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1 **Moderate-medicalisation and an age-neutral NHS Hearing Aid Service**

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15

16 Abstract

17 Age-related hearing loss is one of the most common chronic health conditions experienced by
18 adults. However, many individuals who would benefit from a hearing aid do not seek help
19 and many that do seek help, experience symptoms for several years prior to attending for a
20 hearing assessment. One of the main reasons for delayed access and poor hearing aid uptake
21 is the stigma associated with hearing loss. Recently, there have been several calls to promote
22 earlier and easier access and recommendations, such as the de-medicalisation of NHS hearing
23 aid services, have been suggested. In agreement with this, we argue that approaches to
24 reduce hearing loss stigma should be prioritised. However, we propose a reduced form of
25 medicalisation, rather than a de-medicalised, approach is required. Furthermore, in addition
26 to what we refer to as 'moderate-medicalisation', we argue that a less 'older-age-focused'
27 NHS hearing service will facilitate earlier access to assessment and hearing technology. We
28 suggest some service delivery changes that will promote moderate-medicalisation and an age-
29 neutral service.

30 **Key points**

31 Our propositions are:

32 • Reducing the stigma of hearing loss should be prioritised if easier and earlier access to
33 NHS hearing services is to be achieved.

34 • A less medicalised and less ‘older-age-focused’ NHS hearing aid service will reduce
35 stigma and facilitate earlier access.

36 • Changes to NHS hearing services that promote moderate-medicalisation and age-
37 neutrality are recommended.

38

39 **Background**

40 A recent UK based survey reported that 10.7 % of adults aged 40-69 have substantial hearing
41 loss, with the likelihood of hearing loss increasing with age (Dawes et al., 2014). This is
42 consistent with reports from other developed nations (e.g. Plomp & Mimpen, 1979; Smits et
43 al., 2006; Chia et al., 2007), making age-related hearing loss (ARHL) one of the most
44 common chronic health conditions experienced by adults worldwide. Furthermore, research
45 suggests it is more prevalent than such reports indicate and is increasing in younger age
46 groups (Agrawal et al., 2008). The effects of ARHL are well known and include negative
47 impacts on emotional, social, and physical well-being (e.g. Mulrow et al., 1990; Strawbridge
48 et al., 2000; Arlinger, 2003; Dalton et al., 2003; Chia et al., 2007; Gopinath et al., 2009). The
49 use of optimally fitted hearing aids (HAs) is crucial in counteracting these effects of hearing
50 loss.

51

52 Anecdotal reports from NHS HA services indicate that the typical age of an individual
53 presenting for assessment for first time HA fitting is 70 to 75 years old. However, many
54 individuals who would benefit from a HA do not seek help and many that do seek help,
55 experience symptoms for several years prior to attending for a hearing assessment (Davis,
56 1989). This has remained the case despite changes to service delivery, such as modernising
57 hearing aid services, and improvements in technology (Davis, 1989; Dawes et al., 2014).
58 There have been calls for earlier provision of HAs to individuals who are fifty to sixty years
59 old (Wallhagen, 2010; Dawes et al., 2014) in order to provide earlier benefit, facilitate
60 acclimatisation and HA management and, potentially, reduce the risk of developing dementia
61 in later life (Dawes et al., 2014; Lin et al., 2014).

62

63 In support of this, and given the increasing prevalence and the wide-ranging negative
64 consequences of hearing loss, the International Longevity Centre-UK (ILC-UK) recently
65 published the Commission on Hearing Loss Final Report (2014), which is directed towards
66 NHS England, the Department of Health, Public Health England and Clinical Commissioning
67 Groups and providers, and emphasises the need to focus efforts on earlier detection of
68 hearing loss, improving accessibility and implementing treatment-flexibility and choice. The
69 Report discusses the realities of implementing service changes, including drawing attention to
70 costing considerations. However, in addition to cost, a very real challenge for implementing
71 any proposed service changes promoting earlier and increased access is the stigma associated
72 with hearing loss. Whilst the report highlights the need to address this stigma, we argue it
73 should be given higher priority than is implied by the Commission. The effectiveness of a
74 screening programme for earlier detection will be limited if concerted efforts are not
75 undertaken *first* to reduce the negative perceptions associated with hearing loss. Earlier
76 detection and changes to service delivery models to improve access will have little impact if
77 individuals, particularly younger adults, remain reluctant to seek help.

78

79 To this end, and following a series of workshops for audiologists, patients and members of
80 the public during which the medicalised approach of hearing services was raised by attendees
81 as a potential barrier to access and HA uptake, within this paper we provide an overview of
82 the concept of medicalisation and hearing loss stigma in the context of NHS HA services.
83 Following this we make a number of suggestions for service changes that address stigma by
84 reducing the medicalised and old-age focused sub-culture of NHS HA services, and argue for
85 ‘moderate medicalisation’ and an age-neutral environment.

