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## **Review of data collected for OET/ARC Linkage study to verify revised OET speaking checklist**

### **Report**

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## Introduction

This report presents the findings of a study carried out by the Language Testing Research Centre (LTRC) at the University of Melbourne and commissioned by Cambridge English Language Assessment, the co-owner of the Occupational English Test (OET).

It extends findings of a project funded by the Australian Research Council called *Towards improved healthcare communication: Development and validation of language proficiency standards for non-native English speaking health professionals* (LP0991153), which was completed by a project team\* led by Associate Professor Cathie Elder at the University of Melbourne and with the OET Centre in Melbourne as the research partner. The aim of the study was to determine what aspects of health professional performance in interaction with patients were valued by health professionals, that is, to investigate the “indigenous assessment criteria” (Jacoby & McNamara, 1999) of this group. It was anticipated that a better understanding of what health professionals value would inform the revision of the Speaking sub-test of the Occupational English Test, a specific-purpose English test taken by health professionals trained in other jurisdictions seeking to register to work in their profession in Australia.

One of the products of the project that forms part of the final report submitted to the OET Centre (Elder et al., 2013, August) is a checklist of indicators of effective performance in the health professional–patient interaction derived from a thematic analysis of datasets of feedback commentary of health professionals on the performance of trainees in interaction with patients. Thus the checklist is drawn empirically from a dataset. This phase of the project was written up as the doctoral thesis of a PhD candidate working on the project, John Pill. (For a detailed exposition of the analysis process, see Pill, 2013.)

Having become co-owner of the OET while the project was in progress, Cambridge English Language Assessment reviewed the final report and asked Dr Jonathan Silverman, an expert in teaching clinical communication skills to health professionals and co-author of a core text on this subject (Silverman, Kurtz, & Draper, 2005), to meet with the project team. The meeting took place in Melbourne in November 2013. Following this meeting, Dr Silverman proposed some amendments to the checklist based on his work and the process skills inventory of the Calgary–Cambridge Guides. He continued to work with staff members with expertise in language testing at Cambridge English Language Assessment on the revised checklist.

Noting that the original checklist had an empirical basis, the LTRC in discussion with Cambridge English Language Assessment suggested that the contents of the revised checklist be checked against the original dataset to ensure that it remained true to the findings of the study. This work is the focus of the present study. The assumption is made that the original study is an accurate reflection of the views of health professionals in three professions (medicine, nursing and physiotherapy) and, if a revised checklist is to be used for operational purposes, its relationship to the original data should be established.

This report is therefore a practical response to a particular research question posed in the context of a completed research project and PhD candidature. The findings of the report provide a basis for further studies to consider how to proceed with the recommendations

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\* The project team comprised Associate Professor Cathie Elder, Professor Tim McNamara, Associate Professor Robyn Woodward-Kron, Professor Geoff McColl, Professor Elizabeth Manias and Associate Professor Gillian Webb.

for changes to the OET Speaking sub-test made by the original project team in their report to the OET Centre (Elder et al., 2013, August).

It is noted that the original study considered the views of members of three health professions (medicine, nursing and physiotherapy) while the OET currently serves 12 health professions. While articles have been published presenting the project's findings in the specific contexts of physiotherapy (Woodward-Kron et al., 2012) and nursing (O'Hagan et al., 2014), the project's final report notes that the validity of its findings must be confirmed for the nine professions not included in the original study. Similarly, it is important to recognise that Dr Silverman's expertise as expressed in the revisions to the checklist in the current study is based more directly in clinical communication skills in medicine than in the other professions served by the OET.

## Methods

In this study, two checklists of indicators were compared. The original version of the checklist is presented as an appendix in John Pill's doctoral thesis (Pill, 2013) and is included as Appendix B to this report. The revised version of the checklist was provided to the LTRC by Cambridge English Language Assessment for the purposes of this study on 17 July 2014. This is included as Appendix C.

The original version was the product of analysis of research data collected from health professionals in three professions (medicine, nursing and physiotherapy). The research participants gave their feedback comments on the performance of trainees in interaction with patients. Thematic analysis of these data allowed a set of behaviours amenable to assessment on a language test to be created. These behaviours were consolidated to become the indicators on the original checklist, which formed part of the final report of the project submitted to the OET Centre (Elder et al., 2013, August). The revised version of the checklist was created by Dr Jonathan Silverman with staff members at Cambridge Language Assessment.

The original checklist comprises 24 indicators in four groups plus a glossary of nine terms used in the checklist which are explained for language-trained assessors who may be unfamiliar with the terminology as used in the context of clinical communication skills. The revised checklist is based on the original checklist and comprises 20 indicators in five groups plus a six-page glossary in which each indicator is explained and exemplified.

First, the wording and organisation into groups of the indicators in the two checklists was compared. A table (presented in the Findings section as Table 1) was drawn up to show similarities and differences. This process allowed revised indicators that did not match directly with the original indicators to be located. In these cases, the original data was reviewed to look for instances of the participants making comments on trainees' performance that would support the inclusion of the indicator in the revised checklist. This was done in two stages. First, a search for the word (or a stem) was carried out across the computer files containing the transcripts of the workshops, written reports and hospital-based interaction that formed the complete dataset for the original study (including data for medicine, nursing and physiotherapy). For example, the stem "summar\*" was used to locate any mentions of "summarising", "summary", etc. in the data. Based on the outcome of this search, a second review was undertaken, this time manually checking the coded data for the coding categories in which the words occurred. In addition, coding categories were checked

that the researcher supposed would have been used to categorise the particular concept. All relevant references were taken and compiled into a summary document for further review.

Extracts from this document are presented in the Findings section. Each contains a reference to its source, for example, NUR-wk4-123, PHY-wk1-p.5 or MED-R10-1-2. The first three letters indicate the profession (here nursing, physiotherapy and medicine, respectively). Data from a workshop is indicated by “wk” and the number of the workshop; data from written reports – a dataset available for medicine only – gives the reference number of the doctor concerned, e.g., R10, followed by the term of supervised practice he or she was in (1, 2 or 3). The reference concludes with a line number (123) or page number (p.12) locating the start of the extract in its transcript. Because the data extracts in this report are not complicated, a full list of transcription conventions has been omitted. (It is available in Pill, 2013.)

