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Ensuring Equitable Treatment for People of Color Receiving Audiology Care

Isabel Guidotti
iguidot@ilstu.edu

Antony Joseph
Illinois State University, arjosep@ilstu.edu

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Isabel F. Guidotti, B.S.

For Fulfillment of the Doctor of Audiology Degree

Illinois State University Normal, Illinois

Ensuring Equitable Treatment for People of Color Receiving Audiology Care

March 2023

Advisor: Antony Joseph, MA, Au.D., Ph.D., CCC-A, CPS/A, F-NAP

Table of contents

Abstract 1

Introduction: As health care providers, serving patients equitably may require concurrent caring for the concerns and demands of family members as well. When striving to provide equitable care to patients of all backgrounds, familial participation throughout an appointment can play a substantial role. Case Presentation: An older adult male patient who used English as a second language presented with moderate, sloping to severe, mixed hearing loss, bilaterally. Hearing aid options were counseled and discussed in detail with the patient and his spouse. Discussion: The patient's wife played an active role throughout the appointment and served as a valuable advocate. This case serves to remind us that, in some cultures, family participation in the healthcare of a relative is more commonly observed and expected. Conclusion: Family-centered healthcare is a key component for the delivery of a culturally welcoming environment, and this should be a priority for all health professionals.

Case Presentation 1: Working with a Culturally Diverse Patient and an Active Family Member

Introduction

Creating a welcoming environment for every patient is an imperative component in successfully providing equitable healthcare to diverse patient populations (Moxley et al., 2020). This ideal clinical environment is achieved through cultural responsiveness, which is defined as providing services that are considerate of and receptive to the needs of diverse populations (Moxley et al., 2020). This coincides with the concept of cultural safety, which is cultivating an environment that promotes respectful practices and provides safe and inclusive services, as defined by those who are receiving the care (Ho, 2008). Cultural safety is maintained when a patient feels accepted and empowered to voice their concerns without the fear of being dismissed or marginalized (Ho, 2008).

For many patients, family members must be included in the evaluation and treatment, to fully implement a culturally safe environment (Ho, 2008). Often, parents, spouses, adult children, and even adolescent children play essential roles in the healthcare of their loved ones, particularly if the provider does not culturally or linguistically identify with the patient (Moxley et al., 2020). As healthcare professionals, audiologists should attempt to modify verbal and nonverbal communication appropriately, based on the patient and family, while actively aiming to cultivate a culturally and linguistically-sensitive setting for patients to be treated (Moxley et al., 2020). It is the job of an audiologist to adjust evaluation protocols and provide appropriate management options for patients even when cultural barriers exist (Khan et al., 2003).

Case Presentation

An older adult patient who used English as a second language was referred by his primary care physician due to a reported decrease in hearing, which his wife described as a gradual onset over the past 10 years. He presented to the clinic with a history of occasional tinnitus, chronic otitis media, difficulties with balance, and a history of pressure equalization (PE) tube surgery. The patient and his wife explained how his hearing loss caused difficulties when communicating with family members. They also reported difficulties with hearing the television, speaking on the telephone, and communicating in various social situations.

A comprehensive audiological evaluation was conducted that revealed moderate, sloping to severe, mixed hearing loss, bilaterally (Figure 1.1). Tympanometry revealed flat configurations with normal ear canal volumes, bilaterally, which is consistent with the patient's report of bilateral PE tube surgery (Figure 1.2). Speech recognition thresholds were obtained at 50 dBHL in the right ear and at 60 dBHL in the left. Word recognition testing was administered using the Northwestern University Auditory Test Number 6 revealing 86% at 80 dBHL in the right ear and 92% at 80 dBHL in the left.

The patient returned for a hearing aid selection appointment. A Most Comfortable Listening level was obtained at 65 dBHL in both ears. Loudness Discomfort Levels were obtained in the right ear between 103-113 dBHL and 113-120 dBHL in the left for 750 to 3000 Hz. The Quick Speech in Noise test could not be administered due to language differences. After discussing amplification options with the patient and his spouse, binaural behind-the-ear hearing aids were selected.

