Verification of checklist items across professions: an investigation of the relevance of new criteria for assessing simulated professional-patient interactions in the OET Speaking sub-test

Final Report

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Table of Contents

Executive Summary

As part of an Australian Research Council (ARC) funded project undertaken at the University of Melbourne in partnership with the OET Centre, a checklist of indicators of effective performance in health-professional-patient interactions was proposed as a means of better aligning the OET speaking subtest criteria with the aspects of communication valued by health professionals. The checklist was empirically derived from a thematic analysis of feedback from professionals in medicine, nursing and physiotherapy on the performances of trainees' interactions with patients.

This report describes a study designed to investigate the relevance of the proposed speaking checklist across the health professions currently served by the OET. The study was conducted at the Language Testing Research Centre (LTRC) at the University of Melbourne and commissioned by Cambridge English Language Assessment. The aim of the study was to investigate the extent to which the criteria detailed in the revised checklist are relevant across all twelve of the health professions currently served by the OET, including the three represented in the original study. Unfortunately, however, we were unable to access health professionals from dietetics, dentistry, podiatry and veterinary science. These professions are thus not represented in the study. Twelve health professionals from eight of the twelve health professions served by the OET were asked to review the revised checklist and to comment on the relevance and appropriateness of the criteria to their particular professional context. Judgments of relevance and appropriateness were provided as written annotations on the checklist. Nine out of the twelve health professionals also participated in a subsequent telephone interview, in which they were asked to elaborate on some of their judgments.

The results of the study show that despite some profession-specific problems with some of the criteria in each section of the checklist, on the whole feedback was very positive with participants indicating that the checklist was very comprehensive and generally reflective of the sorts of communication behaviours that are highly valued within their professions. Furthermore, all participants from the professions of medicine, nursing, physiotherapy (2 participants) and speech pathology (2 participants) indicated that they found all criteria across all sections of the checklist to be highly relevant. Typically, judgments of slight or no relevance were motivated by perceptions that the communicative techniques and behaviours described in some of the criteria were not well aligned with the sorts of interactions most typical of a participants' health profession. In addition, the array of skills defined in the checklist was viewed by many participants as representing a model of 'ideal' or best practice communication, rather than actual practice by already registered health professions.

Based on the findings from the study, we recommend that:

- a feasibility study be conducted into the development of profession-specific versions of the checklist for the four professions (occupational therapy, optometry, pharmacy, and radiography) for which some aspects of the checklist were only slightly relevant or not relevant. Profession-specific checklists could include definitions of criteria and examples tailored to reflect current practice in each of the health professions.
- a further study be undertaken to verify the extent to which criteria in the checklist are elicited by existing role play tasks, as well as the extent to which tasks need to be modified or reformulated to capture a broader speaking construct.
- fairness implications be taken into account of including such criteria as a pre-registration requirement for professionals from non-English speaking backgrounds.

Introduction

The Occupational English Test (OET) is a specific purpose test designed to evaluate the English-language competence of qualified medical and health professionals who wish to practise in an English-language context. It seeks to ensure that candidates are prepared, in language terms, for work in their profession. It is currently recognised by authorities regulating medical and health professions in Australia, New Zealand and Singapore, as well as the Australian Department of Immigration and Border Protection. The test is taken by candidates from twelve professions: dentistry, medicine, nursing, pharmacy, physiotherapy, dietetics, occupational therapy, optometry, podiatry, radiography, speech pathology and veterinary science. The OET speaking sub-test consists of role play tasks simulating health professional-patient interactions. The role play tasks are profession specific, and the aim of the OET speaking subtest is to provide test users with a valid and reliable assessment of candidates' speaking ability in their particular health-related context.

In 2013, based on findings from an Australian Research Council (ARC) funded project undertaken at the University of Melbourne (Elder et al., 2013) in partnership with the OET Centre, a checklist of indicators of effective performance in health-professional-patient interactions was proposed as a means of better aligning the OET speaking subtest criteria with the aspects of communication valued by health professionals. The checklist was empirically derived from a thematic analysis of health professionals' feedback on the performances of trainees' interactions with patients (see Pill, 2013 for further details).

A review of the ARC project report and the proposed checklist by Cambridge English Language Assessment, co-owner of the OET, in consultation with Dr Jonathan Silverman, led to a revised checklist, which is the focus of the current study. The original checklist was empirically derived from expert feedback on trainee performances from representatives of three health professions, medicine, nursing and physiotherapy. A further study was recently conducted by Pill and Knoch (2014) to investigate if the revised checklist remained consistent with the original dataset.