## Findings

Table 1 presents the indicators on the revised checklist matched against indicators from the original checklist in terms of their scope. There are 24 indicators on the original checklist and 20 on the revised checklist. There are four instances of a noticeable gap in the coverage of the original checklist for a concept included in the revised checklist. These are marked “**GAP**” in Table 1 and are discussed in detail below. In many cases, there is a direct match between the two sets of indicators, and only minor changes in wording occur; the revised checklist is generally less wordy than the original (perhaps because further detail is carried in the expanded Glossary accompanying the revised checklist). In a few cases (e.g., for revised indicators D7, D8 and D9), a partial match in scope with one or more original indicators is noted. Elements of one original indicator are either split up to be accommodated in two revised indicators (e.g., original indicator 8 is split between revised indicators B1 and D8) or vice versa, with two original indicators consolidated into one (e.g., original indicators 16 and 17 are merged in revised indicator D3).

The grouping of indicators under headings is also somewhat different between the two checklists: the original checklist has four sets of indicators while the revised checklist has five, introducing a set of indicators of *providing structure* that is separate from *information-gathering* and *information-giving*. The wording of the headings is also revised. The group from which each of the original indicators is drawn is given in Table 1. For example, two indicators presented in the original checklist as part of information-giving (indicators 20 and 21) have been moved into the group *Indicators of understanding & incorporating the patient's perspective* (as revised indicator B3).

**Table 1. Revised checklist indicators matched with similar indicators in original checklist to highlight gaps in coverage**

In both checklists the indicators are preceded by the stem *In the roleplay, there is evidence of the test taker ...*

Revised checklist		Indicators drawn from original checklist	
<b>Indicators of relationship building</b>			
A1	initiating the interaction appropriately (greeting, introductions, nature of interview)	1 (PM)	initiating the interaction appropriately [with a greeting, introducing himself/herself].
A2	demonstrating an attentive and respectful attitude	3 (PM)	demonstrating a positive, attentive and respectful attitude towards the patient.
A3	adopting a non-judgemental approach	4 (PM)	adopting a non-judgemental stance towards the patient [his/her life choices, views].
A4	showing empathy for feelings/predicaments/emotional state	<b>GAP1</b>	
<b>Indicators of understanding &amp; incorporating the patient's perspective</b>			
B1	eliciting and exploring patient's ideas/concerns/expectations	8 (PA)	seeking to elicit the patient's perspective on the situation, and checking it as the situation changes.
		9 (PA)	investigating what the patient's concerns and needs are, and what his/her situation is [not making assumptions about these topics].
B2	picking up patient's cues	10 (PA)	responding considerately to any cues the patient gives about his/her concerns, needs, emotional state, and so on.
B3	relating explanations to elicited ideas/concerns/expectations	21 (GIV)	explaining in a straightforward way, relevant to the patient's situation and needs.
		20 (GIV)	finding out what the patient wants to know.
<b>Indicators of providing structure</b>			
C1	sequencing the interview purposefully and logically	14 (GAT)	sequencing the process of information-gathering purposefully and logically for the patient [e.g., not jumping from topic to topic].
C2	signposting changes in topic	15 (GAT)	signposting changes in topic and, in particular, any change to a sensitive topic.
C3	using organising techniques in explanations	22 (GIV)	using signposting and organising techniques to structure the process of information-giving.

**Table 1 (continued)**

Indicators for <b>information-gathering</b>		
D1	facilitating patient's narrative with active listening techniques, minimising interruption	7 (PM) supporting the patient's narrative with active listening techniques. 6 (PM) allowing the patient to contribute fully [not interrupting him/her unnecessarily].
D2	using initially open questions, appropriately moving to closed questions	13 (GAT) using an open question to allow the patient to provide more information.
D3	NOT using compound questions/leading questions	17 (GAT) <b>not</b> using compound questions. 16 (GAT) <b>not</b> using leading questions.
D4	clarifying statements which are vague or need amplification	18 (GAT) clarifying and confirming to make sure he/she gets the correct story.
D5	summarising information to encourage correction/invite further information	<b>GAP2</b>
Indicators for <b>information-giving</b>		
D6	establishing initially what patient already knows	19 (GIV) establishing initially what the patient already knows. <b>GAP3</b>
D7	pausing periodically when giving information, using response to guide next steps	?22 (GIV) using signposting and organising techniques to structure the process of information-giving. ?23 (GIV) checking if the patient has understood the information or wants more explanation. <b>GAP4</b>
D8	encouraging patient to contribute reactions/feelings	?8 (PA) seeking to elicit the patient's perspective on the situation, and checking it as the situation changes.
D9	checking whether patient has understood information	23 (GIV) checking if the patient has understood the information or wants more explanation. ?24 (GIV) restating information in different ways for the patient to aid his/her understanding.
D10	discovering what further information patient needs	20 (GIV) finding out what the patient wants to know. 23 (GIV) checking if the patient has understood the information or wants more explanation.

**Key** **GAP** shows where a gap in coverage is perceived; ? shows an indicator from the original checklist which only partially reflects the scope of the indicator on the revised checklist; grouping of indicators from the original checklist are: PM = indicator of *Professional manner*, PA = indicator of *Patient awareness*, GAT = indicator for *Information-gathering* and GIV = indicator for *Information-giving*.

There are indicators on the original checklist that are not included in the revised checklist. For completeness, they are listed here:

Indicators of *Professional manner*

- 2 interacting with the patient in an approachable, professional way.
- 5 showing tolerance and calmness towards the patient [even in difficult circumstances].

Indicators of *Patient awareness*

- 11 predicting what might be unexpected for the patient and preparing him/her for it.
- 12 acknowledging any indication of confusion or misunderstanding from the patient.

Indicators for *Information-giving*

- 24 restating information in different ways for the patient to aid his/her understanding

Original indicator 12 might be covered by revised indicators D4 (“clarifying statements which are vague or need amplification”) and D9 (“checking whether patient has understood information”). Original indicator 24 is not explicitly included in the revised checklist, although it is perhaps related to revised indicator D9 as a technique to check understanding (as suggested in Table 1) and it might also be considered an “organising technique” (C3).

*Concepts added in the revised checklist*

The four “gaps” noted above relate to the following indicators on the revised checklist and their apparent absence from the original checklist.

- A4 showing empathy for feelings/predicaments/emotional state
- D5 summarising information to encourage correction/invite further information
- D7 pausing periodically when giving information, using response to guide next steps
- D8 encouraging patient to contribute reactions/feelings

Table 1 indicates how particular indicators on the original checklist might be seen to cover indicators D7 and D8 in part, and this signals that the concepts are present in the data collected for the original study. Further evidence for the presence of these concepts in the data was sought and the findings are presented below, taking each of the revised indicators in turn.

