

Audiology Today

Issue Number 3, August 1989

Bulletin of the American Academy of Audiology



The Professional Doctorate

?

New Orleans

April 26-29, 1990



2nd Annual Meeting of the American Academy of Audiology

Plans are underway for the 1990 Convention of the AAA. Following in the tradition of the highly successful first convention at Kiawah Island, the program will include special sessions, tutorials, workshops, exhibits, and crossfire sessions focusing on current issues. Evening social functions and fun are another tradition we hope to uphold!

The convention will begin on Thursday, April 26, and continue through Sunday, April 29, 1990. Meetings will be held at the Fairmont Hotel in New Orleans, where a block of rooms has been reserved. The Fairmont Hotel, a New Orleans tradition, is located downtown adjacent to the French Quarter. In addition to the many activities in the French Quarter and along the Mississippi Riverfront, the AAA Convention also coincides with the Annual New Orleans Jazz and Heritage Festival which brings national and international entertainment and many special events to the New Orleans area.

Additional information will follow in future newsletters and special mailings. For additional information at this time, please contact:

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See you in New Orleans!



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Academy of Audiology

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Presidential Address: First Annual Meeting of the AAA

Those members attending the banquet at the 1st Annual Meeting of the AAA were inspired by the Presidential Address delivered by Dr. James Jerger. For those of you who were unable to attend we are pleased to present the address in its entirety in this issue of Audiology Today.

The history of Audiology, in the United States, is the story of a relatively small number of extraordinary individuals, persons whose vision and courage fostered the growth and development of a viable new profession, from a sub-specialization within speech pathology. We are here, today, because of the unrelenting efforts of these pioneers.

If there is a grandfather of the profession, an initial progenitor, it must certainly be C.C. Bunch. In collaboration with an otologist, Dr. L.W. Dean, first at Iowa and later at Washington University in St Louis, Bunch, during the 1920s and 1930s, applied the newly-developed Western Electric I-A audiometer to the assessment of otologic patients. In those years the tuning fork and the Barany noise box were the standard hardware of hearing evaluation. In 1937 only 10% of otologists had electric audiometers. But Bunch showed how much more accurate and quantitative the assessment of hearing loss could be if it were based on what we now call the pure-tone audiogram. In the process he cataloged, for the first time, the audiometric characteristics of many of the clinical entities of auditory disorder.

Late in his career, in the early 1940s, Bunch accepted a post as visiting professor in the School of Speech at Northwestern University. Here he had some influence on a young speech scientist about to enter the Armed Services. As a captain in the Army Medical Corps, Raymond Carhart was assigned to develop an aural rehabilitation program for returning veterans of World War II, at the Deshon General Hospital in Butler, Pennsylvania. With Bunch's teaching and experience fresh in his mind Carhart developed, at Deshon, a protocol for the fitting and evaluation of hearing aids that became the virtual model for clinical practice throughout the nation for the next 40 years.

Among the many distinguished alumni of the Deshon program, at least one sits among us tonight, Dr. Leo Doerfler, longtime head of the program at the Pittsburgh Eye & Ear Hospital, past president of ASHA, now in private practice, and certainly one of the most distinguished leaders of our profession.

After World War II Carhart returned to Northwestern University and developed a graduate training program through which a number of well-known audiologists have passed. Both Leo and I count ourselves privileged to have been a part of that now famous graduate program.

The military hospitals of World War II produced two other giants of the past, William G. Hardy and Grant Fairbanks. Hardy set up the Navy's aural rehabilitation program at the Naval Hospital in Philadelphia, while Fairbanks was associated with the Army program at the Borden General Hospital in Chickasha, Oklahoma. After the war Hardy took a post at the Johns Hopkins Medical School where he and his colleagues pioneered the evaluation of hearing in young children. Fairbanks returned to the University of Illinois and set up the graduate training program which, through the rigor of Fairbanks approach, became a model for the training of hearing scientists.

In a parallel post-war development Hallowell Davis, a physiologist left the Harvard medical school to join S. Richard Silverman, an educator of the deaf, at the Central Institute for the Deaf in St Louis. They were shortly joined by a former radio announcer with a fresh Ph.D from the psychology department at Harvard, Ira Hirsh. This powerful triumvirate at CID pioneered both basic and applied hearing research, in the decades after World War II, laying the foundations for many current clinical applications.

During the 1950s two giants of the past, Wendell Johnson at the University of Iowa and Mack Steer at Purdue, were to exert a strong influence on the development of our profession. Neither was identified as an audiologist. Both had made their marks in other areas, especially stuttering and related speech disorders; but both were influential in lobbying for federal support of research in all areas of the communicative sciences. And this support, in the 50s and 60s did much to strengthen the scientific base of Audiology in the United States.

The first book devoted exclusively to the fledgling field of Audiology was written by Hayes Newby, of Stanford University, in 1958. Here, for the first time, were outlined the lineage of the profession and the basics of current clinical practice.

In my view, however, the single individual who has had the most influence on the profession as we know it is Kenneth O. Johnson, the long-time Executive Secretary of the ASHA. From his vantage point in Washington he saw, with a better perspective than the rest of us, the tides and currents in which the future flowed. In countless issues facing the fledgling profession, Kenneth O. Johnson led us, some more reluctantly than others, toward a truly independent status in the health care system.

Today we stand on the shoulders of these giants of the past. Here, at Kiawah Island we are assembled, for the first time, as an independent profession. More than 25% of the 8000 certified audiologists in the United States belong to our Academy, and the number continues to grow. We have never been stronger, and the future has never looked better. We have truly come a long way. In the early 1950s, when I entered the field, there were fewer than 500 individuals who called themselves "audiologists". Most worked in otologist's offices, carrying out routine air, bone, and speech audiometry. Others worked in University training programs, VA hospitals, or independent Speech & Hearing Centers. Hearing aids were evaluated by the speech audiometric techniques Carhart brought back from the War, and patients who seemed like suitable candidates for amplification were sent to hearing aid dealers to be fitted. As a graduate student at Northwestern in the early 50s I held an assistantship which required me to carry out a seemingly endless series of such Hearing Aid Evaluations, usually on Spanish-American War veterans. There were several brands at our disposal, but there was essentially only one hearing aid, the "body" aid which the patient carried in a shirt pocket, harness, or other equally cumbersome arrangement. A wire carried the amplified signal to the receiver which snapped to a fully occluding earmold. The transistor hadn't been invented yet, so there were no BTEs, ITEs, or canal aids. Nor were there CROS aids, vented molds, skeleton molds, or indeed any concept of earmold acoustics. As if this were not handicap enough, many of our clients came to us fresh from the offices of the doctor who had just told them that, since they had "nerve deafness", a hearing aid wouldn't help them.

But we survived those arduous years and saw, over the next three decades, an incredible burgeoning of technology which has impacted every aspect of our field. In the area of diagnostic evaluation, for example, we had at our disposal in the 1950s only one technique, the alternate binaural loudness balance test, or ABLB. Today acoustic reflex and evoked potential measures have expanded our diagnostic potential by at least an order of magnitude. In no other area has this increased sophistication had a greater effect than in the evaluation of babies and young

children. In the 1950s we were taught that audiometry was extremely hazardous in children less than 3 years old, and that valid results depended more on the skill and insight of the examiner than on the inherent accuracy of the behavioral techniques then employed. Today we can test babies of virtually any age, literally from the moment of birth. Early detection of loss, that elusive goal we had so long sought, is, indeed, a reality. The heartbreak of identifying a deaf child who is three or four years old before intervention is initiated need no longer haunt us.

The past 30 years have seen the flowering of a full-fledged profession from the seedlings so carefully nurtured by the giants of the past.

But the price of an independent profession is not trivial. Having reached our present level we cannot just march off, arm in arm, into the sunset of a better tomorrow. There are still many enemies to be bested, many battles to be won. And, just at the moment, the biggest battle is with ourselves. As the field has grown, in so many new directions and down so many new paths, some have run ahead so rapidly that they have lost sight of the others. We cherish the diversity that finds some of us in university settings, others in hospital and medical school settings, still others in private practice or in association with private medical practices, and a growing number of us in the public schools. We find our work, and our professional satisfaction, in a number of different settings. Some dispense hearing aids, others don't. Some emphasize diagnostic evaluation, others avoid it. Some spend a good deal of their time in operat-

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Poster Presentations at the 1st Annual AAA Convention



In addition to preselected tutorial sessions scheduled at the 1st Annual Convention of the American Academy of Audiology, the general membership had the opportunity to submit poster presentation abstracts. The call for abstract submissions was distributed in the second issue of *Audiology Today*. To our pleasure, the Poster Presentation Committee (L. Beck, M. Block, J. Hall, L. Humes, H. Kaplan, M. Ochs) received 40 abstracts for consideration. Following the review process and given the convention space limitations (exhibitors and poster boards vied for every available square inch), a total of 30 abstracts were accepted for presentation. Posters were displayed throughout the convention and two scheduled periods were designated for authors to discuss and address inquiries.

Because the Program Committee recognized the importance and efforts of the contributors, the Poster Committee was asked to evaluate all posters and determine the top three at the convention. An award was given in recognition for quality and scientific merit to the top rated poster at the banquet. Further, the top 3 posters have been invited to submit manuscripts for publication in the *Proceedings* of the 1st Annual Convention. The award recipients were: Terrey A. Oliver, M.S. and James Jerger, Ph.D., Impact of Central Auditory and Cognitive Deficits on Self-Assessment of Handicap in the Elderly; Donald A. Schum, Ph.D., Noise Reduc-

tion Strategies for Elderly, Hearing Impaired Listeners; and, Larry E. Humes, Ph.D., Comparison of Speech-Recognition Performance Obtained with Three Prescriptive Methods.

On behalf of the poster session committee, I would like to take this opportunity to thank all those who participated in the successful event. The quality of the posters exceeded expectation and have insured that poster presentations will be a regular format at future conventions.

**John T. Jacobson,
Chairman of
Poster Presentations**

AAA Convention Exhibit News

The exhibit space at Kiawah Island Resort was sold out almost immediately as commercial companies scurried quickly to take advantage of becoming Charter Exhibitors. A wide range of the latest technology in products, equipment, hearing aids, books and journals were displayed over the three day meeting.

