



**Ensuring Audiology's Future in Healthcare:
Owning the Profession through a Culture of Practice Ownership**

Practice Model Task Force:

Larry Engelmann, Au.D., Chair

David Berkey, Au.D.

Tabitha Parent Buck, Au.D.

Gretchen Syfert, Au.D.

Melissa Tamres, Au.D.

Susan Williamson, Au.D.

"The best way to predict the future is to create it." — Peter F. Drucker



ACADEMY OF
DOCTORS OF
AUDIOLOGY®

Introduction

The Academy of Doctors of Audiology (ADA) puts forth the following position paper to both challenge and inspire the audiology community, to move audiology to its next evolutionary level, to achieve a better tomorrow, and to ensure a strong position for audiology in healthcare.

The future of the audiology profession and the provision of comprehensive and effective patient care will be best served by audiologists securing ownership of the audiology profession. This will be accomplished by strategically ensuring that practice ownership is the predominant practice model for audiologists, consistent with the recognized character and success of other traditional doctoring healthcare professions.

Audiology and healthcare are continually impacted by internal and external forces, including government regulations, industry consolidation, corporate buyouts, educational requirements, and changing scopes of practice. Therefore, constant adaptation is necessitated by the dynamic forces which exist within our professional environment. Since the late 1980s, audiology has continued to transition in an effort to achieve several goals. These goals include: effecting changes in the Standard Occupational Classification Code; becoming an autonomous profession; becoming a doctoring profession; obtaining Limited Licensure Practitioner status; developing an enriched curriculum with the Au.D degree; and acquiring Direct Access to audiology services by Medicare recipients. Significant progress has occurred towards accomplishing these goals.

ADA has developed this position paper over the past several years (see Appendix A). Extensive peer review of this position paper included surveys of various constituents. A key survey question is noted below in Table 1.

Table 1. “What is your level of agreement in moving audiology from primarily a ‘wage-employment’ to primarily an ‘ownership’ practice model?”^{1,2,3}

Level of Agreement in Moving Audiology from a ‘Wage-employment’ to an ‘Ownership’ Practice Model			
	Strongly agree or agree	Neutral	Strongly disagree or disagree
ADA Members (n=135)	91.4%	6.3%	2.3%
Au.D. students (n=55)	80.0%	16.4%	3.6%
Au.D. faculty (n=67)	56.7%	28.4%	14.9%

At this early stage ADA is encouraged by the responses. Over 80% of students and ADA members, and nearly 60% of faculty responded “strongly agree or agree” to this survey item. Only a small minority of each group, (less than 15% responded in each category) responded “strongly disagree or disagree”.^{1,2,3}

Terminology

The following terminology is defined here for the purpose of clarity and common understanding throughout the paper:

- **Autonomy:** Autonomy is the right of self-governance, e.g., establishing codes of ethics and licensure laws.
- **Independent:** Independent means that the practitioners have the ability to freely exercise their self-determined professional judgments and clinical decisions.
- **Ownership of the audiology profession:** This phrase refers to the persons or business entities who own and control (make the business decisions) audiology services. Those who do will consequently own and control the audiology profession.
- **Self-employment:** The Small Business Administration (SBA) makes a distinction between “self-employment” versus “wage-employment”. Self-employment is synonymous with practice ownership. Practice ownership represents a broad description of how audiology doctors practice, now and in the future. Individual practices may vary in type and scope of services, ranging from a general practice covering a range of diagnostic and therapeutic services for a large patient demographic, to a more specific specialty practice. Practice ownership takes many business forms, such as solo practice, partnerships or group practice models that may involve other audiologists or interdisciplinary partners (e.g. ENT physicians, optometrists, and physical therapists), as well as various corporate structures. Practice activities may involve part-time or full-time work. Practice owners may also provide services to hospitals and clinics. Even public schools can be served by practice owners through contractual relationships rather than by wage-employed audiologists. Practice owners are autonomous, practice independently, and have an equity position in the practice.
- **Wage-employment:** Wage employment means working for a wage and without an equity position in the practice setting.
- **Clinical Rotations:** Clinical rotations refer to the experience of earning academic credit and receiving clinical training in varied types of clinical settings, internships and externships by an Au.D. student.
- **Professional Socialization:** Professional socialization is the process by which individuals acquire, through the educational and the post-graduate professional environments, specific characteristics, knowledge, skills, attitudes, values and norms regarding their professional roles.

Who Should Own the Audiology Profession?

