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Essays

Health Disparities: What About the Deaf?

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When I moved from Iowa to California as a child, I had my first encounter with a member of the deaf community, one of my friends' father. And as a fourth grader, I didn't think too much of it. However, as I grew up, this relationship sparked my interest in the deaf community and American Sign Language (ASL), which led me to enroll in two years of ASL at UC San Diego when I went to college. In additional to learning ASL, the courses provided an in-depth look at deaf culture, through articles, books, and the perspective of our deaf professors. One hour a day, five days a week, I was submerged in learning ASL and deaf culture. Through my experiences in the ASL courses and hospital shadowing, I realized that the deaf community is often neglected and underserved in our healthcare setting.

One of the largest struggles the deaf face in medicine is the communication barrier. However, instead of tackling this barrier and appropriately getting a certified ASL translator to assist, practitioners may choose shortcuts in the interest of saving time. For example, some may ask the patient's relative to interpret, even if they don't know how to communicate medical language, or others will scribble incomplete and nonspecific notes about treatment and care for the patient.

This lack of communication that many deaf patients experience daily at clinics and hospitals can make the patients feel neglected, disrespected, and less likely to trust medical staff in the future. Additionally, important medical history, such as allergies and previous diagnoses, is lost in translation and could result in detrimental effects to the patient's health. For these reasons it is crucial to ensure our hospitals and clinics have access to in-person certified translators or video remote interpreting (VRI) services, where a translator is accessible via webcams or videophones. And while using these services will take time to coordinate or set up, it will ultimately allow for smooth, clearer communication and better health outcomes.

It isn't just language that is a barrier, but also the lack of understanding deaf culture that creates difficulties in healthcare. Some of the deaf community does not view deafness as a disability, but as a part of their culture. Therefore, these patients may be more likely to oppose cochlear implant services and other hearing aid devices. When living in San Diego, I spent an occasional Friday night at the Coffee Bean & Tea Leaf, where deaf members of the community come together to

socialize. It is there that I developed an appreciation of deaf culture and a better understanding of what matters to the community. And while I cannot speak for the sentiments of the whole population, I have learned that some view cochlear implants as a device that threatens deaf culture and American Sign Language. I recall a conversation with one of my deaf friends who explained to me that when his daughter was young, doctors would not listen to his concerns about cochlear implants and were pushy and unaccepting. Though we, as clinicians, desire to give our patients access to the best medical technology to improve their livelihood, we also must be aware of the debate surrounding cochlear implants and try to show our patients that we respect their culture and are not trying to destroy it.

Beyond this discussion, medical education can be a gateway to instruct students to better work with the deaf community in healthcare. Given the large deaf population in Riverside, California, a classmate and I started an interest group at our medical school called Deaf Community Connect, to bring awareness to issues the deaf face. The organization has hosted various deaf presenters to share their experiences and give feedback as to how physicians can better communicate with the population. Through this group, we have witnessed many classmates expressing a strong desire to learn more about and better serve the deaf. I would encourage medical students that are interested in working with the deaf to consider initiating a similar group at their university, as it is a great way to start conversations about the deaf in healthcare.

In addition to student involvement, support from administration is crucial to educate students about the local underserved communities in the region, including the deaf. Discussions surrounding health disparities and affected communities are wonderful tools to stimulate students to consider the populations being served and those that struggle to receive adequate healthcare. Such courses can bring light to the needs of the underserved in medicine, such as the deaf, and train future physicians to not only recognize needs and disparities. Ultimately, these courses can actively work to improve healthcare for such populations.

It is also important to consider how to interact with the deaf during clerkships and future practice. First, I encourage students to learn some basic ASL as a simple way to improve interactions with the deaf. In my experience, when learning a new language, native speakers are thrilled to see others trying to communicate in their language as it makes them feel more comfortable. There are many online resources and two great apps, ASL Coach and Marlee Signs for Android and iPhone, that are straightforward and easy-to-use guides for anyone.

But even with introductory knowledge of ASL, when medical students and physicians finally encounter a deaf patient, there is a chance that in-house translators will not be readably available. In these circumstances, it is best to request an interpreter through outside interpreting services as soon as possible. I recommend becoming familiar with local translation services to prevent delay in processing interpretation requests. For example, in Riverside County, RISE Interpreting and Life Signs are two popular services available for hospital staff to contact when needed. And while many private interpreting companies

will accept last minute requests, the wait time can vary greatly or an interpreter may not be available (depending on the time of day). In fact, I have heard stories of deaf patients waiting over 10 hours in the ED for an interpreter. In this scenario, deaf friends and colleagues have recommended that it is best to proceed with hand writing legible and detailed correspondence in a notebook, if the patient agrees. They also recommend keeping this notebook on record and using it to brief the interpreter, if, or once, he or she arrives. Additionally, when communicating with the deaf about medical information, the use of visual aids can be especially helpful in the patient's ability to better understand their condition.

From cultural differences to communication challenges, there is a lot of work needed to be done in medicine to bring quality services to deaf. However, I believe that each of us can make meaningful contributions to a deaf patient's experience in the medical clinic. Even in the chaos of the ED, an afternoon clinic running late, or in the absence of an interpreter, ask yourself the questions: "How can I make this patient feel welcomed here? What can my medical team do to respect this patient and their culture?" By taking a moment to slow down and consider this, medical students and other professionals are bound to treat not only deaf patients, but all patients, justly, while ensuring quality care and respect in hospitals and clinics alike.