Audiology Today welcomes feature articles, essays of professional opinion, special reports and letters to the editor. Submissions may be subject to editorial review and alteration for clarity and brevity. Closing date for all copy is the 1st day of the month preceding issue date.
ON THE COVER

It is always a challenge to use the ear as the subject of an art form. And, we know from years of experimenting with various approaches how difficult it is to create a new and intriguing view of the often-not-so-beautiful human pinna. But for this cover, we benefit from the talents of our wonderful graphic artists at Tamarind Design and Marketing in Denver who applied their talents and skills to produce a beautiful extruded design from an ordinary image of an ear.
Many of my audiology friends have been asking me if I am ready to assume the presidency of the Academy. How do you get ready? No one has written a book that identifies the step-by-step process necessary for guaranteeing desired outcomes. What I am ready for, though, is the challenge. I have been fortunate to work with Gail Whitelaw over this past year. She has been a very inclusive leader; an excellent mentor in many ways. She has given me the opportunity to understand the numerous issues impacting us as a profession and as an Academy. New issues will arise during the year while the complexities of the current ones may change, as well. The challenge is to maintain a presence and impact change. The Academy is less than twenty years old, yet, the enthusiasm and drive of the membership is far more seasoned than one would expect from such a young organization. Recently, Gail Whitelaw, Academy Executive Director Laura Doyle, and I met to rewrite the mission and goals for each committee of the Academy and to secure compliance with our Strategic Plan. Our dedicated committee chairs and members now have a clear understanding of their charge. This has created a cohesive committee infrastructure and makes it easier to identify when there is the need to reorganize current committees and/or create new ones to meet the on-going dynamic demands of our profession.

A healthy association is predicated on good communication. We have a strong Board of Directors dedicated to solving the issues and guided by the desires and vision of the membership. I welcome our newest Board members, Bopanna Ballachanda, Kris English and Patrick Feeney. The Board of Directors wants to hear from you. Communicate your suggestions. Some changes come easily while others seem like they will never come to fruition. In due time, there is nothing that this Academy can’t secure for its more than 10,000 members.

Speaking of the Board of Directors, we are going to add a new featured section to Audiology Today. Each publication will highlight two board members who will answer personal questions. The purpose of this section is to “personalize” the Board and to give each member the opportunity to show his or her fun side and to reveal personal interests. It is our desire that this “personal touch” will make it easier for you to engage a Board member in discussion when together. This format was used with the Academy Honorees at AudiologyNOW! 2006 and was well received. Ultimately, we can feature committee chairs, members of the Academy, committee members, etc. to promote a connection between the membership and Academy leadership. Our intention is to foster interactions where none existed before. I hope you enjoy this new feature called Direct Access.

This year will be a busy one with ongoing discussions and strategic planning regarding the Accreditation Commission for Audiology Education (ACAE), the American Board of Audiology (ABA) and the American Academy of Audiology Foundation (AAAIF). These groups have a great deal of commonality and the security of our profession rests with their success. It often seems like we are asking for money, but every financially sound professional association has an active and successful non-profit foundation. The non-profit foundation is the financial conduit for important groups such as ACAE and ABA. It underwrites research projects, supports our Academy members affected by disasters such as Hurricane Katrina and annually funds the Marion Downs Lecture, a forum for the most cutting-edge developments in pediatric audiology. These are just a few of the programs funded by our own AAA Foundation. Contributions to the AAAF can be ear-marked (how appropriate for audiologists?) for a specific issue. Please give generously to the AAAF.

Resolution to the numerous issues facing the Academy can be secured more judiciously through collegial partnering. I often read articles written from individuals in leadership roles within other associations boasting to be the first to...or the only
association to engage its membership to write letters. Sometimes being first may mean the association acted too soon; first is not always right. Not engaging our members to write letters may have been purposeful because it was counter-intuitive to our legislative strategies and had potential to antagonize the agency receiving the letters. Securing solutions to the problems facing our profession can’t be approached as a contest. Combining our resources and working together will allow us to look less fragmented and less vulnerable to our opposition. The Academy is the largest organization of, by, and for audiologists, but we do not exist in a vacuum. Collegial partnering affords us the opportunity to speak with a single voice. A unified approach frustrates our opponents who thrive when we are conflicted within our own profession.

I am pleased that the AuD is being recognized as the entry level degree for the practice of Audiology. This is the result of compromise by those in opposition who ultimately put the profession first; another tribute to collegial partnering. This doesn’t minimize the Masters’ degree. Current practitioners who hold a Masters’ degree have years of clinical experience which provides the foundation for sound patient care. As we complete the transition to a doctoring profession, it is essential that we meet society’s expectations of professionalism. A doctor is a professional, not a title. With the degree comes the responsibility of serving patients. The value of the AuD lies in the education and the heightened level of expertise afforded by that degree. Today’s audiologist needs to have a capacity for critical self-reflection that pervades all aspects of practice, including being present with the patient, solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining his or her own values. Audiology programs have raised “the bar” in respect to

**Academy Recommends Uniform Timeline for Fourth Year Externship Placements**

With a growing number of fourth year externs needing placements in their final year, many clinical programs across the nation are receiving year-round inquiries from universities and students. At the request of clinical program directors and in an effort to bring greater uniformity to the application and selection process, the following timeline was developed by the Academy’s Clinical Education Subcommittee and approved by the Academy’s Board of Directors. The timeline will not be ideally suited for every university and every clinical setting; however, movement toward greater uniformity in application and placement should result in a more timely and efficient process, beneficial to students, university programs, and clinical sites.

<table>
<thead>
<tr>
<th>EXTERNSHIP TIMELINE GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student/Faculty Search Process</strong></td>
</tr>
<tr>
<td><strong>Application Period Open</strong></td>
</tr>
<tr>
<td><strong>Applications Submitted</strong></td>
</tr>
<tr>
<td><strong>Application Files Completed</strong></td>
</tr>
<tr>
<td><strong>Interviews</strong></td>
</tr>
<tr>
<td><strong>Offers Made</strong></td>
</tr>
<tr>
<td><strong>Offers Accepted Round 1</strong></td>
</tr>
<tr>
<td><strong>Follow-up Offers Completed</strong></td>
</tr>
<tr>
<td><strong>Externship Begins</strong></td>
</tr>
</tbody>
</table>
My name is Deb Abel.

Childhood ambition... to have been an actress or ballet dancer.

First job... summer job in high school: cleaning hotel rooms.

Inspiration... lessons learned from... my parents.

Fondest memory... what I think I can recall... from Kent State University days.

Favorite movie or book... Monty Python’s The Holy Grail.

Indulgence... chocolate. Chocolate. And then there’s chocolate.

Proudest moment... becoming a member of the board of the American Academy of Audiology.

Perfect day... sitting at the ocean with good friends and an adult beverage in my hand... chocolate in the other hand!)

My life has had its challenges in the last few years, but hoping for some smoother waters...

My profession... Audiology!!

Deb Abel, Aud
My name: Bopanna B. Ballachanda

childhood ambition: CLIMB MOUNT EVEREST.

first job: BILLING CLERK

inspiration: EASTERN PHILOSOPHY

foremost memory: DAY MY SON WAS BORN

favorite movie or book: COWBOY MOVIES / THE WORLD IS FLAT

indulgence: FAMILY ACTIVITIES / TRAVEL

proudest moment: PUBLISHING MY FIRST BOOK

perfect day: MAKING PEOPLE HEAR BETTER / BELOW
PAR SCORE IN GOLF

My life: AN excItIng JOURNEY STARTING IN A SMALL TOWN IN INDIA.

My profession: AUDIOLOGIST

Bopanna B. Ballachanda
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Albuquerque, NM 87111
b.ballachanda@comcast.net
we have all been involved in some form of strategic planning, often to only find the document proudly placed on the shelf after a great deal of effort in developing the plan. It then stays on the shelf collecting dust until it is pulled down and dusted off three to five years later to see if any of the plan was actually accomplished. That is not the case with the Academy’s strategic plan.

When I had my first interview with the Academy Executive Director Search Committee in early 2001, I was handed a copy of a plan and was quickly told, “This is our strategic plan but we hate it.” The first year and a half that I was here, staff struggled with how to accomplish the nebulous “goals” that were in the plan. It didn’t make sense to our leadership and it certainly didn’t make sense to the staff.

So in 2002, we found an incredible facilitator to work with the Board to develop a working strategic plan - one that not only made sense but one that had short-term and long-term objectives with action plans for implementation. Finally, after receiving feedback from Academy, membership as to what they wanted from their Academy followed by many long months of deliberation, leadership and staff developed a plan with which to work. Since its 2002 implementation, this plan has played a huge role in the growth and success of the Academy.

In 2005, Academy leadership devoted several days of the Board’s time to reviewing and updating the plan to make sure we were still headed in the right direction given the various factors and changes that had taken place in the environment and the profession of audiology since 2002. A summary of the most recent version of this document reflects the six stakeholders to the Academy’s vision, which include: Academy members, Audiologists, Other Organizations, General Public, Industry and Leadership. Each of these stakeholders has one or more goals associated with it. The goals then have two or more short-term and long-term strategies linked to them.
which are then associated with specific action items as to how the objectives can and will be accomplished.

It is from these objectives and action items that your leadership has developed the committee charges, thus giving the Committee Chairs definite direction linked to the strategic plan. It is the many entities of the Academy working simultaneously on various aspects of the plan that will ultimately allow us to reach our vision which is to be essential in the lives of audiologists by advancing the science and practice of audiology and achieving public recognition of audiologists as experts in hearing and balance in the most timely and cost effective manner.

This document is an instrument that Academy leadership and staff refer to on a regular basis to make certain that we are working in the direction that was developed as a result of your input. It serves to make sure no one leader can come in and divert the Academy’s direction to accomplish their personal agenda. It is a document that has been developed to ensure that each year as the leadership changes, they will continue to work in the direction that was envisioned by Academy member input. It is our guidebook designed to keep us focused on our primary mission, which is to promote quality hearing and balance care by advancing the profession of audiology through leadership, advocacy, education, public awareness and support of research.

And we will revise and refresh this document again within the next few years without having ever put it on the shelf to collect dust.

**Linkage:**

**Vision, stakeholders, goals, and strategies**

The following graphic illustrates the linkage of the Academy’s stakeholders to the vision, goals and strategies.
Committee Charges

JULY 1, 2006 – JUNE 30, 2007

Honors – Sheila Dalzell

- Identify individuals who have been of exceptional service to the Academy and/or the profession and who are deserving of awards.
- Develop a slate of deserving candidates who will be honored publicly during AudiologyNOW!

Coding – Kadyn Williams

- Identify and monitor the global demands of coding.
- Provide input regarding needs for coding changes and develop strategies to effect changes.
- Communicate coding related information to members.
- Develop Non Physician Work Pool payment methodology and achieve acceptance of plan by CMS to reduce projected 21% cut in reimbursement.
- Medicare Physician Fee Schedule: annual reimbursement policy (regulatory).
- Electronic Medical Records and Electronic Health Records

Business Enhancement Strategies & Tools – Gyl Kasewurm

- Assist audiologists in obtaining the information and resources required to manage all aspects for all audiology practice settings.
- Provide those resources through non-dues revenue publications and networking.

Education & Standards
- Dianne Meyer

- Identify and monitor issues related to audiology education and professional standards.
- Develop processes, documents, databases, action plans, and other appropriate mechanisms to help the Academy maintain a proactive and supportive role in the areas of education and professional standards.
- Oversee continuing education, AuD clinical education, AuD academic education, entry-level professional standards, and AuD student matters.
- Education & Standards Subcommittees:
  - Continuing Education
    - Carole Johnson
    - Academic Education
    - Marc Fagelson
    - Clinical Education - Jack Roush
    - Audiology Professional Standards
    - Kris English
    - Student Services - Carol Cokely
- Education & Standards Task Force
  - Task Force on 4th Year Payment Issues – Alan Desmond

Ethical Practices Committee
- Jane Kukula

- The EPC’s primary role is to educate and increase member awareness of the Academy’s Code of Ethics and the practical application of the code, rules and advisory opinions.
- Periodically review and update the Code of Ethics to which members are bound and produce advisory opinions clarifying ethics principles and rules. (Changes to the Code of Ethics, policies and procedures and advisory opinions must be approved by the Academy Board of Directors prior to implementation and publication.)
- Formulate, review, update, and publicize policies and procedures for the review of complaints.

- Review public and member complaints alleging unethical behavior by members. Adjudicate and determine appropriate disciplinary action. (Decisions are subject to appeal to the Academy Board.)

Government Relations
- Alison Grimes

- Achieve Direct Access.
- Achieve passage of Hearing Aid Assistance Tax Credit Act.
- SOC codes: achieve appropriate change in audiology labor classification.
- Pay For Performance: identify quality measures and evidence based practices for audiology.
- State Licensure: work with states to support changes to state licensure law per their request.
- Telehealth
- Monitor:
  - SGR fix
  - IDEA
  - Fraud and Abuse laws and regulations
  - Social Security Administration regulations
  - FDA policies related to hearing aid regulations, cochlear implant, and other hearing devices (e.g. tinnitus maskers)
  - FCC - Hearing Aid compatibility
  - FEHBP – hearing benefits
  - Other issues: Medicaid, OSHA, Dept of Transportation (regulations), Aural Rehabilitation (coverage for treatment)
& Chairs

Government Relations Subcommittees:
- Pediatric Audiology – Marilyn Neault
- State Licensure – Pam Ison

International Committee – Neil Clutterbuck and Linda Hood
- Increase International membership in the Academy and develop organizational affiliations in order to enhance the development of the audiology profession worldwide through education, support of research and increased collaboration.
- Assess the Academy international membership and advise the Board of international member needs and value added benefits.

Membership - Rebekah Cunningham
- A main focus for this committee is to be the “pulse” of the membership.
- Assess the Academy membership through member connect, the biannual membership survey etc. and advise the board, other committees and appropriate staff about member needs, value added benefits and member attitudes and concerns that affect a member-driven environment that fosters member involvement and leads to professional success.
- Provide periodic review of membership criteria and procedures, and recommend changes that may be required.

Program Committee – Sharon Sandridge
- Organize and coordinate annual AudiologyNOW! program.
- Attract high quality submissions/speakers.
- Design a program to be of interest to a wide cross section of audiology specialties.
- Enhance the educational value of the meeting through innovative teaching methods (i.e. interactive sessions).
- Set the standard for learning opportunities, in conjunction with the Education and Standards Committee.

Program Subcommittees:
- Community Support
- Discussion/Focus Groups
- Employment Services
- Exhibitor Courses
- Featured Sessions
- Learning Lab
- Learning Modules
- Research Posters/Pods
- Student Research
- Student Volunteers

Publications – Mike Valente
- Oversee Academy publications.
- Oversee content and creativity of Academy web site.
- Recommend topics for future publications.
- Review new publications prior to publication.

Publication Subcommittees/Task Forces:
- Editing Subcommittee
- Web Development Task Force – Don Vogel

Public Relations Committee – Clarke Cox
- Promote Audiologists to the general public as the experts in hearing and balance.
- Promote Audiology to the medical and allied health care professions.

Promote Audiology to include, but not limited to, industry and associations.
- Promote the profession of Audiology as a career option.

Research Committee – Sharon Kujawa
- Promote research through member education and Academy Research Awards program.
- Facilitate member awareness of research by and for audiologists.
- Review applications and select recipients of the Academy Research Awards funded by the AAAFoundation.
- Maintain relations with allied organizations that provide hearing and balance research.
- Promote research grant opportunities available through other organizations.
- Facilitate opportunities for members/mentor interactions and training.

State Network – Erin Miller
- Facilitate communication between the states and the Academy, as well as state-to-state.
- Promote a robust national grass roots community to support audiology.