ADA's position is that audiologists should own the audiology profession and not relinquish control of it to external groups or non-audiology individuals. A convincing argument can be made that this is not currently the case. Recent surveys indicate 21% of audiologists report their full-time primary work setting as "private practice", and 14% list themselves as practice owners.^{4,5} This means that as much as 80 – 85% of audiology services in the United States are owned and controlled by non-audiologists. This is in stark contrast to other healthcare doctoring professions whose successful structural characteristics and models have prospered for well over 100 years. Practice ownership is the standard in optometry (75%), dentistry (93%), and podiatry (95%) rather than the exception.⁶⁻⁸

Challenges from Outside the Profession

Unless audiologists take ownership of their profession, challenges from outside the profession will continue to encroach upon audiology's independence and autonomy. For example:

- a) **Medical Media Reports:** Medical Economics published a series of 12 articles on "Adding Ancillaries: Boosting the Bottom Line" for physicians. Audiology was listed as "other ancillaries" along with laser hair removal; nutritional counseling; flexible sigmoidoscopy; counseling for smokers; and botox injections.^{9,10}
- b) **Physicians:** Currently, the single largest practice setting for "wage-employed" audiologists is ENT physicians (otolaryngologists). The Coalition for Hearing and Balance (CHB) comprised of the American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS), American Neurotology Society (ANS), and the American Otological Society, Inc. (AOS) was formed because of changes in healthcare delivery. CHB developed an "otologic technician" training program, the purpose of which is to train personnel to perform basic audiometric and vestibular testing under the supervision of physicians.¹¹
- c) **Hearing Aid Dispensers:** Some hearing aid dispensers hire audiologists to provide audiologic care in their businesses. This practice has the potential to create confusion among consumers of hearing care as to the relative roles and training of each professional. This relationship does not exist in other doctoring professions; e.g., dentists, optometrists, or physicians are not employed by dental hygienists, opticians, or physician's assistants, respectively. In the profession of audiology, there are also examples of the reverse, i.e., audiologist practice owners who hire hearing aid dispensers to provide hearing aid services as an alternative to the expense of hiring an audiologist with a graduate or professional degree.

d) **Industry:** The following are comments from several industry leaders who responded to the ADA Vision Whitepaper Industry Survey:

- The largest external factor that was not considered was the role of manufacturers' ownership of hearing healthcare practices. It needs to be considered.
- I think it's far more likely that the large hearing aid manufacturers will own practices and a majority of the audiologists will be working in these networks or retail chains.
- The future of independent audiology will be driven by the availability of practice ownership, and the current trends in the U.S. industry indicate that further consolidation and ownership by manufacturers will preclude an increase [in practice ownership] from happening. ADA should consider a capital source that allows for audiology practices to remain truly independent to give audiologists the chance to pursue ownership.¹²

The objective of this position paper is to provide a plan for building a more solid foundation and stable infrastructure for our profession to meet and to overcome these challenges.

Importance and Value of Ownership

The value of ownership models should not be underestimated. A 2007 Small Business Administration report to the U.S. president details the vital role that the 26.8 million small businesses in the U.S. play in the economic well-being of our nation. The report describes that new business entrepreneurs provide long-term benefits to the local economy, contribute to maintaining economic growth, employing workers and bringing new innovations to the market place. In addition, a state's ability to generate new establishments is reported as the most critical factor leading to higher gross state product, state personal income and overall state employment.¹³

The following audiology leaders realized even early on that ownership was critical to the future of the profession:

1976: Leo G. Doerfler, Ph.D., one of the founding members of ADA, realized the growth, success, and future of audiology would ultimately pivot on practice ownership. Dr. Doerfler assumed substantial risk to his personal resources and reputation when he started one of the profession's first private practices in 1976.¹⁴

1993: Earl Harford, Ph.D., described audiology's history, struggles, and professional maturation:

Now, we are in need of our autonomy. Another gauntlet is lying at our feet. This one is for our professional independence, and it is time to take it up. As long as we are a 'kept profession', we will never enjoy true

professional independence. Our professional autonomy is directly dependent upon our financial independence. The key to financial independence is a viable private practice structure. To be able, at any moment, to sacrifice what we are, in order to be what we could become, is a quality of genuine maturity.¹⁵

1995: Practice ownership in audiology gained popularity since the formation of ADA in 1977. James Jerger, Ph.D., noted that “As audiology moves into the 21st century, one of the most dramatic trends will be the growth of private practitioners. In a very real sense private practice will form the financial foundation for the profession.”^{16(pvii)}

