

What is already known on this topic

Worldwide, few potentially eligible patients are approached about entry into clinical trials; healthcare professionals find discussing trials and obtaining truly informed consent difficult

Patients are often confused or unclear about the experimental nature of treatment in trials

What this study adds

A training course was designed specifically to help health professionals provide clear information about phase III randomised trials of cancer treatments to patients and to encourage them to approach all eligible patients for recruitment

The course increased participants' reported self confidence about recruiting patients into trials, and objective analyses revealed improvements in the style and content of the participants' discussions

focus on their own perceived areas of difficulty and makes the course work pertinent to their needs.⁷

We have used these types of "trigger" tapes successfully in our previous research with nurses and doctors working in oncology.^{6,7} The intervention reported here was valued highly by all participants.

The positive findings from the course included an increase in participants' reported self confidence about recruiting patients into trials, and objective analyses revealed behavioural changes in the style and content of the participants' discussions. There is strong evidence that if both competence and self confidence are improved then behavioural changes often do transfer successfully into the clinical setting and endure, even without support or consolidation courses.^{7,8}

Our training course is now being rolled out by the national cancer research networks in England and

Wales, and research to see if real patient outcomes are affected is planned.

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Teaching of cultural diversity in medical schools in the United Kingdom and Republic of Ireland: cross sectional questionnaire survey

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Over the past decade, pressure to teach about cultural diversity in the medical undergraduate curriculum has increased.^{1,2} *Tomorrow's doctors* states that "students should have acquired respect for patients and colleagues that encompasses, without prejudice, diversity of background and opportunity, language, culture and way of life."¹ In this study, we used ethnicity as an example of cultural diversity, but we acknowledge the importance of other factors. We aimed to identify the extent to which cultural diversity was being taught in medical schools in the United Kingdom and Republic of Ireland.

Participants, methods, and results

We devised a study specific questionnaire that asked a series of closed questions plus some open ended questions inviting free text responses. We sent this to contacts in all medical schools in the United Kingdom and Republic of Ireland (n=31 at the time of the study). We followed up non-respondents by a further letter and emails. We entered data into SPSS and did a content analysis of the free text responses.

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Responses to yes/no item questions (n=30/31; response rate=97%). Values are numbers (percentages)*

Item	Yes	No	Not applicable	Not known
Does your school provide formal teaching in cultural diversity?	23 (72)	7 (22)	2 (6)	0
Does your school provide formal teaching in cultural sensitivity/multicultural issues?	26 (81)	6 (19)	0	0
Is the course a standalone course?	5 (16)	21 (66)	6 (19)	0
Is it part of a larger course?	23 (72)	2 (6)	7 (22)	0
Is the teaching part of the core curriculum?	24 (75)	3 (9)	5 (16)	0
SSMs/SSCs	16 (50)	11 (34)	5 (16)	0
Is student self study expected?	18 (56)	8 (25)	5 (16)	1 (3)
Does formative or summative assessment take place?	19 (59)	6 (19)	5 (16)	2 (6)
Formative	9 (28)			
Summative	10 (31)			
Is student feedback gathered?	23 (72)	4 (13)	5 (16)	0
Is there teaching about specific ethnic groups?	13 (41)	13 (41)	5 (16)	1 (3)
Are different ethnic groups used to plan teaching?	20 (63)	5 (16)	6 (19)	1 (3)
Are different ethnic groups used to deliver teaching?	18 (56)	6 (19)	7 (22)	1 (3)
Are there plans for further development?	18 (56)	9 (28)	Under development, 4 (13)	1 (3)

SSM=special study module; SSC=student selected component.

*Denominator for percentages is 32, as two medical schools completed questionnaires for both their four year and five year programmes.

Thirty (97%) medical schools responded to the questionnaires; 32 questionnaires were returned, as two medical schools completed questionnaires for both their four year and five year programmes. The table shows the items to which yes/no responses were possible.

Teaching and assessment methods

Fourteen (44%) schools used three or fewer teaching methods, and 11 (34%) used four or five methods. The most commonly used teaching methods were small group based teaching (21), discussions (16), lectures (16), problem based learning (11), community placements (9), and workshops (8).

Ten (31%) respondents stated that their school used only one assessment method; six (19%) respondents used two methods, and five (16%) used three methods. Nine (28%) respondents stated that the question was not applicable. The most commonly used methods were short answer questions (8 schools), essays (7), objective structured clinical examinations (6), and projects (5). Other assessment methods were used by three or fewer schools.

Thirteen (41%) respondents stated that cultural diversity was integrated throughout the curriculum. Eight (25%) respondents stated that cultural diversity was taught in the first year; we received one (3%) positive response for each of years two, three, four, and five. Very positive or positive feedback was reported by 18 (56%) respondents.

Findings from the free text

We identified the following themes from the free text comments: staff related factors (how staff were valued, as well as their difficulties in managing the organisa-

tion and delivery of diversity teaching); students' perceptions and evaluation of courses; contents and organisation of the course (the time allocated, where the course was placed, and how teaching was organised); and delivery and outcomes of the course.