Strategic Documents – Craig Newman
- Oversee specific task forces, which have been appointed by the President after direction from the Board, to develop specific documents.
- Develop, finalize and monitor existing (review) documents including position statements, practice guidelines and white papers.
As accrediting bodies mandate sets of competencies that evolves over time for practitioners, the academic and clinical programs charged with didactic education, clinical practice, and student evaluation must keep pace with the field’s dynamic scope of practice. Graduating audiologists must be competent healthcare providers capable of using existing and emerging technology for the diagnosis and management of individuals with hearing and balance disorders. The responsibility for conveying essential information and providing clinical opportunities to practice with this technology rests as it should with the universities and their affiliated clinical placements. National organizations, such as the American Academy of Audiology (AAA) and the American Speech-Language-Hearing Association (ASHA), must be sensitive to the dynamics of the field’s scope of practice.

Program applicants seek information from many sources, and many sample the Internet to identify programs that meet both their own criteria for graduate education as well as the criteria established by accrediting entities. The comprehensive search of AuD programs of study and posted curricula presented below should be considered a snapshot of the field from the perspective of a prospective Fall 2006 AuD applicant.

We completed an internet search of all academic programs listed as accredited by ASHA and ABA as of July 1, 2005 for information specifically pertaining to available curricula. At the time of the search, 59 programs had posted curriculum information, all of which were listed on the Academy’s website as offering degrees. At the same time, 65 programs offering AuD degrees were listed by ASHA as accredited, approved with accreditation pending, or planned. Therefore, the results reported below represent a sample of 59 out of 65 accredited, approved or planned academic programs.

Courses found in each curriculum/program of study were entered in a spreadsheet by name and tallied. Several course names were similar across institutions, although their names were not identical. In obvious cases, these courses were combined and the total number of programs offering the courses reported. For those cases in which the similarity was less clear, the courses were reported separately. Examples are
provided below of both instances so that readers may draw their
own conclusions regarding the appropriateness of this method. Care
was taken to avoid counting a class twice when ‘similar sounding’
classes were offered by the same program. For example, one
program listed separately courses called,
“Business Management” and
“Professional Issues” whereas in seven
other instances, programs listed one
course or the other.

Courses were then categorized
with regard to the Standards
specified by the Accreditation
Commission for Audiology Education
(ACAE). The ACAE specified that
students must display competence in
several areas of audiologic practice:
Diagnosis and Management (D & M),
Foundation, Professional,
Communication, Research and Clinic.
In this way it was possible to
determine the areas in which
programs concentrate their curricula.

RESULTS AND DISCUSSION

The objective of this brief report
is to provide an overview of course
offerings in programs offering the
clinical doctorate in audiology. A
more thorough comparison of
curriculum consistency across other
fields that utilize clinical doctorates,
such as optometry, physical therapy
or pharmacology, would be valuable.
Another comparison of interest
would involve a thorough cross-
correlation of program offerings
within the field of audiology that
considered course descriptions and
content. Such an analysis would
require more easily accessible
course descriptions and far more
specific information than was
available for this report.

<table>
<thead>
<tr>
<th>COURSE TITLE</th>
<th>N</th>
<th>OTHER COURSE NAMES</th>
<th>IN COMBINATION WITH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amplification Systems</td>
<td>59</td>
<td>Sensory Technology</td>
<td>Speech Percept. (1)</td>
</tr>
<tr>
<td>Audiology Evaluation</td>
<td>56</td>
<td>Diagnostic Audiology, Differential</td>
<td>Lab (8)</td>
</tr>
<tr>
<td>Pediatric Audiology</td>
<td>56</td>
<td>Newborn Assessment</td>
<td>Educational . (3)</td>
</tr>
<tr>
<td>Electrophysiology I</td>
<td>56</td>
<td>Phys. Assessment, Clinical EP</td>
<td>Seminar (1), Lab (6)</td>
</tr>
<tr>
<td>Hearing Conservation</td>
<td>54</td>
<td>Industrial/Noise, Prev. &amp; Identification</td>
<td></td>
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<tr>
<td>Amplitude Sys. II</td>
<td>54</td>
<td>Seminar in Amplification</td>
<td>Vestibular Rehab (8), Tinnitus Mgt. (3)</td>
</tr>
<tr>
<td>Vestibular Science I</td>
<td>46</td>
<td>Vestibular Diagnosis/Disorders/Treatment</td>
<td>Lab (6)</td>
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<tr>
<td>Cochlear Implants II</td>
<td>40</td>
<td>(Implantable) auditory Prostheses</td>
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<tr>
<td>Aud. Rehab. for Adults</td>
<td>27</td>
<td>Management of Adult Hearing Loss</td>
<td>Amp. for Adults (1)</td>
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<tr>
<td>Central Auditory</td>
<td>26</td>
<td>Processing Disorders</td>
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<tr>
<td>Aural Rehabilitation</td>
<td>26</td>
<td>AR across the Lifespan</td>
<td>Lab (4)</td>
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<td>Aud. Rehabilitation for Children</td>
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<td>Management of Pediatric Hearing Loss, Auditory Problems - Pedes</td>
<td>Audiology in the Schools (2)</td>
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<tr>
<td>Amp. Sys. III</td>
<td>22</td>
<td>Auditory Prostheses, Advanced Seminar</td>
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<tr>
<td>Educational Audiology</td>
<td>18</td>
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<td>CAPD (1)</td>
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<tr>
<td>Tinnitus</td>
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<td>Tinnitus Workshop (1)</td>
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<tr>
<td>Vestibular Science II</td>
<td>7</td>
<td>Vestibular Rehab. (3), Adv. Seminar (1)</td>
<td>Tinnitus Mgt. (1)</td>
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<tr>
<td>OAEs</td>
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<td></td>
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<tr>
<td>Audiological Rehab. II</td>
<td>7</td>
<td>Advanced Seminar in AR</td>
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<tr>
<td>Gerumen Management</td>
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<td></td>
<td></td>
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<tr>
<td>Pediatric Amplification</td>
<td>5</td>
<td>Management of Pediatric Amplification</td>
<td></td>
</tr>
<tr>
<td>Aud. Evaluation III</td>
<td>4</td>
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<td></td>
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<tr>
<td>Imaging Technologies</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Augmentative Comm I</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Audiology II</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensory Technology I</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>Newborn Screening and</td>
<td>2</td>
<td></td>
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<tr>
<td>Management</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>Pediatric/Adult Comm.</td>
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<td></td>
<td></td>
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<tr>
<td>Disorders</td>
<td>2</td>
<td></td>
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</tbody>
</table>
Program Administration

Curricula were analyzed with regard to the academic courses offered and academic credit hours of the programs. The programs considered in these analyses were exclusively AuD programs, but of course audiology students may also pursue the PhD or the ScD. Discipline-wide trends were also charted as components of the curricula were divided into groupings based upon the number of programs in which the courses appeared. Credit hours for many courses were variable, and a follow-up analysis that compared credit hours along with course descriptions would be valuable.

Table 1 contains a breakdown of the programs by program length, the academic year structure (semester or quarter system), and the didactic and clinic credit hours offered in programs. The vast majority (90%) of the programs operate as four-year programs on a semester/trimester schedule. Three programs operate as four-year programs on a quarter system, while two offer degrees through three-year, quarter system. One program offered a three-year semester sequence of courses and clinics.

Programs of Study: Competency Areas

The breakdown of courses in each ACAE category appears in Figure A. By far, audiology programs offer the most courses in Diagnosis and Management (D & M) and Foundation areas. Of the 113 total different audiology courses offered, 84 (74%) were from one of these two areas.

Table 2 contains courses consistent with the D & M competencies. More courses corresponded to this category than the other ACAE competencies. Several courses in this category featured multiple or advanced sections. This category also contained the only class that appeared in all sampled curricula: Hearing Aids /Amplification Systems I. Other courses appearing in the vast majority (more than 90%) of the programs included introductory, or first semester Audiologic Evaluation, Pediatric Evaluation, Electrophysiology, Hearing Conservation and a second or advanced course in Amplification. While

### Table 3: Courses that would provide didactic instruction for the Foundation competency as specified in the ACAE standards.

<table>
<thead>
<tr>
<th>COURSE TITLE</th>
<th>N</th>
<th>OTHER COURSE NAMES</th>
<th>IN COMBINATION WITH:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomy and Physiology</td>
<td>56</td>
<td>Bioacoustics, Physiologic Acoustics, Biology of the Cochlea, Physiological Bases of Sys.</td>
<td>Vestibular &amp; P (9), Path. (1)</td>
</tr>
<tr>
<td>Hearing Science and Psychoacoustics</td>
<td>51</td>
<td>Fundamentals of Hearing Measurement</td>
<td>Instrumentation (2)</td>
</tr>
<tr>
<td>Instrumentation</td>
<td>41</td>
<td>Calibration (18), Electrical Fundamentals</td>
<td>Acoustics (1)</td>
</tr>
<tr>
<td>Medical Audiology</td>
<td>34</td>
<td></td>
<td></td>
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<tr>
<td>Pathologies of the System</td>
<td>28</td>
<td>Disorders</td>
<td></td>
</tr>
<tr>
<td>Speech Perception</td>
<td>27</td>
<td></td>
<td>Psychoacoustics (5), Signal Processing (1)</td>
</tr>
<tr>
<td>Neuroanatomy I</td>
<td>27</td>
<td>(Developmental) Neuroscience</td>
<td></td>
</tr>
<tr>
<td>Statistics</td>
<td>25</td>
<td>Biostatistics: Quant. in CDIS</td>
<td></td>
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<tr>
<td>Geriatric audiology</td>
<td>23</td>
<td>Aging</td>
<td>Aural Rehabilitation (1)</td>
</tr>
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<td>Psychological Aspects of Hearing Loss</td>
<td>19</td>
<td>Psychosocial Aspects of Hearing Loss</td>
<td>Acoustic Phonetics (1)</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>15</td>
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<td></td>
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<tr>
<td>Genetics</td>
<td>13</td>
<td>Development of Auditory System</td>
<td></td>
</tr>
<tr>
<td>Speech &amp; Language Dev.</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaf Cultures</td>
<td>8</td>
<td>Deaf Community</td>
<td></td>
</tr>
<tr>
<td>Child Speech/Language Dis.</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Science</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech/Language/Reading in Deaf &amp; Hard of Hearing</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLP for the AuD Student</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acoustic Phonetics</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applied/Advanced (Acoustic) Phonetics</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Science II</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Sci. w/separate Psychoacoustics</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acoustics (stand alone)</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anatomy &amp; Physiology II</td>
<td>3</td>
<td></td>
<td>Genetics (1)</td>
</tr>
<tr>
<td>Neuroanatomy II</td>
<td>3</td>
<td>Cortical Connections</td>
<td></td>
</tr>
<tr>
<td>Adv. Lang. Science/Phonology</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction to Electroacoustics</td>
<td>2</td>
<td>(separate from Amp. Sys I)</td>
<td></td>
</tr>
<tr>
<td>Neuro-Otology</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dis. in Phonetics &amp; Articulation</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Linguistics</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4: Courses that were listed in one program that would provide didactic instruction for the Foundation (F) and Diagnosis and Management (D & M) standards.

<table>
<thead>
<tr>
<th>COURSE TITLE</th>
<th>ACAE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Language Disorders</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Advances in Audiologic Care</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Amplification Systems IV</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Assistive Listening Devices</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Augmentative Comm II</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Central Auditory Processing Disorders II</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Community Service</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Deaf Cultures II</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Immittance, Site of Lesion, &amp; Pseudohypacusis</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Instrument Repair and Modification</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Intraoperative Monitoring</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Measurement Techniques (separate Eval Course)</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Principles of AR</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Verbotoral</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Advanced Speech Science</td>
<td>F</td>
</tr>
<tr>
<td>Advanced Speech/Lang Development</td>
<td>F</td>
</tr>
<tr>
<td>Auditory Perception by Hearing Impaired</td>
<td>F</td>
</tr>
<tr>
<td>Communication Interaction</td>
<td>F</td>
</tr>
<tr>
<td>Electrophysiology III</td>
<td>F</td>
</tr>
<tr>
<td>Epidemiology</td>
<td>F</td>
</tr>
<tr>
<td>Experimental Audiology</td>
<td>F</td>
</tr>
<tr>
<td>History of Audiology</td>
<td>F</td>
</tr>
<tr>
<td>Signal Processing</td>
<td>F</td>
</tr>
<tr>
<td>Statistics</td>
<td>F</td>
</tr>
<tr>
<td>Temporal Bone Anatomy</td>
<td>F</td>
</tr>
</tbody>
</table>

Table 4 indicates that the majority of programs incorporate courses in Anatomy and Physiology to Instrumentation/Calibration and courses in diversity, speech, and language. Although courses are not identified by all programs in these areas, it is likely that the material is folded into most curricula at some point. This eclectic set of Foundation material, the stuff from which audiologists form their base of knowledge, covers an impressive spectrum of topics. It also suggests that many programs still prioritize the inclusion of speech-language pathology coursework and faculty in their training of audiologists. To further illustrate the varied course options available, Table 4 contains the courses from the D & M and Foundation Areas that were listed in only one program.

Table 5 contains courses from the Professional area of practice. As opposed to the D & M and Foundation areas, few courses in this area appear in a majority of the program curricula. Of the eight courses, only two appeared in more than half the curricula; the remaining six courses appeared in less than 10% of the programs accessed. Therefore, it is likely that most material from the Professional area is folded into one or two classes: Practice Management and/or Legal Issues.

Table 5 indicates that a strong majority of programs (more than 80%) require a course in Research Design. Statistics is folded into this course by name in five programs. In practice, statistics appears as a prerequisite for admission to many programs, and would be folded into Research Design in several others. An additional course in this area specified by five programs is Evidence-Based Practice.

In terms of student research, 38 out of 59 programs

Table 5: Courses that would provide didactic instruction for the Professional competency as specified in the ACAE standards.

<table>
<thead>
<tr>
<th>COURSE TITLE</th>
<th>N</th>
<th>OTHER COURSE NAMES</th>
<th>IN COMBINATION WITH:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional/Legal/Disability Issues</td>
<td>37</td>
<td>Standards and Practice</td>
<td>Clinic (1)</td>
</tr>
<tr>
<td>Business Management/Practice/Leadership</td>
<td>34</td>
<td>Marketing, Clinical Mgt./Admin., Service Delivery</td>
<td></td>
</tr>
<tr>
<td>Healthcare In America</td>
<td>4</td>
<td>Ethics and Healthcare</td>
<td></td>
</tr>
<tr>
<td>Introduction to Audiology/Profession</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional/Legal/Disability Issues II</td>
<td>4</td>
<td>Seminar in Prof. Issues</td>
<td></td>
</tr>
<tr>
<td>Leadership Seminar</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marketing Concepts</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational and Community Audiology</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6: Courses that would provide didactic instruction for the Research competency as specified in the ACAE standards.

<table>
<thead>
<tr>
<th>COURSE TITLE</th>
<th>N</th>
<th>OTHER COURSE NAMES</th>
<th>IN COMBINATION WITH:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Methods I</td>
<td>48</td>
<td>Many variations w/ audiology</td>
<td>Statistics (3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinic Research &amp; Design</td>
<td></td>
</tr>
<tr>
<td>Research Methods II</td>
<td>9</td>
<td>Advanced Research Design</td>
<td></td>
</tr>
<tr>
<td>Research Forum/Practicum</td>
<td>8</td>
<td>Analysis of Readings, Doctoral Theory and Research</td>
<td></td>
</tr>
<tr>
<td>Evidence-Based Practice</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab Procedures in</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiology &amp; Hearing Sci.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7: Courses that would provide didactic instruction for the Communication competency as specified in the ACAE standards.

