COURSE DATA

Data Subject	
Code	34455
Name	Communication
Cycle	Grade
ECTS Credits	4.5
Academic year	2022 - 2023

Study (s)

Degree	Center	Acad. year	Period
1204 - Degree in Medicine	Faculty of Medicine and Odontology	1	Second term

Subject-matter

Degree	Subject-matter	Character
1204 - Degree in Medicine	9 - Social medicine and communication skills	Obligatory

Coordination

Name	Department
LUCAS DOMINGUEZ, RUTH	225 - History of Science and Documentation
SIERRA SAN MIGUEL, MARIA PILAR	260 - Medicine

SUMMARY

Quality health care necessarily involves health care professionals with solid theoretical knowledge and technical skills on clinical interview as a human communication process. Elements such as appearance, empathy, security, confidentiality and continuity of care are essential in our clinical work in order to achieve high clinical standards; as well as knowledge about the necessary elements for registering and retrieving clinical information and the retrieval about health care information.

PREVIOUS KNOWLEDGE

Relationship to other subjects of the same degree

There are no specified enrollment restrictions with other subjects of the curriculum.

Other requirements

COMPETENCES (RD 1393/2007) // LEARNING OUTCOMES (RD 822/2021)

1204 - Degree in Medicine

- Listen carefully, obtain and synthesize concrete information regarding the problems which may affect the patient and understand the content of such information.
- Write clinical reports and other medical records in an understandable way for any third party.
- Communicate in an effective and clear way, both writing and orally, with patients, their relatives, the media and other professionals.
- Acquire basic training for research activity.
- Proper organisation and planning of the workload and timing in professional activities.
- Team-working skills and engaging with other people in the same line of work or different.
- Criticism and self-criticism skills.
- Capacity for communicating with professional circles from other domains.
- Acknowledge diversity and multiculturality.
- Consideration of ethics as a fundamental value in the professional practise.
- Working capacity to function in an international context.
- Knows the legal foundations of the medical practise and profession. Informed consent. Confidentiality.
- Knows how to perform professional practise with respect towards the patients, their beliefs and culture.
- Is aware of healthcare planning administration at a global scale, in Europe, Spain and the autonomous communities.
- Knows the economic and social implications which medical practise entails, considering effectiveness and efficiency criteria.
- Knows, evaluates and uses technology and sources of clinical and biomedical information to obtain, organise, interpret and communicate clinical, sanitary and scientific information.
- Is able to handle a personal computer with autonomy, uses searching and retrieval information systems, knows and handles clinical documentation procedures.
- Knows the principles of telemedicine.
- Knows and manages medical principles based on (the best) evidence.

- Knows of the aspects of communication with patients, their relatives and their social environment: clinical relationship models, interview, verbal and non-verbal communication and interferences. Delivering bad news.
- Knows how to compile histories, records, instructions and other register documents, in a comprehensible way for patients, their relatives and other professionals.
- Knows how to present scientific work and professional recordsto an audience, both written and orally.

LEARNING OUTCOMES (RD 1393/2007) // NO CONTENT (RD 822/2021)

- Acquire the skills to consult clinical documents.

- Understand the use of clinical information.

- Knowing index and rank by diagnoses and procedures.

- Knowing retrieve and understand the key health indicators.

- Learning main issues of communication with patients, relatives and social environment: Models of clinical relationship, interview, verbal and non-verbal communication, and interferences.

- Knowing how to define the patient's problem.

- Breaking bad news properly.

- Learning the most relevant strategies to foster treatment adherence.

- Being able to deal with difficult situations that may occur in clinical practice.

DESCRIPTION OF CONTENTS

1. The communication of the professional experience.

2. Sanitary sector and Sanitary Organisation.

3. Information needs for health care (I). The medical record: concept and content; production, structure, main record types. The medical records: uses, keeping and preservation, relevant legislation.

4. Information needs for health care (II). The organization and use of medical records in primary care / out-patient care.

5. Information needs for health care (III). The organization and use of medical records in specialized care / in-patient care (hospital). The integration of information from primary and specialized (hospital) care.

6. The management and processing of health care and public health information: main tools of vocabulary control (I). The classifications of diseases and procedures: rationale, concept, structure and major classifications.

7. The management and processing of health care and public health information: main tools of vocabulary control (II). The control and treatment of the terminology: semantic interoperability: the SNOMED-CT

8. The management and processing of health care and public health information: main tools of vocabulary control (III). The International Classification of Diseases, the ICD-9-CM, the CIE-10-ES: structure and uses.

