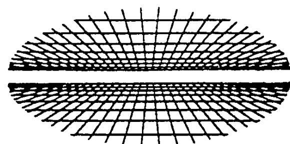

Perspective

The Evolution of Audiology: A Professional Odyssey

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From it's conception in the military rehabilitation programs of WWII, through its embryonic stages in early academe, to the profession as we know it today, audiology has been growing, changing, and developing. As early as 1964, Hayes Newby, in his ASHA Presidential address, put forth the idea that we (the speech and hearing professions) had reached an age of maturity at 40. Unfortunately, he failed to recognize the paradox in his proposition when he quoted from the 1942 address of then ASHA President Samuel Robbins who had declared us mature at the ripe old age of 17. The contradiction is clear. It seems that one's level of maturation is a matter of opinion more than anything else.

As I reflect upon the maturity theme I find I do not like the analogy to human development—from infant to child to adolescent to mature adult. This paradigm, followed to its logical conclusion, indicates that on the heels of maturity comes aging, decline, and inevitably, death. Such an analogy does not bode well for any profession. As the columnist George Will points out, for institutions it is a matter of adaptation or extinction. He was writing about GM, Sears, and IBM but the message applies to professions as well. In other words, nature is not kind to those who cannot or do not adapt.

I prefer to think of audiology as a living, breathing community thriving on circumstances that help it to change, to adapt, to evolve. Such evolution has always resulted not only in the survival of the community or species, but in a new breed, a descendant that is stronger, hardier and more resilient. True professions are dynamically evolving entities.

True professions, such as medicine and law, have been with us so long that we fail to recognize the individual steps on the ladder of their evolutionary processes. It is easy to forget, for instance, the blood-letting barber, predecessor to the surgeon; or the lens-grinder, ancestor to the optometrist. Yet aspects of these professions can be traced back, each to their unique and individual ancestry. Certain features of their practices, even at their current levels of evolution, reflect back upon their unique histories. Yet, true professions have not been content to rest upon the knowledge, techniques, and practices of their ancestors--and a good thing too, else we might, upon a visit to our chosen surgeon, be confronted with a bottle of leaches or a razor-sharp fleam. One won't, of course, see either of those "instruments" because the profession has evolved beyond that level of "technology." As technology advances and new discoveries broaden the knowledge base, true professions grow and change, absorbing the new elements and adapting to the new environment. As Paul Starr has pointed out in The Social Transformation of American Medicine, "When opportunities in a profession change, so does the profession." (1982)

We often fail to recognize key practice elements which distinguish true professions. In true professions, the individual practitioner is identified, for better or worse, with the quality and value of the service he or she provides. In contrast, in the practice of a vocation which has not yet reached full professional status, it is the institution, employer, or supervisor who gets the credit or blame for services performed by an individual. In a true profession, the practitioner is responsible to the patient not to another practitioner. Additionally, fees for services rendered in a vocation have traditionally been determined by the institution, or employer, instead of the practitioner who renders the service. True professions, on the other hand, encourage autonomy, and as Morgan Downey has pointed out, level of autonomy is inextricably linked to level of income (1989). That is, people who earn more income tend to be more autonomous, and those who are more autonomous tend to earn higher incomes.

Although audiology shares similarities with psychology, we have a unique history, which differs from other true professions in several ways. There is a similarity between our history and that of psychology and we share many of the same problems. Unlike audiology and psychology, most true professions were not born in academia. Most go through a long history of service delivery before becoming part of the academic establishment. In effect, they are born in the streets in response to specific needs, and then work their way into academia. Even those true professions which were born first in academia eventually worked their way into the public arena and the practical application of services to meet specific needs. Our profession began as an academic discipline. The founding father of audiology, Ray Carhart,

was a professor of speech pathology at Northwestern before WWII, which explains the birthing of audiology as a discipline in academe. In the beginning, there was little systematic preparation for entering practice. Though our graduates gradually started going into practice, audiology remained at heart part of an academic discipline, housed in the university and parented by academics. The problem with that is, as Ulbrich has observed: "A disdainful attitude toward constituency-centered professional activities pervades the university. 'True' academics are supposed to listen to the inner voice, set their own agenda, and disdain the noisy world requesting service, objective advice, directions, broad vision and concrete application" (1992). It seems clear to me that many audiology educators adhere to the system defined by Ulbrich.

