The Concept of Utilization of Supportive Personnel

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Introduction

During the past several years, a new concept related to speech pathology and audiology has come into focus in the United States. The concept has been applied into real working situations in a variety of clinical settings including community, university, and hospital speech and hearing clinics as well as in public schools. I refer to what has been labeled by such titles as communication aides, communication disorders aides, audiometric technicians, speech aides, and supportive personnel. During this presentation, the term supportive personnel will be used. At the present time, there is no formal definition of supportive personnel although various guidelines have been designated by groups including the American Speech and Hearing Association. It should be emphasized that no groups have taken it upon themselves to set any kinds of limits on what supportive personnel may or may not do with regard to hearing and speech problems; there have been suggestions, however. The present state of affairs lends itself to complete freedom of the hiring institution to utilize supportive personnel as it wishes. My presentation is not intended to either accept or condemn the concept but rather to inform you of a situation that exists which will have real effects on the profession of audiology and speech pathology; effects which should be of great concern to our profession so that we may plan for the future appropriately. It is my strong feeling that supportive personnel are here to stay, and whether this situation is good or bad is probably incidental at this time. Further, it is my contention that professionals should be in a position to determine what these individuals can and cannot do as well as to have a say in whether or not they are even necessary.

SOME HISTORICAL ASPECTS

Supportive personnel have been used for many years in a variety of ways—their activities have ranged from clerical assistance to the professional to hearing screening and some types of therapy. The reason the situation has now come into real focus is because some sources, including the Federal Government, have indicated a great need for delivery of services to persons who have communication problems. The most recent Public Health Service figures indicate that there are approximately 8-million persons who have some serious degree of hearing impairment, as well as about 300,000 persons who have been labeled deaf. Manpower figures, which are quite inconclusive at this time, have revealed to us that there is a serious shortage of qualified personnel to evaluate and habilitate or rehabilitate these individuals with communication difficulties. In essence, it has been stated that we need additional persons to work with the hearing impaired as soon as possible. Certain branches of the Federal Government feel that it is not necessary to train fully qualified ASHA certified people to engage in this task. It has been stated that ASHA requirements are too

high, that the organization is too professional, and that our standards are not necessary. In addition, some persons have commented that college degrees are not necessary in order to work with hearing impaired individuals. The Federal Government has even funded various supportive personnel programs to work with those with communication disorders. This situation represents almost a complete turn about by the government which three years ago was willing to accept certification and standards for dealing with human beings who have hearing and speech disorders. Many decisions affecting our profession, unfortunately, have been high level decisions made by persons who are not really acquainted with the nature of the field and who feel that it sounds good to say that the government is providing services to the handicapped. Unfortunately, there is an inkling of political rather than professional decision making. While we are told of the great need for services by the Administration, I am compelled to cite to you figures that are frightening—two years ago the Rehabilitation Services Administration funded 650 traineeships, this past academic year the number was 450, and for the next academic year the number will be only about 250, which is for continuing trainees. There will be no new RSA traineeships for the 1971-72 year in the United States. Many queries have been directed to the Federal Government about this situation. We have been told two major points. One is that our profession lacks accountability of previous trainees. The issue is that millions of dollars have been expended for training persons with federal funds to become hard core rehabilitation workers and that many of the trainees found their way into university training positions—not within the real mission of RSA. The second major point is concerned with manpower needs. Is there a shortage of professional personnel? If so, for what kind of positions, what kind of settings, and in which geographical areas in the country? Although there appears to be inconsistency with respect to manpower needs, the basic issue now is what should be the appropriate credentials needed in order to work with the hearing impaired. Can people be used with three weeks training, six months training, two years of training, or some other arbitrarilly determined length of time? Is a college degree necessary? With a profession that is about 50 years old in the United States, we have come to the sober realization that audiology and speech pathology (even) lacks identity as a separate profession. Who are we and under whose auspices do we engage in work? Are we to become subordinate to the medical profession, become part of special education, or really become a respected entity of speech pathology and audiology? Now we must stop and think seriously about what we do and whether or not the training we received is necessary. For the first time in history of our profession, the burden has been placed on us to determine whether or not we are indeed a separate discipline. Supportive personnel have forced us to define and justify ourselves. Those audiologists who have been content to be only diagnosticians better look to see what their future holds. Even what I regard as the total audiologist; i.e., the person concerned with diagnostics and habilitation and rehabilitation needs to justify his presence. Is it true that training institutions are engaging students in programs that in five years will lead to "no" employment? Are ASHA requirements necessary; is the college degree mandatory? I am concerned, not because I am opposed to supportive personnel, but rather because of a situation in which we have not sold the profession as an entity in itself.

