DEAFNESS FORUM AUSTRALIA

oneinsix

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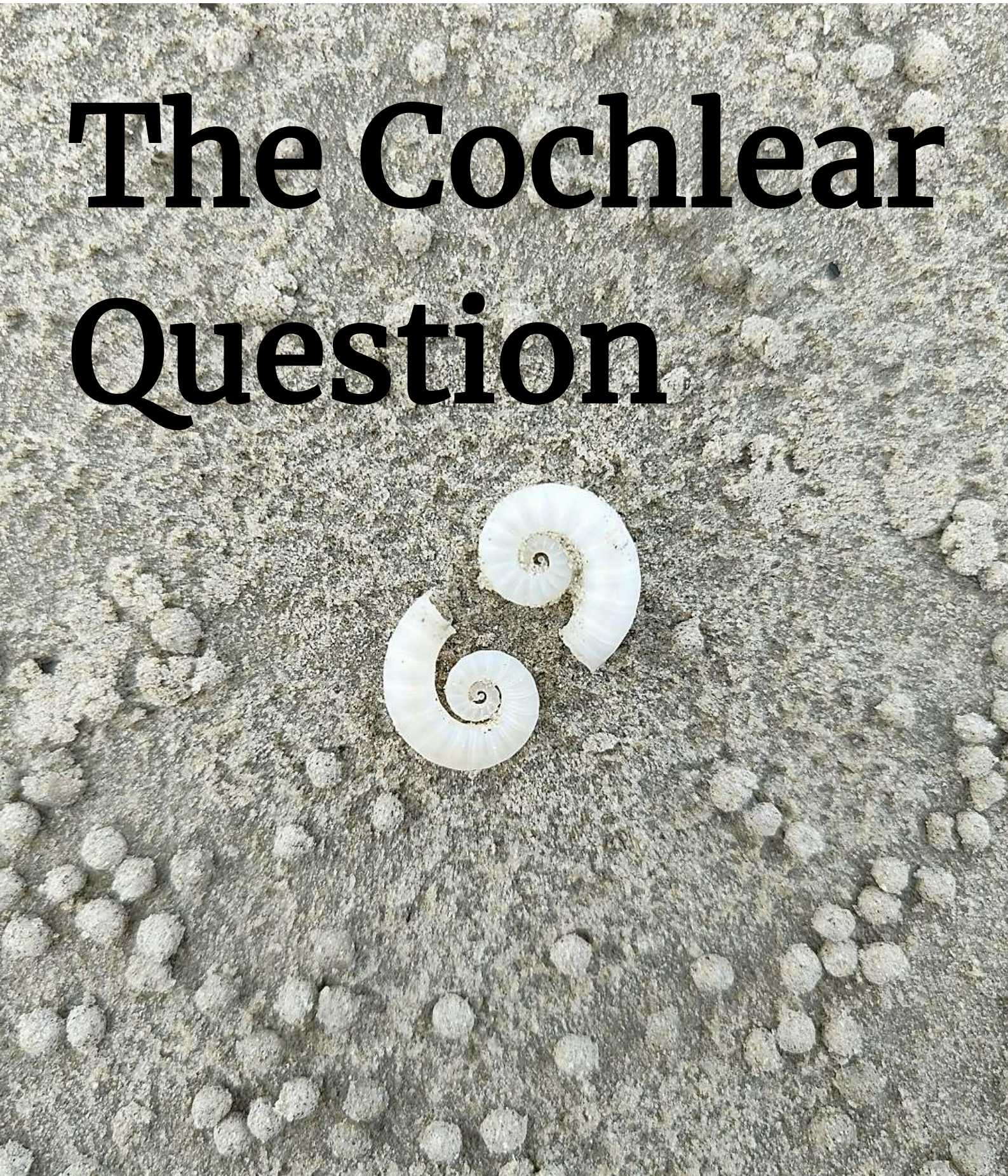
The Cochlear Question



For many, the term *hearing loss* suggests a deficit. Something broken that needs fixing. But what if deafness was simply a different way of experiencing the world? And what if the solutions we assume are straightforward, like cochlear implants, were far more complex than they seem?

I understand these questions intimately. I was once a successful STEM educator, thriving in classrooms full of students, until I lost my hearing as an adult. Suddenly, I could no longer communicate as I once had. Conversations became exhausting. I struggled to keep up at work and felt increasingly disconnected from the world around me. At first, I relied on hearing aids, but as my hearing loss progressed, they were no longer fit for purpose.

What I didn't realise and what many adults in my position don't know is that I was eligible for a cochlear implant years before I was ever referred for one. Unlike children diagnosed with hearing loss, whose families are guided through structured referral pathways, adults with progressive hearing loss are often left without clear direction. Many health professionals, including GPs and audiologists, didn't fully understand cochlear implant candidacy. As a result, I was reliant on hearing aids long after they stopped being effective, unaware that I had other options. This systemic issue leaves many struggling unnecessarily - isolated, frustrated, and unable to fully participate in work, relationships, and everyday life.

When I finally received a cochlear implant, the impact was life changing. I could hear sounds I had long forgotten, such as the clock ticking, the birds at dawn, and the tap drip. I was able to rejoin the workforce and my social networks.

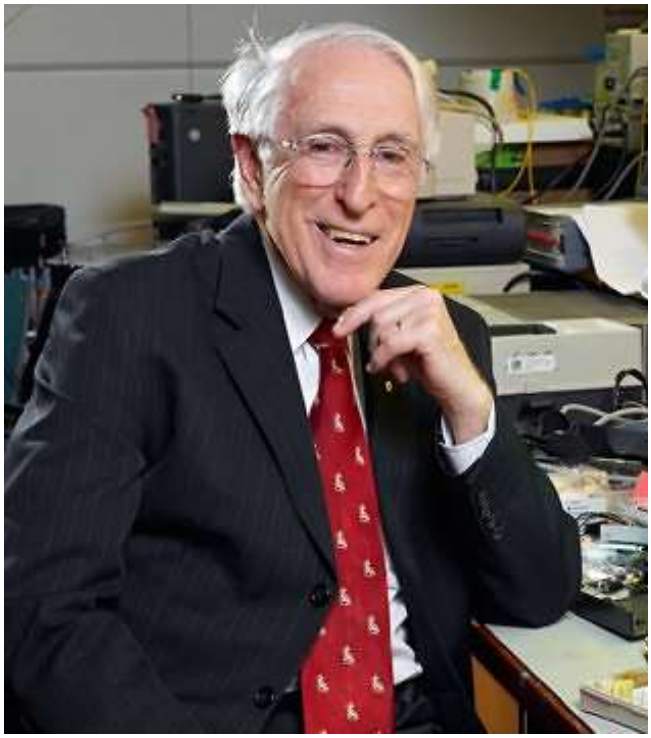
For me, technology alone wasn't the answer. Learning Auslan opened an entirely new way of connecting - a language that didn't rely on sound but on vision, expression, and community.

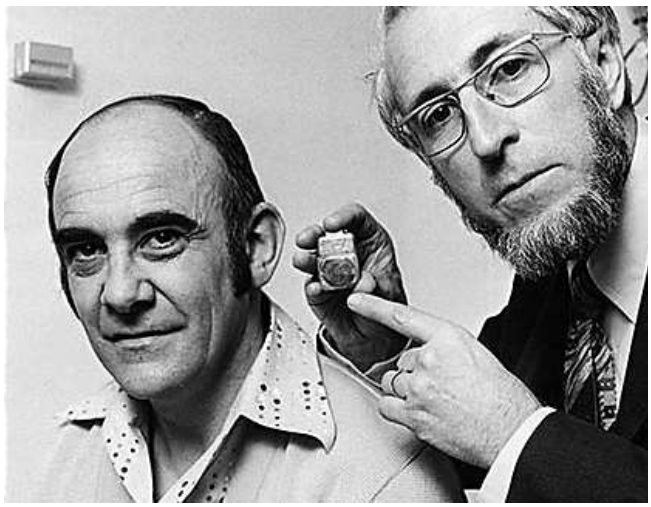
My experience highlights a fundamental truth: deafness is not a singular experience. It exists on a spectrum, shaped by personal choices, cultural identity, and evolving technologies. I have lived on both sides of *The Cochlear Question* as a hearing person, as a newly Deaf adult, and now as someone who embraces both spoken and sign language. I know how complex and deeply personal this decision was as a deaf adult, and I can only imagine how much more difficult it is for parents of deaf children. The conversation is never as simple as ''fixing'' hearing or choosing one world over another.

