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Are we missing a trick?

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said they provided training, only 8 made this compulsory. Six provided a formal qualification in Sign Language or deaf awareness and 10 (63%) offered no formal qualification. Teaching methods included seminars, workshops, role plays and small group work. Time spent in training ranged from 1–2 hours to 6 weeks. Eleven schools involved relevant professionals, including audiologists, hearing advisors, speech and language therapists and staff from local deaf centres. Only one involved Action on Hearing Loss, though 13/16 involved a deaf person as a tutor in training delivery.

Deaf awareness training can have a positive effect on patients, healthcare staff and medical students (Steinberg et al. 2006). Whilst such basic training can never result in sign language fluency, and make communication completely straightforward, deaf and hard of hearing people do feel positively about staff receiving training.

Lack of expertise can prevent medical schools from running training courses. Six respondents expressed an interest in developing deaf awareness training, stating that information about how to create and run such a course would be useful. Practical guidelines and illustrative course materials have therefore been incorporated in a DVD, available on request to all health educators and also online at www.med.qub.ac.uk/DeafAwareHealth/index.html.

Further research is needed to gauge the effectiveness of training and to elucidate the experiences, attitudes and skills development and retention of students who have completed such training courses.

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Personality and attitudes towards dying patients: An Italian pilot study among medical students

Dear Sir

Nowadays doctors have to deal not only with death but also with the "end-of-life" stage. That requires specific skills and attitudes, but it remains unclear what medical students' attitudes are towards end-of-life care (EOLC).

For this reason, we designed a pilot cross-sectional study to investigate the attitudes towards EOLC and their possible relationships with personality traits in a sample of second-year medical students who attended the Turin University. Ethical approval was obtained. We used the Italian version of the Frommelt Attitude Toward the Care of the Dying Scale form-B (FATCOD-B) (Frommelt 1991) and the Temperament and Character Inventory (TCI) (Cloninger et al. 1994). Of the 280 students invited to participate, 165 returned both questionnaires (45.5% male, 54.5% female).

Regarding attitudes towards EOLC, students obtained a mean total score of 113.4 (SD = 7.8) (normative data are not available in literature), without significant differences between males and females.

Regarding personality profile, we compared total scores with normative data. Observed students scored significantly higher on Harm Avoidance and lower on the Reward Dependence, Cooperativeness and Self-Trascendence dimensions. Females scored significantly higher than males on Harm Avoidance, Reward Dependence, Self-Directedness and Cooperativeness dimensions.

Regarding the associations between FATCOD-B and TCI, significant positive associations were found between Self-Directedness ($p = 0.038$) and Cooperativeness ($p = 0.040$), while Harm Avoidance showed a significant negative association ($p = 0.002$).

Despite the limited sample size, this study is the first to show a relationship between personality traits of undergraduate Italian medical students and their attitudes towards the care of dying patients. Highly self-directed and cooperative students, with low Harm Avoidance, probably could develop a more mature character that helps them to be more conscious of their own and others' life conditions and thus to be more prone to care for dying patients. Our results suggest that it may be important to consider also the personality profile for career counselling of the medical students oriented to the EOLC context.

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Are we missing a trick?

Dear Sir

Whilst on an Obstetrics and Gynaecology placement, I was pleasantly surprised at the benefits of working alongside an allied health care student – a student midwife.

This is the only time in my undergraduate training I have shared any teaching with an allied health student, and the benefits of this were great. Peer teaching is on the increase and heavily encouraged in medical schools, and has a large presence online with peer teaching resource exchange freely available from many internet sites.

Yet peer teaching is typically medical student to medical student. We are overlooking the fact that many allied health care students are focally excellent in their subject areas.

My experience showed me the midwife student had the skill and passion about her subject to teach us, and her knowledge easily surpassed that of mine. I have had 6 weeks on an Obstetrics and Gynaecology ward, compared to her 30 months. But, this is the strength in the concept, as with her 30 months of learning she was able to pass over to me purely the important facts.

I am very aware that inter-professional teaching has been used effectively for a great period of time now, I am indeed one of the fortunate people who have benefited. Is it not now the time to extend this to peer teaching?

Medical undergraduates should have some learning integrated with other health professions. We should be encouraging education interaction. A great many of my medical colleagues feel some inter-subject teaching should be trialled. The obvious subject areas that would integrate well with medicine are Midwifery and Pharmacy.

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