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Deaf Dentists Diversifying Healthcare: Stories of Struggle and Success through a Comparative Case Report

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ABSTRACT

Context: Deaf and hard of hearing (DHH) dentists are well suited to provide quality care for many diverse patients including those in the deaf community. However, DHH dentists face unique challenges in dental school, and as practicing medical professionals. Past research has focused only on hardships experienced by DHH dental patients. This comparative case study aims to be the 1st formal effort to learn more about DHH dentists' experiences and investigate strategic tools that could guide future DHH individuals pursuing dentistry.

Case report: This comparative case study was performed through observations and semi-structured interviews with two deaf dentists, and an interview with one hearing coworker each (n=4). Field notes were taken during each observation, and interviews were recorded and transcribed into English text. Thematic analysis identified three common themes among participants:

1. Challenges faced and adaptations used by DHH dental professionals
2. Hearing peers' support of, and learning experiences from deaf dentists and
3. Unique qualities deaf dentists possess.

Conclusion: Findings from this case study show minimal need for accommodations in most aspects of dentistry. The largest areas of concern regarded missing informal office communication, difficulty explaining complex terms, and challenges with captioning or interpreting in dental school/clinical. Hearing coworkers made small adjustments to support communication, and encouraged positive attitudes among patients. Both DHH dentists reported that their deafness contributed to their unique motivation to become a dentist, elevated skills in dentistry, and additional sense of responsibility for teaching oral health education to their DHH patients.

Keywords: Attitude; Communication; Delivery of health care; Dentistry; Hearing loss; Oral health; Sign language

INTRODUCTION

Background on Deafness

430 million people worldwide experience hearing loss that impacts communication access [1]. In addition to communication challenges, many deaf and Hard of Hearing (DHH) people also experience lower socioeconomic status and lower health literacy due to various struggles and systemic biases they face [2,3]. Statistics show that the deaf community experiences lower rates of postsecondary education completion and higher rates of enrollment in community colleges or trade schools than their hearing peers [4]. Hearing dentists will very likely encounter DHH patients during their careers, and may not be aware of the challenges involved, or familiar with methods to provide adequate communication and treatment.

Challenges Faced in Dental Offices

Countless medical professionals and much of society, view deafness as a malady that must be 'fixed' as opposed to a diverse culture that should be embraced [5]. The persistent

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misconception that hearing aids and cochlear implants 'cure' deafness combined with lack of cultural competence knowledge and unfamiliarity of non-verbal communication modes contribute to a significant communication gap between dental providers and their DHH patients [6]. The recurring nature of dental appointments and the process of oral health education can be especially challenging for both parties.

Common concerns DHH patients have regarding dental visits include miscommunication, poor understanding, facial obstruction due to masks, and background noise [7,8]. Negative attitudes towards individuals with hearing loss by the auditory-dominant society are another challenge [9,10]. Health personnel tend to lack training on how to communicate and interact with DHH patients which contributes to not only patient dissatisfaction but also induces fear and anxiety for many, resulting in less frequent dental visits [11-13]. In many cases, these patients seek treatment only in dental emergencies [6]. When patients do not receive regular dental care, they typically have limited oral health knowledge and worsened dental conditions. Studies have shown that there exists a large knowledge gap between hearing and DHH adolescents on proper tooth brushing and a higher prevalence of dental caries and gingivitis in DHH children [14-16]. It is evident that DHH patients don't typically receive adequate health care from hearing clinicians.

Prior Efforts towards Solutions and Accommodations

Challenges experienced by DHH patients in healthcare have been well-documented as well as the advent of various strategies to mitigate barriers, one being clinician use of introductory American Sign Language (ASL). Jones and Cumberbatch reported that Case Western Reserve University School of Dentistry in the United States designed an 'Introduction to Deafness' course in the 1980s, though it was never actually offered [17]. The University of the West Indies in Jamaica was the 1st to actually implement and sustain a sign language course; however it is unknown whether their graduates continue using sign language in their practice. The advantage behind sign language training is that not only does it enhance dentists' communication ability with their DHH patients; it also develops a more empathetic and culturally aware dentist. There is no record of hearing dentists fluent in sign language of their nationality.