Limited space in the exhibition hall permitted only 20 full booth-type exhibits and 27 table-top exhibits. Unfortunately, a number of additional exhibitors were turned away because of floor space problems. In spite of the tight quarters, convention exhibitors expressed enthusiasm for our new organization and felt that the success of this first meeting amply justified their participation at the Convention. Exhibitors in attendance were awarded Charter certificates from the AAA.

Plans are underway for the exhibits at next year's annual meeting where space will be much more readily available as the Fairmont Hotel in New Orleans boasts 10,000 square feet for exhibition area. Jerry Northern will again serve as Exhibits Chairman and his committee will include volunteers from the commercial firms including Peggy Mazzoni of the Amplus Corporation, E. J. "Bud" Majest of Frye Electronics, Inc. and Bradford Melancon of Life-Tech, Inc.

Audiometrist Program

As we move toward the ultimate goal of a doctoral level profession, it is becoming increasingly clear that there will be a growing future need for supportive personnel at a level of training sufficient to carry out routine audiometric testing and related activities under the supervision of an audiologist. Such "audiometrists" will typically be employed in medical or educational settings. Their role will be to relieve the audiologist of much of the simple and routine activity involved in audiologic practice so that more time will be available for the decision processes inherent in diagnostic, educational, and rehabilitative activities.

In order to assure appropriate standards for audiometrists, the American Academy of Audiology has appointed a special task force to develop guidelines for the training and certification of such supportive personnel. The task force is chaired by Dr. Robert Harrison, University of Miami School of Medicine. Other members include Dr. Don Worthington, Boy's Town Institute; Dr. William MacFarland, Otologic Medical Group, Los Angeles; Dr. Don Bender, U.S. Army; and Dr. Robin Martinette, Mayo Clinic.

We have invited both the American Academy of Otolaryngology - Head & Neck Surgery (AAO-HNS) and the American Neurotology Society (ANS) to appoint members to participate in the deliberations of the task force. The AAO-HNS has appointed Dr. Robert Dobie, University of Washington, as their representative. The ANS has appointed Dr. Robert Keim, Oklahoma City, OK to a similar role.

Academy members with ideas or suggestions for this task force may communicate them directly to Chairman Harrison at the following address:

Dr. Robert Harrison
University of Miami, School of Medicine
Audiology & Speech Pathology
P.O. Box 016960
Miami, FL 33101

President's Address, from page 2

ing rooms, engaged in electrophysiological monitoring. Others will have no part of it.

There is a broad, and growing, diversity to the activities of audiologists, and that is all to the good. It strengthens our financial base, and it heightens the importance of our position in the health care system. But accompanying this increase in breadth has been a tendency for those who follow a particular path to want to redefine the entire profession in their image. Thus some who dispense hearing aids according to a particular philosophy would like to insist that everyone else who dispenses aids must conform to that philosophy. And some who eschew traditional audiologic activities in order to devote full time to averaged evoked potentials want you to believe that what they are doing will define the field in tomorrow's better world. Still others firmly believe that the professional educational system is remiss unless it teaches principles of business management to the aspiring audiologist.

We can, and should, argue these matters among ourselves, but there is an urgent need to close ranks, suspend our differences, and present a united front when we deal, as we must, with related professions, related professionals, government agencies, third party insurers, etc. We cannot afford the luxury of intra-professional warfare when the future of

the entire profession is at stake.

On this great occasion, as we declare before the world our independent status, let us put aside self interest and unite under the banner of this new Academy. Let us say, in a clear voice to those giants of the past upon whose shoulders we now stand, Your work was not in vain! We have built upon your solid foundations. The field you conceived is a reality. We, the heirs of your efforts, are proud of the unified profession we have jointly created.

James Jerger,
President
American Academy
of Audiology
April, 1989

From the President's Desk

The Professional Doctorate



The American Academy of Audiology has been committed, from its outset, to the concept of a doctoral level profession. Indeed, it was written into our bylaws that, after 1992, all new members must hold the doctoral degree. It was with more than passing interest, therefore, that we noted the proposal of Dr. David Goldstein, of Purdue University, to initiate an "Audiological Doctor" or "Au.D." degree, through the Academy of Dispensing Audiologists (ADA). Goldstein's proposal was recently published in the ASHA magazine, has been strongly endorsed by the ADA, and is now being promoted by a new foundation, the Audiology Foundation of America (AFA). The full details of the Goldstein-ADA proposal are available to interested parties in a document entitled, "Proceedings, Academy of Dispensing Audiologists, Conference on Professional Education, 7-9 October, 1988." You may obtain a copy of this document by writing to the Academy of Dispensing Audiologists, 3008 Millwood Ave., Columbia SC 29205. On May 20, 1989, the ADA convened, in Phoenix, Arizona, a meeting of individuals representing various audiologic organizations, to discuss the Goldstein-ADA proposal. Dr. Roger Ruth represented the AAA at that meeting. His report appears elsewhere in this issue.

It is important to emphasize, at the outset, that the AAA has **not** endorsed the Au.D. proposal. It has endorsed **only** the concept of the professional doctorate, **not** the specifics of the Goldstein-ADA proposal. In accepting Dr. Goldstein's motion that the Academy "support and advance efforts to make the audiology profession a doctoral level profession..." AAA Advisory Board chairman Rick Talbott specifically requested (and here I quote from the official minutes of the AAA Advisory Board) "...confirmation from D. Goldstein that the clear intent of the Advisory Board's recommendation to the Executive Committee was that the AAA be actively involved in future planning for implementation of *some* professional doctorate, and that *this was not a blanket endorsement of any particular plan at this time*" (italics mine). Indeed, as subsequent sections will show, many members of the Academy have serious reservations about the Au.D. proposal. We (for I count myself among those with serious reservations) see three potential problems. First, the proposed curriculum is too narrow for adequate professional preparation; second, we are not persuaded that there are adequate safeguards of quality in the educational programs that would grant the degree; and third, Goldstein's proposal to grandfather existing master's level audiologists into the Au.D. degree could have potentially disastrous consequences for the profession.

CURRICULUM

In essence Goldstein proposes that, after two years of undergraduate preparation, the Au.D. candidate would enter a 4-year program terminating in the awarding of the Audiological Doctorate. The total time spent in post-high-school academic preparation would, in theory, be 6 years, or the average time now spent by a typical master's degree professional. At the

end of the sophomore undergraduate year, the candidate would enter a 4-year program of professional training in Audiology. The proposed curriculum is heavily technique-oriented. It includes courses in sign language (7 hrs), auditory assessment (3 hrs), counseling (3 hrs), management of a practice (3 hrs), differential audiological diagnosis (3 hrs), diagnosing the communication disorder (6 hrs), hearing aids (8 hrs), clerkship (6 hrs), internship (16 hrs), and clinical experience (96 hrs). These courses and clinical practica, collectively, account for 151 of the total of 180 hrs in the total 4-year program. The remaining 29 hrs are devoted to foundation courses in acoustics, phonetics, electronics, language development, anatomy and physiology, neuroanatomy, audition, embryology and genetics, computers, medical aspects, industrial audiology, and pediatrics. It is noteworthy, perhaps, that the total number of hrs committed to audition, acoustics, electronics and phonetics (11 hrs) exactly equals the number of hrs committed to hearing aids and management of a practice (11 hrs), perhaps reflecting the bias of the Academy of Dispensing Audiologists, one of the strong sponsors of the Goldstein scheme.

Conspicuously missing from the Goldstein-ADA proposed professional curriculum is any apparent course work in the areas of psychophysics, basics of neurophysiological measurement, auditory evoked potentials, statistics, scientific methodology, and aural rehabilitation. Pragmatists will undoubtedly argue that such academic subjects are beyond the scope of practical training for immediate life success. Such a stance fails to appreciate, however, that professional fields are in a constant state of change, and that one of the principal goals of

any educational program is to prepare students for a changing world by making them intelligent consumers who can understand and keep pace with advances in their field. Audiology today is quite different from the Audiology of only 20 years ago. And change comes at ever shorter intervals. It is as important to prepare students for tomorrow's world as it is to prepare them for today's market. Many educators feel that this goal is best achieved, not by emphasis on technique and practicum, but by dedication to the development of those skills which make it possible for students to understand advances in the field and how they will impact tomorrow's professional practice. In any profession based on science, true professionals must be able to follow the literature of the field, a literature which is becoming increasingly technical and complex. This argues strongly for preparation in the basics of the field in addition to the mastering of clinical techniques.



ASSURANCE OF STANDARDS OF QUALITY

Any proposal to offer a new doctoral degree program, different from the existing Ph.D. programs now serving the profession, must include specific safeguards of quality. The danger is that non-university based degree-granting programs (i.e., diploma mills) will arise to meet the demands of individuals who seek the easiest possible road to the doctoral level. This is a particular hazard if the existing educational facilities are slow to embrace the new concept. This has certainly been the experience in other fields attempting to implement the professional doctorate. Our colleagues in Psychology, for example, are plagued by a number of free-standing institutions willing to offer the Psy.D. degree to those unable to enter university-based programs. Monitoring the quality of these programs is a very difficult task indeed.

But the Goldstein-ADA proposal does not speak to this issue. While admitting that the present educational establishment may find it difficult or impossible to implement the Au.D. program, the Goldstein-ADA proposal fails to grapple with the important question of how quality of the educational product will be maintained when other avenues for granting the professional degree are inevitably mobilized. How will admission standards be established and guaranteed? How will a competent faculty be established and guaranteed? How will the rigor of the student's work be guaranteed? In the present educational system these minimal guarantees derive from the basic organization of Universities, especially the safeguard of interdepartmental evaluation. Whether or not the present educational establishment is as receptive to change as we would like it to be, it does have the undoubted virtue that the system ensures a certain minimal level of quality of the educational product. If the Au.D. degree is offered outside this framework, then how will standards of quality be enforced? This is an important question that must be addressed.