Discussion

As the country's population becomes increasingly ethnically diverse, it is the job of an audiologist to continue personal education on an ever-changing patient demographic and become culturally competent by learning how to collaborate, communicate, build relationships, and work effectively with patients from these populations (De Guzman et al., 2016). The demand for hearing care professionals to increase competency for culturally safe and equitable care is imperative, as approximately 92% of audiologists and 63% of hearing aid specialists identify as White (Joseph, 2022). Although the United States Census Bureau does not currently provide a category for individuals to identify as Middle Eastern, the Arab American Institute Foundation estimates approximately 3.7 million Arab Americans currently reside in the United States (AAIF, 2017). For many racially and ethnically diverse populations served by audiologists, such as patients of Middle Eastern descent, family-centered healthcare is indispensable.

While it should never be assumed that an individual fully identifies with the generalizations often associated with a cultural group, as a provider it is crucial to keep considerations in mind while serving a population one does not identify with (Moxely et al., 2020). In this case, it should be evident that the patient preferred his wife to be actively involved in conveying the specifics of his hearing health history. As such, she voiced her opinions throughout the amplification selection procedure. In situations such as this, a review of the literature stressed the importance of practicing active listening, empathy, and engagement when serving culturally diverse patients (De Guzman et al., 2016). Consequently, this will not only facilitate a culturally safe environment but also acknowledge an appreciation for the similarities and differences among cultures (De Guzman et al., 2016).

Conclusion

It is of utmost importance that patients with ethnically diverse backgrounds be provided fair services and equal treatment. One positive or negative experience with a clinician may set the tone for future encounters for the patient and their family. Practicing cultural responsiveness with patients and ensuring cultural safety are fundamental components in creating an atmosphere where a patient and their families can feel comfortable. In combination with audiologists working to actively continue their education, cultural responsiveness and cultural safety can be pivotal when successfully working with racially and ethnically diverse populations.

Abstract 2

Introduction: For patients of color with limited-English proficiency (LEP), cultural safety includes undisputed access to interpreting services during healthcare appointments, whether that be provided through a professional interpreter or a relative. As healthcare providers, we are both ethically and legally bound to have interpreting services available for patients to utilize. Case Presentation: An older adult female patient who used English as a second language presented with severe sloping to profound hearing loss in the right ear and a profound hearing loss in the left. Hearing aid options were presented and discussed in detail with the patient and her adult daughter, who acted as the patient's interpreter. Discussion: While the patient's daughter was sufficient in completing the appointment despite the extensive language barrier, some might suggest that a professional interpreter would be beneficial. By the same token, others might argue that using a family member as an interpreter would enhance cultural safety. Conclusion: The advantages and disadvantages of using a professional interpreter over a family member can be largely contended, but the central principle remains: an interpreter must be present in an appointment with a LEP patient.

Case Presentation 2: Working with a Patient and Family Interpreter

Introduction

The presence of an interpreter in an appointment with an LEP patient is a fundamental element in promoting cultural safety. Both professional and family interpreters seek to accomplish this, as they aid in promoting a bond of trust between the provider and the patient (Leanza et al. 2010). Cultural safety is sustained when the patient is treated equitably throughout the process of receiving healthcare services, which is significantly influenced by individual interactions (Ho, 2008). Ultimately, it is the provider's responsibility to ensure effective communication with patients. Healthcare professionals must develop intercultural and interlinguistic sensitivity, which cannot be achieved without acknowledging the importance of accessing services in their primary language (Leanza et al., 2010).

Although interpreter accessibility is considered an ethical condition for maintaining cultural safety, it also has medico-legal implications. According to Section 15 of the Language Assistance Services Act rendered by the Illinois General Assembly, health facilities are legally required to ensure a patient's access to medical information and services, regardless of one's limited-English proficiency (210 ILCS 87, n.d.). Several regulations within the state of Illinois outline the obligations of healthcare facilities, such as maintaining an annually updated policy regarding language assistance services, advertising the availability of interpreting services, and educating healthcare workers as advocates for patient rights (210 ILCS 87, n.d.). While the legal duty to provide language services to patients is clear, confusion can arise when utilizing a family interpreter in a professional setting.

Case Presentation

An older adult female patient who spoke English as a second language was referred by her ENT to be evaluated for amplification. The patient's adult daughter played an active role throughout the appointment as an interpreter, as her mother's first language was *Gujarati*. She presented to the clinic with a history of otorrhea but denied any history of chronic otitis media, aural pressure, or tinnitus. The patient's daughter explained that her mother's hearing loss impacted her in most social situations which prohibited her from effectively communicating with family members.