<table>
<thead>
<tr>
<th>COURSE TITLE</th>
<th>N</th>
<th>OTHER COURSE NAMES</th>
<th>IN COMBINATION WITH:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling for CDIS</td>
<td>43</td>
<td>Rehab Counseling</td>
<td>Professional Issues (2)</td>
</tr>
<tr>
<td>Sign Language</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiculturalism in CDIS</td>
<td>8</td>
<td>Comm Dis Across Lifespan and Cultures</td>
<td></td>
</tr>
<tr>
<td>Sign Language II</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Application of ASL</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Masking</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sign Language III</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8: Courses that would provide didactic instruction for the Clinic competency as specified in the ACAE standards.

<table>
<thead>
<tr>
<th>COURSE TITLE</th>
<th>N</th>
<th>OTHER COURSE NAMES</th>
<th>IN COMBINATION WITH:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Rounds</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision</td>
<td>6</td>
<td>Advanced Pract. in Supervision</td>
<td>(Didactic Credit)</td>
</tr>
<tr>
<td>Clinical Studies in Audiology</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Issues</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduate Audiologist</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Programs require students to complete a research project, doctoral project, thesis, dissertation, independent study, investigative project, or capstone experience. In most cases, students registered for at least three course credits associated with this project. Specific outcomes of student research projects were not typically stated although some programs cited state/national conventions and/or a requirement to submit a manuscript for publication as goals of the assignment.

Table 7 contains the courses intended to support the Communication competencies. Ironically, as audiology is a field in the communication sciences, it appears that this set of courses is the thinnest when compared to the stated competencies. While most programs include a course specific to counseling, more than 20% do not have a stand-alone counseling class. Further, only 13 programs out of 59 offer a sign language course by name. Certainly, sign is woven into rehab, counseling, clinics and pediatric classes, but it is surprising that so few programs charged with the education of hearing health care providers offer even a one-credit didactic class devoted specifically to sign language.

Table 8 indicates that students are expected to register for didactic credit in clinical courses in only a few programs. Slightly more than 10% of the programs offer courses in supervision. A course in Grand Rounds was specified by seven programs, although it is also likely that programs incorporate case review and presentations at regular meetings between students, supervisors and/or faculty.

Table 9 contains the options for elective courses. 32 out of 59 sampled curricula utilized elective coursework in the program of study. Up to 15 credits of elective coursework was required by these programs offering the AuD degree. Note that most courses in the list of electives were offered as required courses in other programs. Electives would allow students the option to pick a track (usually pediatrics or adult) in which to concentrate their study and clinical experience. However, this strategy would appear to be at odds with the goals of accrediting bodies that stress all students must graduate with a basic set of competencies.

All programs required some form of comprehensive exams. The timeline for comps was not always specified; however, all programs listed written comprehensive/ qualifying examinations as a requirement. Nearly half the programs (26 out of 59) indicated more than one set of comprehensive examinations was required for doctoral candidacy and matriculation.

**CONCLUSIONS**

Prospective students, and ultimately the public, should expect our programs’ academic coursework to support the objectives and goals that accrediting
Table 9: The options for elective courses.

<table>
<thead>
<tr>
<th>COURSE TITLE</th>
<th>ACAE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>C</td>
</tr>
<tr>
<td>Early Intervention</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Neuroscience/Neuroanatomy</td>
<td>F</td>
</tr>
<tr>
<td>Law and Policy</td>
<td>B</td>
</tr>
<tr>
<td>Business</td>
<td>B</td>
</tr>
<tr>
<td>Educational audiology</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Special Problems</td>
<td>NA</td>
</tr>
<tr>
<td>Independent Study</td>
<td>NA</td>
</tr>
<tr>
<td>Health Care Mgt.</td>
<td>B</td>
</tr>
<tr>
<td>Marketing</td>
<td>B</td>
</tr>
<tr>
<td>Aural Rehabilitation</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Legal Issues</td>
<td>B</td>
</tr>
<tr>
<td>Functional Brain Imaging</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Intraoperative Monitoring I</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Intraoperative Monitoring II</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Presbycusics</td>
<td>F</td>
</tr>
<tr>
<td>Ethics in Research</td>
<td>R</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>F</td>
</tr>
<tr>
<td>ASL, III</td>
<td>C</td>
</tr>
<tr>
<td>Education of the Deaf</td>
<td>F</td>
</tr>
<tr>
<td>Deaf Culture</td>
<td>F</td>
</tr>
<tr>
<td>Hearing Aid Assembly and Repair</td>
<td>D &amp; M</td>
</tr>
<tr>
<td>Statistics</td>
<td>F</td>
</tr>
<tr>
<td>Psychology</td>
<td>F</td>
</tr>
<tr>
<td>Business Management</td>
<td>B</td>
</tr>
</tbody>
</table>

bodies set as priorities. As with many other professions that require a clinical doctorate as the entry-level degree, audiologists practicing in 2006 must be invested in the graduates of May 2006, and onward, for the profession to survive in a recognizable form into the next generation. Similarly, program directors must acknowledge the essential components required to provide the didactic coursework to support clinical practice. Access to distinct clinic populations and unique faculty specializations should be exploited when possible. However, it is unavoidable, as the scope of practice and technology serving Audiologic practice evolves, that programs and affiliated clinics will have to weigh the cost of specialization against standardization in the training of audiologists.

There should be no doubt that the results of this survey would have been different one year ago, nor should there be any doubt that the results will be different next year. Program directors should be sensitive to the changing needs of prospective students, and webmasters must accurately depict their curricula in public domains.

REFERENCES
One of the sessions at the recent Audiology NOW! ("Has the Ethics Board Gone Too Far: What Were They Thinking?") involved the Ethical Practices Committee (EPC) presenting the 13 cases brought before them this year and discussing their decisions. Based on the comments made during the session, I want to discuss the criteria used by the EPC in their decision-making process.

**What is legal versus what is ethical?** It was especially disconcerting to me that in every one of the 13 cases, phrases such as "after a great deal of discussion," "after considerable thought," "we felt that..." "we assumed that..." "it seemed like..." were used. Understandably, every case was complex. My question is "Where is the attorney?" The EPC reached a final decision regardless of whether the complaint was a legal matter or ethical issue. In my opinion, and considering that each of our 50 states have laws that regulate professional and business practices, the EPC has no business making the determination between ethics and legality. The first person to see these cases and decide if there is an ethical or legal issue should be an attorney who specializes in ethics. Then, and only then, should the EPC discuss those cases determined to be issues of ethics.

**What is the fundamental parameter used to determine if something is ethical or unethical?** As indicated by some of the cases presented, the debate over the hearing aid and equipment manufacturers’ relationships with audiologists continues. The EPC chair said the rule of thumb that should be applied was, "If this was published on the front page of the New York Times, would you want your patients to see it and what would they think?"

Let’s apply this analogy to the following dilemma: What if it were published on the front page of the New York Times that the American Academy of Audiology (AAA) accepts money from hearing aid manufacturers and equipment manufacturers to support the AAA national convention? In addition to this “donation,” (although disclosed as “commitment levels” and not dollar amounts), the manufacturers are also expected to pay rent for space in the exhibit hall. Would this be construed as a Conflict of Interest? I feel that the EPC would vote resoundingly “Yes.”

Or we could use a different approach; one of pragmatic logic rather than sensational journalism. I understand that a major part of the Academy annual operating expenses are generated by the annual convention. If all ties were severed as would be indicated by the analogy used by the EPC, how would the Academy raise the revenues needed for operating expenses? Will the convention registration be increased to provide that money or will membership fees be increased or both? Perhaps the convenience of buses running between hotels to the convention center will become a memory without a sponsor? I suppose that other convention sponsored activities such as internet access in the convention hall, immediate registration of CEUs, ice cream breaks, and the message center would be eliminated. We would have to return to our own briefcases, paper, and pens without exhibitor sponsorships. Will the attendees be allowed to participate in manufacturers’ parties or dinners that are held for customers? And, no more box lunches?

If members are unable to obtain continuing education by using hearing aid unit sales to help pay our registration fees, hotel or airfare expenses, I predict that the annual convention attendance will decrease. Many private practitioners do not have income for travel and continuing education, unlike our colleagues who are supported by their employers such as university, educational, military and VA audiologists. These colleagues likely have paid vacation time and/or personal leave days and they do not suffer a loss of income by being absent from work. So as convention attendance decreases, we may see fewer exhibitors, creating additional decrease in revenues for the Academy.

Because of the violation of Academy ethics in partnering with manufacturers to buy equipment based on hearing aid sales, how will the small private practitioner afford the new equipment that may cost as much as $8,000-$11,000? If older technology is used or new dagnostic techniques are omitted, will members face ethics violations? Although the chair of the EPC said that the committee is not “telling us” how to do business, I heartily disagree. EPC is limiting our ability to stay abreast of new technology and compete with large practices and clinics with bigger budgets and even university clinical programs whose annual budgets are not based in total on their net revenue.

It is with some irony that the Academy awards CEUs for instructional classes offered on manufacturers’ incentive trips. I believe that there is a fear that industry interaclion with the audiologist will somehow taint our morals; consequently, we and ultimately our patients, must be protected. When did manufacturers became “the enemy?” I thought we were all committed to the same basic principle of helping the hearing impaired. Because audiology is still not a household word, we actually have digressed into agreeing with this thinking or being afraid of it. Our relationships and partnerships with manufacturers ultimately will help our patients.

Life is not black and white; life is gray and each of us decides where we need to or want to draw the lines. I believe that it is an individual decision and not one for others to regulate or to legislate. I think the EPC has gone too far in drawing the lines and audiologists will suffer from our fear of impropriety. Do not legislate all of us because of the 1% or less who will choose differently. Let the 99% of us who are comfortable with our ethics continue as we are.

Cydney Fox, Los Angeles, CA
The Ethical Practices Committee (EPC) understands and appreciates the concerns raised by Ms. Fox in her recent Letter to the Editor. She asked: “What is legal versus what is ethical?” and “What is the fundamental parameter used to determine if something is ethical or unethical?” Further, she raises questions regarding the educational relationship manufacturers have with audiologists and the financial impact of change on business practices.

What is legal versus ethical? Ethical and legal practice issues are not mutually exclusive; some unethical practices are clearly illegal. For example, providing kickbacks to a physician for referrals is illegal as it violates the Anti-Kickback Law. This is also a violation of the Code of Ethics Rule 8b “Individuals shall not engage in dishonesty or illegal conduct that adversely affects the profession.” The EPC procedures require complaints involving potential violation of state or federal laws to be reported to the appropriate governmental agency. The EPC does not adjudicate issues of law. Releasing a complaint to legal authorities does not prohibit the EPC from adjudicating potential violations of the Code of Ethics. Legal counsel is available as needed and the value of legal counsel is in advising on complaints with potential legal implications and procedural issues. Further, attorneys Hahn (2003) and Liang (1999) have provided legal opinions regarding business practices to which some audiologists continue to cling. The Ethical Practice Guidelines on Financial Incentives From Hearing Industry Manufacturers was drafted to assist audiologists with practicing in an ethical manner, following the guidelines will also assist in practicing in legal manner. A copy of the guidelines can be reviewed and downloaded at www.audiology.org.

Conversely, there may be issues that have no legal ramifications, but are unethical. For example, consider an audiologist who is able to provide services but refuses to provide services to a patient who could benefit simply because the patient purchased hearing aids elsewhere. This is not illegal, but unethical in that it violates Rule 1a “Individuals shall not limit the delivery of professional services on any basis that is unjustifiable or irrelevant to the need for the potential benefit from such services.” The role of the EPC is to deliberate and adjudicate ethical issues. The “fundamental parameter” used to determine ethical versus unethical is the Code of Ethics. Just as in a legal court of law a jury must look at the available evidence and determine if the law was violated, the EPC reviews available information to determine if the Code of Ethics has been violated.

Ms. Fox also raised the issue of continuing education credits and vendor trips. Manufacturers have a responsibility to train audiologists regarding their products and software. Product training trips are acceptable. Many manufacturers also offer other types of educational activities. As of May 2006, when applying for CEUs manufacturers are now required to attest that product training and other educational activities will not be held in conjunction with an event that does not comply with the Ethical Practices Guideline for Financial Incentives from Hearing Industry Manufacturers.

Further, Ms. Fox challenges the financial impact of change. As we examine the profession, previously accepted practices are challenged. Herefore, it may have been considered acceptable practice to enter into agreements with vendors to assist an independent practitioner in outfitting a new practice. In years past, banks and other financial institutions may not have considered a private practice in audiology a good financial risk. From an ethical perspective, dispensing decisions may be influenced by the relationship with the vendor. From a financial perspective, where is the sense in having hearing aid manufacturers keep a portion of what is paid for hearing aids in an account where the manufacturer determines how it will be spent? Certainly, an accountant would recommend that audiologists pay less up front keeping the money in their own practice. Often fear of change can lead to over-reaction; there is no evidence that changing these practices will result in financial hardships. On the contrary, many audiologists in all settings practice in accordance with the guidelines and thrive.

Independent governance and skilled service to society are hallmarks of an autonomous profession. As an autonomous profession audiology must regulate the professional behavior of audiologists. We are obliged to evaluate past and present professional behaviors and business practices, how these practices are viewed by the public and the professional image they project. Hawkins (2002) revealed that consumers view some of these practices very differently than audiologists. As audiology enjoys increasing public recognition and trust as an autonomous and self-regulating profession, the need for a shared commitment to upholding the highest standards of professional behavior increases. Ethical behavior by audiologists, whether they are Academy members or non-members, is governed by following professional behavior standards as stated in the Code of Ethics. The Code of Ethics is the profession’s proclamation to the public announcing the behavior patients can expect from the profession.

Culture change takes time. Consider that 25 years ago, smoking indoors and in any location was acceptable, even in the sound booth while testing. Today this is no longer acceptable and in many cases illegal. This is also true of ethical practice, as audiology continues to grow in autonomy previously accepted practices are no longer appropriate. Continued growth requires careful, deliberate and robust discussion and planning. Moving towards ethical practice is a long-term commitment to asserting that audiologists can stand the test of external examination and scrutiny, whether by the front page of the New York Times or a visit by a member of the 60 Minutes team.

Audiologists are obliged to dispense products that are in the best interest of the patients based on scientific evidence, not the need to achieve a monthly sales quota. Changing and rethinking how we do business is an essential part of our professional growth and autonomous rank. It must result in ways and means that do not present or create the perception that audiologists have compromised their most important obligation to the hearing impaired, to serve them by placing their needs and interest first, through the application of current scientific knowledge, free and independent of enticements. There remains no doubt that even the appearance of inappropriate relationships damages audiology as a whole as it lowers the public’s perception of the integrity of the profession. ☹️

References


In the last five years, the American Academy of Audiology (AAA) and the Academy of Dispensing Audiology (ADA) have made major efforts to educate their members about their respective Codes of Ethics and how they should be interpreted in light of relationships with hearing instrument manufacturers. These efforts began in 2001 when an AAA Presidential Task Force was formed to make recommendations about how the Academy should proceed on a variety of issues related to potential conflicts of interest (COI). Based upon the recommendations of this task force, the AAA Ethical Practices Committee (EPC) and ADA leadership developed a set of guidelines that were endorsed by both AAA and ADA. These guidelines were published in the May/June issue of Audiology Today in 2003 for member comments. Following member input, The Ethical Practices Guidelines for Financial Relationships with Hearing Industry Manufacturers was adopted by the AAA and the ADA, thus providing direction for audiologists on these issues. The Guidelines reaffirmed the AAA Code of Ethics, Rule 4c “Individuals shall not participate in activities that constitute a conflict of profession interest” and gave some specific examples of conflicts of interest. At that same time, then AAA President Angela Loavenbruck embarked on a series of talks and seminars to educate the membership about the importance of these issues. The AAA EPC also started systematic efforts to inform the membership and raise its awareness of the importance of COI through state and national convention presentations and frequent articles in Audiology Today.

The 2001 AAA Presidential Task Force considered the results of a survey of 42 hearing-impaired consumers and 182 audiologists (Hawkins, Hamill, Van Vliet and Freeman, 2002) before recommending that EPC develop guidelines. This survey presented 17 situations and asked the respondents to react to each on a rating scale ranging from “clearly unethical” to “nothing wrong.” Given the recent educational efforts to raise awareness of COI issues, the EPC requested that this same survey be administered again to determine if audiologists’ views on COI had changed. This article discusses the findings.