For example, academic audiologists who teach and prepare future practitioners have been discouraged from seeing patients. In contrast, in medical schools the professors who teach and prepare future physicians for practice, still see patients. Medical professors continue to have hands-on experience in the practice and application of what they teach; audiology professors all too often do not.

"To maintain that audiology and speech pathology are a single field because they both deal with a single process, communication disorders, is to suggest that laryngology and proctology are also a single field because they deal with a single process, digestion."

Over the years our profession has evolved so that the primary purpose of most of our training programs is the preparation of practitioners — persons trained to serve the public. Yet despite the evolution from servicing academic requirements toward meeting professional training demands, our students continue to pursue academic degrees, and our departments still tend to be located in schools which are more comfortable with disciplinary education than with professional education.

In order to survive in this environment, our training programs have had to commingle academic researcher education with professional education. Like the man who tried to please everyone and ended up pleasing no one, including himself, this commingled system has exacted a toll not only on professional education but on research education as well. Ever increasing needs for professional training in an expanding scope of practice environment are not being met, while depleted research training endeavors are losing ground in the competitive world of scientific investigation and grant writing/procuring. This solution, commingling researcher education and professional education, is not resolving the problem, it is not meeting the need. It's almost a case of the cure being deadlier than the disease.

It seems apparent to me that we are faced with three major, inter-locking obstacles. These obstacles form the basis of the changing environment to which we must adapt if we are to survive as a community and evolve into true profession status. Those obstacles may be defined as: the lack of a specific degree designation and identity, insufficient visibility as a profession; and specialization in the absence of a comprehensive entry level professional education.

With a few small exceptions, most successful true professions are defined by a single degree: MD means physician, DDS means dentist, OD means optometrist. Practitioners in these successful true professions operate under the same degree and license regardless of the setting in which they practice. A physician is an MD holding the same license to practice medicine regardless of whether he or she provides services in private practice, on the staff of a hospital or clinic, or as a company doctor. The same holds true for the DDS and OD. Not so for audiologists, who may hold one of 18 different degrees and who tend to define themselves according to the setting or circumstance of their employment; educational audiologist, industrial audiologist, military audiologist, dispensing audiologist, forensic audiologist, rehabilitation audiologist, cochlear implant audiologist, research audiologist, left ear audiologist, etc.

Furthermore, most successful true professions are defined by their (state) licensure. Audiology [and speech-language pathology] are the only professions I know of who are certified as well as licensed. ASHA is the only organization which offers a certificate of clinical competence to professionals whose legal status is defined by state licensure. In fact, we are taught to seek, hold and preserve our ASHA C's even after we are licensed. ASHA continues to insert certification language into lobbying for federal and legislative initiatives.

Schools constitute another unique deviation from the norm. To practice in a school setting, audiologists need not be licensed at all in most states; instead, they need a school certificate. It is hard for me to imagine a physician or dentist needing a school certificate rather than state license to provide services in that setting.

Lastly, successful true professions have their own

independent licensure board, eg. medical board, dental board, and optometric board. Audiology usually shares its board with another profession — speech-language pathology. If we are to continue to evolve, we must institute the specific definition of practitioners by degree and licensure as is customary in other true professions. Such definition would no doubt also go a long way toward increasing our visibility as a profession.

Each year tens of thousands of people remain unaware that they have received audiological services from a practicing audiologist because the service occurred in the office of another professional's practice. It's no wonder we lack visibility. Another shining example of the problem can be gleaned from a brochure put out by the National Health Council to recruit students into careers in health care. The brochure lists 15 career areas:

Clinical Laboratory Services
Dentistry
Dietetics and Nutrition
Education
Health Information and Communication
Health Services Administration
Medicine
Mental, Physical and Social Specialties
Nursing
Pharmacy
Podiatry
Science and Engineering
Technical Instrumentation
Veterinary Medicine
Vision Care

Within each area are listed several professions or groups. For instance, dentists are listed under dentistry, optometrists are listed under optometry, physicians are listed under medicine, and podiatrists are listed under podiatry.

I had the hardest time locating audiology until I discovered that I had to look it up under "M" for "Mental, Physical and Social Specialties." If I were to find audiology among the titles listed under Mental, Physical and Social Specialties, I would have to look it up under "S" for... "Speech-Language Pathology and Audiology."