2008 Robert Glaser, Ph.D. and Robert Traynor, Ed.D., M.B.A., noted:

Independent private practice is a growing sector of audiology. Practitioners are choosing not to practice in hospitals, clinics, and ENT practices which are increasingly viewed as restrictive to professional autonomy and/or financial opportunity. Private practice has now become a “new frontier” for entrepreneurial audiologists.^{17(p2)}

Benefits of Ownership

The Profession

- **Increased public recognition of audiology:** Many practice owners will invest about 10% of the practice’s gross earnings for marketing and advertising. For example, an audiology owned practice grossing \$500,000 per year may spend \$50,000 per year on consumer education in promoting the practice as well as audiology. Increased public education by audiologists should encourage more patients to seek audiologic care directly from independent practitioners.
- **Improved inter-professional relationships with other healthcare providers:** Audiology practices will be held in higher regard when the practice model is more closely modeled after other independent providers.
- **Maintenance of independent clinical decision-making and responsibility for the audiology care provided to patients:** The profession is better positioned to fund legislative, regulatory, policy and community service efforts to benefit patients and the profession when audiologists can contribute to a greater extent. For example, Foltner and Engelmann report that as income increases, Political Action Committee (PAC) contributions increase.¹⁸ Table 2 illustrates that presently, audiologists contribute less PAC money per member than other doctoring professions.

Table 2. 2006 PAC Election Cycle¹⁸

2006 PAC Election Cycle		
Profession	By per member population	Total PAC
Podiatry	\$68.53	\$788,142
Optometry	\$33.17	\$1,127,784
Otolaryngology	\$32.29	\$322,999
Dentistry	\$15.37	\$1,921,682
Chiropractic	\$14.70	\$294,149
AAA Audiology	\$13.15	\$131,537

Au.D. Programs /Faculty

- **Better positioning to compete for strong pre-professional students:** According to the ADA 2007/2008 Vision Whitepaper Student Survey, 75% of the Au.D. students come from the historical undergraduate programs in Communication Sciences and Disorders rather than from the pre-professional curricula expected by other healthcare doctoring professions.³ As audiology transitions to the Au.D. model as well as to the model of practice ownership, additional applicants, such as those commonly attracted to optometry, dentistry, or podiatry, would be drawn to audiology programs. An expanded pool of applicants should contribute to an enriched educational environment.
- **Increased Alumni Support:** Foltner and Engelmann give us a glimpse at audiology and optometry from the Pennsylvania College of Optometry (PCO), which houses both an optometry and audiology school in Table 3. Foltner and Engelmann reported: “Those with doctoral degrees and the corresponding increased earning power gave more than those with master’s degrees. Also, a higher percentage of those with a larger income (i.e., optometrists) donated larger sums of money.”¹⁸

Table 3. PCO Fund Raising by Degree¹⁸

PCO Fund Raising by Degree			
	FY 2007 total alumni population	Funds raised per graduate in 2007 - total graduate population	Average gift per donation in 2007
OD	22%	\$63 - \$95	\$287 - \$435
Au.D.	16%	\$19	\$117
Master’s	7%	\$3	\$43

- **Higher availability of preceptors for audiology owned practice rotations:** 15% of the ADA membership responded to ADA's 2007/2008 Vision White Paper Member Survey, and of those respondents 23.6% are currently preceptors, 18.0% are interested in becoming preceptors, and 35.0% are possibly interested in becoming preceptors, for a total of 76.6% potential ADA practice owner members as preceptors.²

[RTF bookmark start: }_Toc187209690

Practitioners

- **Increased lifetime earning potential:** Table 4 shows the 2006 income data reported by the American Academy of Audiology reports for its members, representing Mean Total Compensation (Salary + Bonus + Commission) for each full-time Primary Work Setting. The largest category of employers for audiologists is currently ENT physicians. The mean annual compensation for the wage-employed audiologist in ENT practices is \$69,374. Audiologists who are practice owners earn \$110,000 annually.⁴ If these figures were consistent over a 30 year career, the lifetime earnings of the wage-employed audiologist at an ENT office would be \$2,081,220. The same calculation for the audiology practice owner yields a lifetime income of \$3,300,000. In a 2001 article, Engelmann and Burba explained that the financial gap at the end of the professionals' careers actually will be widened further by the investment growth accumulated in the two different groups' retirement accounts.¹⁹ Practice owners commonly can make larger tax-deferred contributions, have a business which can be sold, and possibly real estate to sell or rent, unlike the wage-employed audiologist.