GRANDFATHERING

Implicit in the Goldstein-ADA proposal is the concept of "grandfathering." A mechanism would be developed whereby practitioners who

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now hold the master's degree would, for a limited time, be grandfathered into the Au.D. degree, in view of the fact that they have "...largely achieved the knowledge and skill expected of the Au.D. degree holders..."(Proceedings, p.12). No part of the Goldstein-ADA proposal has a greater potential for disaster than the grandfathering provision. How will this pseudo-credentialing be viewed by our colleagues in related health-care professions with whom we must interact on a daily basis? Will physicians, the largest single group of employers of master's level audiologists, accept such a bold step? Or will it only place further strain on already tenuous professional relationships? The Goldstein-ADA proposal cites, as precedent, the fact that medicine and optometry have used the grandfathering mechanism in the past. It is important to remind ourselves, however, that this grandfathering occurred 50 to 100 years ago. Is it reasonable to expect that, in today's more complex health-care system, with its heavy dependence on third-party payers, such broad grandfathering of individuals with varying degrees of competence and experience will be tolerated? Do we, ourselves, think it is a good idea to sweep the present approximately 7000 individuals holding the master's degree in Audiology up to the doctoral level? Is it ethical to grant doctoral status to a large number of individuals who have not completed the equivalent of doctoral work, or are we just deceiving the public?

It has been erroneously suggested that grandfathering would be a legal requirement if the professional doctorate were launched, since failure to grandfather would interfere with audiologists' ability to pursue their profession and earn their livelihood. But initiating a new kind of training program, per

se, would have no limiting effect on an individual's ability to pursue his profession. Eventually, the doctoral level might become a requirement for certification or licensing. In that event, current master's level practitioners would have to be grandfathered into certification or licensure. But the professional doctorate, itself, would not have to be grandfathered to anyone.

There is a very real danger that reckless grandfathering of everyone who now holds the Masters degree would be unacceptable to the public and would damage our credibility irreparably.

THE BOTTOM LINE

Although we are indebted to Dr. David Goldstein, and to the ADA, for taking the first step on the road to the professional doctorate in audiology, the specifics of the Goldstein-ADA proposal need careful attention. The curriculum needs to be rethought, mechanisms for guaranteeing the quality of degree-granting programs must be developed, and the concept of grandfathering should be very carefully re-evaluated.

It is time to develop a broader base of support, to bring the entire profession into the debate. I would like to propose that a truly representative council of individuals, representing all facets of the profession, be formed and charged with the responsibility for extending and revising the Goldstein-ADA proposal into a program for the professional doctorate that we can all live with.



Every audiologist will be affected by the professional doctorate. It is appropriate, therefore, that every audiologist be represented in its development.

In order to stimulate further thought and discussion of these very important problems I have invited a number of individuals to comment on the general issue of the professional doctorate and the specific issue of the Goldstein-ADA Au.D. degree proposal. In subsequent sections Dr. Roger Ruth reports on the recent meeting called by the ADA in Phoenix, Dr. Linda Hood delineates relevant issues that need to be considered, Dr. David Goldstein reviews the historical development of the concept of professional doctoral training and the arguments for his Au.D. proposal, Dr. James Yates raises some serious problems associated with the Au.D. proposal, Dr. Susan Jerger reviews Psychology's experience with the Psy.D. degree and its relevance for audiology, and Drs. Cynthia Fowler and Richard Wilson ask whether our present problems might be corrected by changes in the existing educational structure rather than by the development of new educational tracks.

There is no more important issue facing audiology today. Accordingly the executive committee of the AAA has created a special task force, under the leadership of Richard Talbott, to develop an AAA plan for the professional doctorate (see back cover). I urge every member of the AAA to read this series of communications carefully and to communicate your own thoughts to Chairman Talbott. We are all involved whether we like it or not. Let all voices be heard.



ADA SPONSORS MEETING TO DISCUSS PROFESSIONAL DOCTORATE

*Roger Ruth, Ph.D.
University of Virginia*

The Academy of Dispensing Audiologists (ADA) recently sponsored a meeting of various Audiology-related professional organizations to discuss the concept of a professional doctorate in Audiology. This meeting was held on May 20, 1989 in Phoenix, Arizona in conjunction with their annual spring conference. The intention of this meeting was to create a Professional Audiology Coalition (PAC) representing the diverse areas of interest within the field of Audiology. The goal of the PAC, as defined by the organizers, was to work cooperatively to develop, implement and support the Au.D. degree. Ten different professional organizations were represented. Those organizations and their representatives included:

- American Academy of Audiology — Roger Ruth
- Academy of Rehabilitative Audiology — Joseph Smaldino
- Council of Graduate Programs in
Communication Sciences & Disorders — Fred Minifie
- Academy of Dispensing Audiologists — Tomi Browne
- American Academy of Private Practice
in Speech Pathology & Audiology — Angela Loavenbruck
- American Auditory Society — Wayne Staub and Ross Roeser
- Council of State Speech Language
Hearing Association Presidents — Robert Nellis
- American Speech-Language-Hearing Association — Carol Flexer
- Audiologic Resources Association — Gordon Fletcher

The majority of representatives indicated that their organizations support the concept of a professional doctorate in Audiology. The primary concern expressed by the group regarded the mechanism by which this would be accomplished. One proposal, offered by the ADA included formation of a not-for-profit educational corporation to be known as the Audiology Foundation of America (AFA). The stated mission of the AFA is to:

1. Provide awards and recognition to universities whose Au.D. degree programs demonstrate excellence in standards as established by the Foundation board.
2. Provide scholarships and other incentives to outstanding students in Au.D. degree programs.
3. Develop and support a mechanism for awarding the title of Doctor of Audiology to currently practicing audiologists.

Left unresolved was the manner in which the members of the governing board of the AFA would be selected and whether professional organizations should be represented on that board. The ADA should be congratulated on their efforts to establish the Au.D. degree and

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A PROFESSIONAL DOCTORATE IN AUDIOLOGY - SOME ISSUES TO CONSIDER

Linda J. Hood, Ph.D.

LSU Medical Center

New Orleans, Louisiana

There is a growing consensus that a doctorate is essential to the provision of comprehensive services to the hearing impaired and, indeed, to the future of audiology. Several factors have contributed to this consensus and to the recent renewal of interest in a professional doctorate in audiology. First, concern that a two-year Master's degree program cannot keep pace with the proliferation of knowledge in audiology or assure acceptance by other professions continues to increase (Miller and Deutsch, 1983; Feldman, 1984; Aronson, 1987; Spriestersbach, 1989). Second, the American Academy of Audiology included in its charter recognition of the need to upgrade audiology to a doctoral level profession and a goal of instituting this process within five years of its formation (Jerger, 1988). Third, the increase in the number of audiologists entering into private practice has brought focus upon a need to interact on an equal level within the health-care community. Fourth, the proposal of a specific AuD curriculum (Goldstein, 1989) has spurred discussion of the type of program that should lead to a professional doctorate in audiology.

We currently face both an opportunity and a need to consider carefully the manner in which we wish to meet our future educational goals. A series of questions follows that address some, but not all, of the issues that must be considered as we look toward audiology's future.

Question 1: How much education is appropriate?

The current audiology educational format of a four-year baccalaureate degree and a two-year Master's degree program falls short of many other clinical health-care fields. While most students entering medicine, dentistry, psychology and optometry programs have also completed a four-year baccalaureate degree, their education then continues for an additional 4 to 9 years for a total of 8 to 13 years, depending on the length of residencies and/or M.A.-Ph.D. tracks.

The professional doctorate discussed by Feldman (1984) and Aronson (1987) approaches other disciplines in that training extends to 2 to 3 years beyond the Master's degree or 3 to 4 years beyond the Bachelor's degree for an average total of eight years of education. The Au.D. degree program outlined by Goldstein (1989) totals just six years beyond high school which is similar in length to the current Bachelor's-Master's track in audiology. Education is focused toward certain areas of audiology in this AuD program, begins after two years of a college level pre-audiology program, and does not include acquisition of a Bachelor's degree.

Along with the length of a program of study, the necessity of a broad basic foundation as well as specialized education and the time needed for maturation of students into professionals should be considered. For example, an audiologist, in addition to "performing a test," should be able to explain the anatomy and physiology underlying diagnostic procedures and results as he or she interacts with physicians and other health-care professionals. Furthermore, a modicum of maturity, counseling experience, personal sophistication and experience managing patients is critical in successful clinical practice. These skills may take more than six years post high school to nurture.

Question 2: Should training take place in academic programs, professional schools, or both?

A number of specific issues should be addressed in relation to this question. First, can research/academic and professional doctorate tracks co-exist within current graduate programs? Can they support and complement each other? Is it important to encourage development of clinical research skills? Second, should a doctoral level degree in audiology be granted through a professional school? If yes, then should professional schools be free-standing or under the governance of existing academic institutions? A third issue concerns the type of degree to be granted and is related to discussion of the research nature of the Ph.D. Should a professional doctorate be something other than a Ph.D.? What should a professional doctorate in audiology be called? If degrees with clinical emphasis are granted through both academic and professional programs, should the name of the degree from each program be the same or different? Should everyone who graduates from either program be called an audiologist?

Question 3: When should students be recruited into audiology?

This question addresses two concerns: (1) the background necessary to assure a broad knowledge base prior to entry into audiology and (2) the selection criteria necessary to assure production of highly skilled, mature audiologists who can succeed in the health-care community.

Professional programs in related health-care disciplines nearly universally recruit students who have completed baccalaureate degrees. Rigorous acceptance criteria include academic excellence, successful performance on

national examinations, interviews, and recommendations. Students who do not, for some reason, succeed in the graduate program at least have a Bachelor's degree to "fall back on."

In evaluating the appropriate entry point into audiology (post-baccalaureate versus just out of high school versus after one or two years of college), we should consider the point in a student's college career when he or she can best select audiology as a profession and the point when the college record is sufficient to allow recognition by recruiters of students who are most likely to succeed.

Question 4: What is a well-balanced and comprehensive curriculum?