**METHOD**

All active members of the AAA were solicited directly by email in February 2006 and invited to participate in the survey. Participation involved visiting a website, logging in, and spending approximately ten minutes responding to the survey. The survey was completed by 1,633 AAA members. For comparison purposes, the results from the Hawkins et al. (2001) study of 42 hearing-impaired consumers and 182 audiologists will be included.

The 17 situations from the questionnaire given to the audiologists are noted within Figures 1-17. Respondents were asked to rate each of the activities in one of four categories:

1. “I think there is nothing wrong with that practice.”
2. “While not unethical, that practice may not be in the patient’s best interest. I would be more comfortable working with a professional who did not engage in that business practice.”
3. “I think this business practice is highly suspect and certainly borders on unethical.”
4. “I think this business practice is clearly unethical.”

On the figures that are shown in the Results section, these four categories will be shortened into the following descriptions: 1) Nothing Wrong, 2) Better If Not Done, 3) Borders on Unethical, 4) Clearly Unethical.

The content area of the various questions can be described as falling into one of four areas: 1) business incentives from hearing aid manufacturers, 2) entertainment, small gifts, and visits from manufacturer representatives, 3) CEU events sponsored by hearing aid manufacturers, and 4) business practices. It should be emphasized that inclusion of an activity in the survey does not imply that the EPB considers that activity to be unethical or to place the member in a COI, and in fact some of the activities are considered acceptable given the 2003 guidelines.

**RESULTS**

The survey results are shown in Figures 1 – 17. A chi-square analysis of each question was performed to determine whether the distribution of responses was significantly different for 1) the
Aids Revisited: A Survey

2002 audiologists versus the 2006 audiologists, and 2) the 2002 consumers versus the 2006 audiologists. These results are analyzed below in terms of the groupings of the questions described above.

**Business incentives from hearing aid manufacturers**

Figures 1 – 4 show the results for the four questions that addressed business incentives from hearing aid manufacturers. There has been a significant shift in opinion from 2002 to 2006 among the audiologists on the question of accepting cruises and gifts from manufacturers. More respondents indicated that it is not appropriate to accept gifts or cruises in exchange for purchase of a certain number of hearing aids (Figure 1, chi-square, p<.0001). For example, 30% more audiologists found this practice “clearly unethical” in 2006 and the percentage who found “nothing wrong” dropped from 32% to 17%. Interestingly, the distribution of responses for the 2006 audiologists and 2002 consumers was not significantly different (p<.20).

Figure 2 shows that audiologists have a different view when the manufacturer rewards the buying of hearing aids with money deposited into an account to be used for equipment or CEUs or other business expenses. Both today and in 2002, the majority of audiologists found the practice acceptable, while 85% of the consumers had found the practice unethical or bordering on unethical. While over 50% of audiologists retain the view that there is nothing wrong with this incentive, and some 10-12% retain the belief that it is clearly unethical, there was a significant shift in the degree to which the remaining audiologists viewed the practice (p<.001), with more now considering the practice as bordering on unethical. Audiologists consider it more problematic when the incentive is equipment purchase in exchange for agreeing to purchase a set number of aids in the next year (Figure 3). The consumers held similar views for both the reserve account and the agreement to purchase hearing aids to repay the equipment purchase. Again, the distribution of opinions of audiologists changed significantly with more finding it unethical (p<.001) to
accept equipment for hearing aid purchases; however, the current audiologists’ opinions still differ significantly from those of the consumers (p<.001). The perception of the practice of receiving money or a traveler’s check from a manufacturer for hearing aids purchased is summarized in Figure 4 and is virtually identical to the answer for the cruise/gift question (Figure 1). The audiologists have clearly become more concerned about this activity as a significant shift has occurred (p<.001) and the opinions of the audiologists in 2006 are now similar to those of the consumers in 2002 (p<.10).

Entertainment, small gifts, and visits from manufacturer representatives

Figures 5 - 10 show the results for six questions that addressed entertainment, small gifts and visits from manufacturer representatives. The results in Figures 5 and 6 show that there is little concern about the practice of sales representatives visiting audiologists and bringing small items such as pens and notepads. There has been no significant change in the opinion of audiologists over the last four years on these two practices (p<.43 and p<.13, respectively). While consumers are also rather accepting of these practices, there is still a significant difference (p<.001) between the consumers and audiologists, with a small minority of consumers showing some reservations about any sales visit.

Similarly, if the sales representative visits and brings lunch or takes the audiologist out to lunch to discuss products (Figure 7), approximately 85% of audiologists see no problem and opinions regarding this practice have not changed significantly from 2002 to 2006 (p<.36). The consumers remain different from the 2006 audiologists (p<.001), with only 45% seeing nothing wrong with the practice. When the audiologist and spouse are taken to dinner and products are only briefly discussed (Figure 8), more concern is seen by all groups. Audiologists have become significantly more concerned since 2002 (p<.001) and the 2006 audiologists are not significantly different from the consumers (p<.051) with respect to this issue.

Figures 9 and 10 show the results for the two questions addressing entertainment at conventions. When an audiologist attends a party that is open to everyone (Figure 9), an
overwhelming 93-95% of audiologists report nothing objectionable. While most consumers seem to approve of this activity as well, the distributions are significantly different (p<.001), with 33% of consumers expressing some concern. When the party is by invitation only, the majority of audiologists in 2002 and 2006 still approve (76 and 74%, respectively). Continuing the trend of consumers being more conservative in ethical issues, significantly more concern (p<.001) is seen by the consumers on this question as well, with only 36% seeing nothing wrong with this practice. Although the audiologists’ change in opinions on the question of parties has been modest, it did reach statistical significance (p<.01 for each question.)

**CEU events sponsored by hearing aid manufacturers**

Figures 11 and 12 show the results for two questions related to CEU events sponsored by hearing aid manufacturers in the local town of the audiologist. When the audiologist attends a company-sponsored, state-approved workshop in town (Figure 11), 97% of audiologists see no problem and this view has not changed in the last four years (p<.62). When meals are offered along with the CEU events (Figure 12), the consumers are more bothered, as evidenced by the “nothing wrong” percentage dropping from 86% to 64% with the addition of meals. The percentage of audiologists approving when meals are added remains high (92-93%) and has not changed in four years (p<.95). Consumers and audiologists remain different in their responses to both questions (p<.001).
At the annual audiology convention, the audiologist attends a dinner party that is by invitation only. The audiologist was given the invitation by the area hearing instruments sales representative.

An audiologist goes to a company-sponsored, state-approved CEU workshop in town.

All groups expressed more concern when a company-sponsored CEU workshop is out of town and the manufacturer pays the audiologist's expenses to attend. Figure 13 shows the results when the expenses are paid for the audiologist and Figure 14 when a spouse attends as well. When only the audiologist attends with expenses paid, slightly over half of the audiologists see nothing wrong, with the percentage dropping from 66% in 2002. This represents a significant shift for the audiologists (p<.001) and again, the consumers are more concerned than the 2006 audiologists (p<.001). When the spouse also attends at the expense of the manufacturer (Figure 14), only 16% of the audiologists in 2006 reported seeing no problem with the practice, down from 26% in 2002 (p<.001).

While the distribution of responses for the audiologists in 2006 and consumers in 2002 are quite similar for this situation, the difference is still statistically significant (p<.01).

**Business practices**

Figures 15 shows the results for the issue of using hearing aids from one manufacturer because of a volume discount when the audiologist believes this brand is a good one. While very few respondents thought this practice was clearly unethical, some reservations are obviously felt by all three groups. The audiologists did change significantly (p<.01) from 2002 to 2006, with more seeing a problem with this practice. The consumers again expressed more problems with the practice (p<.05).

The results are similar when the practice of purchasing a franchise and dispensing a single line of hearing aids almost exclusively is presented. Figure 16 shows the results and while it is clear that the majority see nothing wrong with the practice, 40-50% of all groups express some concern through their answers. Again, the modest shift in opinion and the difference between 2006 audiologists and consumers reached statistical significance (p<.001 and p<.025, respectively).

The issue of receiving a commission on the sale of hearing aids is addressed in the remaining question and is shown in Figure 17. The audiologists are not different from 2002 to 2006 (p>.20) and while the majority see nothing wrong, 45% see some reason for concern about the practice. The consumers are significantly different from the 2006 audiologists (p<.001) and clearly are concerned, as only 10% see nothing wrong with receiving a commission for hearing aid sales.

**DISCUSSION**

The 2003 *Ethical Practice Guidelines on Financial Incentives from Hearing Instrument Manufacturers* reminds audiologists that the interests of the patient must come before the financial interests of the audiologist. If a business practice has the appearance of conflict of interest, it must be avoided, even if there is no actual conflict of interest. Stated another way, just because an audiologist on introspection believes an incentive does not affect his or her judgment does not mean that it is appropriate to accept that incentive.

A COI exists when an arrangement has any one of three following three characteristics: 1) a kickback, a quid pro quo arrangement, a gift of money or other item of value tied to the purchase of a product, 2) a gift of value even when not tied to the purchase of a product, and 3) an arrangement which has the appearance of a benefit to the audiologist. An added concern is that under certain circumstances these activities are not only unethical but can be illegal. Hahn et al. (2005) stated “Under the Federal Anti-Kickback Statute…it is a felony for any person (including an audiologist) to knowingly and willfully solicit or
receive remuneration, directly or indirectly, overtly or covertly, in cash or kind, in return for purchasing, leasing or ordering (or recommending purchase, lease or ordering) of any item or service reimbursable in whole or part under a federal health care program” (p. 34).

This survey indicates a large change in audiologists’ opinions about the most blatant conflicts of interest: accepting gifts and cruises in return for hearing aid purchase. While half of audiologists find this clearly unethical, which is the position of the Academy, audiologists’ opinions on the acceptability of professionally related gifts in exchange for hearing aid purchase has not changed as markedly. Consumers viewed the ethics of accepting cruises or business equipment in exchange for hearing aid purchases similarly. Regardless of whether equipment is purchased from funds deposited into an account as a reward for purchasing hearing aids, or whether a loan is repaid by purchasing a given brand of hearing aids, about half of the consumers find this clearly unethical. Because the consumer could reasonably question whether the motive of the audiologist for selling a brand was to fund office equipment, the conflict of interest guidelines prohibit this practice. Apparently, many audiologists continue to justify the “greater good” of the business-related incentives. The problem that arises is that the “goodness” of the gift, e.g., hearing aid fitting hardware or education, gives an appearance of “goodness” to the transaction but in actuality this can be considered a money laundering scheme. Regardless of the “goodness” of the gift, the audiologist is still accepting a gift that is of value. It is the value to the audiologist, regardless of potential benefit to the patient, that creates the appearance of a COI.

While the Academy strongly supports the use of state-of-the-art equipment and the funding of continuing education, it is recommended that the audiologist negotiate up-front hearing aid discounts from manufacturers rather than engaging in covert business arrangements. Discounts should be reflected on the manufacturer’s invoices and passed on to those third-party payers who reimburse actual costs. This offers legal protection, as failure to disclose the true cost of goods (e.g., if a Medicaid aid purchase was rewarded) is a violation of the Federal Anti-Kickback statute.
An audiologist finds that Brand X is at least as good as other brands. By purchasing Brand X hearing aids almost exclusively, the audiologist gets a 20% volume discount; therefore, the audiologist predominantly uses this brand.

An audiologist has purchased a hearing aid franchise from a company with a well known name, one that advertises nationally, one that consumers easily recognize. The sign on the door indicates the brand name. The audiologist dispenses this product line almost exclusively. The audiologist only uses another manufacturer’s product when there is no franchise product that can meet the client’s needs.

Audiologists had similar opinions about volume discounts and purchase of a hearing aid franchise. Consumers did not strongly object to either practice, but found the franchise to be more acceptable. This may be because the consumer walking into a franchise has full knowledge that a single brand is dispensed, while volume discounts are not generally disclosed.

Manufacturer training on use of products and software is crucial. The conflict of interest guidelines advise audiologists that manufacturer representatives’ offers of business related items valued at less than $100, offered when a representative visits a practice to discuss products, can be ethically accepted, as can business lunches. Audiologists’ opinions on this have not changed markedly; most agree with the Academy position. Similarly, the Academy views open-invitation parties at convention as ethically acceptable, a view that is also supported by the membership.

Entertainment that has “strings” attached is not considered acceptable according to the conflict of interest guidelines. The example scenarios in this survey were the non-business dinner invitation that includes the audiologist’s spouse and the invitation-only convention party. There has been more change in audiologists’ beliefs that the non-business dinner with the spouse is unacceptable, with nearly half finding that unethical or borderline unethical. There has been less acceptance of the idea that an invitation-only party for the company’s best accounts is an unacceptable reward. The Academy position is that this is a conflict of interest, as it is a reward for past business that is intended to create a social obligation that patients may view as compromising the objectivity of the audiologist.

This same rationale applies to company-sponsored training. The Academy prefers that audiologists not accept travel expenses
if training must be held out of town, but recognizes that manufacturers sometimes will find it educationally necessary and more economical to conduct training in a central location. In those cases, the audiologist is permitted to accept travel expenses and meals; however, it would not be acceptable to permit the manufacturer to provide entertainment expenses or spousal travel. There has been a recent trend among manufacturers to offer training trips outside of the country. Although the Academy views product training as a responsibility of manufacturers and supports regional and national product training activities, there is a problem with product training activities which take audiologists out of the country. While at times a product training trip outside of the country may be as cost effective as in the United States, audiologists still need to be aware that the appearance of extravagance creates a conflict of interest. The survey results show that most audiologists are now in agreement. Almost 75% found it unethical or borderline for a manufacturer to fly the Florida audiologist and spouse to New York for training, which compares to 69% of the consumers who held that view.

The conflict of interest guidelines did not specifically address the practice of audiologists receiving a commission for the sales of hearing aids, but the survey has shown a slight change in how audiologists view this practice. Physician and lawyer Bryan Liang addressed this issue in his invited presentation at AudiologyNOW! 2006 in Minneapolis. He views a sales-volume incentive system as entirely inappropriate and a clear conflict of interest, but believes other forms of incentives can be entirely ethical. Receiving a commission based on a percentage of the sales price creates a conflict of interest because the patient may question the motive behind the recommendation. Receiving a work-based incentive is a more acceptable means of rewarding productivity. That is, if an incentive system rewards all forms of productivity equally, it is ethical. Liang suggested a system where diagnostic testing has value units and fitting/ dispensing has value units (that are not based on the product prices). In such a system, a practice may decide to award more value units to some forms of dispensing, such as to new users or children, because of greater work involvement, but would not be free to reward an activity more simply because it is more profitable, such as selling a high-end digital hearing aid over a mid-range digital aid. Liang counsels that the incentive plan should be arranged in advance and applied equally to all employees, in which case it models the relative value unit incentive plans offered to physicians, which are widely accepted.

CONCLUSIONS

The 2006 survey of audiologist’s opinions of the ethics of relationships with manufacturers shows that audiologists are increasingly of the opinion that accepting gifts or cruises is unethical, which was the major focus of the Academy’s 2003 guidelines on relationships with manufacturers. While changes were also seen in viewpoints on the more subtle, but still unethical, practices such as the acceptance of equipment in return for hearing aid sales, it is clear that further member education is required. The Academy has recently published Ethics in Audiology: Guidelines for Ethical Conduct in Clinical, Educational, and Research Settings and AudiologyNOW! 2006 offered 8.5 hours (.85 CEUs) of continuing education in ethics. These efforts may foster further evolution in the beliefs of audiologists about the impact of conflict of interest on the doctoring profession of audiology.

