Medical Errors for Audiologists to Avoid

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Medical Errors for Audiologists to Avoid

- Historical perspective
- Definitions of important terms
- Standard of care
- General steps for preventing errors and minimizing liability
- Professional responsibility, professional liability, and risk management in audiology
- Patient tips to prevent medical errors
- Guidelines for patient referral to physicians (otolaryngology)
- Questions and answers
Medical Records:
Reasons for Demise on Actual Death Certificates

- “Went to bed feeling well ... woke up dead.”
- “Don’t know ... never fatally ill before.”
- “Nothing seriously wrong.”
- “Blow to head. (Contributory cause was another man’s wife.)”
- “Don’t know ... died without the aid of a doctor.”
Types of Medical Errors: Early Published Paper
Leape, Lawthers, Brennan et al. (1993) Preventing Medical Injury,
Quality Review Bulletin, 19, 144-149

- Diagnostic Errors
  - Error or delay in diagnosis
  - Failure to employ indicated tests
  - Use of outmoded tests or therapy
  - Failure to act on results of monitoring or testing

- Treatment Errors
  - Error in the performance of an operation, procedure, or test
  - Error in administering the treatment
  - Error in the dose or method of using a drug
  - Avoidable delay in treatment or in responding to an abnormal test
Types of Medical Errors: Early Published Paper
(From: Leape, Lawthers, Brennan et al. (1993) Preventing Medical Injury, Quality Review Bulletin, 19, 144-149)

- **Preventive Errors**
  - Failure to provide prophylactic treatment
  - Inadequate monitoring or follow-up of treatment

- **Other Errors**
  - Failure of communication
  - Equipment failure
  - Other system failure
Types of Medical Errors: Widespread Recognition

1999 Institute of Medicine Report

TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM

Health care in the United States is not as safe as it should be—and can be. At least 44,000 people, and perhaps as many as 98,000 people die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor vehicle wrecks, breast cancer, and AIDS.

Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Among the problems that commonly occur during the course of providing health care are adverse drug events and improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistakes in patient identifications. High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments.

Beyond the cost in human lives, preventable medical errors exact other significant tolls. They have been estimated to result in total costs (including the expense of additional care necessitated by the errors, lost income and household productivity, and disability) of between $17 billion and $25 billion per year in hospitals nationwide. Errors also are costly in terms of loss of trust in the health care system by patients and diminished satisfaction by both patients and health professionals. Patients who experience a long hospital stay or disability as a result of errors pay with physical and psychological discomfort. Health professionals pay with loss of morale and frustration. As a result, it is not being able to provide the best care possible. Society bears the cost of errors as well, in terms of lost worker productivity, reduced school attendance by children, and lower levels of population health status.

A variety of factors have contributed to the nation’s epidemic of medical errors. One oft-cited problem arises from the decentralized and fragmented nature of the health care delivery system—or “nosystem,” to some observers. When patients see multiple providers in different settings, none of whom has access to complete information, it becomes easier for things to go...
Medical Errors for Audiologists to Avoid: 10 Medical Errors That Changed Standard of Care (Barry Bialek, MD)

- Trauma Care: introduction of Advanced Trauma Life Support (1980)
- Anesthesia Monitoring (1982)
- Fetal Heart Monitoring (1980)
- Wrong Site Amputation (JCAHO)
- Sponge Counts
- Fatal Allergies
- Potassium Mishaps
- Decubitus Ulcers
- Lifting Techniques
- Breast Exams
Hospital Errors are the Third Leading Cause of Death in U.S., and New Hospital Safety Scores Show Improvements Are Too Slow

Washington, D.C., October 23, 2013 – New research estimates up to 440,000 Americans are dying annually from preventable hospital errors. This puts medical errors as the third leading cause of death in the United States, underscoring the need for patients to protect themselves and their families from harm, and for hospitals to make patient safety a priority.

Press Inquires

We are happy to help members of the press inform the public about the Hospital Safety Score. For interview requests or additional information for print, electronic and broadcast journalists, please contact:

Ashley Duvall
(908) 325-3865

If you are a hospital looking for a template press release to announce your Hospital
How Many Die from Medical Mistakes in U.S. Hospitals?

