INTERACTING with Deaf and Hard of Hearing Patients

Ensuring accessibility in booking and rescheduling medical appointments

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Healthcare professionals and service providers sometimes face challenges in meeting the needs of d/Deaf and hard of hearing patients. The term "deaf" refers to hearing loss as a medical condition, whereas "Deaf" with a capital "D" emphasises the cultural identity associated with using sign language rather than disability or deficiency. Sign languages are not universal, and Singapore Sign Language (SgSL) is used locally. Given that not every deaf person signs, we discuss below different communication strategies and recommendations for providing access,[1] based on feedback from the local d/Deaf community and the Singapore Association for the Deaf (SADeaf).

Identifying and respecting patients

Upon identifying a patient as d/Deaf or hard of hearing, it is important to establish his/her communication preferences, flag this information in his/her medical records, and alert other colleagues during transfers of care. Taking these steps would allow colleagues to prepare communication aids (eg, a pen and blank paper), or engage a trained sign language interpreter before seeing the patient. This not only saves time, but also helps to minimise miscommunication and contributes to professionalism.

Some d/Deaf Singaporeans have reported facing communication difficulties because healthcare professionals missed their "deaf" status when interacting with them. In one instance, a doctor spoke extensively to a patient because he had missed the "deaf" label on her records, despite her gesturing to indicate that she could not hear. Finally, he let her explain through writing that she was deaf. Unfortunately, the doctor then scribbled his advice on scrap paper (which had another patient's confidential information printed on it and had to be thrown away). The patient was, however, allowed to take a picture of the doctor's illustration for her own reference. This situation could have been avoided if the doctor had observed the "deaf" label and taken care to obtain proper writing tools, have a speech-to-text application downloaded onto his/her phone, or taken an earlier pause to let the patient express her concerns.

Additionally, we have received feedback for people to avoid using disrespectful terms. Acceptable terms include d/Deaf or hard of hearing. "Dumb" is offensive because it wrongly connotes a lack of intelligence to laypersons. "Mute" can be inaccurate because a d/Deaf person may have a voice but choose not to use it. "Hearing impaired" also has negative connotations for some people.[2]

Communicating with patients

Some d/Deaf and hard of hearing individuals may use speech, writing and/or sign language to communicate, depending on their degree of hearing loss and personal preferences. Tan et al's recommendations for effective communication,[3] and additional suggestions based on input from the d/Deaf community,[4] are summarised below.

Sign language and speech-to-text interpretation

SADeaf and disability support organisation Equal Dreams can provide sign language interpreters and speech-to-text interpreters for patients who require them. Healthcare providers should, however, be responsible for engaging and paying for the trained interpreters. This is because doctors bear the burden of ensuring that d/Deaf patients can give informed consent to treatment by communicating medical advice in a way that facilitates understanding and supports patient autonomy.[5] When engaging such services, it would be good to check that the interpreter has the necessary training and experience to provide medical interpretation.

For sign language interpretation to be effective, it is helpful for healthcare providers to observe the following rules of etiquette. Address and direct your queries to the Deaf patient (not the interpreter), speak clearly and use simple sentences. Pause after each point, making one point at a time, so that the interpreter can follow and seek clarifications.[6] If a d/Deaf person requests that someone accompanies them in consultations, their wishes should preferably be respected. In one instance, a deaf patient was left alone in the emergency department while her sister waited outside. Although the patient mentioned to a nurse that she was deaf, the staff were overwhelmed and her requests to bring her sister in to help explain what was happening were ignored. It was only after the patient made multiple attempts to reach out

and exhibited signs of anxiety that the nurse finally allowed her sister to enter the holding room. Conversely, when a d/Deaf person has not given consent, it would be inappropriate and a breach of confidentiality to ask his/her friends or family to join the consultation and provide lay interpretation against the d/Deaf person's wishes.[4]

It is important to note that there are some d/Deaf people who may have received little education. They may understand gestures but have poor comprehension of written English. As a result, miscommunication could still occur when a medical professional writes on paper to convey relevant information. In such cases, an experienced sign language interpreter may be more adept in understanding and conveying information to the d/Deaf person. An example of this was when a d/Deaf patient had insisted on returning home without receiving the appropriate rehabilitation after a bad fall. She lived alone and did not have family support or caregivers. In spite of written notes from the doctor and medical social worker, she was not convinced and insisted on getting out of bed and returning home. An experienced sign language interpreter was thus engaged. After communicating through gestures for almost an hour, the patient was finally convinced that rehabilitation was necessary to strengthen her legs, so as to reduce fall risk that could lead to a dreaded re-admission.