Kumar described an experiment with DHH adolescents using Visual Performance Reinforcement (VPR) approach as an alternative to extensive sign language training, or reliance on interpreters in India [18]. The VPR technique included a video of cartoon characters providing oral health education in sign language with captions in English text. Following this, the provider gave tooth brushing instructions on a model, and the patient practiced on the model. This VPR technique showed statistically significant success in lowering gingival and plaque scores in DHH adolescents, and similar success was also observed with DHH Saudi Arabian adults [19].

Additional accommodations may also need to be considered, such as lowering or removing one's face mask to allow for lip reading during basic conversation. While lip reading is not completely accurate, it continues to be a communication preference for many DHH people as this mode is the most accepted norm by mainstream society [20]. This practice was compromised during facial mask mandations in light of the COVID-19 pandemic, placing additional stress on DHH patients and their healthcare providers, hearing and DHH [21]. A wide spectrum of communication preferences among people with hearing loss arises from a combination of their educational and familial backgrounds, and 1st language of acquisition [22]. Therefore, accommodations are best developed through direct, individual consultation with each patient to ensure their unique preferences are most accurately adopted.

Limitations of Hearing Dentists

While many communication tools and accommodations may seem like simple adjustments, they appear to be met with a great deal of reluctance. It is ironic that healthcare professionals learn about the etiology and biomechanics behind hearing loss, yet common misconceptions about issues involving DHH persist–their communication ability, intelligence level, literacy, and sociocultural norms [23]. Today, many hearing dentists continue to rely heavily on the lip reading abilities of their DHH patients-which is known to be inaccurate and inadequate unto itself [7,24,25]. Yet 62% of dental providers expect their adult DHH patients to understand their articulation while using face masks that cover their lips [11], which seems to be contradictory to their medical training regarding hearing loss. Others use written notes-which are time consuming and dependent on individual literacy levels [7,12,24]. For ASL users, the medical terminology and syntax differences between ASL and written English may also impede full comprehension of what is being explained [13]. Şuhani found that 68% of hearing dentists interviewed believed they were not qualified to provide adequate dental care to deaf patients due to communication barriers, necessity of extended appointment times, and cost of interpreters, with 16% outright refusing to provide care to DHH people [26]. Hearing dentists may feel uncomfortable giving proper care to DHH patients due to the absence of dental school curriculums teaching necessary communication skills [22]. Barriers to accessing dental care still exist, regardless of legislation requiring effective communication among physicians and patients, as outlined by the Americans with Disabilities Act (ADA) passed in 1990 [22].

Benefits Deaf Dentists Offer

DHH healthcare providers are more willing to care for deaf people, some reporting that 1/3rd of their caseload consists of DHH patients [27]. Many deaf professionals redefine their career success by serving others, which drives them to take on broader roles where they can help more people in their communities [28]. For example, many DHH physicians and dentists do not specialize, but choose general paths where they can treat more of their community members.

Deaf medical professionals are also more likely to provide quality care by using effective communication strategies and exhibiting cultural competency [29]. Examples of communication strategies that deaf clinicians may be more aware of are opening doors slowly when knocking is not an option, minimizing background noise, facing the patient, ensuring adequate lighting, and refraining from obscuring their face [22]. Due to shared experiences, DHH medical providers are also more em-

pathetic with their patients' complex feelings surrounding their deafness: Denial of hearing loss, mourning loss of communication, sense of isolation, and feeling blamed for needing support [22].

Not only can DHH healthcare professionals provide superior care to their own patients, they often elevate their colleagues' expertise and tolerance for treating DHH patients [30]. Similarly, DHH healthcare students often educate their classmates on communication and care strategies for the DHH population [31]. Therefore, considering DHH dentists provide better care and accessibility for DHH patients, it would be beneficial to learn what tools can help support their success.

