1976 PROCEEDINGS
THEME—AUDIOLOGIST OR HEARING CLINICIAN:
TERMINOLOGY AND PROFESSIONAL RESPONSIBILITY

The Iowa Position

JULIA DAVIS
The University of Iowa
Iowa City, Iowa

At least three factors are involved when designations to be applied to professional personnel are chosen: the standards that specify minimum requirements for the use of the designated title, the needs of those institutions and agencies that employ the personnel, and philosophical considerations that determine how we view ourselves professionally. These factors are not independent of each other, since standards presumably reflect needs and philosophy influences standards. In Iowa, at least, these three considerations have resulted in a strong commitment to the term *audiologist.*

Standards for those persons designated as audiologists are set by three agencies in Iowa. The University of Iowa has established requirements for the Master's degree in Audiology, the Department of Public Instruction has established requirements for certification of audiologists who work in the public schools, and the Iowa legislature has established legal requirements for persons who perform the activities associated with the term audiologist. Although the terminology differs from document to document, the definitions of the term *audiologist* and the minimum educational requirements needed for use of the term, are virtually identical with the addition of a series of education courses for those who plan to work in schools. Furthermore, they reflect accurately the definitions and standards established by the American Speech and Hearing Association. The reason for this is not simply collusion; it has to do instead with the philosophy underlying each standard and the needs of the public for audiological services.

What is the philosophy? If you read the definition of an audiologist published in ASHA, by the State Department of Public Information, or

the State of Iowa, it is unmistakeably clear that the audiologist is one who measures hearing and *rehabilitates* persons who have hearing loss. In no case are audiologists defined in terms that exclude rehabilitation.

Such definitions are not unique to ASHA and the state of Iowa; they are typical of those used throughout the country. Obviously, the profession of audiology has always included rehabilitation as a part of its defined identity; what audiologists have done in practice is a separate question and one that lies at the cause of the present controversy over terms. It also has created a national identity crisis for audiologists that is heightened by recent statements issued by medical organizations that seek to define audiologists as narrow technicians who are not professionally autonomous. Without belaboring the point that audiologists in the past have often failed to deliver rehabilitative services, it is necessary to recognize this fact and to seek to determine both its cause and its effects. Two of the most obvious causes are: (1) Audiologists have been much more comfortable as evaluators because those of us who train them are more comfortable as evaluators. University programs pay lip service to the concept of rehabilitation, but, until recently, this aspect of audiology was represented in most curricula by one course (often not required of audiology majors) and few or no practicum opportunities (Davis, 1976). Graduates of audiology training programs practice audiology as they have been prepared to do. (2) Early employment opportunities for audiologists tended to be in medical settings, in which the audiologist gathers data for physicians as an adjunct to diagnosis of hearing disorders. In this setting many patients are seen daily, and there is time only for rapid testing and interpretation of test results. Rehabilitative procedures are too time consuming to be economically feasible.

Two obvious effects of the failure of audiologists to provide rehabilitation services are:

(1) Audiological needs of the public have been neglected. Because of incomplete training and economic considerations of employment, audiologists have been unable to exhibit and to lobby effectively for comprehensive audiological services to the hearing impaired. School children are unidentified or, if identified as hearing impaired, receive inadequate follow-up services since nobody knows what to do with them or has the time to do it. Elderly individuals struggle with communication problems that are often compounded by the use of a hearing aid; rehabilitative services are often simply unavailable to them.

(2) Other professionals and non-professionals have usurped the activities associated with audiology. Since audiologists have not provided rehabilitative services, and since the needs for such services have become more and more evident to the public and to other professionals, personnel such as teachers, speech clinicians, psychologists, learning disability spe-

cialists, special education personnel, hearing aid dealers, and physicians have begun to provide services associated with the practice of audiology. Ironically enough, these services include the evaluation of hearing, the one activity all audiologists are trained and willing to perform. In the face of such a variety of willing hands it was inevitable that the question should arise: "Audiologists: Who needs them?"

Who, indeed. Those persons with communication, language, educational, vocational and social problems associated with hearing loss badly need both the evaluative and habilitative skills of well-trained audiologists? Fortunately, a growing awareness of the role the audiologist has in the effective management of hearing disorders appears to be developing. Not everybody recognizes the role yet, including audiologists who advocate the splintering of the profession into audiologists (who evaluate hearing, wear white coats, and advise people) and hearing clinicians (who "work with" the hearing impaired). The same ill-advised trend is evident in the proliferation of terms currently used to describe audiologists. The terms educational audiology, pediatric audiology, medical audiology, clinical audiology, and rehabilitative audiology are useful as course titles and *perhaps* as employment titles; they are detrimental to the profession when used to differentiate between training curricula.

Audiologists should be trained as audiologists and they should function as audiologists. The employment setting in which they choose to work and the activities they choose to emphasize should not be dependent upon their training at the M.A. level. Instead, audiologists should be educated in all aspects of audiology, prepared to evaluate hearing, to interpret test results, to counsel patients, to plan remedial or habilitative programs, to carry these programs out or to supervise them, to select and monitor amplification, to make educational recommendations, to serve as consultants to other professionals, and to represent the profession of audiology to the public. This is far from an impossible task and audiologists are being educated in this manner in a few programs at present. It takes a little longer and precludes persons with minimal background in the field from obtaining a master's degree in one year. The curriculum for such broadly based training includes basic speech and hearing sciences; language development and disorders; disorders of hearing; assessment techniques and interpretation; amplification and instrumentation; educational, social, linguistic and vocational effects of hearing loss; and remedial procedures for reception and expression of speech and language. Knowledge of these topics is necessary for any audiologist in any employment setting. How can an audiologist make appropriate recommendations for amplification in the absence of an understanding of the communicative problems involved in the patient's life? How can parents be counseled intelligently if the audiologist has no knowledge of the "real

world" experienced by hearing impaired children. How can an audiologist (or hearing clinician) provide a maximally effective remedial program without a thorough understanding of the hearing disorder and the amplification needs and problems involved. It simply isn't enough to be able to test hearing or teach syntax; a thorough understanding of the hearing loss, how to quantify it and its effects is essential. The professional most likely to have that understanding is the well-educated audiologist.

If our profession is to survive audiologists must take the responsibility for full audiological services to hearing impaired persons. While the services offered in any given setting may vary, the audiologist must be familiar with all of them and must be visible to the public as one who is knowledgeable about and willing to become involved in all non-medical aspects of hearing loss. Otherwise audiologists will be reduced to serving as technicians, and the hearing impaired will not receive the integrated services they need, because other groups will provide fragmented services based on incomplete or inadequate knowledge of the problems involved.

The suggestion that the audiologist's past failure to provide adequate rehabilitative services is ground for the development or encouragement of a separate sub-specialty, i.e., hearing clinician, is absurd. It is no more valid than an assertion that, since speech pathologists did not treat children's language disorders effectively twenty years ago, they shouldn't be expected to do it now. The state of knowledge changes as do the recognized needs of people. We have the knowledge, the expertise, and the impetus to provide audiologists who have a broadly-based knowledge of hearing impairment. There is really no excuse not to do so and there appears to be no valid reason not to call such a person an *audiologist*.

REFERENCES

DAVIS, J., "Report of the ARA Committee on Educational Models and Continuing Education," *Jour. of Acad. of Rehab. Aud.*, IX, October, 1976, 17-21.