

The Silence Behind the Mask: My Journey as a Deaf Pediatric Resident Amid a Pandemic



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A PATIENT HAD just arrived from the emergency department with respiratory failure, and I felt the high tensions given the potential for coronavirus disease of 2019 (COVID-19). Feelings aside, the intensive care unit (ICU) team assembled, buzzing around me with personal protective equipment on full display—yellow gowns, gloves, surgical masks, and N95s. The code cart and ventilator were eerily on standby. Our patient was flawlessly cared for by the skilled ICU team, but there was just one problem. As a deaf resident, I had no idea what was going on.

The COVID-19 pandemic exposes multiple disparities, especially related to hearing loss. This contributes to significant isolation for individuals like myself, and not only from the lack of social interaction to keep the virus at bay, but also from the rising barriers in daily communication. As the sole resident with profoundly reduced hearing in a large, academic, quaternary hospital, I was used to the solitude, but this introduced a new level of loneliness I could not comprehend.

One of the most critical interventions to decrease the risk of transmission of COVID-19 has been the institution of universal mask wearing. This was properly established at our hospital for the protection of the patients and the employees. However, as the rest of the hospital employees relished this extra layer of safety, I felt a knot in my stomach tightening. I communicate primarily by reading lips, but this new policy eliminated that critical skill. To protect myself and others from this virus, I lost the one tool that allowed me to participate in important interactions and to execute clinical care. The irony left me feeling hopeless and inferior, forcing me to retreat alone to my dark call room, a place where I expected the silence.

There are modified surgical masks with a clear window surrounding the mouth to allow for lip-reading. These masks have alleviated a significant amount of distress, however, they are not universally available and only allow me to control my immediate work environment. In the beginning of the pandemic, they were on back-order due

to a large influx of requests. I carried around a box in the ICU, careful of who I would administer a mask to. I felt patronizing and shallow, deciding who was worthy of a mask and a conversation with me, a mere resident. In a busy 30-bed ICU, the opportunity for learning was so rich, but I couldn't be greedy as my supply dwindled.

Even now with an adequate supply of masks, my ability to communicate and interact independently with the world remains limited. I cannot engage in small talk with the masked cashier in the cafeteria, and instead act busy as if I'm warding off a call, hoping that I do not seem impolite for avoiding a conversation. I no longer order my specialty sandwich for fear of the masked chef asking me questions I cannot understand. Instead, I now select pre-prepared food, and although a minuscule issue, it was previously the highlight of my long, grueling shifts. If I am asked hospital-related geographic questions from lost patients and their family members, I look down at the ground, avoiding eye contact in the hope that they choose another employee to approach. I keep my face glued to my cellphone in the elevator to avoid casual conversations about the weather. I drag my partner to my own health care appointments, putting him in the awkward situation that we must be the exception to the visitor policy so he can help me understand. Maybe I should blame my mid-western roots for valuing these small interactions and my independence, but the lack of engagement left me feeling less and less like a human being.

Another tremendous obstacle in this pandemic is the shift away from in-person congregation to the virtual world—meetings, conferences, clinics, even interviews for my next step in training. I struggle to articulate how lip-reading on a screen is more difficult. There are many small challenges that aggregate into substantial barriers, including participants choosing to forego the webcam, or not having this feature available, inhibiting my ability to lip-read. The small screen of a computer or phone minimizes the lip-reading view for those with webcams

enabled, and the message becomes unintelligible with a dim-lit face or poorly positioned camera. Most conferences, lectures, and patient visits are without closed-captioning, eliminating a strategy to ensure adequate communication. In addition, audio-visual delays cause discrepancy between spoken language and the motions of the lips, making it difficult to interpret what is being communicated. I recall the deep insecurity I felt in the ICU when the morning team huddle transitioned virtually to maximize safe distancing, and the shame I felt when I had to rely on my coresidents and nurse practitioners to translate messages. In each artificial meeting, I feel myself becoming more and more distant.

As a deaf health care professional, I have faced many challenges in my life and training, but never with such an intensity as is occurring during this pandemic. The disconnection has accelerated pre-existing feelings of burnout during my rigorous training. I fear that many of my fellow deaf and hard-of-hearing (DHoH) health care professionals may also be experiencing the same exhaustion both in the workplace and also in the community. Some skeptics may worry that accommodations to neutralize barriers for the DHoH may not be worth the hassle as there are many qualified candidates without disabilities, but we serve a very important role in contributing to diversity of the work force and to closing the gap of health inequities faced by populations with hearing differences in addition to providing exceptional care.¹ My deafness has made me an active listener as I engage my undivided attention on those I converse with to ensure no misunderstanding. I'm in tune to subtle changes in body language, developing empathetic connections with patients and families and forming a therapeutic alliance. By advocating for my own accommodations in my institution, I use my unique platform to pave the way to provide accessible health care to DHoH patients and other health care professionals who may also need a clear mask or other similar resources. I also help rewrite the narrative that disabled individuals cannot pursue esteemed careers, which helps to decrease implicit bias within the medical care system and allows for us to serve as mentors and role models for young DHoH children.

In the heat of this pandemic, I urge all health care professionals to be cognizant of the barriers faced by your DHoH colleagues and patients. My self-advocacy can only reach my immediate environment, so there needs to be a more robust response from health care workers to be patient and empathetic. There are many reasonable actions that help alleviate the burden. Although not every institution will have clear masks, I found substituting a more readily available clear, powered, air-purifying respirator can serve as protective personal equipment and does not completely render lip-reading ineffective. There is a

wealth of technological tools and smartphone applications to assist in communication when interpreters and lip-reading visuals are not available.^{2,3} For virtual conferences, lectures, and meetings that do not require Health Insurance Portability and Accountability Act protection, Google Meet and Microsoft Teams have a live captioning feature to aid in ensuring the content is understood by all parties involved. Ultimately, I have found the most powerful tool to be recognition of these barriers, and collaborative advocacy to overcome them.

As I think back on my experience in the ICU at the beginning of the pandemic, the glimmer of hope that shined through was seeing the product of persistent advocacy and empathetic responses from my colleagues. On my developmental medicine rotation in residency, I had the opportunity to explain and suggest some simple accommodations to my coresidents, and they selflessly stepped up, communicating brief messages of the fleeting consultants, redirecting other health care personnel when they got distracted by the way the clear masks look, assisting with communication on rounds, and most importantly, always making sure I was still learning. I communicated early to program leadership who worked to establish a running supply of clear masks. But in a busy and unfamiliar setting, I fear a new DHoH patient walking into the hospital will be overwhelmed and intimidated by the quiet commotion. I want the health care community to be more prepared when they learn that someone is DHoH without a long explanation of how they can help. I hope this can provide you with tools to recognize the fear, and the empathy to help overcome the silence behind the mask.

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