This report relates to a study conducted at the Language Testing Research Centre (LTRC) at the University of Melbourne and commissioned by Cambridge English Language Assessment. The aim of the study was to investigate the extent to which the revised checklist is relevant across all twelve of the health professions currently served by the OET, including the three represented in the original study. Unfortunately, however, we were unable to access health professionals from dietetics, dentistry, podiatry and veterinary science. These professions are thus not represented in the study. Health professionals from 8 of the 12 health professions served by the OET were asked to review the revised checklist and to comment on the relevance and appropriateness of the criteria to their particular professional context. The report is organised as follows: an outline of the methods used in the study, followed by a results section in which details of the health professionals' feedback is provided. The report concludes with some final recommendations based on the study findings.

Methods

Participants

Practitioners and/or educators representing all 12 professions served by the OET were sought as participant informants for the study, with the aim of recruiting two participants from each profession (24 in total). The OET Centre provided contact details for health professionals from all professions except dietetics. Of the 22 health professional contacts provided by the OET Centre, 6 participated in the final study (originally 10 agreed, but 4 did not respond to further contact attempts). The 6 participants represented the following six professions (one from each): nursing, pharmacy, occupational therapy, optometry, radiography and speech pathology. The LTRC recruited a further 5 participants, one from each of the following five professions: medicine, occupational therapy, physiotherapy, radiography and speech pathology; one further participant representing physiotherapy was accessed via a contact list provided by Cambridge English Language Assessment.

To summarise, 12 participants across 8 of the health professions served by the OET were involved in study: medicine (1), nursing (1), occupational therapy (2), optometry (1), pharmacy (1), physiotherapy (2), radiography (2) and speech pathology (2). All participants had several years of professional experience, and at least one participant from each profession was also an experienced educator as well as practitioner (10 out of 12 participants in total). All participants also had at least some experience working with and supervising health professionals with English as an additional language, with most (9 out of 12) reporting they had a lot or extensive experience either working with or supervising such professionals. 7 participants across 6 professions were aware of the English language skills standard and registration processes relevant to their profession. The following professions were not represented in the study: dietetics, dentistry, podiatry and veterinary science.

Data collection instruments

Participants were each asked to complete a short questionnaire (Appendix A) before the interview to provide details of their professional experience, involvement with overseas trained practitioners in their profession, and knowledge of registration processes and the English language skills standard in place.

The revised checklist was provided to participants prior to the interview, so that they had time to conduct their review without time pressure. Participants were invited to record judgments on the level of relevance to their profession of each of the criteria in the checklist by adding written annotations to each in a right column (see Appendix B). Once participants completed their review of the checklist and submitted their annotations, a telephone interview was conducted. The duration of each interview was approximately 30 minutes. The interviews were audio recorded. 9 out of 12 participants participated in interviews, while the remaining 3 provided detailed written comments on the revised checklist.

Semi-structured interviews were conducted with participants to elicit their views on the relevance of the checklist to effective HP-patient communication in each of the respective professions. The protocol therefore included questions on the relevance of the items, appropriateness of wording, and comprehensiveness of the aspects of HP-patient communication covered. The interview protocol is outlined below:

- Have you had sufficient time to review the checklist provided?
- Are there aspects of health professional–patient communication that are not included on the checklist but which you feel are more important/ relevant than those that are.
- Are there items on the checklist which are not relevant to your health profession and should be removed? Are there any items less relevant to your health profession? Why are these items not/less relevant to your health profession?
- Are there any items or terminology on the checklist which you don't understand or you think is ambiguous? Do you think any items or terms should be expressed differently to make them suitable to the context of your health profession?
- As a representative of your profession, to what extent do you see the checklist items forming a valid view of aspects of successful/appropriate communication in health professional–patient interaction?

Data analysis

As mentioned above, the twelve participants each reviewed the checklist and judged the relevance to their profession of each of the criteria under each of the four sub-headings in the checklist: A. Relationship building; B. Understanding and incorporating the patient's perspective; C. Providing structure; and D. Information gathering and information giving. These judgments were provided as written annotations on the checklist. Nine out of the twelve health professionals also participated in a subsequent telephone interview, in which they were asked to elaborate on some of their judgments. Their annotations and interview comments in relation to the individual criteria comprising each of the four sections of the checklist as well as their comments on the checklist overall were coded thematically according to perceived relevance and appropriateness to the spoken communication that takes place during professional-patient interactions in each of their specific health professions.

Results

For the purpose of clarity, the annotated judgments and interview comments of participants across the eight professions represented in the study have been grouped into five sections; the first four according to the four checklist subheadings. In each of these four sections, participants' judgments are summarised in table form, followed by details of their annotations and comments provided in the interviews. In a fifth section entitled 'General feedback on the checklist', participants' comments on the checklist as a whole are described.

Section A of the checklist

As shown in table 1, 10 out of 12 participants found all four criteria related to 'Relationship building' relevant to their professions. The participant representing optometry described criteria A2 and A4 as only slightly relevant, and the participant from pharmacy found A1 and A2 to be of slight relevance.

