Larry's response to Hearing Healthcare 2020: The Future of Audiology (04-02-2020)

I appreciate the broad overview from the various contributors. During this age of rapid change in health care, students and audiologists need to become aware of and understand both internal and external forces applying pressure on our profession so they can learn to quickly adapt. Rigorous open exchanges can offer important contributions to this process.

For perspective to my comments, I have practiced audiology for 43 years. Part of that time was devoted to cochlear implant and middle ear implant research and working at an otology clinic. I have owned and operated my private practice for 38 years. I have served on numerous AAA and ADA committees, served on the AFA Board, and am a past-president of the Academy of Doctors of Audiology.

The focus of my response is directed at Nancy Tye-Murray, Ph.D.'s "Some Thoughts on the Future of Audiology." I agree with her comments about audiologist's need to provide aural rehabilitation programs, auditory brain training, and telehealth to improve patient care. However, I am shocked by and profoundly disagree with much of the rest of what Dr. Tye-Murray wrote.

1) *"… as the expert in the room I'm peppered with questions, the most common being, "Why should I go to an audiologist when I can get good hearing aids for so much cheaper at Costco?"; "I don't always have a compelling answer."; "We're supposed to say that the level of service is higher at a clinic. But if you compare patients' experience at many Costco's to that which they receive in a private practice audiology office, there often isn't much difference other than the private practice has prettier décor and better music."*

It is alarming when an audiology professor cannot confidently and decisively answer this question. A noted psychologist, Dr. Carl Jung, said, "If someone asks you who you are and you don't know, the world will tell you who you are."

Hearing loss is the 3rd highest chronic disease in the U.S. Audiologists, by their professional degree, are positioned in the health care hierarchy as general practice, point-of-entry, primary care doctors of the healing arts who diagnose and treat audio-vestibular disorders. Costco is a wholesale warehouse, and the person selling hearing aids likely only has a high school diploma. Will Rogers said, "Quality is a lot like buying oats. If you want fresh, clean, first quality oats, you have to pay a fair price. But if you can be satisfied with oats that have been through the horse, those come quite a bit cheaper!"

2) "*If audiologists are to remain relevant, apart from embracing new solutions and procedures, here's what I hope our future holds: The scope of audiology becomes more specialized and the general AuD requirement might be replaced with a lesser degree (e.g., MS or MA) and supplemented with specialization in specific areas of practice, similar to the medical model of residency."*

I find this comment offensive and uninformed. In the late 1980s and early 1990s, several visionary leaders created the Au.D. degree. The reason was that our profession's knowledge base had expanded to the extent that a two-year masters degree no longer provided sufficient time to adequately train and prepare students for contemporary practice. That has not changed. Those teaching in audiology schools are suppose to be professionally socializing students on how to integrate themselves into becoming an accepted and productive member of the healing arts doctoring professions, how to integrate and utilize audiologist assistants, and about how to protect our profession. They are not to convince these young minds to turn our profession's direction backwards 40 years when audiology was considered an allied health care profession.

Further, the Au.D. degree is a general practice degree, not a specialty degree. And, a medical 'residency' model consists of four years of professional medical school followed by a post-graduate specialty residency that lasts about 3-7 years. To follow Dr. Tye-Murray's logic, physicians, dentists, optometrists, etc. should eliminate two years of their professional school as well and become allied health care professions followed by post-graduate specialty training. That makes absolutely no sense.

3) "A current challenge new audiologists face is student debt, having paid for 4 years of undergraduate schooling and then up to 5 years of post-graduate training. By limiting their time in school and targeting their focus while they're there, we could reduce debt and thereby take the onus off audiologists to make big money quickly through hearing aid sales and afford them the time to provide in-depth diagnostics and aural rehabilitation. We might also avoid overtraining; e.g., a private practice audiologist will never be called upon to perform intra-operative monitoring."

No doubt that student debt is a challenge. I was 38 years old when I finally paid off my student debt. I never thought of my school debt as a burden. Rather, I saw it as an investment in my future. I find it disturbing when I hear someone talking about shortening professional doctoring education. Student debt exists as a real concern in other professions as well, not just audiology. Again, following Dr. Tye-Murray's logic, then the other healing arts doctoring professions should shorten their professional education programs. If shortening a student's education is something to put on the table for discussion, then let's talk about shortening the undergraduate program, not the professional school education.

Let's talk about: a) Replacing the Undergraduate Program in Communication Sciences and Disorders for students desiring a career in audiology with a two-year pre-professional curriculum that is consistent with the other healing arts doctoring professions. That would be a 2 + 4 = 6 year model instead of 4 + 4 = 8 year model. Student debt would be reduced, and the student's professional education would not be short-changed and watered down; b) Getting rid of the CCC-A burden on students and faculty in audiology programs (1); Replace "Capstone projects" (which should not be part of a professional degree) with 2-3 courses on Business/Practice Management as well as adding more clinical teaching hours to graduation requirements to better prepare students to learn how to adapt to these rapid changing environments that are being discussed and that are being thrust upon audiologists by non-audiologists; c) Consulting with other doctoring professions to see how they are dealing with student debt.