9. The production of health care information for research and management (I). Information processing of the hospital minimum basic data set (MBDS), other registries and other registries of health care activity.

10. The production of health care information for research and management (II): Activity indicators: Quantitative and qualitative: patient classification systems.

11. Information needs for public health (I). Mortality. Morbidity. Epidemiological surveillance. Specific disease registries (Cancer, HIV, etc).

12. Introduction to the subject of Communication, health care part.

13. Human communication.

14. Doctor-patient relationship.

15. Non-verbal communication

16. Communication skills (I)

17. Communication skills (II)

18. Finding out the patient's problem. Delimiting the reason of the visit to the hospital.

19. How to give information? Genre perspective. Children, old people. How to give bad news?

20. Strategies to improve adherence to treatment.

21. Difficult situations (I).

22. Difficult situations (II)

23. PRACTICES

Computer classroom practice

1. Medical records in primary care (ABUCASIS).
2. Medical records in specialized care (ORION CLINIC).
3. Access and use of information sources on specialized care activity and use of healthcare resources.

Seminars

1. Doctor-patient relationship: the clinical interview.
2. Verbal and non-verbal communication.

3. Communication skills.
4. Finding out the patients problem. Presenting information. Breaking bad news.
5. Dealing with special situations: aggressive patient, emotional release, accompanying persons interference.

Tutorials

Indexing of a medical record summary sheet and classification and coding of diagnosis and procedures with the ICD-10-CM.

WORKLOAD

ACTIVITY	Hours	% To be attended
Theory classes	25,00	100
Seminars	10,00	100
Computer classroom practice	6,00	100
Tutorials	4,00	100
Development of group work	20,00	0
Study and independent work	25,00	0
Readings supplementary material	2,50	0
Preparation of evaluation activities	20,00	0
TOTAL	**112,50**	

TEACHING METHODOLOGY

The teaching methodology of the subject is the following:

-**Theoretical Lessons** (22 Thematic Units). The theoretical lesson will be made through an oral exposition along with the image materials and corresponding visual schemes, with references to the practical lessons and seminars in order to integrate both aspects of teaching. The students' participation will be encouraged through their questions. All the materials will be available in the Aula Virtual.

- **Computer Practical Lessons** (3 Thematic Units). The practical lessons will allow the student to work actively with the Spanish real health information sources in the corresponding websites (MSSSI, INE, etc.) recovering information and solving concrete problems. Moreover, they will go through the elements of an anonym computer clinical history and will actively consult the different information. The materials will be available in the Aula Virtual.

- **Seminars** (5 Thematic Units). In the seminars, a practical application of the theoretical lessons will be made. The students will make videos in small groups focused on the topics taught in the lessons (communication skills, how to deliver bad news or handling of special situations) in a role-play format. These films will be exposed in the classroom and will be discussed. To fulfill each seminar, students will be provided with the teaching materials (assessment scales and check-list) and the proper bibliography for their preparation.

-Tutorials (1 Thematic Unit). The students will write a piece of work, in groups of 3-4 people. With the tutelage of the professor, they will analyze anonym discharge reports, will practice with the Clasificación Internacional de Enfermedades (CIE-9-MC) and will resolve exercises of classification, codification and recuperation of clinical and health statistical information in order to be familiar with the structure and uses of the CIE-9-MC in a practical way. Finally, each group will make an oral presentation with slides of their work results. The materials will be available in the Aula Virtual.

EVALUATION

This subject is taught by the Library and Documentation area and by the Psychiatry area. The final mark will be the average of the Psychiatry part (50%) and the Documentation part (50%), having obtained a mark equal to or greater than 5 out of 10 in each of the two parts. If one of the two parts is suspended in the first call, it will only be necessary to present this part in the second call, keeping the note of the approved block.

Documentation:

Theoretical evaluation: 30% of the final grade. It will be carried out by means of a written test, multiple choice with multiple answer. The test consists of 24 questions. Each question is worth 0.25 points. Every question wrong answered subtracts 0.083 points. For every 3 wrongly answered questions, 1 will be subtracted from the correct answers. Blank responses do not count.

Practical evaluation: 20% of the final grade. It consists of: the practical assumption that accompanies the test: 1 point (10%); the evaluation of practices: up to 1.5 points in total (15%) (0.5 per practice); and the

Tutored practice: up to 1.5 points (15%). The completion of the tutored practice is mandatory in order to pass the documentation part. In case of failing the subject, the note of the practices will be kept only during the following course.

