

Clinical Education IN Audiology

A CASE OF THE EMPEROR'S NEW CLOTHES

BY VIRGINIA RAMACHANDRAN

Many of us feel a bit like the emperor and his subjects when it comes to clinical education in audiology. We have a nagging feeling that the whole enterprise does not quite make sense.



IN CASE YOU DON'T REMEMBER THE TALE, IT GOES SOMETHING LIKE THIS....

Once upon a time, two men of poor character were hired to make an emperor a new suit of clothes. The suit of clothes was said to be made of a magnificent fabric, invisible to those who were intellectually challenged, incompetent, or unfit for their position. Naturally, the emperor's advisors and subjects, as well as the emperor himself, all professed to see the fabric, which in truth, did not exist. Only a small child possessed the naivety to proclaim the emperor's nakedness as he paraded

down the street in his new finery. And in the end, everyone kept up the pretense, even though all secretly knew the truth.

Many of us feel a bit like the emperor and his subjects when it comes to clinical education in audiology. We have a nagging feeling that the whole enterprise does not quite make sense, even though we have all been through it at one point or another. Whether you are a student, a clinician, a clinical educator, or an academician, if you have thought this, you are not alone.

Clinical education involves numerous factors, each of which has evolved substantially in the past decade or two. So it is no surprise that we may feel a bit uneasy when it comes to understanding clinical education today. Some major challenges of clinical education include models for clinical education, credentialing of audiologists, and accreditation of academic programs.

The Evolution of the Master’s Degree to Doctoral Degree

Prior to the past decade, of course, a master’s degree was the entry level for clinical practice in audiology. An audiology student would take courses in audiology and would receive some clinical instruction. Most students would graduate from a college of liberal arts and sciences or a college of education, generally from a joint speech-language-pathology and audiology department. The degree would be nondescriptive, meaning that it did not designate that students were educated as audiologists. Instead, they would receive a degree such as master of arts, master of science, or master of communication disorders (MA, MS, MCD, etc.).

At the time that students graduated, it was generally agreed upon that they did not yet possess sufficient clinical skill to be qualified for independent practice. In order to complete their clinical education, the graduates would complete a clinical fellowship year (CFY). The purpose of the CFY was to allow the students to obtain clinical experience under the instruction and supervision of qualified audiologists.

The problem with the master’s model was that the quality of postgraduate training could differ tremendously. In addition to differences in clinical experiences and environments, the level and quality of supervision could

vary. And in the end, there was no measure to ensure that the CFY student had, in fact, become a skilled clinician; there was merely an attestation by the clinical supervisor that the requisite number of supervised hours had been completed.

By the 1990s audiologists were recognizing that they were not uniformly graduating with what they felt was sufficient didactic or clinical education to be autonomous members of the health-care profession. Thus began the movement toward the clinical doctorate (the AuD) as the entry level for clinical education.

The doctoral model moved the responsibility for clinical education from the CFY clinical preceptor to the university, which provided at least some assurance that someone was watching over clinical education, even when it was not being provided by the university program directly.

Today when students graduate, they have an AuD (doctor of audiology) degree. The name of the degree signifies that the course of study was in audiology. In addition, the degree has been designed to entirely prepare students for entry-level clinical practice. In contrast to the master’s model, the AuD student is meant to be prepared to practice independently upon graduation.

The Evolution of Credentialing

At the same time that changes were occurring in the educational programs, changes were also occurring in the credentialing of audiologists. Historically, the primary credential used to indicate that one was qualified as an audiologist was the Certificate of Clinical Competence in Audiology (CCC-A), conferred by the American Speech-Language-Hearing Association (ASHA). The requirements for certification are developed by the Council for Clinical

Table 1. Audiology Education Models

	Master’s Model	AuD Model
Credentialing	Certification	Licensure
Degree	Numerous (MA, MS, MCD...)	Single degree designator (AuD)
Clinical Education	CFY model	All clinical education during graduate program

Certification (CFCC). This credential was granted following the completion of the CFY.