REFERENCES
Thumbs Up!
The reviews are in, and AudiologyNOW! 2006 was a smashing success! As the new name of the Academy’s annual convention implies, AudiologyNOW! is a state-of-the-art meeting in a perpetual state of reinvention and discovery. Two weeks after AudiologyNOW! in Minneapolis, I was meeting with Sharon Sandridge, the 2007 Program Chair for a debriefing meeting at Academy headquarters to review what worked and what didn’t at AudiologyNOW! 2006. We began the work of enhancing AudiologyNOW! 2007, and developed a timely focus of Hearing Loss Prevention.

What were my favorite moments at AudiologyNOW! 2006, you might ask? Well my first thrill was seeing the giant “A” hanging above the registration area. After working with the Program Committee and Academy Staff for over a year, it was a wonderful symbol of the “A” effort they devoted to the project. I had another thrill during the newly formatted General Assembly hearing Gail Whitelaw and Paul Pessis count down Audiology’s Top 10 events of the last year. It was also a thrill to learn about innovation from a master of innovation, John Sweeney, who summarized his talk at the receiving end of a knife-throwing act. Talk about cutting-edge stuff! (Check out this link to re-live the moment: http://events.streamlogics.com/avwtelav/audiology/apr06-06/index.asp).

Speaking of cutting edge stuff, did you catch the Legends of Auditory Science session? William Brownell, Peter Dallos, Robert Galambos and Jozef Zwislocki enchanted the audience with stories that ranged from the history of auditory research to the most recent developments in our understanding of cochlear function. It was a magical moment, but stay tuned: AudiologyNOW! 2007 will have….its own Legends!

What were your favorite things about AudiologyNOW! 2006? You were given the opportunity to complete an online, post-AudiologyNOW! survey of your experiences. The following is a sample of your favorite things. Can you find Waldo?
**Thumbs Down!**

**Challenge:** Overbooking Situation at Hyatt Minneapolis.
A few attendees experienced an unpleasant surprise at check-in: the Hyatt was overbooked and, even though they had a confirmed reservation, the hotel was relocating them to another hotel.

**Solution:** Unfortunately, the Academy cannot control the actions of its vendors. However, we can “fight” for our attendees who “book-in-the-block.” In other words, attendees who made reservations through our housing reservation system and were turned away by the Hyatt Minneapolis Hotel were compensated financially for 1) free room at another hotel, 2) taxi money, and 3) money for phone calls. Anyone who had made a reservation directly with the Hyatt Minneapolis Hotel—booked out of the block—and was turned away was given nothing. The Academy encourages you to continue to reserve hotel rooms through our housing system so the Academy can help protect you, should an unfortunate situation arise. Book-in-the-Block!

**Challenge: Not enough rooms in the block.** Some attendees commented that there were not enough hotel rooms in the block or that when they went to reserve a hotel room shortly after the opening of the housing process, all of the properties were booked. Potential attendees reserving rooms immediately—even before registering—create this phenomenon.

**Solution:** To better manage the number of hotels rooms being reserved, the convention registration and hotel reservation process will be linked sequentially. Attendees will first register to attend AudiologyNOW! 2007. Upon successfully completing the registration process, the attendee will be directed to a website for reserving a hotel room.

**Challenge: PreviewNOW! did not list all of the sessions and/or some did not receive it.** At the suggestion of Academy members, the submission deadline was moved later in 2005 for AN! 2006 to capture the most current research and topics. As a result, the later submission dates precluded those sessions from making the deadline for the mailing of the preliminary program.

**Solution:** Sessions with invited presenters—Featured Sessions, Learning Labs and Focus Groups—are listed in PreviewNOW! The complete list of sessions will be available online in early 2007, including a downloadable .pdf version. The Academy is working with the Itinerary Planner vendor to further improve the searchable itinerary system.

Over 13,000 copies of PreviewNOW! were mailed to current and potential Academy members. If you did not receive one we suggest confirming your current address by e-mailing equinn@audiology.org.

**The Box Office Numbers Are In!**

With 3,893 attendees and 3,172 exhibitors, a grand total of 7,065 experienced the first-ever AudiologyNOW! culminating in the highest attendance number in the past five years!

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<th>International Registrants</th>
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<td>International Attendees hailed from 54 countries! (Countries with 5 or more attendees)</td>
<td>Clinic 14%</td>
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<td>Argentina 24</td>
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<td>Australia 32</td>
<td>ENT/Physician Office 13%</td>
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<td>Columbia 43</td>
<td>Primary/Secondary School 3%</td>
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<td>Denmark 109</td>
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**AUDIOLGY TODAY 33**
The 2007 Program Committee met recently in Denver to begin planning AudiologyNOW!. Members of the Committee, being carefully watched over by the Big Blue Bear, include (from left, back row) Todd Ricketts, Marc Fagelson, Patrick Feeney, Dick Danielson; (from left, front row) Patricia Kricos, Paul Pessis, Sharon Sandridge (Program Chair), Judith Gravel, Linda Guenette, Mona Klingler, Robert Traynor, Patricia McCarthy and Brandon Lichtman (student member).

At right....The 2007 Program Committee checks out the Big Blue Bear sculpture peering in the window at the Colorado Convention Center.

Cheryl Kreider Carey (left), Deputy Executive Director of the Academy with responsibilities for conventions, exposition and education activities, is shown above in a busy strategy planning moment for AudiologyNOW! 2007 with Sharon Sandridge, 2007 Program Chair.

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AudiologyNOW! 2007 Program Committee
Please contact the appropriate subcommittee members if you have suggestions or questions.
It’s All About Relationships

The term “relationship marketing” refers to building solid relationships with patients that will last for a lifetime. The goal of relationship marketing is not unlike the one that you have for family or good friends. It’s not about having a “buddy-buddy” relationship with patients and colleagues, but rather it’s about creating a bond that will last a lifetime. Retaining patients and referral sources means keeping them informed and connected with you or your organization. If you don’t, they will slip away and eventually no longer be your patients, just as friends don’t stay friends if you don’t communicate and show interest in them.

Despite the goal of developing “patients for life,” many audiologists only communicate with their patients when they want to inform them of new technologies. I liken this to only inviting family and friends for events associated with gift giving. So, if you want to develop a long-time, meaningful relationship with someone, what should you do?

Take time to get acquainted - When a new patient visits your practice or organization for the first time, make them feel welcome. Take some time to introduce them to the staff and show them the facility before you start testing. Let them know that you are pleased they chose your facility for their hearing healthcare. Patients have a choice of providers so thank them for choosing YOU. If your facility serves refreshments, ask the patient and their guest if they would like a cup of coffee or water and some cookies while you gather some information.

Give them your undivided attention – During the initial interview, allow the patient time to share their story and make notes of the key points so you will remember them during future visits. Be a good listener and make sure you have ample time scheduled so you don’t have to rush. When you are with a patient, that person should be the ONLY thing on your mind. A successful practitioner is usually a busy practitioner, but reports and walk-in patients should never get in the way of devoting your full attention to a patient who has scheduled an appointment with you.

Repeatedly share information – Once the patient has left your office, you should send information on a regular basis. A good first step is to send every new patient a thank you note. Let the patient know how much you enjoyed working with them and that you look forward to an ongoing relationship. It's great to share the most recent product developments but make sure this isn’t the ONLY information you share with patients. Include updates on the staff and the educational progress they have made. Think about sharing information via email and/or printed newsletters. Postcards are also great ways to send brief messages to patients.

Show them you care – It's paramount that you notice when patients fail to come in for a long period of time, and this will require a means of tracking patient visits. This type of data will enable you to follow and actually predict patient behavior. When a long-term patient fails to visit your office, it becomes obvious that his or her relationship with you has changed. You need to let the patient know that you recognize their absence and that you are concerned. If you only call a patient when you want them to buy something, they may feel like you only care about selling them something.

Recognize their accomplishments – Patients appreciate it when you remember their birthdays, special anniversaries, or significant events in their lives like the birth of a child or grandchild or a job promotion. Think how special you feel when a friend sends you a card out of the blue. Patients have similar feelings. Remember to acknowledge the death of a patient by sending the family a sympathy card.

Since patients are living longer and acquiring hearing loss at younger ages, the importance of developing lifetime relationships with patients is becoming more valuable to a business. When you want to form a lifetime relationship with a patient, go the extra mile to make them feel welcome and take every opportunity you can to make them feel special. Treat every patient as if they are a special friend that you would hate to lose. Live by the motto, “Love your patients and the money will follow.” (Nägen)

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EDITORIAL

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Cl Specialty Certification Thrives

Sara Blair Lake, ABA Staff Director, Reston, VA

In 2004, after several years in development, the Cochlear Implant Specialty Certification Task Force of the American Board of Audiology™, together with a nationally recognized educational and testing consultant, completed work on an examination that represents the first of its kind in the field. The content of the examination, designed to assess a core body of knowledge representative of audiological practice in the field of cochlear implants, is the result of a nationwide job analysis. The job analysis surveyed audiologists working with cochlear implant patients, to identify knowledge considered important to practice. The examination was developed in accordance with the content outline by the combined effort of qualified subject matter experts, including Committee Co-Chairs Patricia Chute and Cheryl DeConde Johnson, as well as testing professionals.

The ABA first offered the examination in March 2005, following the 10th Symposium on Cochlear Implants in Children in Dallas, Texas. Since that time, ABA has offered the examination on four other occasions in venues across the US including Washington, DC; Scottsdale, AZ; Valencia, CA; and Minneapolis, MN.

The ABA is pleased to report that at the conclusion of the first year and one-half of the program, there are now 53 Board Certified Audiologists with a Specialty in Cochlear Implants. This represents about 13% of the estimated US audiologists who specialize in cochlear implants. In the future, the ABA plans to offer administrations of the examination in conjunction with each year’s AudiologyNOW! convention and following the biennial Symposium on Cochlear Implants in Children. Additionally, if a state academy of audiology or other group would like to offer an administration of the examination in its geographic area and has a sufficient number of candidates interested in taking the examination, the ABA will work with the group to hold such an additional administration. Those interested should contact the ABA office.

The ABA is in the process of redesigning and updating its website (anticipated date of completion is Fall 2006) and a new feature will spotlight those professionals holding the Cochlear Implant Specialty Certification. This credential is important as it will assist both hearing health professionals and consumers in identifying those audiologists who have demonstrated that they possess knowledge representative of professional practice in this highly specialized area of audiology.
Audiology professionals, most often through their professional associations, have a number of critical imperatives as they attempt to balance their responsibilities to the public and society in general and to their practitioners. Through a variety of self-regulatory functions, professions define their scope of practice and the body of specialized knowledge, skills and competencies that must be mastered prior to entry into the profession. In American higher education, accreditation of higher education institutions and specialized programs within those institutions is voluntary. Through voluntary accreditation, society attempts to ensure that the services provided to its citizens by various professions meet self-imposed standards of quality and are delivered with integrity. The self-regulatory process prevalent in North America is unique—in most countries throughout the world, national ministries of education perform this quality assurance function. In this country, while accreditation is voluntary, it often serves as a gatekeeper for federal funds and therefore must be responsible to the public for institutional performance in accredited programs. In the Audiology profession, standard development and accreditation is undergoing an historical change, which places it firmly in the forefront of state of the art changes in the accreditation process.

For the past 20 years, and most certainly over the past 10 years, Audiology has evolved into a distinct and unique profession. In its early development, Audiology was linked academically to speech-language pathology, a profession whose educational model and political agenda had become increasingly mismatched. As this mismatch became more noticeable, audiologists joined together to form two new national organizations that could better serve their needs. The Academy of Dispensing Audiology (ADA) was formed to represent the burgeoning interests of those audiologists who were dispensing hearing aids and starting practices. The American Academy of Audiology (AAA) was formed to be a voice of, by and for audiologists alone. Through the leadership of these professional organizations, our educational and training model evolved from one which stressed classroom education and student teaching assignments to educational models that stress integration of classroom and clinical education. Rather than systematically devaluing clinicians, the profession’s move to doctoral education with a distinctive designator, the AuD, increases the value placed on clinical education and the practitioners who deliver these services. Our evolution has aligned the AuD degree with the attainment of knowledge, competencies and skills needed to enter the Audiology profession. Our licensure laws are slowly falling into line with the new realities of our profession. All of these developments are steps toward the autonomy of the Audiology profession.

The development of both academic standards for university programs and professional practice standards for audiologists represents the underpinnings of our profession. Our development into a doctoral entry-level profession has meant that these standards had to undergo a critical revision to coincide with the change in entry-level degree requirements. Throughout our history, the process of standard development and the process of accreditation of Audiology programs have been closely tied to ASHA’s certification program. ASHA’s accreditation standards have demanded that students be prepared for the ASHA certificate and have permitted supervision only from individuals who have also purchased the ASHA certificate.
Universities have been required, as part of the accreditation process, to list the ASHA membership numbers of all faculty, staff and off-campus audiologists who provide supervision. ASHA’s standards structure did not permit input from Audiology professional organizations, nor from audiologists who chose not to purchase the ASHA certificate. In addition, ASHA standards failed to differentiate sufficiently between Masters level preparation and doctoral preparation and were based on practice survey data which had not been updated. Finally, the ASHA accreditation standards included PhD programs designed to prepare researchers rather than specifically recognizing the AuD as the entry-level degree for the practice of Audiology.

As our evolution proceeded, it became clear that our Audiology professional organizations had the responsibility to create and monitor our profession’s standards, both for individual practitioners and for the educational institutions that prepared audiologists. If these organizations were truly to represent the profession and its practitioners, they had to develop standard setting and accreditation mechanisms rather than continue to cede these vital functions to other professional organizations.

Throughout its history, AAA has called for the development of independent standard setting bodies which were supported by all Audiology professional organizations, rather than being controlled by a single organization. In a 1994 letter to Kenneth Moll, Chair of an ASHA “Joint Committee on Accreditation”, then AAA president Lu Beck recommended that “joint” committees should indeed have representation and voting rights for all interested parties, that accreditation should be carried out by an entity which was separate from any single organization and that accreditation of Audiology education should be administered by an accrediting body which is separate from one addressing speech-language pathology issues.

In the years since then, AAA has initiated many efforts to form an independent accrediting body.

In 2003, the development of a new accreditation body, the
Accreditation Commission for Audiology Education (ACAE), was accomplished jointly by AAA and ADA. Funding has been provided by both of these membership organizations along with some initial funding from the Audiology Foundation of America. The Accreditation board is made up of practitioners and academics, and a unique web-based accreditation program has been developed specifically for AuD programs. ACAE is an independent non-profit organization whose accreditation mission is to recognize, reinforce and promote high quality performance specifically in AuD educational programs through a rigorous verification process. In 2004, ACAE engaged the services of Liaison International, Inc/Academic Management Systems to begin work on the development of an interactive, web-based accreditation system that would allow educational programs seeking accreditation from ACAE to complete virtually all aspects of the accreditation process online. In addition to the enormous time savings of this innovative process, programs would easily be able to retrieve important national data about applications, enrollments, graduation rates, student achievement, and other data important to academic programs. Programs would also be able to share generic data with their Deans, Provosts and Presidents, as needed.

There are two major components of the ACAE Computerized Accreditation Program (CAP). The first component is an automated online accreditation process consisting of four parts:

1) an accreditation home web site for standards, policies and procedures;
2) a program management database;
3) electronic surveys which form a data warehouse and data retrieval system for each program;
4) an ACAE self-study website to be used by each program as it proceeds through the accreditation process and a post-visit assessment web site.

The second component consists of competency assessment metrics that will be offered to AuD programs for their use with student and program evaluation. The metrics will be used to assess student learning outcomes at several stages throughout their education, defined in terms of particular levels of knowledge, skills, abilities and competencies that a student has attained during the AuD program.

The ACAE Board of Directors began the process of writing the educational standards for accreditation in early 2003, with review and comment requested from innumerable experts from external agencies and organizations. After 18 months, a draft set of Standards and request for comment was distributed to 16,000 audiologists via web sites (AAA, ADA, AFA and ACAE) and hard copies were also sent to each academic program and to numerous external groups. After review of comments, the standards were adopted by ACAE in March 2005. Simultaneously, ACAE began the process of obtaining recognition as a new accrediting body for AuD programs from the United States Department of Education.