Gap 1 (A4) showing empathy for feelings/predicaments/emotional state

Review of the datasets used in the original study shows that the term “empathy” is used by health professionals in their feedback commentary on trainees’ performance. Indeed, in the set of reports written by visiting educators on the performance of general practice trainees consulting with patients in routine clinics, “empathy” was one of the prompts for the section



“Communication skills & the Pt–Dr relationship” in the report template. Consequently, it is not surprising that educators’ comments consider this topic, as in the following example.

In case 2 with the 8 year old with a possible visual acuity defect you were empathic and followed the mother's cues with regard to her concerns. [MED-R05-1-3]

However, similar comments were also made in the data-collection workshops, where such a prompt was not given.

one of the ways to encourage and demonstrate empathy might have to pick up on the cue. You know, he [=patient] commented at least once or twice about going home. So what, you know, “you seem really, really keen to get home,” you know, what’s going on with that? You know, yeah. You had a great big open door there for an important conversation. [NUR-wk4-346]

Several examples of the use of “empathy” and related terms link it to acknowledging the patient’s situation or needs and following the patient’s (or carer’s) cues regarding what he or she is concerned about. The following example indicates how difficult this might be.

he’s a, a kid in his probably early twenties dealing with a 90-year-old woman, I think he just – I think a lot of them [=trainees] struggle to understand you know and empathise with people to know you know what impact these sorts of things have on their lives. You know, they, probably live at home and get their washing [done] and dinners made and don’t really put that into the context of what this poor lady’s going through. [PHY-wk1-p.14]

The data also show how empathy is seen to be performed through the provision of appropriate verbal responses (which are sometimes referred to as “empathic statements”).

You picked up well on patient cues like with the first patient who said that she could not afford the private physiotherapy ... You also empathised well with her when she expressed her loss of income saying “That must be hard” and with the final patient when she was worried about her loss of memory “It’s really a frightening thought to think that you are losing your memory”. [MED-R24-1-9]

there was evidence he [=trainee] was listening to the patient he was his questions did sequence nicely with the patient’s information. He made a couple of strong efforts to display empathetic statements. Um, and he was – seemed to be tracking the patient’s story well. [PHY-wk1-p.2]

you used some good empathic statements, especially in the OSCE practice cases of the man seeking temazepam and the woman wanting to quit smoking. Saying “That sounds difficult” goes a long way to telling the patient you are on their side [MED-R09-3-2]

So being able to use an empathic statement to follow that up. “I don't think you're mad. You're obviously upset. You've been kept waiting forever. This is really you know terrible and I appreciate that, I'd find it difficult as well.” I mean all sorts of things that you could say to take the heat out of his emotional um distress at that time. [NUR-wk1-p.4]

really the patient needed her emotion identified and empathic statements supplied in order to show that er the doctor understood the patient’s concerns and was

going to assist the patient in a management plan that would deal with those concerns [MED-wk1-359]

A medical educator contrasts a trainee being “a bit casual in her approach” initially with her becoming “a lot more empathic later on” [MED-wk2-71, 74]. In other commentary, the term is used in statements that provide a broader context for “empathy” and why it is viewed as important.

you have a mature and thoughtful approach to patients with an empathetic and confident manner that engenders good rapport and trust. [MED-R18-1-2]

you demonstrated good communication skills by being empathetic about giving relatively bad news in relation to some investigation results. [MED-R01-3-7]

You listen very well, and put your patience at ease. We discussed how you sometimes have people crying right at the start of the consultation as they start to talk. I think this is partly because of your natural empathy for people, and your skills in opening the consultation. [MED-R20-1-2]

Nursing educators compare an empathetic approach with an overly clinical or efficient approach.

those are difficult situations where empathy is so important, you know, not being judgmental, being empathetic, um, encouraging the patient to feel like “you are important,” you know, “whatever’s happened to you, I’m not going to judge you but I’m here to help you.” Cause they were trying to help, but it was the way that they did it, almost, very clinical, and sometimes we can be too clinical in our approach to our patients, and we forget about that empathy that patients really need. [NUR-wk4-322]

patients have reported this – they don’t want efficient nurses, they want efficient empathetic nurses is what they want [NUR-wk4-362]

The Discussion section below considers why the term “empathy” was not used in the original checklist.

Gap 2 (D5)      summarising information to encourage correction/invite further information

Evidence for summarising as a technique in the process of information-gathering is found explicitly in the data. In the first medicine workshop, four participants contribute to defining the behaviour.

P1 The other thing that was good was that she [=trainee] repeated back the phrases.

P2 Yeah, she was –

P3 Yeah, she clarif(ied) them.

P2 She did that really well.

P1 So, two weeks and, worse at night and – whatever.

P4 Little summaries dotted all the way (through). [MED-wk1-119]

In the first physiotherapy workshop, the facilitator (a researcher on the project team) prompted a participant to comment on the topic.

- R2 Can I ask you a question, [P1]. In terms of the – um, [trainee name], not taking notes, in Physio would you expect your students at the end of a history-taking sequence to have a phase in the sequence to say, “well so you’ve come in because of blah blah blah,” so do a little summary?
- P1 (xx) summary, yeah.
- R2 So is that something you would expect as a s- these – you know t- to you know, if he hasn’t taken notes –
- P1 (xxx) we do as part of our training, yeah. [PHY-wk1-p.13]

Summarising as part of the information-gathering phase is also mentioned in one of the nursing workshops.

getting people to try and ask the open-ended questions but also follow where the person is, then doing a summary summarising of what the person's been saying [NUR-wk1-p.9]

Summarising is also mentioned as a technique for information-giving: providing the patient “with 2-3 take home messages” [MED-R23-1-16].

Gap 3 (D7) pausing periodically when giving information, using response to guide next steps

There was some evidence for this behaviour in the educators’ comments on information-giving. The problem is raised of a trainee not seeking a response from the patient to the information he or she has been given (this also relates to Gap 4 – D8 – considered below).

I note at times you repeat the same advice several times in a consultation, I suspect because you are fearful that the pt may not get the message. Unfortunately if the patient is not engaged, this usually does not work and I would look at ways of repackaging the message instead eg using the Australian Risk charts as we discussed. ...

You tend to cram a lot in to fast explanations and I am not sure that the patient is always with you, or even always understands what you are recommending. [MED-R05-3-10, 25]

There is one instance in the dataset of pausing being suggested as a solution in such a situation. (Note again that this example is also relevant for indicator D8 below.)

