opening of minds to look closely at what newer research of the past 10 to 15 years has revealed. In the Ethics Rounds discussion, most of the participants agree that emerging research shows that ASL reduces the risk that deaf children will have delayed language and cognitive development. Those who attempt to portray the choice as being between speech and listening or signing are perpetuating a myth. This is not the choice. Many families choose both, and, in fact, there are many research studies that show a strong correlation between fluency in ASL and reading ability in English. Both languages are needed to reduce the risk of harm to deaf children when many are unable to fully acquire spoken language through speech and listening alone.

As an organization composed primarily of deaf and hard-of-hearing adults who have experienced every kind of educational methodology, we are united in expressing our support for the use of both ASL and English for all deaf children. We also want to affirm our love and respect for our parents, and communicate with them fully as a family. With a solid education in both ASL and English, we are not segregated from society but are fully empowered to engage as equal partners. The NAD has many parents and professionals as our members and allies, and we welcome everyone who supports our mission of preserving, protecting, and promoting the civil, human, and linguistic rights of deaf and hard-of-hearing people in the United States. Thank you again for this Ethics Rounds.

Howard A. Rosenblum  
Chief Executive Officer, National Association of the Deaf  
E-mail: howard.rosenblum@nad.org

Christopher D. Wagner  
President, National Association of the Deaf

Conflict of Interest:  
None declared.

REFERENCES


doi:10.1542/peds.2015-3106B

Ethics Rounds Needs to Consider Current Population of Deaf Children

The July 2015 article, “Ethics Rounds: Should All Deaf Children Learn Sign Language,” concludes that the benefits of learning sign language clearly outweigh the risks and that this approach seems clearly preferable to an approach that focuses solely on oral communication, and all deaf children should learn sign language.

As a professional in the field for >30 years and speaking as the executive director of the Center for Hearing and Communication (CHC) in New York City, I do not believe that there is one way for “all” deaf children to learn language or to be educated. At CHC, we provide a wide range of services to people with all degrees of hearing loss regardless of mode of communication. That said, our habilitation program for children who are deaf or hard of hearing is an auditory-oral program with the goal of having the children attend a mainstream educational program, typically beginning in the preschool years. Although we recognize that this approach may not be the right choice for every child, with the advent of universal newborn hearing screening, technical advances in amplification (including early bilateral cochlear implantation), and access to early intervention, this is a realistic option for more children than ever before.

At CHC, it is no longer unusual for us to begin working with infants as young as 4 weeks of age, immediately providing amplification and beginning a habilitation program with the infant, family, and other caregivers. It would be an extremely rare case where a trial of hearing aids was not medically indicated, and with current amplification technology, some degree of hearing aid benefit is always provided. It is becoming the “norm” for infants to receive a cochlear implant, if not 2 implants, by the age of 7 months. As a result of this early intervention, the children we see are achieving age-appropriate linguistic and cognitive milestones at very young ages. It is our hope that when pediatricians find themselves in a position to counsel families of newly diagnosed deaf children that they recognize, as we do, that every family and child is unique and every recommendation must be individualized. We also hope that in this ever-changing field, they recognize that the outcomes possible today for deaf children learning spoken language far exceed those that are seen in published research of just a few short years ago. The controversy over whether sign language should be incorporated into a deaf child’s communication system is almost 200 years old. The field of early childhood deafness and the opportunities for management...
have dramatically changed even within the past 5 years, and how we discuss this controversy must change as well.

Laurie Hanin
Executive Director, Center for Hearing and Communication
E-mail: lhanin@chchearing.org

Conflict of Interest:
None declared.

doi:10.1542/peds.2015-3106C

Author’s Response
Deaf Children, Cochlear Implants, and Language Acquisition

The question of how best to raise and educate deaf children has been a vexed question for more than a century.¹ Although everyone recognizes the remarkable benefits of cochlear implants (CIs),² there is considerable debate about whether children who receive a cochlear implant should continue to learn sign language (SL).³

Those who favor an exclusive focus on listening and spoken language (LSL) suggest that the use of SL leads to worse auditory and spoken language skills and thus defeats the purpose of the cochlear implant. Those who favor a bilingual approach, that is, the use of SL in addition to LSL, argue that all deaf children can become fluent in SL without any detriment to their skills in LSL. The debate thus turns on 2 distinct empirical questions. First, do children who receive a CI and who then focus solely on LSL predictably have outcomes that are sufficiently good so that they will never need SL to learn and communicate? Second, does continued use of SL lead to worse outcomes?

The questions are difficult to answer because many studies have limited sample sizes, lack of matched controls, and other methodological problems.⁴ Still, it is clear that many children who receive bilateral CIs before the age of 2 can do well in school. It is also clear that many children do not achieve normal speech perception levels and experience severe difficulties in challenging listening tasks.

There are very little data about the second question. For example, in arguing that continued use of SL is detrimental, Sugar and Goldberg cite a study that was presented as an abstract in 2009 but has never been published.

A big problem with assessing outcomes for deaf children who learn SL along with auditory-verbal communication is that, for most of those children, neither their parents nor their educators are fluent in SL. In one study in which such children were raised by deaf parents who were fluent in SL, the children learned both LSL and SL well.⁵ But like other studies, it is very small.

Based on the data, then, it is hard to know with certainty whether learning SL in addition to LSL will lead to better, similar, or worse outcomes. And therein lies the source of all the disagreement.

The problem can thus be summarized straightforwardly. If one does not believe that concurrent SL impairs long-term outcomes for LSL, then the choice is clear. Learn both languages. If one believes that SL is harmful, then there is a more complex set of probabilities to consider. Do you choose the exclusively auditory route, hoping that, by doing so, the child will have the best chance to develop age-appropriate school skills, but knowing that many children who go that route do not attain those skills? Or, do you choose the bilingual route, thereby guaranteeing that the child will be fluent in at least 1 language but taking the risk that it could impair the child’s outcomes in LSL? There clearly can be no single best right answer to these questions.

References


4. van Wieringen A, Wouters J. What can we expect of normally-developing children implanted at a young age with respect to their auditory, linguistic and cognitive skills? Hear Res. 2015;322:171–179


doi:10.1542/peds.2015-3106D

John D. Lantos
Director, Children’s Mercy Bioethics Center, Children’s Mercy Hospital
E-mail: jlantos@cmh.edu

Conflict of Interest:
None declared.
Ethics Rounds Needs to Consider Current Population of Deaf Children
Laurie Hanin
*Pediatrics* 2015;136:e1488
DOI: 10.1542/peds.2015-3106C

Updated Information & Services
including high resolution figures, can be found at:
http://pediatrics.aappublications.org/content/136/5/e1488

Subspecialty Collections
This article, along with others on similar topics, appears in the following collection(s):
Administration/Practice Management
http://classic.pediatrics.aappublications.org/cgi/collection/administration:practice_management_sub

Permissions & Licensing
Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
https://shop.aap.org/licensing-permissions/

Reprints
Information about ordering reprints can be found online:
http://classic.pediatrics.aappublications.org/content/reprints
Ethics Rounds Needs to Consider Current Population of Deaf Children

Laurie Hanin

*Pediatrics* 2015;136:e1488
DOI: 10.1542/peds.2015-3106C

The online version of this article, along with updated information and services, is located on the World Wide Web at:

http://pediatrics.aappublications.org/content/136/5/e1488