

Deaf and Hard of Hearing Students in Health Sciences Programs

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Abstract

Many health sciences programs and disability and rehabilitation professionals have taken the view that deaf or hard of hearing students will have difficulty succeeding in such programs. Actually, healthcare professionals who are deaf and hard of hearing have been and continue to be successful nurses, doctors, and dentists. The Health Sciences: Faculty Education Project is a three-year federal grant project located at Oregon Health & Science University (OHSU). The Project is one of 22 federally funded grants focusing on issues of educating faculty in higher education regarding the issues of students with disabilities. This is the only grant to focus specifically on health sciences programs.

Project Overview

As the number of students with disabilities has steadily increased in higher education programs, “high stakes” programs such as medical schools, law schools, nursing schools, and business schools are now feeling the impact of that increase of a diverse student population, including students with disabilities. Health sciences programs seem to be quite uncomfortable with the idea of students with disabilities as future doctors, nurses, and dentists. This project has focused specifically on training faculty in health sciences programs to the unique qualities of their programs and how to more effectively include students with disabilities in their programs. Faculty training has focused on the clinical training portion of students’ education. This is done through an interactive workshop called “A Day in the Life . . .”, which follows a student with a particular disability (deaf, LD, blind) through their clinical requirements in their particular course of study (nurse, doctor, dentate). Faculty play a key role in helping to “level the playing field” for the student in the case scenarios, as they brainstorm how to make it work while maintaining patient safety. Another key component of the training with faculty is the viewing of interviews we have conducted with practicing health care professionals who have disabilities themselves. These

videos illustrate the real life situations of successful health care practitioners with disabilities. These professionals discuss how they made it through school, what accommodations and strategies they used, and the value-added aspects they bring to their professions. These videos are available for purchase through our website at <http://www.healthsciencefaculty.org>

Unique Issues in Health Sciences Programs for All Students

There are several unique issues that come up when discussing *all* students in health sciences programs. The top two that are of consistent concern for faculty and students are clinical settings and patient safety. Students will be in clinical settings for a large portion of their training, and they will be working directly with patients. In fact, in some allied health programs there is very little classroom work, but rather the bulk of the training takes place in a clinical setting. Medical school programs usually include two years of clinical rotations.

A third unique issue for health sciences programs is the concept of the undifferentiated graduate, or the idea that all students must perform all skills. Even if someone chooses a specialty, such as pediatrics, s/he must perform all the clinical rotations – surgery, family medicine, ob/gyn, etc. This is true for all students. Students graduate with a broad education. Then, they spend their residencies focused on their particular specialties.

Most health sciences programs are lock-step programs. That is, there are very little to no choices about the classes students take and no choices about the order in which they take them. Lock-step programs have pros and cons. One of the pros is that students and faculty know what is coming next. It is not a surprise in what order classes will be taken; therefore, faculty and students can plan ahead of time. However, problems can arise if a student steps out of the program for any reason; this can include an illness or a family emergency (disability-related or not), and the student must wait a full year to get back into the rotation of classes.

A technical standard in health sciences programs is also a very hot topic. This includes all the non-academic requirements to get into a program. For most health sciences programs, there are usually prerequisites – a certain GPA and technical standards. Some technical standards are written very narrowly or specifically – for example, “You must be able to hear through a stethoscope” or “You must be able to

transfer a person from a bed to a wheelchair unaided.”

National exams are a fact of life for students in health sciences programs. In most cases, students have to take national and state exams to become licensed. The difficulty is that students with disabilities are receiving accommodations for their exams while in their programs, and healthcare professionals are receiving workplace accommodations; however, students are finding it very difficult or impossible to receive accommodations for state and national exams. This is very frustrating for students and faculty. A great deal of money is spent to educate and train health sciences students. These students are seen as capable and qualified, and they are graduating with their degrees from medical, nursing, and allied health programs. However, when these students take their exams – national and state – and request accommodations, they are being denied these requests.

Health sciences programs are fast-paced and rigorous. They want to keep students moving at a very quick pace, and students experience a great deal of stress. The environment is highly also competitive. Many of the students in these programs were top pupils in their undergraduate programs. They knew they were doing well and did not always have to work hard. However, in most health sciences programs, other extremely successful students surround them. Entrance into such programs is highly competitive, and students who have been accustomed to being at the top of their classes must compete with other students who are coming from the same perspective. No longer are students able to just slide through, so to speak, without much work; now they must actually study to pass.

