

THE LEGAL AND ETHICAL CARE OF PATIENTS WHO ARE
DEAF OR HARD OF HEARING
WITH AN EMPHASIS ON COMMUNICATION METHODS

by

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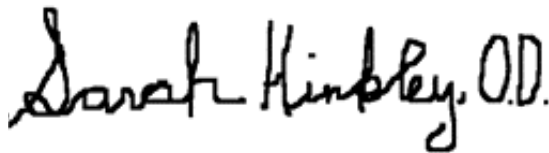
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ABSTRACT

Background: As the deaf and hard of hearing population has increased over the last few decades, the prevalence of American Sign Language as a person's primary language has increased with it. However, many optometrists are unsure as to how to approach an exam, and what the law states is necessary to accommodate these patients. *Methods:* Via thorough literature review, information was gathered and summarized as to how properly care for and communicate with a patient who is deaf or hard of hearing, with special attention to the legal requirements of an optometrist.

Results: To optimize the health care environment for patients who are deaf or hard of hearing, the most important step is for the optometrist to know local resources, such as sign language interpreters, legal support, and community agencies, that can benefit the patient and their chair time. This varies depending on what the deaf/hard of hearing patients needs, and should be adjusted accordingly. The supplemental use of pictures or diagrams to illustrate tests or procedures may also help solidify communication between patient and doctor, but may not be a substitute for "effective communication" as outlined in the Americans with Disabilities Act. Above all, it is important to meet these legal requirements, as well as address the specific needs of the patient, preferably with preparation before the exam. In addition, this information is presented in pamphlet format for distribution to the optometric community.

Conclusion: The Americans with Disabilities Act lays out legal guidelines that physicians must follow when it comes to patients who are deaf or hard of hearing, including

optometrists. It is important for optometrists to study these requirements and be aware of them, should the situation arise when a patient who is deaf or hard of hearing schedules or presents in a clinical setting.

This work, in addition to a lifetime of gratitude and love, dedicated to my parents, Arthur and Pamela Pscheidl, for being the first to believe in me, with every dream I ever had.

Also, for Your glory and graciousness, Lord. Without You, none of this would have been possible.

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CHAPTER 1

INTRODUCTION TO COMMUNICATION IN THE DEAF AND HARD OF HEARING POPULATION AND HEALTH CARE EXPECTATIONS

“I will place the treatment of those who seek my care above personal gain, and strive to see that none shall lack for proper care”: reads of the ten components of the Optometric Oath that optometrists of the United States strive to obey in practice.¹ However, when it comes to seeing a patient who is deaf or hard of hearing, it is often difficult for health professionals to know and conform to the legal parameters accompanying these patients, in order to give them the best care. As the deaf/hard of hearing population in the United States has increased over the last few decades, the use of American Sign Language has increased with it. According to the National Health Interview Survey (NHIS) conducted by the federal government, approximately 1,000,000 people (0.38% of the population) over five years of age are “functionally deaf” (namely, those identified as either unable to hear normal conversation at all, even with the use of a hearing aid, or as deaf). In addition to these demographics, the NHIS reports that about 8,000,000 people (3.7%) over five years of age are hard of hearing (that is, having some difficulty hearing normal conversation even with the use of a hearing aid). With these prevailing numbers, hearing loss is the sixth most common “chronic condition” in the United States.^{2,3}

Accompanying these demographics are the statistics of people in the United States who use American Sign Language (ASL). According the United States Census Bureau, as many as 500,000 Americans used ASL in 1972.⁴ Currently, this number has skyrocketed to two million ASL users.⁵ In addition to this, ASL is the primary language of an estimated 500,000 Americans. This population includes deaf native signers, hearing children of deaf parents, and fluent deaf signers who have learned ASL from other deaf individuals.⁴

Because of limited access to health information through communication barriers, many people in the deaf/hard of hearing community find themselves unable to make knowledgeable health care decisions, both for themselves and their families. In addition, it is not uncommon for healthcare professionals to not know the proper procedure to follow when they have a patient who is deaf or hard of hearing. Often, they find themselves turning to online forums to ask, or often try to “get by” with whatever method works best, and sometimes is the least expensive for them. Instead of having a certified interpreter present, some doctors may resort to relying on the patient’s ability to lip read, utilizing a family member or friend as a translator, or writing back and forth on paper or a computer word document. The aforementioned methods can quickly take a turn for the worse, with possibility of patient misunderstandings, a lawsuit against the doctor, or worse – the patient losing their vision because of inadequate communication and knowledge. The purpose of this literary review and analysis is to not only examine the legal requirements for caring with patients who are deaf or hard of hearing but to also investigate existing barriers and solutions to providing health care to the deaf and hard of hearing community, and explore what benefits and disadvantages arise through different

methods of communicating with deaf/hard of hearing patients in a health care setting, with an emphasis on optometric care. In addition, an at-a-glance reference guide will accompany this review to provide healthcare professionals with a tool to better tend to the needs of their deaf and hard of hearing patients (see Appendix A).

