Navigating Healthcare:
A Qualitative Study of the DHH Student Experience at RIT

Anonymous Authors
Rochester Institute of
Technology
Rochester, New York

ABSTRACT

Deaf and Hard of Hearing (DHH) students may encounter communication barriers in healthcare, like needing to use an interpreter to communicate. This may bring up concerns about privacy, trust, and correct treatment. Our study investigates the experiences and communication preferences of DHH students at the Rochester Institute of Technology (RIT) Student Health Center. Through in-text interviews with four DHH students, we asked questions about their preferred communication methods, privacy concerns, and the influence of generational context. Our findings revealed a strong preference for in-person communication through an interpreter or a provider fluent in American Sign Language (ASL). Most participants expressed frustrations with Video Remote Interpreting (VRI) due to technical difficulties and lower opportunity to build rapport with their healthcare provider. While one participant was highly concerned with privacy with interpreters, others had confidence in their professional ethics. The overall result of our study highlights the importance of patient autonomy and the need for diverse communication options. Our findings were limited by the small sample size from a single institution. We suggest that future research involves a larger, more diverse population, and include the perspectives of interpreters and healthcare providers.

1. INTRODUCTION

Healthcare access is influenced by both medical proficiency and the effectiveness of communication between patients and providers. Healthcare interactions for Deaf and Hard of Hearing (DHH) individuals sometimes rely on intermediary systems, such as interpreters, captioning devices, or written communication. Although these accommodations seek to establish equity, they concurrently present problems about privacy, trust, and accessibility. Previous studies emphasize that healthcare settings often favor verbal communication, rendering DHH patients susceptible to misinterpretation, diminished autonomy, and disparate treatment outcomes.

At the Rochester Institute of Technology (RIT), which houses the National Technical Institute for the Deaf (NTID), numerous DHH students access healthcare services via the Student Health Center (SHC). Despite the availability of interpreting services and assistive technology, many students express concerns about interpreter shortages, the quality of video remote interpreting (VRI), and the confidentiality level during medical appointments. Generational disparities, degrees of auditory impairment, and individual encounters with healthcare professionals significantly influence preferences for communication modalities, including in-person interpreters, video remote interpreting (VRI), direct American Sign Language (ASL) utilization by providers, or written English correspondence.

Our research focuses on the lived experiences of DHH RIT students during healthcare contacts. This study investigates the emergence of communication preferences and privacy concerns in interactions with the SHC, as well as the impact of generational context and severity of hearing loss on these preferences. To guide our investigation, we ask the following question: What are the preferred communication strategies for Deaf and Hard of Hearing students with their healthcare professionals?

2. METHOD

2.1 Procedure

For our study exploring the experiences of deaf and hard of hearing students at RIT when they visit the health care, we conducted interviews through text to learn more from students ourselves. Our goal was to gather in-depth, firsthand accounts to understand the nuances of their interactions with healthcare professionals. Specifically, two researchers conducted in-text interviews with deaf and hard of hearing individuals. The other two researchers focused on coding and thematic analysis.

2.2 Participants

The participants of this study were recruited students from RIT. The target population included students who identified as DHH and have gone to the Student Health Center (CHS). We conducted recruitment through various channels, including direct outreach to groupme and discord groups and reaching out to on-campus DHH student organizations. Most participants were contacted due to personal connections, and they were informed on the study's purpose and provided consent to their involvement. We recruited a total of 4 participants for our final study. The group was 4 males who were all RIT students, but notably, there were 3 graduate students and 1 undergraduate student.

2.3 Analysis

After sharing our interview data with each other, two researchers focused on coding the transcripts. The coding process involved a series of comments (with highlight) in a Google word document, and Google sheets to represent a code book for each interview. After this coding process, another researcher identified major themes within each coding, and refined them into one unifying codebook to avoid convoluting the data. This researcher created a clear and straightforward visual to represent our patterns and relationships more effectively, whilst the initial coding helped us understand the nuance behind the patterns.