Two AuD programs (CID-Washington University and Central Michigan University) volunteered to serve as Beta sites to test the CAP system before launching it to other academic programs. The beta sites have greatly assisted ACAE in streamlining the web-based process. Both programs have completed the first phase of CAP, the completion of eight surveys, and have begun the self-study process. In addition, ACAE held its first site visitor training session in April 2006. Ten additional programs have expressed strong interest in the ACAE accreditation process.

As might be expected, the development of a new accreditation body has created controversy. Audiology programs that exist within Speech-Language Pathology departments are concerned about the need to undergo two different accreditation processes. Others are concerned about the ability of the Audiology profession to fund a new accrediting body. Funding is of course an issue. Accreditation is an expensive process. At this time, funding from the Academy and ADA continues. The ACAE Board and Executive Director, Doris Gordon, are actively pursuing foundation donors for this critical effort.

The Academy has also created an Education Committee charged with developing professional practice standards for entering audiologists. In addition, ABA has begun the process of creating a new national exam to replace the Praxis exam currently used by all licensure boards. As an Accreditation body, ACAE’s function is to be informed by the profession’s definition of the knowledge, skills and competencies which define an audiologist, and to use this definition in its academic standards. This three pronged effort by ACAE, Academy’s Education Committee, and ABA finally put the Audiology profession in control of the essential components of its autonomy. For more information about these efforts, visit the following web sites: www.acae.org, www.audiology.org, www.AmericanBoardofAudiology.org.
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Hearing loss is often caused by death of hair cells in the inner ear. Common causes of hearing loss include aging, noise toxicity, certain chemotherapeutic drugs and genetic conditions. Consequences of loss of hair cells in the inner ears are hearing and balance impairments. Unfortunately, hair cells in the inner ear of mammals are not regenerated after injury. Therefore, the hearing loss that results from hair cell death is permanent. Mature hair cells are said to be “terminally differentiated,” meaning they do not divide. Recent evidence suggests that a gene called retinoblastoma may represent a key regulatory element that could help “unlock” hair cells and allow them to undergo cell division and thereby to regenerate.

The retinoblastoma protein (pRb) is the gene product of the tumor suppressor gene RB1, the first tumor suppressor gene to be cloned (Friend et al., 1990). The protein derives its name from the malignancy retinoblastoma, which results when both alleles of the RB1 gene are mutated. Retinoblastoma is the most common childhood cancer of the eye (Finger et al., 1995).

What is a tumor suppressor? As the name suggests, the function of a tumor suppressor is to prevent a cell from becoming malignant. Different tumor suppressor gene products can achieve this function via different mechanisms. The mechanism by which retinoblastoma functions involves the suppression of proteins that promote cell cycle progression. The general cell cycle consists of 4 stages: 1) The G1 phase (first growth phase), during which the cell is metabolically active and carries out its functions, 2) the S phase, during which DNA is duplicated such that each daughter cell has the right amount of genetic material to undergo cell division, 3) the G2 phase, a second growth phase, and 4) the M phase, mitosis, during which the cell divides into two identical daughter cells.

At several stages in the cell cycle, there are “checkpoints” to ensure the integrity of the cell. If any serious error is detected in the cell’s DNA, it is the role of the tumor suppressor to stop the cell cycle. In this way, cells with damaged DNA are prevented from dividing, and the formation of a tumor is suppressed.

The retinoblastoma protein (pRb) plays an important role in regulating the expression of proteins that control the checkpoint at the transition between the G1 and S phases of cell division.

A recent report by Sage et al. (2005) examined the effects of deleting the retinoblastoma gene on hair cells in mice. They investigated whether hair cells could divide when pRb is absent. They showed that preventing the expression of pRb in the inner ears of immature mice lead to an increased number of hair cells, indicating that pRb plays a role in cell cycle arrest in hair cells. These data further show that mammalian hair cells, even “terminally differentiated” ones, can reenter the cell cycle, and new hair cells can be generated from preexisting ones. Finally, the new hair cells derived from these cell divisions were shown to fully differentiate into functional hair cells.

As the results indicate, pRb plays a key role in regulating the cell cycle of mammalian hair cells. The most immediate implication of these findings is the possible generation of a large number of hair cells that could be utilized in studies for investigations of hair cell differentiation and regeneration. Further studies investigating the manipulation of this gene may offer insight into the development of potential therapies aimed at inducing hair cell regeneration in humans with hearing loss. However, many additional intensive studies will be required to reach this ultimate goal. As Taylor and Forge (2005) point out in their comment on the paper by Sage et al., pRb should only be inactivated temporarily to cause hair cell regeneration to a desired degree, and it would then have to be reactivated to stop cell division. Otherwise, hair cells would continuously divide, which is characteristic of tumors. Last but not least, Sage et al. carried out their studies on hair cells from very young (neonatal) animals. Hence, it is still unclear whether the inactivation of pRb would produce the same effect on the cell cycle of mature (adult) hair cells.

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Interview with the Council on Academic Accreditation

AT Speaks with CAA Chair, Amy Wohltert

Could you provide us with an overview of regional accreditation and accreditation by the Council on Academic Accreditation (CAA)?

Since 1965, the Council on Academic Accreditation (CAA) (or its antecedents) has granted and monitored accredited status for audiology and speech-language pathology programs at 265 different colleges and universities. The CAA is what’s known as a specialized accreditor because we concern ourselves only with entry-level professional preparation programs in audiology and speech-language pathology (SLP). There are many other specialized accreditors, such as the Accreditation Board for Engineering and Technology (ABET), the National Council for Accreditation of Teacher Education (NCATE), and so on. Regional accreditors are the six organizations that accredit entire institutions of higher education. Regional accreditation is extremely important for institutions because it is required for access to many types of federal funding. The CAA only accredits programs that are housed in regionally accredited institutions.

Just to keep things confusing, there are also national accrediting bodies that accredit for-profit institutions, although some for-profits have regional accreditation, too.

Accrediting agencies can be accredited, too. The CAA is currently recognized by both the Council on Higher Education Accreditation (CHEA), which creates and monitors quality standards for accreditors, and by the US Department of Education, which grants recognition to regional, national, and specialized accreditors that meet their recognition criteria.

Professionals in our disciplines are often confused about the difference between the job of the American Speech-Language-Hearing Association (ASHA) Council for Clinical Certification (CFCC) and the CAA. The CFCC creates and monitors standards for individuals who engage in clinical practice and certifies those individuals who meet current standards. Similarly, state licensure and other credentials, such as those from the American Board of Audiology and public school certification programs, are awarded in recognition of an individual’s ability to meet the standards of those agencies. The CAA, on the other hand, creates and monitors standards for professional education. CAA standards encompass entry-level degree programs’ administrative structure and governance, faculty sufficiency and qualifications, academic and clinical curricula, student policies, student and program assessments, and program resources. Our focus is on programs, not individuals.

Naturally, we expect entry-level programs to prepare their students to become credentialed professionals, so we pay close attention to certification and licensure standards and students’ ability to meet those standards.

The CAA is an entirely autonomous agency in terms of creating and applying standards, and all the academic members of the CAA are elected directly by the accredited programs. The current CAA standards contain an explicit list of the knowledge and skill areas in which we expect programs to prepare their students for practice in audiology. New accreditation standards are undergoing a final round of peer review, and those proposed standards include separate curriculum sections for audiology and speech-language pathology, each with its own knowledge and skills inventories.

In the past we simply referred to certification standards for the knowledge and skills, but the new proposal makes it clear that the CAA is responsible for determining what programs need to provide for their students. The CAA is undertaking a “practice analysis” in the coming
year so that we can update the knowledge and skill requirements for education in both professions.

CAA’s fees for accreditation are quite low in comparison to other accrediting bodies and the fee mentioned by the Accreditation Commission for Audiology Education. How has CAA been able to keep the fees so reasonable, and do you believe that the current fee structure will be retained?

The CAA is responsible for generating 40% of its operating budget. We review fees every three years to make sure that we honor that commitment. The remaining 60% of our budget comes from ASHA, because the membership recognizes that the quality control provided by accreditation is a significant benefit for members, students, and the public. We hope to maintain that financial relationship because it creates an affordable process for programs while allowing the CAA full autonomy to carry out its mission.

Can you outline the major recent changes in accreditation, considering that most of us graduated from master’s programs and are used to tallying clock hours? What are the major changes since the 1993 standard that called for 27 credits of basic science and 36 credits of professional coursework, 350 clock hours, and the CFY?

Your question relates mainly to recent changes in ASHA certification standards, but accreditation standards will be changing, too. We are mandated to review the standards regularly. The current CAA accreditation standards went into effect in 1999, and we expect to finalize a new revision this year, for implementation in 2008.

The proposed accreditation standards emphasize quality indicators, rather than numbers. For example, the draft that is now being peer-reviewed says that the curriculum must be sufficient to allow students to acquire the knowledge and skills listed in the standard. We give implementation guidelines suggesting that for a clinical doctorate, this usually means four years of graduate study including at least 12 months of full-time clinical experience, interspersed appropriately in the curriculum. Because programs count credits in many ways, it did not seem as useful to try to define an adequate curriculum in terms of credit hours. However, students must be aware that certification and licensure standards have their own requirements, which can differ from state to state and agency to agency, and those standards may indeed specify certain numbers of credits and hours of clinical contact.

The KASA (Knowledge And Skills Acquisition) Summary Document is a CFCC form used to track an individual’s acquisition of the knowledge and skills required for ASHA certification. CAA standards stipulate that programs maintain some sort of tracking system for their students, showing each student’s progress through the curriculum and their progress in preparing for certification, licensure, and any other appropriate credentials. Many programs use a form based on the KASA to do this, but the CAA does not require programs to do so.

So, programs no longer have to offer X hours of diagnostics coursework, Y hours of treatment coursework. But am I remembering correctly that doctoral programs must have at least 75 semester hours, of which 65 semester hours are of didactic instruction, in order to be accredited?

In the current (1999) CAA standards, doctoral level programs must offer a minimum of 75 post-baccalaureate credit hours, plus an aggregate of at least 52 weeks (fulltime equivalent) of supervised clinical practicum. Regardless of the number of credits or clock hours, the current accreditation standard also states that the curriculum must be sufficient in breadth and depth for graduates to achieve the knowledge and skills outcomes identified for entry into independent professional practice. In the proposal for revised standards, we wish to focus on the crucial outcomes rather than on numbers of credits, which may not be reliable quality indicators.

Last fall, the CAA circulated a proposal for standards revision that specified 75 didactic hours, including no more than 10 thesis/dissertation hours and excluding clinical practicum hours, but the feedback we received led us to make further revisions of that proposal. We are now circulating an amended proposal in which we have replaced credit hour rules with duration guidelines, as discussed in the last question. We will evaluate the responses from this latest round of peer review at our next CAA meeting in mid-July 2006, when we hope to vote on a final version. The peer review survey www.asha.org/peer-review/Standards-GradPrograms.htm was open through June 18, 2006. The CAA can also be contacted by e-mail at caastandards@asha.org.

When must programs ensure that all graduates earn a doctoral degree (rather than a master’s) in order to retain accreditation?
The profession of audiology has determined that the clinical doctorate is the appropriate entry-level degree. Because the CAA wants to ensure that graduates of accredited programs are appropriately prepared to begin practice, we will no longer accredit master's programs in audiology after December, 2006.

You mentioned that CAA standards call for academic instruction in the full scope of practice of audiology, and that there are specific lists of the needed knowledge and skill sets to be mastered. What clinical experiences must be provided? For example, can an accredited program provide students with academic knowledge, but no actual clinical or lab experience in a given area, e.g. vestibular assessment, or auditory intervention group treatment?

The CAA standards (both the current and the proposed) state that the curriculum must be sufficient to prepare students to begin independent practice across the full depth and breadth of the scope of practice. The standards list the specific knowledge and skills that must be addressed in the curriculum. Clinical experience is an important part of the educational process, and the CAA expects programs to demonstrate that every student has access to coursework and clinical opportunities adequate to acquire both knowledge and practical skill in every listed area. Because the scope of practice evolves, the CAA must conduct regular practice analyses and update the standards accordingly to ensure that our requirements remain consistent with the scope of practice. We plan to begin new practice analyses in both audiology and SLP in the coming year.

I think this one’s a critical issue, so let me be sure I’m understanding you here. If a program provided instruction on vestibular evaluation, but its students had no clinical practicum, or if a program did not make provision for students to administer a formal aural rehabilitation program, then the program would not qualify for accreditation?

It is not adequate for a program to provide only opportunities to gain knowledge in an area; the program must provide sufficient opportunities to develop the requisite skills, too. If a program does not provide students with educational experiences that are adequate to achieve entry-level independence in all the knowledge and skill areas listed in the standard, then the program would not be in compliance with that accreditation standard.

Aural rehabilitation and balance disorders are among the listed knowledge and skill areas.

Previously, all diagnostic experiences had to be directly monitored for at least 50% of the evaluation, while all treatment hours were at least 25% supervised. Is this still a requirement?

The proposed CAA standards state that “the program must demonstrate that the nature and amount of supervision is determined and adjusted to reflect the competence and growth of each student.” The current standards have a similar statement. Certification and state licensure standards may include more explicit regulations for minimum amounts of supervision, so students and program directors should be familiar with those standards, too.

The current standard 3.1 states “the curriculum (academic & clinical education) is sufficient to permit students to meet ASHA-recognized national standards for entry into the profession.” ASHA certification requires that clinical experiences are supervised by an audiologist who is ASHA certified. Must a program ensure that all students have the equivalent of 1820 hours of clinical experience from a CCC-A preceptor? Would it be acceptable if students who wish to attain certification be provided that opportunity (placement with CCC-A preceptors), while those who do not hold that career goal be permitted to extern with a non-CCC-A preceptor?

The proposed accreditation standards indicate that supervision must be provided by qualified individuals and allow students to achieve the professional credentials they desire. State licensure regulations and certification standards are more specific about the qualifications of supervisors/preceptors used for their purposes and about the number of hours required.

For CAA accreditation, a program must show that students are able
to achieve common professional credentials and that all supervision is conducted by individuals who have appropriate qualifications—which means appropriate experience and education, as well as appropriate licensure and/or certification. The CAA requires evidence that supervisors/preceptors used for hours counted towards ASHA certification have CCC-A, and supervisors/preceptors used for other purposes have the credentials appropriate for those purposes—which might not include CCC-A.

Faculty and staff who do not provide direct supervision of students for the purpose of ASHA certification hours do not need to hold the CCC-A. However, it is important that the program provides evidence that it has sufficient access to supervisors/preceptors who have appropriate qualifications, including CCC-A, so it is clear that students can choose to pursue certification as well as other credentials.

As you have mentioned, the new standards are outcomes based, where student competencies are evaluated and tracked. Am I correct in believing that currently, the university faculty provide the instruction, and then the university faculty assess the effectiveness of the instruction in each of the student skill areas — there is no longer a CFY report or other form of student evaluation by someone outside the university that is reported to either CFCC or CAA? This is an area of concern to me – I believe there is no individual student validation of skills by anyone outside the university. I think a weak program could verify student performance using their own (weak) standards.

The CAA monitors the ability of programs to provide students with the required knowledge and skills. Thus, we look at objective outcome measures such as the percentage of students in a program who pass the Praxis examination. We also require that programs seek evaluation by people outside the program, such as alumni, employers, and clients, in order to determine if their students in general are considered to be well prepared to begin independent practice. Accredited programs must not only compile this information, but also show that they evaluate the results and use them for planning program improvements.

I don’t know if the CFCC has plans for external evaluation of individual students’ clinical skills.

You mentioned the Praxis exam (some may recall it as the NESPA). Must students pass the Praxis exam for a program to retain accreditation?

