Pregnancy for women who are deaf, prison-based mental health care, sexual health non-attendance, and compassion in medicine

Pregnancy for women who are deaf. Although women who are deaf experience poorer pregnancy and birth outcomes than women who can hear, the factors contributing to these disparities are unclear, prompting a team from New York to complete an interview study using American Sign Language. They found that inaccessible communication, difficulty obtaining health information, and healthcare provider selection were common challenges. However, when clinics provided on-site interpreters and study participants received accessible health information, they described more positive pregnancy and birth experiences. All participants noted the importance of self-advocacy in ensuring a positive birth experience. An important study with clear, attainable recommendations that maternity services everywhere should adopt.

Prison-based mental health care. Women in prison often have a history of trauma and face past and current mental health challenges. A recent Irish study sought to synthesise the literature on this topic to gain a deeper understanding of the experiences of women in the context of prison-based mental health care. Four analytic themes were identified that detail women’s experiences of prison-based mental health care: the type of services accessed and challenges encountered; a reduction in capacity to self-manage mental wellbeing; the erosion of privacy and dignity; and strained relationships with prison staff. Notably, though, they were able to find only seven studies to include in their synthesis, leading them to argue that further research is needed to bring greater policy attention to this important topic.

Sexual health non-attendance. Non-attendance at sexual healthcare appointments is problematic for individuals and organisations, and a recent study from Birmingham set out to understand why it happens and what can be done about it. Perceptual factors included beliefs about the outcomes of attending; sense of responsibility to attend; and concerns about privacy and security. Practical factors included competing demands and disruption to daily life; ability to attend; and forgetting. Organisational factors included the mode of appointment delivery and availability of appointments. The authors use this model to outline a list of seemingly straightforward interventions that sexual health clinics could adopt to tackle non-attendance. I suspect that implementing these will be far more challenging than they imply.

Compassion in medicine. While few would argue against the importance of compassion in medicine, the professional and organisational cultures of modern medicine have increasingly adopted policies and positions that create barriers to compassionate care, rather than facilitating it. Given that ‘compassion depletion’ is thought to originate in medical school, a recent study in the US used focus groups with key stakeholders in medical education to characterise beliefs about the nature of compassion. Study participants described compassion as being about more than empathy, demanding action, and capable of being cultivated. They identified self-care, life experiences, and role models as facilitators. The consistently identified barriers to compassion were time constraints, culture, and burnout. In sum, both medical students and those training them agreed that undergraduate medical education does not deliberately foster compassion and may be directly contributing to its degradation. Lots to chew on for those of us who work closely with medical students.

REFERENCES


4. Lane CB, Brauer E, Mascaro JS. Discovering compassion in medical training: a qualitative study with curriculum leaders, educators, and learners. Front Psychol 2023; 14: 1184032.