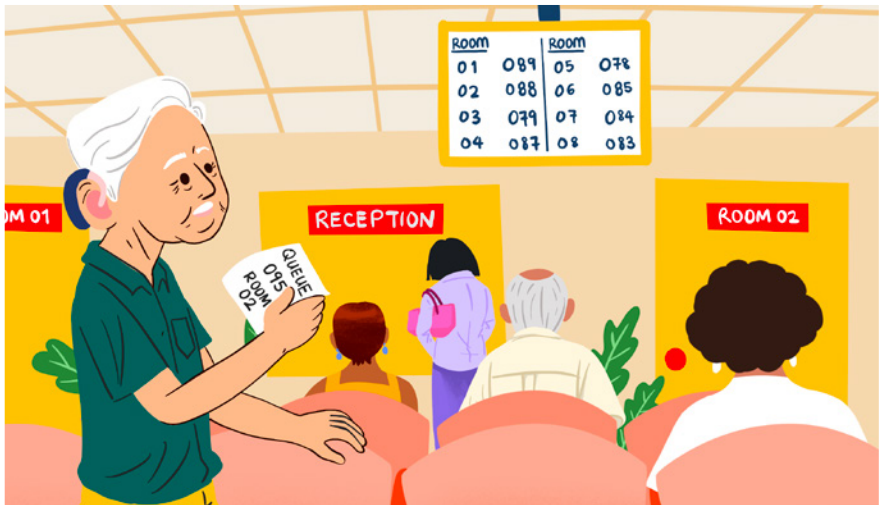
Speech and assistive technology

Some patients rely on lip-reading, so it is important to face them while speaking and to remove surgical masks or wear clear ones. Sit closer to the patient, speak at a normal volume and pace, and ensure that there is good lighting and reduced background noise. It is helpful to use less jargon, because patients may have varying levels of linguistic proficiency and familiarity with the topic discussed.[3,4] Some patients may hide incomprehension by smiling and nodding, so it is important to ask questions to ensure that they are following.

Additionally, assistive devices may be necessary, because only about 30% to 45% of spoken English can be understood through lip-reading.[7] Speech-to-text applications are available online and can be downloaded onto smartphones. Such apps include Google Cloud Speech-to-Text and Otter.ai real-time voice transcription. Installing induction loops or frequency modulation systems in clinics can improve sound quality for hearing aid users and enhance residual hearing. A pocket sound amplifier (a mini microphone attached to headphones) can be helpful for speaking with elderly patients with age-related hearing loss.[3]

Writing and visual aids

When using pen and paper, it is important to use good handwriting, avoid technical abbreviations, and draw diagrams. Using anatomical models, charts and pictures is also helpful, because d/Deaf and hard of hearing people are generally more visual. However, remember not to simultaneously speak and point to a visual aid, since patients can only look at one thing at a time.



Provide audio-visual displays instead of reading queue numbers aloud

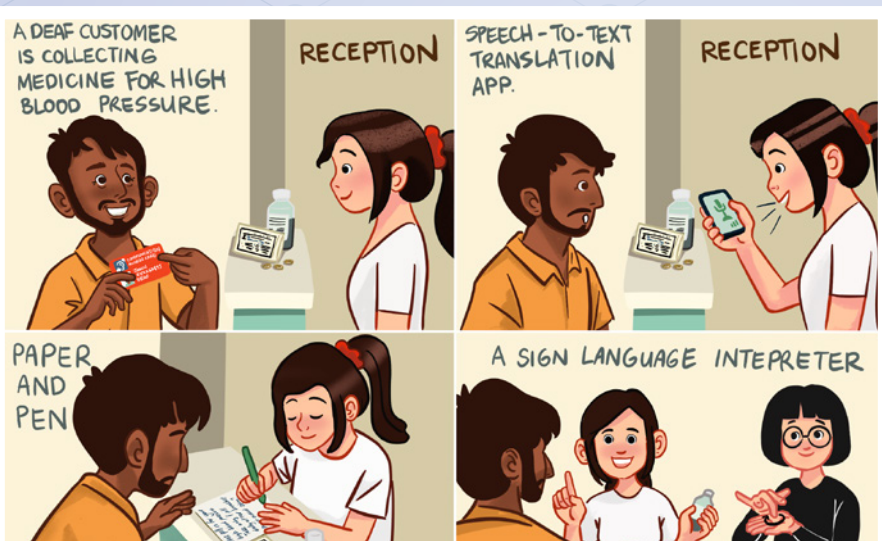
Applying the presumption of capacity

Sections 3(2) and 3(3) of the Mental Capacity Act 2008 (MCA) state that persons aged 21 and above must be presumed to have capacity, and a "person is not to be treated as unable to make a decision unless all practicable steps to help [him/her] do so have been taken without success". Furthermore, Section 4(3) states that a person should not be assumed to lack capacity merely by reference to a condition he/she has, such as hearing loss. The MCA recognises sign language as a valid mode of communication and that a person should not be "regarded as unable to understand the information relevant to a decision" if he/she can understand an explanation given "using simple language, visual aids or any other means" as stated in Sections 5(1)(d) and 5(2).

Unfortunately, d/Deaf and hard of hearing patients may be mistaken to lack capacity when communication attempts are not seriously pursued. Therefore, healthcare professionals should rigorously apply the MCA and avoid making false assumptions about people's capacity. Elderly patients may misunderstand information or give incorrect answers due to age-related hearing loss (presbycusis), which is easily mistaken for dementia. Such patients should be screened for presbycusis and referred to an audiologist.[3] In emergencies, healthcare professionals should ascertain patients' communication needs by checking their medical records and exercising discretion to contact next of kin.

