

The National Council on Interpreting in Health Care Research Reports Series



Deafblind Patients During the COVID-19 Pandemic: Insight from Healthcare Interpreters

This report was written by members of the NCIHC Research Work Group, which operates as part of the Policy, Education, and Research Committee: Gabriela Espinoza Siebach, Hank Dallmann, Linda Golley, Maichou Lor, Eva Stitt, and Michelle Scott. This report presents data from a 2021 64-item survey that had the intent of understanding the impact of the COVID-19 pandemic on language access in healthcare through the experience of healthcare interpreters.

Introduction

The National Council on Interpreting in Health Care (NCIHC) is a multidisciplinary organization whose mission is to promote and enhance language access in health care in the United States. One of its goals is to develop and monitor policies, research, and best practices. The COVID-19 pandemic created a different landscape locally, nationally, and internationally, and healthcare interpreters have had to adapt and adjust to help themselves and the communities that rely on them for support.

In 2021, the NCIHC issued a 64-item survey. The overarching goal of this study was to understand the impact of the COVID-19 pandemic on language access within the healthcare system in the United States, with a particular focus on the experiences of interpreters. This report delves into the communication access and support provided to deafblind¹ patients amid the pandemic. The analysis and interpretation of the data presented here are limited to Questions 34-39 only.

Background

As described by the National Center on Deafblindness, individuals who are deafblind have limited access to auditory and visual input. Some may have the ability to see at close distances, while some have sufficient hearing capabilities to understand some speech and/or verbal skills (National Center on Deafblindness, n.d.). The communication needs of deafblind patients may vary to include tactile interpreting (tactile/protactile sign language or tactile fingerspelling) and close-vision interpreting (interpreting near the deafblind individual and visual frame interpreting), both of which require the interpreter to be in close proximity to the patient. (World Federation of the Deafblind, 2019)

During the COVID-19 pandemic, physical proximity of less than 6 feet was deemed unsafe and a contributing factor to the propagation of the virus. Physical distancing was one of the internationally accepted recommendations to break the chain of transmission (World Health Organization, n.d.).

Multiple studies have shown that effective communication is essential in healthcare and it correlates to the quality and delivery of care, as well as to overall patient health outcomes and general length of hospital stay (Ratna, 2019; Stewart, 1995, 1423; Sherwood & Barnsteiner, 2021, 85-108). Effective bidirectional communication between healthcare providers and their patients has been shown to contribute to overall patient satisfaction with care (Madula et al., 2018).

Considering the Americans with Disabilities Act (ADA) requirements for effective communication (U.S. Department of Justice Civil Rights Division, 2020), the impact of effective communication on patient outcomes, the specialized communication needs for working with deafblind patients, and COVID-19 recommendations for physical distancing, the NCIHC Research Work Group sought to understand workforce experiences of American Sign Language (ASL) interpreters

¹ The term deafblind appears in different ways depending on the source, with variations in hyphenation and capitalization. The authors of this report are using a non-hyphenated, non-capitalized term as defined by a National DeafBlind white paper to refer to “a diagnosis of a combined loss of vision and hearing.”

who provided services to deafblind patients in healthcare settings before and/or during the pandemic.