86

87 **The stigma of hearing loss: ageism and medicalisation**

88 Previous research has identified real and perceived stigma as a reason for individuals with
89 ARHL to be reluctant to seek help, be provided with and use a HA (Wallhagen, 2010; Meyer
90 et al., 2014; Preminger & Laplante-Lévesque, 2014) (e.g. Knudsen et al., 2010; McCormack
91 & Fortnum, 2013). Stigma is used to describe an attribute that is demeaning and can lead to
92 experiences of rejection, isolation, prejudice, institutionalised discrimination, and what
93 sociologist Erving Goffman (Goffman, 1963) describes as a ‘spoiled identity’. Stigma can
94 affect all aspects of the hearing loss continuum (including acceptance of hearing loss,
95 whether to be assessed or seek treatment, the type of HA selected, and when and where HAs
96 are worn) and is linked to three interrelated experiences: alterations in self-perception, vanity,
97 and particularly pertinent to this article, ageism (Kochkin, 2000; Wallhagen, 2010; Hickson
98 & Meyer, 2014; Meyer et al., 2014; Preminger & Laplante-Lévesque, 2014).

99

100 Ageism is the stereotyping and discriminating against individuals on the basis of their age
101 and includes prejudicial attitudes towards older people, old age and the ageing process
102 (Iversen, Larsen & Solem, 2009). Implicit ageism, the subconscious thoughts and feelings
103 one has about older people and the ageing process (e.g. the negative associations of growing
104 old such as cognitive decline, disability, reduced ability to function in society), will likely be
105 felt most acutely by those younger individuals who perhaps have most benefit to gain from a
106 hearing aid fitting. These individuals are still likely actively engaged in their work and
107 careers and otherwise feel fit and well; they do not ‘feel old’ and do not wish to be perceived
108 as ‘old’ and, consequently, frail and ill.

109

110 To improve access rates, HA uptake and achieve the espoused benefits linked with earlier HA
111 use, a necessary step is therefore to identify practical strategies to breakdown the negative
112 association between hearing loss, HAs, ageing and illness, and ultimately to reduce stigma
113 associated with ARHL. Within the NHS setting, this association is reinforced by the
114 medicalised culture of HA services. Medicalisation is the process by which human
115 conditions, such as ARHL, come to be defined and treated as medical conditions (i.e. based
116 around what is designated by the medical profession as normal and abnormal; Morrall, 2009).
117 Because ARHL is medicalised, the typical location for a NHS HA service is within a hospital
118 and individuals with ARHL require referral from their general practitioner to access these
119 services. Such clinical intervention and settings can reinforce stigma (Conrad, 2007; Morrall,
120 2009) and medicalising ARHL potentially perpetuates the belief that ‘normal’ ageing and
121 ARHL are associated with illness, and may also encourage the notion that they are full-blown
122 disease states. Inappropriate or overzealous medicalisation can result in unnecessary
123 labelling and poor treatment plans (Moynihan, 2002). In addition, it can increase dependency
124 on health professionals and health services, instead of encouraging acceptance of normal
125 aging that can be coped with either with minimal medical involvement or none at all (Illich,
126 1976).