The expanding knowledge base in audiology and specialization by some audiologists in particular areas of professional practice raise certain questions for training programs. As various models are evaluated, many specific issues should be considered. Is sufficient time allotted to cover material in all areas of audiology? Is the curriculum directed toward a specific type of audiology practice or is it broad-based in content? Courses covering foundation material such as hearing science, computer science, acoustics, instrumentation, and statistics are basic to many areas of specialization. How much should be included? Are mechanisms available to acquire the amount of direct patient contact proposed? How much orientation/experience toward research should be included in a clinical track? Enough to read critically and apply the literature to clinical practice? To carry out clinical research? How can we achieve a balance between highly focused, practical information and sufficient breadth and depth of knowledge to produce effective practitioners who have sufficient background to learn new techniques and procedures?

Question 5: How will the quality of programs and graduates be assured?

Will educational programs be evaluated through self review, external review, accreditation? While programs within academic institutions have evaluation methods in existence, how would free-standing professional schools, if they are implemented, be evaluated and credentialed? How will candidates be evaluated? Should licensing and/or certification requirements be considered minimal standards or comprehensive standards?

These issues have particular importance since simply acquiring the term "doctor" will not solve problems if the professionals using that title do not meet the standards of peers in related professions, the expectations of referral sources and the needs of the public. The title of "doctor" and the doctoral degree also may be diminished in health-care settings if one is unable to obtain third-party reimbursement directly.

Question 6: What can we learn from other disciplines?

Other professions have dealt with many of the issues that audiology faces today. For example, the field of psychology developed the Psy.D. degree, a four-year post-baccalaureate professional degree granted through academic institutions and free-standing professional schools with a curriculum that follows a medical school model and emphasizes patient contact. While the Psy.D. degree was instituted with the intention of

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upgrading and improving the profession, this has not occurred without problems. Dr. Susan Jerger discusses the impact of the Psy.D. degree on the field of psychology in this issue of *Audiology Today*. Rather than blindly accept any proposals, we should study the histories of other professions, discuss the manner in which similar problems were addressed, and benefit from their experience.

Question 7: What are the long-term effects of the changes we implement?

With whatever program or programs are ultimately instituted, assurances must be made to produce highly competent, highly skilled, well-rounded professionals. We must carefully define our role in the health-care model to assure our participation on the level that we desire and that our education reflects. We should also consider the perspectives of individuals in all areas of specialization within audiology and in all types of work settings.

In conclusion, the above questions are intended to highlight some of the many factors involved in implementing a professional doctorate in audiology and to address some of the potential shortcomings of a program such as the Au.D. proposed by Goldstein (1989). We should openly express our opinions, discuss and carefully consider various solutions and models, and draw upon the experience of related disciplines. The impetus for change has begun. As we continue this process, we must carefully and thoroughly analyze the impact of each change on the future of audiology.

References

Aronson, A.E. The clinical PhD: Implications for the survival and liberation of communicative disorders as a health care profession. *Asha* 29:35-39, 1987.

Feldman, A.S. In support of the professional doctorate. *Asha* 26:24-32, 1984.

Goldstein, D.P. AuD degree: The doctoring degree in audiology. *Asha* 31:33-35, 1989.

Jerger, J.F. Report from the president. *Audiology Today* 1:1-4, 1988.

Miller, M.H. and Deutsch, L.J. Future directions in audiology. *Asha* 25:39-42, 1983.

Spiestersbach, D.C. Professional education and communication disorders. *Asha* 31:77-78, 1989.

(Note: Portions of this paper were presented in an invited discussion at the 1989 Summer Institute of the Academy of Rehabilitative Audiology.)



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the framework thus far developed. However, this complex and monumental step with its far-reaching ramifications necessarily deserves study and consideration by a larger sector of our profession. Needless to say, much depends on the manner in which the AFA carries out its mission. As such, it is incumbent on the AAA to take an active role in the ongoing development of plans for the professional doctorate and the formation of the AFA.

AUDIOLOGY LAUNCHES A NEW BEGINNING

On April 21-24, 1989, the American Academy of Audiology held its first annual meeting at Kiawah Island in South Carolina. Because the Academy was not yet one year old, the organizers of the meeting had limited time for planning and advertising the conference. Nevertheless, the response to the meeting far exceeded everyone's expectations. Close to 600 participants, including 45 commercial exhibitors, attended the meeting and overflowed the conference facilities at Kiawah.

The focus of the program was a series of invited tutorial presentations. The majority of these programs targeted pressing issues currently facing the profession and special topics that were of concern to the practicing clinician. In addition, technical papers presented in the form of poster sessions were an important component of the conference.

The meeting was kicked off with a large "social gala" sponsored by Starkey Laboratories, Inc. This successful, well-received event was attended by almost 500 registrants. Saturday was filled with tutorial sessions and, during the luncheon period, rap sessions referred to as *CROSSFIRE*, were conducted on controversial areas associated with the profession. Several intensive workshops were conducted on Saturday evening. A special feature of the workshops was an excellent presentation by David T. Kemp of the University of London on "Practical Aspects of Otoacoustic Emissions." On Sunday, the business meeting was conducted by Fred H. Bess, president-elect, in lieu of James Jerger, who was unable to attend the meeting. The day was capped off with a special

banquet and program hosted by Jerry Northern. The evening program was highlighted by a presidential address via videotape from James Jerger. Dr. Jerger officially launched "A New Beginning" and declared to all the profession's independence.

Numerous individuals contributed to the overall success of this important new beginning. Brad Stach, Marlene Stephenson, and Jeanine Pruitt coordinated activities from Houston headquarters. Jerry Northern served as the chair of commercial exhibits and coordinated many of the social events. John Jacobson was responsible for the poster sessions and will be editing a proceedings of the conference. Susan Logan worked tirelessly in her efforts to coordinate an overflowing pool of registrants. Dottie Adams, secretary to Fred Bess (Program Chair), spent numerous hours working out hotel accommodations for those individuals who were unable to obtain room reservations on the Island. Students from Vanderbilt University and the University of Georgia generously gave of their time to assist with child care and to help with registration and continuing education. Trish Blake expertly coordinated Continuing Education for both ASHA and the National Institute for Hearing Instrument Studies. Numerous others volunteered time and talent to ensure a successful first annual convention. To all of them — we are most grateful.

Indeed, there was consensus that the conference was a success and that the meeting brought about a new spirit, a new momentum for the profession of Audiology. Let us carry it on!

Fred H. Bess
Vanderbilt University

2000th Member of the Academy



Barbara C. Kirk, M.A. (left) was honored at the 1st Annual Convention of the AAA as the Academy's 2000th member. Ms. Kirk lives in Rutland, Vermont where she has a private practice. She is co-owner of Audiology Associates, Inc. She has worked as a Clinical Audiologist for over 15 years and states that the American Academy of Audiology is the first national audiology organization other than ASHA that she has joined. Her reason for joining AAA was her search for an organization that represented and supported the overall needs of Audiology.

ROOTS AND FRUITS OF THE Au.D.

David P. Goldstein, Ph.D.

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When first asked by Jim Jerger to write this article for *Audiology Today* it seemed an unusual task — the professional doctorate is something which has been discussed in the literature for almost 20 years. A bibliography of articles would be lengthy and a brief history could be voluminous. As most of this material revolves around “Why we should have a professional doctorate now,” it might be helpful to look at the reasons professional education in audiology was not adopted in the first place before touching on the crucial points relative to the Au.D.

In training of health care professionals, the standard rule is the professional doctorate — audiology’s M.S. program is the exception. This is not because audiology is a less taxing program of study or because it is less scientifically rigorous but because it has different roots than that of medicine, optometry, and dentistry. These professions developed using the “apprentice” model for education. Even after universities took over the education process in medicine, dentistry, and optometry, the roots of these disciplines still nurture their professional orientation. Audiology arose in academia as the applied end of a scientific discipline. The structure and content of its training and certification program has mirrored that of traditional academic programs. The Highland Park Conference in 1963 gave the blueprint for professional education in Audiology — using the Master’s degree as the level of entry into the profession (logically the next step in academic progression after the B.S.). At the same time, the conference formalized a commitment to the scholar-practitioner, recognizing the importance, at least on paper, of the role of the clinician. As clinical orientation flowered and grew in audiology and speech pathology, problems became apparent in the professional education program. In 1969 Darley discussed our shortfalls in professional education, interestingly, in a paper in which he shared his disappointment at the reaction of his university colleagues to his decision to leave academia in order to join the Mayo Clinic as a practitioner. His critique raised issues that have become all too familiar in audiology — insufficient time in the Master’s level program to develop the clinical skills necessary for practice. He urged that the amount of time spent in hands-on lab experience be greatly increased. In his 1969 paper Darley stated:

“Our goal is the provision of first-rate patient care. How are we to achieve it? By bolstering, enriching, and increasing experience under the watchful eye of master clinicians in settings that provide interprofessional stimulation and influence, together with making a scientific attack in the real life questions that grow out of that clinical situation and are answerable only in it.”

This critique has cropped up again and again through the history of audiology — it has the makings of a classic paradox —

- 1) The Master’s degree is the entry level for professional practice.
- 2) There is no room in a Master’s level program for the additional didactic, lab, or clinical learning requirements of modern audiology education.
- 3) The next level of academic progress, the Ph.D., is research oriented. The professional doctorate program began to be seriously considered as a way out of the paradox.

In 1976, a conference on the professional doctorate was held by the Big Ten University programs in speech pathology and audiology. This conference was concerned with the need for a professional doctoral program, the expected benefits, potential problems, and possible strategies for establishing such a program. The histories of professional doctorate programs

in the sister disciplines of optometry and psychology were discussed and a draft of curriculum considerations for a professional doctorate program in audiology was created. But this discussion went nowhere.

While the idea of a professional doctorate was not well received in academia, its supporters found themselves with research bedfellows at the 1978 ASHA Task Force on Science. This conference of scientists was assembled because of concerns about the deficiencies in the quality of research — the professional doctorate was presented as a way of pumping much needed clinical experience time into the professional education program and reserving the Ph.D. for the scholar wishing to pursue a research career.