Existing Literature on DHH Medical Professionals

As we have seen throughout this review, supporting deaf dentists is an effective way to augment patient care. However, most existing literature focuses on DHH as patients and examines what strategies could be utilized to accommodate them. There is a research gap on challenges faced and adaptations used by DHH professionals practicing dentistry and dental school students. To date, we have not identified any prior research specifically focused on DHH dentists; however, we have found limited research that has been conducted concentrating on DHH medical professionals in general.

One research study involving DHH medical professionals reported high satisfaction rates regarding their accommodations, which include modified stethoscopes, auditory equipment, note-taking, Computer-Assisted Real-Time Captioning (CART), signed interpretation, oral interpretation, and telephone adjustments [30]. The biggest hindrance described in this study was the significant amount of time each professional spent arranging their own accommodations towards equal access as their hearing counterparts. DHH dentists have their own unique experiences and therefore may use different accommodations than other medical professionals, or than previously used in academic training. This needs to be investigated and recorded to share among aspiring DHH dentists, so they can have a greater chance to succeed and go on to serve the DHH patient population.

DHH Students

In addition to supporting DHH dentists, DHH dental students also need advocacy. Students with impairments, including DHH students, are severely underrepresented in medicine and dentistry [32]. One reason for under-representation is that many teachers and parents do not encourage DHH students to pursue advanced careers in science, technology, engineering, and math (STEM) as they do for hearing students, leading to discouragement and lack of belief that careers in any occupation are achievable [33]. In addition, there is a paucity of deaf role models in medical professions and in scientific fields. One study reported that there are no deaf science teachers in any schools for the deaf in New York State [31].

A significant barrier towards DHH matriculation into medical training programs is technical standards. These standards list traits or actions that medical students must have or be able to perform without aid, rather than outcomes that could be reached with reasonable accommodations [34]. These harsh regulations prevent many students from applying to medical and dental schools, and discourage others from disclosing their disability [35]. However, many physicians experience hearing loss later in life and continue practicing medicine, proving that technical standards do not outline necessary attributes for practicing medicine [31]. In fact, it is well-known that dental professionals experience noise-induced hearing loss due to high noise levels in the operatory [36], and yet they continue practicing. Arguably, DHH students have more experience living with hearing loss and therefore have more tools for success than those that became deaf later in life. With this in consideration, DHH students may actually be able to teach strategies to hearing students and those who acquire deafness later in age [31].

Accessing accommodations can also be challenging for DHH students, because they often do not know what is available, or what current technological advancements there are, such as in amplified electronic stethoscopes [37,38]. Disability resource providers are meant to assist in these situations, but most are not trained in medical fields, and cannot provide adequate advising [39]. Therefore, many DHH medical students struggle to request appropriate accommodations. Some students were more successful in developing strategies for overcoming their hearing loss or requesting accommodations if they had previous work experience [10]. However, students also must disclose their disability if they request accommodations, thus risking a shift in their teachers' opinions of them [40]. Even if a student had the knowledge, ability, and support to request access services, 31% were denied those accommodations [38]. As a result, it is often implied that using accommodations in medical training or residencies is discouraged-a significant problem, as studies have shown that DHH people who have inadequate access to accommodations in school exhibit a higher prevalence of depression [27].

Institutional Preparedness

Despite the countless struggles students encounter during postsecondary schooling and medical training, most institutions place the responsibility of being prepared for success on the students themselves, many who do not know what resources are available to them. Universities are responsible for providing accommodations that assist DHH students in social environments as well as in the classroom as mandated by ADA and section 504 [40]. However, they insinuate that it is the student's responsibility to possess not only academic knowledge, but also self-advocacy, leadership, and social skills for success [41]. Some universities do not provide intersectional training in cultural awareness and acceptance to ensure their faculties are able to offer appropriate accommodations without bias. DHH and other disabled students frequently experience identity erasure, and seek homes where they fit in on their campuses [42]. Most universities do not have the resources to support intersectional students. Some institutions have tried to address this by shifting their disability service offices to Disability Cultural Centers, which aim to celebrate those students' intersectional identities [43].

