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The costs and utility of the Mini-CEX

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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