Methodology

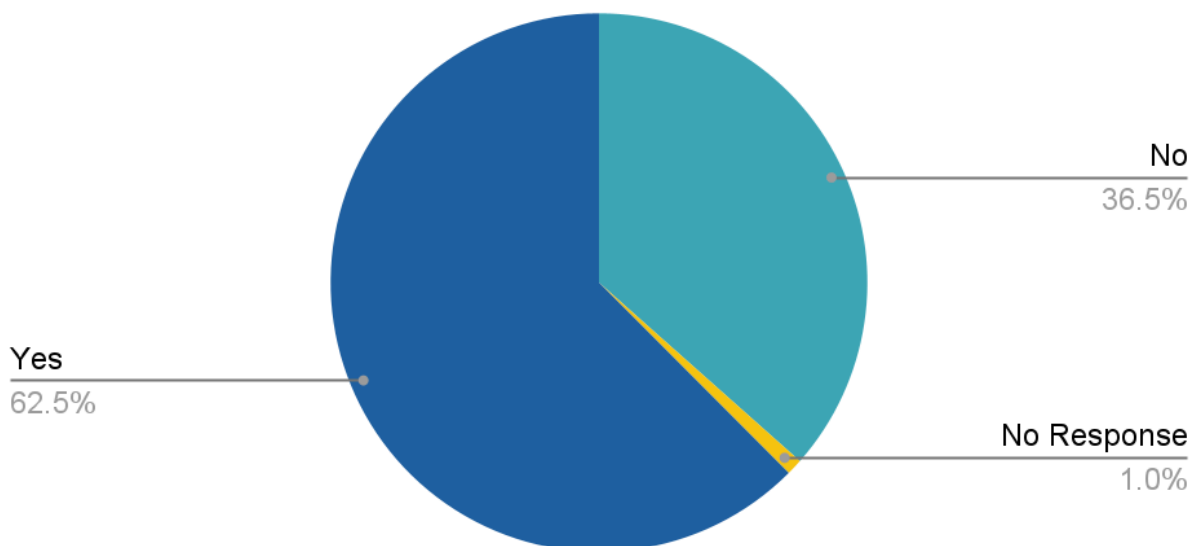
A cross-sectional questionnaire of 64 items with multiple-choice and open-ended responses was administered to medical interpreters nationally. The NCIHC Research Work Group distributed the questionnaire online with the support of the NCIHC Board, several interpreting organizations, and numerous language service companies. The survey was open from February 14 to April 23 of 2021. A total of 1,673 working healthcare interpreters responded; of these, 216 expressed that one of their working languages is ASL. Of the 216 ASL healthcare interpreters that responded to the survey, 167 self-identified as female, 13 as male, 1 as nonbinary, and 3 indicated they preferred not to answer, and 32 did not respond to this question. ASL interpreters who responded to the survey were from 35 U.S. states and the majority ($n=153$) indicated they had interpreted for over 100 hours in healthcare settings in the 12 months preceding the survey.

This report is an analysis of the responses to Questions 34-39, which relate to interpreting for deafblind patients. The results of both quantitative and qualitative responses were considered. Descriptive statistics were calculated for questions 34-39. The open-ended questions were examined and tabulated based on identified categories.

Results

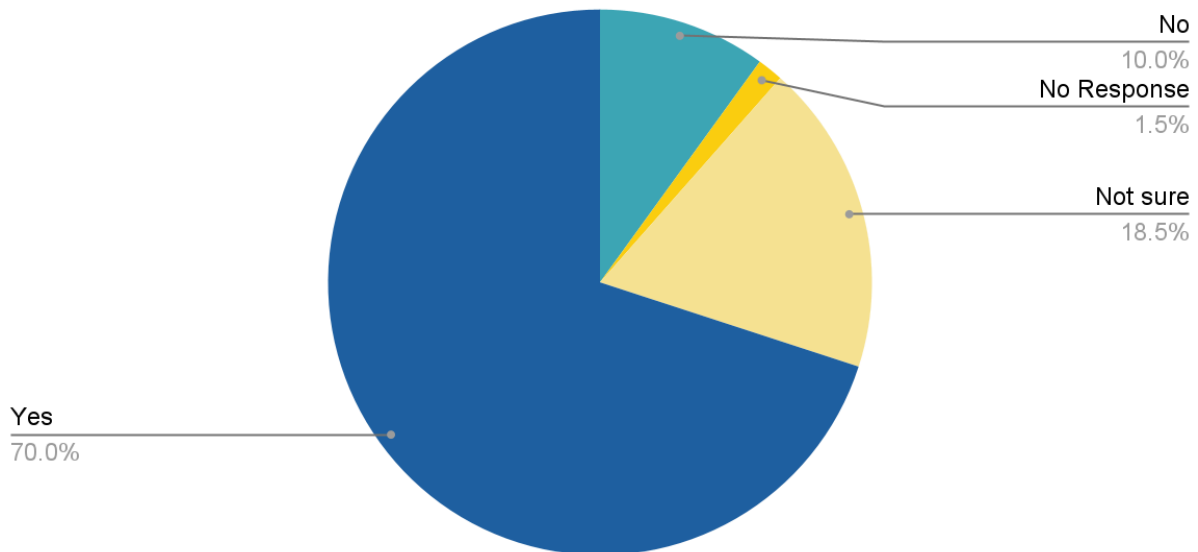
When asked if they had worked with deafblind patients, 208 respondents (14%) indicated that they had done so prior to the onset of the COVID-19 pandemic and 62.5% of those respondents ($n=130$) indicated that they continued to work with deafblind patients after the onset of the pandemic.