An updated estimate says it could be at least 210,000 patients a year, more than twice the number in a frequently quoted Institute of Medicine report.

By Marshall Allen and ProPublica | September 20, 2013

It seems that every time researchers estimate how often a medical mistake contributes to a hospital patient’s death, the numbers come out worse.

In 1999, the Institute of Medicine published the famous “To Err Is Human” report, which dropped a bombshell on the medical community by reporting that up to 98,000 people a year die because of mistakes in hospitals. The number was initially disputed, but is now widely accepted by doctors and hospital officials 2014 and quoted ubiquitously in the media.
Ongoing Concern About Medical Errors: The Problem Is Not Going Away

Brigham and Women’s airing medical mistakes
Hospital reports errors to staff in drive for improvement

Surgical errors rise in Mass. despite new controls
Many preventable mistakes cited, but few of them caused serious harm
Nightmare stories of nurses giving potent drugs meant for one patient to another and surgeons removing the wrong body parts have dominated recent headlines about medical care. Lest you assume those cases are the exceptions, a new study by patient-safety researchers provides some context.

Their analysis, published in the BMJ on Tuesday, shows that “medical errors” in hospitals and other health-care facilities are incredibly common and may now be the third-leading cause of death in the United States — claiming 251,000 lives every year, more than respiratory disease, accidents, stroke and Alzheimer’s.

A study by researchers at Johns Hopkins Medicine says medical errors should rank as the third leading cause of death in the United States — and highlights how shortcomings in tracking vital statistics may hinder research and keep the problem out of the public eye.

The authors, led by Johns Hopkins surgeon Dr. Martin Makary, call for changes in death certificates to better tabulate fatal lapses in care. In an open letter, they urge the Centers for Disease Control and Prevention to immediately add medical errors to its annual list reporting the top causes of death.
Medical Errors for Audiologists to Avoid: Changing Attitudes About Preventing Medical Errors

- **System approach**
  - Introduce systems to prevent errors and promote safety
  - Medical checklists
  - Computerized systems for medications
  - Regular training and “in-services”
  - No fault, no blame approach to encourage disclosure of errors

- **Add accountability and blame for health care workers who don’t follow rules (e.g., hand-washing or pre-surgery “time out”)**
  - Mandatory training for health care workers
  - Loss of patient care privileges
  - Loss of operating room time
  - Loss of pay for defined periods
Medical Errors for Audiologists to Avoid: 
*Ongoing Weaknesses in Preventing Medical Errors*

- Most patients who suffer harm do not file formal complaints
  - 1 in 7 Medicare patients harmed each month
  - 15,000 Medicare patients (1.5%) are victims of an event that leads to death per month

- Hospital failure to report unexpected harm to patients, or “sentinel adverse events”
  - States report only 12% of harmful events reported to HHS inspector general
  - Hospitals report only 1% of harmful events

- A few “rotten apples” are the cause of most medical errors
  - Physicians almost never lose hospital privileges
  - Physicians almost never lose license to practice
Medical Errors for Audiologists to Avoid: 
*Historical Perspective*

- Five common preventable medical errors
  - Medication error
  - Too many blood transfusions
  - Too much oxygen for premature babies
  - Health care-associated infections
  - Infections from central lines
  - The impact of culture (safety is #1 priority)

- What are the most common *audiology* errors
  - ?
  - ?
  - ?
  - ?
  - ?
Medical Errors for Audiologists to Avoid

- Historical perspective
- **Definitions of important terms**
- Standard of care
- General steps for preventing errors and minimizing liability
- Professional responsibility, professional liability, and risk management in audiology
- Patient scenarios … Errors and steps to prevent them (You make the call!)
- Guidelines for patient referral to physicians (otolaryngology)
- Questions and answers
“An individual who causes injury to another either intentionally or unintentionally can be held liable for the action. By virtue of advanced knowledge, training, and skill, a professional has a responsibility to conform to certain standards of conduct to protect the public from unreasonable risks.

... The responsibility of licensed and/or certified professionals to conform to those standards may be referred to collectively as professional liability.”

