The Culture Wars in Communication Sciences and Disorders: Who speaks for audiology and speech-language pathology?

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The tone of the discourse on the future of audiology and audiology training in the United States is as heated and perhaps as non-productive as the discourse between the neoconservatives and the progressives in the political arena. In the war between the republicans and the democrats it is not a struggle between those with values and those without values but rather a battle of how values are framed. Cognitive Science has helped us see that we understand statements and facts not in terms of the inherent structure in the statements but rather by the cognitive frames that form the perspectives we use to make sense of the statements. Put in the simplest terms it is the context that is critical to how an utterance is understood. The study of speech perception is replete with examples of such context or frame effects.

Linguists like George Lakoff have provided an interesting explanation of why far-right conservatives seem to now have the upper hand in politics. His argument goes like this. People are more inclined to vote on the basis of values than on the basis of self interest. This may explain why many working poor effectively voted against more money for things like education and health care and for tax cuts for the wealthy and why some wealthier progressives voted for taxes and for social programs that they don't need. Lakoff suggested that it isn't that conservatives are for family values and that progressives are against family values but that the former have seized control of the discourse and framed the issues from their perspectives. Lakoff suggests that progressives have taken the bait and been forced into the debate which is framed from the 'strong father' model of family values to which the conservative right subscribes. He suggests that everyone subscribes to either the 'strong father' model or to a 'nurturing parent' model or some blend of the two. In the political battle strong adherents of either model must convince enough of the large number of those in the middle that the particular way in which the values are framed matches their own values.

The debate about who sets standards and what the difference should be between clinical certification standards and program accreditation standards has for many reasons devolved into something akin to the cultural war in American politics. Interestingly the debate is not just simply about what the relationship should be between entry level standards and indicators of excellence in clinical practice. What might be a very interesting debate on the philosophy of professional training and certification has become inextricably tied to a different debate which may have nothing at all to do with standards.

In the minds of some, establishing audiology as an autonomous profession is of paramount importance. This is in part driven by a long history of tension with the medical profession, in particular with otolaryngology and in part from a sense of marginalization in the field of communication sciences and disorders and a dissatisfaction with how the American Speech-Language-Hearing Association (ASHA) served the needs of audiologists. Like other constituencies in ASHA who have been dissatisfied with the organization's ability to respond to their particular needs, audiologists have created their own organizations (American Academy of

Audiology, AAA). The birth of the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD) was in part a function of a belief on the part of academic programs that ASHA was too focused on the needs of the practicing clinician and not on the profession's training and research missions. The debate on standards and their application is not simple and many of the issues continue to revolve around the myriad ways the autonomy issue is raised. Academic programs are caught in the crossfire of the current debate and individuals respond to the arguments of both sides not out of self interest but because of the specific way the discourse has been framed around a particular issue. To the extent that ASHA or AAA or any other organizations endeavor to convince individuals and programs to subscribe to their views may very well determine not only the future of audiology as a field but whether academic programs can exist and marshal university resources to provide the education mandated by the standards setting bodies.

At this time when academic institutions in the United States are facing the challenges of increasingly shrinking state and federal support, departments and programs in audiology and speech-language pathology that were always expensive propositions are at risk. If programs play no active role in the debate on standards and accreditation, we may very well find ourselves unable to provide students with the experiences mandated by certification standards and unable to meet program accreditation standards. This is not a problem limited to smaller and weaker programs. As the current debate on standards for supervisory staff has revealed, programs both in audiology and speech-language pathology are facing problems getting their students all the clinical practica they would like to see them have. In some cases it is not a question of the practicing clinician having the appropriate training or clinical experience but a question of whose certification or licensing standards they meet and subscribe to. Clearly competing alternatives to certification and the conflict between certification and licensing both contribute to the dilemma faced by training programs.

The reasons why individuals have dropped ASHA certification range from simply economic ones to the lack of a requirement for certification by employers as well as the political choice to de-affiliate from ASHA. This it turns out is not merely an audiology issue, as many SLPs particularly those working in the schools have also dropped their CCCs. It is unfortunate that maintaining certification when it is not a requisite of employment is not seen as intrinsically valuable to clinicians. Any maintenance of certification or licensure that requires continuing education and with it associated costs is less likely to occur when keeping a job does not require it. As a consequence, academic programs that are required to have qualified staff in order to meet accreditation standards find that the pool of available clinicians in certain settings is shrinking.

If we can engage in a dialog about the role of certification and accreditation without the rancor of the politics of who should do it we may be in a better position to address the question of what constitutes a quality clinical training program and the knowledge and skills expected of both the entry-level and the master-level clinician. In any field it would seem appropriate to examine both the input and the output of training programs. From that it follows that both academics and practicing clinicians are primary stakeholders in standards setting and that the standards bodies need to be accountable to external constituencies most importantly the individuals served by the clinicians. If we hope to have programs that turn out exceptionally good clinicians we must consider not only what it means to be able to practice independently but what it takes to turn the beginning student into a novice clinician and eventually into the master clinician. Thus the standards we set for training programs must be cognizant of the environment

in which clinical training programs work and the students that are matriculating in those programs.