Health care professionals are surrounded by the no-flaw myth. There is the feeling that if healthcare professionals are prescribing to others what they need to do to be healthy, they must present that they themselves are healthy. This means that they cannot admit that they smoke, that they do not exercise, or that they have any kind of flaw – such as, a disability. Few healthcare professionals will admit this, but it is pervasive. Students may bring this idea with them when they enter their programs, or they may be taught the idea directly or indirectly during the course of their studies.

Faculty members in health sciences programs play a different role than in most other postsecondary programs. Most college faculty members have a specialty they teach. They are knowledgeable about their topic and can assist students in the research and in-depth study in that field. Healthcare faculty members are usually clinicians first who also teach classes. They have the title of faculty but see themselves first and foremost as clinicians. When there is a student with a disability in the program, there are faculty members who will use their clinician roles to talk to the students as clinicians. They will make such comments as, “Have you been going to physical therapy? I know a specialist who can help you.” How-

ever, the students want to be taught; they do not want someone to take care of them. Faculty members do not intend this; rather, they resort to a role that feels the most comfortable to them. This role confusion can be hard on students. They are expecting to work with and communicate with their professors as faculty and mentors – not as clinicians who are questioning them about their own healthcare situations.

Disclosure Issues

Disclosure of a disability in health sciences programs feels unsafe and is, indeed, unsafe. There have been several court cases related to issues of accommodations for students with disabilities in health sciences programs. There is an immediate sense from institutions that if a student has a disability, s/he is automatically at a higher risk for issues related to patient safety. There are currently no studies or statistics that indicate that students with disabilities in health sciences programs have a higher level of patient safety incidents. Anecdotal information from students who have disclosed their disabilities shows that they feel a higher level of expectations and scrutiny. As a result, they feel there is no room for error, which is not the case for their non-disabled peers. There is a sense in the health sciences programs that students with disabilities do not belong there. The faculty, administrators, and students perpetuate this. It is not and does not feel safe to disclose; therefore, students with hidden disabilities (learning disabilities, attention disorders, and psychological disabilities) choose not to disclose. This is frustrating for the faculty members who are receptive to working with students with disabilities, as they feel they are unable to support or assist the students. There are some institutions that are receptive to having students with disabilities in their programs.

It is a competitive process to gain acceptance to most health sciences programs, and students who are accepted are considered excellent students. These are students who were accustomed to being the “cream of the crop” at their high schools or at their undergraduate institutions. They have had very little experience in failing to do good coursework. It is a new experience to be in a program in which *all* the students come from this same experience. Consequently, competition among students can be fierce. They do not want to admit to any flaws, and pride is at stake. They do not want to feel inferior, and they fear their peers’ reactions. They also do not want to be perceived as receiving favors or anything “special.” It is a culture that makes it difficult for students with disabilities to disclose. They do not want the resentment from their peers and would simply rather struggle than ask for accommodations.

ADA 101

The Americans With Disabilities Act (ADA) is not an entitlement law; it is a civil rights law that is akin to the Voter’s Rights law. The goal of the ADA, an anti-

discrimination law, is to assist individuals in getting in the door, so to speak. Unlike IDEA, the goal is not to foster successful learning but rather to create and set up a level playing field. There is a sense that if accommodations are provided the student will automatically be successful. In fact, the ADA is an outcome-neutral law; one is not guaranteed success. Individuals have the right to fail or succeed like everyone else does. However, a level playing field – that is, access to the educational environment – needs to be provided. This is different from IDEA, which stipulates the establishment of successful learning environments.

Southeastern Community College versus Davis (1979)

Southeastern Community College versus Davis (1979) is the only higher education court case to go before the Supreme Court. It happened eleven years before the birth of the ADA. However, 504 was in place.

Francis B. Davis was a hard of hearing person who applied to a nursing program at Southeastern Community College; thus, the existence of this case.

