SPEAKING Assessment Criteria Glossary (from September 2018) (public version)

I. Linguistic Criteria

Intelligibility

This criterion refers to the ability to produce comprehensible speech. It includes such features as pronunciation, intonation, stress, rhythm and accent. Assessors consider whether the candidate

- pronounces words/sounds clearly (especially final consonants, recognisable vowels, correct word stress)
- projects/pitches the voice appropriately, without mumbling or slurred speech
- uses intonation and selective stress effectively / appropriately (to enhance meaning)
- produces a natural English sentence rhythm.

NB While L1 accent is to be expected in even the most able candidate, the main point to consider is the extent to which this causes strain for the listener. In many cases, accent poses no impediment to communication.

Fluency

This criterion refers to the rate and flow of speech. Assessors consider whether the candidate speaks

- at a normal rate (not too fast or too slow) that can be easily understood
- continuously and smoothly, with pauses or hesitations that are situationally appropriate, rather than a sign of searching for words or structures (indicated by disruptive false starts, excessive use of fillers, or unnecessary repetition of words or phrases).

Appropriateness of Language

This criterion refers to the ability to use language, register and tone that are suitable for the situation and the patient. In particular, assessors consider whether the candidate

- uses expressions comprehensible to a lay person in explaining technical procedures or medical conditions (are inappropriate choices a barrier to communication?)
- adopts a tone of voice suitable to the situation, with the flexibility to adapt as necessary.

Resources of Grammar and Expression

This criterion refers to the range and accuracy of the candidate's linguistic repertoire. Assessors consider whether

- the candidate's vocabulary and control of grammatical expression are adequate to express necessary ideas clearly and unambiguously, and whether any deficits form a barrier to communication
- the candidate can paraphrase when required
- the candidate has the capacity to maintain longer utterances rather than single sentences, with appropriate use of cohesive devices
- can use idiomatic expressions accurately.

II. Clinical Communication Criteria

A. Indicators of **relationship building**		
A1	Initiating the interaction appropriately (greeting, introductions, nature of interview)	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.
A2	Demonstrating an attentive and respectful attitude	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 distressing matters.
A3	Demonstrating a non-judgemental approach	Accepting the patient's perspective and views reassuringly and non-judgementally without initial rebuttal 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.
A4	Showing empathy for feelings/predicament/emotional state	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 emotions or predicament.

B. Indicators of **understanding & incorporating the patient's perspective**		
B1	Eliciting and exploring patient's ideas/concerns/expectations	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.
B2	Picking up the patient's cues	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.

		Some of the techniques for picking up cues would include echoing, i.e. repeating back what has just been said and either adding emphasis where appropriate or turning the echoed statement into a question, e.g. "*Something could be done…?"* . Another possibility is more overtly checking out statements or hints, e.g. *"I sense that you are not happy with the explanations you've been given in the past*"
B3	Relating explanations to elicited ideas/concerns/expectations	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 worrying about their still unaddressed concerns.

C. Indicators of **providing structure**		
C1	Sequencing the interview purposefully and logically	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. 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.
C2	Signposting changes in topic	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. For instance, it is helpful to use a signposting statement to introduce a summary. Signposting can also be used to make the progression from one section to another and explain the rationale for the next section.
C3	Using organising techniques in explanations	A variety of skills help to organise explanations in a way that leads particularly to increased patient recall and understanding. Skills include: categorisation in which the health professional informs the patient about which categories of information are to be provided labelling in which important points are explicitly labelled by the health professional; this can be achieved by using emphatic phrases or adverb intensifiers chunking in which information is delivered in chunks with clear gaps in between sections before proceeding repetition and summary of important points.

D. Indicators for **information gathering**		
D1	Facilitating the patient's narrative with active listening techniques, minimising interruption	Listening to the patient's narrative, particularly 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 the patient's feelings. Interruption of the narrative has the opposite effect and in particular generally leads to a predominantly biomedical history, omitting the patient's perspective. Observable skills of active listening techniques include: **A.** the use of silence and pausing **B.** verbal encouragement such as *um, uh-huh, I see* **C.** echoing and repetition such as "*chest pain?"* or *"not coping?"* **D.** paraphrasing and interpretation such as *"Are you thinking that when John gets even more ill, you won't be strong enough to nurse him at home by yourself?"*
D2	Using initially open questions, appropriately moving to closed questions	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. Closed questions are questions for which a specific and often one-word answer is elicited. These responses are often "*yes/no*". Open questioning techniques 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.
D3	NOT using compound questions/leading questions	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. An example would be *"have you ever had chest pain or felt short of breath?"* A leading question includes an assumption in the question which makes it more difficult for the respondent to contradict the assumption. e.g., *"You've lost weight, haven't you?* or "*You haven't had any ankle swelling?"*
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 (or more) possible meanings: it is important to ascertain which one is intended.

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.

E. Indicators for **information giving**		
E1	Establishing initially what the patient already knows	One key interactive approach to giving information to the patient 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.
E2	Pausing periodically when giving information, using the 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 the patient ample opportunity to contribute, they will respond with clear signals about both the amount and type of information they still require.
E3	Encouraging the patient to contribute reactions/feelings	A further element of effective information giving is providing opportunities to the patient to ask questions, seek clarification or express doubts. Health professionals must 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.
E4	Checking whether the 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 *"does that make sense?"* although many patients will say 'yes' even though they are still unsure because they don't want to admit that they didn't understand. A more effective method is to use patient restatement, i.e. asking the patient to repeat back to the doctor what has been discussed to ensure that their understanding is the same
E5	Discovering what further information the 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.