The Hearing Journal Podcast - August 2022: Dr. Heather Malyuk, AuD

MAIN
00:44 Dr. D'Anne Rudden: How many of you took Music Appreciation in college? If you were like me, you probably took the class because you already "like" music. So, the thought of a class on "appreciation" of something you are already pretty happy with seems kind of like a fast track to an "Easy-A".

And one could argue that the appreciation of anything is inherently "un-rigorous." But as any of you that actually took that class learned pretty quickly, music appreciation is much more than liking or not liking music.

Throughout the course, what we were learning is that if we possessed the power to observe and listen to the world, we can interpret that world for ourselves.

I'm confident that we made no discoveries that were not already known by many before us, but we were being taught to believe in ourselves, as creators of knowledge and self-knowledge... above all.

We were learning a lesson about rigor, namely, that a course is as rigorous as you would like to make it, and that rigor that lives within a person is much more powerful than that, which we attempt to impose from the outside.

So, what if, "music appreciation" and the rigor of understanding the nuances of the listening experience, were the key to an Audiology's future?

This month on the podcast is a veritable cornucopia of delight as we dive into music audiology, with Dr. Heather Malyuk.

Dr. Malyuk is a musician and an audiologist who hails from Northeast Ohio but is internationally known as an expert clinician and public speaker in the field of hearing wellness.

Dr. Malyuk grew up in a musical family and since the age of two, she has been singing, playing piano, violin, fiddle, and guitar. In her early teens, she began teaching music, touring and recording.

She received an undergraduate degree in Music History and Literature from the University of Akron and went on to earn her Doctor of Audiology (AuD) degree from Kent State University.

To prove that she's no slack in any way she performs in this arena, she also served from 2013 to 2017 as the Clinical Director at Sensaphonics Hearing Conservation in Chicago, Illinois.

She was mentored by the one and only, Michael Santucci, who was also a trailblazer and luminary for Musicians Hearing Wellness. Dr. Malyuk’s time at Sensaphonics furthered her passion for music and audiology, propelling her to become one of the world's leading experts on hearing wellness for those who love the sound.

Dr. Malyuk, welcome to the Hearing Journal Podcast! I am so psyched to have you here.
Dr. Heather Malyuk: No, I'm psyched to be here. Thank you for having me.

Dr. D'Anne Rudden: I started dreaming a little bit about music audiology, and it sounds magical. I am not a musician, but can you explain to us what is the difference between music audiology and regular audiology?

Dr. Heather Malyuk: It depends on what we call regular audiology. Let's start there. When I think of regular audiology, the primary rule of audiology is just in our field. It is someone who is dispensing hearing aids, testing hearing, or maybe working with geriatric population for that kind of thing.

I view music audiology not necessarily as a separate field, but as a subspecialty. Like any other subspecialty, there are cochlear implant audiologists, pediatric specialists, and tinnitus specialists. It is learning a new set of best practices, a new literature-based, and an offshoot of hearing conservation.

So many audiologists took a noise class in college but know a little bit about fitting an ear plug. They aren't considering themselves hearing conservation audiologists, which we all should be. Music audiology stems from that, and it has some amplification components. It's sort of interesting in the past, I wanted to say maybe like five years, I've watched the social media audiology channels get pretty busy and there are all these conversations about the best practices.

If someone's not doing the best practices, let's shame them or say the things need to be done a certain way or whatever, yet I see so many "regular audiologists" practicing "music audiology" without following the best practices, without a testing hearing, without fit checking earplugs. There's a double standard in our field. It's a different set of skills and a different set of best practices.

Dr. D'Anne Rudden: Do you think it requires someone who is a musician, someone who is on the other side of things, as the receiver of care to truly understand the needs of a musician?

Dr. Heather Malyuk: I think it helps, but I absolutely do not think it's necessary because there are many musicians who are audiologists who could go out and take ear impressions for someone, and say, "Well, I'm a musician, so I'm going to relate to them better." They might do better with a music audiologist who's never picked up an instrument.

My background helps me build rapport with my patients. It helps me relate to them in a deeper way. There's a certain connection that we can make because of shared experiences within the industry because I came from the music industry into audiology, but that's not a unique story in audiology. How many friends and colleagues do we have who have a degree in music first, who is an audio engineer, or who still plays in their local orchestra? For anyone listening thinking, I'm not a musician, I'll never be able to do this. I don't think you have to be.