The percentage of students who pass the Praxis exam each year is one of the outcome measures that accredited programs report annually to the CAA. Programs whose pass rate falls below the national average pass rate (currently, about 80% of students who take the Praxis exam in Audiology and SLP pass) are asked to explain the reason for the low rate and show their plans for helping students to be successful. A low pass rate for a number of years in succession would certainly be a cause for concern, but the effect on accreditation status would depend on a variety of factors.

How often is the Praxis audiology exam updated? Who writes the questions?

The Educational Testing Service (ETS) owns, administers, and updates the Praxis exams. The audiology exam questions are continuously updated by a team of subject matter experts (audiologists).

Do you know when it was last updated, and has CAA evaluated the current test, which serves as a significant means of evaluating the university programs?

The audiology exam questions are continuously updated by a team of audiologists, and the ETS performs regular tests of the validity and reliability of its examinations. The CAA does not evaluate Praxis examinations, but we do listen to programs’ input about how well or poorly Praxis exam results reflect their success in educating students.

Is CAAA developing any formative examinations, or is this solely the responsibility of the university program?

At this time, the CAA has not discussed the possibility of developing any formative examinations to be used by all programs. Personally, I think the idea has merit for accreditation as a means for programs to calibrate their success in delivering each stage of their curriculum.

Are there any points I didn’t cover that you would like to address?

Your readers have probably heard enough from me at this point, but I hope they will let me know if there is anything I didn’t cover, or any points that are still confusing. Thanks for giving me the opportunity to talk with you.
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With the Academy’s MasterCard or American Express card from Bank of America, you will become a part of the WorldPoints program. WorldPoints benefits include no annual fee, absolute fraud protection, and points for travel and brand-name merchandise. Call 1-866-277-1553 and mention priority code FA04 for Mastercard and priority code FA07 for American Express.

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Members can get up to 15% off with Alamo and up to 20% with National car rental services. Call 1-800-GOALMO and mention the code 706768 for reservations with Alamo. For National, call 1-800-CAR-RENT and use the code S2B565. Receive membership discounts with Hertz by using CP# 1299750 when you make your reservation. Reservations can also be made through the company links designed specifically for Academy members on the benefits web site. Coupons or discount codes are available on the web site for all car rental programs. Contact the home office for Hertz coupons.

COMPENSATION & BENEFITS SURVEY:
The American Academy of Audiology conducted its fifth annual Compensation and Benefits Survey in the Fall of 2005. A full report of the survey with detailed information is available for Academy members online at www.audiology.org/hearcareers.

GEICO AUTO INSURANCE:
Academy members may qualify for an additional discount off GEICO’s already low rates. Call GEICO today for a free rate quote at 1-800-368-2734. Tell them you are a member.

HEARCAREERS:
Whether you are seeking a job or advertising a position, the American Academy of Audiology’s HearCareers site has everything you need to achieve your employment goals. This online employment service allows job seekers to post their resumes and view job postings for free. HearCareers also offers discounted rates to members advertising positions. Go to www.audiology.org/ hearcareers to make your next career connection with HearCareers.

HEALTH INSURANCE:
Association Health Programs provides health, long-term care, life, disability, dental and vision plans (amongst others!) to meet the insurance needs of our members. For more information please call 888-450-3040 or visit their web site at www.associationpros.com.

WORLDWIDE CALLING CARD:
This dual-purpose card can be used as a GlobalPhone domestic or international calling card. It is also your permanent membership card for easy reference to your membership number. U.S. rates are from 3.9 cents per minute with no surcharges. To activate your calling card, call 1-866-895-574 or go to www.audiology.org/calling card.

PROFESSIONAL LIABILITY INSURANCE:
The Academy has endorsed the professional liability insurance program offered through Healthcare Providers Service Organization (HPSO). We selected this program because of the plan’s many benefits, affordable rates, and their commitment to customer service. For more information, call 1-800-982-9491 or visit their website at www.hpspo.com.

For more information about these benefits, contact Vanessa Scherstrom, Member Benefits Coordinator, at 703-790-8466 x1044 or vscherstrom@audiology.org.
Just when you thought you knew all of the letters…. HHS, CMS, OMB, POTUS (President of the United States), here comes another one: SOC Codes. They are actually quite important. SOC stands for Standard Occupational Classification. The Office of Management and Budget (OMB) in the White House designate SOC codes after being proposed in the Federal Register and open to public comment. A notice has just been published in the Federal Register to start the process of reconsidering the current classifications.

The SOC Codes are binding on the entire federal government and they have an effect on the private sector as well. Audiologists are included in the SOC designation, but not exactly as we would like.

The Academy participated extensively in the last revision of the SOC, and submitted comments on four separate occasions, November 17, 1995; May 3, 1996; September 4, 1997; and October 9, 1998. In our comments, we made two requests:

First, we asked that audiology be recognized as a distinct profession, separate from speech-language pathology.

Second, we asked that audiology be taken out from under the subheading “29-1120 Therapists,” and placed in a separate, stand-alone category under the main heading.

OMB responded favorably to our request that audiology be classified separately from speech-language pathology and that change was made. However, OMB did not make the other change we requested even though therapy is only one part of what an audiologist does. We continue to believe that audiologists should be taken out from under the subheading “Therapists,” and placed in a separate, stand-alone category. It is our hope that this change will be made as part of the current SOC revision process, and we will be asking our leadership, at the State and national level, to participate in the process with a letter.
Standard Occupational Classification Codes Revisited

History of the Academy’s Participation in the SOC Process

The American Academy of Audiology participated extensively in the last revision of the SOC during Carol Flexner’s presidency. Since the finalization of the 1998 SOC, the Academy has continued to interact with OMB and the Bureau of Labor Statistics in an effort to renew our second request, i.e., removal of audiologists from the subheading “Therapists” and placement in a stand-alone category under the main heading. Specifically, on January 26, 2000, we raised this issue in a letter to Katherine K. Wallman, Chief Statistician, OMB. In addition, on May 10, 2000, we met with Paul Bugg, an OMB economist, and Stephen Tise of the Office of Research and Planning, Bureau of Health Professions, Health Resources & Services Administration, Department of Health and Human Services, to discuss the Academy’s concerns regarding the categorization of audiologists as “Therapists.” On June 14, 2000, we sent a letter to the Standard Occupational Classification Policy Committee (SOCPC), requesting that this categorization issue be addressed. Finally, on October 27, 2004, we sent a letter to OMB requesting that this change be made during the next revision of the SOC.

In the Academy’s view, classification of audiologists as “Therapists” is inaccurate because it fails to reflect the full range of services we are licensed to perform. According to OMB, “occupations should be classified based upon work performed, skills, education, training, licensing, and credentials.” When these factors are considered, we think it becomes clear that audiologists do not belong under the subheading “Therapists.” By way of comparison, we note that optometrists are classified in a separate, stand-alone category: “29-1040 Optometrists.” With regard to overall skills and type of work performed, audiologists are most similar to optometrists, among the professions listed in the SOC.

You Can Help

While the SOC issue can be seen as a dull, technical matter, it is our hope that you will agree it is an important matter and that you will respond with a letter to the Bureau of Labor Statistics and help continue to move the profession in the correct direction. Letters should be sent to: Ms. Anne Louise Marshall, Standard Occupational Classification Revision Policy Committee, U.S. Bureau of Labor Statistics, 2 Massachusetts Avenue, N.E., Suite 2135, Washington, DC 20212. Email: soc@bls.gov
Three years after publishing the proposed rule, the Centers for Medicare and Medicaid Services (CMS) published a Final Rule (Federal Register, April 21, 2006, p. 20754) which revises Medicare enrollment requirements that affect all providers and suppliers who currently bill the Medicare program and wish to maintain their Medicare billing privileges, as well as those who wish to become new enrollees in the program. Those who have “opted out” of the Medicare program are not affected by the rule. The new requirements went into effect on June 20, 2006.

CMS has incorporated a number of enhancements and changes to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities. The final regulation makes Medicare enrollment requirements more uniform and standardizes existing enrollment requirements that have been used by the various Medicare contractors that process and pay claims.

Specifically, the regulation requires that new and existing providers and suppliers complete and submit a Medicare enrollment application. Individual or solo practitioners (but not incorporated) must use the CMS-855I form to enroll or change their enrollment information. To enroll as a group or corporation, fill out the CMS-855B form. Individual practitioners who wish to reassign benefits to an employer or group practice must fill out CMS-855R form.

Once enrolled in the Medicare program, providers and suppliers are required to report any changes in their enrollment information within 90 days, with the exception of change in ownership or control of any provider or supplier, which must be reported within 30 days. If a change of ownership involves a change in the entity’s tax ID number, a new enrollment application will generally be required. Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are also required to report enrollment changes within 30 days to the National Supplier Clearinghouse.

All providers will be required to revalidate their enrollment information every 5 years. CMS may also request off-cycle revalidation to certify accuracy of enrollment information, and conduct unannounced site visits to ensure that providers are meeting their enrollment requirements.

A significant change to the new Medicare enrollment application is the requirement of the National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System (NPPES). While it is true that providers and suppliers are not required to use their NPI in all electronic transactions until May 23, 2007, in order to build and validate a crosswalk in a timely manner and assure timely payment of claims by the deadline, Medicare is requiring submission of the NPI with the enrollment application. Furthermore, the NPI Final Rule does not prohibit any health plan, including Medicare, from requiring providers and suppliers to submit their NPI prior to the compliance date.

The new application also requires that providers and suppliers receive payments through the Electronic Funds Transfer (EFT), as mandated under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

CMS may deny, revoke, or temporarily deactivate a provider or supplier’s enrollment for reasons set forth in the regulation. For example, if a provider or supplier does not submit any Medicare claims for 12 consecutive months, or fails to report a change in enrollment information as required, CMS may deactivate the provider or supplier’s enrollment.

To read the full summary of the Final Rule on Medicare Enrollment, please visit the Academy’s web site at www.audiology.org/professional/members/medicare/. To learn more about the Medicare enrollment process, including the mailing address and telephone number for the contractor serving your area, visit the CMS web site at www.cms.hhs.gov/MedicareProviderSupEnroll/. To download the application, click on “Enrollment Applications” on the left side of the page.
NEW Academy Service
How’s your hotel contract negotiation? Ask an Expert!

Want to free up your time to practice audiology? Use the expertise of the Academy’s staff to negotiate that pesky hotel contract. Listen to audiologist Erin Miller’s experience:

“The Ohio Academy of Audiology (OAA) was struggling with contract negotiations with the hotel of choice for our biennial Ohio Audiology Conference. We contacted AAA to see if they could provide any advice that might assist our efforts. Not only did they provide advice but they also offered to handle these negotiations for the OAA. The OAA was relieved that we had experts helping to negotiate our contract and believe we received excellent advice about location for the event and will now have a hotel staff that is willing to work with our group. I would recommend this service to any of the state academies who are trying to negotiate these contracts themselves. It really will give your group piece of mind that you have received a fair price and all the amenities that hotels offer other similar sized groups.”

For a nominal fee, this expertise is now available to state audiology organizations as well as related audiology organizations. For more information, contact ccarey@audiology.org.

AFA Awards Otoscopes to AuD Students

Over 100 AuD students recently participated in the Audiology Foundation of America (AFA) new “Clued-In to Audiology” otoscope program, which tested the students’ knowledge of the history of their profession. Students were asked to read four articles detailing information on the history of the AuD degree and audiology’s transition to a doctoring profession. They were then required to pass a short quiz on the material before being awarded an otoscope. The program was opened to all third-year AuD students in four-year AuD programs. Seventy-eight NAFDA students participated in the program, and received their otoscopes from AFA Director/Treasurer Veronica Heide, during a special presentation at AudiologyNOW in Minneapolis. AFA was presented with a “Friend of NAFDA” award in recognition of its support of students. Funding for the “Clued-In to Audiology” otoscope program was provided by the Hal-Hen division of Widex, which supplied over $11,000 in otoscopes in support of the AFA and AuD education. The AFA is a non-profit foundation founded in 1989 to lead audiology’s transition to a doctoring profession with the AuD as its unique designator. Its vision includes the goal of changing state licensure to incorporate the AuD as the basic criteria for practice.

Engineering and Hearing Enhancement Conference

The Rehabilitation Engineering Research Center on Hearing Enhancement (RERC-HE) in conjunction with Gallaudet University and New York University-School of Medicine will hold a three-day conference addressing the aural rehabilitation needs of adults and exploring the evidence base for current and emerging practice. The meeting will take place September 18-20, 2006 on the Gallaudet University Campus. Visit www.hearingresearch.org for conference and registration details.


**Hearing Health Screening and Issues Forum**

Congressman James Walsh (R-NY) receives a hearing screening from Anne Arrazaeta, AuD, an audiologist and member of the Academy, at the Hearing Screening and Issues Forum held on Capitol Hill on May 18th. Rep. Walsh is a cosponsor of H.R. 415, the Hearing Health Accessibility Act and chief sponsor of H.R. 5250 the Early Hearing Detection and Intervention Act of 2006. (photo: ASHA®2006, Alice Cabrera Elspas)

New CDs Available of Published Journals


The American Academy of Audiology, through Joyanna Wilson, Publications Manager, and Jerry Northern was instrumental in the development of the JAAA project. Einar Laukli (Tromsø, Norway) and Stig Arlinger (Linköping, Sweden) were responsible for making *Scandinavian Audiology* available. Arlinger and the Medical Library at the VA Medical Center, Long Beach, provided most of the *Scandinavian Audiology* materials. The Danavox Symposia materials were provided by Nikolai Bisgaard, Senior Vice President for Intellectual Properties and Industry Relations GN ReSound (Taastrup, Denmark). The following graduate students and assistant research audiologists contributed to the project: Christine Powers, Nina King, Kelli Chauk, Tash-Marie Olinger, Christopher Burks, Laura Fleenor, Wendy Cates, and Jeff Py.

The CD set may be obtained by sending a priority mail stamp ($3.85) along with a mailing label, and your e-mail address to Richard Wilson, Audiology-126, VA Medical Center, Mountain Home, TN 37648.

In conjunction with the Congressional Hearing Health Caucus, the Academy co-sponsored a May 18, 2006 Hearing Health Screening and Issues Forum held in the U.S. Capitol Building on Capitol Hill. The event resulted in over 50 Hill staff members receiving a hearing screening. Rep. Jim Ryun (R-KS), chief sponsor of H.R. 415 the Hearing Health Accessibility Act served as a keynote presenter along with Reps. James Walsh (R-NY), Mark Kennedy (R-MN) and Carolyn McCarthy (D-NY). Local Academy members Ken Henry, Ann Arrazaeta and Michael Rairigh provided hearing screening services for the event.

**National Hearing Conservation Association 2007 Annual Meeting**

The National Hearing Conservation Association (NHCA) will host its 32nd Annual Conference, February 15-17, 2007, at the Hyatt Regency Savannah, Georgia. For more info, please visit [www.hearingconservation.org](http://www.hearingconservation.org).
International Society of Audiology Scholarships
The Executive Committee of the International Society of Audiology (ISA) and the A. Charles Holland Foundation are pleased to announce our second biennial scholarship winners. Four students have been awarded $1000 scholarships to attend the XXVIIIth International Congress of Audiology to be held September 3-7, 2006 in Innsbruck, Austria. The scholars were selected by the ISA Scientific Committee based on mentor recommendations and the merit of their research. Students will attend and present their research at the Congress. Stig Arlinger, Chairman of the ISA Scientific Committee, announced the following students as the 2006 Scholarship winners: Julie Martinez Verhoff (USA), Vicky Zhang (Hong Kong), Srikanta Mishra (Southampton, UK) and Alma Janeth Moreno Aguirre (Cuernavaca, Mexico). Information about the XXVIIIth ISA Congress can be obtained by logging on to www.isa-audiology.org.

