December 3, 1991

Editor, American Journal of Audiology:

We read with great interest our distinguished colleague, Dr. James Jerger’s “Viewpoint” (Milestones and Boundaries) in the inaugural issue of the American Journal of Audiology (AJA). Dr. Jerger’s point that “a truly autonomous field or discipline is defined by a broadly-conceived mission” is well taken. Our interpretation of this statement, however, is different from that of Dr. Jerger. A broadly conceived mission should not be restricted to the narrowly defined scope of communication disorders. Although we do not believe that “what we do is what everyone else should be doing,” we do believe that in the 1990s there is room within our field for new and advanced clinical practice areas that have been appropriately earned by many of our colleagues through innovation, learning, and experience. The distinction between technician and clinician should not be based on what the individual does, but how the individual functions in a certain healthcare environment. One can argue that an audiologist performing predominantly pure-tone audiometry, without active participation in patient counseling and management, acts as a technician despite functioning within the narrow confines of communication disorders. Conversely, an audiologist managing a balance function program, including interpretation of results and the active participation in the administration of therapeutic measures, indeed functions as a clinician. In fact, the areas singled out by Dr. Jerger for exclusion from the scope of practice of audiologists have been recently accepted by the Legislative Council of ASHA for inclusion in the scope of practice. Opposition to the inclusion of new clinical practice areas into our field is counterproductive. We need instead to channel our efforts and energies to continue to improve our skills, influence training programs to provide up-to-date and relevant, state-of-the-art education, and continue our efforts to enhance our professional and economic status.

Sincerely,

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Reply to Kileny and Shepard

Kileny and Shepard’s letter exemplifies the kind of dialogue that we so desperately need on matters that may profoundly affect our professional future. I am more than a little depressed, however, that they find the field of communication disorders too “narrowly confining.” From my perspective, there is still a good deal of interesting work to be done. We continue to lack, for example, a satisfactory method for evaluating the performance of hearing aids, and have almost abandoned this whole area to our colleagues in engineering. Why not spend some time thinking about that one? There is another very large terra incognita in the evaluation of children with central auditory processing problems. There are few satisfactory test instruments and there is little rationale for effective intervention. We don’t even have a consensus on how to define the disorder. Yet the prevalence of this potentially serious communication disorder far exceeds the number of dizzy people by anyone’s way of counting. These are just two examples of the many challenging problems still facing us within the “narrow confines” of communication disorder.
We seem to agree that a field must be defined by a “broadly conceived mission,” but we are not in perfect harmony on what “broadly conceived” means. I take the entire concept to mean that whatever breadth we strive for must be contained within our uniquely defined mission—helping people with auditory problems function more effectively as communicators.

But Kileny and Shepard find this definition overly restrictive. For them it is apparently appropriate to include any new or advanced clinical area in which a person qualifies by virtue of “innovation, learning and experience.” The problem with this approach is that, without some kind of rational boundary, we are quickly led to a reductio ad absurdum. What about electroencephalography (EEG), for example. Here is an area with considerable relevance to auditory evaluation. So why not, through innovation, learning, and experience, include the administration and interpretation of EEG within our scope of practice? Because, gentle reader, we would be very quickly notified of the fact that we were treading on someone else’s turf. And they wouldn’t like it. Not one little bit. “But,” you might reply, “no one is telling us that ENG is somebody else’s field. In fact, the medical people asked us to do this. They needed us! They were glad to have us!” To which I would just observe that, from an historical perspective, this was a marriage of convenience for both parties at a particular moment in time. But marriages of convenience have a way of falling apart, often in a particularly ugly fashion, when one of the partners no longer finds it convenient.

So where do we draw the line? And who draws it? I would argue that each individual must draw the line for her/himself, based on a clear understanding of how our turf is defined by our mission. In this context, professional organizations should articulate the mission and formalize the consequent boundaries, quite independently of what some people happen to be doing or how they “function in a certain healthcare environment.” In this connection, the action of the Legislative Council of ASHA seems more self-serving than persuasive. It is rather like the Confederate legislature agreeing that slavery is ok because, “look at the fine people who are doing it.”

It is difficult for me to understand how the diagnosis and treatment of dizziness, or the monitoring of somatosensory evoked potentials during brain surgery, can ever be within the scope of audioligic practice.

Do it if you must, respected colleagues. But please don’t confuse it with our real mission.

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