CHAPTER 2

METHODS

In this systematic literature review, many databases were accessed to provide the most up-to-date information on the rights and laws of deaf and hard of hearing Americans nationwide. The databases accessed, starting with the most heavily utilized, include the United States Department of Justice – Civil Rights Division, the Ferris Library for Information, Technology, and Education at Ferris State University, Google Scholar, and the United States Department of Health and Human Services.

The United States Department of Justice – Civil Rights Division is responsible for the implementation and enforcement of the Americans with Disabilities Act that was signed into law in 1990.⁶ Additionally, this division is responsible for the enforcement of the 2010 ADA Standards for Accessible Design that were implemented to revise accessibility standards to the original Americans with Disabilities Act. A copy of the Americans with Disabilities Act was obtained and thoroughly examined to report on the legal specifications that accompany the healthcare examination of patients who are deaf or hard of hearing. Additionally, the United States Department of Justice’s governmental website was accessed to cite specific examples of the enforcement of the Americans with Disabilities Act, as well as provide information and technical assistance to the application of Americans with Disabilities act in the healthcare setting.

The Ferris Library for Information, Technology, and Education at Ferris State University library catalogue was also accessed during this literature review. Search terms included, but were not limited to: deaf patients, hard of hearing patients, deaf cultural competency, deaf patients, public health for deaf patients, deaf sign language users, healthcare and the Americans with Disabilities Act, communication methods with deaf patients, and accessible healthcare for deaf or hard of hearing patients.

An additional online database that was utilized is the online database of Google Scholar. Similar search terms that were used with the Ferris State University library catalogue were applied to Google Scholar due to Google Scholar having a larger database accessible for in-depth research.

The United States Department of Health and Human Services was also consulted for literature, as its online governmental database includes that of the National Institutes of Health and their subpart, the National Institute on Deafness and Other Communication Disorders. This governmental department functions to fund programs, research training, and health information dissemination with regards to hearing and communication disorders. The governmental website was utilized for literature mainly involving the healthcare professionals' experiences with, perception of, and training involving the communication tools and steps necessary to safely and effectively communicate with deaf and hard of hearing patients.

Inclusion criteria for chosen sources consisted of the following: sources that are based on work undertaken in the United States, sources directly related to the topic at hand, and sources that include qualitative and quantitative studies, sources can include

observational studies. Exclusion criteria when reviewing literature included the following: sources that were published before the instatement of the Americans with Disabilities Act, sources that were considered editorials, and sources that did not include references.

With regards to ethical considerations, all information and sources were obtained lawfully, reported accurately, and respected doctor-patient confidentiality to the highest degree.

CHAPTER 3

RESULTS: LEGAL RESPONSIBILITIES AND COMMUNICATION METHODS

Laws for Communication Between Professional and Deaf/Hard of Hearing Patient

Because the vast majority of health professionals do not know how to communicate using American Sign Language, and thus rely on other methods of communication, it is important to note laws regarding interpreters, or more generally, “effective communication” with deaf or hard of hearing individuals.

According to the Americans with Disabilities Act, “No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.” Additionally, discrimination is outlined as “...a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services...” Furthermore, the ADA definition of “auxiliary aids and services” includes “qualified interpreters or other effective methods of making aurally delivered materials available” to individuals who are deaf or hard of hearing.⁶

Examining these laws, it is noted that any place of public accommodation is obliged to provide sign language interpreters, or other effective means of communication

(sometimes this may include assistive listening devices). One extremely important “public accommodation” area covered by the ADA includes the medical field. For example, all areas in hospitals - from the emergency room to the gift shop - must provide an effective form of communication to any deaf or hard of hearing individuals, whether it be patients, family members, or hospital visitors.