I cannot believe that in this day and age that anyone in this profession still has a problem with audiologists making money and are talking about overtraining audiologists and thinking that private practice audiologists are not involved in intra-operative monitoring. Audiology students are supposed to be educated and trained to the profession's full scope of practice, not to a focused specialty area. Dr. Jim Jerger said, "As audiology moves into the 21st century, one of the most dramatic trends will be the growth of private practitioners. In a very real sense private practice will form the financial foundation for the profession" (2). The ADA put forth a compelling position paper that is in line with Dr. Jerger's statement (3).

4) "*Another plus in changing our current educational practices might be to re-invigorate the doctoral program. My sense is that fewer and fewer students pursue doctorate degrees and research careers because the AuD is so expensive and time consuming. This may be the reason that both our diagnostics and aural rehabilitation methodologies have, at least to some extent, stagnated and why we are still practicing in much the same way that audiologists did 40 years ago."*

The last time I checked, the Au.D. degree is a doctorate degree. The Au.D. is an entry-level clinical practice doctorate degree like the M.D., D.D.S., O.D. D.O., etc., not a terminal Ph.D. research degree. I believe that it is unrealistic to expect to use students interested in clinical practice and patient care as a

primary recruiting pool for a research career. Efforts would be better served to recruit from a math and science pool of students. However, for those few audiologists who are interested in pursuing a research career, then it is appropriate for our profession to establish a few programs that offer a combined and shortened Au.D./Ph.D. degree track. The common professional model is to earn the professional degree followed by the research degree.

The reason that our profession has stagnated has nothing to do with the cost or length of audiology education. It has everything to do with professors and clinicians not effectively pushing to expand our scope of practice. Especially in this era of healthcare turmoil, our profession should come together and collectively brainstorm on how to expand our scope of practice. Doing so, will contribute to navigating the rapid change that is occurring and will continue to occur into the foreseeable future. Diversifying into other areas will add to the value of not only our profession but also to our patients and their care. Because of being general practitioners, audiologists can already add services in the areas of tinnitus, auditory processing, vestibular/fall/balance, and electrophysiologic diagnosis and treatment and others.

Remember, whenever there is a void, something or someone will come along and fill it. We have seen this in health care, e.g., where NPs and PAs are filling the void where there are physician shortages. They are expanding their scopes of practices. We have also seen hearing aid dealers attempting to expand their work roles into audiologist's scope of practice with, e.g., tinnitus care. Audiologist's identities are being threatened by those who continue to refer to audiologists as 'Hearing Health Care Providers/Professionals" instead of keeping separate identities for audiologists, hearing aid dealers, and physicians (4).

Let's start talking about audiologists having limited prescriptive rights and being able to order lab and radiology tests. Of course, with the latter, the results would be forwarded to the patient's primary care physician for medical interpretation and medical follow-up care. This would be cost-effective, convenient, and expand important patient care. NPs and PAs have the equivalent of masters' degrees and have these privileges. Audiologists, as members of the healing arts doctoring professions, are licensed to 'diagnose and treat', and there is no good reason for us to not be able to have similar privileges. Optometrists transitioned to prescriptive rights some 25 years ago; it only makes sense for audiologists to follow their lead. It is also within our purview to do, e.g., neurologic and dermatologic screenings, as we become directly involved in comanaging patients with comorbidities. Remember what Eric Hoffer said, "In times of change, learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists."

References

(1) Engelmann, Larry, M.S., Au.D., "Reboot or Delete Audiology Board Certification: Time to Debug ABA-BC and CCC-A", In Audiology Practices, Vol. 2, No. 3, September 2010.
(2) Hosford-Dunn, H. and Harford, E.R., In "Audiology Business and Practice Management", San Diego, CA: Singular Publishing Group, Inc.; 1995.
(3) Engelmann, L., Berkey, D., Parent-Buck, T., Syfert, G., Tamres, M., and Williamson, S., "Ensuring Audiology's Future in Healthcare: Owning the Profession through a Culture of Practice Ownership", ADA's FEEDBACK Supplement, Vol. 19, No. 3, Fall 2008.
(4) Engelmann, Larry, M.S., Au.D., "Branding the Lie or Branding the Truth: the Need to Differentiate Audiologists from Hearing Aid Dealers", In Audiology Today, Part 1, July/Aug 2018, pps. 34-44; Part 2, Sept/Oct 2018, pps. 50-63; and Nov/Dec 2018 Letter to the Editor, pps. 12-14.