Are you continuing to work with DeafBlind patients since the onset of the pandemic?



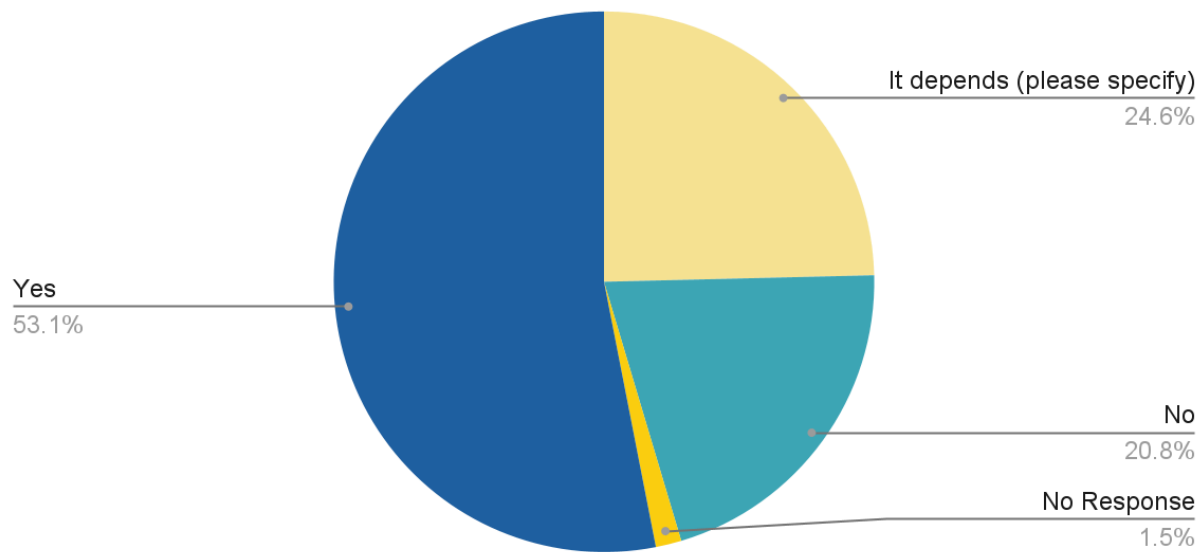
When healthcare interpreters were asked if they felt confident about their knowledge of how to avoid the risk of COVID-19 transmission when working with deafblind patients (Question 36), 70% of respondents ($n=91$) answered in the affirmative, and 28% of respondents ($n=37$) were either not confident or unsure.

If you are currently working with DeafBlind patients, do you feel confident you know how to avoid the risk of COVID transmission?

