Deafness might damage your health

One in seven people in the UK are deaf, most of whom are hard of hearing. About 70,000 of these individuals are profoundly deaf, either from birth or before acquiring speech. Most communicate through British Sign Language (BSL) as their first or preferred language, rather than spoken English. These individuals together form the Deaf community, with their own language, culture, and history.

People from the Deaf community encounter many barriers in the health-care system and often have bad experiences, usually because of poor communication. Most health-care workers have little experience of sign-language users because few are in the public eye or are health-care professionals. Ignorance leads to negative attitudes, and patients from the Deaf community endure both individual and institutional discrimination.

Clinicians regarding BSL users as disabled come across as patronising, and entries are still seen in patients’ medical records stating that a full history has not been taken because the patient is deaf.

In *The Lancet*, Johannes Fellinger and colleagues review the extensive evidence of mental health problems in deaf people, which are substantially more common than in hearing populations. Many anecdotes of poorer physical health in people from the Deaf community exist, but there are no robust studies. Research is needed to establish whether people from the Deaf community have poorer health than do hearing individuals, and to explore underlying causes.

Poor communication in a consultation can lead to medical error. Reliance on lip-reading is inadequate, because lip-readers understand only part of a conversation and use guesswork to fill gaps. Communicating through a series of handwritten notes is an unsatisfactory substitute for a full consultation, not least because people from the Deaf community have often had poor-quality education, and many have lower-than-average literacy.

A qualified interpreter should be present in a consultation between a clinician and a patient who uses BSL to enable full communication for both professional and patient. Without an interpreter, the clinician cannot make an adequate clinical assessment or explain the diagnosis and treatment, and the patient is denied the opportunity to discuss his or her concerns. However, interpreters are scarce and advance booking is necessary, so they are often unavailable for appointments with family doctors or for emergencies. Therefore, patients frequently rely on family or friends to interpret, but few are qualified interpreters, and patients’ autonomy and privacy are compromised. Online access to interpreters via computers and webcams has improved availability, particularly at short notice. Some services now provide 24 h cover.

A UK survey showed that 77% of BSL users had difficulty communicating with hospital staff. 33% left consultations with their family doctor unsure about medication instructions or subsequently took the wrong doses. Reeves and colleagues reported that BSL interpreters were present at 17% of consultations with a family doctor and 7% of those in hospital emergency departments. The study showed that people from the Deaf community have substantially poorer access to primary care and emergency services, and have difficulties at all stages of the health-care process. The main causes were poor deaf awareness of doctors, nurses, and reception staff, and insufficient provision of interpreters. Nevertheless, 87% of family doctors feel that they can communicate effectively with their hard-of-hearing patients and those who use BSL.

Most worryingly, however, 30% of BSL users avoid seeing their family doctor because of communication difficulties, thereby risking their health rather than facing another struggle with the health-care system.
Mainstream health promotion is done via speech and writing through radio, television, leaflets, and websites. Very little information is available in BSL, although patient-information leaflets are available in many foreign languages. Access for members of the Deaf community is mainly limited to the written word in leaflets, websites, and television subtitles; literacy issues can further reduce this access. A US study showed that understanding and knowledge of AIDS and risk behaviours were lower in people from the Deaf community than in hearing participants. Other investigators noted that people from the Deaf community in Scotland were marginalised from health-promotion programmes.

Marmot recorded a 7-year life-expectancy gap between the richest and poorest people in the UK. Other factors associated with poor health include unemployment and mental ill health. People from the Deaf community are at risk of poorer health because of a combination of poor-quality education, three-fold higher unemployment than in hearing individuals, increased mental ill health, and decreased availability and accessibility of health information. This risk is compounded by poorer access to primary and secondary health-care provision. For example, reduced access to health information and care could mean that control of diabetes in patients from the Deaf community is inadequate, leading to increased risk of complications, such as blindness (which would be particularly devastating for people who rely on visual communication).

How then can we improve health care for the Deaf community? Good communication is the key, and small changes made by staff can make a big difference. Deaf-awareness training for all health-care staff is a priority and should be provided by people from the Deaf community in an interactive, thought-provoking way. The medical records of people from the Deaf community should be flagged with preferred communication methods, and longer appointments than usual should be scheduled. The UK Equality Act 2010 necessitates provision of an interpreter when it would enable or make it easier for people from the Deaf community to access the service; organisations should maintain up-to-date details of interpreting agencies including those which provide out-of-hours service for emergencies. Other reasonable adjustments are use of text messaging and email to book appointments and contact health-care staff. In the UK, deaf people can already contact ambulance services by text message. Patient information leaflets and government health advice should be available in BSL, with subtitles on DVDs and websites; the National Health Service could act as a national resource.

UK law clearly states that people from the Deaf community should have equal access to health-care services, but few examples of best practice or recommendations exist. National guidance co-written by members of the Deaf community is needed. The health of people from the Deaf community should be targeted in the same way as that of other groups. For example, many recommendations of the report entitled No patient left behind, which examined inequality of health-care access for minority ethnic groups, could be extended to the Deaf community. The Department of Health’s programme to improve access to family doctors included people from the Deaf community, and this work could be developed by ensuring that the National Health Service Commissioning Board and clinical commissioning groups specifically consider access to all health-care services.

Patients from the Deaf community have the same need for good communication and safe care as everyone else. Clinicians have a responsibility to recognise that communication is a two-way process, and that they need assistance to communicate with this group of patients. So what should you do when you meet your next patient from the Deaf community? Putting yourself in their shoes and asking them how best to communicate would be a good start.

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Evidence supports the obvious: suicides need not happen

Although suicide is a devastating and tragic event, it is a relatively rare one. Every year in England and Wales, roughly one suicide occurs per 1000 patients in treatment with mental health providers, the group at greatest risk. Yet one suicide death is too many, leaving in its wake a legacy of pain and traumatic grief. Reduction, and even elimination, of suicide deaths is a high public health and clinical priority.

One consequence of the low base rate of completed suicide is that proving the effectiveness of interventions designed to reduce suicide deaths is very difficult. Without evidence to support such practices, mustering of social, institutional, and political will to sustain them might be impossible. David While and colleagues report such evidence in The Lancet for a range of nine widely used suicide prevention practices in public sector mental health service settings. They used data for suicides occurring from Jan 1, 1997, to Dec 31, 2006, in 12 881 patients who were in contact with any of 91 mental health services in England and Wales in the 12 months before death, describing changes in rates relative to regional uptake of key mental health service recommendations over time. Unsurprisingly, the investigators showed that as more service recommendations were implemented, suicide rates in the target populations of service users with mental illness declined. From 2004 onwards, there were fewer suicides in services in which seven to nine recommendations had been implemented (10·80 suicides per 10 000 in 2004, 95% CI 9·99–11·65) than in those where zero to six recommendations were implemented (12·63, 11·70–13·61). Removal of ligature points on inpatient wards was associated with reduction in overall psychiatric inpatient suicide rates (11·98 suicides per 10 000 per year).