As this edition of *One in Six* explores *The Cochlear Question*, we invite readers to consider the complexity of these decisions. For parents of deaf children, adults navigating their hearing journeys, and society at large, the conversation about cochlear implants is not just about sound. It's about identity, access, autonomy, and ensuring no one is left behind. It is about the right to choose your own path and shape your own future.

Rae Walker
Chair, Deafness Forum Australia

How Graeme Clark's Innovation Changed the World.





Graeme Clark is an exceptional Australian professor and otolaryngologist who spent most of his life researching a way to help his deaf father and others suffering from profound hearing loss gain a better connection to those around them. His invention, the cochlear implant, has changed the lives of people around the world, with more than half of them being children.

Graeme Clark was born in 1935, in Camden, New South Wales, Australia. His father was a pharmacist with hearing loss, which initially inspired Clark to study the ear. Clark observed the difficulty his father had communicating with people who came into his pharmacy, often having to ask people to speak up.

At just 10 years old, Clark told his local minister that he wanted to be an ear doctor when he grew up. In 1957, he earned his medical degree from the University of Sydney. That year, the Faculty of Medicine at the University of Sydney was celebrating its centenary, having been formally established in 1856 - the medical program at that time was a six-year course. A fellowship followed at the Royal College of Surgeons, London. He returned to Australia and held the position of senior ENT surgeon from 1963 to 1966.

Clark then began researching the possibility of an electronic, implantable hearing device in the hopes of restoring hearing to deaf individuals. He returned to study and completed his PhD thesis at the University of Sydney on "Middle Ear & Neural Mechanisms in Hearing and in the Management of Deafness."

From 1970 to 2004, he held the William Gibson Chair of Otolaryngology at the University of Melbourne. In 1999, he was appointed laureate professor at the University of Melbourne.

Graeme Clark with Cochlear's first multi-channel Nucleus implant, which he inserted in a patient in 1982.

Cochlear implant

By the mid-1960s, Graeme Clark's desire to help deaf individuals became a reality. He read a scientific paper by Dr. F. Blair Simmons, Professor of Surgery and Otolaryngology, describing how the deaf could hear via electrical stimulation. However, understanding speech remained a barrier. Clark gave up his senior surgical position to commit his life to research in auditory brain science, including speech recognition.

In 1967, Graeme Clark began exploring the potential for an electronic, implantable hearing device, while acknowledging the importance of safety. Many people were concerned about the risk of meningitis, tissue damage, and other hazards associated with placing a current in the human body. Clark was challenged by many of his colleagues, who argued that his idea was futile, his research was fabricated, and that operating on the inner ear would be reckless. Clark proved them wrong.

One fundamental moment in his research came when he was at the beach, playing with a shell that resembled the structure of the cochlea. He realised that a piece of grass, if flexible at the tip, could traverse the cochlea's turns, just as an electrode would need to do. The first bionic ear prototype was implanted in 1978 after Clark and his team discovered how speech could be coded using multiple electrical signals. The following year, he received a grant to fund commercial development, and by 1982, he had completed the first successful clinical trial. Cochlear implants were approved for adult patients in 1985 and for children 17 and under in 1990.

Impact and legacy

When hearing fades for individuals, so does the world around them. Although Clark's father had a major impact on his aspirations in life, he was primarily motivated by deaf children since they had their entire lives ahead of them.

A generation ago, deaf individuals had no hope of ever hearing again. Thanks to Graeme Clark and the cochlear implant, deaf individuals, particularly children, now have a much better outlook on life. Graeme Clark's desire to help the deaf and his dedication to finding a way to restore their hearing has changed the lives of thousands of people around the world.

The cochlear implant is recognised as a landmark discovery in medical science. His perseverance and dedication did not end with the first successful implant, as he continued researching to improve it. He has also been an inspiration to many, paving the way for other researchers to continue seeking ways to bring hope and restore life to those with other neurosensory disorders.

[From Silence to Sound: Graeme Clark's Cochlear Implant]

Sue Walters was the first person in New South Wales to receive cochlear implant surgery, performed by Professor Gibson.

“It was so brave of Bill to go ahead, I think, with this surgery, because there was a lot of opposition. So, I'm eternally grateful to you for that.”

At the age of 22, Sue lost all hearing after a case of meningitis.

“I didn't even know anyone who was deaf, and my conversations were all written on notepads. I thought, well, why not try the implant? I thought it had to be a lot better than what I had, which was nothing except loud head noise,” she said.

Pioneering surgeon, Professor Bill Gibson AO, was running a program for multichannel cochlear implants at the time, when Sue volunteered to be the first recipient.

The surgery at Royal Prince Alfred Hospital, Sydney took many hours and was completed with Dr Barry Scrivener AM, Australia's first specialist otologist, and nurse Denise Lithgow.

With the implant’s success, Sue also became the first deaf person in the world to make a phone call using a cochlear implant when she called Professor Gibson and had a conversation.

In 2024, Royal Prince Alfred Hospital celebrated 40 years since Sue Walter’s surgery.

It was also an opportunity to recognise Dr Halit Sanli, cochlear implant biomedical engineer, who created protocols and enabled accurate physiological testing during his thirty-year career.

“Here at Royal Prince Alfred, we stand on the shoulders of giants, and we continue this pioneering cochlear implant work,” said Clinical Professor Catherine Berman, current ENT surgeon.

Sue Walters has become an advocate and is currently the president of CICADA, a charity and volunteer organisation dedicated to supporting hearing-impaired Australians who use cochlear implants.

In Australia and overseas, the advent of cochlear implants sparked strong opposition, public demonstrations, and heated debates within the Deaf community.

The development of cochlear implants began in the 1950s and 1960s, but it wasn't until the 1970s and 1980s that they started to gain traction as a viable treatment option. Many in the scientific community initially were sceptical about their effectiveness, with some experts doubting that they could restore useful hearing. As technology improved and more successful outcomes were reported, the focus shifted from technical feasibility to ethical and cultural concerns.

The Deaf Community's Perspective

A significant source of opposition came from within the Deaf community. The introduction of cochlear implants was seen as a threat to this identity, with some arguing that it could lead to the erosion of Deaf culture and the decline of sign language. The term "ethnocide" was even used to describe the potential impact of widespread cochlear implantation on Deaf culture.

Public Demonstrations and Debate

In the United States, opposition to cochlear implants became particularly vocal in the 1990s. Public demonstrations and debates highlighted the concerns of the Deaf community, with many arguing that cochlear implants were not only unnecessary but also unethical. The World Federation of the Deaf and other organisations actively campaigned against the medicalisation of deafness, advocating for the preservation of Deaf culture and the use of sign language. Similar debates took place in Australia, with Deaf organisations in Australia expressing opposition to cochlear implantation, especially in children. The concern was not just about the potential impact on Deaf culture but also about the rights of children to make their own decisions on their bodies and identities.

Evolution of Perspectives

Over time, some initial concerns have dissipated. Many in the Deaf community now view cochlear implants as a tool that can be used to access the hearing world without necessarily eroding Deaf identity. However, the debate remains complex, with ongoing discussions about the balance between preserving cultural identity and providing access to auditory experiences.