In very few cases, the ADA specifies that an appropriate means of communication can be limited to written notes back and forth between the speaker and the deaf or hard of hearing patient. However, when a conversation is deemed more complicated - such as outlining a medical procedure, explaining a patient’s symptoms, or signing paperwork, to name a few - a qualified interpreter is mandatory.⁶

In the ADA, “effective communication” seems to be loosely defined for some cases. It is of utmost importance for health professionals to note that “effective communication” is not something that can be determined by the doctor, but by the one receiving the communication. Additionally, the ADA Standards for Accessible Design revisited the topic of effective communication and determined that whatever method was used in interactions with a deaf or hard of hearing person is dependent on the method that the person uses in their routine life, the nature, length, and difficulty of the communication involved, and the complexity of what is being communicated. The Standards for Accessible Design also provides a list of possible auxiliary aids and services that can be used for deaf or hard of hearing individuals, pending their preferences, including: qualified sign language interpreters in person or through video remote interpreting, exchanging written notes, assisted listening devices, closed caption decoders, and real-time computer-aided transcription services, to name a few.⁸

Often, healthcare professionals will attempt to use writing back and forth with their patients as a means of effective communication. However, it is important to note that half of deaf people in the United States read English at a 4th grade reading level or lower, mainly due to the fact that their native language is American Sign Language, a language with its own grammar, syntax, and rules, and is considered its own language separate from English.⁷ Because of this, it is crucial to obtain information from patients, most efficiently accomplished when the patient is scheduling their examination, as to what accommodations they need in order to feel that their communication needs are being met according to the ADA.

A question that many healthcare professionals struggle with, is how the ADA plays a role when pediatric patients who are not deaf or hard of hearing have a deaf or hard of hearing caretaker that attends the examination with them. It is important to note that because this parent or legal guardian plays an active, crucial, and legal role in the child's health care as well as giving informed consent to the child's medical treatment, this individual must also be provided with auxiliary aids or services necessary for effective communication.⁶

In the past, some doctors questioned the ADA as to what classifies as an "undue hardship," as the laws states that the provision of auxiliary aids or services are not required if they result in an undue hardship. Many small practices felt as if this cost to provide these accommodations for deaf or hard of hearing patients could be claimed as "undue hardship," however the 2010 ADA Standards for Accessible Design revisited the original ADA wording and determined undue hardship highly unlikely and determined on a case-by-case basis. Additionally, if undue hardship can be proven, the office or

healthcare professional must still legally meet the requirement of effective communication to the maximum extent possible with alternative auxiliary aid or service.⁸

Many deaf or hard of hearing patients who use American Sign Language as their primary language will request an interpreter to be present for their medical visits. It is important for doctors to know that an interpreter qualified under ADA is defined as “able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.”⁶ One of the most important parts of this definition includes “impartially” – meaning that having a family member or close friend of the patient may not be an impartial interpreter, as they have a personal relationship with the patient at hand. Additionally, it is important to note that under the Health Insurance Portability and Accountability Act (HIPAA), interpreters are considered a covered entity, meaning they can use and disclose a patient’s protected health information without the patient’s authorization during the course of the examination, a crucial component to accurate and thorough history and examination findings. Another important component to the definition of “interpreter” consists of the ability to use “any necessary specialized vocabulary.” Often times when requesting interpreter services through an agency, these agencies will take into consideration the communication needs of the event for which interpretation is being provided, and will often send interpreters that specialize in interpreting in the medical field.⁹

For emergency patients that are deaf or hard of hearing, doctors often question what must be accommodated on such short notice for effective communication. According to the ADA Standards for Accessible Design, entities must provide the best possible communication methods for a patient’s needs, with respect given to the

immediate and emergent nature of the case at hand. However, hospitals and other government-run agencies must always be prepared for these scenarios with deaf or hard of hearing patients and have effective means of communication on-hand.⁸ Many hospitals, however, do not have a certified interpreter on staff, but will use a video interpreting program to broadcast the patient to the interpreter, in order to achieve effective communication for the patient.