Table 4. Audiologists' Mean Annual Compensation⁴

Audiologists' Mean Annual Compensation	
Primary Work Setting	Mean Total Compensation
Hospital	\$67,963
ENT Practice	\$69,374
Private Clinic (non-profit)	\$70,771
Public/Private School	\$72,131
University	\$72,135
Univ./Teaching Hospital	\$74,656
Other Medical Practice	\$76,344
Other	\$77,474
Federal Government	\$84,922
VA Hospital	\$85,511
Private Clinic (for profit)	\$88,588
Private Practice	\$99,133
Manufacturer	\$105,420
Industry (Industrial Audiology)	\$106,388
Practice Owner	\$110,000

- **Independence:** Guglielmo explains how physicians involved in practice ownership not only enjoy what they do but are also establishing new practice models. He states:

Small practice owners like being small and reject the notion that bigger is better – or that becoming an employee is a panacea. Independence is part of the allure. A solo practice, or even a group of two, three, or four physicians, makes it easier for doctors to be their own boss, set their own hours, choose their own staff, and be the captain (at least partially) of their own destinies. They're also happy to be free of the typical corporate hassles – the top-down decision-making, the dictates of an owner or CEO, and the expected or mandatory committee service – that comes with larger groups.^{20(para2-3)}

- **Decision-making:** Professional care is directed by practitioner choices, rather than employer dictates.
- **Increased Earnings:** Increased earnings allow reinvestment in the practice and the ability to continually incorporate new technology.
- **Autonomy:** As the percentage of practice owners grows, the availability of equity positions in practices will likewise increase. This will strengthen professional autonomy and unity.

Students

Audiology students will benefit from an enhanced curriculum to include practice development and management coursework, as well as clinical rotation experiences in audiologist-owned practices. A practice ownership track will be an attractive and viable career option for graduates, allowing for higher income to be achieved and repayment of student loans with less hardship. Newly graduated doctors of audiology who pursue equity ownership in their practice careers will provide effective independent care of patients, become autonomous doctors, control their personal and professional time, receive increased financial compensation; and experience enhanced career satisfaction and security.

- One of the main reasons cited by dentists and dental students for pursuing a career in dentistry was to "be their own boss".²¹
- Over 88% of the graduates from dental schools in 2000 indicated the most important factor in selecting dentistry as a career was the ability to "control their time of work in relation to family and personal interests." The factors of "self-employment" and "service to others" were equally ranked as the second most important factor by 82.5% of the seniors.²²
- The retirement of optometrists and the establishment of new offices create most of the new opportunities for graduates.²³

- Practice ownership/partnership enhances professional and personal prosperity over the professional's working career. It should also reduce the likelihood of career dissatisfaction and relocation. Most American Podiatric Medical Association (APMA) members in practice were owners rather than employees. Solo practice was the primary arrangement of most respondents in 2005 (3079 members responded), as it was in previous surveys. Older podiatric physicians (>45 years) tended to be in solo practice, whereas younger members (<45 years) were more likely to be in group practice.⁸

Patients

As patients become better educated, their expectations for superior care are consistent with the qualities found in successful audiologist-owned practices. Practice ownership allows for many freedoms that enhance patient benefit, including the ability to:

- set standards for length, type, and frequency of patient contact;
- have more latitude in developing patient education programs;
- have more freedom in developing supplementary services;
- achieve enhanced overall patient satisfaction through personalized care by the doctor and ancillary staff;
- have more of a personal vested interest in strengthening the doctor-patient relationships.
- have greater freedom to establish their practices in more convenient locations for the patients;
- have the latitude to provide expanded office hours to better meet the needs of their patients;
- respond more swiftly to product changes as technology advances, allowing consumers to receive "state-of-the-art" audiologic care;
- provide stability and longevity to the practice in order to provide services year-after-year;
- provide pro bono treatment and services for those in need.

Industry

Industry includes many businesses and manufacturers covering a variety of sectors, such as hearing aids, diagnostic equipment, assistive listening devices, and telecommunications. Audiologists who are practice owners have the authority to determine manufacturer, product and equipment choices as they are the decision makers.

Influences That Could Affect How and When Audiologists will Own Audiology

Au.D. Programs/Faculty

As gatekeepers of the audiology profession, educators and training programs have a significant and important impact

on the future practice of the profession. They are responsible for the type of students recruited and admitted into the Au.D. programs, who will enter the profession, and also how well the young practitioners are prepared.^{24,25} For roughly 60 years, the "career counseling" aspect of audiology students' professional socialization has clearly been dominated by a wage-employment model for audiology practice following graduation.

