cases it's still the case that males disproportionately are in leadership positions more than females are. I know that's part of your platform. And I know at AAA in Seattle, I think it was, we had an outstanding speaker on diversity, equity, inclusion and belongingness. And so my last question to you... Israel Green was his name. He's outstanding. But to a young professional or to an existing professional as now the figurehead for the American Academy of Audiology, what do people need to feel or how is it that you make them feel like they belong in the academy as part of your platform? What will you do to increase the feeling of belongingness to the professional organization? Because there's a lot of organizations out there.

Dr. Patricia Ga...: Yeah. I think we have a lot of work to do to who make our profession a profession of belonging. We're very heavily women in numbers, but we're also a very white profession. And so I think that, first of all, beyond the Academy, but I think programs need to reach out to people from various backgrounds to just even enter their profession. We reach out to historically Hispanic universities and historically Black colleges and universities to try and bring diversity into our profession. We need that.

And so the Academy has a DEIB committee and we have representation to the different councils for that. But I think it's also trying to invite various people into presenter positions, into committee positions, and really bring people in because we need that diversity and hearing from people from diverse backgrounds. I have one life and I have one perspective, and I don't necessarily understand some of the issues that other people have. And so we need to bring them to the table so that we can hear the various lived experiences that people have so that we can make our academic program stronger, that we can make our patient care stronger, we can make our profession stronger. So I really feel like that's a big part of what we need to strengthen in audiology overall.

Dave Fabry: 100%, and I've heard it said, you can't be what you can't see. And so we need to have representation from individuals. Because I would say college is too late. High school maybe is already borderline too late. We got to capture people's interests, and unless they can see audiologists that look like them, if you're a minority, that you don't even consider it as a profession.

Well, thank you so much Tish, for having this conversation about your professional journey and your professional involvement through every stage of your career, through the important Fall Prevention Awareness Week. And then

also, I wish you much success during your tenure as president of the American Academy of Audiology, and I know that you're up to the task, but thank you for being with us today on Sound Bites.

Dr. Patricia Ga...: Thank you so much for having me.

Dave Fabry: And for our listeners, thank you for listening. As always, if you like this episode, please share it with your friends, your colleagues, your network. Subscribe so you don't miss any future episodes. And if you have ideas for future content, send us an email at SoundBites@Starkey.com. That's SoundBites@Starkey.com. Thank you for listening and we look forward to seeing and hearing you again very soon.