



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION

December 18, 2009

Michael D. Maves, MD, MBA  
Executive Vice President, Chief Executive Officer  
American Medical Association  
515 N. State Street  
Chicago, IL 60654

Re: ASHA Response to AMA Scope of Practice Data Series: Audiologists

Dear Dr. Maves:

This letter is in response to the *AMA Scope of Practice Data Series: Audiologists* sent to the American Speech-Language-Hearing Association (ASHA) for comment. ASHA is the professional, scientific, and credentialing association for 135,000 members and affiliates who are audiologists, speech-language pathologists, and speech, language, and hearing scientists in the United States and internationally.

ASHA appreciates the opportunity to comment on the document as it advances numerous inaccuracies and misstatements. It is the intent of this letter to cite some of these inaccuracies and present factual information so that the AMA retracts this document. ASHA takes issue with the presumption of the AMA that it should develop such a document and especially for the stated purpose to “serve as a resource for state medical associations, national medical specialty societies and policymakers.” One profession does not have the right to restrict the scope of practice of another legally recognized profession. Further, it is curious that the AMA chose to develop “a carefully researched, fully documented assessment of the profession of Audiology...” without conferring or collaborating with ASHA, the professional home for the discipline since 1925. Such oversight begs the question as to the actual motives behind such a self-serving document and will most assuredly cause reasonable policymakers to doubt its credibility.

The profession of audiology has been a standards-based profession for over 50 years. Society and the profession benefit from the knowledge, skills, and experience of its scientists and clinicians that have led to the development of the profession’s own standards, scope of practice, and ethical principles—the hallmark of an autonomous profession. To imply, as you do in the *Overview* and explicitly stated in the *Introduction*, that there are political motives behind advocacy initiatives to expand a profession’s scope of practice misdirects the audience from the fact that scopes of practice legitimately grow as a profession’s research and knowledge base increases. Just as in medicine, audiologists and hearing scientists spend careers developing best practices that are carefully evaluated to ensure patient safety and welfare, as well as the efficacy of interventions, while addressing the patient’s communication needs.

As noted in the AMA document, “the education and training of audiologists prepares them to provide essential and significant nonmedical and nonsurgical treatment for hearing and balance disorders.” In addition, the audiology profession’s own best practices coupled with rigorously applied ethical standards necessitates appropriate and necessary referral to medical practitioners, further ensuring the health and welfare of the patients we serve.

Given that approximately 95% of adults with complaints of hearing loss have sensorineural hearing loss for which medical or surgical treatment is not typically beneficial, asserting that effective patient care is best accomplished by means of physician oversight is not a cost-effective argument. Moreover, it assumes a level of audiologic knowledge that does not exist for most physicians and presumes a model of health care that does not reflect society’s acceptance of autonomous allied health practitioners.

The section identified as, *Audiology as a Profession*, contains many examples of misleading, incomplete, and inaccurate information through a definition of the profession of audiology provided by a group calling itself America’s Hearing Healthcare Team (AHHT). The AHHT is not an interdisciplinary group of health care professionals. It consists of physicians and hearing aid dispensers and has no more standing to define the profession of audiology than the AMA itself does.

There are further examples of misleading and inaccurate statements in both the *Introduction* and the *Education and Training* sections of the document. In one particular part, there is significant verbiage which implies that most audiologists with an AuD degree obtained their degree via “educational ‘shortcuts’ to the doctoral degree.” This statement is inaccurate and misleading. There is no acknowledgement that ASHA successfully defeated in court the Earned Entitlement effort by the Audiology Foundation of America (AFA), the result of which signified the value of obtaining a doctoral degree within an institution of higher education. Specifically, a doctoral degree must be earned either through a regionally accredited institution offering a distance learning doctoral program for credentialed and experienced audiologists or an accredited audiology program for those initially preparing to enter the profession.

Furthermore, the rationale noted for change in academic degree is completely misleading and is based upon the AMA’s focus on the statements of a few that completely overlooks the facts. ASHA does not subscribe to the rationale for the profession moving from the master’s to the clinical doctoral degree as the entry level for independent professional practice in audiology as being based on audiologists’ desire for professional advancement and the quest to transform audiology into a “doctoring profession.” The true impetus for this change was the profession’s need for knowledge and skills to keep pace with the scientific, technological, environmental, and practice changes that were occurring.

ASHA has an ongoing commitment to following best practices for its credentialing programs. ASHA conducts systematic and periodic reviews of its standards to identify the academic knowledge, clinical practice, and other requirements for the acquisition of essential knowledge and skills necessary for entry-level, independent professional practice of audiology. As a part of that process, ASHA commissioned the Educational Testing Service to conduct a skills validation study for the profession of audiology, which was completed in 1995. Following a review of the data provided by that study, practice-specific literature, feasibility studies, and other pertinent

information, it was determined that the breadth and depth of knowledge and skills required for entry into the profession could not be adequately covered in a master's degree program of study. As a result, revisions were made in the expected curriculum standards for accreditation in order to make the scope and level of professional education in audiology consistent with the scope of practice of the profession. These changes were made to address the significant discrepancies between the level of educational preparation and requirements for practice that were identified in the skills validation study. Graduate education programs were provided sufficient time to gain approvals for the change in degree level and to modify the curricula accordingly. In addition, the accrediting body announced in 2004 that it would cease accrediting master's level programs in audiology as of December 31, 2006.