Recall that at this point in the history of our profession, clinical education was not complete upon graduation. Certification was the vehicle by which audiologists could indicate that not only had they completed their academic preparation, demonstrated by their degree, but that they had completed a postgraduate period of clinical training as well. Because no other credential was available to indicate this, certification was necessary to establish the individual as a qualified audiologist among peers and consumers.

Over time more and more states began establishing licensure for audiologists. Licensing boards set standards for acquisition and maintenance of the professional license. By and large, the state licensing standards mirrored, and in some cases exceeded, the standards for ASHA certification in audiology. Licensure, rather than certification, provided audiologists the legal right to practice (see TABLE 1).

Currently, licensure for audiologists exists in every state. It is the standard credential necessary for clinical practice. Because audiologists now receive all clinical training during their doctoral program, students in nearly every state can graduate with their diploma, obtain a license in their state, and begin practicing. Certification has become an optional, adjunct credential, not necessary for clinical practice or reimbursement.

The Evolution of Accreditation

Another major factor in clinical education is the accreditation of academic programs in audiology. Accreditation is a process by which academic programs are evaluated to ensure that they have met certain quality standards. The accreditation of an academic program is technically voluntary, but because audiologists must have graduated from accredited programs in order to obtain licensure or certification, the programs have a de facto obligation to obtain and maintain accreditation.

Historically, all audiology programs have been accredited by ASHA's Council on Academic Accreditation (CAA). As audiology programs began to change from master's level to doctoral level programs, changes needed to be made to the requirements for accreditation of audiology programs to reflect the goal of greater academic and clinical preparation of students.

Many in the audiology community felt that the changes made to the CAA accreditation standards for clinical doctoral programs lacked the rigor necessary to substantially and meaningfully elevate the performance

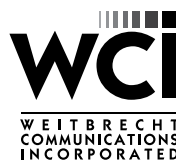


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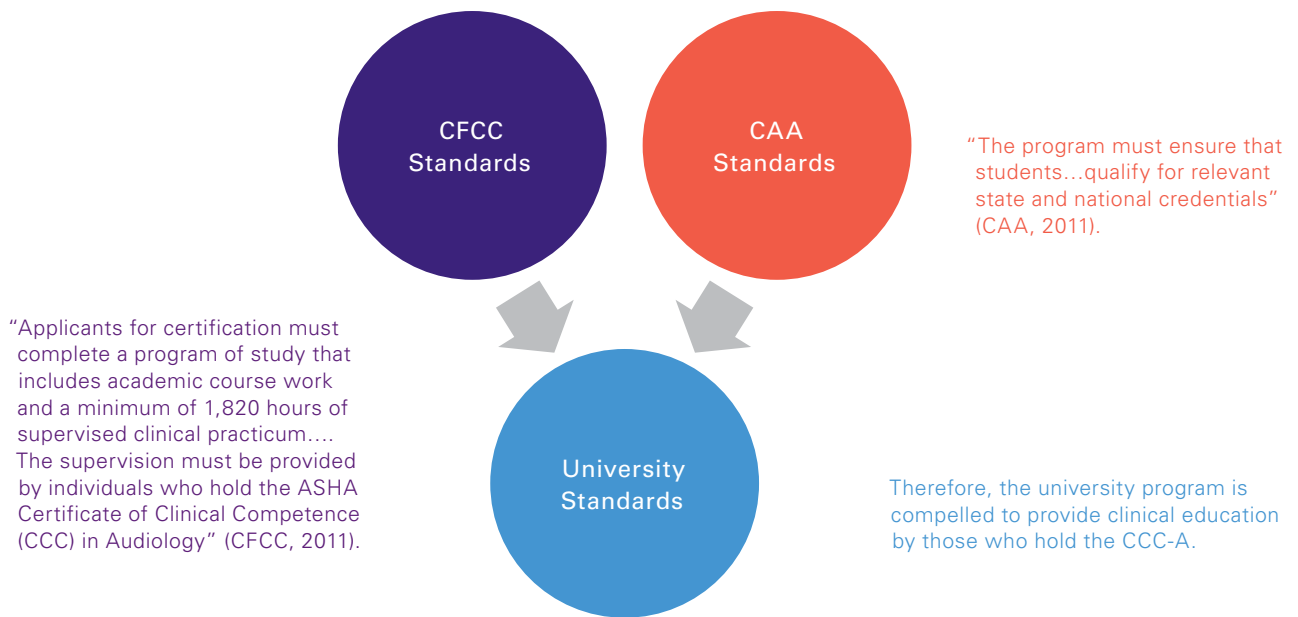


