HELP HEALTHCARE ENGLISH LANGUAGE PROGRAMME
Project no. 2014-1-ES01-KA203-004735

DIDACTIC-METHODIC INPUT FOR WRITING

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What is medical writing:

Medical writing involves writing scientific documents of different types which include regulatory and research-related documents, disease or drug-related educational and promotional literature, publication articles like journal manuscripts and abstracts, content for healthcare websites, health-related magazines or news articles. The scientific information in these documents needs to be presented to suit the level of understanding of the target audience, namely, patients or general public, physicians or the regulators. Medical writers require an understanding of the medical concepts and terminology, knowledge of relevant guidelines as regards the structure and contents of specific documents, and good writing skills. They also need to be familiar with searching medical literature, understanding and presenting research data, the document review process, and editing and publishing requirements.

The demand for medical writing is growing steadily in pharmaceutical and healthcare communication market.

How to teach medical writing:

Provide appropriate input:

- Pre-teach relevant vocabulary
- Present a draft form; ideally if it is an **authentic material**
- Leave time for literature search and review of information

Provide context:

- Set it in the context of a module

Design an activity with a purpose:

- Explain why and how it is needed in real communication
- Present situations for the use

Include awareness of cultural aspects of language use:

- Expand the perspective of writing from the classroom into authentic communication patterns

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Formulaic writing assignments – form filling:

1. **Handovers (between shifts) = handover shits**

Types of handovers:
- Verbal handover
- Bedside handover
- Written handover

They are pre-prepared sheets containing patient details. The sheets and frequency of passing them on may differ depending on the number of patients, dependency and staffing levels. It is important that patient safety issues are forwarded to the next shift.

They contain **(Rule of FIVE Ps)**:
- P1 – **Patient's name**, diagnosis, doctor and past relevant history
- P2 – **Patient's date**, reason for admission
- P3 – **Present restrictions**
- P4 – **Plan of care**
- P5 – **Progression** – what role will you play in the next shift?

2. **Patient records / notes**

Good record keeping is an integral part of nursing practice; it is an essential element to guarantee safe and effective care. Nowadays electronic record keeping is more frequent than paper based records.

Function of patient records:
- explain how decisions related to patient care were made
- support the delivery of services
- support clinical judgments
- support patient care
- make continuity of care easier
- provide documentary evidence of services provided
- promote better communication among healthcare team
- help identify risks
- support clinical audit, research and legal processes

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Documents included into patient records:

- clinical notes;
- emails;
- letters to and from other healthcare professionals;
- test results;
- printouts from monitoring equipment;
- incident reports;
- telephone notes;
- text messages

Good records:

- contain dates and time for all actions taken
- have actions listed in chronological order
- have a clear message; are factual, communicate fully and effectively
- avoid unnecessary abbreviations, jargon and meaningless phrases
- use understandable language

3. **Charts, e.g. care pathways**
4. **Forms, e.g. lab requests**
5. **Drug orders (topic 9 – Drugs)**
6. **Prescription charts**
7. **Telephone messages**
8. **Referral letters**
9. **Incident reports (topic 12 – Safety measures at work)**
10. **Ambulance Trip Sheet (topic 12 – First Aid)**

11. *Academic articles*
12. *Reflective journals*

a. *What happened?*
b. *What did you do?*
c. *What was the outcome?*
d. *How did you feel?*
e. *What went well and what didn't?*
f. *How could this inform your future practice?*

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Types of reporting:

SBAR – Situation, Background, Assessment and Recommendation

- used to communicate clinical information about a patient's condition

S – outline information about the patient, his problem
B – give the background information, relevant medical history, treatment, state admission diagnosis, date of admission
A – list changes in the patient's condition, give cause for concern
R – state what shall be done

Medical written language includes:

- abbreviations
- acronyms
- medical terminology
- everyday health terms (vernacular English)
- reported speech – to document what patient said
- passive voice – objective and distanced

Online forms:

http://www.tidyform.com/medical-forms.html

References:

http://www.nclrc.org/

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3149406/

Allum V., *Teaching English for Medical Purposes*