THE PROFESSION OF AUDIOLOGY

Several years ago, Ira Hirsh discussed the clinical activities in which audiologists engage. As we become more specific in our discussion about who should do the job, Hirsh's statements assume great importance and are quoted here:

> We have spoken only generally about several clinical activities in the field of audiology. Let us be more specific and outline what these activites are. What are the procedures that are carried out in the attempt to help hard-of-hearing or deaf individuals? We list them briefly, without regard to the particular professions that carry them out: (1) measurement of hearing, (2) diagnosis, (3) pragnosis for surgical, pharmaceutical, physical, or educational therapy, and (4) therapy itself. Let us restate these in everyday language. First, we must find out how much hearing a patient has, not only the kind of hearing that is reported in the audiogram but also the hearing for speech and other sounds above the threshold. (This has been the responsibility of the audiologist.) Second, we must attempt to find out what kind of pathology is responsible for the defective hearing and, if possible, specify the site of pathology in order to help our prediction of what kind of therapy may be used. (This traditionally has been the responsibility of the otologist and the audiologist, with the audiologist contributing special test information to the physician.) Third we must make further measuremnts in order to predict whether surgical procedures, certian drugs or changes in the diet might produce beneficial changes or, lacking these, how much benefit might be anticipated from a hearing aid and / or educational procedures such as auditory training, lip-reading and certain kinds of psychotherapy. (Traditionally, the otologist, the audiologist and the hearing aid dealer have been involved in this process.) The fourth and final stage involves the therapy itself. The therapy often involves a combination of several procedures. Surgery alone may be insufficient and require the support of auditory training, which would make whatever hearing remains more useful to the patient. A hearing aid by itself can rarely provide as much benefit as it can when it is used in cooperation with an orienting program of auditory training and lipreading. (Therapy has been the responsibility of the "total" audiologist; hearing aids have been controversial in terms of dispensing and pre- and post-hearing aid orientation between the audiologist and the hearing aid dealer).

The Dictionary of Occupational Titles published by the Department of Labor (1965) generally specifies the audiologist as one who is involved in hearing measurement, special tests, hearing aid evaluations, counseling and hearing therapy including lipreading, auditory training and speech therapy. This definition is rather consistent with that of Hirsh's.

AUDIOLOGY AND SUPPORTIVE PERSONNEL

It now is imperative to focus on the tasks performed by audiologists relative to what audiometric technicians are being trained for. Supportive personnel are being trained to engage in hearing screening, pure-tone and speech audiometry. In addition, there are otologists who are self-training technicians to engage in special tests and give the information to them for total hearing

assessment interpretation. These supportive personnel are being trained in far less time than our present concept of university training programs and ASHA certification. Supportive personnel training programs have indicated that technicians *should*, not *must*, work under the direction or supervision of an ASHA certified clinician. There are no laws which limit the extent of involvement in which a technician may engage. Traditionally, most of these tasks have been performed by the certified clinical audiologist. I now pose this question to you—What happens to the M.A. trained clinical audiologist? Also—What happens if supportive personnel can engage in these tasks in a much shorter period of time? If supportive personnel can do the tasks, otologists and hiring agencies and institutions are not going to expend funds to employ M.A. supervising audiologist. The Federal Government, which is willing to fund supportive personnel programs, is the same Government that has cut funds to train certified audiologists. A number of universities that I have visited during the past year have told me that, for the first time, their M.A. audiology candidates are having difficulty finding jobs. I reiterate, we need to do some soul searching about this profession, where it stands now, and what its implications are for the future. Let us now discuss the rehabilitative aspects of hearing impaired persons with regard to supportive personnel. There are no guidelines, enforceable by law, to prevent these personnel from engaging in hearing rehabilitation; i.e. lipreading, auditory training, counseling, and speech therapy. It does appear, however, that audiometric technicians are in a more favorable position to eliminate the "disgnostic" clinical audiologist than the professional engaged in hearing rehabilitation. Ironically, though, most clinical audiologists prefer to be diagnosticians and leave the rehabilitation to someone else. Then, if we can consider those who are labeled deaf, we better realize that few audiologists feel there is anything they can contribute to this group of hearing impaired. It would seem to me that the future of the professional audiologist has the best chance for survival by being concerned with all of aspects of hearing loss in terms of diagnostics, habilitation, and rehabilitation. The total audiologist also should be concerned with the infants, the preschoolers, the school age, the adults, and the geriatrics. Perhaps there should not be an Academy of Rehabilitative Audiology but rather an Academy of "Total" Audiology. Yet, the real issue facing us is whether or not supportive personnel can actually do the job that traditionally has been done by the audiologist. Who is in a position to determine answers to this critical problem? We are. Have we done it? I don't believe so. Should we do it? We had better. Without answers to accountability, manpower need, and responsibilities, I predict that within five years the profession of audiology will be looked at in historical perspective rather than as a functioning process. We must answer this question not only for medicine, the government, special education and other disciplines, but for ourselves. I charge all of us to seek these answers. If we don't, others will do it for us.