3. RESULTS

After analyzing the data, our team discovered six core themes underlying the 4 participants' interview responses: communication preferences and modalities, technology in healthcare access, trust and views towards interpreters, experiences with healthcare providers, community and identity, and patient autonomy. A significant point of discussion emerged in the theme of "communication preferences and modalities", where participants frequently expressed their preference for in-person interpretation or otherwise that their doctor be able to communicate with them independently (e.g. through ASL, writing). In relation to this, we encountered some strongly negative accounts of the video remote interpreting (VRI) service that is otherwise used in many off-campus health service settings. In our core theme of "technology in healthcare access", participants expanded on these negative experiences with VRI, with participant 1 citing "there's glitching, the camera freezes, there's tech issues" and "There's no rapport", and participant 3 citing "sometimes the screen freezes, making my user experience a bit slower." And "When [VRI] freezes, the screen and audio tend to black out and the doctor has to call again." In addition to this, one participant also expressed distaste for virtual AI interpreting characters due to perceived generational differences, a lack of rapport, and a lack of trust that it could effectively translate complex communication. In the core theme of "trust and views towards interpreters", we found some variance of privacy concern, with participant 2 citing extreme concern and the desire for legally binding agreements to privacy, opposed to the other participants' responses reflecting higher levels of trust in the system and the code of ethics the interpreters must follow. Generally, participants expressed positive views of in-person interpreters' services. Specific to the RIT Health Center, the theme of "experiences with healthcare providers" produced a dichotomy of opinions; participants were either very satisfied with the service they received both from their doctor and method of communication, and one expressed that it was an overwhelming experience and that their doctor had been dismissive towards them. Participant 1, who reported satisfaction with their experiences, offered that they knew other DHH students that did not have positive experiences, citing personal feelings of overwhelm and a lack of interpreter availability. Through this, the two final core themes of "community and identity" and "patient autonomy" revealed themselves; all participants acknowledged that while they may not struggle with certain aspects of their communication, what works for them may not be applicable to others in the DHH community. They expressed that unique challenges such as those of international students, those who have experienced varying levels of language deprivation [1], and a lack of interpreter availability/options posed significant challenges for some members in the DHH community. Participants further expressed the desire for more options to accommodate these members as well as the importance of the patient's right to choose what works best for them.

4. DISCUSSION

4.1 Preferences

The analyzed results show a clear preference among DHH students for in-person communication with their healthcare providers. Participants favored direct interaction using ASL or writing, often with a human interpreter, over remote modalities. While remote technologies such as video remote interpreting (VRI) promote accessibility in theory, our participants reported that these systems often introduced frustration through glitches, technical delays, and the absence of in-person rapport. Several also expressed skepticism about virtual AI interpreters, citing distrust and difficulty in capturing the nuance of complex communication. Our findings reinforce the idea that new technologies, such as VRI or virtual AI interpreters, should first demonstrate reliability and cultural alignment before they can be accepted into their target community.

4.2 Barriers

Some participants expressed concern about interpreters' involvement in sensitive conversations, particularly in relation to privacy, while other participants were confident in interpreter professional ethics. These differing perspectives mirror reports in the literature that interpreters can both enable access and inhibit openness depending on the context and patient's comfort level; in a 2008 study on DHH accessibility in healthcare agree that "though interpreters are bound by a confidentiality agreement, the presence of a third person in a highly private conversation may reduce a deaf person's comfort and inhibit their willingness to speak candidly" [2]. In this sense, our results highlight the importance of autonomy: specific communication support should not be imposed, but rather offered in ways that allow patients to choose what feels most appropriate for them.

The findings also reflect broader issues of equity in healthcare access. Participants' concerns about interpreter availability, their mixed experiences with campus health services, and their acknowledgement of the diverse needs within the DHH community underscore the risks of standardized accessibility solutions. To achieve equitable care and mitigate patient overwhelm, healthcare providers should record and respect individual communication preferences, expand the availability of in-person interpreting and alternative methods, and train providers in DHH communication norms such as ASL.

4.3 Limitations

This study has several limitations. The small sample size of four students limits the generalizability of the findings, and all participants were from a single institution, which may not reflect the experiences of the wider DHH community. Self-selection bias is possible, as individuals with stronger opinions about healthcare communication may have been more likely to participate, as observed in some of the more extreme dichotomies of responses. The study also did not include perspectives from healthcare providers or direct observations of patient-provider interactions. These factors mean the findings should be interpreted as exploratory rather than representative.

5. CONCLUSION AND FUTURE WORK

The findings show that participants mainly prefer to have in-person interpreters or doctors who can communicate independently with ASL or through writing. Many participants were opposed to the use of VRI due to technical issues. There were mixed views on privacy, some participants had high trust while others did not. All the participants, but one expressed positive satisfaction with the services provided from RIT Health Center. These results addressed the research question for DHH students' preferred communication with their healthcare professionals. However, the study was limited by a small sample size of only four participants from a single institution, which does not provide enough information for broader DHH community experience with healthcare. Further research could involve a larger sample of DHH participants from a variety of institutions, interpreters, and health professionals.

REFERENCES

[1] Hall, Wyatte C et al. "Language deprivation syndrome: a possible neurodevelopmental disorder with sociocultural origins." Social psychiatry and psychiatric epidemiology vol. 52,6 (2017): 761-776. doi:10.1007/s00127-017-1351-7

[2] Piper, Anne Marie & Hollan, James. (2008). Supporting medical conversations between deaf and hearing individuals with tabletop displays. 147-156. 10.1145/1460563.1460587.