	A1	A2	A3	A4
Medicine	R	R	R	R
Nursing	R	R	R	R
Optometry	R	**S**	R	**S**
Pharmacy	**S**	**S**	R	R
Occupational Therapy (1)	R	R	R	R
Occupational Therapy (2)	R	R	R	R
Physiotherapy (1)	R	R	R	R
Physiotherapy (2)	R	R	R	R
Radiography (1)	R	R	R	R
Radiography (2)	R	R	R	R
Speech Pathology (1)	R	R	R	R
Speech Pathology (2)	R	R	R	R

Table 1. Relevance of criteria related to 'Relationship building'.

Key:
A1=Initiating the interaction appropriately
A2=Demonstrating an attentive and respectful attitude
A3=Demonstrating a non-judgmental approach
A4=Showing empathy for feelings/predicament/emotional state
R=relevant, S=slightly relevant, N=not relevant

In relation to criterion A2, the optometry participant's written annotation shows that he views some aspects of the criterion as relevant, but for the most part he viewed the description in the checklist as not aligning well with the communicative demands of a typical consultation:

> *"There are situations where an optometrist may need to make contact with a patient in order to fit them with a trial frame to test their prescription, move in towards them to look into their eye, guide their heads into the appropriate position. However, most people attending the optometrist know that their personal space will be invaded and this is part of having their eyes tested. I think that asking the patient if they are in any discomfort at any time is a good idea though*."

He elaborated further in the interview, explaining that it was unlikely for an optometrist to ask permission and consent to proceed in a consultation. He also mentioned that consultations rarely involve embarrassing or sensitive matters, as per the expanded definition of A2 in the checklist (see appendix A):

> "*You know, we would normally say 'look, I'm just going to have a look at the back of your eye using this', but I would never say 'I'm going to put my fingers on your forehead, or I'll be going to pull down on your cheek to take your contact lens out', I think those sort of things are, if you're here for a contact lens fitting, you know that I'm going to put a lens in your eye. So I'll say: I'll put the lenses in your eye now, you won't' feel any pain, I'll just get you to look up for me. There is no sort of sensitivity and embarrassment and discomfort probably doesn't exist in that environment. And I guess it's because a. the patient knows why they're there, and b. while its invasive I think they, most patients appreciate they're getting their eyes tested*."

Criterion A4 was seen as relevant but only in particular circumstances, according to his annotation:

"*If a patient has been told they have a serious eye condition that may cause loss of sight, this may require a show of empathy for feelings and/or their emotional state.*"

The representative of pharmacy viewed criteria A1 and A2 as slightly relevant, as mentioned above. Her annotations indicate that the criteria are relevant in some situations in some practice settings, but not necessarily in others:

A1 – "*Relevance depends on the nature and setting of the interaction. Works well in the hospital ward setting, where the patient is unlikely to know it is a pharmacist speaking to them.*"
A2 – "*Relevant in the hospital ward setting. Not entirely relevant in the community pharmacy setting*."

She elaborates further in the interview, explaining that the nature of interactions between pharmacists and clients in the community pharmacy setting often leads to a different conversational routine than the type represented by the criteria:

"*Some of the things that were expected may or may not happen depending on the context of the pharmacy interaction. So usually the, in a community pharmacy setting, very often it's the patient that's initiating the conversation, so… and again, there's a number of scenarios you could draw, but often somebody comes in and says could I speak to the pharmacist or they speak to the pharmacy assistant first, and the pharmacy assistant will say, oh look, it'd be best if you speak to the pharmacist about that. So then when the pharmacist comes out, often in real life often the person then just knows obviously that that's the pharmacist and they're often wearing a badge that says so. But on the other hand, it certainly would make sense for the pharmacist to come out and say I'm so and so, I'm the pharmacist, how can I help you. But the parts about saying I'm here now to talk to you about such and such, is it convenient and can I sit here and all of those sort of easing into the conversation things, don't really, aren't really relevant to what the pharmacist would normally do. But on the other hand, if it was a pharmacist speaking to somebody in a ward, they may very well have come out of the blue and the patient won't have any idea who they are or what they are, and in those circumstances, the criteria that are on the list are fine.*"

To sum up, participants across six out of the eight professions involved in the study found all four criteria related to section A of the checklist, 'Relationship building', relevant to their professions. As noted above, however, participants from optometry and pharmacy questioned the relevance of two of the four criteria listed in this section.

Section B of the checklist

As shown in Table 2, participants from six out of the eight professions represented found all three criteria related to 'Understanding and incorporating the patient's perspective' relevant to their professions. The participant representing optometry described criteria B2 and B3 as only slightly relevant, and the two participants representing radiography described criterion B3 as slightly relevant.