At the St. Paul Conference in 1983, Angela Loavenbruck made a compelling case for the professional doctorate not only on the well-established ground that preparing clinicians for practice requires much more time than the overburdened Master's program can provide but also from the standpoint of the overall health of the profession. Loavenbruck stated that audiology must find ways to attract and encourage students whose seriousness of commitment to their profession is equivalent to that found in other more established and prestigious professions. Such commitment can only be reasonably expected where the rewards, socially and financially, are similar. "We will never function on an equal level with physicians and other health practitioners in the eyes of the public we serve until our titles and training are equivalent." Loavenbruck also emphasized the importance of "grandfathering" — the establishing of a procedure by which existing practitioners could upgrade their skills and earn the title of doctor.

In November 1987, Aronson detailed the arguments in favor of the clinical Ph.D. as the minimum standard of practice. Aronson cited such factors as increased acceptance by other professionals; the ability to resist territorial invasion by allied professionals; the proliferation of knowledge in the profession; the need for equitable remuneration for service; and the ability of such a program to prepare one for a more intellectually stimulating life. Not addressed in Aronson's article is the reality that our current Doctor of Philosophy degree is a clinical Ph.D. in the eyes of scientists while students wishing a doctorate for practitioner goals shun this degree because it is a research degree.

The year of 1988 is a turning point in this story. Responding to dissatisfaction among audiologists to the state of affairs in their profession, the American Academy of Audiology was founded with its central theme being the transformation of audiology into a doctoral level profession. Responding to the same winds of change, a Conference on Professional Education in Audiology, with practitioner participants in the majority, was convened in October of that year (ADA, 1988). The practitioners had reached an age of majority and a critical mass whereby they could have a forum to contribute their insights on the problem of professional education. The Conference on Professional Education recommended the establishment of the Au.D. and described the essential program characteristics (pre-audiology curriculum, admission standards, audiology curriculum, and plan for existing practitioners). This conference has helped raise support among the professional community for the Au.D. Support for the Au.D. now comes



from many different areas of audiology: practitioners, scientists, and academicians.

It is always difficult to change the way things are done, especially if "they've ALWAYS been done that way." But it is important to understand that the model for audiology education was established when audiology itself was in its infancy. The role of clinician was not expected to be as demanding and complex as it ultimately has become. As the scope of professional practice has increased, the breadth and depth of entry level knowledge has also increased; intraoperative monitoring to hearing aid dispensing, central auditory processing testing to child language assessment, and lipreading training to industrial hearing conservation. Although the Bachelors/Masters program is the traditional way of educating audiologists, it is a program bursting at the seams. The professional doctorate model, one that has been used in health care professions similar to ours, is needed. It works well.

Debate over the Au.D. degree is strangely reminiscent of the 1970's when we argued for the direct dispensing of hearing aids by audiologists as part of their rehabilitation activities. Reasoned minds developed scholarly arguments about the perils to the profession of taking this step. Now it is hard to imagine audiology without hearing aid dispensing as an element in its array of services and products provided to the hearing impaired public. It took a U.S. Supreme Court decision to achieve that step. Today, it is the massive support and understanding of audiology practitioners all over this country that will make the Au.D. the benchmark of our profession.

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PROFESSIONAL EDUCATION IN AUDIOLOGY: A NEW DILEMMA

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Most of the arguments for and against professional or clinical doctorates have been around for a long time. In fact, it is but an accident of history that the profession of audiology grew within traditional academe. Why did a profession spawned in a hospital by a physician and speech pathologist in clinical practice become so wedded to graduate as opposed to professional education? Probably (possibly?) because Raymond Carhart, a speech pathologist turned audiologist, returned to his academic roots at Northwestern. It's only natural that the direction of audiology followed the course of the education model. Moreover, it would be some years before the science of audiology would be sufficient to support a field of practice in the truest sense.

During the early years, the Master's degree became the clinical standard and the doctorate, typically the Ph.D., was reserved for the researcher/teacher. Looking back to our own education program, it seems probable that the field would have been hard-pressed in the 1940's, 50's, or even early 60's, to offer a clinical doctorate worthy of the name.

As the fund of knowledge in Audiology grew and the traditional system of educating audiologists became more confining, alternatives were considered. The concept of a professional doctorate was sufficiently enticing that in 1963, the National Institute of Neurological Diseases and Blindness sponsored a conference in Graduate Education in Speech Pathology and Audiology that included discussion of a separate professional doctorate (ASHA, 1963). The Highland Park Conference was followed by the Monterey Workshop in 1971, and in 1979, by the Ann Jordan Conference, both of which considered the professional doctorate (Professional Doctorate in Audiology, 1987). Clearly, the concept of the clinical doctorate was gathering adherents.

Alan Feldman was a proponent of the professional doctorate during his tenure as vice-president, then president, of ASHA. He lobbied for a number of changes in the field, notably professional independence, greater representation in the private sector, and a move away from what he saw as excessive control from "external forces and traditional academic models" (Feldman, Presidential Address, ASHA 1981).

Most recently, Spriestersbach (ASHA, 1989) discussed the issue of professional education. Although stopping short of proposing a clinical doctorate, he had done so earlier at the conference of Big Ten University Programs (1976). These early conferences and papers stimulated discussion but no real agreement. The field was not ready to accept the need for such drastic alteration of the status quo.

Examination of the lists of participants and organizers suggests that these historical efforts largely were producer- rather than consumer-driven. Even Feldman primarily was an educator at the time, albeit with considerable credentials as a clinician. The assorted conferences and articles failed to generate a broad base of support of the professional doctorate from practitioners.

The movement for a professional doctorate was kept alive by a few hearty souls. The Council of Graduate Programs in Communication Sciences and Disorders has considered resolutions of one sort or another regarding support for the concept of the professional doctorate each of the past few years. This year, for the first time, there was majority support for the concept. The Academy of Rehabilitative Audiology voted unanimously in favor of the concept of the professional doctorate at its 1989 Summer Institute. The vote was not associ-

ated specifically with the Au.D. or any other proposal.

The change in attitude probably is due to the catalytic effect of the Au.D. proposal. Previous efforts to develop the professional doctorate lacked two essential ingredients. First, there was not broad-based support from practitioners in the field. Second, and of equal importance, there was not a model training program to serve as a rallying point. The proposed Au.D. degree might have been the answer.

The Au.D. is the product of an effort by the Academy of Dispensing Audiologists. They are over 700 audiologists, most of whom are active clinicians. Certainly, the Au.D. proposal meets the test of being consumer based.

The second critical need in the desire to produce a viable doctorate is for someone to produce a model program. Such a program moves discussion from the abstract and can force decisions. The Academy of Dispensing Audiologists' proposed Au.D. is a milestone in our professional development. For the first time, there is an actual proposal with title, content, etc. sufficient to focus debate.

The ADA is to be congratulated for this effort, if not the product. They have produced a model training program that is sufficient in detail to discuss on merit. Their proposal reflects significant expenditure of energy and thought. Unfortunately, it appears to be equally representative of compromise and concession; self-serving, even self-destructive in nature. The proposal not only fails to answer the prime objection of the anti-professional doctorate forces, it reinforces many of them. The Au.D. proposal is not the program that will meet the professional needs, overcome objections of the opposing forces, and establish credibility for the clinician.

The classically held objections to the professional doctorate have centered around issues of quality, appropriateness, and image. The point most often made by the anti-professional doctorate forces is that a professional doctorate would be inferior to the Ph.D. in fact or in image. Examination of the Au.D. proposal reveals it not only to be inferior to the Ph.D. in terms of standards and content, but to be of questionable strength vis-a-vis the current Master's degree.

The Au.D. is described as a 48-month course of study following a minimum of two years of pre-audiology education which would place its holder "on a par with others holding doctorate degrees (ADA Proceedings, 1988, p. 9)." The student following the six-year program outline will graduate with an Au.D. having completed some 63 semester hours of pre-audiology coursework and 82 hours in the Au.D. curriculum or a total of 145 semester hours. The typical Master's degree graduate has spent six years in preparation, including some 125 semester hours in undergraduate training and 45 at the graduate level - 35 hours more than the minimum proposal in the Au.D.! Of course, the CFY which follows the current Master's education is the fourth year of the proposed Au.D. That explains, in part, how the student can attend the same six years and complete approximately 35 hours less education.

The fourth year "residence" basically incorporates the current CFY, an abomination in its own right, into the academic program. In ADA Conference Proceedings (1988), the 'clinical residence' is thusly described:

"The Clinical Resident (sic) is a CFY concept, probably off-campus. The student will typically complete this experience by working 35 hours per week for a nine-month (40 week) period, yielding approximately 1400 hours of clinical learning experience." (p. 52)

Although we have been told that this is different from the present CFY, the major departure seems to be that it has been renamed. Does calling the nine months a residency, rather than fellowship, somehow increase the intrinsic value? Does renaming overcome the many shortcomings of the present CFY?



The concept of a true clinical residency is a defensible inclusion in a program that follows the medical model. A quality residency would strengthen any clinician's program of education. Unfortunately, nothing in the ADA Conference Proceedings or in Goldstein's presentations at the Council of Graduate Programs and the Academy of Rehabilitative Audiology indicated the proposal to be a truly substantive residency.

It is inconceivable that an unbiased observer would compare the Ph.D. and Au.D. degrees and find them to represent comparable attainment. Although the authors represent the Au.D. as equivalent to the Ph.D. in status and rigor, the facts do not support such claims. In fact, the authors concede the relative superiority of the Ph.D. to the Au.D. in the model depicting the Au.D. degree in Audiology (Figure 1, p. 31, ASHA, 1989). The ASHA article shows the Au.D., conventional Master's track, and Ph.D. degrees. The M.S. track and Au.D. degrees are similar in time frame (6 years for each) and depicted as equals. Both are illustrated as potential feeder

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sources for the post graduate study at the Ph.D. level. The visual message is very clear: The Au.D. is comparable to the existing Master's degree and could be an entry step to the Ph.D. The Au.D. degree is not a doctoral level standard and should not pretend

to the title.

To maintain that the Au.D. "places its holder on a par with others holding doctoring degrees...medicine, dentistry, optometry" (ADA Proceedings, 1988, p. 9) simply is indefensible. The Au.D. in no way compares with the M.D.