Medical Errors for Audiologists to Avoid: Definitions of Important Terms

- **Civil professional liability**
  - **Tort** *from Latin for twisted or distorted*: Any wrongful act, damage, or injury done willfully or negligently
  - **Action in tort** is a private legal action in which
    - ✓ A plaintiff seeks a remedy (generally monetary) for damages to health, property, peace of mind, or reputation
    - ✓ The defendant is the health care provider to provided services to the plaintiff
    - ✓ Plaintiff must prove defendant fault before payments are required from defendant
Medical Errors for Audiologists to Avoid: Definitions of Important Terms

- Civil professional liability
  - Intentional tort
    - Illegal actions were intentional
    - A reasonable person would conclude that the alleged result was substantially certain to follow the action, e.g.,
      - Assault (attempt to do violence)
      - Battery (unauthorized physical contact), e.g., failure to obtain consent to treat
      - Defamation of character
      - Violation of confidentiality, e.g., unauthorized release of PHI
Medical Errors for Audiologists to Avoid: Definitions of Important Terms (2)

- Unintentional tort
  - Most common form of negligence in civil litigation
  - Defendant failed to exercise standard degree of care, e.g.,
    - Negligence
    - Misdiagnosis
    - Incorrect or inadequate treatment
    - Injuries from equipment or premises
Unintentional tort

Four elements of unintentional tort

- A legal duty, that is, a practitioner/patient relationship, exists between audiologist and plaintiff
- Breach of legal duty exists (e.g., Improper diagnosis)
- Cause and effect established ("proximate cause") between breach of duty and injury
- Injury results in actual loss or damage
Medical Errors For Audiologists to Avoid: Definitions of Important Terms (3)

- **Criminal (versus civil) liability**
  - Commission of misdemeanors or felonies during conduct of professional activities, e.g.,
    - Battery
    - Fraud
    - Grand larceny
    - HIPAA violations
  - Often criminal liability reflects ignorance of regulations, e.g.,
    - Medicare and Medicaid law
    - State insurance codes
  - Audiologist is subject to fines and incarceration
Medical Errors for Audiologists to Avoid: Definitions of Important Terms (4)

- **Employer liability**
  - Employer has “vicarious” responsibility ("respondeat superior") for those who work for them
  - Unlicensed person inadequately supervised by licensed audiologist
  - Support staff under supervision of an audiologist

- **Product liability**
  - Audiologist drawn into third party liability litigation following dispensing of a product or device, e.g.,
    - Ingestion of hearing aid battery by a child
    - Allergic reaction an ear mold or to electrode paste
    - Malfunctioning FM systems
    - Defective cochlear implants
Medical Errors for Audiologists to Avoid

- Historical perspective
- Definitions of important terms
- Standard of care
  - Definition
  - Practice guidelines for audiologists
  - State rules and regulations
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"Those who fall in love with practice without science are like a sailor who steers a ship without a rudder or compass, and who can never be certain whither he is going."

Leonardo Da Vinci (1452-1519)
Medical Errors for Audiologists to Avoid: 
Standard of Care

- Consistent with local, regional or national clinical practice
- Follows guidelines or recommendations on clinical practice approved by national multi-disciplinary professional committees or panels, e.g., Joint Committee on Infant Hearing
- Follows guidelines or recommendations on clinical practice approved by national professional organizations, e.g., AAA or ASHA
- Is consistent with statements of
  - Scope of Practice
  - Code of Ethics
- Is in compliance with Federal guidelines for clinical practice and services, e.g., Joint Committee on Accreditation of Healthcare Organizations (JCAHO)
Medical Errors for Audiologists to Avoid: 
A Sample of Legal Definitions of Standard of Care

- In tort law, the standard of care is the degree of prudence and caution required of an individual who is under a duty of care. (en.wikipedia.org/wiki/Standard_of_care)

- In tort law, the degree of caution that a reasonable person should exercise in a given situation so as to avoid causing injury. (en.wiktionary.org/wiki/standard_of_care)

- The degree or level of service, attention, care and protection that a person owes another person according to the law (see also Duty of care). (www.ibc.ca/en/need_more_info/glossary/S.asp)

- It's the level of care, which an average practitioner would practice. Or in other words how a similar qualified practitioner would manage their patient's care under similar circumstances. Medical Malpractice claims must establish the standard of care and show that the standard has been breached. (www.gmlaw.com/medical-malpractice-resources-terms.cfm)
Common Evidence Grading System:
Four Categories