A comprehensive audiological evaluation and hearing aid selection were conducted. The audiologic evaluation revealed severe sloping to profound hearing loss in the right ear, and profound hearing loss in the left ear (Figure 2.1). Bone conduction audiometry was not completed due to previous test data, which demonstrated absent bone conduction responses at the limits of the audiometer, bilaterally. Tympanometry revealed low peak compliance in the right ear and a flat configuration with a normal ear canal and absent peaks in the left ear (Figure 2.2). Speech awareness thresholds were obtained at 75 dBHL in the right ear and at 95 dBHL in the left ear. Word recognition testing, The Quick Speech in Noise, Most Comfortable Loudness Level, and Loudness Discomfort Level testing could not be completed due to language incongruity between the patient and test instruments. After discussing amplification options with the patient and her daughter, binaural behind-the-ear hearing aids were selected.

Discussion

For some, interpreting can be adequately achieved through the use of family members. This scenario fulfills the legal requirement for a facility to ensure that the patient has access to appointment information. That being said, there are several advantages and disadvantages to a

family member taking on both personal and professional roles within a medical appointment. Similarly, some argue for the importance of engaging professional interpreters, as they are both qualified and objective, although they may not accomplish the same level of cultural safety and patient advocacy as a family member.

This case poses a difficult question and potentially ambiguous answer: Would this patient's experience be improved or diminished through the use of a professional interpreter? Even though the patient's daughter sufficiently relayed the conversation within the encounter, she inherently adopted the role of both caregiver and interpreter. Family interpreters often feel a social responsibility to the patient, which results in mediating and advocating rather than objectively relaying information as a trained professional might (Leanza et al., 2010). In addition, relative interpreters often extend their role to facilitate the patient's diagnosis, treatment, and recovery (Rosenberg et al., 2007). Nevertheless, professional interpreters have formal education on health literacy, serving as cultural informants, and directing effective communication between patients and providers (Ho, 2008). Situations such as this suggest that not all cases are straightforward when ensuring the best care for LEP patients, which suggests that professional literacy is essential to the provision of equitable care.

Conclusion

First and foremost, interpreting services must be offered and available to each LEP patient to instill an environment of cultural safety, as well as practice according to state laws. When deciding which type of interpreter should be solicited for an appointment, it is ultimately at the patient's discretion because it is their healthcare experience. Regardless, providers must strive to develop knowledge and sensitivity on the topic, to ensure that appropriate steps are taken with LEP patients.

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Figures: Case 1

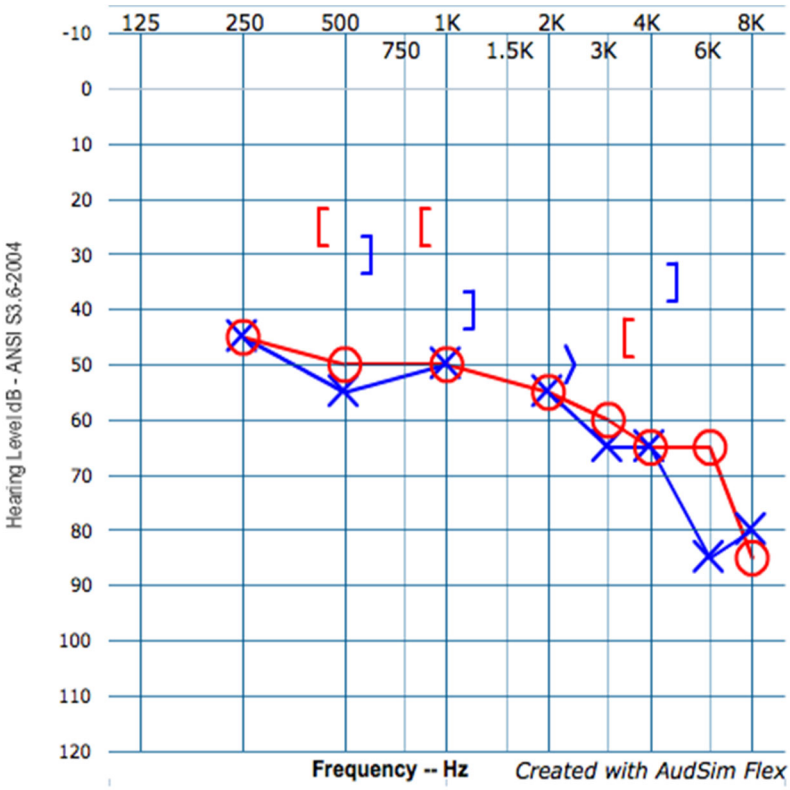

Figure 1.1 Pure tone audiometric data obtained from a previous audiological evaluation. The symbols connected by solid lines represent the air conduction thresholds.