FIGURE 1. The mandate for certification as a credential for clinical education.

of academic programs at producing clinical audiologists (CAA, 2011). The solution developed by these individuals was an alternative accrediting body, the Accreditation Commission for Audiology Education (ACAE), with a goal of creating a higher standard for the accreditation of clinical doctoral audiology programs.

Currently, there are 72 doctoral programs in audiology accredited by the CAA and four programs accredited by the ACAE. All ACAE-accredited programs are also accredited by the CAA.

Academic accrediting organizations obtain their authority to accredit programs from two main sources, the U.S. Secretary of Education and the Council for Higher Education Accreditation (CHEA). The CAA is recognized by both. The ACAE is recognized by the U.S. Secretary of Education and is currently undergoing initial review by CHEA.

Requirements for Clinical Education

One of the biggest challenges in audiology clinical education is that the standards differ depending on who you ask. It is the job of university programs to educate students. In order to do this, they create standards and curriculum for the education of their students.

In theory, the accrediting body ensures that the university program is meeting certain widely accepted standards through the accreditation process. So the accrediting body has a separate set of standards.

For CAA-accredited programs there is a third level of standards, that of certification of the clinician. Why does certification play a role in clinical education requirements at the level of the university program? Well, the answer is that it should not.

Typically, certification is a credential that is earned through additional study and skill development, beyond that required for graduation from the academic program and entry into the profession. Think of the board-certified otolaryngologists with whom you may have worked. Following completion of their graduation from medical school, where they earn their doctor of medicine (MD) degree, they complete rigorous residency and fellowship training programs, at the end of which they may become board certified in otolaryngology. The same model holds true for most professions, including speech-language pathology, wherein certification is granted only following postgraduate clinical instruction in the form of the CFY. This also used to be the case in the master’s-degree model for audiology education.

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Well, the answer is that it should not.

With the advent of the AuD degree, the most common certification in audiology, the CCC-A, has become redundant with academic requirements for graduation. In other words, in order to graduate and earn a diploma in audiology, the audiology student must necessarily have completed the requirements for certification.

So how did CCC-A certification go from being a postgraduate credential to being redundant with the diploma? The answer lies in the CAA's standards for clinical education. Specifically, the CAA (2011) states that "the program must ensure that students ... qualify for relevant state and national credentials."

This CAA standard raises a few questions. One question regards what exactly is meant by "national credentials." There is no state-level certification of audiologists, so presumably "state credentials" refers to licensure. There is no national audiology license, so national credentialing is presumably certification. But what form of certification is necessary? There are numerous potential certifications available to audiologists, including the American Board of Audiology (ABA) certification, various specialty certifications, and ASHA certification. Must students qualify for all of these national certifications? Or perhaps one? Which one(s)?

Because answers to these questions are not clear, university programs are left to guess at how they might fulfill this requirement. Most university programs assume that the answer is that students must be eligible for ASHA certification in audiology upon graduation. Those few programs that do not require students to fulfill this particular certification requirement generally have students sign a waiver indicating their awareness that they will not have completed these requirements upon graduation.

Another important question is "Why would audiology students be required to be qualified for certification when they graduate?" In the past, audiologists used to

be eligible for certification only following additional postgraduate study. Speech-language pathologists, whose programs are also accredited by the CAA, are only eligible following postgraduate study. This is the case in nearly every other profession.