127

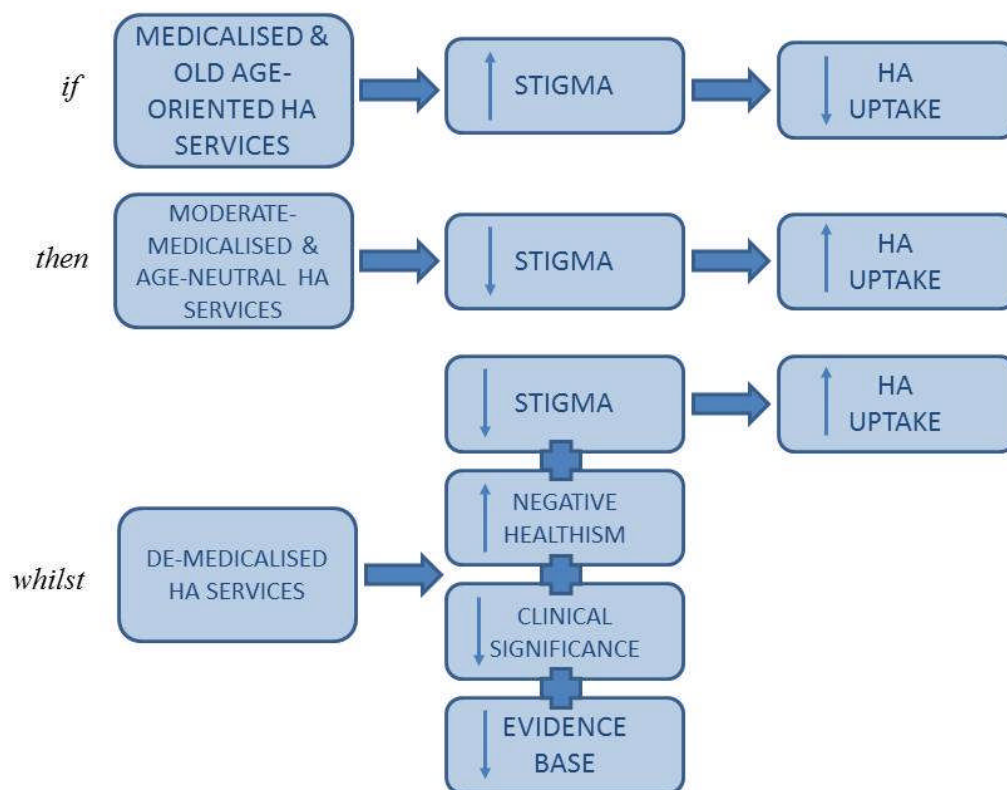
128 An argument therefore follows that *de*-medicalisation of NHS HA services will produce
129 positive consequences, such as normalising ARHL and reducing stigma (Munro et al., 2013;
130 ILC-UK, 2014), and thus remove barriers to earlier access to hearing services and hearing
131 technology. However, the process of de-medicalisation is complex, and can also have
132 negative effects. The space left by de-medicalising a particular condition is often filled by
133 negative aspects of “healthism” (Crawford, 1980; Morrall, 2009), i.e. a commercial and
134 consumerist-driven obsession with health and well-being that, for example, leads to the

135 resurgence of non-evidence based practices such as aromatherapy or homoeopathy, and
136 increased media attention to the ideal body and mind. De-medicalisation can also lead to a
137 depreciation of the significance of a condition. The medicalisation of writing and reading
138 difficulties (that is, dyslexia) resulted in an increased awareness of the condition and the
139 creation of important educational and employment-related policies (Morrall, 2009). This
140 might not have happened had dyslexia not been medicalised. Moreover, medical science
141 colludes with natural and technical science to yield sophisticated diagnostic techniques and
142 treatment regimens, so that to decouple from this store of research, knowledge, and expertise,
143 would leave HA services and their ‘clients’ vulnerable to inadequate provision if not
144 quackery.

145

146 Therefore, given the negatives as well as the positives of medicalisation (and de-
147 medicalisation) we suggest changes to service delivery that will make NHS HA services *less*
148 medicalised and *less* “older-age-focused”, rather than totally *de*-medicalised. We call this
149 approach “moderate-medicalisation”. Figure 1 provides a simple outline of the reasoning of
150 our moderate-medicalisation model. In making these recommendations we are not
151 advocating privatisation of NHS HA services. Rather, we argue the approach required is
152 *similar* to the approach undertaken by optometry services (but not the same due to important
153 differences such as that glasses can rectify vision whereas hearing aids do not restore normal
154 hearing) some thirty years ago wherein services were freed from the policies and protocols
155 associated with being located in hospitals and were able to adopt high-street retail influences
156 (Barty-King, 1986). This has seen glasses shift from being undesirable medical devices
157 associated with old age to being fashion accessories worn by people of all ages.

158



159

160 **Figure 1. A simple model outlining the proposed relationship between medicalisation,**
 161 **stigma and HA uptake, and the potential effects of de- and moderate-medicalisation.**

162

163 **Changes to create an age-neutral and a moderate-medicalised NHS HA service**

164 In the UK an individual seeking intervention for hearing loss must visit their GP in order to
 165 obtain a referral to a NHS audiology service. This requirement, in addition to the subsequent
 166 hospital-based audiology appointments, increases the amount of time spent within
 167 medicalised environments, and may therefore reinforce the belief that having ARHL is a sign
 168 of illness. To reduce the amount of time individuals are in a medical environment (and
 169 overcome any barriers that occur as a result of this) shortening the patient pathway by
 170 allowing direct access to audiology services could be considered (Munro et al., 2013; Dawes

171 et al., 2014; ILC-UK, 2014). Self-referral would also have the added benefit of making the
172 process quicker and easier (ILC-UK, 2014).

173

174 The medical sub-culture typical of hospitals is immediately apparent to individuals in many
175 audiology waiting areas and treatments rooms. For example, wipe clean chairs and hand
176 cleaning gel dispensers are ubiquitous. Similarly, some departments require their
177 audiologists to wear white tunics that are synonymous with caring for people who are ill.
178 Whilst infection control is an important consideration and the use of hand gel is important in
179 this regard, wipe clean chairs and tunics are arguably unnecessary given audiologists are
180 rarely exposed to bodily fluids. The wearing of suitable but personally chosen attire would
181 go some way to support the creation of a less medicalised environment.