Many doctors often question what type of legal action can be taken when ADA laws are not upheld for patients who are deaf or hard of hearing. When these cases are presented to the courts, they are classified as civil rights cases, meaning that malpractice insurance will not cover the costs that may occur if a doctor or practice is sued. One example of this is with Abused Deaf Women's Advocacy Services representing three patients versus Northwest Hospital and Medical Center in Washington, where a settlement of \$182,500 was awarded to the patients for the hospital failing to provide interpreter services when requested and bedside pages instead of use of the intercom when it was expressed that the patient could not hear the speaker.¹⁰ Another example of civil rights cases against doctors who fail to comply with ADA laws is of a deaf patient in New Jersey who was seen at 20 different appointments and asked her doctor numerous times for interpreters. The patient brought contact information for an interpreting service, had an interpreter contact the doctor, and even had the interpreter explain the ADA laws to the doctor. The doctor, and sole practitioner at the office, refused each time, stating that it would cost undue hardship to his practice, when later it was revealed that his taxable income was \$425,000 for that year. The jury of the New Jersey Superior Court of Hudson County ruled in favor of the patient, awarding her \$400,000.¹¹

Using an Interpreter as an Intermediate: The Benefits and Ill Effects

As with any chosen method of communication with patients who are deaf or hard of hearing, there are advantages and disadvantages to having an interpreter as a primary method of effective communication.

To start, certified interpreters are trained professionals in specific languages, meaning that their career is built on being a medium between people, ensuring that communication between all parties is as clear as possible. The use of a sign language interpreter allows both the patient and the health professional to speak in their native languages, ensuring succinct expression between both parties. Especially in a health setting, where a miscommunication can often result in misdiagnosis or medication errors, using an interpreter may allow for minimization of costly misunderstandings and possibly medical malpractice cases. Interpreters are also not just fluent in the language at hand, but also have a handle on the culture associated with each language, and can help the parties overcome cross-cultural differences that can often skew communication if not handled properly. One deaf patient recounted an experience with her physician and an interpreter that her physician hired: “Once we got into the doctor’s office, we did introductions, and communication was at the right pace. It was wonderful. I signed whatever I wanted to say, and if the interpreter was confused by medical terms, she stopped me, and I wrote down the medical thing. So often it’s ‘hurry up, get in, and get out.’ This doctor took the time to explain everything to me, and I was pleasantly amazed.”¹² When it comes to using an interpreter in an optometric setting, it is very easy for a patient to sign to his or her interpreter, even if the patient is behind a phoropter or

positioned in a slit lamp. The interpreter can then relay the information easily to the doctor, continuing the exam smoothly and efficiently.

Consequently, using an interpreter as a medium may be accompanied by some negative consequences, especially in medical settings. One of the largest examples is that the deaf or hard of hearing patient may be too embarrassed to tell the interpreter intimate details such as sexual activity, certain symptoms, or how possible injuries occurred, and as such, the health professional would not know crucial information. Additionally, most aspects of health and wellness are seen as private information between a patient and the health professional, and adding an intermediate in between can result in an uncomfortable environment, even if the interpreter is considered a covered entity under HIPAA. A deaf patient recapitulates her discomfort and fear during her examination: “They didn’t tell me what they were going to do... ..The doctor didn’t say to me, ‘This might be uncomfortable,’ or tell me how much pain to expect. I never went again.”¹² For those patients who use interpreters as a medium and experience discomfort, it is highly possible that it will discourage the patients from returning, which puts their health at risk. Additionally, according to the Americans with Disabilities Act, “Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.”⁶ This means that the financial responsibility of using an interpreter falls on the doctor or office that the patient visits, which results in the doctor not profiting as much as he or she would for a similar exam with a patient who doesn’t need auxiliary aids. During eye exams, patients view of the interpreter may be hindered by being inside the phoropter, unless the interpreter positions his or herself in the light of sight, or the patient may need to sit back from the slit lamp to properly see the

interpreter. Even though these maneuvers may slow down examination time, it is crucial that the patient obtain all the information and has the ability to ask questions pertaining to their ocular health and the examination.