- **Grade 1**
  - 1a: Well-designed meta-analysis of randomized controlled trials
  - 1b: Well-designed randomized controlled trials

- **Grade 2**
  - 2a: Well-designed controlled studies without randomization
  - 2b: Well-designed quasi-experimental studies

- **Grade 3:** Well-designed non-experimental studies, i.e.,
  - Correlational studies
  - Case studies

- **Grade 4:**
  - Expert committee reports, consensus conferences and clinical experience
Examples of Current Practice Guidelines in Audiology

- 2007 Joint Committee on Infant Hearing (JCIH) Position Statement
- 2008 Guidelines on Identification, Diagnosis, and Management of Auditory Neuropathy Spectrum Disorder in Infants and Young Children
- 2010 American Academy of Audiology Clinical Practice Guidelines: Diagnosis, Treatment, and Management of Children and Adults with Central Auditory Processing Disorders
- 2010 American Academy of Audiology Clinical Practice Guidelines: Childhood Hearing Screening
- 2012 American Academy of Audiology: Audiologic Guidelines for the Assessment of Hearing in Infants and Young Children
- 2013 American Academy of Audiology Clinical Practice Guidelines: Pediatric Amplification
- American Academy of Audiology Clinical Practice Guidelines: Otoacoustic Emissions (in progress)
Example of A Practice Guideline in Audiology: Year 2007 JCIH Position Statement Protocol for Evaluation for Hearing Loss In Infants and Toddlers from Birth to 6 months

- Child and family history
- Evaluation of risk factors for congenital hearing loss
- Parental report of infant’s responses to sound
- Audiological assessment
  - Auditory brainstem response (ABR)
    - Click-evoked ABR with rarefaction and condensation stimulation if there are risk factors for auditory neuropathy
    - Frequency-specific ABR with air-conduction tone bursts
    - Bone-conduction stimulation (as indicated)
    - Auditory steady state response (ASSR) is optional
  - Otoacoustic emissions (distortion product or transient OAEs)
  - Tympanometry with 1000 Hz probe tone
  - “Clinical observation of infant’s auditory behavior. Behavioral observation alone is not adequate for determining whether hearing loss is present in this age group …”
- Caregiver concern regarding hearing, speech, language, or developmental delay.
- Family history of permanent childhood hearing loss
- NICU stay of > 5 days or
  - ECMO
  - Assisted ventilation
  - Exposure to ototoxic medicines
  - Hyperbilirubinemia requiring exchange transfusion
- In utero infections, e.g.,
  - CMV
  - Herpes
  - Rubella
  - Syphilis
  - Toxoplasmosis
- Craniofacial anomalies, including involvement of the
  - Pinna
  - Ear canals
  - Ear tags and pits
  - Temporal bone anomalies
Physical findings associated with a syndrome, e.g., white forelock

Syndromes associated with hearing loss, e.g.,
- Neurofibromatosis
- Osteopetrosis
- Usher syndrome
- Waardenburg
- Alport
- Pendred
- Jervell
- Lange-Nielson

Neuro-degenerative disorders, e.g.,
- Hunter syndrome
- Sensory motor neuropathies
  - Friedreich ataxia
  - Charcot-Marie-Tooth syndrome

Culture positive post-natal infections associated with sensorineural hearing loss, e.g.,
- Confirmed bacterial and viral meningitis

Head trauma requiring hospitalization

Chemotherapy
Prior (2000 JCIH) recommendations for follow up at 6-month intervals of all NICU graduates (approximately 400,000 babies annually) placed an excessive burden on audiologists.

2007 JCIH shifts responsibility for surveillance of all infants to the primary care provider who will refer to audiologists as needed, e.g.,:
- Concerns or findings consistent with hearing loss
- Risk factors for delayed/late onset or progressive hearing loss

2007 JCIH recommends at least one audiologic referral for low risk infants by age 24 to 30 months.

Early and more frequent referral (every 6 months) to audiologists for risk factors associated with delayed onset/progressive hearing loss:
- Family history
- CMV
- ECMO therapy
- Potentially ototoxic chemotherapy (e.g., cisplatin)
- Neurodegenerative disorders
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Medical Errors for Audiology to Avoid

“An ounce of prevention is worth a pound of cure.”