The National Association of the Deaf, a prominent organisation in the United States that advocates for the rights of Deaf people, had expressed strong opposition to cochlear implants, particularly for children, citing ethical and scientific concerns. It now views cochlear implants as a tool for communication but emphasises that they are not a cure for deafness. It supports parents' rights to make informed decisions about cochlear implants while advocating for comprehensive support services, including visual language development.

The history of cochlear implants is complex and multifaceted, reflecting both technology's transformative potential and cultural identity's importance. It is crucial to respect the diverse perspectives within the Deaf community and to ensure that everyone has access to the information and support they need to make informed decisions about their hearing health.

Today, the narrative around cochlear implants is evolving to be more inclusive and nuanced.

The Cochlear Question

This Essay was originally published as The Cochlear Question on Aeon.

As the hearing parent of a deaf baby, Abi Stephenson was confronted with an agonising decision: should I give her an implant to help her hear?

Abi writes, "I knew my daughter could hear: not just because she loved music, but because she had perfect rhythm." She punched her fists in the air like a human metronome and brought a doughy heel to the ground precisely on each down beat.

So when she didn't form consonants at the prescribed time, I made a deliberate choice to ignore it. It didn't occur to me that deafness might not be an either/or binary, and that certain vibrations and pitches – the down beat of a Wiggles song, say – could be apprehended, while other subtle speech sounds might be snatched out of a sentence. So, it was a couple of months after her first birthday when we discovered our Botticellian baby had mild hearing loss, and two years after that when she lost almost all of her remaining hearing entirely.

Like most hearing parents of deaf children, my first close relationship with a deaf person was with my child. Despite a relatively broad cultural education, I knew next to nothing about hearing loss or Deaf culture. What little I had absorbed was an incomplete and almost entirely inaccurate patchwork of pop culture snippets – the mother's horror when her baby doesn't react to the fire engine's siren in the film *Mr Holland's Opus* (1995); Beethoven's struggle to hear the premiere of his Ninth Symphony; the lift scene in the film *Jerry Maguire* (1996); Quasimodo's apparent industrial deafness; and, worst of all, the appalling memory of my university housemate imitating a deaf accent for laughs. This bleak landscape of ignorance and misinformation is often the lookout from which parents begin making decisions, as D/deaf critics have rightly pointed out. But although I began educating myself belatedly, it didn't take long for the calcified layers of assumptions and approximations to disintegrate. Chief among them was the unquestioned belief that hearing loss, for an early deafened person, is even a loss at all.

In a recent interview with the news site Truthout, the Deaf philosopher Teresa Blankmeyer Burke argues that the language of tragic loss seems particularly ill-fitting for a deaf child: 'Some of us do not share this experience [of loss] at all, but only know what it is to be in our bodies as they have always existed.' News headlines about childhood deafness and hearing technology often slip into the 'from deaf tragedy to hearing miracle' narrative, missing this crucial point about self-concept entirely.

For many parents, this has intuitive clarity too. Absolutely smitten with my baby's many tiny perfections, I had a stubborn sense that her deafness was not a pit she had fallen into, but just one of many extraordinary discoveries about her that I was making every day. It was a comforting certainty to cling to in the wee hours, when I was beset by a looping reel of terrors about the shadowy obstacles she would undeservedly face, and that I would be impotent to protect her from. Even accepting the reality of life's vicissitudes, most of us hope for a relatively smooth course for our children - unfettered sensorial access to the world being at the bottom of a hierarchy of wishes, and fundamental to the rest. The idea that so much was arbitrarily denied a baby so new to the world was, at times, almost impossible to withstand.

From the moment of discovery of their child's hearing loss, a parent finds themselves not only unmoored by circumstance, but adrift in a tempestuous cultural debate. While not exactly a global topic of dinner-table conversation, the battle for the identities and futures of deaf children is fiercely fought. Arguments drift down from academic journals to social media, where many new parents are washed ashore in the absence of a definitive source of information about their child's future. Trying to reconcile the contradictory advice given by a new cast of characters – GPs, paediatricians, ENTs, audiologists, speech therapists, disability insurance advisers, interested observers – I took to Instagram to find some clarity in authentic, lived experience. Starting with a few anodyne hashtags, I initially found a bunch of mothers (differing in every respect, but always, always mothers) sharing inspiring stories about the lives of their D/deaf and hard-of-hearing children. Unlike the normative 'blend-in-or-else' dictats of my 1980s childhood, this new world was a sea of diversity – confident smiles, 'Deaf Gain' wallpapers, kids signing in slang, and proudly visible, *macaron*-coloured hearing technology. I was buoyed to be a part of this extraordinary community and lifted yet again when my daughter's metallic pink hearing aids arrived. She no longer had to jam her Wiggles keyboard to her ear to hear the music, and all of my hesitations and ambivalences were converted into happy certainties.

But the tone of my feed shifted quite quickly. Gone were the mothers meticulously crafting Spider-Man hearing aid covers and Peppa Pig cochlear implant cases, and in their place were reels and posts that had a more political flavour. We had begun working with a speech-therapist using the LSL (Listening and Spoken Language) or AVT (Auditory-Verbal Therapy) approach, which aims to ensure children don't miss the verbal data bombardment they need in early childhood to develop spoken language. This is essentially about optimising hearing technology – hearing aids or cochlear implants (CI) – so that a deaf or hard-of-hearing child can access the full range of speech sounds, and then using play-based games and activities that focus on listening and speaking (very similarly to traditional speech therapy for hearing children with speech delay). Historically, some exponents of this approach discouraged the use of sign, but not these days, and certainly not in my experience. But they do prioritise spoken language in the early years, recognising that sign languages can be tricky for hearing adults to attain *in the necessary proficiency and syntactic complexity* in the time a child needs them to.

'Switch-on porn' spoke of a normative desire to fix something that was not in their view broken.

But what I had experienced as a genuinely caring, evidence-based and pragmatic attempt to empower deaf children and give them the widest set of options had been singled out as an example of 'audism' by influential Deaf and Deaf-adjacent critics – a sinister assimilationist model with paternalistic colonial overtones and a complicated history. Critics argued that Alexander Graham Bell – the founding father of what is still one of the major LSL programs in the

USA – was not so much a benevolent supporter of deaf children, but a eugenicist and 'oralist' with grotesque views about deafness on a self-appointed mission to eradicate sign languages.

There were traumatised adults distancing themselves from their parents entirely for forcing them, despite great difficulty, to listen, speak and lip-read. The wet-eyed social media phenomenon of babies with hearing aids and CIs being filmed hearing sound for the first time was disparagingly called 'inspiration porn' or 'switch-on porn' – the vulgar showboating of an arrogant hearing class determined to convert their perfectly deaf children into imperfectly hearing ones.

Not only was it inaccurate (no hearing technology makes hearing easy or natural for deaf people), but it spoke of – at best – a normative desire to correct or fix something that was not in their view broken – only different. There were videos about so-called 'language deprivation'– when a child is effectively linguistically starved because parents and providers incorrectly assume their aids or implants give them sufficient access to the subtle speech sounds around them (it is unarguable that only signed languages are easily accessible in *all* situations). Through this lens, the speech therapy games we parents were playing weren't cute or supportive – they were the pastel-coloured attempts of a hegemonic hearing overclass to convert their happy deaf children into unhappy hearing ones.

On one level, I was very moved by these arguments, and it seemed fair to lend more weight to the opinions of those with lived experience of deafness than to those without. I began to wonder if I was compelling my non-consenting deaf daughter to 'pass' imperfectly and at great personal cost in a hearing world, rather than empowering her to flourish easily by her own lights in the Deaf one. While my husband was able to contextualise the Deaf culture proponents as a small but noisy minority, I became ever more anxious and fixated on their arguments. And when my daughter progressively lost what remained of her hearing and cochlear implants were proposed, my wheels began to spin in the ethical mud.