Consider the average first year student in an accredited American medical school. The typical student is male, 23.9 years of age, and has a 3.4 GPA overall. He was a science major, most likely Biology, and had a 3.32 GPA in the sciences. His MCAT score was a 671 with fairly stable unit scores. There is a 15 percent probability that he has two Bachelor's degrees or a Master's degree. He will spend four years in medical school, intern, then spend 3-7 years in residency. Along the way, he will take and pass a number of rigorous national standard exams including a comprehensive. If he aspires to board certification, there will be specialty examinations along with practice requirements.

The student in the Au.D. model must have a GPA equivalent of 4.75 on a 6-point scale, pass an aptitude test of an unspecified nature and might be of Junior standing with 55 college credits (ADA Proceedings, 1988, p. 39). These are not the credentials of an aspiring professional. When the Au.D. student graduates at age 24, the

medical student is in the second year of professional training.

Finally, the most frightening aspect of the Au.D. is in sections IX and X of the proceedings "Plan for Existing Practitioners" (ADA Proceedings, 1988, p. 21). Basically, these sections confirm that obtaining the title of "Doctor" was a central issue for supporters of this program (Section IX). The **title** of Doctor of Audiology would be awarded to those already in the field "without forcing current practitioners to abandon their practices." Eligibility for the title of Doctor of Audiology would be based on the following:

1. holding Master's degrees and licensure or equivalency
2. at least 3 years continuous experience as an audiologist
3. Board review of transcripts, vitae, etc.
4. Board interview
5. completion of selected advanced education experiences as recommended by the Board.

This awarding of the title cheapens the Au.D. and our profession. This component alone is sufficient to raise questions about the motives of this proposal.

There is no evidence that the Au.D. concept and content are designed for the needs of the public or the practitioner. The Au.D. is not innovative. The curriculum content area (ADA Proceedings, 1988, pp. 15-18) are consistent with the subjects covered in today's better Master's programs. In fact, the curriculum is more distinguished by what it omits than by its inclusions.

The Au.D. is heavily biased toward the medical model with a majority of the academic and clinical preparation focused on diagnosis and provision of prostheses. There is nothing wrong with a model asserting that we be accomplished diagnosticians if we wish to call ourselves audiologists. Certainly prostheses will be central to rehabilitation efforts in the foreseeable future. However, to ignore that part of our potential service base outside the hospital/dispensing offices is professionally, politically, and practically wrong.

The profession has devoted years to obtaining independence. Part of the success of that effort is due to acceptance of the idea that medical intervention is not the answer to all disorders of hearing. The Au.D. model leaves a vast segment of the population unserved. Perhaps the designers of the Au.D. omitted part of today's audiology purposefully, intending to reshape the practice through their degree. Perhaps the omission was an oversight. If the former is true, the profession needs to say forcefully to the ADA that while the field may well need redirection, such changes should come from enlightened planning by professionals committed to serving the public and those changes should be discussed openly. If an oversight, the omissions disqualify the ADA by reason of self-serving tunnel vision. The proposal appears to be the product of individuals more interested in pursuing a title than obtaining education.

I believe that the field of Audiology should have a professional doctorate. Such a degree should be developed as part of an overall plan that places audiology on a new direction.

The professional doctorate should be competency-based. Clinicians and those who understand and value clinical service should evaluate the present and future market, identify the role or values of audiologists, and design a doctorate that is appropriate to the needs of the consuming public and to the practitioner. The product must be above reproach academically because anything less will prohibit our earning

the respect we all covet.

In the summary of the ADA proposal, the discussion group that developed the Au.D. model is quoted as closing with a saying:

“Today we put our toe into the water
Now we wait for the tidal wave!” (ADA Proceeding, p. 26)

We in Hawaii know something about tidal waves or tsunamis as we call them. They have enormous destructive power but also bring new sand for the beaches. When the tidal wave is coming, we prepare our defenses, move to high ground, and plan to rebuild.

The tidal wave is coming. The options are to strengthen the degree to withstand the forces or watch the wave carry it away.

References

Academy of Dispensing Audiologists (1988). *Proceedings of the Academy of Dispensing Audiologists Conference on Professional Education*. Columbia, SC, October 7-9, 1963.

American Speech-Language-Hearing Association. *Graduate Education in Speech Pathology and Audiology*. The Highland Park Conference. Interstate Printers and Publishers.

Feldman, A.S. The Challenge of Autonomy. 1981 Presidential Address. *ASHA* 23, (12) 941-945, 1981.

Goldstein, D.P. AuD Degree: The Doctoring Degree in Audiology. *ASHA* 31 pp. 33-35, April 1989.

Goldstein, D.P. Presentations to Annual Meeting of the Council of Graduate Programs in Communication Sciences and Disorders, Tampa, FL, 1989.

Goldstein, D.P. Presentations to the Academy of Rehabilitation Audiology Summer Institute, Austin, TX, 1986.

National Institute of Neurological Diseases and Blindness. *Highland Park Conference: Graduate Education in Speech Pathology and Audiology*. Highland Park, IL, 1963.

Spiestersbach, D.C. Doctoral Programs: Patterns for Change. Paper presented at the Conference of Big Ten University Programs, Chicago, IL, March 1976.

University of Alabama, Birmingham. Ann Jordan Conference: Program in Audiology. Conference held in August, 1979. Department of Biocommunication, School of Medicine. Birmingham, AL, 1979.



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References

Aaronson, A.E. The clinical Ph.D.: Implications for the survival and liberation of communicative disorders as a health care profession. *Asha* 28:35-39, 1987.

ADA. Proceedings: Conference on Professional Education, 1988.

ASHA. Graduate Education in Speech Pathology and Audiology. Highland Park Conference, 1963.

ASHA. Proceedings of the Task Force on Speech, Language and Hearing Science, 1978.

Big Ten Conference. The Professional Doctorate in Speech Pathology and Audiology: A discussion of the issues, 1976.

Darley, F.L. Clinical training for full time clinical service: a neglected obligation. *Asha*, 11:143-148, 1969.

Loavenbruck, A. How may we better prepare clinicians for the reality of providing services to the communicatively disordered in a variety of settings. *ASHA REPORTS*, 13:52-57, 1983.

DOCTORING OF THE AUDIOLOGY DEGREE

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The Professional Doctorate is a prospect that presents both exceptional opportunities and extraordinary dangers. A wise determination of how to proceed will require bold, insightful, and far-sighted planning. *Audiology Today* is encouraging us to examine the issue of a Professional Doctorate closely by providing a forum that allows audiologists to share their thoughts.

One proposal for the Professional Doctorate that is already “on the table” is the Audiology Doctorate or Au.D. degree espoused by Dr. David Goldstein and the Academy of Dispensing Audiologists (ADA). We must carefully decide whether this specific proposal will advance our profession or diminish it. And, WE means all of us. The future of our profession should not be left to other individuals. We must all speak out and share our experiences.

I find the “Goldstein-ADA” proposal disquieting. The proposal acknowledges the experience of fields such as Medicine, Optometry, and Dentistry, but it virtually ignores the experience of one of our most closely-related professions, Psychology. This seems unfortunate. Experience with the Professional Doctorate in Psychology, the Psy.D. degree, is an important resource that may benefit our thinking in several ways.

Compelling parallels exist between the fields of Audiology and Psychology. We both have scientifically-oriented and clinically-oriented professionals; we both interact with medical specialists who have similar health-care interests; and emphasis on both types of clinical services accelerated at about the same time, around 1946, when large numbers of World War II veterans required clinical services.

The post-War era educational model for clinicians in both Audiology and Psychology combined training in the scientific and clinical spheres, leading to a master’s degree or a Ph.D. degree. About 15 years ago, however, the “scientist-practitioner” educational model of Psychology was challenged by some who favored a two-track educational approach (Strickland, 1987). In this view, the intent of one track was to train scientists, leading to the Ph.D.; the intent of the other track was to train clinicians, leading to the Psy.D. (Stricker, 1975).

The reasons for establishing the Psy.D. degree sound very familiar - better services to the public, prestige, professional opportunities, etc. (Bickman, 1987). Services to clients would improve because practitioners would be better trained in clinical skills; prestige would improve because everyone would recognize the higher quality of the services provided; professional opportunities would improve because other professionals and the public would become more appreciative of this valued resource. Some felt (Bickman, 1987) that a professional interested in providing clinical services would no longer be subjected to “inconsequential” academic exercises, such as a dissertation. Instead, a clinically-oriented professional would progress through a more “meaningful” program that stressed training in the provision of clinical services. New graduates would be “ready to practice,” rather than having to be trained “on the job” (Fox, Kovacs, & Graham, 1985).

It is important to ask whether the Psy. D. degree has delivered these anticipated benefits. Let’s take them one by one. First, services to the public, have they improved? Apparently not. Clinicians as a whole are not better trained (Altman, 1987). Either “meaningful” clinical training programs were harder to actualize and maintain than anticipated or traditional academic training programs weren’t doing such a bad job after all. Perhaps training in science, which teaches such things as formulating good questions, systematic observations, controlled measurements, and reliance on results rather than intuition, was not such poor

preparation for clinical practice. At the 1987 National Conference on Graduate Education and Training in Psychology, a resolution affirmed the value of science and research as a part of all training programs, even those preparing students for clinical practice (Strickland, 1987; Belar, Bieliauskas, Larsen, Mensh, Poey, & Roelke, 1989).

What about prestige? Has the prestige associated with practicing clinical psychology improved? Again, apparently not. Now, instead of the accustomed two-caste prestige system, a three-caste system has evolved: hard scientists, soft scientists, and practitioners (Spence, 1987). One of the probable factors contributing to the development of a three-caste system was non-uniform standards for the Psy.D. degree. Professional schools of psychology have a wide range of standards, from rigorous to unusually lax. Professional schools associated with universities typically have the most stringent standards whereas free-standing professional schools typically have the most slack standards (Peterson, 1985). In an attempt to address the problems created by the wide range of standards for the Psy.D. degree, the 1987 National Conference on Graduate Education and Training in Psychology recommended that all doctoral programs be affiliated with accredited universities (Resolutions Approved by the National Conference on Graduate Education in Psychology, 1987).