She she [=trainee] ploughed on and I wanted her to say “Oh, tell me (again/OK)” and just to pause and listen to the [patient’s] concerns. And again some of the explanations as everybody heard were just a little bit confusing um a bit of jargon and a bit rapid an- and just didn’t s- stop to say “Wha- what’s your understanding about this situation and do you know of this?” and seeing what the person really understood before they before she launched into her explanation. [MED-wk1-443]

While pausing to allow the patient to respond is not clearly stated as a possible solution elsewhere, behaviours that may involve pausing are indicated by the health professional participants; for example, they mention giving the patient “space”. However, some of these comments relate to the process of information-gathering rather than information-giving.

She [=trainee] achieved a good balance in giving the person enough space to talk and feel understood but also directing conversation such that it was clinically useful. [MED-R03-1-5; a general comment about the consultation as a whole]

the pauses, it was good he [=trainee] gave her [=patient] some time to answer and to think about it [his question] [PHY-wk1-p.11; in an information-gathering context]

again there were the questions about you know moving her forward towards the end. “Do you know what's going on?” “Do you have any questions for me?” There's a sort of tone in that that doesn't allow a lot of space for people to raise questions. [NUR-wk1-p.8; in an information-gathering context]

#### Gap 4 (D8) encouraging patient to contribute reactions/feelings

Examples in the dataset show that the participants want the trainees to ascertain their patients’ response to the information that has been provided (information-giving). These more general examples relate also to the data for indicator D7, presented above. The first two examples below indicate that the trainee (R05, in separate reports) has not been doing this.

Last time I visited you were giving patients explanations or making recommendations followed by the words OK without allowing the patient to answer or discuss options available. This only happened occasionally today but is still [an] important practice to avoid. [MED-R05-2-7]

You need to listen carefully to patients [*sic*] views then modify your advice accordingly. [MED-R05-3-7]

you don’t just dictate to patients that that’s [a particular procedure] going to happen. You need to involve them in the decision-making process obviously and find out what their concerns are. [MED-wk1-291]

Participants’ comments refer to eliciting a patient’s views on the information that has been provided by the health professional. However, participants do not make this point in terms of the health professional “encouraging” the patient to respond. Furthermore, they do not particularly focus on the patient’s “feelings”. The following examples illustrate this.

she [=trainee] was pretty comprehensive in the information that was given and the patient was then allowed that opportunity, and I think when that sort of communication occurs the patient actually feels very comfortable about offering or asking questions. Um, because it wasn’t rushed, and it was, you know, that sort of focus on the patient. [NUR-wk4-155]

So perhaps phrasing this question in a more open manner might allow her [=patient] to express any further concerns. For instance, “what do you think of that plan?” [MED-R12-2-23]

[You (=trainee)] gave her [=patient] an explanation of what you were going to do next. You exposed your thinking of how you had come to your diagnosis or differential diagnoses and what you were planning to do next to confirm your thoughts. You checked on her expectations and if she was happy with the management plan that you had put to her. [MED-R16-2-12]

A comment from the first physiotherapy workshop appears to capture the intent of the proposed indicator, but it is made in relation to the process of information-gathering.

I [=educator] thought he [=trainee] could use more reflective kind of statements to encourage some discussion around what the patient was feeling [PHY-wk1-p.8]

## Discussion

The apparent differences between the two checklists – the original and revised indicators – may reflect differences in the perspectives of their authors regarding the relative values given the behaviours described in the indicators and how the concepts being described relate to each other. The grouping of indicators under headings is also somewhat different between the two checklists and may similarly reflect alternative conceptions held by the authors of the alignment of the indicators. The somewhat different views of applied linguistics and of healthcare education – the consideration of two sides of the same coin – are inevitable. However, it is important to note that they are not found to be in direct conflict with each other. Behaviours described in a particular indicator might well be categorised by the authors under different groupings because they are, for example, supportive both of effective information-gathering and of relationship building between patient and health professional. The work to be accomplished in any health professional–patient interaction is complicated and requires a set of inter-related skills. The indicators in the checklists relate to what is to be done in practice and also to the goals of the interaction, which may be less tangible. A particular behaviour may contribute to the achievement of more than one goal in the same way that several behaviours may combine to realise another. The perspectives of applied linguistics and healthcare education will inevitably focus on different aspects of the performance of the interaction (see Pill, 2013).

In this section, the issue of “empathy” is discussed. The term was consciously avoided by the researcher when preparing the original indicators. One reason for this was the prevalence of its use in the literature on clinical communication skills. While this indicates the importance of the concept to health professionals, the concept is also contested in the literature regarding exactly what it is and how it can best be observed. The question raised is whether effective communication is best viewed (and taught) as a set of specific behaviours to be performed or as an overall approach in which positive outcomes require creativity from the health professional as well as competence in a set of particular skills (see, e.g., Salmon & Young, 2011).

A second reason for its exclusion was concern that it may not always be clear how empathy is “performed”, that is, at least for outsiders to the healthcare professions, the lack of a practical sense of which behaviours achieve empathy. Nevertheless, the term does appear in the dataset, with participants in the research workshops apparently assuming that others present share their understanding of it. In the coding of the data, then, the concept of “empathy” may have been fragmented into more practical aspects that contribute to its realisation. It was thought that these aspects, which are present in the original indicators,

would be more easily recognised by OET assessors, who may not share the same understanding of “empathy” assumed of the health professionals. It is clearly important for fairness and accuracy of a test that its assessors all have a common conception of the aspects of performance they are required to assess. In the case of the OET, a language test, the assessors must focus on a test taker’s ability to use language to achieve effective interaction with the patient in the healthcare context; it may be difficult to standardise how a test taker “shows empathy” in any broader sense. On the other hand, of course, it may be the case that a test taker demonstrates that he or she can “talk the talk” by using “empathic statements” (as described by participants in the research workshops) but the performance overall nevertheless appears to any observer to be devoid of any “real” empathy.

Regarding the other three “gaps” in the original indicators, the findings show that there is at least limited evidence in the data of participants commenting on the value of summarising in the information-gathering phase (revised indicator D5), pausing to allow to patient to respond and guide the next steps (D7), and encouraging the patient to contribute his or her reactions and feelings regarding the information given (D8). The number of mentions in the data is low and this may be a reason these topics did not feature in the original indicators. Table 1 demonstrates how some overlap between original and revised indicators can be observed to cover the “gap” for indicators D7 and D8.

