Hearing Loss Association of America

POLICY STATEMENT

The Doctor of Audiology Degree

It is generally accepted that the profession of audiology had its genesis during and immediately after World War II. Servicemen deafened by war injury required aural rehabilitation services, and various types of health care professionals joined forces to provide such programs. After the war, these programs became the basis for the creation of formal academic programs in colleges and universities designed to train "speech and hearing therapists". These professionals were trained to evaluate the auditory system and to define and manage the communicative implications of a hearing loss. At that time, aural rehabilitation conducted by these therapists consisted mainly of speechreading and auditory training, and the recommendation, but not the dispensing, of hearing aids.

As the profession matured, the speech (and language) areas became differentiated from the "hearing" areas, a development that has continued to this day. Certification requirements for both areas were defined and promulgated by the American Speech-Language-Hearing Association (ASHA). These requirements reflected the increasing proliferation of knowledge necessary both to evaluate the status of the auditory system and to conduct the non-medical therapeutic measures designed to reduce the impact of the hearing loss (again, excluding the actual dispensing of hearing aids). The standards under which the audiology profession is currently operating were implemented in l965, at which time certification requirements were defined at a single level (the current Certificate of Clinical Competency, or CCC). At the time these standards were adopted, it was considered unethical for an audiologist to actually dispense hearing aids. This position was modified in the late l960s, primarily because many audiologists believed that this position prevented them from providing follow-up hearing aid services and that it interfered with their rehabilitative interactions with clients. To qualify for the CCC in audiology, a candidate had to complete a master's degree (M.A.) with a minimum of 30 graduate academic credits, work under supervision for a clinical fellowship year (the CFY) after graduation, and pass a national examination administered by the Educational Testing Service. While the M.A. was considered the "entry" level degree for clinical practice in audiology, many audiologists continued their education and completed a doctoral degree, most often the Ph.D. Many doctoral level audiologists functioned, and continue to function, as advanced clinicians rather than the traditional scholarly and research role that this degree was designed to fulfill.

Hearing Loss Association of America

POLICY STATEMENT

In the last ten years, not only has the extent of available information regarding the evaluation and management of auditory disorders increased dramatically, but the scope of practice of audiology and audiologists has also been extended to encompass additional clinical areas. Audiologists are now found in medical centers and physician offices, non-profit Audiology centers, nursing homes, school settings, industry, and, increasingly, in various kinds of private practice. Their clinical obligations span the age range from the neonatal to the geriatric population, with responsibilities that include the administration and interpretation of advanced diagnostic auditory and vestibular tests. They are expected to define and manage the communication implications of a hearing loss, which includes the evaluation and selection of all types of hearing assistive technologies. It is in response to this increasing body of knowledge and clinical responsibilities that the profession is now engaged in another effort to upgrade the proficiencies of the clinical practitioner.

After much debate and discussion, a consensus was achieved among audiology organizations that the entry level into the clinical practice of audiology should be a doctoral degree. This degree is seen not only as a clinical necessity, with the opportunity it offers for intensifying training programs and experiences, but a practical necessity as well since, in this era of managed care, a practitioner's credentials may influence professional autonomy and reimbursement patterns. The current, operative document regarding the new credentials is that developed by the ASHA Council on Professional Standards, adopted after all member audiologists had an opportunity to review the draft version. (Modifications proposed by the American Academy of Audiology do not appear to address these initial standards, but focus instead on re-credentialing issues.) This degree is designed to supplant the current M.A. degree, but not the Ph.D., which would revert to a stringently defined scholarly and research degree.

There is also a consensus that the Au.D. (doctor of audiology) should be the designator for this new, doctoral-level clinical degree in audiology. Instead of 30 graduate credit hours, the Au.D. will consist of 75 post-baccalaureate hours. The program is designed to last for four years, one of which will be a full-time, 12-month, clinical experience supervised by the training facility. At the conclusion of the program, candidates will be required to take and pass a national examination in order to be certified. This training requirement will become effective for people who apply for initial certification after December 31, 2006. The doctoral degree will be an additional requirement for those who apply after December 31, 2011. During the period between 2006 and 2011, in other words, while the Au.D. itself will not be obligatory for new audiologists, the increased certification standards will be in force. Existing M.A. audiologists may continue to function with their present degree and credential. For those who wish to upgrade to the Au.D. while maintaining their clinical practice, a number of universities are organizing distance learning programs that can accommodate them. How long it will take an experienced M.A. audiologist to complete the Au.D. requirements is not explicitly defined; most

likely a committed candidate could complete the requirements in about two years. While these university programs may award credit for experience or by equivalent examinations, they will also require a demonstrated fulfillment of a doctoral- level curriculum before awarding the degree.