Contrary to what many imagine, cochlear implants are not just fancy hearing aids. A hearing aid amplifies sound using the existing mechanisms and pathways of the ear, but the clarity of speech can tail off once hearing loss is in the severe to profound ranges, with things sounding a lot louder, but not necessarily clearer.

A cochlear implant, by contrast, is an electronic device that creates the sensation of sound by bypassing the inner ear entirely and stimulating the auditory nerve with a set of electrodes. There is an internal component, with a magnet, a receiver and an electrode array that spirals around the cochlear (a biomimetic design inspired by a strand of grass curling around a shell's spiral) and an external component with a microphone to pick up sound, together with a processor to encode it.

While hearing aids are relatively speaking uncontroversial, the internal portion of a cochlear implant requires surgery, which of course entails risk. There is a significant period of rehabilitation as the brain learns to make sense of a totally new type of electronic input, and the external processor itself is slightly larger and more visible on the head. Deaf adults can of

course make this decision for themselves, but increasingly the recommendations are for parents to implant their children in infancy as this generally produces the best outcomes. Even in the past few years, the age of recommended implantation for severely to profoundly deaf babies has dropped to nine months. Their astonishing success rate in aiding the understanding of speech has meant a new generation of deaf adults are emerging who do not use sign language in the way they would have done only a few decades earlier.

While for some this is one of the great advances of modern medicine, for others it is a deeply worrying evolution. The new technological possibilities and their swift adoption have understandably caused widespread consternation in Deaf communities globally. The future of their complex and rich visual languages is endangered by the developments, as well as the communities and ways of life that stem from them. These are genuine and valid concerns, and ones that are rarely addressed in moderate, bipartisan terms. There are also broader ethical concerns raised by surgical intervention of this kind on children whose lives are not threatened, and who are not in a position to request or consent.

Why does society want to frame deafness as a medical abnormality, rather than a sensory difference?

Why is the case of cochlear implantation so different from other parallel medical situations that a parent has to navigate? Why is it controversial in the way that an artificial limb or cornea transplant is not? Unlike the parent of a child with vision loss who pursues laser surgery in an uncomplicated way, the parent of a deaf child is implicated in a much larger politico-cultural struggle. To my outsider's eyes, a lot of this was not the tangled snarl of identity politics but seemed largely to stem from a fundamental disagreement over the metaphysics of deafness.

Whereas the hearing world, hand in hand with the medical one, has conceptualised deafness as a sensory deficit that can be relatively effectively 'restored' – albeit partially, temporarily and imperfectly – parts of the Deaf-World argue that this approach demonstrates an outdated pathologisation of difference.

Happily, we live in an era where neuro- and other divergences are no longer seen as aberrations, but rather as part of a welcome heterogeneity of biology and perspective. Deaf critics and disability theorists thus pose the question: why does society want to frame deafness as a medical abnormality, rather than a sensory difference? In their view, the medical model is the outward face of a punishing normative tyranny. Any deviations from the standard hearing model are ushered – either gently, kindly or violently, oppressively – back to the midline. Like the demented 'benevolent' logic of gay conversion therapies, even the so-called good intentions of parents and bystanders (as anti-racist campaigners have long argued) could perpetuate discrimination just as easily as the malign ones.

The psychologist Harlan Lane went even further, and argued that deafness is actually more akin to an ethnicity than to a disability. If the same rights and protections apply as apply to other cultural, religious and racial minorities, then the entire therapeutic landscape looks incredibly sinister. At its mildest, the mainstream model of improving a deaf child's hearing becomes the enforced alteration of a member of a cultural and linguistic minority. And at worst, like with the cochlear implant, it is not only an invasive surgery that endangers and irrevocably changes a child, but also threatens the extinction of an imperilled language and the erasure of a cultural group.

Harlan Lane likens the hearing parents of a deaf child to parents who adopt a child from a different racial background, arguing they have a similar responsibility to uphold the cultural mores and traditions of their child's ethnic group. Tom Humphries, the Deaf culturalist who coined the term 'audism', has a deeply cynical view of hearing parents, positioning them simply as legal

'owners' of their deaf children, many of whom eventually 'migrate' back to what he strongly implies is their true cultural home. He explicitly likens this pattern of ownership and return to that of African American slaves or Latin American populations under colonial rule.

As a parent, this line of argumentation is jarring, to say the least. While at the extreme end of the debate, many Deaf critics have joined Humphries in arguing vociferously that hearing parents cannot be trusted to give informed consent on behalf of their child – surgical or otherwise.

With these sorts of arguments informing a good deal of the public discourse around deafness, what is the hearing parent of a deaf child to think? And more importantly – how are they to act? The underlying assumption of CI critics seems to be that the neutral stance is to do nothing, and that any intervention at all requires moral licence. But doing nothing isn't always neutral – most obviously in medical scenarios – and can be a malign act of withholding. There is a genuine moral dilemma here, because a parent must give informed consent one way or the other. Not acting while the child is young is potentially equally culpable.

If the anti-CI arguments are not convincing, then it's possible that their proponents have indirectly harmed the potential development of some children and their ability to flourish in the widest set of circumstances. Alongside the passionate critiques of Lane, Humphries and others, there is also considerable weight lent to the academics arguing quite the opposite – that denying a deaf child a cochlear implant is neglect. In the Western world, where early paediatric implantation in severely to profoundly deaf children is considered to be the 'standard of care', making the choice not to implant could be seen as a relatively radical decision to withhold a mainstream technology that most of a deaf child's peers will be using.

And what are the ethics of withholding when that technology has safety implications, and could enable the deaf child-then-adult to apprehend dangers to themselves or others? Footsteps in the dark, a window breaking, a car approaching on a quiet street, a fire alarm, a scream in the shopping centre, a baby crying in the next room – none would be audible to my daughter without an implant. And from a feminist perspective she might need, as women always have done, a loud voice to shout, or to argue with her healthcare providers, or to advocate for herself in an emergency. The implant would provide her with a clearer pathway to power and impact in the world, and to positions of influence where she will be underrepresented both as a woman, and as a deaf person.

To refuse her a CI on the basis of Lane et al's arguments would be to use the future of an individual as a blunt weapon to achieve benefit for the broader Deaf community. Now, this could open me up to the charge that it would be individualistic and anti-solidaristic to prioritise my daughter's personal future at all expense.

But here there also seems a persuasive argument that what benefits the deaf individual is, when multiplied, what raises the collective. It strikes me that the more deaf people can participate actively in positions of power and influence (and, as much as we may wish it wouldn't, this entails having considerable proficiency in the primary mode of communication), the better the outcome for deaf people en masse. In strictly utilitarian

terms, a successful implant hugely expands the number of people a deaf person can communicate with – amplifying their perspective and connecting them in the hearing world, while not precluding their ability to communicate solely using the richness of sign language/s in the Deaf one.

For me, it is a version of the dilemma that plagues any other movement for systemic social justice. In my experience, this debate often arises in discussions among women too – there is a tension between our responsibility to unpick larger hegemonies and create opportunities for change, and our attempts to personally flourish within the world as it *is now*, however flawed. But there is a way to have a measure of both.

> The fork in the road in front of us was not only binary, but time-critical.