Some further general comments can be made about the generation of the indicators. First, the purpose of the original checklist was to provide a training tool for use with OET assessors to assist them in understanding the scope of additional criteria proposed for the Speaking sub-test. The new criteria seek to expand the scope of the assessment scheme to include more of what health professionals value in spoken interaction with patients. The OET is a specific-purpose language test and its assessors have language teaching backgrounds, not healthcare backgrounds. The checklist, originally drawn up by an applied linguist, is therefore likely to take a more linguistic view of the aspects of performance found to be valued by health professionals and concentrate on specific observable language behaviours. Consequently, the discussion above about the avoidance of the somewhat nebulous term “empathy” might, for example, also be applied to “encouraging” in revised indicator D8.

Second, the checklist explicitly excluded aspects of non-verbal communication although the research found them to be of great importance to the health professional participants. Practicalities of recording the Speaking sub-test role-plays for assessment have limited the assessment to audio only. A recommendation to the OET Centre in the final report for the original study is to review this situation (Elder et al., 2013, August). Nevertheless, the assessment criteria and the checklist reflect current practice, meaning that some behaviours that are clearly found to influence effective performance are not assessed. This may also have affected the extent to which related behaviours were considered for inclusion in the checklist, despite the fact that they *can* be recorded in audio-only format (e.g., pausing).

Third, the original checklist was drawn up assuming the constraints of existing OET role-play tasks – the stimuli used to obtain the spoken performances from test takers. Their revision was not part of the scope of the study although, as with audio-only recording of test performances above, a recommendation from the project is that this area should be reviewed if the proposed assessment criteria are to be introduced in routine test administration. The issue is that at least some of the currently used tasks may not allow a test taker to demonstrate all aspects of performance that the checklist, and therefore the proposed assessment scheme, seeks to assess. It is obviously not fair to penalise a test taker for not demonstrating a behaviour that the role-played situation does not require. As a minor example, the revised indicator A1 includes the health professional indicating the “nature of interview”; some of the current stimuli do not involve a full interview (from start

to finish), which might make this a difficult point for the test taker to mention. (This might also affect C1 and the structure of the interview as a whole.) Similarly, one role-play scenario of five-minutes may not include scope for each of the revised indicators for information-gathering and information-giving (D1 to D10) to be observed.

As a final (minor) point, the wording of some of the revised indicators may be problematic in the context of language testing. Some assume particular behaviour of the patient that may not be realised in every case. For example, a health professional may be unable to elicit a patient's concerns (from indicator B1) if the patient is uncooperative and does not let him or her do so. Also, the "picking up" of cues in indicator B2 might be achieved by the health professional without generating any linguistic evidence in the interaction. This is problematic in a direct language test where evidence of linguistic ability in the performance is being sought.

Overall, this study indicates that the revisions suggested can be supported with examples from the datasets used to create the original checklist. The purpose of the final checklist should perhaps decide the most appropriate way to present its content. If the checklist is to be used to guide OET assessors – who are not trained in medicine or healthcare but who are experienced language teachers – to recognise and assess consistently particular instances of language use which have been shown to be valued in effective interaction between health professionals and their patients, then a language-focused description of these indicators seems more appropriate. If, on the other hand, the checklist is to demonstrate to stakeholders (e.g., potential users of test results) how well aligned the OET assessment criteria are to espoused practice in the field of clinical communication skills, then the revised version may be more suitable. This report is not the place for a review of the argument about the extent to which language assessors can and should act as proxies for health professionals, but it is clearly part of it.

Three separate points are noted to finish the Discussion section. The first relates to a lack of clarity about the criteria which are drawn from the checklist indicators. The indicators in the original checklist informed the creation of two criteria that are proposed for use in the assessment scheme of the OET Speaking sub-test along with four existing analytic criteria. The proposed criteria are each abstracted from two groups of the original indicators: the criterion *Clinician engagement* comes from indicators of professional manner and patient awareness, and the criterion *Management of interaction* comes from indicators for information-gathering and information-giving. In the revised version of the checklist, it is not clear whether the indicators still inform the same overarching criteria or whether this needs to be reconsidered. If the same criteria are intended, how they are to be drawn from the revised indicators has not yet been made explicit.

The second point concerns a possible danger that test users believe the OET is assessing directly the clinical communication skills of health professionals rather than the language skills they need to perform their work. This mistaken view may be encouraged by the glossary for the revised checklist, which provides several pages of information about the purpose of the various behaviours expected of the health professionals. However, the OET assessors, who, it is assumed, would use this knowledge to inform their assessment of health professional test takers, are not in a position to assess any more than the language skills used by the health professionals. Their assessment is necessarily that of an outsider and care must be taken that this outsider's view (albeit a highly informed one regarding language and general communication skills in the healthcare context) is not taken to be the same as an insider's view. The glossary text seems to blur the boundary between what language assessors are able to make decisions about and what are issues of professional competence, which would seem to be problematic (see also Wette, 2011).

The third point draws attention to aspects of performance covered by original indicators which are not included in the revised checklist. While the revised checklist describes how an effective health professional should act with a patient, it generally does not include aspects of performance that would be poor or ineffective. (An exception is the use of closed and compound questions, covered in indicator D3.) Original indicator 5 – “showing tolerance and calmness towards the patient [even in difficult circumstances]” – may be thought of as a given in many contexts. Nevertheless, it cannot be assumed that every health professional will behave in this way. In the context of assessment, such indicators must be included so that poor performance can be penalised directly. If the behaviour is not explicitly part of the assessment tool, it is rendered invisible and therefore not assessable. There is consequently a case to be made for dis-preferred behaviours to be noted explicitly in the checklist.

## **Conclusion**

This study has shown that the aspects of performance introduced in the revised indicators and checklist are present at least to some extent in the dataset from which the original indicators and checklist were drawn. The revised checklist involves changes in the wording and organisation of the indicators of performance when compared with the original checklist rather than any more fundamental revision. It is suggested that these changes relate to the different perspectives on the context of health professional–patient interaction held by the authors of the original and revised versions, namely a “language” perspective and a “healthcare education” perspective. Such a difference is inevitable in the field of language testing for specific purposes.

The selection of one or other perspective as represented in the content and wording of the checklist may depend on its ultimate purpose. It is suggested that the checklist’s use as a training tool for OET assessors to become familiar with language-related aspects of what health professionals value would favour a more specific and language-focused format, while its use to persuade test users and stakeholders in the healthcare professions of the value of the OET would privilege a wording that those groups are comfortable with.