Dr. D'Anne Rudden: I'm going to change gears because I tried to do a little bit of research, and I learned more than I knew about music audiology so that I'm not showing up to the conversation thinking, Oh, well, I fit a couple of earplugs for people going to a concert, so I may know a thing or two.

What I loved about diving into this is that there is a distinction between music-induced hearing loss and noise-induced hearing loss. Your point about it comes from hearing conservation, which we think of noise and the damage it can do. We think of music as something that could be damaging, but very distinct. Can you talk a little bit about that?

Dr. Heather Malyuk: Sure! Yes, they're distinct in a few different facets. We can think about the actual stimulus like music versus noise. We think of noise as a kind of industrial factory work because of our regulations. The OSHA and NIOSH, or if you're in a different country, or province, or whatever you have in your area is based on industry noise.

Music has different acoustical properties, and different psychophysical properties. There's more frequency
correlation, the dynamic range is bigger, or we would call it a crest factor. I would call it dynamic range. It's simply a different stimulus, and there have been many authors throughout the decades, researchers, and specialists who have argued that the standards we have right now for noise-induced hearing loss really don't fit with the music.

However, we use them. I teach my patients the OSHA and NIOSH scales because it's the best we have right now, and clinically, the way we speak about it. Music audiologists speak very differently about loss caused by music than the loss caused by noise. Musicians, engineers, and people in the industry immediately noticed the change in language when they speak with the General Audiologist versus a Music Audiologist.

I would never look at a noise notch on an audiogram and say, "Well, that's a noise notch." I might explain to them that that's what it's called, but if they've never had noise exposure, then I would say it's sound exposure or music exposure.

The other thing in the music industry, is we look at music-induced hearing disorders more than we do with industrial work. With musicians, when looking at prevention and "music-induced hearing loss"—what disorders are we really trying to prevent? Tinnitus, hyperacusis, dysacusis, and diplacusis.

My whole point is that the language is different as well as the stimulus. It is not that industrial conservation doesn't talk about tinnitus—they do. It's part of education, but it can be a more emotional conversation with a musician.

10:41 Dr. D'Anne Rudden: That's not just their livelihood, it's often, you're speaking to their passion. There are not a lot of factory workers that are passionate about the things that they do. I could be wrong, but you definitely think when you’re speaking with a musician, you're going right to something that hits them right in the heart.

11:07 Dr. Heather Malyuk: Yes, you are. What’s interesting about that is the language that they give back to you. I’m actually pulling up a quote I received today from a new patient of mine who contacted me because he has music-induced hearing loss. I said to him, "What's going on with your hearing? Can you explain more to me?" He's in another country, and we're doing kind of back and forth, and he goes, "I'm missing the energy, determining pitch and resonance, and it's distracting from what I call free falling in love when he plays."

This is the type of language I hear on a daily basis from my patients. I think of music, as a musician, and my history in music, it's another language we all speak together another culture. It's very much an identity. Anything that comes in, and has an effect on that, like a hearing disorder, you are dealing with someone's identity. It's a very fragile thing to hold in your hands as an audiologist.

12:12 Dr. D'Anne Rudden: I want to circle back to a couple of terms that I'm going to call "Reg." Those of us regular audiologists, not music audiologists might be a bit more unfamiliar with dysacusis and diplacusis you said earlier. Talk about those specifically and how those types of phenomena may impact musicians' livelihood?

12:39 Dr. Heather Malyuk: Sure. Dysacusis is simply about distortion. When it's clinically present, I often hear patients say, "It sounds like a broken speaker." This could be across the board; it could be with certain tambours of instruments; it could be with certain frequency range and certain notes. There are some people who only perceive it at loud intensity inputs or high-intensity inputs. Diplacusis, if you look at an actual definition, you'd probably see something as hearing one pitch, but the ears perceive it differently or maybe the pitches split in an ear in one ear. I lump in what I call frequency smearing, as well. It's someone who is dealing with not being able to tune their instrument anymore because they can't tell pitches apart.

You can think of dysacusis as distortion and think of diplacusis as pitch perception issues. Both of those are pretty devastating. Whenever I think of distortion, I think of the worst case I ever saw a man who was a studio engineer, not very old, and his distortion had gotten so bad from sound injury, that he could no longer work. So, he had built a fantastic studio, a fantastic reputation, but he was so embarrassed. He was training a younger engineer to take over his studio, and he had to have him check all of his mixes to make sure they were okay. It was very meaningful
to him. We have a lot of counseling sessions together.