Figures: Case 1

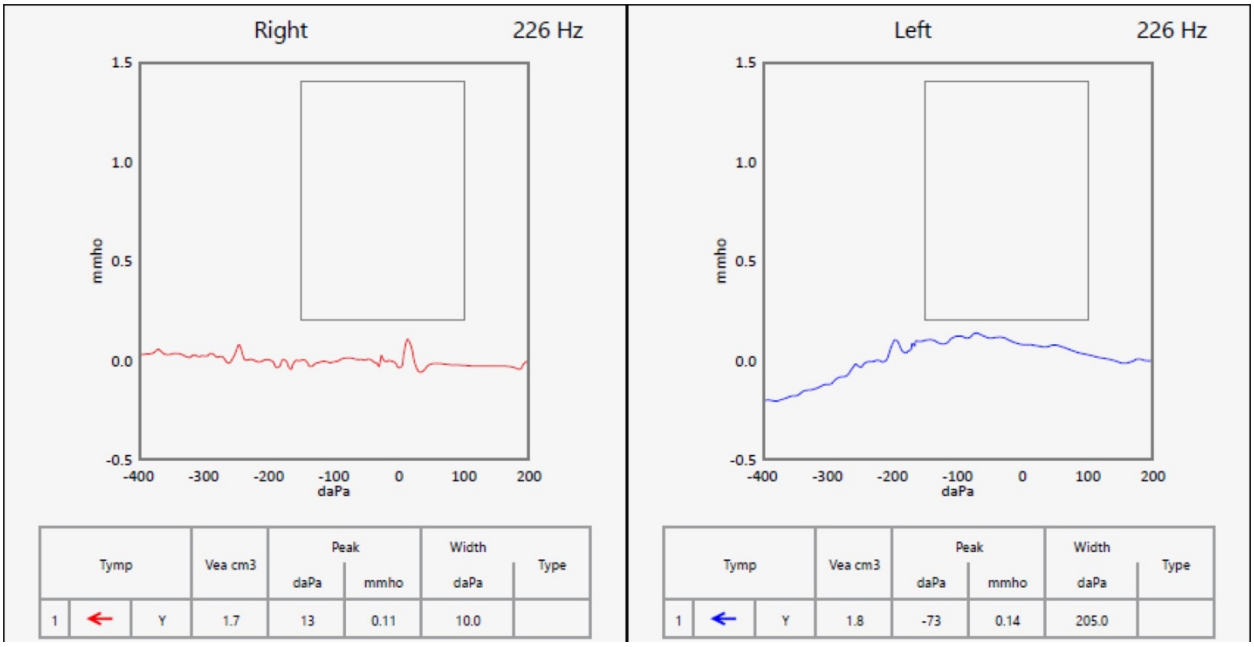

Figure 1.2 Tympanometric data from a previous audiological evaluation that revealed flat, Jerger Type B configurations with normal ear canal volume, bilaterally.