Comment

Some progress seems to have been made since the publication of a survey in 1995,³ in that 72% of schools now report some teaching in cultural diversity. However, the number of respondents reporting that their school is teaching cultural diversity compares unfavourably with the United States,⁴ albeit more favourably than Canada.⁵ Teaching of cultural diversity has been developed in the United Kingdom but seems rather fragmented. A great deal of uncertainty seems to exist about what constitutes diversity teaching.

This study has limitations in that it was a questionnaire survey and the terminology used may not have matched the terminology of the schools. The staff who returned the questionnaires might not have been best placed to complete them. Nevertheless, the survey presents a snapshot of the state of teaching of cultural diversity in the United Kingdom and Republic of Ireland in 2003. Further work is needed to embed teaching of cultural diversity within the medical undergraduate curriculum and to ensure that it is valued by staff and students.

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What is already known on this topic

Until recently, little attention has been paid to teaching medical students about cultural diversity

What this study adds

Teaching of cultural diversity is being developed but seems rather fragmented

Uncertainty remains as to what constitutes cultural diversity teaching

What the educators are saying

Reducing junior doctors' work hours reduces medical errors

Concern about medical errors has resulted in increased regulation of trainees' hours in the United States and Europe. To begin to quantify the effect of these changes on patient safety, trainees were randomised to a "traditional" work schedule that included extended shifts (at least 24 hours) or a schedule that did away with extended shifts and cut the number of hours per week. During 2203 patient days involving 634 admissions, trainees on the traditional schedule made almost 36% more serious errors than those on the reduced shift, leading to a 22% increase for the entire critical care unit. Of particular note, the number of unintercepted errors for the traditional work schedule increased by more than 56%. Eliminating extended shifts and reducing the working week can improve patient safety.

N Engl J Med 2004;351:1884

Vignettes can help in assessing clinical quality

Computer based clinical vignettes are an inexpensive and easy way to assess doctors, so it would be good to know if they reflect actual performance in practice. To address this question, practice performance was measured by introducing standardised patients into the primary care clinics of the doctors who were participating in the study. The reports of the standardised patients, the medical records of the visits, and performance on a matched set of vignettes were scored against identical criteria. Scores for the clinical vignettes were within 5% of the other two measures. More work is needed, but these results suggest that clinical vignettes can be useful in assessing actual performance in practice.

Ann Intern Med 2004;141:771-80

Online medical education can make a difference in practice

More and more continuing medical education (CME) is now delivered on line, but there has been little evaluation of this approach. In a study that used standardised evaluations of 30 different online CME courses to determine if they were effective, the evaluations showed that doctors' knowledge and knowledge retention were increased. Almost all of the doctors reported changing their practices as a result

Laparoscopy novices have a long learning curve



LARRY MULVEILL/SPFL

Many guidelines assume that doctors need to do a procedure only a few times before they are proficient. When the performance of doctors learning laparoscopy was assessed on a laparoscopy virtual reality simulator, trainees required 21-29 repetitions to reach ultimate proficiency, and performance levelled off several times on the way. A sizeable and variable number of repetitions is needed for proficiency in these and perhaps other procedures.

J Surg Res 2004;122:150-6

of the courses. Standardised evaluation could be done online, allowing comparisons between different providers and courses. With practitioners under pressure to increase productivity, providing a valid approach to CME on line is important.

J Contin Educ Health Prof 2004;24:68-75

Reducing didactic learning doesn't affect knowledge

Involving learners more and reducing teacher driven content could improve the educational process. Assessment of the knowledge and perceptions of postgraduate trainees randomised to a one hour lecture delivered by a teacher, or a 30 minute lecture followed by 30 minutes of interaction between trainees, showed that both teaching methods resulted in improved scores. Trainees in the active learning sessions were more engaged with both the session content and each other, and those in the didactic session felt it offered greater educational value. Further

study is needed, but it seems that reducing the time spent in didactic learning does not affect knowledge and can improve interactions between learners.

Adv Health Sci Educ 2004;9:15-27

Surgeons' critical appraisal skills improve with internet based journal club

The ability to critically appraise the literature is central to the practice of evidence based medicine, but the effectiveness of interventions to develop these skills in practising doctors has not been studied. Participating surgeons were randomised into two groups, with the experimental group receiving clinical and methodological articles, participating in an online discussion, and engaging in clinical and methodological critiques. The control group received only the clinical articles. Surgeons in the experimental group performed better on a test of critical appraisal skills, showing that doctors can improve their critical appraisal skills without leaving their practice settings.

Surgery 2004;136:647-9

Multiple mini-interview assesses applicants' non-cognitive qualities

Whether current selection tools for admission to medical school measure non-cognitive or personal qualities accurately is not known. The multiple mini-interview (MMI) is a new method designed specifically to capture such information from students during their interviews. When the results of the MMI and other traditional measures to predict performance through the pre-clerkship portion of the curriculum were compared, the MMI was the best predictor of grade-point average as well as performance on the objective structured clinical examination (OCSE). Further testing is needed to determine which non-cognitive characteristics the MMI measures, but its ability to predict performance in medical school looks promising.

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