2006 Scott Haug Foundation Retreat
In the days of old, as adventurers pulled up stakes seeking a fresh start, three letters were often found etched on old homestead doors to reveal where they were headed: GTT… GONE TO TEXAS! The Scott Haug Foundation invites you to get out of town and head to Texas on September 28th through October 1st for the 22nd Annual Scott Haug Hill Country Audiology Retreat. Our new meeting location is the TBarM Ranch and Resort in New Braunfels, Texas, located 30 miles outside of San Antonio, and 45 miles from Austin. Once there, you’ll get to experience Texas style learning, fellowship, and the fun of all the family-friendly activities offered on-site.

The Scott Haug Foundation will host an educational slate of outstanding speakers including Richard Seewald, Gus Mueller, Tomi Browne and Robert Turner.

So post the GTT! Sign on your office door and join us as we learn practical ways to improve our professional lives, enjoy spirited discussions with colleagues, and take time to have some fun in the spectacular Texas Hill Country. Visit www.scotthaug.org for conference details and registration information. Reservations with the TBarM Ranch and Resort can be made directly by calling (800) 292-5469.

Current Provost Becomes Gallaudet University’s Second Deaf President
Jane K. Fernandes, Gallaudet University Provost since 2000, was introduced on May 1, 2006, as Gallaudet’s ninth president.

She will take office in January 2007. Fernandes will replace long-time Gallaudet president, I. King Jordan, who made history in 1988 becoming the first deaf person selected to lead a university when he was named Gallaudet’s eighth president. Jordan announced his retirement in the summer of 2005 after more than 18 years as president. Jordan will retain the title “President Emeritus” and will continue to assist the new president and the university.

A native of Worcester, Mass, Fernandes attended public schools. She is a graduate of Trinity College (Connecticut), earning a BA in French and comparative literature, and the University of Iowa, where she earned an MA and PhD in comparative literature. After graduating from Iowa, she worked for Northeastern University before coming to Gallaudet as chair of the Dept. of Sign Communication. She later moved to Hawaii where she established the Interpreter Education Program at Kapi’olani Community College and served for five years as the director of the Hawaii Center for the Deaf and Blind.

In 1995 she returned to Gallaudet to become the vice president for the Laurent Clerc National Deaf Education Center where she and her team developed innovative curriculum, materials, and teaching strategies for schools serving students who are deaf throughout the nation. Last year, more than 450 schools had adopted the Clerc Center’s methods. Fernandes has authored and co-authored numerous scholarly publications, and will soon be sending her new book, Signs of Eloquence: A Study of Deaf American Public Address (with James Fernandes) to press. Gallaudet University is the world leader in liberal education and career development for deaf and hard of hearing undergraduate students. Gallaudet is located in Washington, DC, where it was founded in 1864 by an act of Congress, and its charter was signed by President Abraham Lincoln.
Randy Morgan, CEO of Westone Ear mold Labs, passed away on June 6 at his ranch outside Woodland Park, CO. Morgan had been battling brain cancer over the past several months. Randy Morgan guided Westone as President and CEO for the last 20 years. His vision and leadership helped propel Westone from a small earmold lab to one of the most recognized and respected firms in the hearing healthcare industry. Morgan worked personally with thousands of audiologists during his lifetime, and was a strong supporter of the American Academy of Audiology. His presence and creativity will be maintained at Westone Labs, and he will be missed by his many audiology friends.

Frederick N. Martin retired from his faculty position in the Communication Sciences and Disorders at The University of Texas at Austin, where he has served since 1968. During his outstanding career, Martin, a prolific writer, authored more than 150 publications in books, monographs, chapters and journal articles, and presented about 100 conference and convention papers. Martin won the Teaching Excellence Award of the College of Communication, the Graduate Teaching Award, and the Advisor’s Award of the Ex-Students’ Association of The University of Texas, and the Beltone Award for Outstanding Teaching in Audiology. He received the “Career Award in Hearing” in 1997 from the American Academy of Audiology and is a Fellow of ASHA.

Paul R. Kilency has received the prestigious Presidential Citation from the American Otological Society. Kilency is a professor in the Department of Otolaryngology and the Department of Pediatrics and Communicable Diseases at the University of Michigan Health System, as well as director of Audiology and Electrophysiology and the Hearing Rehabilitation Program.

American Academy of Audiology Foundation

VanVliet Runs For AAA Foundation

Audiologist, AAA Foundation Board member and runner, Dennis VanVliet, ran and completed his first marathon on June 4 in the San Diego Rock-n-Roll Marathon. This accomplishment is special because VanVliet ran to raise money for the AAA Foundation. VanVliet’s supporters pledged over $1,200 for his effort, meaning that Dennis raised $46 for the AAA Foundation for every completed mile.

You can make a donation to the AAA Foundation in honor, or in memory, of your colleagues at www.audiologyfoundation.org.
ILAA Awards Student Scholarships

The Illinois Academy of Audiology (ILAA) Board of Directors and the ILAA Scholarship and Honors Committees announced the names of the 3rd annual AuD Scholarship Awards. These awards are presented to outstanding students who are in at least their second year of study in an Illinois audiology graduate program. Selection is based on the potential for the student to make a significant contribution to the field of audiology; demonstrated academic accomplishment and intellectual ability; and review of the applicant’s character, school and community activities, personal motivation, and leadership potential. The 2006 scholarship recipients are Megan Mulvey and Magdalene Sikora from Rush University and Lia Ferro and Darrin Worthington from Northwestern University.

Florida Audiology Licensure Law Modified

The Florida Senate Bill 0370 was signed into law by the Governor on June 7, 2006. This bill modified the current language in the audiology license law to require the doctoral degree for audiologists applying for a new license after Jan. 1, 2008. Persons with a Master’s degree must have had the Master’s conferred prior to Jan. 1, 2008. Current practitioners with a Master’s degree are grandfathered into the law and do not need to earn the Master’s degree. The modified law defines the educational requirements for new applicants by competencies rather than clinical clock-hours and specific coursework.

The modified law changes the educational requirements for Audiology Assistants to a high school diploma or its equivalent and Board approved on-the-job training. A complete text of the law (SB 0370) can be found at: www.flsenate.gov/Welcome/index.cfm?CFID=1462549&CFTOKEN=30634769.

Management of the Tinnitus Patient

The 14th annual conference on Management of the Tinnitus Patient will be held at the University of Iowa, Sept. 21. The conference is intended for audiologists, otologists, psychologists and nurses who provide clinical management services for patients with tinnitus. The purpose of the conference is to review current evaluation and management strategies for the treatment of tinnitus. Special guests of honor are Dirk De Ridder from the University of Antwerp, Belgium, Anthony Cacace from Albany Medical College, New York and Paul Davis of Curtin University of Technology, Perth, Australia. Other invited speakers are Roger Juneau and David Fagerlie, as well as the University of Iowa staff including Marian Hansen, Rich Tyler, Paul Abbas, Catherine Woodman and Anne Gehringer. For program and registration and information visit www.uihealth-care.com/depts/med/otolaryngol.
GlaxoSmithKline Partners with Audiology Awareness Campaign

To shed some light on the issue of hearing loss in America, the Audiology Awareness Campaign (AAC) and GlaxoSmithKline (GSK) Consumer Healthcare, makers of Debrox, (ear wax removal product) have partnered to educate consumers who may be slowly losing their hearing and think there is nothing they can do to prevent or treat it. The AAC has joined with GlaxoSmithKline Consumer Healthcare to get the word out to consumers about hearing healthcare by creating Caring for your Ears and Hearing, an informational insert to be placed inside Debrox packaging. Starting in July of 2006, more than 670,000 packages of Debrox will include the insert — Caring for Your Ears and Hearing — that will educate consumers on key hearing health issues including lowering your risk for hearing loss, maintaining proper ear hygiene and information on where to turn for hearing health questions and concerns. The initial distribution will include more than 10,000 pharmacies and retail outlets nationwide. For additional information visit http://www.audiologyawareness.com.

IMPORTANT NOTICE for Masters’ Degree Students

Attention Audiology Masters Students and Professors!

EFFECTIVE JANUARY 1, 2007, applicants for membership in the Academy, who are 2007 or later graduates entering the field of audiology, must hold a Doctoral degree with a major in audiology from a regionally accredited institution of higher learning.

2006 or earlier graduates may apply with at least a Masters degree. The Academy strives to be an inclusive organization, and as such, we want to make you aware of this impending policy change.

Masters’ students graduation in 2007 or later, you are currently eligible for student membership in the Academy. If you join now, you will be guaranteed that the new policy will not exclude you from membership in the future. For an application, visit our website at www.audiology.org. Complete the application, and be sure to have a Fellow of the Academy sign the sponsor’s portion. Time is running out! Please contact the membership department at 800-222-2336 if you have any questions.

A colleague appears to have a problem with alcohol. You are increasingly suspicious that he is starting to drink around 3:30 in the afternoon. You confront him, and he admits that he is having problems. You tell him you are obliged to report him. He begs you to wait. He says he will enter treatment and that, in fact, he has been to AA a time or two but keeps falling off the wagon: “Give me six months. I’ll be clean by then.” Should you report him, or should you give him the chance he requests? Would your response be different if he were your employer?

After reading the Academy’s new Ethics in Audiology (© 2006), you will have the tools you need to approach this and many other difficult ethical dilemmas.

Ethical Dilemma? The Academy’s New Book Can Help!

To meet the growing need for practical advice on common ethical issues faced by audiologists, the Academy’s Ethical Practices Board has authored a book on the subject entitled Ethics in Audiology: Guide lines for Ethical Conduct in Clinical, Educational, and Research Settings (affectionately referred to as “the green book” for its green cover). Written in a concise and accessible style, chapter titles include “Standards of Professional Conduct,” “Ethics in Audiological Research,” “Relationships with Hearing Instrument Manufacturers,” “Ethics of Professional Communication,” “Child and Elder Abuse,” “Ethical Issues in Practice Management,” “Ethical Considerations in Supervision of Audiology Students and Employees,” and “Ethical Issues in Academia.” And as if all this relevant and timely information weren’t enough, up to 1.1 Tier 1 CEUs can be earned by reading and answering questions about the book.

Brand New CEU Opportunity! Up to 1.1 CEUs can be earned by reading the Green Book. For more information, including Learner Outcomes and Assessments, see the Green Book CEU Program Web page at www.audiology.org.

Please note that the Green Book CEU Program can also be used to meet ABA recertification requirements. To earn ABA Tier 1 CEUs (required for ABA recertifications after January 1, 2008), a minimum of three hours needs to be submitted at the same time. In addition to having the ability to earn Tier 1 CEUs, you can also fulfill the ABA three-hour ethics requirement (required in a three-year certification period) by reading the Green Book. For more information contact the ABA at aba@audiology.org.

CEUs AVAILABLE

Ethics in Audiology is available to members for $45.00 and to nonmembers for $75.00. A 10% bulk rate discount is available for orders of 10 or more. To order online, visit the Academy Web site at www.audiology.org. For more information, contact Elizabeth Hargrove, Communications Coordinator, at ehargrove@audiology.org or 703-790-8466, ext. 1039.
Posting a job is a key service offered through the Academy's year-round employment service, HearCareers. Although it is key, it is just the beginning as far as features go.

Employers who post on HearCareers also receive:

- A Searchable Database of Over 200 Resumes
- Low Competitive Advertising Rates
- A Database of Candidates Working Only in the Field of Audiology
- The Ability to Create a Resume Agent
  - Alerts you to candidates that match your search criteria
- The Ability to Post Jobs Instantly
- No Limit on Your Job Description Length
- The Ability to Link Your Company’s Website to Your Job Description
- Customer Service/Help
- The Ability to Track All Job Search Activity
- A System That is Easy to Use
- Salary Information

When you decide to advertise a position on HearCareers, you will first need to create a Login name. A password to your account will be emailed to you. Once logged into your account you have a variety of flexible services at your fingertips. Start with a description of your company. You can edit this at anytime. This is especially handy if you add a new office or have an address change. If you are not the only person who posts vacancies for your company, you can add other users to your account.

Next you will be prompted to fill out your billing contact information. If you happen to be the person in charge of tracking payment and you forget to turn in an invoice, you can log into your account and view your payment and purchase history. Not only can you view invoices, but you can email them to others right from your account.

HearCareers not only tracks your current company and billing information, but it also tracks information about potential candidates for your job. You will immediately be able to see which applications you have and have not viewed. HearCareers also records how many people viewed your job listing; how many applied; how many job seekers emailed your job to friends; and how many applicants came from a Job Agent. Check out the “Statistics” link for any job you have posted to view this information. All of these features without even touching on the main reason you opened an account with HearCareers in the first place...to get the word out about a job vacancy.

To get the word out, you will need a good job description. If you need to go into great detail for specific job requirements, take as much space as you need. Once you have written your job description, you have the ability to fine-tune it at anytime. HearCareers will also keep a record of all the jobs posted on your account. Once the job post period is over; you can easily go back and repost a position if any of your job openings have not been filled. Just copy it from your records and repost. Why rewrite the entire job?

If you need your job to really stand out, make it a “Featured Job.” When you “feature” a job, not only is it in bold and starred, but it also appears on the job seeker sign-in page. A job seeker doesn’t even have to search for a job to see the listing of “Featured Jobs.”

HearCareers is the whole package—It tracks your company information, billing, applicants, resumes, the job itself and allows for multiple account users. Make sure you utilize everything your Academy’s employment service has to offer. Remember, you need all the pieces of HearCareers to solve the hiring puzzle.
MICHIGAN

AUDIOLOGIST – Director of Clinical Instruction and Audiology Services, Division of Audiology, Central Michigan University (CMU). Full-time, 12 month, at will position beginning August 1, 2006 (start date negotiable).

Responsibilities: Administration of a multi-faceted audiology clinic involving on-campus, as well as several off-campus, educational, residential and adult-care facilities; coordination and participation in clinical instruction, coordination of externships for AuD students; direct patient care; marketing and public service activities.

Qualifications: Required: Doctoral Degree in Audiology; CCC-A; minimum of 4 years of audiologic clinical experience, with evidence of recent practice; excellent oral and written communication skills; student clinical supervision; demonstrated competency with amplification; evidence of strong interpersonal and organizational skills; eligible for, or hold Michigan audiology license.

Desirable: Three years administrative responsibilities; experience with cochlear implants, evoked potentials, and assessment/management of balance disorders.

Applications will only be accepted online at www.jobs.cmich.edu. For further information contact G. Church, P.D (churclg@cmich.edu), Search Chair, 989-774-7301.

Applications will be accepted until the position is filled. Review of applications will begin immediately.

CMU, an AA/EO institution, strongly and actively strives to increase diversity within its community (http://www.cmich.edu/aeo/)

Author’s Clarification:
From the “Meet the Media – The iPod News Frenzy” article published in the Vol. 18:3 (May-June, 2006) issue of Audiology Today, Brian Fligor points out that Table 1 sound pressure levels were taken from “stock earbuds.” Audiologists should understand that significantly different sound levels will be obtained with different earphones, depending on earphone sensitivity and on ear acoustics, used with personal music devices.

Pack Your Lederhosen in September!

The XXVIIIth International Congress of Audiology (ICAud2006)
September 3 - 7, 2006
Innsbruck, Austria

Preliminary Scientific Program Focus
• Implantable hearing devices
• The role of the efferent auditory system
• Electronic communication in Audiology

Free paper sessions & poster exhibition
• Audiology education and training • Clinical Audiology • Cochlear Implants: technologies and outcomes • Environmental & occupational noise and hearing loss • Epidemiology and genetics of hearing impairment • Hearing aids: new technologies, benefits and outcomes • Physiological measures of hearing and hearing loss • Newborn hearing screening • Tinnitus • Use of tests and questionnaires in Audiology • and more.

The ICAud2006 is the official biannual congress of the International Society of Audiology (ISA).

Time: Sept. 3 to 7, 2006
Location: Innsbruck, Austria/ Europe Congress website: www.icaud2006.at
Deadline for online registration:
August 15, 2006