We can gain further insight from that little brochure on another issue which deals with our need to evolve into a more visible profession. In the brochure, each profession is followed by a paragraph describing what the practitioners do. Let me quote the opening sentences from a few of these descriptions:

"Dentists treat oral diseases and disorders such as tooth decay, gum disease, and crooked teeth."

"Doctors of optometry are persons specifically educated, clinically trained, and state licensed to examine, diagnose and treat conditions of the vision system."

"Physicians treat and prevent human illness, disease and injury."

"Podiatrists prevent, diagnose, and treat diseases and disorders of the foot and leg."

Notice how these sentences all use active voice with action words to describe professional activity. Words like examine, diagnose, treat, prevent, specifically educated, etc

Now then, lets look at the opening sentence of the definition of audiologists.

"Speech-language pathologists and audiologists are specialists in communication disorders."

No power in that statement.

Operative words in the rest of the short, defining paragraph include: "...primarily concerned with..." and "...work in both areas [dual]..." I think that this incisive definition must have been authored by the same person who came up with the definitive phrase "a strong possibility of a firm maybe."

In all of the profession examples cited above, except audiology, a four year professional doctorate is required to enter practice. The operative statement in the paragraph describing audiology says, "...plus a master's degree in speech-language pathology and/or audiology is required".

You may have heard of the Council on Post-Secondary Accreditation. This is the agency that grants ASHA and other associations the privilege of accrediting education programs. As I looked through its membership directory, I had no trouble finding dentist under "D", optometrist under "O", podiatrist under "P", even chiropractor under "C". But, as you may have guessed, I had to look under "S" to find audiologist.

I think we need more evolving.

The third obstacle concerns the issue of specialization. In most true professions the formula for success is a basic foundational education followed, if so desired, by specialization. For example, the physician begins with a GP and may thereafter decide to specialize. The same holds true for dentists and optometrists. But in audiology the order is reversed, with what I call specialization-by-default during the entry level master' s degree. Let me explain.

There are 118 ASHA accredited audiology education programs in this country. Many of these are less than two year programs. All of these programs (I must assume) prepare practitioners to be skillful in at least one area of the vast array of practice areas. Yet few, if any, even approach a professional entry level of preparation across all of the basic skills needed to practice audiology today, to say nothing of tomorrow. Some represent audiological rehabilitation very well while others may just talk about it. Some truly prepare student audiologists for the dispensing experience while others provide only slight experience. Some Masters programs give students good preparation to deal with children while others have little representation in this area. Under the current system, it simply is not possible, even in those programs which are two years in duration, to accomplish this broad general level of preparation. I am told

that we have a reasonably good audiology education program at Purdue. We have had a two-year Master's degree for over 15 years, and I can assure you that we are unable to reach the goal of a broad level of preparation across all the basic skills needed to practice audiology today.

Specialization in a profession which has a comprehensive professional education as the entry point is a prescription for strength and success. Specialization in a profession whose entry level preparation is not comprehensive is a prescription for weakness, fragmentation, and inevitable failure.

Steven Muller, President of Johns Hopkins University, in his report for the Association of American Medical Colleges, entitled, *Physicians for the Twenty First Century,* affirmed that "to respond to the patient's personal concerns and problems and to prepare for specialized education in medicine, requires a general professional education." True professions have a common, rigorous foundation of general education which precedes specialization and this is what we need to have in audiology.

I am sometimes asked if a startling new "medical" discovery were made, would it put audiology out of business? The answer is: Not if its practitioners were appropriately trained. This is precisely what happened in optometry when contact lenses were developed. Now contact lenses are a major element of optometric practice. A parallel might be drawn between this and some of the small steps we have made toward the evolution of our scope of practice. We used to be prohibited from dispensing hearing aids. Now we dispense them regularly. We never used to take ear impressions. Now we routinely take impressions. We were never taught otoscopy, in fact we were discouraged from pursuing it. Otoscopy is now a routine part of audiology. If our practitioners have a good education, like practitioners in other true professions, they will simply absorb all or a major part of the service associated with any new activity as part of the natural evolution process. The new activity or technology would then become part of the foundation on which specialization could be built.