What about improved professional opportunities? Again, professional opportunities do not seem to have improved. Positions that were previously dominated by psychologists are now shared with

“counsellors”, “therapists”, psychiatric nurses, and social workers. A diminishing job market for those with Psy.D. degrees may have been abetted by problems with third-party reimbursements. It is the case that a third-party payer must attempt to get the best value at the least price. The third-party payer cannot support the fee of a Psy.D. professional if a master’s level professional can provide equal services. The lack of rigorous, uniform standards for the Psy.D. has made it more difficult to verify the superior qualifications of psychologists with professional doctorates and has encouraged other professionals to seize some of the job market.

What can we learn from the Psy.D. experience? A primary message is the need to build in safeguards that help to assure the quality of professional doctorate programs. We should do at least two things.



First, we should mandate that all professional doctorate programs be in or affiliated with accredited universities. The self-monitoring of professions does not promote quality (Luce, 1987). The responsibility for evaluating and maintaining standards of excellence must be multidisciplinary, as in universities. Second, we should mandate that the principles of science be included in all doctorate programs. Incorporating scientific principles into our professional doctorate program will help to develop educated professionals, rather than technically-trained professionals. With programs that produce “prepared minds,” not technicians, Audiology will be assured of growth and prosperity in the coming years of increasingly sophisticated technologies and expanding scientific knowledge bases.

References

- Altman I. (1987). Centripetal and centrifugal trends in psychology, *American Psychologist*, 42, 1058-1069.
- Anon. (1987). Resolutions approved by the national conference on graduate education in psychology, *American Psychologist*, 42, 1070-1084.
- Belar C, Bieliauskas L, Larsen K, Mensh I, Poey K, Roelke H. (1989). The national conference on internship training in psychology, *American Psychologist*, 44, 60-65.
- Bickman L. (1987). Graduate education in psychology, *American Psychologist*, 42, 1041-1047.
- Fox R, Kovacs A, Graham S. (1985). Proposals for a revolution in the preparation and regulation of professional psychologists, *American Psychologist*, 40, 1042-1050.
- Luce R. (1987). Should there be a common core for graduate study in psychology? *Proceedings of the National Conference on Graduate Education in Psychology*. University of Utah, Salt Lake City, American Psychological Association, 1987, pp. 42-45.
- Peterson D. (1985). Twenty years of practitioner training in psychology, *American Psychologist*, 40, 441-451.
- Spence J. (1987). Centrifugal versus centripetal tendencies in psychology: Will the center hold?, *American Psychologist*, 42, 1052-1054.
- Stricker G. (1975). On professional schools and professional degrees, *American Psychologist*, 30, 1062-1066.
- Strickland B. (1987). On the threshold of the second century of psychology, *American Psychologist*, 42, 1055-1056.



MORE DEGREES, BUT NO MORE DEGREES

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The current discussion regarding establishing a professional degree in audiology indicates a dissatisfaction in the present educational process by which one becomes an audiologist. This dissatisfaction is related to the weaknesses in the present educational system and to the rapid expansion of technology in the field. The options for dealing with the weaknesses are (a) to identify and correct the problems within the current educational structure, leading to the masters or Ph.D. degrees, and (b) to devise a new system, leading to a professional degree, the Au.D. We propose that the educational/training problems can be corrected by incorporating changes in the existing degree structure rather than by developing new educational tracks.

The general lack of an appropriate, quality education in audiology can be traced (a) to the speech pathology roots from which audiology evolved, (b) to the emphasis and design of the masters programs, and (c) to the lack of clinical involvement in the doctoral programs. Students wishing to become audiologists should spend less undergraduate time on communication science courses and more time acquiring a liberal arts education with a major emphasis on the sciences and math. This recommendation was made by the 1983 National Conference on Undergraduate, Graduate, and Continuing Education (ASHA, September, 1983) but has yet to be implemented by the universities. Perhaps the Academy and ASHA should recommend a specific set of prerequisites, including math/science course work and GRE scores, for entry into graduate programs to ensure a measure of uniformity in academic preparation that will make the teaching of advanced courses and concepts more efficient.

There are positions for which the masters level of education is appropriate, e.g., school settings and physicians' offices. The training programs offering a terminal masters degree in audiology need to be restructured and revitalized. The clinical aspects of many training programs are considered secondary to course work as evidenced by the lack of faculty appointments for the clinical staff and the paucity of involvement of the doctoral faculty in clinical training. The 375 hours of clinical experiences required for licensure in many states and for ASHA certification are insufficient. Programs should provide students with sufficient clinical hours of varied experiences with staffings geared to the integration of clinical and theoretical concepts. The clinical fellowship year should be considered an extension of the education process and be under the auspices either of the university or of an approved clinic facility. Too many audiologists complete their CFY in isolation with no real supervision or interaction with experienced audiologists.

For those individuals who have positions requiring education beyond the masters degree, the Ph.D. is appropriate. Except for medicine and dentistry, the professional degree, like the Ed.D. and the Psy.D., are regarded as inferior to the Ph.D. Recently, psychologists, whose profession is similar to audiology with both clinical and academic/research components, have reevaluated their 20 years of experience with the professional degree, the Psy.D. The disadvantages of the Psy.D. were (a) the refusal of most major universities to offer the degree or recognize Psy.D.s as qualified faculty, (b) the lack of job opportunities for the Psy.D.s, given the preference of employers for Ph.D.s, and (c) a rift between clinicians and academicians/researchers in the profession. These factors have remained despite the movement of Psy.D. programs to require dissertations and the Ph.D. programs to require

clinical experience. The primary advantage of the professional programs in psychology was the recognition that quality requires a flexible program leading to the Ph.D., which allows incorporation of clinical issues and training as well as research experience. Audiology should look carefully at the lessons learned from the professional degree in psychology.

Currently, the interest in doctoral training for clinicians is for practical purposes nonexistent. Few masters audiologists pursue the many openings in the existing doctoral programs. Since the 1983-84 academic year, <30 Ph.D.s/year in audiology have been awarded by the 50 institutions that offer a Ph.D. in audiology, suggesting that many pre-doctoral positions are left unfilled (1986-87 National Survey by the Council of Graduate Programs in Communication Sciences and Disorders). This inequality in numbers suggests that many of the Ph.D. programs are not meeting the needs of students. One problem is that doctoral programs are aloof from the clinical aspects of the profession. Taking a clue from psychology, audiology must incorporate clinical issues into the Ph.D. training programs and recognize that our orientation toward the human aspects of hearing, from the understanding of normal and abnormal processes to the diagnosis and treatment of hearing disorders, is the core of our profession that separates audiology from the neurosciences, physiology, and experimental psychology. Researchers need clinical contact to know the issues that need investigating; clinicians need the research contact to update their diagnostic and rehabilitative procedures. This mutual dependency of research and clinical issues demands that audiology continues as one profession with research

and clinical components. Audiology cannot afford the kind of schism that is occurring between the Psy.D.s and the Ph.D.s in psychology.

The lack of students in doctoral programs is partially attributed to the increasing specialization within audiology that requires students to choose an area of concentration before selecting a doctoral program. This situation precludes the student from exploring areas he/she was not exposed to at the masters level and does not produce a well-educated audiologist. Graduate programs must make an effort to acquire a well-rounded faculty to provide the student access to physiology, psychology, bio-engineering, and computer science and to integrate those basic science fields with concepts derived from human hearing science. Too many graduate programs are too small; the strength of the programs is based on one or two faculty members, and the character of the program changes radically when faculty are replaced. Some of these problems are owing to the economics of the university and have no easy solution.

The proposed Au.D. is a short-sighted and limited solution to the problems of education in audiology. The proponents of the Au.D. point to other professions as having established the precedent of professional degrees, such as medicine and dentistry, but without questioning whether the medicine/dentistry educational model is the best model for professional training. Whereas the ostensible reason for the Au.D. is insufficient training because of the expansion of the field of audiology, proponents of the Au.D. suggest compressing the knowledge now gained in a six to seven year bachelors/masters program (including the CFY) into a six year Au.D. program with no bachelors degree. The difference between the current masters and the Au.D. programs is that the Au.D. curriculum advocates earlier specialization in audiology at the expense of the educational foundation necessary for understanding advanced concepts and rapidly expanding technology. It is incomprehensible that the proposed Au.D. curriculum can address the weaknesses in the educational system for practitioners of audiology.



Some proponents of the Au.D. have suggested a grandfathering mechanism whereby masters level audiologists are conferred the "Doctor" title based on experience, not formal education. Such grandfathering of professional degrees would closely parallel mail-order degree factories and make a mockery of graduate education. The purpose would seem to be to mislead the public and to indicate that further education is not as important as the title itself. Masters audiologists who want the "Doctor" title must undergo the rigors of a doctoral program that will provide the training and self-respect that is associated with an advanced graduate degree.

In summary, the title of doctor does not guarantee respect for a field or for practitioners in that field. Medicine, optometry, and psychology, for example, all have doctor titles and all are not accorded the same measure of respect from the public or from fellow professionals. The Ph.D. is not an ivory-tower degree reserved only for hard-core scientists, but a degree signifying education that provides the tools and critical thinking necessary for attacking clinical or research problems. In the long run, the degree is less important than the knowledge, competence, and service provided by the members of the profession.

Candidates for 1990

The following are biographical sketches of the candidates for Executive Committee Offices beginning in 1990. Jerry Northern and Richard Talbott are candidates for the office of President-Elect. The term of this office is two years, one year as President-Elect and the second year as President. Lucille Beck and Robert Keith are candidates for the office of Member-at-Large. The term of this office is four years. Ballots will be mailed to all members in September.

Candidate for Member-at-Large

Lucille Beck, Ph.D.

Current Position

Lucille Beck is Associate Chief, Audiology and Speech Pathology Service and Chief, National Hearing Aid Program, Veterans Administration, Washington, D.C. Dr. Beck is currently a member of the Advisory Board of the American Academy of Audiology.

Education

B.A. from Adelphi University in Speech and Hearing.
M.A. and Ph.D. from the University of Maryland in Audiology and Hearing Science.