Transition from School to Work

DHH students may struggle even more after postsecondary school due to lack of preparation, additional challenges, and identity changes. One study described a student as being "shocked" to find out how difficult it was to fight for workplace accommodations after graduation [38]. This study revealed that institutions may need to take steps towards better student preparation for the reality of the workforce. In other situations, universities with strong social justice standards shelter their students from discrimination, thus students are not well prepared to handle prejudice encountered in their professions [33]. Many DHH students feel that lack of understanding about hearing loss will be the biggest barrier in their career success due to negative attitudes and incidents of frustration from their coworkers or employers [10,38]. Due to new challenges in a post-graduation environment, many students will alter their identity when they leave university and stop identifying as disabled, for fear of others' reactions [32]. A DHH person should not have to hide parts of their identity, but it is often the result of surviving in an ableist society.

On the other hand, academic curricula do not adequately expose hearing healthcare students to caring for patients with diverse abilities, which contributes to insufficient preparation to meet their needs, such as the unique communication needs of the DHH population [12]. Gilmore described an effort to expose medical school students through an optional deaf awareness and basic sign language module during their 2nd year [44]. Greene and Scott designed a Deaf Culture session during the ear anatomy unit for medical school students in their 1st two years, also with optional attendance [45]. A similar educational workshop designed by Lock was also offered electively to 1st and 2nd year medical school students [23]. These short-term, elective programs do not have lasting effects in the long term, as evidenced by continued disparities in healthcare access for DHH patients. Even more, these efforts do not benefit the rare DHH healthcare student. The dental field needs to support not only hearing professionals but also DHH individuals who can succeed in their endeavors while celebrating their identities.

Goals of this Study

This study aims to learn the experiences of two practicing DHH dentists, including their challenges and type of accommodations used in dental school and in a dental practice. In addition to the DHH dentists, two hearing coworkers will be included to give their insights into what it is like to work with a DHH healthcare professional, highlight where accommodations are most needed, and what lessons can be learned from DHH dentists. This information will be the 1st step towards building a knowledge base that can support DHH dentists, dental students, and hearing stakeholders. Culturally competent dentists trained in ASL will provide a higher standard of care for DHH patients, increasing their oral health literacy and overall dental hygiene.

METHODS

Comparative Case Report

Ethical considerations: Ethical clearance was obtained from our Institutional Research Board. This study strictly adhered to the ethical standards of human experimentation and the Helsinki Declaration of 1964, as amended in 2013.

Methods: Data was collected through observation and semi structured interviews with two deaf dentists. At the time of this research, there are 6 known DHH dentists (four in the United States, One in the United Kingdom, and one in Egypt). Due to the small sample population, two participants in the United States were directly recruited. Prior to interviews, verbal and written consent were obtained from each participant. Each interview was video recorded and transcribed into English text by a team of ASL interpreters and the interviewer. The observations were performed over two full work days with each dentist. A hearing coworker was recommended by each DHH dentist and interviewed to learn their unique perspectives gained by working with a deaf person as a healthcare professional, not as a patient. Identifying information was removed or altered. Study methods are illustrated in Figure 1.

Figure 1: Diagram depicting study methods

Participants: In an effort to gain a more holistic sense of how DHH dentists function in their clinical environments, two participants with contrasting features were recruited. Dentist #1 is older, more experienced, and practices in an area with a large DHH community. Dentist #2 is younger, less experienced, and practices in an area with a smaller DHH community. Dentist #1 works in a large group practice while Dentist #2 practices as an associate in a clinic (with hopes of branching out into their own practice someday). Their hearing coworkers also brought contrasting experiences, one being familiar with DHH in general while the other had no prior experience with DHH. Figure 2 compares and contrasts the DHH dentist and hearing coworker participants.

Interview structure: Interview questions focused on three main themes:

- Challenges and adaptations used in a dental practice and how those compared to dental school

- How a hearing dentist or coworker may offer support to, or learn from a DHH dentist and
- What DHH dentists do differently than hearing dentists, and how that might contribute to the larger DHH community or their own sense of identity as a person with hearing loss.