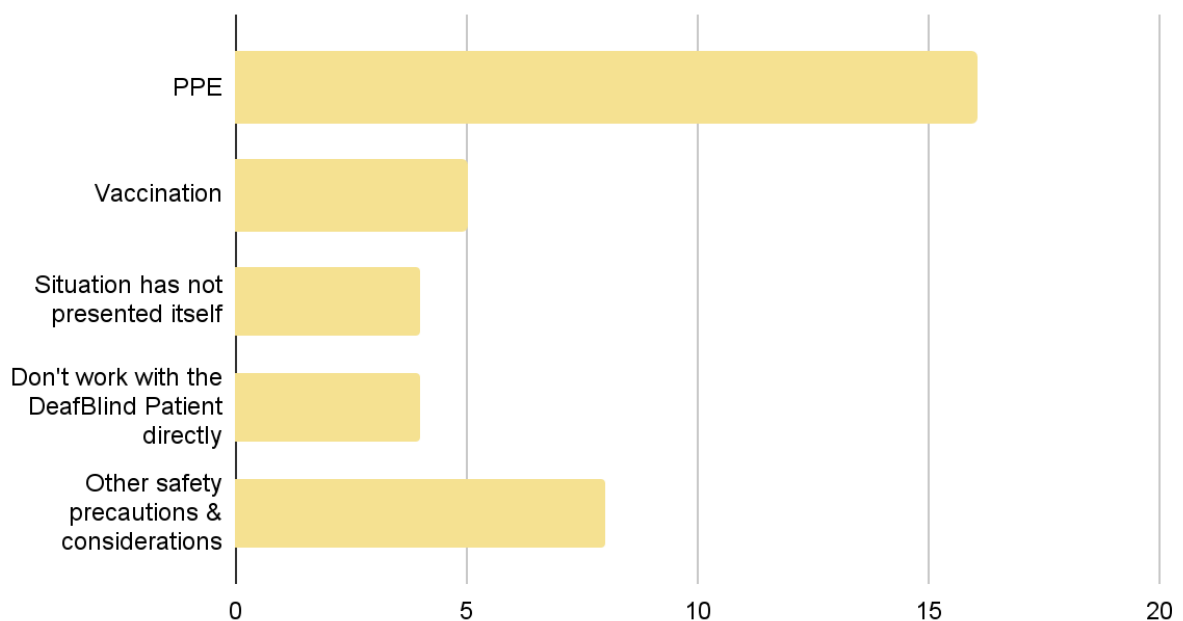


When asked about whether interpreters would still be willing to work on site with a deafblind patient (Question 37), 53% ($n=69$) indicated that they would be willing to provide onsite interpreting services to a deafblind patient with COVID-19, while 21% ($n=27$) indicated that they would *not* be willing to do so. Additionally, 25% of respondents ($n=32$) indicated that it would depend on a number of factors. When asked to explain, 8 respondents indicated that the situation had either not presented itself or that they do not provide the interpreting services directly to the deafblind patient. For example, some team up with another professional, such as a Certified Deaf Interpreter, who provides tactile interpreting. Additional factors indicated were the availability of PPE, the interpreter's own vaccination status, and safety precautions or considerations.

If you know that a DeafBlind patient has COVID, are you still willing to work on site with them?

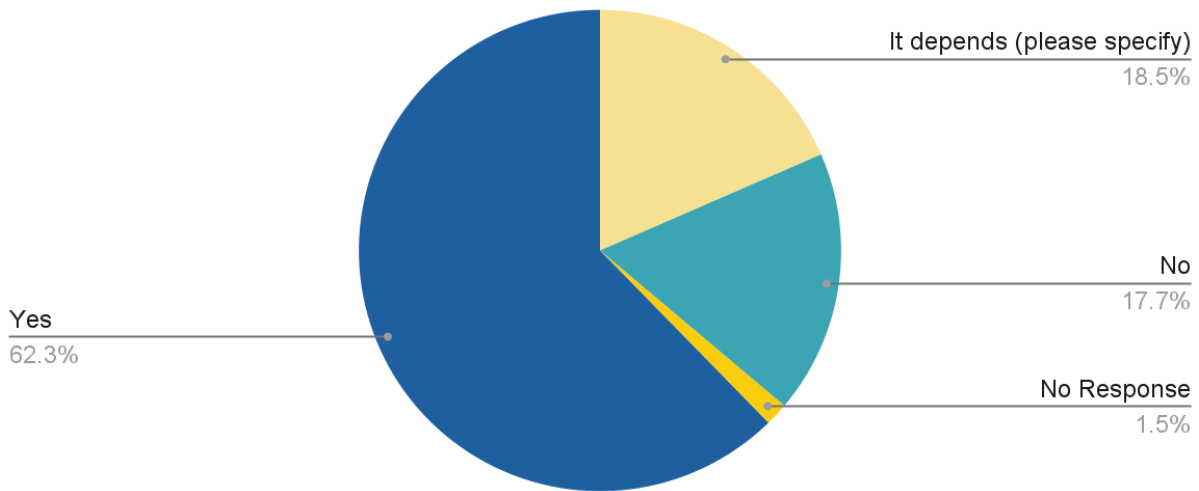


Summary of written responses for respondents that indicated "It depends" regarding providing services to confirmed Covid DeafBlind patients.