Sometimes, people can train. They are trained for these disorders, so they can resolve them. I have experienced diplacusis myself from a loud sound exposure. Mine—"resolved", which could have been my brain recalibrating to it. Maybe technically, I still have it, but I don't know it.

For others, it's really devastating. I have a couple of pianists I've been working with the past couple of years when the left hand of the piano has so low frequency that does not sound like it's in the same key as the right hand. Having to recalibrate the brain to that.

There is some literature out there about the amplification for diplacusis, even hearing aids. This is true of other people, not just musicians the emotional effect is pretty rough. It also affects their income. If they can't play, they can't work. Suddenly, you've got someone who has trained for decades of their lives to be a pro musician. They haven't focused on anything else, and now, they're looking at restarting their lives. It's a huge thing for them. From the emotional standpoint, it can be pretty devastating.

15:25 Dr. D'Anne Rudden: When you talk about recalibrating, are you doing therapies? You mentioned amplification, but I'm feeling that's sound awareness, or changing sound awareness. Are there other types of therapies that you're doing with them specifically to try to resolve these things?

15:45 Dr. Heather Malyuk: Yes. I was making up as I go because I don't have a lot of literature to help me here. There are some little research studies I'm working on right now to try add to the literature. I think all audiologists need to make little studies all the time, and to helping each other.

For example, with this one pianist I'm working with...often with musicians I will fit hearing aids for speech understanding if they need it, and then we will do something else musically. For this one person, for example, we use the 3D ME from ASI audio. He and I have been working on adding amplification where his hearing loss is. By using an electronic tuner to show him where the pitch is, to let him see it visually. We also did recordings that he plays back. We've been making slow progress. He's able to keep playing along with a lot of talking, a lot of experimenting with things...even different ways of playing different volumes. He's been making progress. Is it me? Is it anything that I'm helping him with? I don't know. It could be that I'm just getting him to keep playing his piano, and his brain is working it out.

What I am saying is that we don't have a lot of data for cases like this. I'm not going to say, "Oh, I've created something, and it's working for him." I don't know if that's the case. Many musicians with a disorder will stop playing. They'll get depressed, and they feel their instruments hurting them. The counseling or therapy component with the musician for anyone listening is to get them to not separate themselves from the thing that they love. It is helping them figure out how to work with it.

I like it when you're dealing with a disorder or an injury of some kind. As a musician, I feel like you're going through a divorce with your instrument. It's important to getting the person to reconnect on an emotional level. I've been with varying people experimenting with Diplacusis. I have seen success, but I don't know if it's anything I'm doing. It might be that I'm keeping them connected to the instrument.

18:02 Dr. D'Anne Rudden: But, you're having the conversation?

18:04 Dr. Heather Malyuk: Absolutely.

18:05 Dr. D'Anne Rudden: You are willing to be open, and to try things that maybe could help.

18:11 Dr. Heather Malyuk: All I say to these patients are, "Here are the two or three articles I have found." To which I often send to the patients. I'm one of these practitioners that often says, "Hey, I don't know. Let's try a couple of things together. Let's work it out. I'm willing to read the research and guide you."
I had someone call me a few weeks ago with an issue, and I said, "Can you please book three to four weeks out, so I have some time to read some articles?" I often send it to the patient, if it's a disorder that I'm not as familiar with, like misophonia. I find it's very helpful for the patient to be involved. The pianist who I mentioned happens to be a research nut, too. He's reading articles with me. He's very involved in the process. That's how I go about things. It's not for everyone. Not everybody has that personality, but it works for my clinic.

19:00 Dr. D'Anne Rudden: I'm just blown away. I wish everyone could see the passion in your eyes and in your face as you talk about this. It's so infectious. I wish everyone could see you right at this moment. I hope they hear it in your voice, but you clearly are someone who cares deeply about this, both from the standpoint of helping others and also forwarding this for the future. That's what I really appreciate about you, and how you show up in audiology.

19:40 Dr. Heather Malyuk: Oh, thank you.

19:41 Dr. D'Anne Rudden: I can't believe the 15 minutes have gone by so quickly. We're at the end of our main segment, but I hope everyone comes back to the Aftershow because we're going to dive in even deeper with Dr. Heather Malyuk. Thank you so much for being here.

19:59 Dr. Heather Malyuk: Thank you.

AFTERSHOW
00:44 Dr. D'Anne Rudden: We are back on The Hearing Journal Podcast Aftershow with Dr. Heather Malyuk. We're talking about all things—Music Audiology. I am still stunned at how quickly our time passed in the first segment, but I'm thrilled that we have even just a little bit more time to get into it all.