Preceptors are in reality adjunct faculty. It should become a high priority of Au.D. programs to establish guidelines for preceptor training and to engage preceptors in the process of students' professional socialization.

Business Education Courses and Externship Rotations

An essential component to establish and solidify audiology's owning the audiology profession is the availability of practice development and management courses and clinical teaching in academic programs and continuing education opportunities.

In 1995, James Jerger, Ph.D., noted:

...it is widely lamented, however, that audiology-training programs are notoriously deficient in preparing students for the private practice arena. The audiologist who contemplates private practice has been ill-prepared for the vicissitudes of the business world and typically doesn't know where to turn for help.^{16(pvii)}

Cardall, et al reported on several aspects of dental education, noting that "Students commonly perceived clinical experience to be the most important aspect of their education. As students neared graduation, they perceived business management as more important and lab work as less important."^{26(p600)}

In 2006, Fagelson analyzed 59 Au.D. programs' curricula.²⁷ As of July 2005, 42.4% did not offer required or elective courses that were categorized as "Business Management/Practice/Leadership". In April, 2007, ADA's Practice Model Task Force reviewed 67 Au.D. programs. Of those programs, 31% had no identifiable course listing that resembled business, practice development, or practice ownership education. Some courses appeared to be more "survey" courses combining business aspects with peripheral topics such as licensure and ethics. These courses did not provide a strong focus on establishing, maintaining, and succeeding in practice ownership. In addition only four programs required more than one course in this topic area. A look at these statistics indicates a slight trend towards programs offering more Business Management/Practice/Leadership courses. This can be interpreted as a positive indicator that the audiology programs are moving in the right direction.

In response to the ADA's 2007/2008 Vision White Paper's faculty and student surveys, 48.8% of faculty and 36.4% of students who responded reported that their Au.D. programs required at least a "partial private practice extern rotation".^{1,3} There is a definite gap between didactic and clinical teaching. It is difficult to transmit a "culture of practice ownership" if students are not exposed to it in real-life.

Audiology Certification

Audiology certification via the Certificate of Clinical Competence in Audiology (CCC-A) remains controversial, primarily because it has been so enmeshed with state license laws for audiologists in past years and can sometimes be seen in employment qualifications. Currently, there is still a great deal of pressure put on students in Au.D. programs to pursue American Speech-Language-Hearing Association (ASHA) certification, despite the fact that all, or almost all, state license laws do not require the CCC-A as a qualification for licensure. Although certification is not a requirement to practice, it exists in the language of some laws with a statement such as "or equivalent", and presenting documentation of CCC-A may enhance portability of the right to practice from state to state via reciprocity. It is beyond the scope of this paper to fully address the concerns and solutions. However, certification still has broad impact on students' exposure to audiologist-owned practices in clinical rotations. A large number of practice owners have ceased to maintain their ASHA certification. Students who desire to complete certification cannot receive credit towards this if their preceptor is not certified as well.

In ADA's 2007/2008 Vision Whitepaper Student Survey, more than half the respondents believed that the CCC-A was required to practice audiology upon graduation.³ It is likely that many students are unsure of the value of ASHA certification and would be reluctant to accept rotations in settings that do not provide credit towards that end. In particular, when audiology faculty encourages students in the certification path, the real-world result is often a shortage of quality clinical rotations with practice owners.

Program Accreditation

The accreditation of audiology training programs is in transition. For the vast majority of training programs in audiology, ASHA's Council on Academic Accreditation (CAA) is still the accrediting body. One of the tenets of CAA's accreditation process is to assure that the curricula lead to eligibility for that organization's CCC-A certification.

In an effort to address this dilemma and move towards an independent accrediting body, in 2003 the Accreditation Commission for Audiology Education (ACAE) was formed through the efforts and initial financial support from ADA and AAA, with additional contributions from the Audiology

Foundation of America (AFA). It is the position of ADA that the best interests of the profession and professional training would be served by transitioning all professional training program accreditation to the ACAE. An independent audiology accrediting body is another beneficial and logical step in the maturation of our profession that will contribute to strengthening the program curricula and the appropriateness of required learning objectives.

Student Debt and Practice Ownership

Much of the momentum and desire to achieve the objectives in this position paper must come from audiology students. In a recent ADA survey of 99 residential audiology students' career plans, 78.5% rated "compensation" and 63.9% rated "control/autonomy of practice" as "very strong" or "strong" influences on their career choice.³ In 2002, Doyle and Freeman reported that out of 76 first through fourth year residential audiology students surveyed, 61% indicated that they intended to own their audiology practice.²⁸ We must encourage those audiologists who wish to pursue practice ownership by providing the necessary business and financial knowledge as well as strategic mentoring. ADA is committed to providing this support under its organizational mission.