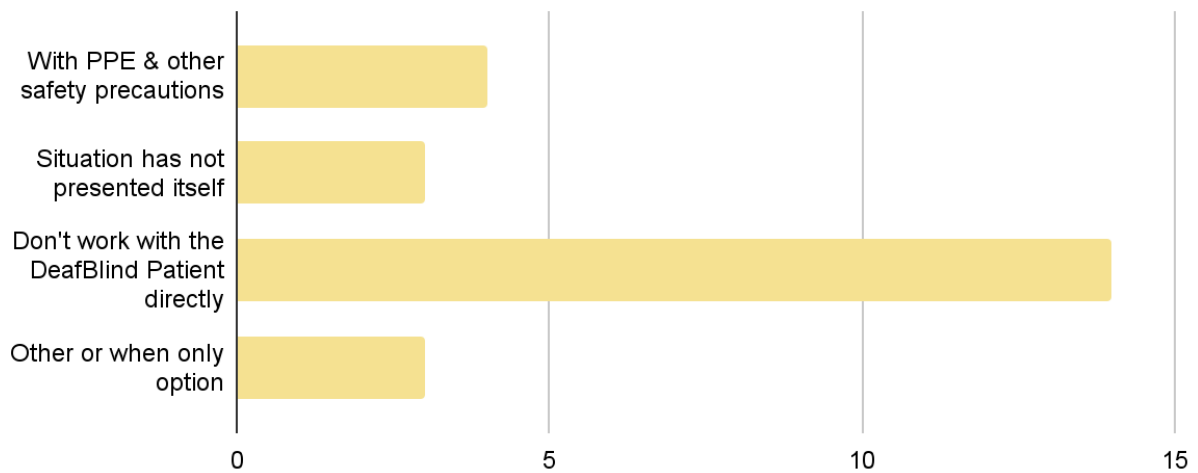


Of the 130 interpreters that reported working with deafblind patients since the onset of the pandemic, 62% ($n=81$) indicated that they continued to incorporate the use of touch (such as human guiding, ProTactile, Haptics or other touch cues, tracking, tactile ASL, etc.) in their practice. Among the 18% ($n=24$) of interpreters who indicated that their use of touch depended on certain factors, the majority (58%, $n=14$) indicated that they currently do not work directly with deafblind patients.

When working with DeafBlind patients during the pandemic do you continue to incorporate the use of touch (for instance human guiding, ProTactile, Haptics or other touch cues, tracking, tactile ASL, etc.)?