Benjamin Franklin (1706-1790)
Medical Errors for Audiologists to Avoid: General Preventive Strategies and Steps (1)

- Awareness and education of the audiologist
  - Identify potential risks
  - Reduce risks by providing accepted standard of care
  - Practice within the scope of audiology
  - Remain up to date with professional developments through formal and informal continuing education
  - Know
    - State licensing laws
    - Code of ethics
    - Patient Bill of Rights
    - Policies and procedures of your institution
Make appropriate patient referrals

- Refer when you do not have knowledge, expertise, or credentials to provide a service the patient needs
- Verify licensure, certification, and other qualifications of professionals you refer patients to
- “When in doubt ... refer out!”

Maintain professional credentials in audiology, e.g.

- State license with required continuing education
- ABA certification with required continuation education
- ABA specialty certification
Effective communication with patient and family, e.g.,
- Establish positive relationship with patient and family
- Explain all test findings, treatment options, and treatment goals
- Fully disclose fees, billing schedules, etc
- Provide written warranties and warnings
- Secure patient signature on informed consent, release of information, and other documents
- Maintain adequate verbal and written communication with patient and family
Medical Errors for Audiologists to Avoid: General Preventive Strategies and Steps (4)

- Documentation, record keeping, and reporting
  - Written documentation in official medical or clinic records
  - Documentation is legible and thorough
  - Make corrections appropriately
  - Document all contacts with patient and family (face to face, telephone, email)
  - Document all contacts with professionals regarding the patient
  - Retain all correspondence between audiologist with or about the patient
  - Remember … if it’s not documented in writing, then it didn’t happen
Medical Errors for Audiologists to Avoid: General Preventive Strategies and Steps (5)

- Compliance with state and federal privacy and security regulations, e.g.,
  - Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Follow accepted policies for infection control, e.g.,
  - Compliance with Joint Commission
  - Institutional policies
- Equipment calibration
  - Periodic physical calibration with documentation
  - Daily biological checks
- Meet or exceed national standards of care for audiology
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- Guidelines for patient referral to physicians (usually an otolaryngologist)
- Questions and answers
Medical Errors for Audiologists to Avoid

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Medicine (9 questions), e.g.,

- Make sure your doctors know about every medicine you are taking
- Bring all of your medicines and supplements to your doctor visits
- Make sure your doctor knows about any allergies and adverse reactions you have had to medicines (or ear molds, electrode gel, etc)
- When your doctor writes prescription for you, make sure you can read it
- Ask for information about your medicine in terms you can understand …
20 Patient Tips to Help Prevent Medical Errors
Agency for Healthcare Research and Quality (www.ahrq.gov/)
The term “Doctor” is used for a health care provider … like an audiologist.

- Hospital Stays (2 questions)
- Surgery (2 questions)
- Other Steps
  - Speak up if you have questions or concerns
  - Make sure someone coordinates your care
  - Make sure your doctor has all important health information
  - Ask a family member or friend to go to appointments with you
  - Know that more is not always better (may be better off without treatment)
  - If you have a test, don’t assume no news is good news
  - Learn about your condition and treatments … ask your doctor and use other reliable sources
Medical Errors for Audiologists to Avoid

“I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing.”

Hippocratic Oath (c. 460-400 B.C.)

“...I will keep pure and holy both my life and art ...”
You’ve just stepped into the control room to begin a hearing assessment, and you see these audiometer settings. What’s wrong with this picture?
You’ve just stepped into the control room to begin an audiologic assessment, and you see this audiometer screen. What’s wrong with this picture?
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Retrocochlear Auditory Dysfunction: A High Risk Patient Population

85% of tumors in CPA are acoustic tumors

Another 10% are meningiomas

Chance of an acoustic tumor in a lifetime is 1/1000
Medical Errors for Audiologists to Avoid: Two Legal Cases Involving “Failure to Diagnose an Acoustic Tumor”

- Each of two plaintiffs (two separate cases) were adults with vestibular schwannoma
  - Tumors were suspected after second visit to otolaryngologist
  - MRI confirmed tumor
  - Tumors were removed surgically
  - Plaintiffs claimed hearing would have been spared with earlier diagnosis and/or tinnitus would have been avoided