Figures: Case 2

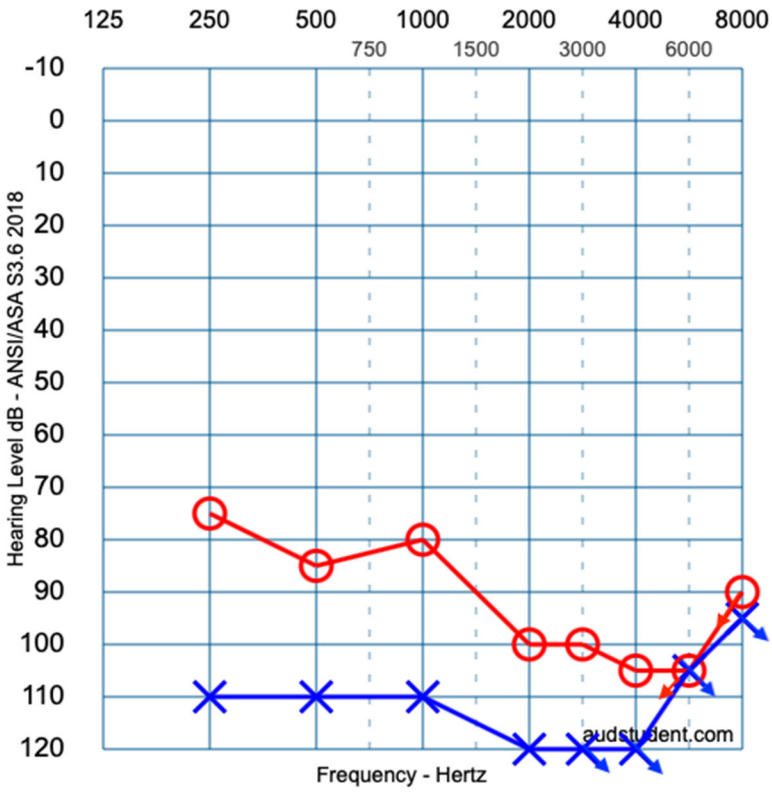

Figure 2.1 Pure tone audiometry obtained from a previous audiological evaluation that shows severe sloping to profound hearing loss in the right ear and a profound hearing loss in the left. The symbols connected by solid lines represent the air conduction thresholds.

Figures: Case 2

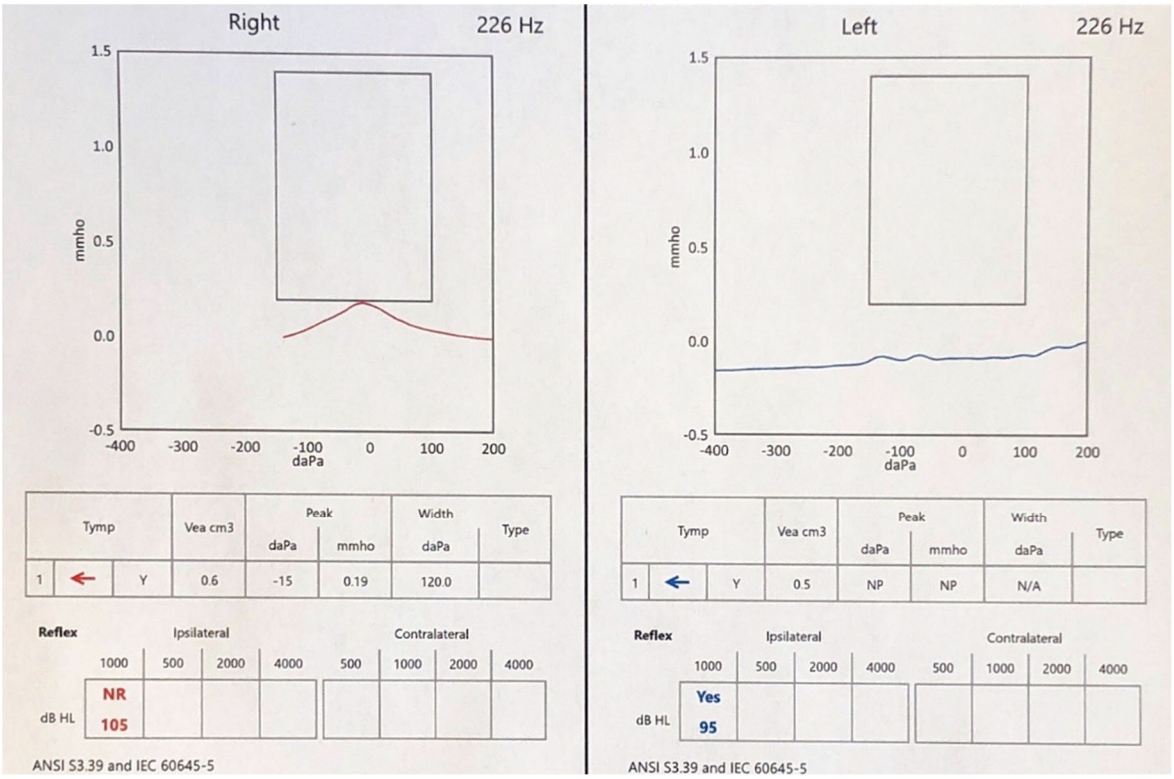

Figure 2.2 Tympanometry from the audiologic evaluation revealed low peak compliance, Jerger Type As configuration in the right ear and flat, Jerger Type B configuration with normal ear canal and absent peaks in the left ear.