In professional doctoral education, students in four year programs commonly accumulate close to \$100,000 in loan debt by the time they graduate. It can be difficult for a new graduate to view this debt as an investment in their professional future. The Pennsylvania College of Optometry (PCO) recognizes this and provides financial and debt management counseling to professional students throughout the four year program.²⁹ This provides a model and establishes an early foundation for responsible financial planning and debt management that is necessitated in a practice ownership environment. This preparation can also help young audiologists overcome the fear regarding the costs involved in practice ownership by providing knowledge and options early in the experience.

Financial Risk and Private Practice

In October 2007, the Executive Committee of the National Association of Future Doctors of Audiology (NAFDA) reviewed the draft whitepaper and gave the ADA Task Force the following feedback: "... the risk and significant financial seed-money needed to purchase an existing practice or finance a new practice makes for a daunting task upon graduation." Further, they commented that, "In that same realm, statistics show that a large number of small businesses will fail in the first five years. ...This should not necessarily be considered a reason not to work in private practice, but more a caution that those entering private practice should be fully educated about the risk and how to minimize that risk as much as possible."

Kent Faison, a banker who has worked with professionals for years who are transitioning from their student loans with his bank to acquiring professional business loans notes that:

The Small Business Administration [SBA] offers an excellent opportunity for medical professionals looking to finance the startup of a new practice, the acquisition of an existing practice, or the expansion of an existing practice. Programs offered by the SBA allow banks to provide favorable financing terms that include longer repayment terms and reduced equity and collateral requirements. These terms provide a foundation for success, but the ultimate success is based on the entrepreneurial drive and passion of the professional.³⁰

Faison also explains that “Medical professionals have one of the highest success rates according to the SBA. For the six year period ending 9-30-06, the weighted average failure rate for medical professionals is 3.11%.”³⁰

Although stand-alone data for audiologists is unavailable, Faison notes that for a category in which audiology is combined with physical, occupational and speech therapy, the loan failure rate is 1.77%, which compares favorably to the other doctoring professions.

Preconceptions should not be held on how and when one may enter into practice ownership. As future generations are better prepared to understand the “business of audiology”, they will be more inclined to plan for and seek practice ownership early in their careers. Many may seek employment agreements that will enable them to gradually earn their way to partner or owner status, while others may desire to go out on their own or find a partnership arrangement.

Many audiologists choose to pursue careers in research, academia, military audiology positions or industry, rather than to become practice owners. These audiologists provide contributions that are part of the backbone of our profession and are not to be undervalued in any way. In fact, those contributions are essential for our profession. But while these alternate paths are viable and necessary elements in the landscape of the entire profession, the predominant practice model should be one of practice ownership for audiology to take its place among the doctoring professions, and for audiologists to take ownership of audiology.

Strategy and Recommendations

Practice Ownership

To achieve the objectives in this position paper, audiology will need to emulate the equity models of other healthcare doctoring professions and develop models of ownership acquisition that simultaneously allow for sufficient annual

income to service student debt, while building equity in a practice. Such models can include: installment purchases; “earn-out” agreements; employment agreements leading to equity positions; and starting a new practice. At the same time they must address the conventional concerns of young practitioners (e.g., home ownership, raising a family, saving and investing for the future).

To succeed in practice ownership, stakeholders will need access and exposure to appropriate educational and financial resources, practice management models and career guidance. The profession as a whole will need to experience a paradigm shift from wage-employment practice models to practice ownership models, characteristic of other doctoring professions. ADA already embraces this viewpoint, as evidenced by the 2007 ADA Survey in which 65% of ADA member-respondents described themselves as practice owners, and 25% of respondents not in private practice expressed interest in starting one.²

Business Education

Business education needs to be more widely available to Au.D. students as they complete their training. One option is for third party education providers to develop a comprehensive business curriculum for audiologists that can be incorporated into residential programs on a rotating schedule. This curriculum could also be provided through online programs for both students and current practitioners. Professional associations such as ADA could act as a clearinghouse for this type of activity, with the additional support of industry when appropriate.

The ADA has a long established tradition of providing continuing education in business content areas, and can help establish beneficial and appropriate learning outcomes for business courses, in conjunction with academic program faculty and accreditation standards. Audiology practice owners can provide necessary insight regarding the skills and underlying knowledge which are key to practice development and management in audiology.