At the same time that the change to the clinical doctoral degree was underway, the profession made the decision to establish expected student learning outcomes, or specific knowledge and skills, required for entry into independent professional practice in audiology. This was a significant change from the earlier concept of requiring specific courses or practice experiences and a mandatory number of credit hours in the curriculum, which did not necessarily provide assurance of acquisition of the identified knowledge and skills. In addition, the move to identify student learning outcomes is consistent with best practices in higher education and with external expectations of the U.S. Department of Education (ED) and the Council for Higher Education Accreditation (CHEA) for recognizing accrediting agencies. This movement also was related to escalating stakeholder interest in outcomes and accountability for graduate education (i.e., higher expectations of student preparation by employers, students, general public, etc.). Further, the vast majority of accreditation and certification agencies have already moved in this direction, away from "inputs" in the educational experience (i.e., requiring specific course work) toward outcomes-based standards and the acquisition of specific competencies. In addition, ED prompted the accreditation community to enforce specific mandated measures of student learning, such as completion/graduation rates, employment rates, and acquisition of state licensure and/or national certification.

The *Education and Training* section of the document contains multiple instances of mistaking national standards for certification of individuals with standards for accreditation of graduate education programs. The groups that govern the establishment of standards for accreditation and certification are completely separate and function independently in carrying out different scopes, charges, and purposes. There are many references in the document to changes in standards attributed to the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA); however, most of these were actually changes in individual certification standards established by the Council for Clinical Certification (CFCC).

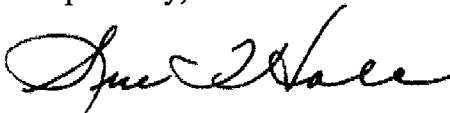
Other numerous examples of factual errors can be found in the *Licensing and Certification* section. For example, although the AMA document correctly notes that the Praxis examination in audiology is one of several requirements for the Certificate of Clinical Competence in Audiology (actually the exam is a certification standard), the AMA document incorrectly identifies this as the 'national licensing exam.' In actual fact, licensing boards have adopted the Audiology Praxis exam because of the rigor by which it is developed and administered. Further, the statement, "There is no consistent maximum possible score on the Praxis exam; instead the maximum possible score varies from edition to edition" is incorrect. The fact is, the Praxis series covers quite a few credentialing professional areas and this statement takes that into consideration. All

of the exams in the Praxis series have different maximum possible scores. However, the Audiology Praxis exam specifically has a score range from 250 to 990 reflecting consistency. Moreover, the passing score is established through a scientifically-based process administered by the Educational Testing Service (ETS) in collaboration with subject matter experts in audiology.

As another example, the AMA states that licensing requirements have not generally been modified to reflect the change in educational requirements. Actually, states are modifying their statutes and regulations to reflect the change to a doctoral degree. Currently 24 states have language requiring compliance with doctoral degree standards. Another misstatement refers to continuing education (CE) for license renewal. While it is true that six states do not require continuing education, that hardly constitutes confusion as the remaining 44 do have CE requirements for license renewal and, further, all audiologists with ASHA CCC (over 14,000) are required to achieve continuing professional development during consecutive three year intervals.

In summary, the document is rife with opinions, misstatements, innuendos, and factual errors; as such we see no value in correcting it line by line. Rather, while ASHA appreciates the opportunity to point out examples of inaccurate and misleading information in the *AMA Scope of Practice Data Series: Audiologists*, we remain extremely concerned that such a document has been crafted at all; and, for the purpose noted. The profession of audiology is a legally recognized profession and will continue to be an independent, autonomous profession responsible for establishing its own educational and practitioner standards; establishing its own clinical practice guidelines, including the scope of practice; providing quality patient care; and monitoring quality patient outcomes. It is disappointing that the AMA has chosen to produce this document without conferring or collaborating with ASHA, the home of audiology for over 80 years. Retraction of the *AMA Scope of Practice Data Series: Audiologists* is in the best interest of all concerned.

Respectfully,



Sue T. Hale, MCD  
President

We, the undersigned, representing health professional organizations support ASHA's position in opposing the AMA's development of the Scope of Practice Data Series: Audiologists.

American Academy of Private Practice in Speech Pathology and Audiology  
Academy of Rehabilitative Audiology  
Association of Schools of Allied Health Professions  
Council of Academic Programs in Communication Sciences and Disorders  
Directors of Speech and Hearing Programs in State Health and Welfare Agencies  
Educational Audiology Association  
Military Audiology Association