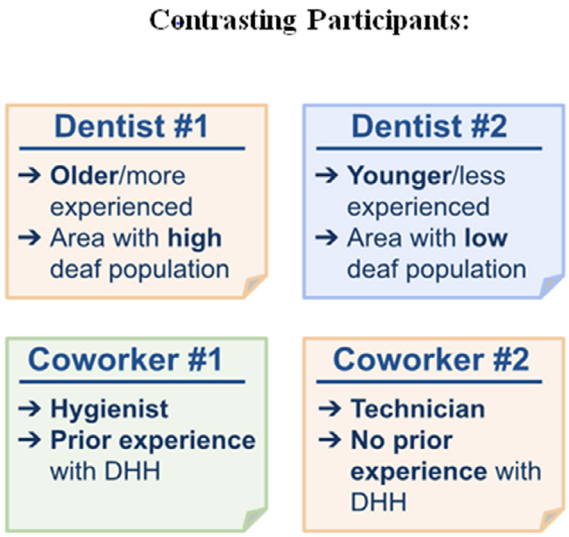

Figure 2: List of the main characteristics setting the participants apart

Participants were observed before their interviews, allowing the interviewer to expand on the initial questionnaire to include their unique individual experiences. Despite the differences in these dental professionals' backgrounds, there were many clear similarities. The initial themes were strongly evident in their responses as well. **Figure 3** summarizes each theme and their associated findings.

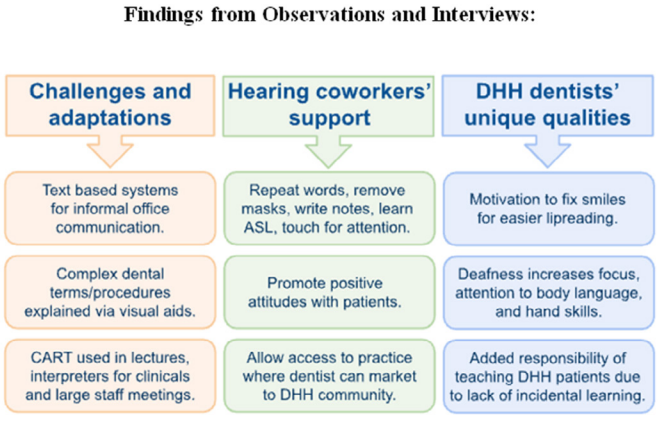

Figure 3: Model showing the main findings across the three themes

Theme 1: Challenges and adaptations: The 1st theme focused on challenges faced by DHH professionals in dentistry and what adaptations were used to overcome those challenges, as well as how those experiences compared to dental school. Observations revealed that dental appointments typically involve a one-on-one interaction which eases communication challenges during appointments. Indirect communication in the office still posed challenges though. Dentist #1 uses a "text-based communication" system in their office to communicate informal information among coworkers, and email or text to communicate with patients (personal communication, July 14, 2023). This eliminates the use of phones, which was seen as the biggest barrier in Dentist #1's early career since there was no adaptive technology such as teletypewriters, relay services, computers, or cell phones. Technological advancement is largely responsible for mitigating communication barriers. Dentist #1 explained that their text-based system also benefits hearing colleagues, as text messages can be "more efficient" and less "disrespectful to the patient" (personal communication, July 14, 2023).

Another common communication challenge was describing complex dental terms, procedures, or anatomy to patients. To overcome this, Dentist #1 typically shows visual aids such as X-rays, pictures, and diagrams on a television screen to help explain intricate topics. The dental hygienists also use visual aids typically in the form of printed information about dental procedures or products (personal communication, July 14, 2023).

When asked about accommodations used in dental school, Dentist #2 stated a preference for Communication Access Real-time Translation (CART) during lectures to help with understanding "big words and terminology." However, during clinicals, an interpreter was preferred due to challenges with the additional delay in translation with captioning (personal communication, July 27, 2023). Dentist #1 had no access to accommodations during dental school, as ADA had not yet been passed. Dentist #1 shared an example of self-advocacy used instead. During an interview with a dental program, the room was backlit making it hard to lipread the interviewers. Dentist #1 asked the interviewers to relocate to the other side of the room. This self-advocacy was recognized by the interviewers, and they immediately accepted Dentist #1 into their program. After ADA was passed, Dentist #1 was able to request interpreters for work-related large-group interactions such as monthly staff meetings and holiday parties held at their dental practice (personal communication, July 14, 2023).