Making information accessible

Making auditory information accessible to d/Deaf and hard of hearing people is important for inclusivity. During the COVID-19 pandemic, the Ministry of Health (MOH) launched hotlines for advice about recovery plans. Upon receiving feedback from members of the d/Deaf community that phone calls were inaccessible, MOH added video-call and text-messaging options for consultations with telehealth providers.[8] This is a good example of providing "reasonable accommodation", which the United Nations Convention on the Rights of Persons with Disabilities (CRPD) defines as making necessary and appropriate adjustments not imposing a disproportionate or undue burden,



Engage trained sign language interpreters for Deaf patients who require them

to provide equal access for persons with disabilities.[9]

Some clinics and emergency departments have a practice of reading queue numbers aloud. This causes d/Deaf and hard of hearing patients to miss their turn.[7,10] Instead, queue numbers could be announced through audio-visual displays. Text-messaging and video-call options could be provided for appointment bookings and telehealth consultations and advice.[11] A video-call option should be provided for emergencies, as patients may be too incapacitated to type. Moreover, a video call facilitates immediate visual inspection of the accident or injury.

Building an inclusive healthcare system

The Singapore Government's Enabling Masterplan 2030 recommends ensuring that "health services are accessible for persons with disabilities".[10] Healthcare professionals and service providers can play their part by adopting inclusive practices towards d/Deaf and hard of hearing patients, and engaging disability organisations like SADeaf to provide training on accessibility.

We, the authors, are "hearing" (not deaf) but Lynette is a lay sign language interpreter who communicates regularly with the d/Deaf, while Hillary is an SgSL student. We were motivated to write this article after a few d/Deaf friends shared their experiences in navigating the local healthcare system. They expressed that there were many instances when doctors did not seem to understand what deafness meant and sometimes gave the impression that d/Deaf and hard of hearing patients could be communicated with in the same way – by speaking loudly. Some of their anecdotes and inputs have been included above. Perhaps doctors could have a chart, similar to the pain scale, for d/Deaf patients. This may help them understand the level of deafness of each patient better, so as to communicate more appropriately.

This feedback was communicated to us in SgSL, which Lynette translated into English. Hillary has published a longer paper on "Healthcare Access for the Deaf in Singapore".[7] This featured an anecdote from a local nurse who knew basic sign language and could therefore communicate with a d/Deaf patient who had been ignored by other staff in the ward. Medical professionals who wish to learn SgSL may register for classes with qualified Deaf teachers at SADeaf or Equal Dreams. d/Deaf and hard of hearing patients have CRPD rights to receive information on an equal basis with others and enjoy the highest attainable standard of health without discrimination on the basis of disability. Striving to communicate well with d/Deaf and hard of hearing patients and attend to their needs – whether through learning SgSL or providing reasonable accommodation – goes a long way for inclusivity.

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References

1. The Singapore Association for the Deaf. Sign Language & Sign Systems used. Available at: https://bit.ly/4cVuQCz. Accessed 5 September 2024.

2. The Singapore Association for the Deaf. About Deaf Community and Deaf Culture. Available at: https://bit.ly/4edMBOy. Accessed 5 September 2024.

3. Tan TS, Lim ECY, Low WK, Tan NC. Effective Communication with Hearing Impaired Patients: An Approach for Family Physicians. The Singapore Family Physician 2011; 37(1):61-6.

4. Disabled People's Association What Are the Barriers to Inclusion Faced by Deaf People in Singapore – Interview with Deaf Advocate, Jessica Mak. In: Research and Policy Blog. Available at: https://bit.ly/3TijVf5. Accessed 5 September 2024.

5. Hii Chii Kok v Ooi Peng Jin London Lucien and another [2017] 2 SLR 492.

6. Centre for Culture, Ethnicity & Health. Communicating via an Interpreter. Available at: https://bit.ly/3Muyk46. Accessed 5 September 2024.

7. Chua H. Healthcare Access for the Deaf in Singapore: Overcoming Communication Barriers. Asian Bioeth Rev 2019; 11(4):377-90.

8. Tan T. Deaf Covid-19 patients can now communicate with MOH through SMS and e-mail instead of phone call. The Straits Times [Internet]. 5 January 2022. Available at: https://bit.ly/3yWUVTR.

9. Convention on the Rights of Persons with Disabilities. In: United Nations Office of the High Commissioner for Human Rights. Available at: https://bit.ly/3XgZVui. Accessed 5 September 2024.

10. Enabling Masterplan 2030. In: Ministry of Social and Family Development. Available at: https://bit.ly/3ANvIvo. Accessed 5 September 2024.

11. Tan T. My mum is my ear. Without her, I cannot ask for help, says deaf Covid-19 patient. The Straits Times [Internet]. 29 November 2021. Available at: https://bit.ly/4dPMatJ.

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