I want to get into the concept that you talked about in the first segment about how we refer others in our field, and how we should be doing more of that? There are experts, there are sub-specialties, and yet sometimes we have these perceptions that if I send my patient to someone else that's (a) I'll never see them again, and (b) I'm not smart enough, or there's some problem with me. Talk about your take on that. What do you notice?

01:52 Dr. Heather Malyuk: What you just said is so true. I noticed in audiology that there's this fear of losing patients, and I think it stems from the overarching business model. The way that it's been geared toward a very small percentage of the general population. We're fighting over a small percentage of the population, trying to get them in the door to purchase something from us, most of the time. I think that's a failure in audiology, but no one is necessarily responsible for it. It's an evolution that happened that we're having a hard time getting out of.

There is a statistic that 24 million people a year in the US go see an audiologist, and about 20% of them continue care. The 81% left without a solution, even though they went with an issue. Often people who talk about amplification use that statistic to say that the audiologist should have more options. When I look at the statistics, as a music audiologist, I think maybe someone had tinnitus, maybe one was a musician, or someone had a processing disorder that didn't get caught. The audiologist maybe didn't know how to handle it and said, "We'll come back when your hearing is worse." I hear that a lot from patients who come to see me.

We know there are 700 million ears in our country. It's about 350 million people—they all need us. There are about 18,000 audiologists in the country, but 11,000 work full-time, that's the statistic. My goodness! We've got more work than we can handle. The audiologists could lean into hearing conservation more. They could lean into tinnitus management more, instead of saying, "Well, you've got tinnitus. If it's not too bad, then we're not going to talk about it." That's what I hear so often. Someone will come and say, "I have tinnitus. I went to see an audiologist, and they told me it wasn't that bad." I said, "If it's bad to you, then it's bad. Let's handle it here." It was not a direct answer to your question because I don't really know why our field is that way.
It's disheartening to see there's not much collaborative care. I mentioned to you right before we started recording that I saw someone with a complicated hearing loss, and I have not fitted a hearing aid for that kind of hearing loss in a long time, so I referred them to an audiologist who's about a mile from me because I trusted him, and his skills.

I said to the patient, "I'm not well-equipped here. This is not my specialty. You're complicated for someone like me, so you need to go see this other audiologist, and you will be in fantastic hands." Some audiologists refer the patients to me when someone needs earplugs or when they're a musician. We should be doing more collaboration, and we can now in the era of telehealth, which is so cool. We should be working together instead of fighting over patients.

05:18 Dr. D' Anne Rudden: Yes, maybe caring together for someone. It doesn't have to be pulling in a speech-language pathologist. Two audiologists can actually work together outside of their own hospital system. That's a thing.

You brought up telehealth, so I'm not going to let that one go because I know all of us should be more familiar with the concept of telehealth since the pandemic. Thank you, COVID.

I also know that you utilize telehealth and teleaudiology as a part of your private practice. Talk about your history with teleaudiology because I have a feeling you've been doing this a lot longer than the rest of us. How has it changed how you work with patients?

06:15 Dr. Heather Malyuk: I've been dabbling in teleaudiology since 2015 or 2016. I wasn't doing it properly, to begin with. A lot of my patients are on tour. They're not always in town, they might need to see me, and they might have questions about things, so I Skype with people. I hop on a Skype call and talk about your tinnitus. I was then "fitting alternative amplification" and non-hearing aid devices, etc.

Interesting side notes, I recently for a lecture researched the history of telehealth. The first mention of telehealth was in 1879 in a The Lancet article. It blew me away! It was mentioned because the phone had been invented, and they were thinking about how can this be used to help people when we didn't have phones? It didn't pan out until the 1950s, and then they started using it.

What's amazing to me is that teleaudiology has been around for decades! This is not new. I'm the head of Audiology for a new telehealth company, and no one has invented this recently. I had a professor in college who had been doing it since the late '80s. Even just a phone call with someone is teleaudiology. We also have HIPAA compliance portal which I use a lot for tinnitus management follow-up.

With the new hearing aid software, we can do remote tweaks to hearing aids, which is really cool. I had a patient today who came in for tweaking, and she lives an hour away. I said, "You know what? I just learned how to do this over recently with the resound software. Next time, you stay home, let's try it together." She's like, "Okay, cool." What's great about it is that she plays the piano. She's a music director at a church, and I told her to set up her piano, so we could do it that way.