There are several issues that arose as a result of this case – the question of “otherwise qualified,” the fundamental alteration of a program, and unreasonableness. This case has and continues to be one that Vocational Rehabilitation counselors, disability support service providers, and faculty use as a way to refuse deaf and hard of hearing students’ admission into nursing programs.

Was Davis otherwise qualified? At that time, the ADA did not exist. The court decided that Davis had to meet the qualifications to get into the program *in spite* of her disability. Reasonable accommodations that might be used in the course of the program were not taken into account. Was she qualified with her hearing loss and without taking into account possible accommodations? The answer was no. Now the ADA has combined these two concepts – otherwise qualified and reasonable accommodations. In the Davis decision, these two concepts were not seen as related. Since the Davis case, there have been education and employment cases that have combined these two concepts. Today, courts also consider mitigating measures. They ask, is the individual still a person with a disability after mitigating measures are taken into account?

At the time, Davis read lips. It was 1979, and most of the technology we take for granted now did not exist or was not readily available. The nursing program said that the only way she could get access to information in the clinical setting was if she was closely supervised on a one-on-one basis. The institution deemed this to be unreasonable.

There is quite a bit of controversy surrounding this case, and it is still debated and discussed among disability professionals and lawyers. Was there a thorough investigation into the effects and level of her hearing loss? Were there other alternatives for her, aside from being closely

supervised and monitored on a one-on-one basis? Davis was not given the opportunity to demonstrate how she would safely access information and do her required tasks. The institution made its decision based on its experience with her during the interview process and the interviewer teams’ difficulty in communicating with Davis. Based on this, they determined and assumed that she would be unsafe in her work with patients.

The original court found in favor of Davis, and the case went to the Supreme Court. Since that time, the ADA has been passed, and the concepts of otherwise qualified and reasonable accommodations have been combined.

Technical Standards

Technical standards are “all the nonacademic criteria that are essential to participate in the program in question” (34CFR §104 Appendix A, ¶ 5). How they are written is important. Technical standards should assess *what* and not *how*. If the standard is “the student must be able to transfer someone or move 50 pounds,” then that is the *what*. One can move it by asking for help or using a lift, etc. This meets the *standard*. Technical standards, however, often detail the *how*, such as “the student must be able to lift the 50 pounds by him/herself” or “the student must be able to talk to patients.” Often, technical standards are written using exit criteria as entrance criteria, such as “the student must be able to hear to detect a heart murmur.” It is difficult to accept that as an entrance requirement. By the completion of the program, a student should know and be able to detect a heart murmur, but, prior to entrance into the program, s/he may not know what a heart murmur is. They are in the program to learn that information.

Technical standards should not be written specifically to exclude people with disabilities or as a description of impairment. However, this occurs all the time. Standards such as, “must be able to hear,” “must be able to see,” and “must be able to communicate through talking” exist. Technical standards are often written specifically to exclude people with disabilities. Furthermore, programs are not required to have technical standards unless their certifying body requires them. There are a few programs around the country that have done away with technical standards all together. Instead, they rely on academic entrance requirements, personal statements, and personal interviews for the entrance requirements.

Most programs have competencies students must complete in order to proceed in their programs and/or pass and graduate from their programs. Often these competencies assess the issues that many institutions try to pre-screen for by establishing technical standards. The hidden agenda surrounding the issue of technical standards is the issue of patient safety. Most institutions have a list of technical standards that are sent to accepted students. Students are expected to read and sign the standards, indicating they are able to meet/fulfill the listed

standards. Students are not asked to demonstrate whether or not they meet the technical standards – not until students have obvious or disclosed disabilities. Then, suddenly students are asked to show/prove that they meet the technical standards. If any student has difficulty in a class, most institutions will not reject or dismiss the student. Instead, they work with the him/her to remediate the problem or difficulty. The same needs to be done for the student that experiences a disability. There are many safety nets already in place. Institutions will not graduate unsafe students with or without a disability. If a student fails a competency or task in the lab setting, s/he is not allowed to proceed to the clinical setting. The student with a disability needs to be treated the same. Disability does not automatically raise a student to a higher risk level. If you *only* ask the person with the disability to prove they can fulfill the technical standards, that is a problem. Other students are asked only to sign-off on the technical standards while the person with a disability must, in some cases, actually prove they can meet the technical standards.