Theme 2: Hearing coworkers' support: The 2nd theme investigated how hearing coworkers can support or learn from a DHH dentist. Observations revealed several strategies employed by various hearing coworkers to make communication smoother. When both dentists used their voice, their technician repeated what was said for better patient understanding whenever needed. The technician also repeated anything said by the patient while the dentist's back was turned. This was efficient because the technician had prior knowledge and experience with the terms being used and the procedures being performed. During oral communication, coworkers removed their mask temporarily so the DHH dentist could lip read. When this was not possible in the operatory during the COVID-19 pandemic, they wrote notes on paper. All coworkers were also careful to obtain the DHH dentist's attention *via* touch, light flashing, or throwing a small object. This allowed for optimal face to face communication and lipreading. Only a few of the hearing hygienists or coworkers had any prior knowledge of ASL, but one did learn a few signs such as "test" and "ready" to let the DHH dentist know the patient was ready for an exam. Both coworkers felt that there were no difficulties in making these adjustments. Coworker #1 thought there were more challenges in interacting with their DHH patients than with the DHH dentist because "they've worked together so long" (personal communication, July 19, 2023). Both coworkers spoke highly of the DHH dentists, and feel that they have learned to be more

patient while communicating with their own patients.

Hearing coworkers also support DHH dentists in their practice by advocating for the DHH provider. Dentist #2 shared an anecdote about a patient who had a negative reaction and did not want to be seen by a DHH provider. The hearing colleagues in that situation (a clinical setting in dental school) refused to treat that patient, sending the patient to a different clinic in the area (personal communication, July 27, 2023). This is a strong demonstration of advocacy for the DHH dentist, and even more powerful because another colleague could have offered to treat the patient instead. Alternatively, they showed zero tolerance for any discriminatory attitude.

Another way hearing coworkers can support DHH dentists is helping them have access to a practice that allows them to embrace their Deaf identity and market themselves to the DHH community. Dentist #1 has years of experience, and works at a large group practice located within a large deaf community, allowing him to treat many DHH patients. Dentist #1 recalls feeling very overwhelmed doing a residency in a hospital system and feels much more supported in this group practice setting. Contrarily, Dentist #2 is younger, and works as an associate at a small practice where the patient pool is limited to prior existing patients. Dentist #2 feels they must hide their Deaf identity in their profession until they can open their own practice and promote themself to the DHH community (personal communication, July 27, 2023).

Dentist #1 recounts a time when he was discouraged from pursuing dentistry by his teachers due to his deafness, but later found encouragement from a DHH orthodontist during a shadowing experience.

Well-meaning teachers would ask me what I wanted to do after graduation. When I replied that I wanted to be a dentist, they were adamant that I couldn't be one. When I asked "why", they said, "Because you're deaf"... I saw that the orthodontist was deaf like me. He used lipreading with patients. He was a good communicator, and he had a team of people to assist and help with communication for him. There were no barriers to using phones because his office workers were responsible for the phones. He was focused on his patients, and he was friendly and sociable with them. I thought, "If he could do it, I could do it too." I was even more determined to become a dentist. (Personal communication, July 14, 2023).

DHH people pursuing a professional career face discouragement from many hearing people, which makes support from those in their field that much more important. It is also crucial that DHH students have access to shadowing experiences with DHH professionals, so they can observe and learn methods to overcome the challenges they will face, and gain confidence in themselves.

Theme 3: Deaf and hard of hearing Dentists' unique qualities: The final theme examined the unique qualities DHH dentists possess that allow them to be well suited for the dental profession and serve the DHH community. The 1st unique quality both DHH dentists share is their motivation for becoming a dentist. Both expressed a strong desire to fix teeth and improve peoples' smiles to allow for easier lipreading.