The other thing I noticed with telehealth is the type of patients I'm getting through the company I'm involved with. It's an employee benefit where I have been seeing a lot of young people in their 30s, 40s, and 50s in the workforce using headsets for more than five hours a day. They're dealing with intense auditory fatigue, and they're getting tinnitus. They have questions about their hearing, but they view audiologists as the hearing aid clinic. They're not going to step into it because they don't think it's for them, but when they are offered a benefit through their company to get on a teleaudiology call, they hop on and say, "Why are my ears ringing? Why at the end of the day are my ears so tired?" You teach them about a binaural summation, and by taking advantage of EQ or new software like Sonic Cloud. Their eyes lit up, and they had no idea it was an aspect of health care that I could learn something about.
These are all the different ways that I am using telehealth, and I think every clinic could because there are millions of people who need us whom we are not seeing.

09:18 Dr. D'Anne Rudden: I'm going to name the telehealth company that you are working with because I think if people are interested in seeing what is possible, then I want them to be directed appropriately. You're working with Tuned? Correct?

09:33 Dr. Heather Malyuk: Yes. I am working with Tuned. It is like a health benefit. I think a lot of audiologists shy away from telehealth because it comes with some younger populations. It comes with questions about non-hearing aid devices, and audiologists are not prepared for that.

One of my colleagues Dr. Laura Sinnott who I work with at Tuned. Anything on the site, she bets and puts through objective measures, real ear measures, subjective measures, and does a full-on. Here's one sheet for the audiologist, and we send devices for them to listen to. We call it a Listening Club.

It's just a way to get more education about caring for the new population who maybe has mild hearing loss or maybe no hearing loss. If they walk into a clinic, the audiologist would say, "Your hearing is beautiful." The patient would respond, "Why am I struggling then?"

10:31 Dr. D'Anne Rudden: Yes. What if we were like experts in all things audio?

10:39 Dr. Heather Malyuk: What a concept?

10:41 Dr. D'Anne Rudden: What a Concept! We're talking about people with their entire lifespan.

10:46 Dr. Heather Malyuk: Wow! I always say to the students that they are doctors of hearing, not doctors of hearing loss. We're more than that of other vestibular, but I'm not trying to cut anybody out. In my clinic, I always say, "You are doctors of hearing, not doctors of hearing loss." Often, they come to me for placement, and they don't know what to do to someone with normal hearing. You've got a gorgeous hearing to save. Teach them about all the ways they can save their hearing, and how vascular health plays a role. All these things that an audiologist learned. I remember learning all these in a four-year doctorate, but then we just don't use it. We only use like 10% of what we learned.

11:28 Dr. D'Anne Rudden: Yes. It also opens up auditory processing, which I have been trying to become more educated about because it is kind of the missing link. All of these things are beyond the ear, beyond hearing loss. We are just dealing with run-of-the-mill presbycusis. We've got a lot more things we can dive into in the world.

11:54 Dr. Heather Malyuk: And, to collaborate. I never used to see kids in my clinic, but I started recently, and I had an eight-year-old. I've started doing the acoustic pioneer APD screening. I loved it, she was my first one. It was cool.

I did the screening with her, and she loved it too. I got the results, and I told her mom that I want to collaborate with another audiologist here because I don't do APD, and I don't have time to learn it. It's just one of those things. We truly cannot specialize in everything. She's now going to work with an audiologist who is a specialist in it. She came to see me first because they learned about me from somewhere, and I was able to screen, and then pass it along. It's a beautiful thing when we can all work together.

12:43 Dr. D'Anne Rudden: Awesome. Well, let's educate a little more because I want to take advantage of your knowledge, and your time, and help us all level up a bit.

You fit in your monitors, and hearing protection, and that's a part of what you do to protect musicians hearing health. Let's get down to the nitty-gritty on taking ear impressions, and why it's so important to the best practices
of how we care for musicians' hearing health?

13:22 Dr. Heather Malyuk: It is. Although ear impressions are one of these things I think people see music audiologists as being like ear impression takers. There are certain things that are different about taking ear impressions like hearing protection, or in your monitors versus hearing aids. But there's more behind it.

Let me start with why do you want to take a look at ear impression? Why does that matter? With something like in your monitors, for example, when you want someone to use your monitors safely, you want them to be able to have control over their volume. The best way they're going to do that is by wearing both earpieces, having isolation, and an educational component being taught to do it. If the ear impression is not taken deeply with high viscosity material, and captured the largest diameters of their ear canal through movement, through playing their instrument, or whatever position they're going to be in. You might sacrifice attenuation. You might sacrifice the ability for them to have a good signal-to-noise ratio, and in return get hearing loss and disorders.