- Defendants were general otolaryngologists
  - Conducted complete history and physical examination
  - Only performed (automated) screening audiometry
  - Questions: What is standard of care for physicians?
  - What are the guidelines for physicians for referral of patients for MRI to rule out vestibular schwannoma?
Detection of an Acoustic Tumor with MRI
Medical Errors for Audiologists to Avoid: AAO-HSN Criteria for Identifying Candidates for MRI to Rule Out Vestibular Schwannomas*

- Asymmetric pure-tone air-conduction sensorineural thresholds
  - Asymmetric SNHL of 25 dB or more at any two consecutive test frequencies
  - Unilateral or asymmetric hearing impairment by AAO-HNS criteria
    ✓ Average difference in air-conduction thresholds between ears of 15 dB or greater at 500, 1000, 2000, and 3000 Hz

- Asymmetric word recognition scores
  - Statistically significant difference in word recognition scores (WRS) between ears using Thornton & Raffin (1978) data and NU6 word lists

- Persistent unilateral or asymmetric tinnitus

* Same guidelines should be used by audiologists for referral of patients to otolaryngologists to rule out vestibular schwannomas
Tumor Growth Rate is Very Slow: “Growth Spurts” are Alleged by Plaintiffs

DISTRIBUTION OF ANNUAL GROWTH RATES FOR ACOUSTIC NEUROMAS (N = 50)

Source: Strasnick et al, 1994
Medical Errors for Audiologists to Avoid:  
**AAO-HSN Criteria for Audiologist Referral to a Physician**

- History of active drainage from the ear within the previous 6 months
- History of sudden or rapidly progressing hearing loss within the previous 6 months
- FDA rules for unilateral or asymmetrical hearing loss
  - Air-conduction PTA (500, 1000, 2000, 3000 Hz) difference of ≥ 15 dB
- Sudden or recent onset within the previous 6 months
- Bilateral hearing loss greater than 90 dB
- Complain of hearing impairment with positive history of:
  - Tuberculosis
  - Syphilis
  - HIV
  - Meniere’s disease
  - Auto-immune disease
  - Otosclerosis
  - Von Recklinghausen’s NF
  - Paget’s disease of the bone
Visible congenital or traumatic deformity of the ear
- History of active drainage from the ear within the previous 90 days
- History of sudden/rapidly progressing hearing loss within previous 90 days
- Acute or chronic dizziness
- Unilateral hearing loss of sudden/recent onset within the previous 90 days
- Audiometric air-bone gap $>\ 15$ dB at 500, 1000, and 2000 Hz
- Pain or discomfort in the ear
- Child under 18 years of age
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal

- NOTE: Cerumen, including cerumen impaction, is not a criterion as cerumen management is within the scope of practice of audiology in the state of Florida
Medical Errors for Audiologists to Avoid:
2015 Florida Statutes 468.1225

(4) A licensed audiologist who fits and sells hearing aids shall obtain the following medical clearance: If, upon inspection of the ear canal with an otoscope in the common procedure of fitting a hearing aid and upon interrogation of the client, there is any recent history of infection or any observable anomaly, the client shall be instructed to see a physician, and a hearing aid shall not be fitted until medical clearance is obtained for the condition noted. If, upon return, the condition noted is no longer observable and the client signs a medical waiver, a hearing aid may be fitted. Any person with a significant difference between bone conduction hearing and air


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(6) Unless otherwise indicated, each audiometric test conducted by a licensee or a certified audiology assistant in the fitting and selling of hearing aids shall be made in a testing room that has been certified by the department, or by an agent approved by the department, not to exceed the following sound pressure levels at the specified frequencies: 250Hz-40dB, 500Hz-40dB, 750Hz-40dB, 1000Hz-40dB, 1500Hz-42dB, 2000Hz-47dB, 3000Hz-52dB, 4000Hz-57dB, 6000Hz-62dB, and 8000Hz-67dB. An exception to this requirement shall be made in the case of a client who, after being provided written notice of the benefits and advantages of having the test conducted in a
“It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood, who strives valiantly; who errs and comes short again and again; because there is not effort without error and shortcomings.

... his place shall never be with those cold and timid souls who know neither victory nor defeat.”

Theodore Roosevelt (1858-1919)