Both DHH dentists also believe that their deafness gives them additional skills that help them to succeed in dentistry professionally. They reported that they have better focus, peripheral vision, and attention to body language. An example described by Dentist #1 was the ability to "see when the patient is clenching their hands" and inquire whether they are in pain and need more novocaine (personal communication, July 14, 2023). Dentist #2 stated that growing up using sign language can help DHH dentists be more "skilled with our hands" which in turn enhances dexterous manipulation of tools in dentistry (personal communication, July 27, 2023).

The last unique characteristic that both DHH dentists in this study share is their sense of added responsibility for serving and teaching DHH patients. Deaf people miss out on incidental learning opportunities and therefore often have knowledge gaps regarding many things, including their health. Dentist #1 takes this responsibility very seriously and always performs the 1st cleaning for every new DHH patient. Such appointments are scheduled for an hour, which allows the time to "explain what's happening [and] fill in those gaps of dental information" (personal communication, July 27, 2023). Dentist #2 does not treat many DHH patients in their current practice, but still strives to teach DHH patients by creating educational oral health videos in ASL.

RESULTS AND DISCUSSION

These findings describe important insights to two DHH dentists' experiences. Through observation and interviews, we learned their preferred accommodations in dental school and in dental practice. In dental practice, fewer accommodations were needed as most interactions were one-on-one. Support from the hearing hygienists and technicians were seamless, as the technicians and hygienists were well versed in the terminology and procedure protocols. The ease of communication in their dental practices is an encouraging sign for aspiring DHH dentists.

In dental school, obtaining accommodations were successful, but required individual proactivity and knowledge of their ADA rights. Disclosing disability and showing competency in self-advocacy are likely to help a student succeed in matriculating in dental school. With recent social reform movements, dental schools are looking to increase diversity in their incoming classes, bolstered by studies demonstrating that a diverse healthcare workforce contributes to increased quality of care given to marginalized and underserved patients.

Technology has removed many barriers as well, enhancing text and visual based communication. The development and widespread use of intra-oral cameras, scanning systems, and better X-rays allows the patient to see what is happening in their mouth, and eases communication struggles for all dentists, DHH included.

One challenge noted in this report is that for DHH dentists to be able to market their services to the DHH population, they must have access to a practice where that is a possibility, and have the support from their coworkers to make that happen. This is an additional challenge many young DHH professionals face, as they may not have those resources when getting started in their career. It is important for the dental community to find a way to support DHH individuals in setting up their prac-

tice. These findings show that DHH dentists experience challenges, but are well suited for careers in dentistry for a number of reasons.

In addition, accommodations used by these professionals can act as an example for aspiring DHH dentists to better prepare for their own professional journeys. If these challenges can be shared with stakeholders in the dentistry and deaf communities, students can come prepared with solutions and resources for dental school and have a better sense of what to expect in their careers. Hearing instructors and coworkers can also be better informed about working with DHH individuals. Many triumphs were exemplified from the DHH dentists, and it is important to share their successful strategies with the broader community.

CONCLUSION

This study revealed that the two DHH dentists had unique motivations in pursuing dentistry, exceptional skills to contribute, and felt a responsibility to teach their marginalized patients. It is our hope that this research is a 1st step towards building a knowledge base for members of the deaf and dental communities to draw from in supporting DHH dental professionals. Future steps could include obtaining narratives from other DHH dentists, DHH hygienists, and more hearing coworkers. Our research uncovered a deaf-owned dental clinic run by a DHH dentist with DHH technicians and staff. Their experiences warrant further research. Considering recent efforts to implement short-term modules in various medical training facilities, it is worthwhile to investigate dental school curriculum for cultural competence training, deaf awareness, or other content related to care of minority patients that is mandatory, instead of optional and long-term. It is our goal to continue learning more about experiences of DHH dentists and their hearing coworkers and consolidate their narratives into a repository that can be shared amongst dental school students and instructors, as well as those in the field.

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CONFLICT OF INTEREST

There are no conflicts of interest.

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