Editorials

Supporting patients who are deaf who use a signed language in general practice

Patient A: *'My GP — I am really impressed with them to be honest, because they will NOT see me without an interpreter* [...] *Which I think, is really good.'*[1]

Patient B: *'... they* [GP] *would say, "No, if you are really ill, then yes, we will bring an interpreter but if it's just a general medication or blood test then no it's not necessary."'*[1]

Patient C: *'... my writing skills are not very good, so it was like communicating in 18th century fashion in black ink, and I didn't understand what was being written ...'*[1]

Estimates on the number of deaf sign language users across the UK vary; however, on 18 March 2003, the Secretary of State for Work and Pensions formally announced: *'The Government recognise that British Sign Language* [BSL] *is a language in its own right regularly used by a significant number of people ...* [as] *their preferred language for participation in everyday life.'*[2]

Studies have shown that the health of deaf people can be adversely affected by both barriers in accessing NHS primary care services and a range of social determinants, including an educational attainment gap,[3] resulting in health inequality. They are less likely to be able to fully comprehend health literature in written English,[4] and varying levels of health literacy can limit their understanding of health conditions, reduce their ability to manage their health, and prevent their informed choice in avoiding potentially unhealthy lifestyles.

ATTEMPTING TO ACCESS THE ACCESSIBLE?

From 2013–2019, a range of Healthwatch reports across England have indicated common themes in the deaf sign language user's struggle to effectively access healthcare services, including general practice.[5] Notwithstanding the legislative framework (Equality Act 2010; Public Sector Equality Duty 2011) and the implementation of the *NHS Accessible Information Standard* in July 2016, deaf people still express their concern with regards to a number of ongoing access issues. The issues encountered in general practice range from difficulty in booking appointments; confusion as to who provides the sign language interpreter; ineffective communication with reception staff; lack of deaf awareness; auditory/PA call systems; too short an appointment slot to achieve successful communication; difficulty understanding the information provided; over-reliance on written communication; to variable provision/quality of sign language interpreters with incidences of utilising family and friends to interpret. As a result, deaf people state that these lived experiences bring about a lack of confidence and trust in using primary healthcare services.[6] In the worst-case scenario this lack of confidence and trust stops deaf people from using GP services and makes them rely upon piecemeal information strategies from friends, family, and social media. This contains inherent risks, in particular when considering the higher incidences of mental health issues reported within this community.[7] NHS England also forewarn care commissioning groups that *'... poor deaf awareness* [in GP settings] *may lead to misdiagnosis or underdiagnosis of mental health problems'*.[8] Although the NHS provides a large quantity of video resources, only a small percentage of these have access in BSL.

In 2015, Emond *et al*,[7] in the first comprehensive study of its kind, compared the health of the signing deaf community in the UK with that of the general population. The data collected via BUPA health assessment interviews indicated that deaf people's health is poorer, with probable underdiagnosis and undertreatment of chronic conditions, putting them at risk of preventable ill health and potentially reduced life expectancy. Emond *et al* subsequently provided a succinct overview of solutions for primary care services to improve access and communication with deaf patients.[9]

Though in 2018 the National Institute for Health and Care Excellence established guidelines for the assessment and management of hearing loss in adults,[10] equivalent guidelines for the delivery of primary care services to deaf sign language users is not yet available. In the same year, NHS England introduced *Guidance for Commissioners: Interpreting and Translation Services in Primary Care*[11] to assist with when patients and clinicians do not share the same language. This guidance sets out a range of principles to consider, including: service access for patients; a personalised approach; and the contracting of and working with interpreters. A welcome development is that this document specifically includes reference to BSL users and BSL interpreters.

Although Healthwatch reports cite some examples of the effective provision of sign language interpreters in general practice and other primary care settings,[1,12,13] such provision however will require specific considerations during the interpreted appointment in order to promote and provide optimum conditions to achieve effective understanding between the GP, the deaf patient, and the interpreter. Although a single or even a double GP appointment cannot resolve the health awareness deficit of deaf sign language users, small adjustments to the communication styles employed with this patient group can help to maximise interpreter effectiveness, patient understanding, safeguard patient wellbeing, and, in the longer term, save time and NHS resources.

MEANING MAKING

There is often an assumption that interpreters work within absolute conduit parameters. The interpreter as a 'conduit' is a somewhat mechanistic approach, where the interpreter adopts a presence that leans towards being more neutral and passive in both managing meaning making and the flow of communication. Interpreters may prioritise the exact phrasing and words over meaning, without deviation to clarify or elaborate, in order to ensure effective communication has taken place. Sometimes, this approach can work reasonably well, such as with patients who are fluent users of BSL and who are confident communicators and articulate. The trained and skilled interpreter can then process the flow of information between doctor and patient relatively easily. They can deliver the respective languages without having to make too many adjustments, often implementing a simultaneous approach (delivering the target language while simultaneously processing the incoming source language) with only a few seconds' delay for processing.

However, although sign language users can be considered a linguistic minority, there is considerable diversity in their sign language competence. This sublinguistic diversity, coupled with a plethora of other intersectionalities, may result in inherent challenges for the interpreter, who might need to adopt a consecutive approach whereby information is broken into chunks (the doctor or patient is asked to pause while the interpreter uses this additional

time to optimise understanding for both parties). They might also need to make use of additional semiotic resources such as images, drawings, or anatomical models, and adapt the sign language production in such a way that it incorporates more gesture and enactment to maximise the opportunity for meaning making.

Imagine the following scenarios: Patient 1, a woman in her fifties, has an established GP–patient relationship and can fluently express herself in her native BSL. Her GP has been monitoring cholesterol and blood sugar levels because the patient is pre-diabetic. This patient knows what these terms mean and the sign language interpreter in this appointment can manage the transfer of meaning between both languages without having to unpack concepts or significantly elaborate in order to convey them. Meanwhile, that same interpreter might take a very different approach for Patient 2. He is a deaf man, without similar BSL competence, and with additional communication needs due to Usher's syndrome, which requires sign language delivery with a greatly reduced visual field. In order to manage this, and draw upon other semiotic resources to make meaning, the interaction requires more time.

SHARED RESPONSIBILITY WITHIN TRIADIC ENCOUNTERS

In recent years, freelance sign language interpreters and interpreting agencies have highlighted an additional linguistic/cultural challenge, namely higher incidences of non-UK deaf sign language users within GP appointments.[14]

Lehane and Campion[15] address the issue of NHS-provided interpreters and ask if practices should recognise interpreters as more than simply translators of words (or signs when these interactions involve sign language users). Their answer is 'absolutely', for interpreters are cultural brokers, navigating meaning making with individuals that experience the world in different ways. Often, interpreters are perceived as being there for the patient, but actually they are there for the whole communicative act and all of the participants therein. Behind the ultimate goal of the patient's health enquiry sits the interpreter's goal of meaning making and to do so in a way that neither party has to work too hard to understand what the other has conveyed. Sometimes, the added variables of an educational attainment gap, reduced health literacy, additional disabilities (sensory, learning, or physical), and variable linguistic and conceptual competencies make it a minefield task of great complexity.

Therefore, it is somewhat reassuring to note that there are those who refer to the interpreter-mediated doctor–patient encounter as a 'triad'.[15] We posit that an acknowledgement of interpreters as visible co-participants in doctor–patient interactions is beneficial for all those involved — the GP, deaf patient, and the interpreter — whose role and intention it is to facilitate effective communication between both parties. This adjustment within the communicative approach helps to foster trust and understanding, and may result in improved patient attendance, which can ultimately help towards reducing the health inequalities that this community often still experience.

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