

Editorial

In Support of a Post-Au.D. Fellowship

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It has been estimated that vertigo is the presenting complaint in 5 per 1,000 patients each year who are evaluated by primary care physicians (Storper and Roberts, 2010). In addition, it has been estimated that dizziness is the presenting complaint in 10 per 1,000 patients (Storper and Roberts, 2010). Lastly, dizziness affects more than half the population of elderly and is the most common complaint of elders >75 yr of age (Tusa, 2009).

Despite the large number of dizzy patients presenting to physicians it is estimated that there are only ~500 practicing neurotologists (i.e., ear surgeons who have completed fellowship training in the diagnosis and medical and surgical treatment of inner ear and nerve origins of hearing and balance diseases/disorders; <http://www.dizziness-and-balance.com/default.html>) in the United States and less than ~45 practicing otoneurologists (i.e., neurologists who have completed fellowship training in the study of the eye movement system, the inner ear system, its brain connections, and the diagnosis and treatment of the various diseases and disorders; <http://robbmd.com/>). In the absence of sub-specialty trained medical and surgical physicians who specialize in vertigo and dizziness, patients must be evaluated, triaged, and treated by primary care physicians, emergency room physicians, general otolaryngologists, nurse practitioners, and physician assistants—most of whom do not have the specialized training to effectively diagnose and treat these patients.

A solution to this problem would begin with the development of a method to ensure patients receive an accurate and timely diagnosis. In this regard, one might train primary caregivers to diagnose and treat the many otologic, neurologic, and systemic origins of dizziness and vertigo. Another solution might be to provide more comprehensive training to entry-level audiologists, some of whom have had some relevant didactic training, and are technically adept at graduation. Unfortunately, most audiologists receive one course covering the assessment of the vestibular system during their Au.D. training. Some universities and consortia have two courses, and a few others offer three. However, there is wide variability in the level of expertise and experience of the in-

structors teaching these classes: some may have never worked in tertiary care clinics and hospitals where the flow of patients enables the teacher to draw upon extensive clinical experience in the classroom. Moreover, there has been no attempt to provide detail or create standards in what knowledge and skills should be mastered by students who intend to pursue a career in, for example, the vestibular sciences (and this applies to other technically complex and sophisticated subspecialty areas). I (GJ) have said many times that offering one or even two classes in the area of “vestibular clinical sciences” would be equivalent to offering the same number of classes in the audiology curriculum and expecting the student to graduate as a fully-skilled audiologic clinician. Truly, for every audiology course, one could develop an analog course for a degree in vestibular science.

So, how might we improve the knowledge and skills of audiologists who wish to specialize? One way would be to develop a number of standardized post-Au.D. fellowships, where recent graduates (some even not so recent) could receive focused clinical training under the teaching and guidance of a mentor (or mentors) for one year in their special area of interest. We want to draw a distinction from the CCC-A. There would be no certification tied to this focused training and no requirement to complete a fellowship to practice. The fellow would be expected to be licensed in the state where the fellowship would occur. In this way the fellow would earn their salary by generating clinical revenue. The fellow would be mentored by a senior-level master clinician. The training might include exposure to the process of conducting clinic-based research. At the completion of the fellowship the fellow would receive a certificate attesting to completion of training and nothing more. The value of the certificate would be indexed by the prestige/notoriety of the location where the training took place (as occurs for medical/surgical fellowships). One might hope that a small number of fellows would choose a career in clinic-based research. As their careers unfold, they themselves might become experts and train other fellows, and in that way the quality of this training would be perpetuated. We have used vestibular sciences as an

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example only because that is the area with which we are very familiar. One could substitute intraoperative neurophysiological monitoring, or even implantable technologies (including CI and ABI) as other areas a post-Au.D. fellow might specialize. This proposal follows the medical/surgical model of postresidency training.

One of the indicators of the maturation of a clinical profession is the development of subspecialty areas that culminate eventually in credentialing. Examples include pediatric audiology and cochlear implantation (AAA) and intraoperative neurophysiological monitoring (American Audiology Board of Intraoperative Monitoring - AABIOM: ASHA). Although successful completion of a proposed fellowship will not produce a credential, it is our hope that the development of advanced knowledge and skills gained from the fellowship will lead to success in the acquisition of specialty credentialing where it is offered. It is noteworthy that neither IOM nor even the vestibular sciences have been fully embraced by the profession. It may be that acquisition of expertise in these areas for most is not a requirement to practice. Also, at present, there is no financial incentive associated with obtaining specialty credentialing. At the same time, with no critical mass, we will neither be better trained, nor will we reap any financial benefits.

In various forums we have expressed our concern about the lack of young Ph.D.s to replace those who are ending their clinical and research careers (e.g., reference the editorial by GJ titled “Figure 1, and why it should worry you (at least a little bit),” *J Am Acad Audiol*, 24(6):450–451). Also, there will be challenges from other medical and health professions who may contend they are best prepared to provide these special services. We do ourselves harm by not anticipating these challenges and responding to them in a timely, creative, and constructive manner.

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