Communication Through Writing: Advantages and Disadvantages

A tempting solution to satisfy communication requirements with deaf or hard of hearing patients lies within writing back and forth between the health professional and patient. This eliminates the need for an interpreter to serve as an intermediate, thus increasing the odds that the patient will be open to discussing sensitive issues. Additionally, there are many deaf or hard of hearing individuals who do not use sign language due to losing their hearing later in life, so these individuals may communicate more effectively with their health care provider through written notes. Using this method also means that the doctor or office would not have to pay to hire an interpreter for the exam. It is crucial to remember that the patient is the party responsible for determining if communication is deemed “effective” per ADA law.⁶

American Sign Language, the primary language of those who are deaf or hard of hearing, is a language of its own. It is not a dialect of English, and is, in fact, completely unrelated to spoken English. ASL has different rules regarding morphology, syntax, and grammar, and is therefore linguistically complete. Many non-ASL speakers -including health care professionals - do not know this, so it is important to note that English, and subsequently, written English, is considered a second language to certain deaf or hard of hearing patients, and is therefore not a preferred method. According to one study, fewer than 20% of deaf individuals report fluency in written English.¹³ Because of English being a second language to most, the reading level of many deaf or hard of hearing

individuals is not as high as hearing, English-speaking individuals, so writing will not always be effective communication. Additionally, health professionals' handwriting – especially that of doctors' – is infamously indecipherable, which would provide another barrier to the deaf or hard of hearing patient who wishes to understand written information. Moreover, the practice of written communication between a deaf or hard of hearing individual and their health professional tends to be slow and unwieldy. Because of this slow process, it is also highly possible that a health professional will provide less information through writing than he/she would provide if in a traditional, speaking setting. Additionally, when this patient seeks out optometric care, it is possible that he or she can find note-writing to be difficult due to conditions that may result in low vision such as cataracts or macular degeneration, that would make not only the patient's ability to write difficult, but also the ability to read. When a patient's health is at stake, this should not be a risk any provider would be willing to take.

Lip Reading: Support and Opposition

Some deaf or hard of hearing people do rely on lip reading, whether solely or in addition to other methods, to communicate through daily life. Because of this, lip reading can prove to be quite useful in medical settings. Using lip reading results in a more “natural” way of communicating that the health professional is used to and eliminates the need for an interpreter to act as an intermediate between professional and patient. If the patient expresses that he or she prefers this method and the environment is appropriate – as in, adequate lighting, minimal distractions, good eyesight from the patient – then lip reading can be a useful method of communication.

Unfortunately, deaf or hard of hearing individuals often experience issues understanding words when lip reading, especially in a health care setting. Often, an environmental setting will not be appropriate enough to lip read. Common hindrances include the health professional speaking too quickly, turning away, bowing his or her head, having a foreign accent, facial hair that covers the mouth, facing a computer to input information in an electronic medical record, or wearing a mouth/nose mask. Medical language is often more difficult to comprehend for a patient, and can sometimes be combined with a fast pace medical emergency situation, which makes lip reading even more challenging for a deaf or hard of hearing patient in a health care situation.

Issues also arise when patients cannot see the health professional during the appointment, such as certain physical examinations, x-rays, and radiology tests. One deaf patient recalls her visit to a radiology clinic: “I didn't know I was supposed to hold my breath during the x-ray. If a person can't hear, how do they know when to hold their breath? You can't see the technician when they disappear behind protective screens without adequately instructing patients.”¹² This also proves to be an issue with eye examinations, as many times the patient's eye or eyes are occluded, via phoropter or slit lamp, which makes reading lips much more difficult.

Statistically speaking, 40-60% of English sounds look similar on the lips when spoken.² Because of this, a large portion of English sounds are ambiguously visible on the lips. Only 10% of deaf patients report fully understanding of what physicians tell them using lip reading.¹⁴ Even the best lip readers can only understand 25% of what is said in conversation, forcing them to “fill in the blanks” for the remaining 75% of the words.¹² Having to guess what is being said 75% of the time is already enough of a

struggle, but can be detrimental when the patient's health or eyesight could be in jeopardy.

CHAPTER 4

DISCUSSION

Knowing the legal and ethical process for obtaining effective communication for deaf and hard of hearing patients is beneficial for both patients and healthcare professionals alike. Being prepared for this situation when it arises will help the exam flow and increase office efficiency and patient comfort. Being aware of what the law instructs regarding accommodations for these patients will also insure that litigation will be of less concern.