Preceptorship

Providing direct exposure to audiologist-owned practices via clinical rotations for all students is essential. The ADA will assist by encouraging practice owners to serve as preceptors, by developing training programs for preceptors and establishing a database of preceptors. Practice owners are uniquely positioned to provide direct experience on the application of business principles, and to provide support for students who desire to be practice owners as they progress in their audiology careers.

Communication strategies and mechanisms must be developed to establish and strengthen relationships with primary

influencers (Au.D. program faculty, students, practitioners) that will help drive the idea of practice ownership as a normal career objective, rather than as an exception.

Recommendations for Achieving Critical Objectives

The following recommendations are made with an understanding that involvement of the entire audiology community, including all professional associations and the audiology educational leadership and industry, is needed and necessary to move these objectives forward:

1. Continually identify and promote best business practices for practice owners.
2. Provide access to continuing education and networking opportunities that focus on business knowledge and learning for current practice owners and their employees.
3. Create, promote and define professional ownership mentoring opportunities (for both peer-to-peer and owner-student pairs).
4. Develop and promote descriptions of practice ownership alternatives that are feasible, affordable, and address the current and future concerns of all partners and owners, buyers and sellers, as well as the needs of those beginning a new practice.
5. Provide professional socialization that promotes the desire to *own the profession through practice ownership* to current and future students in audiology training programs.
6. Establish business education opportunities for current wage-employed practitioners desiring or considering practice ownership.
7. Make business education and peer support accessible and affordable in both real and virtual communities.
8. Expose all audiology students to practice ownership through clinical rotations in audiologist-owned practices.
9. Create an ADA Member Preceptor Training and Placement Program which simultaneously meets the needs of the preceptor, student and educational institution.
10. Ensure quality of training programs and audiology graduates through support of the ACAE accreditation process.

Summary and Conclusions

The future of the audiology profession and the provision of comprehensive and effective patient care will be best served by audiologists securing ownership of the audiology profession. This will be accomplished by strategically ensuring that practice ownership is the predominant practice model for audiologists, consistent with the recog-

nized character and success of other traditional doctoring healthcare professions.

Audiology has made great strides in its evolution to a doctoring profession. We hear much talk about “autonomy”, or self-governance of our profession. We also strive to be “independent”, or to be able to freely exercise our self-determined judgments and clinical decisions. What we, as a profession, have not considered is the question, “Who owns the audiology services provided by audiologists?” We cannot expect to be fully in charge of our profession’s destiny and to truly have autonomy and independence unless we also have ownership of the profession.

For over 60 years, audiology was an allied healthcare profession that was professionally socialized to accept the “wage-employment” practice model as the norm. Consequently, only 15-20% of the audiology services in the United States are owned and controlled by audiologists. The other 80-85% of audiology services owned by non-audiologists represents millions of dollars of revenue per year leaving the audiology profession that audiologists are unable to utilize to best serve the profession, themselves, and their patients. In the traditional healthcare doctoring professions, professional practices are *predominantly* owned by the respective doctors.

An essential component to enable audiologists’ ownership of the profession is the availability of practice development and management education through coursework in academic programs and clinical rotations for students. As of 2007, two-thirds of existing Au.D. programs had course listings that were related to business, practice development, or practice ownership education. Yet, less than half of faculty, and only one-third of students reported that their Au.D. programs required at least a “partial private practice extern rotation”. There is a definite gap between didactic and clinical teaching. Furthermore, in over 30% of the programs there were *no* business or practice management courses offered. It is difficult to transmit a “culture of practice ownership” if students are not exposed to it in real-life. As future generations are better prepared to understand the “business of audiology”, they will be more inclined to plan for and seek out practice ownership early in their careers. Access to business training and resources for existing practitioners is imperative for those who wish to become practice owners/partners and for continued growth and success of practices.

Unless audiologists take ownership of their profession and do not relinquish control of it to external groups or non-audiology individuals, challenges from outside the profession will continue to encroach upon audiology’s independence and autonomy. Audiology should not remain a “kept