182

183 Waiting areas are also often noticeably old-age-oriented with upright chairs and myriad
184 information, on noticeboards and as leaflets, associated with growing old e.g. regarding
185 mobility, illnesses associated with age and social support for the elderly. Whilst we
186 recognise these are relevant and important to a large proportion of individuals, making
187 departments more *age-neutral* might improve earlier access rates. Simple changes could
188 include making waiting areas more contemporary with consideration to colour schemes, the
189 addition of some stylish chairs and sofas, magazine choices appealing to both a younger and
190 older readership, equal emphasis on information pertinent to a younger client e.g. information
191 regarding use of HAs at work and with modern technology, and access to the internet. The
192 latter may be particularly pertinent in promoting earlier access by a younger demographic
193 who are still working and may wish to work whilst waiting for their consultation. HA
194 advertisements could also be used more effectively, within waiting areas and treatments

195 rooms, to highlight benefits for *all* age groups and could positively reinforce HA use by
196 presenting HAs as fashion accessories and not always stressing the discreetness of the device.

197

198 Following a case history and hearing test, individuals who would benefit from amplification
199 are customarily shown a typical selection, or a single example of, beige, brown or grey HAs
200 prior to their fitting. The assumption is often made that the HA should blend in with skin
201 tone or hair colour, so that it is discreet. Currently, little or no time is available for the client
202 to discuss or try out different colours or designs in front of a mirror. We propose that the
203 approach to being fitted with a HA should be more individualised, in a similar way to how
204 people with poor vision are able to choose between wearing contact lenses or glasses, and
205 further, what model of glasses to wear. We feel it would be beneficial for prospective users
206 to be able to view and try on a range of hearing devices and associated accessories and
207 suggest that this is made possible in the waiting room. Clients will then be better placed to
208 make an informed choice regarding their HAs. Future cohorts of fifty to sixty year olds will
209 be used to the sight of futuristic designed devices clearly observable in people's ears (e.g.
210 hands free mobile phones, personal listening devices). Thus, whilst some individuals may
211 still choose a discrete model of HA, some may opt to make a bolder statement.

212

213 A further aspect which could easily be addressed and one which has been shown to affect
214 attitudes is language (e.g. Young et al., 2008). Anecdotal evidence shows the language used
215 in association with audiology services, be it written or spoken, is often unimaginative and
216 medical. Changes which may have a positive impact would be to routinely call the 'patient
217 case history' an 'interview' and to refer to patients as 'clients'. Although both words have
218 similar definitions, 'patient' is *only* used in medical spheres whereas 'client' is used in other
219 arenas and thus, may be less associated with illness and frailty. Further, when discussing

220 HAs an approach similar to that used when describing modern technology could be used,
221 with HAs called by their commercial names such as “Aero”, “Spirit” or “Halo” (a relatively
222 new device co-developed by the ultra-fashionable Apple and Starkey). These names are
223 chosen by the manufacturers following extensive market research and are synonymous with
224 the futuristic-sounding names given to fashionable modern technology, such as the iPad Air.

225

226 Finally, it should be noted that the negative perceptions associated with the above medical
227 and old-age-oriented factors will be reinforced during each return visit to the department (or
228 local health centre). Thus, it would be preferable to clients (and departments from an
229 economic perspective) if repeat visits could be minimised. As an example, consideration
230 should be given to alternative methods of battery dispensing such as placement of vending
231 machines in areas that are easily accessed and not associated with health such as
232 supermarkets and newsagents.

233

234 **Conclusions**

235 In this article we have presented some ideas aimed at changing the medical and old-age-
236 focused sub-culture of NHS HA services. It is envisaged that moderate-medicalisation and
237 an age-neutral service will reduce stigma associated with ARHL, facilitate earlier access and
238 increase HA uptake. We stress that our argument is for a modified NHS HA service (in terms
239 of its sub-culture) and *not* a call for de-medicalisation or privatisation. Many of the ideas
240 proposed here represent small changes (e.g. the changes regarding audiologists attire, patient
241 literature/posters in waiting rooms and language/terminology) however, we also appreciate
242 that others would require substantial financial investment and major policy change.

243 However, this should not limit their inclusion in any future debates regarding improving
244 services.

245

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251 and patient awareness of the potential for poor information literacy as a barrier to
252 rehabilitative success of hearing impaired adults and children.)

253

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- 320
321
322

323 **Figure 1 A simple outline of the moderate-medicalisation model**