The discrepancy between the level of preparation audiology education provides and the level of preparation it needs to provide can be traced back to Newby's "maturity" theme; to use the all-too-human analogy, we're still living in our parent's house and, as dependent children, we have to live by their rules.

Recently, a renowned linguist-aphasiologist visiting our department at Purdue asked a wonderfully naive question. He wanted to know how it came to be that audiology was in with speech. After commenting (with a wry smile since my SLP colleagues were at the same dinner table with us) that many people are asking that same question these days, I explained how we came to be in the house of our sisters, but stressed the point that we certainly are not conjoined twins. As Leo Doerfler so vividly pointed out in his 1967 ASHA presidential address, "To maintain that audiology and speech pathology are a single field because they both deal with a single process, communication disorders, is to suggest that laryngology and proctology are also a single field because they deal with a single process, digestion."

Doerfler's analogy clearly illustrates the division between audiology and SLP, yet the general perception is that we are one, because "mature" as we may be, we've never moved out of the house. We still live under parental rule, and as is common to dynamically evolving species, the goals that drive the children do not coincide with those held by their ancestors.

The story is even more complicated because in fact we live in two houses. One is the SLP house but the other is the academic degree (or graduate school) house — the researcher education house. From the academic education stand point, the situation is aptly described by Don Peterson, father of the Psy.D. and Dean Emeritus of the School of Professional Psychology at Rutgers University. "The aims of science and the aims of professions are related, but they are not identical. The conditions under which goals can be realized are not identical either, and some are contradictory. Science must be free. Scholarly pursuits must flow where knowledge leads, not where social demands require... education for the profession must be constrained.... Each profession not only has the right but an obligation to impose on its educational institutions requirements for knowledge and skill that all professionals should acquire." (1986) Imposition of these curricular requirements in other true professions has almost universally been done by instituting professional schools. Professional education in medicine, dentistry, etc. takes place in a professional school which is distinctive to that profession, a unit in the accredited university which stands parallel to, but independent of, the graduate school.

There are no schools of audiology, even though the profession has been in existence for almost 50 years. Audiology departments can be found in schools of other professions, like medicine, or in schools which are conglomerates of other professions, such as allied health sciences. Yet it is highly unusual, perhaps even unheard of, to find dental, optometric or even veterinary education in a medical or conglomerate school. We need to have greater influence over our curricular and degree decisions and that is best accomplished in our own professional schools. Basically, we need to move out of the house and get our "own place."

It is not an immediate prospect and it is not going to be easy — striking out on your own for the very first time never is easy, but it will be exciting. Fortunately we have at least one major advantage. Just as you weren't the first kid to move away from home, audiology isn't the first university-born profession to pursue true professional status. Our

biggest advantage is that we can learn from the experience of those who have preceded us in this pursuit. Psychology has left a trail for us to follow. It may be faint here and there, it may sink into quick sand in spots, and be choked with the weeds of compromise in places, but the trail is a textbook in pitfalls to avoid.

For example, as Peterson (1986) pointed out, there are few professional schools in psychology, even though their professional doctorate (Psy.D.) has been around for 25 years. Similarly, even after 25 years less than one quarter of the professional doctoral programs offer the Psy.D. Like audiology, psychology has its roots in academia, and in an effort to win support for its professional doctorate while living in its academic doctorate house, it struck what I call Trojan Horse Compromises. The kind that seem like a good idea at the time but turn out differently later on.

Fortunately for us, it is possible to learn from someone else's experience — if we only will. Toward that end, I bid you to keep in mind the advice of one of my most revered advisors, my grandmother, who even then, was as full of wisdom as she was of days when she said, "Why repeat another's mistakes when you have a chance to make your own?" A profession like audiology, medicine or dentistry is steeped in science but its practitioners are not scientists.

A profession like audiology, medicine or dentistry is very technical in nature but its practitioners are not technicians. This is the lesson that has been learned in the other professions where an education steeped in science is not designed to produce a scientist and an education demanding technical skills is not abhorred lest its practitioners be deemed technicians. Audiology is just evolving into these realities. The next logical step in our evolution must be a professional doctoral education which will provide a rigorous entry level preparation and a distinctive degree designation in its own professional school.

This will be a milestone in our odyssey but not the last step in the journey. AAA

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