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## **Appendices**

Appendix A: Study description

Appendix B: Original version of the checklist (Pill, 2013)

Appendix C: Revised version of the checklist (provided to LTRC on 17 July 2014)

## **Appendix A: Study description**

### *Review of data collected for OET study to verify Jonathan Silverman's revised checklist*

The Language Testing Research Centre will review the workshop data collected in the first phase of the ARC speaking project to consider whether the new checklist items and wording proposed by Jonathan Silverman can be supported with the data. The data sets for medicine, nursing and physiotherapy will be examined.

The LTRC will produce a short outcome report quoting extracts from the data that support the new checklist items and wording or propose reasons why items or wording were not supported by the current data.

## Appendix B: Original version of the checklist (Pill, 2013)

**Instructions:** Complete the checklist for each roleplay. Mark “X” in a box on the right for each item: “yes”, “no” or “n/a” (i.e., not applicable because the aspect of performance described is **not relevant** to the task observed). The term patient may refer to the interlocutor’s role of patient/client, patient’s relative/carer, animal owner, etc.

In the roleplay, there is evidence of the test taker ...

Indicators of <b>Professional manner</b>		n/a	no	yes
1	initiating the interaction appropriately [with a greeting, introducing himself/herself].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	interacting with the patient in an approachable, professional way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	demonstrating a positive, attentive and respectful attitude towards the patient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	adopting a non-judgemental stance towards the patient [his/her life choices, views].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	showing tolerance and calmness towards the patient (even in difficult circumstances).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	allowing the patient to contribute fully [not interrupting him/her unnecessarily].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	supporting the patient’s narrative with <u>active listening</u> <sup>1</sup> techniques.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Indicators of <b>Patient awareness</b>		n/a	no	yes
8	seeking to elicit the patient’s perspective on the situation, and checking it as the situation changes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	investigating what the patient’s concerns and needs are, and what his/her situation is [not making assumptions about these topics].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	responding considerately to any cues the patient gives about his/her concerns, needs, emotional state, and so on.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	predicting what might be unexpected for the patient and preparing him/her for it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	acknowledging any indication of confusion or misunderstanding from the patient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Indicators for <b>Information-gathering</b> <sup>2</sup>		RELEVANT TO TASK? <input type="checkbox"/> YES <input type="checkbox"/> NO		n/a	no	yes
13	using an <u>open question</u> <sup>3</sup> to allow the patient to provide more information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	sequencing the process of information-gathering purposefully and logically for the patient [e.g., not jumping from topic to topic].	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	<u>signposting</u> <sup>4</sup> changes in topic and, in particular, any change to a <u>sensitive topic</u> . <sup>5</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	<b>not</b> using <u>leading questions</u> . <sup>6</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	<b>not</b> using <u>compound questions</u> . <sup>7</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	clarifying and confirming to make sure he/she gets the correct story.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Indicators for <b>Information-giving</b> <sup>8</sup>		RELEVANT TO TASK? <input type="checkbox"/> YES <input type="checkbox"/> NO		n/a	no	yes
19	establishing initially what the patient already knows.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	finding out what the patient wants to know.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	explaining in a straightforward way, relevant to the patient’s situation and needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	using <u>signposting</u> <sup>4</sup> and <u>organising techniques</u> <sup>9</sup> to structure the process of information-giving.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	checking if the patient has understood the information or wants more explanation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	restating information in different ways for the patient to aid his/her understanding.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix B: Original version of the checklist (Pill, 2013)

### Definitions

1	active listening	By repeating, paraphrasing and summarising what the patient is saying, and using fillers (e.g., <i>uhuh, mm, really</i> ) as encouragement while he/she speaks, the listener indicates he/she is assimilating the information provided.
2	information-gathering	Tasks in health professional-patient interaction involving gathering information include all aspects of history-taking and patient assessment: current symptoms, previous illness, family history, social and sexual history, and so on.
3	open question	An open question encourages more than just a yes/no answer – it is also known as a “wh-” (who, what, when, where, how) or “non-polar” question. The effect of an open question is also achieved with requests starting (e.g.) <i>Tell me about ...</i> . In contrast, a “yes/no” or “polar” question is called a closed question.
4	signposting	Signposting in speech is the use of words or phrases to indicate to the listener the direction the speaker is taking and to signal when transitions (changes of topic) are taking place. Signposts give cohesion to the spoken text.
5	sensitive topic	Sensitive topics include discussing alcohol and drug use, mental health issues, and sexual practices and orientation.
6	leading question	A leading question includes an assumption in the question form, e.g., <i>You’ve lost weight, haven’t you?</i> It is more difficult for the respondent to contradict the assumption than if an <u>open question</u> <sup>3</sup> had been asked, e.g., <i>What’s your weight?</i>
7	compound question	A compound question is when more than one question is asked consecutively without allowing time to answer. It confuses the patient about what information is wanted, and introduces uncertainty about which of the questions asked the eventual reply relates to.
8	information-giving	Tasks in health professional-patient interaction involving giving information include explaining a diagnosis, and discussing treatment and management plans.
9	organising techniques	Techniques include sequencing information ( <i>You need to remember three things: first, ...</i> ), breaking up information into chunks (e.g., short-, medium- and long-term goals), and presenting ideas on the same topic together.

### NOTES

**In the roleplay, there is evidence of the test taker ...**

<b>A. Indicators of relationship building</b>	
A1	initiating the interaction appropriately (greeting, introductions, nature of interview)
A2	demonstrating an attentive and respectful attitude
A3	adopting a non-judgemental approach
A4	showing empathy for feelings/predicament/emotional state

<b>B. Indicators of understanding &amp; incorporating the patient's perspective</b>	
B1	eliciting and exploring patient's ideas/concerns/expectations
B2	picking up patient's cues
B3	relating explanations to elicited ideas/concerns/expectations

<b>C. Indicators of providing structure</b>	
C1	sequencing the interview purposefully and logically
C2	signposting changes in topic
C3	using organising techniques in explanations

<b>D. Indicators for information-gathering</b>	
D1	facilitating patient's narrative with active listening techniques, minimising interruption
D2	using initially open questions, appropriately moving to closed questions
D3	NOT using compound questions/leading questions
D4	clarifying statements which are vague or need amplification
D5	summarising information to encourage correction/invite further information
<b>Indicators for information-giving</b>	
D6	establishing initially what patient already knows
D7	pausing periodically when giving information, using response to guide next steps
D8	encouraging patient to contribute reactions/feelings
D9	checking whether patient has understood information
D10	discovering what further information patient needs