So why would qualification for audiology certification be necessary upon graduation? There is no clear answer to this question, although we might find some clues in the CFCC requirements for certification in audiology. One major requirement for CCC-A certification is that "applicants for certification must complete a program of study that includes academic course work and a minimum of 1,820 hours of supervised clinical practicum" (CFCC, 2011). The requirement further states that "the supervision must be provided by individuals who hold the ASHA Certificate of Clinical Competence (CCC) in Audiology" (CFCC, 2011). In addition, the CFCC has clarified that these clinical education requirements must be completed during the student's academic program (personal communication with chair of CFCC). According to the current requirements, if the student does not qualify for certification upon graduation, they never will.

So, university programs that follow the assumption that students must be eligible for ASHA certification upon graduation are compelled to ensure that their students receive 1,820 hours of clinical education provided by ASHA-certified audiologists (see FIGURE 1).

A Bottleneck for Clinical Education

The de facto "requirement" that university programs must provide clinical education from individuals who hold the CCC-A creates a number of problems for clinical education. One problem is that it creates a bottleneck for access to clinical education for audiology students.

Audiologists no longer need certification to practice. Therefore, many audiologists may choose not to maintain or pursue certification for various reasons. This is

especially likely to be true for new audiologists, who are graduating into a profession of licensure and have never had the experience of needing certification to practice. And because the requirements for certification are redundant with the graduate's diploma, entry-level certification does nothing to set the audiologist apart from peers. So they may see little value in paying additionally and annually for the certification.

Unfortunately this means that a large number of audiologists are ineligible to provide clinical training for the 1,820 hours that the CFCC requires for certification of audiologists. This situation has created a strain on the abilities of university programs to find sufficient numbers of high-quality clinical education sites; a situation that is likely to worsen in the future.

A recent Internet-based survey completed by the author and colleagues was distributed to the clinical education coordinators, those people responsible for the external clinical education experiences of audiology students, at 71 AuD programs in the United States. The goal of the survey was to understand the thoughts and

experiences of these professionals as they tackle the difficult task of recruiting and maintaining appropriate clinical educators.

Encouragingly, when asked whether they felt that their students currently had sufficient access to quality external clinical education placements, 91 percent responded affirmatively. However, 70 percent of these same respondents reported that they are also concerned about maintaining or obtaining sufficient access to quality external clinical education placements in the near future. And 38 percent of respondents reported that they have recently noticed decreases in the number of external clinical placements available to their students.

One important reason that many university programs may be experiencing decreases in the number of clinical placements is the CFCC requirement for clinical educators to maintain the CCC-A. When asked whether there were external clinical placement sites that the clinical education coordinators felt would provide fruitful learning experiences for students, but which were not utilized solely due to the requirement

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Certification has become an optional, adjunct credential, not necessary for clinical practice or reimbursement.

for ASHA-certification of clinical educators, 56 percent of respondents said, “yes.” Fifty-six percent of our university programs are reporting that they are being forced to choose between quality clinical education and certification, and they are choosing certification.

A Lack of Evidence

If certification of the clinical educator ensured quality clinical education for the student, the requirement would be justified regardless of the bottleneck that it creates. However, it is clear to most that generalist certification does nothing to ensure quality for clinical education.

When the clinical education coordinators mentioned previously were asked whether they believed that the requirements for obtaining ASHA certification in audiology, beyond the requirements necessary for licensure in their state, helped to prepare audiologists to be effective clinical educators, the response was overwhelmingly “no” (75 percent).

The CFCC requirements make no mention of training or study in the art and science of clinical education, for either obtaining or maintaining certification (CFCC, 2011). And the question is really intuitively simple. If you are a great clinical educator and decide to drop your certification, does this automatically make you a poor clinical educator? If you are a poor clinical educator, does the decision to pay for your certification annually transform you into a good clinical educator?

Furthermore, there is little to no evidence to support the notion that certification does anything to make one a competent clinical educator, yet it is the single most utilized qualification for clinical educators, not formal training in methods and theory of clinical education; not review of the literature on clinical education; not mentorship by university faculty or experienced clinical educators; not even an arbitrary number of years of clinical experience. The most universal requirement for a clinical educator is possession of entry-level certification in audiology.