Honors

Editor's award for Outstanding Manuscript from *Ear and Hearing*, 1987.

Outstanding Collaborator Award from Gallaudet University for exemplary support of graduate programs, 1988.

Commissioner's Special Citation from the Food and Drug Administration, Public Health Service for invaluable guidance in the review of cochlear implants, 1988.

Special Friend of Hearing-Impaired People Award from Self Help for Hard of Hearing (SHHH) for continuous efforts to improve the circumstances of hearing-impaired people, 1989.

Position Statement

The American Academy of Audiology is an organization of, by, and for audiologists. As such, its purpose is to promote the continued development of the profession of Audiology in all areas of the clinical, educational, scientific, legislative, and consumer communities so that excellent hearing care is available to all persons. As we face the challenges of the 1990s, including health care reimbursement issues, the graying of America, rapid technological advances, basic and applied scientific questions, to name a few, we must support the independent provision of hearing health care services by audiologists in all areas of practice. While maintaining a healthy respect for our individual specialties, we must present a well thought out and unified plan for addressing the serious concerns about academic education, standards and scope of practice, and autonomous audiology practice. Plans for the future must consider all audiologists, and the American Academy of Audiology must represent the profession by promoting excellence in all endeavors.



Candidate for Member-at-Large

Robert W. Keith, Ph.D.

Current Position

Robert Keith is Professor and Director, Division of Audiology and Vestibular Testing Center, Department of Otolaryngology and Maxillofacial Surgery, at the University of Cincinnati Medical Center. He is also an Adjunct Professor of Environmental Health and holds a Joint Appointment as Professor of Communication Disorders at the University of Cincinnati. Dr. Keith is currently a member of the Advisory Board of The American Academy of Audiology.

Education

M.A., University of Iowa, 1964.

Ph.D., University of Iowa, 1967.

Honors

Honors of the Association, Ohio Speech and Hearing Association, 1974.

Fellow, American Speech and Hearing Association, 1975.

Honors of Association, Southwestern Ohio Speech and Hearing Association, 1980.

Distinguished Service award, University of Cincinnati College of Medicine, Department of Otolaryngology, 1989.

Position Statement

The American Academy of Audiology is a unique organization, designed specifically to address problems related to the practice of the profession of Audiology. In his initial letter to audiologists announcing the formation of the Academy, President James Jerger listed several examples of problems that need to be addressed. In addition, I feel that we need to clearly establish our identity, to declare the scope of our practice, to enhance our professional stature and interaction with other professions, to increase the financial value of our services, to work for increased reimbursement of our services, and to identify and resolve other problems of our profession. Audiologists have needed an advocacy organization for many years. If elected to membership of the executive committee I would work to support the goals of the AAA, especially in the areas of advocacy that declare the profession of audiology, as it is broadly defined, to have stature, independence, and value to those who use our services.

Candidate for President-Elect

Jerry Northern, Ph.D.

Current Position

Jerry Northern is Professor of Otolaryngology and Associate Professor of Pediatrics at the University of Colorado School of Medicine and Head of Audiology Services at the University Hospital of the University of Colorado Health Sciences Center. In addition, he is Professor of Communication Disorders and Speech Science at the University of Colorado, and Affiliate Professor in the Department of Communication Disorders at Colorado State University and at the University of Northern Colorado. Dr. Northern is currently a member of the Executive Board of the American Academy of Audiology.

Education

Colorado College, Colorado Springs, Colorado, Experimental Psychology, B.A., 1962
Gallaudet College, Washington, D.C., Education of Deaf, M.S., 1963
University of Denver, Denver, Colorado, Audiology-Speech Pathology, M.A., 1964
University of Colorado, Boulder, Colorado, Audiology, Ph.D., 1966

Selected Honors

Fellow, American Speech-Language-Hearing Association, 1971

National Convention Chair (Seattle)
American Speech-Language-Hearing Association, 1990

President, Colorado Speech-Language-Hearing Association, 1987-1989

Executive Board Member, American Auditory Society, 1978-1979
Editorial Board, *Ear & Hearing*, 1985-1989

Editor, *Seminars in Hearing*, 1980-1989

Position Statement

The destiny of the field of audiology is finally in the hands of audiologists. The formation of the new American Academy of Audiology is certainly the most important action taken by our field during my professional career. The entire hearing health community has a new awareness of audiology, and we now have a unique opportunity to confirm our presence and secure our future in all hearing health issues. The major challenge faced by our elected leadership is to maintain the momentum of this new organization without creating dissonance among our various audiology special interest groups. If elected President of the AAA, I will direct major effort to increase our identity and improve our relationship with the hearing-impaired consumer of audiologic services.

Candidate for President-Elect

Richard E. Talbott, Ph.D.

Current Position

Richard Talbott is the Chair, Division for Exceptional children at the University of Georgia for the past five years. He previously served as Chair, Department of Communication Sciences and disorders at the University of Georgia. In August he will be moving to University of Virginia in Charlottesville as Chair of the communication Disorders Program with an adjunct appointment in the Department of Otolaryngology-Head and Neck Surgery. Dr. Talbott is currently a member of the Executive Committee of the American Academy of Audiology and serves as Chairman of the Academy's Advisory Board.

Education

Undergraduate and Masters degrees from West Virginia University.
Ph.D. degree from the University of Oklahoma Health Sciences Center.

Position Statement

Shakespeare's observation that life is a twice told story is once again affirmed in the evolution of the field of audiology. Like other clinical professions which have thrived in the health care marketplace, the progression follows a predictable path growing out of a real or perceived unfilled public need. A few bright and dedicated individuals bring new insights or new technologies to bear on behalf of those in need and the public begins to recognize, appreciate, and support their efforts. Such support attracts more and more individuals to the "practice" and they band together with an appropriate shibboleth to, hopefully, engender the esteem to which the emerging profession aspires and to establish a protective professional veneer around the group.

If the underlying assumptions of the pioneers in the field were valid and the void did exist this will create a force which will attract a critical mass of professionals and the profession will grow. This growth, however, is a double edged sword. While the adage posits that there is safety in numbers, in professional terms there is also danger, for no longer can the "new group" escape the jaundiced eye of the other professions. The initial works of the "dedicated few" hardly disturbed the overall quantum of the health care marketplace; however, as the unit becomes more organized, more visible, more forceful in its influence on the world of finite resources, it is no longer ignored by the "significant others". Audiology is a profession which has risen to the status of being a threat to the sanctity of the shackles placed on it by those others in the health care marketplace.

This is dangerous ground and must not be taken lightly. The evolution of the American Academy of Audiology is tacit evidence of the recognition by our members of the urgent necessity for audiologists to develop strategic plans to insure an even playing field in the health care arena. The court of last resort rests with the consumer of our efforts, be they consumers of our research, our teaching, or our service. As individuals, or associations, we may build whatever edifices we wish to satisfy our hubris, however, just as nature does not long endure a non essential species, so to will the demand for clinical audiology erode if the consumer no longer feels the need which was at our inception.

The Academy must embrace certain assumptions and through effective leadership be influential in assuring that those consumers and power brokers which will ultimately decide our fate are informed and unbiased by those who would detract us from our mission. I believe that the following principles/assumptions should be the undergirding of our public posture in the near future.

1. We must remain ever mindful that the unifying feature of our organization is that we are all audiologists and that we must foster a tolerance for individual and institutional variance in the way we define our universe.

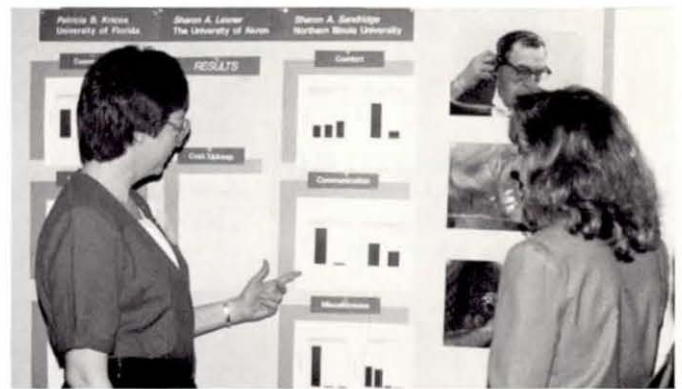
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2. The primary workplace for audiologists now and in the future will be in clinical settings—be that private practice, hospital/community clinics, schools, university clinics or wherever.
3. The variety of clinical practices, and thus the broad range of expertise needed to function in these practices requires a knowledge base and clinical experience which exceeds the current capabilities of university training programs under the "typical Masters degree" model. New and innovative programs within university and college systems are essential.
4. To be truly accepted as a stand alone discipline having its own unique methodology/epistemology, we must not only produce individuals capable of exemplary clinical practice but individuals capable of outstanding basic and applied research as well.
5. Unless the public, through fiscal intermediaries, certification and licensure boards, protection and advocacy groups, universities, etc. are persuaded that there is a need for audiology to exist as a non-prescriptive practice which merits monetary compensation sufficient to attract the intellect necessary to cope with such a practice, the field will be relegated to serving as a technical backup for other established disciplines.

As an outgrowth of these assumptions the Academy should move immediately to:

1. Define our scope of practice in broad terms which are related to demonstrable public need.
 2. Convince an already overburdened health care delivery system that an apparently more costly addition to the system is essential and worthy of public protection by way of accreditation, certification and licensure at newly defined levels of academic/clinical training.
 3. Develop academic and clinical training models which are palatable to college and university systems to fill the obligations defined our the scope of practice and to meet our research needs.
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Kiawah Reflections...



TASK FORCE ON PROFESSIONAL DOCTORATE

A special task force has been formed to develop an academy-sponsored proposal for a professional doctorate. The task force will be chaired by Richard Talbott, Athens, GA. Other task force members include Alan Feldman, Syracuse, NY; Richard Wilson, Long Beach CA; Susan Jerger, Houston, TX; Michael Dennis, Oklahoma City, OK; Lucille Beck, Washington, DC; and Barry Freeman, Clarksville, TN.



Any member of the Academy who has strong feelings on this issue is urged to contact the task force chairman at the following address:

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