Why does this matter? Audiologists think they can take an ear impression as if it is not a big deal. A high viscosity material goes in and distends the ear canal. It's not like any other impression guns that have goopy material. It takes an exact impression which is fantastic for an acrylic hearing aid, but when you want something to go in and actually fit tightly, and not lose its seal, you've got to have something that goes in and pushes the canal to open a little bit.

For anything silicone, I have people bring in their instruments to play. I would highly recommend any audiologists to do that even if they need to be the last appointment of the day or the first appointment of the day. It's very important, especially for people who are using mouthpieces, like brass players when they can really get that on, to assure mouth movement. Sometimes you're at the mercy of an in-ear monitor company where they tell you to use a bite block. There really isn't good science behind that—it just happened. However, if you have a fit issue, the musician sends it back and says, "Well, this audiologist didn't follow your instructions." You'll probably get a call from the manufacturer and have a nasty word or two. The reasoning behind good impressions is you've got to have a good fit, otherwise, you could be sacrificing valuable hair cells.

15:58 Dr. D'Anne Rudden: You are right. Sometimes we think, Well, I can do that. I take impressions for IICs. How hard could it be? But, there's a Science to it.

16:09 Dr. Heather Malyuk: Sure. You can always fit check devices afterward because that gets lost here with audiologists. You can fit hearing protection on anyone, not just musicians. You can do a quick REAT measurement in the clinic or take the cables out of the ears and do the same thing.

I just finished a study with Alex Mabus at the University of Akron looking at in-ear monitor isolation values. We hopped in the sound booth, did a real-ear-attenuation-at-threshold or REAT measurement with fresh noise masking in the opposite ear, and took thresholds without and with the in-ear to see what isolation we were getting. A couple of the companies had zero DB isolation in the low frequencies. The audiologists take impressions for these thinking that their safety devices. The output of these is over 143 DBA, yet we're fitting and giving these to musicians, and then say you've worked with such Rockstar. If you didn't educate and didn't do your best practices, then that person will get tinnitus down the road that you may have contributed to.

17:15 Dr. D'Anne Rudden: Wow. That hits home.

17:18 Dr. Heather Malyuk: Yes, but how often do we see an audiologist get on a Facebook group, and say, "Oh, which in your monitor company is best?" The people would just randomly put the names of companies down, but where's the care here?

17:31 Dr. D'Anne Rudden: I'm speechless because you just hit it. You hit it, and there is no argument in my world, in any shape or form. We've got to work better together. We've got to learn more and be willing to be vulnerable to what we don't know.
Dr. Heather Malyuk: Yes.

Dr. D'Anne Rudden: I, for sure have been practicing for a long time, and there is so much that I don't know.

Dr. Heather Malyuk: Oh, my gosh! Same. I will say about music audiologists, that there are very few of us, but I’m so happy to do little podcasts like this or wherever we are. There's truly no elitism in the music industry side of Audiology. We all talk to people all the time. If you want help, if you want some advice or anything, truly call on us.

I just had a call with a buddy music audiologist this afternoon, and she said to me, "I don't want to do wrong to my patients. What are some things I can do?" The wonderful thing is in the American Academy of Audiology put out a clinical consensus document. I'm one of the authors on that. You can print it out, and go step by step to make sure you're trying your best—that's all you need to do. Many audiologists don't do hearing tests, but the newest statistic is that 63% don't even do a hearing test on a musician when they come to the clinic. It's just impressions. Start there, start doing a test. Have a baseline.

Dr. D'Anne Rudden: Educating them as to why they need to have that.

Dr. Heather Malyuk: Correct. It doesn't have to be complicated. It doesn't have to be going out fitting in-ear monitors, and working with a wireless' system. It doesn't have to be overwhelming. When someone steps into your clinic, just love on them.

Dr. D'Anne Rudden: I feel like it was a mic drop, right there. To love on them, then mic dropped, and we're done. I am so fascinated by what you do, and so privileged to have had some time to chat with you, to learn more, and to feel even more excited about the subspecialty of music audiology. I hope that you keep talking out there and putting out more great information because we could all stand to learn a little more from you. Thank you.

Dr. Heather Malyuk: Thank you for having me.

20:00 END