I've begun to think of this as a sort of dialectical pragmatism – a way of holding two seemingly contradictory things in mind and moving forward in a way that works. Ultimately, I think it's possible to want to create the conditions for the best life possible for our daughter, while simultaneously remaining conscious that she is having to bend painfully to fit a system that doesn't speak for her like it should. With so many strident *either/or*s bouncing back and forth, thinking more dialectically can bring clarity in other aspects of the debate too. We can then hold *both* that her deafness is perfect and does not need to be 'fixed', *and* that she might benefit from a helpful intervention just as I have from things like glasses, medications or surgeries – all of which do not ultimately alter my dignity or identity. We can say *both* that there is justifiable concern from Deaf adults who wish to safeguard their communities and languages from the evolution of hearing technology, *and* that there is a new generation of deaf voices with cochlear implants who haven't entered the debate and will have their own perspectives. We can maintain *both* a dislike for the unnuanced tech-utopian view of CIs as a miraculous cure for a tragic affliction, *and* that they have proven to be an extraordinary, life-changing daily support to people worldwide. It's OK to acknowledge *both* that the hearing perspective is a muddy lens through which we view the world (and which leads us to valorise auditory pleasures in a way D/deaf people don't), *and* that it is OK to want to give one's child the qualia of soaring strings and voices in the final movement of Beethoven's Ninth.

But the fork in the road in front of us was not only binary, but time critical. Forced into a nauseating either/or decision that would torment even the most level-headed parent, my husband and I eventually arrived at a bald piece of logic that wouldn't burn away with challenge: the idea that there was only one option that contained a kernel of both options within it. Only one that really left her with any kind of agency. If she wishes to, in adulthood our daughter can have her cochlear implant removed and fully immerse herself in what is so clearly the rich, joyous, fulfilling Deaf-World.

We plan to learn Auslan (Australian Sign Language) as a family, so that she will have an easy fluency and cultural connection with a community that will, I'm sure, become hugely important to her. But if she wishes otherwise, without full access to spoken English in the critical development window of her early years, she will likely never regain the nuances of spoken communication later. Something that is only a problem in that it will close doors that she may later wish were open, and chiefly – it wouldn't be her choice to do so. She would be constrained by the boundaries of what she may later choose – and what in any other era or in parts of the world would certainly be her future – but to actively place the constraint on her now feels premature. She is three and three-quarters and fluently reading early chapter books for pleasure.

She knows more about the solar system and the workings of the digestive tract than I do, and her future seems as unbounded as her mind.

So we made an excruciating decision that, to us, leaves the fewest limits to the scope of her life as possible, and places the decisions back in her hands, where they should be.

Our neighbourhood pear tree is just beginning to rouse itself after winter, and my little girl has been emerging too – into a Jamesian 'blooming, buzzing confusion' of new sounds that were beyond the reach of her hearing aids. Yesterday she heard the tiniest, most pitiful bird chirp, and told me so excitedly, with a strong, clear voice. On a windy day she stopped, wide-eyed and said: 'I hear the leaves rustling with my coch-le-ah!' with all the triumph she saves for brandishing found treasures on walks.

We hold a both/and view here too, and also celebrate the magic of her 'quiet ears' and the unique perspective they afford her. When she removes her processor before sleep, it's clear she's relieved to submerge into calm again. But she holds the dialectical promise of both silence and sound at once – this time literally, insisting on holding her processor tightly in her palm while she falls asleep. In this way she stands pragmatically astride both worlds. In silence, but with a hearing key right at hand; ready to unlock the blooming, buzzing cacophony of the world whenever she chooses.

She stands pragmatically astride both worlds. In silence, but with a hearing key right at hand; ready to unlock the blooming, buzzing cacophony of the world whenever she chooses.

Abi Stephenson notes:

In keeping with general form, I will use the capital-D Deaf to refer to deaf individuals or groups that use sign language primarily as a form of communication (often with sign as a first language) and identify particularly as being part of the so-called Deaf-World. The lower-case-d deaf will refer more broadly to those with a severe-to-profound degree of hearing loss (Hard-of-Hearing or HoH/HH being the term for mild-to-moderate/severe hearing losses).

Ruth Holt reckons Abi's article fully understood the difficulty of choosing whether a young child should be given a cochlear implant.

It is essentially the issue of choosing for her to be Deaf (those who use signing and identify with the Deaf community) or deaf (those with a hearing impairment who communicate orally).

I recognise and respect those who choose to be Deaf and recognise the richness and value of sign languages. As a deaf person, I received a great deal of support that allowed me to undertake full-time education as an older adult in a creative career, allowing me an equal experience.

I received a cochlear implant as an older adult. I had worked and lived among hearing people with increasing levels of deafness for years. From my own experience, I found it possible to live a full and fulfilled life in the hearing world but it needed a good deal of effort and adaptation from both myself and those I worked and lived with. Even with support it was exhausting.

One issue that is rarely highlighted is the primary effect of deafness on engagement and relationships with others. It is my relationships with other people, hearing or deaf, at every level, that have been revolutionised by my cochlear implant, not just my ability to hear music (the most difficult) and to hear surrounding noise.

Simon Gair from Essex, UK agonised over implants for three of his children.

My wife and I are proud parents to four children, the eldest three who were born profoundly deaf. We were set on the cochlear implant (CI) route when they were infants and all three were implanted before their fourth birthdays.

It was a difficult decision given the thinning of the skull surgery required for the computer element and the invasive surgery that went with the insertion of the implant itself.

We agonised over the decision. Would our older children resent our choices for their lives?

The internet was in its infancy and of little comfort. Opposition to CI was vociferous, from the USA especially.

We figured, as Abi Stephenson's article states, that we were providing optional doors in later life for our infant children, which they could choose to open or close as adults.

Two decades later, our children are all successful in their lives. They all sign. They all speak. They all access the hearing world but enjoy and thrive in their deaf communities. My eldest daughter has passed her level 6 British Sign Language course and my youngest daughter, who was born hearing, is finishing her degree this year as a speech and language therapist.

So many parents of deaf children have to go through hoops unimaginable for most parents: the lack of invitations to birthday parties in primary years; the Sat exams not entered for; the lack of ambition from careers advisers; and the aiming-low mentality of many.

The loneliness of deaf children at times is heartbreaking.

Did we make the right decisions? Our children's lives suggest so, but after all these years my wife and I still have many moments of guilt.

Cochlear implants make a useful addition to sign language.

Parents of a deaf child should not feel pressured to choose between implants and signing, writes Dr Wyatte Hall, Assistant professor of public health sciences, University of Rochester Medical Center, New York, US.

As a deaf researcher focused on language deprivation among deaf individuals, I am often asked about cochlear implants and their role in the lives of deaf children. While cochlear implants are a technological tool that provides access to sound, the critical issue is not the implant itself, but the decision to exclude signed languages from a deaf child's upbringing.

For deaf children, access to a visual language – such as American Sign Language or British Sign Language – is essential, particularly in the early years when the brain is most receptive to language acquisition. Without this access, many deaf children can face significant delays in language development, which leads to lifelong challenges in education, employment and mental health.

Research shows that bilingualism in both a signed and spoken language enhances cognitive flexibility, academic achievement and social integration. Introducing a signed language does not hinder spoken language development; rather, it provides a safety net that ensures the child always has a fully accessible language.

Parents face complex decisions, but they should not be pressured to choose between cochlear implants or a signed language. Both can coexist, offering a holistic approach that respects the child's potential and humanity. My hope is for families and professionals to prioritise the child's linguistic rights and wellbeing, fostering a world where no deaf child experiences language deprivation.

Jenny Froude said her son embraces both worlds and his three hearing children are bilingual.

Since 1980, I have been involved in the Deaf scene with a son who lost his hearing to meningitis at five months. Cochlear implants were in their infancy. An ENT consultant confirmed the deafness, suspected by an astute young nurse on the isolation ward, and said Tom would go on a list to be one of the first to receive one in 10 years' time. Sounded good to us, naive as we were. Without the peripatetic teacher of the Deaf assigned to us, we would have been left floundering. Signing was suggested and Tom's language became the delight it remains to this day. He could play his rightful part alongside his brothers in a hearing family and our local community.

As a teenager, Tom requested an implant, which took years and much pressurising of the NHS to be fitted just before his GCSEs.