Appendix C: Revised version of the checklist (provided to LTRC on 17 July 2014)

Glossary

A1	Initiating the interaction appropriately (greeting, introductions)	<p>Initiating the interview appropriately helps establish rapport and a supportive environment. Initiation involves greeting the patient, introducing yourself, clarifying the patient's name and clarifying your role in their care. The nature of the interview can be explained and if necessary negotiated.</p> <p>An effective example would be: <i>"Hello, I'm Dr. Albert, is it Margaret French? I'm one of the rheumatologists attached to the hospital. Your family doctor has asked me to see you about the joint problems you've been having"</i></p>
A2	Demonstrating an attentive and respectful attitude	<p>Throughout the interview, demonstrating attentiveness and respect establishes trust with the patient, lays down the foundation for a collaborative relationship and ensures that the patient understands your motivation to help. Examples of such behaviour would include attending to the patient's comfort, asking permission and consent to proceed, and being sensitive to potentially embarrassing or sensitive matters.</p> <p>For instance: <i>"May I sit here? What I would like to do is spend 20 minutes with you now discussing your problems and examining you? Is that okay? Please let me know if you are in any discomfort at any time"</i></p>
A3	Demonstrating a non-judgemental approach	<p>Accepting the patient's perspective and views non-judgementally without initial rebuttal or reassurance is a key component of relationship building. A judgemental response to patients' ideas and concerns devalues their contributions. A non-judgemental response would include accepting the patient's perspective and acknowledging the legitimacy of the patient to hold their own views and feelings.</p> <p>An effective example would be: <i>"So what worries you most is that the abdominal pain might be caused by cancer. I can understand that you would want to get that checked out."</i></p>
A4	Showing empathy for feelings/predicament/emotional state	<p>Empathy is one of the key skills of building the relationship. Empathy involves the understanding and sensitive appreciation of another person's predicament or feelings and the communication of that understanding back to the patient in a supportive way. This can be achieved through both non-verbal and verbal behaviours. Even with audio alone, some non-verbal behaviours such as the use of silence and appropriate voice tone in response to a patient's expression of feelings can be observed. Verbal empathy makes this more explicit by specifically naming and appreciating the patient's affect or predicament.</p> <p>An effective example would be: <i>"I can see that your husband's memory loss has been very difficult for you to cope with"</i>.</p>

Appendix C: Revised version of the checklist (provided to LTRC on 17 July 2014)

B1	Eliciting and exploring patient's ideas/concerns/expectations	<p>Understanding the patient's perspective is a key component of patient-centred health care. Each patient has a unique experience of sickness that includes the feelings, thoughts, concerns and effect on life that any episode of sickness induces. Patients may either volunteer this spontaneously (as direct statements or cues) or in response to health professionals' enquiries.</p> <p>The health professional might need to ask directly as in <i>"Did you have any thoughts yourself about what might be causing your symptoms?"</i> or <i>"Was there anything particular you were concerned about?"</i></p> <p>If expressed spontaneously by the patient, the health professional will need to explore this by saying for instance <i>"You mentioned that you were concerned about the effect the illness might have on your work, could you tell me more about that?"</i></p>
B2	Picking up patient's cues	<p>Patients are generally eager to tell us about their own thoughts and feelings but often do so indirectly through verbal hints or changes in non-verbal behaviour (such as vocal cues including hesitation or change in volume). Picking up these cues is essential for exploring both the biomedical and the patient's perspectives.</p> <p>Techniques for picking up cues would include echoing <i>"Something could be done...?"</i> or more overtly checking out statements or hints <i>"You used the word worried, could you tell me more about what you were worried about?"</i> or <i>"I sense that you are not happy with the explanations you've been given in the past"</i></p>
B3	Relating explanations to elicited ideas/concerns/expectations	<p>One of the key reasons for discovering the patient's perspective is to incorporate this into explanations often in the later aspects of the interview. If the explanation does not address the patient's individual ideas, concerns and expectations, then recall, understanding and satisfaction suffer as the patient is still worrying about their still unaddressed concerns</p> <p>An effective example might be: <i>"You mentioned earlier that you were concerned that you might have angina. I can see why you might have thought that but in fact I think it's more likely to be a muscular pain because..."</i></p>



**Appendix C: Revised version of the checklist (provided to LTRC on 17 July 2014)**

C1	Sequencing the interview purposefully and logically	<p>It is the responsibility of the health professional to maintain a logical sequence apparent to the patient as the interview unfolds. An ordered approach to organisation helps both professional and patient in efficient and accurate data gathering and information-giving. This needs to be balanced with the need to be patient-centred and follow the patient's needs. Flexibility and logical sequencing need to be thoughtfully combined.</p> <p>It is more obvious when sequencing is inadequate: the health professional will meander aimlessly or jump around between segments of the interview making the patient unclear as to the point of specific lines of enquiry.</p>
C2	Signposting changes in topic	<p>Signposting is a key skill in enabling patients to understand the structure of the interview by making the organisation overt: not only the health professional but also the patient needs to understand where the interview is going and why. A signposting statement introduces and draws attention to what we are about to say.</p> <p>For instance, it is helpful to use a signposting statement to introduce a summary: <i>"Can I just check that I have understood you, let me know if I've missed something...."</i></p> <p>Signposting can be used to make the progression from one section to another and explain the rationale for the next section. An example would be: <i>"You mentioned two areas there that are obviously important, first the joint problems and the tiredness and second how you are going to cope with your kids. Could I start by just asking a few more questions about the joint pains and then we can come back to your difficulties with the children?"</i> or <i>"Since we haven't met before it will help me to learn something about your past medical history. Can we do that now?..."</i></p>
C3	Using organising techniques in explanations	<p>A variety of skills help to organise explanations in a way that leads particularly to increased patient recall and understanding. Skills include:</p> <p><u>categorisation</u> in which the health professional forewarns the patient about which categories of information are to be provided e.g. <i>"There are three important things I want to explain. First I want to tell you what I think is wrong, second, what tests we should do and third, what the treatment might be."</i></p> <p><u>labelling</u> in which important points are labelled by the health professional e.g. <i>"it is particularly important that you remember this..."</i></p> <p><u>chunking</u> in which information is delivered in chunks with clear gaps in between sections before proceeding</p> <p><u>repetition and summary</u> of important points e.g. <i>"So just to recap: we have decided to treat this as a fungal infection with a cream that you put on twice a day for two weeks and if it is not better by then, you are going to come back to see me"</i></p>