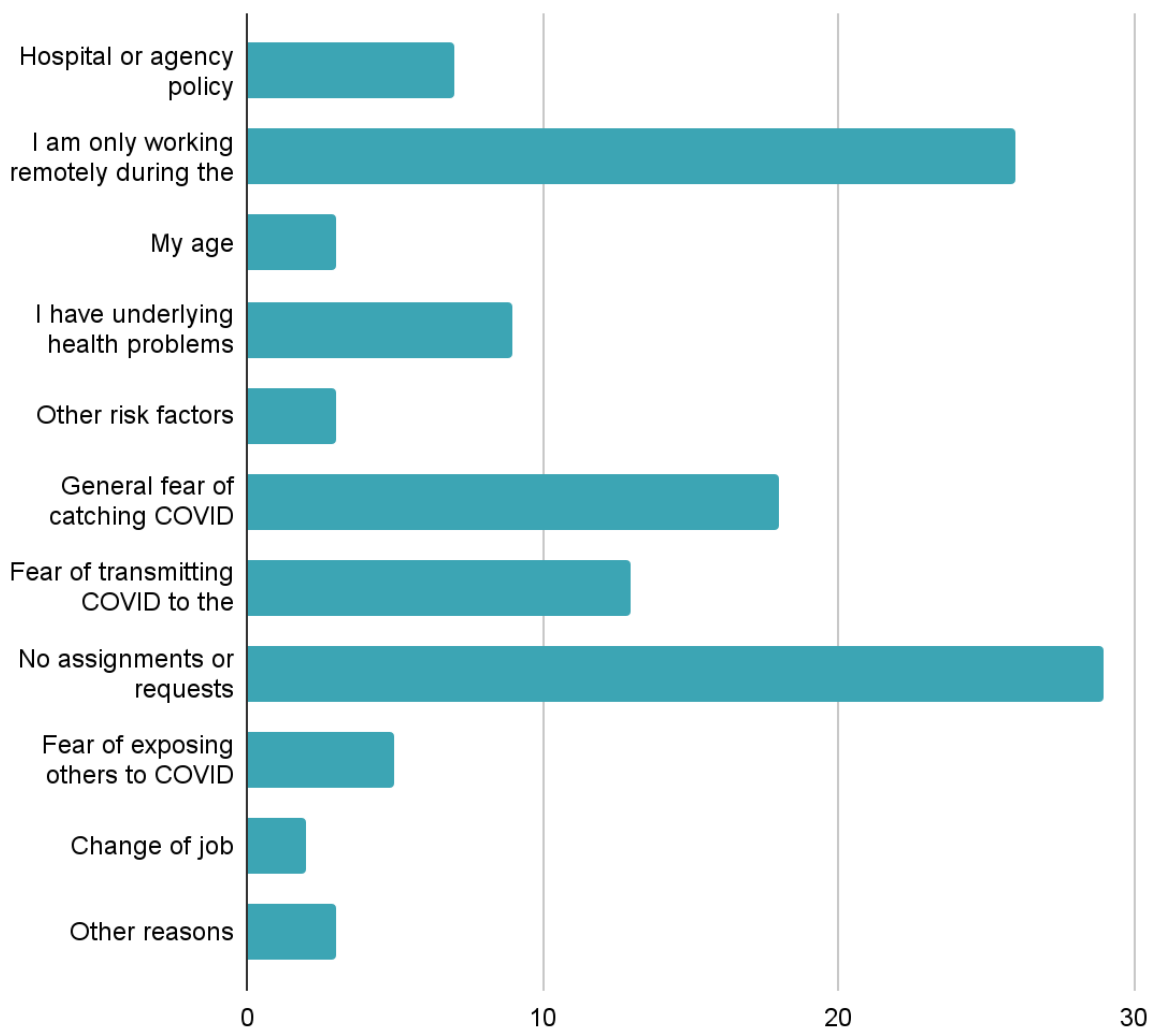


Summary of written responses for respondents that indicated "It depends" regarding providing services through the use of touch during the pandemic.



Question 39 captures the answers of 76 respondents who indicated in Question 34 that they worked with deafblind patients prior to the COVID-19 pandemic, but proceeded to indicate in their answer to Question 35 that they have *not* continued working with deafblind patients since the onset of the pandemic. When asked why they no longer work with deafblind patients, respondents were able to select any of the options that applied to their situation and to provide an open response in the "Other (please specify)" answer option. The most common response (39%, $n=29$) was that no assignments or requests had been received for their services. The next most common reason was remote work (e.g., video remote interpreting) for 22% of respondents ($n=26$). Although when analyzed independently, the fear of contracting the virus (24%, $n=18$), transmitting the virus to patients (17%, $n=13$), or exposing others to the virus (7%, $n=5$) were not the most selected options, when analyzed collectively, the fear of contracting or transmitting the virus was selected by 47% of respondents ($n=36$).

**If you worked with DeafBlind patients prior to the pandemic but are not now, why not?
Mark all that apply.**



Conclusion

Many ASL interpreters who provided communication access for deafblind patients prior to the onset of the COVID-19 pandemic continued to provide services *during* the pandemic, despite the potential risks associated with working in close proximity and their knowledge in regard to how to avoid the risk of transmission. Still, nearly half of those interpreters who no longer provided services to deafblind patients after the onset of the pandemic attributed their decision to transmission-related concerns.

While a significant number of ASL interpreters indicated that they simply had not received any requests to provide services, the reasons for this are not made evident from this survey. It could

indicate a need for raising awareness about the importance of communication access to deafblind patients during a public health crisis. Or, it could be an opportunity to identify new ways to provide interpreting services in close proximity using safety methods to avoid spreading contagion.

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