Many of the sometimes-contentious points Abi describes are ones I considered for his biography. Generations of deaf families hand down Deaf culture and their beautiful British Sign Language within the Deaf community – but his sudden deafness did not mean our son inherited that world.

I agree with Tom Bertling's warning in his A Child Sacrificed to the Deaf Culture that "parents should cast a cautious eye towards anyone wanting to sacrifice a deaf child towards preserving a culture". Our son embraces both worlds and his three hearing children are bilingual – which says it all.

*

Simon, Ruth and Jenny's comments were published in The Guardian.

Abi's essay was originally published as The cochlear question on Aeon.

To start the survey, click here

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The CICADA AUSTRALIA support group was established in 1984 to meet the need for honest and practical information on the benefits of the cochlear implant.

From the first cochlear implant (CI) surgery at Sydney's Royal Prince Albert Hospital in August 1984, the first switch-on in September 1984, after many upgraded models of sound processors and several developments in the internal electrode and receiver/stimulator, cochlear implants have been shown to give the benefit of multi-frequency hearing to those with profound hearing loss.

This first body of volunteers who had direct experience with the CI could demonstrate and speak openly about their new sense of hearing and advocate for its success.

It is a testament to the CI's success that so many have been able to use electronic sound to hear speech and modulate their voices.

CICADA AUSTRALIA has been the main support group in Australia for 40 years. It is active today, advising and advocating for the CI and arranging gatherings to bring people together so they can ask all the questions they need to understand how a CI works in everyday life.

Its website, www.cicada.org.au, has comprehensive information on events across Australia and includes a Guide to Hearing Loss and implantable devices .

All over Australia, implant programs have evolved and developed since the early children's program demanded some habilitation to achieve a spoken voice and comprehend the heard environment.

Many resources are available online for recipients to practise their skills, yet more can always be done to improve access to good-quality care.

Worldwide, the CIICA (www.ciicanet.org) has advocated for CI recipients, teachers, and professionals to band together across Europe, the Middle East, and Asia to build public health resources and bring integrity to all aspects of CI programs.

It is a natural outcome of hearing, that we will speak what we hear.

Most parents choosing implants for their child are hearing parents, naturally accepting that we live in a hearing world. Yet, when it concerns the future of their child, it is still a lot for a new parent to weigh up.

Adults who lose their hearing can decide whether to opt for a CI. The results are remarkable, and most recipients who work on their hearing skills with an implant do very well in conversation and phone calls. You keep working on it, paying attention to detail to fill in some gaps.

There is a lot of environmental sound that can be beneficial and enjoyable to hear:

bird calls, someone knocking at my door, wind in the trees and rain on the roof, appliances around the house, outdoor traffic, alerts and alarms.

Music and singing take practice to find what sounds good to you.

Above all, the CI is a personal choice and should be considered alongside personal consultation with other recipients. CICADA can provide this to help you decide what is right for you. You can meet up with other recipients at one of our social gatherings.

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Cochlear implantation and early intervention: let's think beyond the binary

By Professor Greg Leigh*

With the change of administration in the United States, concepts of diversity, equity and inclusion have been thrust even further into the public discourse. The global response has seen a welcome conversation about their importance. But in thinking about diversity, we need to go well beyond the broad brushstrokes of gender, disability, language, culture, or age.

Often — and wrongly — these groups are reduced to their headline label. But the rich diversity within groups, needs much greater appreciation.

Children who are deaf or hard of hearing, for example, are not, and never have been, a homogenous group. By extension then, we should not apply a one-size-fits-all approach when we support them to develop and learn.

When discussing issues like early cochlear implantation, using signed or spoken language in early intervention, or engaging children with Deaf culture, it's easy to get caught in a binary trap. "Spoken language or sign language", "cochlear implantation or sign language", or even "learning the home language or learning English" are all false dichotomies.

If we respect that reality is complex, keep diversity of need front-of-mind, and think about child wellbeing in the broadest possible terms, the range of pathways for deaf and hard of hearing children and their families become much clearer.

The alternative? We put children at potential risk of long-term disadvantage through linguistic and social deprivation.

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Considering the evidence and history

Thirty years of evidence from well-controlled studies has delivered a clear imperative: intervene early and you will provide a child with the most natural path to develop their first language — whatever that language happens to be — and establish foundations for their cognitive, social, and emotional development.

During those 30 years, two major advances — universal newborn hearing screening and the advent of cochlear implantation for infant children — fundamentally changed the landscape of early intervention. This ensured the development of spoken language became the focus of intervention for most deaf and hard of hearing children.

Research, like the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) Study, has demonstrated that early and effective access to the sounds of speech through cochlear implantation has made age-appropriate spoken language abilities achievable for more children who are deaf than at any time in history.

However, the road to this point has had some potholes. Along the way, early intervention programs for children with cochlear implants typically sought to restrict children's access to sign language. This approach was based on a binary and often very strongly held view that learning to sign would hamper the development of spoken language skills.

Unsurprisingly, this approach led many members of the Deaf community to conclude that the purpose of the cochlear implant and associated interventions was to subvert the possibility of a child identifying or engaging with their community. This has had an undeniable and long-term impact on the attitude of the Deaf community towards cochlear implantation.

But there was another insidious effect of this approach. For children who did not achieve the expected outcomes from using their cochlear implants, the rigidly held binary view about language access all-too-often led to long delays in them receiving access to sign language. This effectively squandered the enormous developmental benefit of learning a language at the earliest possible time.

Welcome developments

Fortunately, thinking has evolved. There have been remarkable strides in recognising the role that cochlear implants can play in the diverse ways that someone can live a life as a deaf or hard of hearing person. Learning more than one language or way of communicating is no longer seen as a barrier to developing spoken language skills for children with cochlear implants.

Conversations around choice are becoming more nuanced and efforts to identify whether alternative pathways are needed or wanted are much more focussed in the early stages of children's development. Those conversations are being driven by families themselves and by organisations like NextSense, which have a focus on tailoring support to child and family needs and goals.

These are conversations that are critical for service providers to have with families. And they can be complex. They need to consider what it means to learn one language or two, and what family resources are needed for that to occur.

For example, in order to develop their first language, children must be able to access ***all*** the elements of that language ***and*** be surrounded by mature users of the language who can consistently and continually interact with them.

This is easy to achieve for hearing families of deaf children who use English or another spoken language to communicate. For children learning Auslan as their first language, it's much harder for hearing families with no signing background to achieve. So, it's not surprising that spoken language is the option most often pursued by hearing parents of children with cochlear implants.

However, this does not, and should not, exclude the potential for their child to learn Auslan as a second language.

For some families, a valid and supportable decision can be to pursue their child's simultaneous development of spoken English and Auslan. When the conditions for learning both languages can be provided (i.e. through a bilingual program for early intervention and providing a strong bilingual language environment at home) this can support good outcomes for both languages.

Such scenarios are vastly different from the past, where all children who received cochlear implants were predestined to be monolingual and were provided access to a sign language only when they didn't develop adequate spoken language abilities.

Keeping our focus

There are some fundamental principles we can adopt to ensure the best possible outcomes when children's hearing loss is identified early, and they receive a cochlear implant.

We should acknowledge that children who are deaf and receive cochlear implants have multiple potential pathways to acquiring language and communication abilities.

Bilingualism and biculturalism are entirely possible for any child that receives a cochlear implant. But there are many possible paths, and we shouldn't seek to demean or subvert any one of them.

All language and communication choices should be respected, including a path to the acquisition of Auslan—whether that be later, based on strong first language abilities in a spoken language, or simultaneously in the context of a bilingual educational approach.

This means that those of us who work with families should be mindful of not closing doors prematurely. In partnering with families, we should respect their choices and be willing to openly explore all options with them in the context of the best possible information.

Finally, and importantly, we must continue to research this area and build our knowledge, so we can support family decisions with the best information about evidence-based approaches.

