Forum

Concern for the Communicative Handicapped?

Several years ago I had the opportunity to serve as chairman of the ASHA Committee on Governmental Affairs. At that time the Committee focused most of its efforts on further developing a model licensure law for speech-language pathology and audiology and assisting states in their legislative efforts to achieve licensure. The model licensure law encompasses the standards for training and competency recognized and accepted by the profession. The model law, recognizing the transient nature of our society, included a reciprocity section that makes it possible for qualified professionals serving the communicatively handicapped to move from state to state without being denied the right to practice. This very important section recognizes the ASHA Certificate of Clinical Competency as acceptable evidence for licensure by reciprocity.

It has recently come to my attention that Utah does not have a reciprocity clause in its licensure law. A respected professional with a Ph.D. and holding ASHA certification in both speech-language pathology and audiology was denied licensure in Utah until he completes over two thousand logged clock hours of direct clinical experience under the direct supervision of a professional holding the Utah license. There is a very real possibility that this competent individual, with years of experience, may be forced out of the profession.

Punitive state licensure laws that, in the righteous name of quality care, deny competent professionals the opportunity to practice raise serious ethical questions. One of the most frequent arguments made by legislators and others opposed to licensure is that they question whether we are really concerned for the communicatively handicapped public or are more interested in the economic advantages of fencing others out of our corner of the lucrative health-care market. A recent study (HEW, 1977) on speech-language pathology and audiology manpower resources and needs reports that approximately eight times as many audiologists and at least three or four times as many speech-language pathologists are needed if sufficient manpower is to be available to meet the needs of the country's communicatively handicapped. State laws that go beyond screening out the unqualified to restrict the availability of qualified professionals are most certainly not in the best interest of those we are committed to serve, and these laws give aid to those that challenge the credibility of our intentions.

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Caveat Descriptor

Attempts by various ASHA committees to provide guidelines for the use of audiometric symbols are commendable in that they have brought some order to the symbols used in everyday clinical work. The committees' recommendations . . . however, have neglected one aspect of audiometric terminology that is the correct usage of the term *Hearing Level (HL).*

The ANSI S3.6-1969 specifications for audiometers recommend that the "amount of decibels by which the threshold of audibility for that ear exceeds a standard audiometric threshold" be expressed as the Hearing Threshold Level (HTL). My interpretation of this ANSI recommendation is best expressed by the following example:

> If the audiometric threshold is 25-dB HTL, and speech discrimination stimuli are presented at 40-dB sensation level (SL), then the resulting presentation level is 65-dB HL.

That is, that HTL represents the threshold level and that HL reflects the audiometric dial reading of suprathreshold stimuli. If this interpretation is correct, then I would suggest that the editorial board of the ASHA journals adopt this terminology. Instead, they have been changing the appropriately used term, HTL, to read HL with the explanation that "the current descriptor is HL."

There does appear to be some confusion about these descriptors, and I would recommend that future committees address themselves to this issue.

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Praise, But—

It was with avid interest that I read the "Guidelines for Manual Pure-Tone Threshold Audiometry." The ASHA Committee on Audiometric Evaluation deserves much praise for the scope and thoughtfulness of these guidelines. I noted a probable error in the document. On page 299 (*Asha*, April 1978), the guidelines explicitly state ". . . the abscissas being frequencies on a logarithmic scale . . . ," and throughout the article references are made to testing intraoctave frequencies, specifically, 750, 1500, 3000, and 6000 Hz. However, according to the graphic representation of the audiogram on page 300, there appears to be a contradiction. The intraoctave frequencies are represented as being half-octave frequencies which would be 710, 1400, 2800, and 5600 Hz, respectively. If it is the intent of the Committee that these frequencies be tested, then audiometer manufacturers need to change their instruments to make these frequencies available. It seems more likely that the intent of the Committee was that intraoctave frequencies commonly available on most audiometers (750, 1500, 3000, and 6000 Hz) be tested under conditions specified in the article. If that is the case, then the abscissas on the graph are distorted, with octave intervals (based on 125 Hz) being on a logarithmic scale, and other frequencies not consistent with the scaling. As represented on page 300, the graph is misleading, since it implies that half-octave frequencies are tested when in fact they are not. As it is now, the graph is inconsistent with the recommendations of section 4.10 of ANSI standard S3.6-1969. One would hope that this error will soon be corrected.

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