Programs in communication sciences and disorders vary in terms of whether they offer audiology and/or speech-language pathology training as well as the type of academic institution in which they are housed. The constraints of working in a health science college are different from those in a college of arts & sciences or a college of education. The nature of the institutions' charters may place restrictions on the types of degrees that can be granted and the type of faculty that can be used. With the change in the entry-level degree in audiology we find that in states like California where clinical training programs are by statute housed in the non-doctoral granting institutions it may be impossible to achieve the higher (doctoral) level of clinical education in audiology. Pragmatically, in California, it might be easier to change the curriculum and clinical experiences needed for a master's degree than to create a doctoral degree with an AuD designator.

Who is served by this dilemma? Not the academic programs in the Cal. State system, nor the students who want to pursue training in audiology in California and in the end not the field of audiology or the individuals who need the services of qualified audiologists. Outsourcing the training of audiologists can't work as geographical constraints limit educational opportunities and make it difficult to attract clinicians from one part of the country to another. Medicine has shown us the gravity of this problem with the inability to provide qualified physicians across the country. Regrettably not too many Harvard Medical School graduates who do residencies at major medical facilities choose to settle and practice in rural or poor communities.

So much for the doom and gloom! Is there a way out of the dilemma we now face and is there a way we can work collectively to put in place a system that will lead to a continual improvement in the quality of clinical care our graduates will be expected to provide? I think there is. We, in the academy, must regain control of the discourse. We must frame the issues in terms of the values we hold. I would like to suggest that the solution for us 'nurturing parent' types is to not let others co-opt our values and destroy the only means by which clinicians can be trained. The 'motherhood and apple pie' of audiology is not something that some 'other elite' few should define. Many of our audiology training programs have clinics that have national and international reputations for the outstanding care that they provide, even though they are 'training clinics'. A very large number of the innovations in the clinical practice of audiology have come from those training clinics as have most of the efficacy studies that are forming the basis of evidence based practice.

The problem we are facing is in part of our own making. We let others set the context and we have been on the defensive ever since. I am not saying that everything has been perfect in clinical education and that we don't need to change a thing; I am not a Luddite! We may not be able to set the clock back on the AuD, but we can endeavor to drive the standards argument rather than be driven into the ground by it. The answer will lie in our ability to collectively recognize excellence in clinical training and to acknowledge that programs will need to find the path that will work at their institution and with the contextual constraints that manifest themselves in their environments. To that end as we work with the growing number of accrediting bodies we will need to aggressively argue that the standards must allow for flexibility in implementation of curricula and clinical instruction. If we see that our 'clinical supervisors' have to be 'clinical teachers' and that their role like that of the classroom instructor is to get students from one knowledge state to the next, we will value the clinical and teaching skills of the individuals we ask to take our students. If these clinicians see themselves as part of the

clinical education system they may have greater buy-in to the standards as well. Just as the practicing clinicians have seen maintenance of a credential as burdensome, academic programs see accreditation as burdensome and are wary of having to maintain multiple accreditation. We must ensure that there is value added from accreditation.

Departments have found that recommendations from external accrediting bodies have helped in their efforts to secure additional resources from their collegiate and university administrations. The danger of competing accrediting bodies that have 'political' agendas is that they will send contradictory messages that will actually hurt departments rather than help them become better. I would like to suggest that as academic programs we have an obligation to ensure that future generations of clinicians can be trained. If the accreditation process leads to weaker departments or wholesale closures of departments, the professions are doomed. I would like to suggest that we work collectively as both audiologists and speech-language pathologists to bring the accreditation process out of the ASHA-AAA political dispute and that we lobby both organizations that a neutral body might best be suited to meet both the needs of the professions and the needs of academic training programs. A neutral body is more likely to see that there are alternative approaches that can be equally effective in training clinicians and can lead us to a well articulated set of indicators of excellence.

The majority of audiology programs are in the same administrative unit as speech-language pathology programs and draw their students from communication sciences and disorders undergraduate programs. This symbiotic relationship has by and large been working and we need to ensure that standards set by audiologists for audiology and by speech pathologists for speech-language pathology need to be cognizant of that relationship and not work against it. This is, I think, the argument for the need of some calibration between audiology and speech-language pathology standards. What both audiology and speech-language pathology have in common is their concern for enhancing individuals' ability to communicate. A speech-language pathologist can not adequately deal with a patient without taking into account the hearing status of the patient. Likewise the audiologist must have some sense of the linguistic & cognitive abilities of their patients. The needs of young recipients of cochlear implants highlight the interconnections of the professions. If we are split into different academic departments who will assure that the quality of the instruction students get in each area is appropriate and up to date? If the accrediting bodies become too parochial, then some standards might in fact become too lax for those domains at the fringes of the scope of practice.

I started with politics, so let me end with a biblical analogy. Perhaps CAPCSD must function as the modern Solomon faced with "professional parents" with equal claims on the baby. Would our world be served well by cutting the baby in half?

Reference: Lakoff, George (2004) Don't think of an elephant! Know your values and frame the debate., Chelsea Green Publishing Co., White River Junction, Vermont