Often, adult patients that were born deaf or became deaf in early childhood have been shown to seek physicians' care less often than adults with no hearing deficits. This is because often, deaf patients who communicate exclusively via American Sign Language feel their communication needs are not met properly and are dissatisfied with their experience. However, these patients report that emergency departments often produce better communication satisfaction than other non-emergency offices, because most emergency rooms have on-call interpreters or video interpreting systems, whereas non-emergency physicians are often less prepared. Additionally, deaf patients who utilize American Sign Language as their communication method and also have primary care offices with full-time interpreter services, reportedly receive preventive services more than their counterparts whose primary care offices did not have interpreter services on-hand.¹⁵

Research has shown that the most effective time for health professionals to be educated on deaf cultural competency is during their educational career. The study concluded that the medical students that were exposed to deaf and hard of hearing culture and communication methods during medical school resulted in less health disparities for their deaf and hard of hearing patients during their career. The study also determined that physicians' lack of cultural knowledge combined with unpreparedness for communicating with deaf patients as well as their lack of knowledge regarding deaf and hard of hearing patients' rights resulted in the physicians themselves reporting discomfort with this population of patients. The study reports that because of this, deaf and hard of hearing patients reported that they felt their physicians acted in more of a paternalistic manner instead of professional doctoral manner, resulting in a reduction in their autonomy.¹⁶

Although this literature review leans heavily towards the use of American Sign Language interpreters, it is important to note the possibility that other methods are more beneficial. The method chosen will change depending on the patient and the chosen method of communication may also change on a case-by-case basis. Therefore, it is advantageous to note multiple possible suggestions to improve communication, regardless of the method used. In order to shorten the communication gap between patient and professional, three general categories can be strengthened: basic procedures, optimal environment, and patient interaction.

To address basic procedures, professionals should strive to instruct all personnel about specific communication efforts. Having a deaf or hard of hearing patient should not be a "surprise" to staff, and personnel and plan accordingly. To do this, the patient-

desired communication strategy should be kept on file in their medical record, so anyone who interacts with this patient will know and understand the situation. In preparation for the patient's comfort, easy-to-read written instructions about exam room procedures should be made readily available, if the patient is experienced in written English. Disseminating basic facts about deaf culture will allow for the cultural gap to be addressed in an appropriate manner, and appreciated by the patient at hand. Finally, understanding legal requirements and compliance will provide for less confusion.

To optimize the health care environment, the most important step is for healthcare providers is to know local resources, such as ASL interpreters, legal support, and community agencies. This will vary depending on what the deaf or hard of hearing patient needs, and should be adjusted accordingly. The supplemental use of pictures or diagrams to illustrate tests or procedures may also help ease discomfort and solidify communication between patient and professional. If it is decided that an interpreter is necessary, planning ahead to stay on schedule is crucial when an interpreter, and thus another party's schedule, is involved. Often, the interpreter cannot be completely flexible with scheduling, so being prompt and punctual is the responsibility of all parties involved. For patients who request an interpreter for their communication needs, online databases such as the Registry of Interpreters for the Deaf, Inc. can function to not only search the database for a certified member of the Registry, but also to find interpreting agencies in the area in order to have multiple options for interpreting available in case of scheduling issues.¹⁷ Additionally, manipulating the environment at hand by arranging the exam room so that the deaf or hard of hearing individual can visualize all interactions,

will prove to be most useful in optimizing communication, whether by lip reading, interpreter, or the interpreter signing.

To improve on patient interactions, the simplest solution is for the health professional to ask the deaf or hard of hearing patient for their preferred method of communication. It is important to note that each patient will be different, and no one method will suffice for the deaf community as a whole. If an interpreter is chosen, it is important that the health professional looks directly at the patient, and not the interpreter, and try to let the interpreter finish before commencing the next point in conversation. However, it is acceptable to occasionally check that the interpreter is keeping up and comfortable with the speed of the exam. It is also beneficial to describe all planned maneuvers, especially informing patients immediately before touching them in any manner. Periodically assessing the effectiveness of the communication, no matter what method, will make the patient feel more comfortable as well.

It is crucial to note that these initiatives from healthcare professionals incorporate not only cultural norms and communication to enhance participation, but also emphasize the importance of comfort and trust between a deaf or hard of hearing patient and the healthcare provider, no matter the communication method used. Research has shown that different groups within the United States are not equally receiving the care that is available; the deaf and hard of hearing population is one of these disadvantaged groups due to their population's cultural background and differing methods of communication.¹⁵ By stressing the importance of quality communication with deaf and hard of hearing patients that many healthcare professionals may often neglect, it is possible that many of the current deaf and hard of hearing population's health care access and communication

issues may be able to experience real change and solve many of the problems that have been cited on the structural end.

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APPENDIX A

FAST FACTS FOR COMMUNICATING WITH
DEAF OR HARD OF HEARING PATIENTS