The bottom line is clinical and patient safety. Bells go off when a student has a disability; there is an automatic assumption that patient safety is at risk. One of the ways for students to address the situation is to do clinical observations. They can spend time at a clinical site with faculty and gain their respect. Faculty will then feel that an understanding of the environment in which they operate is forming. This will also give students the opportunity to determine, in some cases, what serious issues are versus what faculty members say are issues. For instance, many faculty members claim that the inability to hear overhead pages is problematic. However, many hospitals do not use overhead paging systems anymore, because they are sometimes ineffective. Doctors and nurses carry individual papers. This is not problematic for deaf and hard of hearing individuals.

Direct Threat EEOC Guidelines

The EEOC has developed guidelines that institutions and employers can use to determine if there is a significant risk of a direct threat. One cannot randomly decide that a person is unsafe to work directly with patients. The following question needs to be asked: Is this student or any student really at risk of doing harm to a patient? Instead of making a judgment call based on a faculty member's view about what a student with a disability can or cannot do, these guidelines offer a step-by-step process to follow.

Other Issues

Questions are often raised about core requirements or substitutions for such requirements. Another issue can be oral proficiency exams versus written exams. OCR court cases defer to academicians. If programs can prove that a requirement, competency, or specific type of exam

is essential, they do not have to change it. This is true for education in general – not just health sciences programs. The academic side of the court gets to decide what is core or essential. However, faculty or an institution can determine that it makes little sense to prevent a student from continuing or graduating simply because they cannot pass an oral proficiency exam.

Health sciences programs expect students to be as good at knowledge or the didactic portion of their programs as they are at the clinical portions. Students spend time in class showing they understand the material, and then in the clinical situation they must show they are equally adept at applying that knowledge. These are very different skills, and students are rarely equally skilled in both areas. Most faculty will tell you that the most important skill for a healthcare provider is critical thinking. Applying knowledge and critically thinking through problems are very important. However, when it comes to exams, students can pass the cognitive portion of exams with 80% but must pass the hands-on portion of exams at 100%. There seems to be a disconnection here in terms of the traditional culture's training of health sciences students and the reality of the skills they will need. This relates back to the issue of the undifferentiated graduate. Is it really the best medical training model to require students to go through an arbitrary set of rotations? Not all specialties are covered in the rotations, and if there is one of those rotations a student cannot do, s/he cannot become a physician at all.

The Role of Disability Support Service Providers

Vocational Rehabilitation counselors, disability support service providers, and faculty must not limit their clients or students with disabilities. They must not automatically assume that a person with a disability cannot become a healthcare professional, and they must consider what they can do to eradicate misperceptions. It is important to understand that there are many successful individuals who are practicing healthcare professionals and people who experience some kind of disability, including deaf and hard of hearing nurses. It is also important to understand what the Davis case did and did not say. Disability support service providers can use that case as a way to understand program requirements and technical standards – reasonable and unreasonable. They must not use it as a way to deter deaf or hard of hearing students from pursuing careers in the health sciences professions. There are still roadblocks ahead, but healthcare professionals with hearing losses are showing that they are competent, capable professionals who bring a wealth of information and experience with them to the profession.

Resources

Websites:

Health Sciences Faculty Education Project
www.healthsciencefaculty.org

AMPHL (Association of Medical Professionals with
Hearing Loss) www.amphl.org

WROCC Outreach Site at Western Oregon University
www.wou.edu/wrocc

PAH, MD (Promoting Awareness in Healthcare,
Medical and Deaf)
[www.urmc.rochester.edu/smd/stdnt/pahmd/
welcome.htm](http://www.urmc.rochester.edu/smd/stdnt/pahmd/welcome.htm)
E-mail: PAHMD@aol.com

Technology:

Job Accommodation Network (JAN)
800-ada-work (v/tty)
E-mail: jan@janweb.icdi.wvu.edu
<http://janweb.icdi.wvu.edu>

Harris Communication
800-825-6758 (v)
800-825-9187 (tty)

List Serv Chat Group:

NOISE (Network for Overcoming Increased Si-
lence Effectively)
Contact Danielle at drastet@attglobal.net.