Currently, there is a great deal of controversy on this issue in the audiology profession. A significant minority of audiologists (no more than 30 percent) recommend and support an "earned entitlement" (EE) concept. In this concept, practicing audiologists have an opportunity to apply for an Au.D. "designator" (not the academic degree) through application to an independent foundation. The EE application entails that they submit their self-rated experience and credentials to an independent foundation and after being given an opportunity to correct deficiencies and the payment of a fee, the Au.D. designator is granted by the foundation.

The Hearing Loss Association of America believes that the EE concept would be confusing to consumers and not in their best interest. Our judgment is that people awarded Au.D. degrees through accredited universities will be better trained to serve the interests of consumers than those audiologists granted Au.D. "designators" by a private foundation. Consumers will generally be unaware whether an audiologist with an "Au.D." was granted it by a private organization or had earned it through an accredited university. This is an important point: HLAA believes that the doctoral designator Au.D. be restricted to degrees awarded by an accredited institute of higher learning. University-sponsored programs are being organized at a rapid rate. By the fall of l998, there should be at least seven of them in place at accredited universities, with three or four currently (spring l998) operating.

Insofar as the degree itself is concerned, ordinarily this would be considered an internal matter falling under the purview of the profession involved. However, since its ultimate purpose, and the rationale on which it is based, is to enhance the effectiveness of audiologists in working with people with hearing loss, HLAA, representing this population, is a direct stakeholder in this process.

As consumers view the Au.D., they need to be assured that their interests and needs, as they perceive them, are furthered by this new entry level degree for clinical audiologists. If a future generation of practitioners holding this degree are not academically and experientially prepared to provide superior service for people with hearing loss, then insofar as HLAA is concerned, the degree is simply irrelevant.

HLAA recognizes that in the last decade there has been an information explosion in all areas pertaining to health care, and that this information includes material pertaining to Audiology. It seems quite apparent that there is insufficient time in the current M.A. training program to

include all the information that a new generation of audiologists must master. In principle, therefore, HLAA endorses the concept of the Au.D. In practice, HLAA has some reservations. These reservations are based on our reading of the "Standards and Implementation for the Certificate of Clinical Competency in Audiology," approved by the ASHA Council on Professional Standards in September l997.

There does not appear to be sufficient emphasis in the "standards" on topics that relate directly to the psychosocial impact of a hearing loss on the person involved, on the family constellation, in various types of situations, and in different stages in a person's life. No course work in interpersonal counseling or group facilitation is explicitly required. Hearing aids and assistive technology are listed in only three of the nineteen items in the "treatment" section, a fact that could lead to inadequate training and experience in these areas if each item is given equal emphasis in the training program.

From HLAA's point of view, these three are crucial areas that require more explicit attention. Only one "treatment" item refers to aural rehabilitation, which is not further defined. It is not clear whether this item will include such old and modern concepts as coping and repair strategies, assertiveness training, speechreading and auditory training, group hearing aid orientation programs, etc. HLAA has adopted a number of position papers that outline the types of services consumers desire from their audiologists. These services include a comprehensive evaluation of hearing assistive technologies as well as group hearing aid orientation programs that provide information and support crucial for hearing aid users and their families. As written, the standards do not make clear how these consumer concerns will be addressed.

It is true that all of these concerns can be accommodated depending on how the program director and certifying bodies interpret the competency-based statements within the standards. Nevertheless, it may be possible for one program to provide only one or two courses related to hearing aids and assistive devices while another provides three or four, yet for both to be given official approval. One program may emphasize the diagnostic process while another focuses on the rehabilitative.

Before HLAA unambiguously endorses the concept of the Au.D., we do require more assurance that the additional training will be reflected in more knowledgeable and more sensitive attention concerning the psychosocial consequences of a hearing loss and its non-medical management. Consumers need to be convinced that Au.D. audiologists can provide services to them that hearing instrument specialists, many of whom hold no formal academic degree at all, cannot provide. There is no way yet, in other words, to determine how a doctoral level audiology profession will play out in terms of the care, particularly the non-medical care, of

people with hearing loss and their families. This is particularly applicable for older adults with progressive hearing loss, who represent the majority of patients seen in audiology clinics. In theory, there should be a positive impact; in practice, many other factors intervene. HLAA, therefore, while endorsing the concept of an Au.D., is reserving its final judgment until it can be empirically determined that a doctoral-level audiology profession ensures superior rehabilitative services to consumers than is now offered by M.A. audiologists.

8/1/98