



Deaf awareness training in medical schools

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With these circumstances in mind, we established a medical English course for undergraduates. This course consists of two parts: basic medical English and doctor–patient communication. Basic medical English is intended to equip the students with basic medical terms and stylistic features of medical articles. Doctor–patient communication aims to improve the skills in history-taking and physical examination. Cultural aspects were introduced throughout the course. First, a healthy attitude towards foreign cultures was developed. Empathy was advocated and ethnocentrism was opposed to help the students consciously shake off the psychological fetters from their own cultural stereotypes and be open and tolerant to different beliefs and concepts from other cultures (Lukens 1978). Second, essential knowledge of foreign cultures was introduced, especially of medical ethics, religion, psychology, history and customs. Third, communicative skills were trained, for instance, how to build a common ground to make others willing to speak or how to use your body language to make yourself expressive.

The students felt more confident in writing research papers and talking to foreign patients after the course. Setting up a medical English course can be an effective way of developing cross-cultural competence in Chinese medical students.

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The costs and utility of the Mini-CEX

Dear Sir

Brazil et al. (2012) have added another piece of the jigsaw that shows what might constitute cost and value in medical education. However, their approach in measuring costs and in evaluating the utility of the assessment intervention may be flawed.

When measuring costs in education, we must be rigorous, thorough and comprehensive (Walsh 2010). This means that estimates should not be made of costs, but rather all elements of costs should be carefully accounted for and added up until a final definitive sum is arrived at. It appears from the paper by Brazil et al. (2012) that the authors only accounted for the cost of the senior assessor time. This may account for the majority of the costs but are unlikely to account for all of them.

This approach does not include the costs of the time of learners, the costs of the time of administration staff, the costs of consumables (e.g. printed forms), the costs of software and hardware (used to store results), and the costs of blueprinting and standard setting. In assessment programmes that are rolled out, these costs will add up and cannot be ignored.

Next there is the issue of assessment utility. Even though adding the mini-CEX did not affect summative assessment results, both learners and assessors did have positive perceptions about the mini-CEX, and also the “mini-CEX was more effective in identifying the individual domains in which the interns demonstrated deficiencies.” The question therefore is whether these outcomes are worth the sums spent on the assessment. This is not straightforward as the outcomes cannot be expressed in monetary terms. If educationalists, healthcare professionals and members of society place sufficient weight on these outcomes, then the cost will likely be justified. But if they do not, then the cost will not. Only by means of open public debate will be come to a conclusion on this.

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Deaf awareness training in medical schools

Dear Sir

The World Health Organisation predicts that by 2030 adult-onset hearing loss will be within the top 10 disease burdens in developed countries, above cataract and diabetes (Mathers & Loncar 2006).

Deaf and hard of hearing people frequently encounter difficulties communicating effectively in healthcare settings. Doctors are often unaware of such issues, leading to feelings of isolation and exclusion in patients. Clearly, there is a role for training at medical school.

Since the extent of such training provision is unknown, we conducted a questionnaire survey of all UK and Ireland medical schools ($n=38$). Twenty-three completed replies were received revealing significant variations in the scope of training offered.

One-third (7/23) of medical schools did not provide any deaf awareness training and, of the 16 universities who

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-Transcendence 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.