* Professor Greg Leigh AO, has been a leader in deaf education, research, and public policy development for more than 40 years.

He is the Director of NextSense Institute, which runs world-leading research and professional education programs for those who work in the field of sensory disability.

He is a Professor in the Macquarie University School of Education, and longstanding Chair of the Australasian Newborn Hearing Screening Committee.

The 26th Libby Harricks Memorial Address commemorated World Hearing Day and International Women's Day in 2025.

Libby Harricks Memorial Address
DEAFNESS FORUM AUSTRALIA

Hosted by Deafness Forum Australia and The Shepherd Centre, the event at the State Parliament of Tasmania on 11 March featured a distinguished audience and was officially opened by Premier Jeremy Rockliff.

The keynote speaker, the Honourable Jacquie Petrusma, Minister for Health, Aboriginal Affairs, and Veterans Affairs in the Tasmanian Government, is an influential advocate for accessibility and equality in healthcare.

Jacquie Petrusma spoke passionately about her own experience living with hearing loss and a Cochlear implant. Her journey underscored the challenges many face in the hearing health community.

The Address provided a unique opportunity for not-for-profit organisations, service providers, government representatives, and consumers to unite, fostering collaboration and strengthening their collective capacity to drive meaningful and lasting change for the One in Six Australians affected by hearing challenges.

The event was recorded. Watch future editions of *One in Six* for details.

In the photo: the Premier of Tasmania, Jeremy Rockliff; The Shepherd Centre CEO Aleisha Davis; Deafness Forum Australia chair Rae Walker; The Honourable Jacqueline (Jacquie) Petrusma; Deafness Forum's David Brady and Cochlear's Jason Chai.

The Libby Harricks Memorial Address, honouring the memory of Deafness Forum's first Chair, champions her vision of making hearing health and well-being a national priority.

The Shepherd Centre

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Deafness Forum chair Rae Walker, Tasmania's Health Minister Jacquie Petrusma and Independent Audiologists Australia's Julie Watts.

Chair of the Libby Harricks Memorial Address committee, David Brady with interpreter Joyce Clifford.

Hearing Australia's Managing Director Kim Terrell, Deafness Forum chair Rae Walker, and Cochlear Ltd's Director of Market Access and Government Affairs Jason Chai.

MED-EL is a global hearing technology company, dedicated to helping individuals overcome hearing loss as a barrier to communication and quality of life, while continuing to respect and value all cultures.

MED-EL writes: We understand the profound impact that hearing loss can have on individuals and their families, and we are committed to supporting caregivers in making informed decisions for their children.

It is important to acknowledge that 90% of babies born with hearing loss have parents with typical hearing, most of whom have limited experience with people with hearing loss. This can make the journey of navigating their child's hearing loss particularly challenging and overwhelming.

MED-EL advocates for compassionate support for caregivers and their rights to make decisions for their children utilising evidence-based information and guidance from medical and hearing care professionals.

For families who wish for their child to grow up with the ability to listen and talk, childhood hearing loss is a medical emergency that requires timely intervention. Without such intervention, significant barriers to the acquisition of listening and speaking skills undoubtably exist. Research has clearly identified a critical time window for the development of these skills, similar to the urgency seen in corneal transplants for babies born with vision impairment.

Eyes and ears are doorways through which information from our world is passed to the brain. Surgical intervention, with a new cornea, a grommet or a cochlear implant, simply open the doorway to allow the brain access to more information. There are many factors that impact a child's ability to utilise that information but that is a topic for another day.

Newborn Hearing Screening, first introduced in Australia in 2002, acknowledges the critical time window for neurological development. Governments fund this initiative to facilitate early diagnosis of hearing loss and early fitting of appropriate hearing technology to support improved communication outcomes and enhance long-term quality of life. As Australians we can feel proud that our public funding bodies have prioritised early intervention for babies born with hearing loss to provide families with choices and children with opportunities.

MED-EL believes that to make the best possible choice for their child's future, caregivers need access to accurate, easy to understand information that explains hearing loss and the lifelong implications of hearing loss and the various intervention options. In addition, families benefit from ongoing, unbiased support to assist them develop their own sense of identity. They deserve their thoughts, feelings, comments and opinions to be discussed and accepted without judgement.

As families continue along their child's journey, their expectations and goals may change. This is a natural process that occurs with any parenting decisions.

The challenge for parents of babies born with severe to profound hearing loss is the time constraints imposed by the critical period for the development of listening skills. The area of the brain that is responsible for processing information received through hearing depends on good access to sound early to develop efficient neurological pathways.

The earlier children receive cochlear implants, the more likely they are to have listening and speaking skills the same as their typical hearing peers.

Enlightened communities value the contributions of all cultures and uphold an individual's right to self-identify. An infant is not capable of self-identifying so, as with all other cultures, parents make the important decisions until the child can formulate their own thoughts on identity and culture.

A cochlear implant does not prevent an individual from identifying as Deaf and proficiency in sign language can be acquired at any age. Conversely, for babies born deaf, developing spoken language is not possible without cochlear implants early in life. This is a window, or a doorway, that shuts.

Since the 1970s MED-EL research has driven hearing technology innovations that have supported people with hearing loss live full and enriched lives.

MED-EL will continue to advocate for the wellbeing and quality of life of individuals with hearing loss. For families with babies born with severe to profound hearing loss, cochlear implants can represent a life full of possibilities, some of which are the same, and some different from the possibilities available to families who choose a different pathway.

Webinar Invitation

Single-Sided Deafness and Asymmetrical Hearing Loss present unique challenges in auditory perception and quality of life. Join us to explore clinical evidence showing how cochlear implants improve hearing and well-being in both adults and children with Single Sided Deafness.

This webinar will:

- review Single Sided Deafness, its impact on individuals and the benefits of cochlear implantation
- discuss key considerations regarding the etiology and duration of deafness and their effect on cochlear implant success
- explore essential aspects of cochlear implant mapping for Single Sided Deafness recipients to ensure the best device performance and user satisfaction
- provide insights into the latest advancements and practical approaches in managing Single Sided Deafness with cochlear implants.

This endorsed webinar attracts 1 CPD Point.

Tuesday 25th March 2025
Online via Zoom

60 Minutes
Live Webinar Time
18:00 pm AEDT
15:00 pm (WA) | 17:00 pm (QLD) | 17:30 pm (SA) | 18:00 pm (NSW;VIC;ACT) | 20:00 pm (NZ)

Meet your Presenter

Dr. Ilona Anderson is the Corporate Director of Clinical Research at MED-EL. Ilona and her team run pre-market and post-market studies, they conduct clinical evaluations for device updates and recertifications, and supports journal writing activities. Ilona trained as an Audiologist and Speech Language Pathologist at the University of Witwatersrand, Johannesburg, South Africa. Her thesis was on auditory perception outcomes in children with unilateral hearing loss. Ilona completed her Doctorate in Medical Science at the University of Antwerp, Antwerp, Belgium and completed her MBA in Leadership and Sustainability at the University of Cumbria, United Kingdom. Ilona is an author on over 65 publications.

Register here

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A Musical Challenge

Cochlear implants allowed Vicki to reconnect with people, but music was a different story.

Vicki, an avid violin player, had to choose between music and the ability to have a conversation.

Those were the stark choices confronting me as I sat in an audiologist's office in 2007.

The hearing test had taken just minutes, and what the audiologist told me would change my life.

"You can't hear speech," she said.

I'd lived with hearing loss for most of my life, and had been living like a recluse for some time because I couldn't hear well enough to hold a conversation.

When I was 11, my swimming coach noticed I didn't hear him call out when I was in the water. Tests revealed I had "the hearing of an 80-year-old", as an audiologist put it.

Over the years my hearing worsened and I couldn't hear well enough to hold a conversation. Talking with my very patient family was laborious and ineffective. Talking with strangers was almost impossible.