**Appendix C: Revised version of the checklist (provided to LTRC on 17 July 2014)**

D1	Facilitating patient's narrative with active listening techniques, minimising interruption	<p>Listening to the patient's narrative, particular at the beginning of an interview, enables the health professional to more efficiently discover the story, hear the patient's perspective, appear supportive and interested and pick up cues to patients' feelings. Interruption of the narrative has the opposite effect and in particular generally leads to a predominantly biomedical history, omitting the patient's perspective.</p> <p>Observable skills of active listening techniques include:</p> <ul style="list-style-type: none"> <li>• <u>the use of silence and pausing</u></li> <li>• <u>verbal encourages</u> such as <i>um, uh-huh, I see</i></li> <li>• <u>echoing and repetition</u> such as <i>"chest pain?"</i> or <i>"not coping?"</i></li> <li>• <u>paraphrasing and interpretation</u> such as <i>"Are you thinking that when John gets even more ill, you won't be strong enough to nurse him at home by yourself?"</i></li> </ul>
D2	Using initially open questions, appropriately moving to closed questions	<p>Understanding how to intentionally choose between open and closed questioning styles at different points in the interview is of key importance. An effective health professional uses open questioning techniques first to obtain a picture of the problem from the patient's perspective. Later, the approach becomes more focused with increasingly specific though still open questions and eventually closed questions to elicit additional details that the patient may have omitted. The use of open questioning techniques is critical at the beginning of the exploration of any problem and the most common mistake is to move to closed questioning too quickly.</p> <p><u>Closed questions</u> are questions for which a specific and often one word answer, such as yes or no, is expected. They limit the response to a narrow field set by the questioner.</p> <p><u>Open questioning techniques</u> in contrast are designed to introduce an area of enquiry without unduly shaping or focusing the content of the response. They still direct the patient to a specific area but allow the patient more discretion in their answer, suggesting to the patient that elaboration is both appropriate and welcome.</p> <p>Simple examples of these questioning styles are</p> <p>Open- <i>"tell me about your headaches"</i></p> <p>More directive but still open - <i>"what makes your headaches better or worse?"</i></p> <p>Closed - <i>"do you ever wake up with the headache in the morning?"</i></p> <p>Examples of effective open questioning techniques would be: <i>"Start at the beginning and take me through what has been happening...."</i> or <i>"How have you been feeling since your operation...?"</i></p>
D3	NOT using compound questions/leading questions	<p>A compound question is when more than one question is asked without allowing time to answer. It confuses the patient about what information is wanted, and introduces uncertainty about which of the questions asked the eventual reply relates to.</p> <p>An example would be <i>"have you ever had chest pain or felt short of breath?"</i></p>

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		A leading question includes an assumption in the question which makes it more difficult for the respondent to contradict the assumption e.g., <i>“You’ve lost weight, haven’t you?”</i> or <i>“you haven’t had any ankle swelling?”</i>
D4	Clarifying statements which are vague or need amplification	Clarifying statements which are vague or need further amplification is a vital information gathering skill. After an initial response to an open ended question, health professionals may need to prompt patients for more precision, clarity or completeness. Often patients’ statements can have two possible meanings: it is important to ascertain which one is intended.  Examples would include: <i>“Could you explain what you mean by light-headed”</i> or <i>“When you say dizzy, do you mean that the room seems to actually spin round?”</i>
D5	Summarising information to encourage correction/invite further information	Summarising is the deliberate step of making an explicit verbal summary to the patient of the information gathered so far and is one of the most important of all information gathering skills. Used periodically throughout the interview, it helps with two significant tasks – ensuring accuracy and facilitating the patient’s further responses.  An effective example would be: <i>“Can I just see if I’ve got this right – you’ve had indigestion before, but for the last few weeks you’ve had increasing problems with a sharp pain at the front of your chest, accompanied by wind and acid, it’s stopping you from sleeping, it’s made worse by drink and you were wondering if the painkillers were to blame. Is that right?”</i>
D6	Establishing initially what patient already knows	One key interactive approach to giving information to patients involves assessing their prior knowledge. This allows you to determine at what level to pitch information, how much and what information the patient needs, and the degree to which your view of the problem differs from that of the patient.  An effective example would be: <i>“It would be helpful for me to understand a little of what you already know about diabetes so that I can try to fill in any gaps for you.”</i>
D7	Pausing periodically when giving information, using response to guide next steps	This approach, often called chunking and checking, is a vital skill throughout the information giving phase of the interview. Here, the health professional gives information in small pieces, pausing and checking for understanding before proceeding and being guided by the patient’s reactions to see what information is required next. This technique is a vital component of assessing the patient’s overall information needs: if you give information in small chunks and give patients ample opportunity to contribute, they will respond with clear signals about both the amount and type of information they still require  An effective example would be: <i>“So really, given the symptoms you have described and the very typical way that you wheeze more after exercise and at night, I feel reasonably confident that what you are describing is asthma and that we should consider ways we might treat it. (Pause) How does that sound so far?”</i>
D8	Encouraging patient to	A further element of effective information giving is providing opportunities for to the patient to ask questions, seek

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	contribute reactions/feelings	clarification or express doubts. Health professionals have to be very explicit here: many patients are reluctant to express what is on the tip of their tongue and are extremely hesitant to ask the doctor questions. Unless positively invited to do so, they may leave the consultation with their questions unanswered and a reduced understanding and commitment to plans An example would be: <i>“What questions does that leave you with - have you any concerns about what I have said?”</i>
D9	Checking whether patient has understood information	Checking the patient has understood the information given is an important step in ensuring accuracy of information transfer. This can be done by asking <i>“does that make sense?”</i> although many patients will say yes when they mean no to avoid looking stupid. A more effective method is to use patient restatement. An example of this would be: <i>“I know I’ve given you a lot of information today and I’m concerned that I might not have made it very clear – it would help me if you repeated back to me what we have discussed so far so I can make sure we are on the same track.”</i>
D10	Discovering what further information patient needs	Deliberately asking the patient what other information would be helpful enables the health professional to directly discover areas to address which the health professional might not have considered. It is difficult to guess each patient’s individual needs and asking directly is an obvious way to prevent the omission of important information. An example would be: <i>“Are there any other questions you’d like me to answer or any points I haven’t covered?”</i>