The documentation block will be approved with a grade equal to or greater than 5. Attendance at practices will be mandatory.

Psychiatry:

Theoretical evaluation, 30% of the final grade. It will be done through a written test (30 multiple choice questions and 2 clinical cases with 5 multiple choice questions each). In the multiple choice exam, the qualification criteria will be as follows: for every 3 questions answered incorrectly, one of the correct ones will be subtracted. Blank responses do not count.

Practical evaluation, 20% of the total grade. Mark obtained in the seminars and two short questions of a practical case to develop in the exam. IT IS MANDATORY TO PASS THE THEORETICAL PART TO PASS THE EXAM. In case of not passing the theoretical part, the case will not be corrected.

Attendance at practices (5 seminars) is mandatory. 0.2 points will be subtracted for each lack of assistance.

The realization of the video in role-playing format is mandatory in order to pass the assistance part.

The Psychiatry block will be approved with a grade equal to or greater than 5

In case of suspending the assistance part of a course, the practical part will be saved for a year, after this period the attendance to the seminars and the video will have to be repeated.

Students are reminded of the importance of carrying out evaluation surveys on all the teaching staff of the degree subjects.

REFERENCES

Basic

- Psiquiatría

- F. Borrell i Carrió. Manual de entrevista clínica. Ediciones Doyma.
- Coulehan JL, Block MR. The Medical Interview: Mastering Skills for Clinical Practice. FifthEdition.F.A. Davis Company: Philadelphia, 2006.
- Merayo A, Bravo E, Gordon F. La Comunicación con el paciente. España: Elsevier, 2014. ISBN: 9788490227558.
- Recursos e-Salut: ClinicalKey Student. Elsevier (Scopus, ScienceDirect). uv-es.libguides.com/RecursosSalut/BibliotecaSalut

- Documentación Médica

- Asenjo Sebastian, M.A. Gestión diaria de hospitales. 3ª ed. Barcelona. Masson, S.A. 2006
- Casas Galofré, M. La información para la gestión clínica. En: J.L. Temes; M. Mengíbar. Gestión Hospitalaria. 4ª ed. McGraw-Hill-Interamericana, Madrid, 2007. pp. 59-68.
- Clasificación internacional de enfermedades. 9º revisión. Modificación Clínica (CIE-9-mc). 9ª edición. Madrid. Ministerio de Sanidad, Servicios sociales e Igualdad. 2014
- Clasificación internacional de enfermedades. 10º revisión. Modificación Clínica (CIE-10-ES). 2ª edición. Madrid. Ministerio de Sanidad, Servicios sociales e Igualdad. 2018
- Guía de gestión de los servicios de admisión y documentación clínica. Madrid. Instituto Nacional de la Salud, 2000
- Fernandez Hierro, J.M.; Cantero Rivas, R.; Martinez Aguado, L.C.; Moreno Vernis, M. La historia clínica. Granada, Editorial Comares, 2002.
- Recursos e-Salut: ClinicalKey Student. Elsevier (Scopus, ScienceDirect).

- Documentación Médica

- Historia clínica digital del sistema nacional de salud. http://www.msc.es/profesionales/hcdsns/home.htm
- Prestaciones sanitarias del sistema nacional de salud. http://www.msc.es/profesionales/prestacionesSanitarias/CarteraDeServicios/ContenidoCS/Home.htm
- Leiner, F.;Gaus, F.; Haux, R. Knaup-Gregori P. Medical Data Management. A practical Guide. New York: Springer, 2003.
- Ley 41/2002, de 14 de Noviembre, básica reguladora de la autonomía del paciente y de los derechos y obligaciones en materia de información y documentación clínica (BOE 274, 15 Noviembre 2002)
- Ley 14/1986 de 25 de abril. Ley General de Sanidad (BOE nº 102, 29 Abril 1986)
- López Domínguez, O; López Arbeloa P; Temes Montes J.L; Los sistemas de información en la gestión de los centros asistenciales. En: J.L. Temes; M. Mengíbar. Gestión Hospitalaria. 4ª ed. McGraw-Hill-Interamericana, Madrid, 2007. pp. 137-161
- ORDEN de 14 de septiembre de 2001, de la Conselleria de Sanidad, por la que se normalizan los documentos básicos de la historia clínica hospitalaria de la Comunidad Valenciana y se regula su conservación (DOGV 4111, 22 Octubre 2001)
-SNOMED-CT http://www.msc.es/profesionales/hcdsns/areaRecursosSem/snomed-ct/home.htm