Indeed, the reliance on generalist, entry-level certification as a qualification for clinical educators is also troublesome because it lulls us into believing that we have a meaningful method for choosing and evaluating who will provide clinical education to our students, when this is far from the case.

A Conflict of Interest?

We have no meaningful reason to believe that requirements for clinical educators to have entry-level certification improve clinical education. In fact, they may have a negative impact by limiting the number of qualified clinicians available to provide clinical education. Given this situation, we must wonder why the “requirement” for ASHA certification of clinical educators exists.

ASHA’s CAA standards for students to graduate prepared for national certification and ASHA’s CFCC requirement that students must graduate having had clinical supervision provided by an ASHA-certified audiologist in order to qualify for certification has every appearance of a conflict of interest. We must ask ourselves, “Is the CAA working together with the CFCC to use the clinical education of students as a means to maintain audiology certification by ASHA?”

If not, why is certification treated so differently by the CFCC for audiology and for speech-language pathology? For decades, certification was treated similarly for these two professions, with applicants able to obtain certification following postgraduate training. This model is still utilized by speech-language pathology, but now audiology applicants may not obtain clinical training as a postgraduate for this purpose. The training must occur during the academic program. What rational explanation can there be for this? Could it be that ASHA-certified audiologists who are not under the purview of the university, who provided postgraduate training for years, are no longer capable of doing this? Could it be that the CFCC views ASHA-certified speech-language pathologists as fit to provide postgraduate training but

ASHA-certified audiologists as unfit? Or could it be that by forcing university programs to provide ASHA-certified clinical hours, rather than allowing students to choose this particular training qualification for themselves, the CFCC and CAA are seeking to compel audiologists, who might otherwise not, to obtain and maintain certification, simply for the purpose of having the option to provide clinical training to students?

We might also wonder why the CFCC requires that, after January 1, 2012, audiologists who drop their certification for any period of time will be required to have a doctoral degree for reinstatement of certification. If you are a qualified master's-level audiologist and you choose not to maintain your certification, why would you be considered unqualified for entry-level practice upon choosing to reinstate your certification? If you are competent to practice today, why would you be incompetent a year from now simply because you decided not to pay for the certificate? Could the purpose for these particular changes be to scare audiologists into maintaining their certification and to scare young audiology students into pursuing a certificate?

We have a right to expect clear and legitimate answers to these questions.

Looking Forward

Whether you are a current or former student, a clinical educator, or an academic instructor, if you have been confused by the process of clinical education, it is with good reason.

The goal of good clinical education is not merely a nice wish, important only to current students and academic faculty. The ability to demonstrate consistency and effectiveness in clinical education is an absolute necessity for continued recognition as an autonomous and serious health-care profession. We all have a stake in ensuring excellence in clinical education, and we can all contribute to the improvement of clinical education in audiology.

Clinical educators can insist on clear information from university programs regarding the goals and expectations for students entering and exiting their clinical training sites. This will, at the very least, provide direction to the clinical education of students. Importantly, clinical educators can also insist on being included in the national discussion on clinical education. Clinical education standards and methods have traditionally been decided upon by academic institutions, with little input from those who are actually providing the bulk of clinical education—and who are almost invariably volunteering their time and efforts. Clinical educators have a primary

commitment to their patients and practices. There are certain real-world realities that clinical educators must face, including billing issues, attitudes and behaviors of the Millennial-generation students, and time constraints, to which university programs simply must be responsive.

University programs can insist on clear information from accrediting bodies. University faculties are a powerful force in our profession. When the requirements of accrediting agencies conflict with the ability of university programs to provide the best clinical education for students, they must hold accrediting agencies accountable rather than submitting to unproductive standards.

All of us, students, clinicians, and faculty, can ask questions of ourselves, our institutions, and our national organizations. We can also insist that priority be given to establishing an evidence base for clinical education outcomes and processes for the purpose of establishing meaningful and effective standards and methods.

We cannot afford to stand by, failing to notice our own nakedness, while the procession goes on. 

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