Even going to the supermarket was stressful. I would watch the check-out operators carefully and respond appropriately to "cheque, savings or credit?"

But if they said anything else, it would turn into a humiliating repetition of, "sorry, what's that?" until both of us gave up in embarrassment.

A flatlined graph

Still, I was incredulous at what the audiologist was telling me. I said, "I'm talking to you, aren't I?"

She pushed my audiogram towards me. I knew the test hadn't gone well, but I couldn't quite believe what I was seeing. The graph almost flatlined — for both ears.

"You just don't realise how good you are at speech reading," she said.

She told me I would probably continue to lose any remaining hearing. Hearing aids were of little use because they only amplify existing hearing. If I wanted to talk with people again, my best option was to get cochlear implants.

Musical challenge

Cochlear implant research and development prioritises helping people to understand speech. However, music uses a broader range of frequencies than speech.

Hearing with cochlear implants is not analogue like natural hearing. There are gaps in the frequencies implants use, which means some sound information in music is missed.

Technology is improving all the time, but enjoying music with cochlear implants can be a challenge.

I loved music, as many people do.

I played the violin, and it was as if classical music flowed through my veins. I played by ear and could pick out tunes on almost any instrument.

As a teen in the 80s I spent countless hours poised beside the tape recorder, ready to hit record the instant one of my favourite songs came on air.

I earnestly sang along to lyrics I was far too young to fully understand. There was always a tune in my head.

Music was fundamental to who I was.

Now, I had to make a decision that could leave me without it forever.

Adjusting to a new reality

But the truth was I couldn't hear music well, even then. Cochlear implant surgery would destroy any remaining hearing — but, as I'd just learned, there wasn't much of that.

I had to prioritise, and my priority was to reconnect with people.

In 2008 I was implanted in both ears.

Of course, I hoped for a miracle. Straight after my cochlear implants were activated (a process sometimes called 'switch-on') I couldn't resist playing a song on the car CD player as I headed back to work.

The dirge that poured out of the speakers bore no resemblance to the familiar melody I'd hoped to hear. It was off-key and distorted, like an old vinyl record being played at very slow speed.

Given both ears were implanted at the same time, I had no back-up hearing to compensate for any frequency gaps.

Cochlear implants enabled Vicki to hear the words to songs. *(ABC News: Julian Robins)*

But I could hear words! I couldn't understand them all, but I could hear them. It had been a long time since I'd been able to discern words in songs. I was fighting back tears as I drove.

Rehabilitation after cochlear implant surgery is extensive, and I'd love to tell you that, although it took a while, music is now beautiful to me again. But real life hasn't quite played out like that.

Filling in the gaps

To an extent, I have come to 'hear' music, so long as it's something I knew before I went deaf. The brain has an extraordinary ability to fill in the gaps when it expects sound to be present. I can listen to my old music, and it's okay. I play my violin and can even immerse myself in it, though I can no longer tell if I'm playing in tune. But music that's new to me? That's a hard no.

In 2013 my husband and I honeymooned at a dive resort on a tiny island in Papua New Guinea. With a maximum of 12 guests on the island, meals were communal affairs around a long table. The dining room was an open-sided thatched hut with floors of soft white sand, Gilligan's Island style.

One evening the other diners seemed to be unhappy with the background noise.

"Is there something wrong with the music?", I whispered to my husband.

He whispered back, "That's not music. That's howling dogs."

We still have a good laugh about that one.

Conversation starter

Yet, despite their limitations, cochlear implants have given me back my life. They are, ultimately, enablers.

Almost nothing is more precious than to be able to talk with my family again. And after years of avoiding people in case they talked to me, it was astounding to find myself confident enough to — gasp — actually start a conversation.

Cochlear implants enabled me to learn to scuba dive, complete a university degree, embark on a new career and buy a house. I would otherwise have done none of these things.

Not even music is more important.

To those who say, "I couldn't live without music," I say, I'm living without it. And my life is absolutely worth living.

By Vicki Taylor: Cochlear implants allowed Vicki to reconnect with people, but music was a different story

Australia boasts one of the highest adult cochlear implant uptake rates globally, yet there's still significant room for growth.

Remarkably, only 8% of those who could benefit from a cochlear implant receive one. This gap in utilisation suggests a vast potential for improving hearing health nationwide.

Australia's largest cochlear implant program, NextSense, operates 22 centres nationwide and performs approximately 400 implants annually.

Looking at the broader picture, it's estimated that between 2011 and 2021, approximately 8,754 adults across Australia received cochlear implants. This figure represents a significant portion of the over one million cochlear implants implanted globally as of 2022.

Navigating the Journey to Better Hearing: CICADA Queensland

As a hearing implant support organisation, at CICADA Queensland, we understand that choosing a cochlear implant is a deeply personal decision, influenced by cultural identity, personal values, and concerns about medical technology.

We respect and appreciate the significance of these choices and are committed to providing balanced, informative, and compassionate support to individuals and families navigating this journey.

Advancements in cochlear implant technology have been transformative in addressing these challenges. Over the years, innovations have significantly improved hearing outcomes and quality of life for implant users. There has never been such an incredible range of cochlear implants and assistive technologies available, providing individuals with more options than ever to find the best solution for their hearing needs. Additionally, the adoption of the 60/60 guideline - where individuals with a hearing threshold of 60 dB or poorer and a word recognition score of 60% or less are considered potential candidates - has made cochlear implants more accessible to those who may have previously been overlooked. Expanding candidacy criteria means that more people experiencing significant hearing loss can benefit from this life-changing technology.

In Australia, organisations like CICADA Queensland have been instrumental in supporting individuals with hearing loss, providing information on a wide range of hearing implant solutions, as well as ongoing rehabilitation and social support. For anyone considering a cochlear implant for themselves or their child, finding the right healthcare professionals - those who respect cultural perspectives, personal values, and individual needs - is essential to making informed decisions and achieving the best possible outcomes.

We are incredibly fortunate to live in a country where advanced hearing solutions such as cochlear implants are not just a possibility, but a reality for so many, opening up the world of sound, connection, and communication to those with hearing loss.

CICADA Queensland is a not-for-profit charity that assists people of all ages who live with hearing loss, who may have a hearing implant, or are considering one. Hosting ‘meet-ups’ in locations across Queensland.

CICADA
QUEENSLAND
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Cochlear implants have revolutionised the treatment of severe hearing loss, offering significant improvements in speech perception for many adults.

However, the rate of progress varies among recipients, and understanding the factors that influence this progress is important for optimising outcomes.

The main factors that influence progress:

1. Issues related to the health of the auditory nerve and how well the implant interacts with the nerve. Such factors can affect how well the implant works.
2. Cognitive abilities, such as memory and attention, play a significant role in how well someone adapts to a cochlear implant. Neurocognitive challenges can hinder speech recognition.
3. Age and duration of deafness: While age is not a barrier to benefiting from a cochlear implant, longer durations of deafness can lead to poorer speech recognition outcomes.

Early Performance Predicts Long-Term Success

Research shows that how well someone performs with a cochlear implant in the first few months often predicts their long-term success. Early sentence recognition scores can indicate whether additional support or rehabilitation is needed.

Improving Outcomes

By identifying and addressing limiting factors early on, healthcare providers can tailor rehabilitation strategies to improve outcomes for cochlear implant recipients. This personalised approach can help maximise the benefits of cochlear implantation.

Knowledge is Key

Cochlear implants offer life-changing improvements for many adults with severe hearing loss. Understanding the factors that influence early progress can help ensure that recipients achieve the best possible outcomes from their device.

From Barriers to Early Progress in Adult Cochlear Implant Outcomes

Don't miss out on the next One in Six — subscribe directly to ensure our emails land right in your inbox!

Let us know at hello@deafnessforum.org.au