References

1. Academy of Doctors of Audiology (ADA). *Vision Whitepaper Faculty Survey*. Unpublished. 2007.
2. ADA. *Vision Whitepaper Member Survey*. Unpublished. 2007.
3. ADA. *Vision Whitepaper Student Survey (of NAFDA Students)*. Unpublished. 2007.
4. American Academy of Audiology (AAA). *2006 Compensation and Benefits Report*. 2007. <http://www.audiology.org/NR/rdonlyres/DE337F1B-71E3-4771-81FC-20CAC95A4AAD/0/2006CompensationSurveyReport.pdf>.
5. American Speech-Language and Hearing Association (ASHA). *Demographic Profile of ASHA Member and Nonmember Certificate Holders Certified in Audiology Only – Table 6*. Jan. 1st – Dec. 31st 2005. <http://www.asha.org>.
6. American Optometric Association. *Caring for the Eyes of America: A Profile of the Optometric Profession*. 2008.
7. American Dental Association. *Distribution of Dentists in the United States by Region and State*. 2004. <http://www.ada.org>.
8. American Podiatric Medical Association. *2005 Podiatric Practice Survey*. 2006. <http://www.apma.org>.
9. Eaton KW. Adding ancillaries: Listen up! Audiology boosts our bottom line. *Medical Economics* [serial online]. December 2, 2005. <http://medicaleconomics.modernmedicine.com/memag/article/articleDetail.jsp?id=253663>. Accessed August 25, 2008.
10. Garfinkel-Weiss G. Adding ancillaries: Audiology services. *Medical Economics* [serial online]. December 2, 2005. <http://medicaleconomics.modernmedicine.com/memag/article/articleDetail.jsp?id=253665>. Accessed August 25, 2008.
11. Denny J. Otologic technicians are coming!. *AAO-HNS Bulletin*. July 2003.
12. ADA *Vision Whitepaper Industry Survey*. Unpublished. 2007/2008.
13. Office of Advocacy of the U.S. Small Business Administration. *The Small Business Economy for Data Year 2006: A Report to the President*. United States Government Printing Office; December 2007. http://www.sba.gov/advo/research/sb_econ2007.pdf.
14. Walsh S. Tribute to Leo. Video presented at the Academy of Dispensing of Audiologists Convention; October 14-16, 2004; Tucson, AZ.
15. Harford E. The impact of the hearing aid on the evolution of audiology. 1993 Carhart Memorial Lecture. Presented at the Annual Meeting of the American Auditory Society; April 15, 1993; Phoenix, AZ.
16. Hosford-Dunn H, Dunn DR, Harford ER. *Audiology Business and Practice Management*. San Diego, CA: Singular Publishing Group, Inc.; 1995.
17. Glaser R, Traynor R. *Strategic Practice Management: A Patient-Centric Approach*. San Diego, CA: Plural Publishing, Inc.; 2008.
18. Foltner K, Engelmann L. Autonomy: Realities, Myths, & Impact for Audiology. Presented on Audiology Online; June 19, 2008.
19. Engelmann L, Burba R. Why getting the Au.D. is the light at the end of your tunnel. *Advance for Audiologists*. September/October 2001.
20. Guglielmo W. Small practice evolution: New models go mainstream. *Medical Economics* [serial online]. May 2, 2008. <http://www.modernmedicine.com/modernmedicine/article/articleDetail.jsp?id=512297>. Accessed August 25, 2008.
21. American Dental Association. *Careers in Dentistry*. 2005. <http://www.ada.org>.
22. Valahovic RW, Weaver RG, Sinkford JC, Haden NK. Trends in dentistry and dental education. *Journal of Dental Education*. 2001;65(6):539-561.
23. Association of Schools and Colleges of Optometry. *Optometry: A Career Guide*. May 2001. <http://www.opted.org/>.
24. Woodward JM, Brazeau GA, Leader WG, Mason HL. Report of the council of faculties task force on professional socialization. *American Journal of Pharmaceutical Education*. Winter Supplement 1997;61:31S-34S. Accessed at <http://www.ajpe.org/legacy/pdfs/aj610431S.pdf>.
25. Teschendorf B, Nemshick M. Faculty roles in professional socialization. *Journal of Physical Therapy Education*. Spring 2001. Accessed at http://findarticles.com/p/articles/mi_qa3969/is_200104/ai_n8935867.
26. Cardall W, Rowan C, Bay C. Dental education from the students' perspective: Curriculum and climate. *Journal of Dental Education*. 2008;72(5):600-609.
27. Fagelson M, Panayiotou G, Quillen J. The Current content of Au.D. curricula. *Audiology Today*. July/August 2006;18(4):14-19.
28. Doyle LW, Freeman BA. Professionalism and the audiology student: Characteristics of master's versus doctoral degree students. *Journal of the American Academy of Audiology*. 2002;13(3): 121-131.
29. Pennsylvania College of Optometry. *Financial Aid Handbook 2007/2008*. http://www.pco.edu/pdf/finaidbook07_08.pdf.
30. Faison K. *Personal Email Communication*. President of BancFirst Commercial Capitol. Oklahoma City, OK. December 2007.