	B1	B2	B3
Medicine	R	R	R
Nursing	R	R	R
Optometry	R	**S**	**S**
Pharmacy	R	R	R
Occupational Therapy (1)	R	R	R
Occupational Therapy (2)	R	R	R
Physiotherapy (1)	R	R	R
Physiotherapy (2)	R	R	R
Radiography (1)	R	R	**S**
Radiography (2)	R	R	**S**
Speech Pathology (1)	R	R	R
Speech Pathology (2)	R	R	R

Table 2. Relevance of criteria related to 'Understanding and incorporating the patient's perspective'.

Key:
B1=Eliciting and exploring patient's ideas/concerns/expectations
B2=Picking up patient's cues
B3=Relating explanations to elicited ideas/concerns/expectations
R=relevant, S=slightly relevant, N=not relevant

In his annotations to B2 and B3, the participant from the profession of optometry attributed his judgment of slight relevance to the rarity with which there is a need for such communicative behaviours in typical optometrist-patient consultations:

"*Most patients are forthcoming, they feel safe in a non-threatening environment. Possibly patients may choose not to mention particular medications if they are embarrassed or can't see the benefits.*" (B2)

"*Patients may occasionally present with a family history that is concerning them or symptoms that are concerning them.*" (B3)

He elaborates in the interview, explaining that while picking up on patient cues is important, it is rarely necessary due to the nature of typical professional-patient interactions:

> "*The patient's sitting there and the optometrist tests their eyes, so the patient's cues during the history taking or the early stage of the examination, a lot of it is, the patient comes in and they have a problem or they need a pair of glasses, or they have a red eye, it really isn't a lot to pick up on patient's cues, but there are the occasional ones, small instances*."

Regarding B3, he similarly explains that the types of interactions where an optometrist would need to do the things described in the criterion definition are rarely encountered:

> "*Those sort of conversations probably less take place because patients come in to see the optometrist, really having little or no knowledge of what they may or may not have, so a lot of eye disease is detected through testing rather than through patients feeling symptoms and going like 'I have this specific condition'... So um, 'explanations to elicited ideas/concerns/expectations', obviously there's always going to be a some people that have heard about macular degeneration on the radio, or they have a family member that has glaucoma and they think: oh my god, I have something. There's always going to be those, but then they're the minority, the majority of patients attending an optometrist generally don't have eye diseases*."

As mentioned above, the two participants representing radiography found criterion B3 of only slight relevance to their professional context. Their annotations were as follows:

Radiography participant 1 (RP1): "*The radiographer would not discuss a specific condition. However it is important to continue dialogue after a procedure and not just abandon the patient.*"

Radiography participant 2 (RP2): "*While radiographers don't provide a diagnosis they can allay a patient's fears and refer the patient back to their physician for more information*."

Both of the participants explain in the interview that they saw the definition of B3 as relating more to scenarios where a health professional would be involved in an extended interview with the patient, including providing a diagnosis, which, as their annotations, above, also indicate, is not something that is done by radiographers:

RP1: "*Anything that relates to an extended interview, that is not something that we do, unless we're dealing with special procedures. I mean, there are instances where you do do that for a considerable length of time, but it's not the norm*."

RP2: "*If they have concerns about having the procedure done, or they want more information about why they're having the test or what it might indicate or so, we wouldn't be the one to give them that*."

To sum up, as with section A, participants from six out of the eight professions represented found all three criteria related to section B of the checklist, 'Understanding and incorporating the patient's perspective', relevant to their professions. The participant representing optometry described two of the three criteria as only slightly relevant, and the two participants representing radiography described one of the three criteria as slightly relevant.

Section C of the checklist

As with section B, for section C of the checklist participants from six out of eight professions found all of the criteria relevant to their professions, as shown below in table 3.

	C1	C2	C3
Medicine	R	R	R
Nursing	R	R	R
Optometry	R	R	R
Pharmacy	R	R	R
Occupational Therapy (1)	**S**	R	**S**
Occupational Therapy (2)	**S**	R	**S**
Physiotherapy (1)	R	R	R
Physiotherapy (2)	R	R	R
Radiography (1)	**S**	**S**	R
Radiography (2)	**S**	R	R
Speech Pathology (1)	R	R	R
Speech Pathology (2)	R	R	R

Table 3. Relevance of criteria related to 'Providing structure'.

Key:
C1=Sequencing the interview purposefully and logically
C2=Signposting changes in topic
C3=Using organising techniques in explanations
R=relevant, S=slightly relevant, N=not relevant

The annotations from both participants from radiography (RP1 and RP2) indicate that the relevance of the criteria in section C was limited to certain specific interactions involving complex procedures, such as magnetic resonance (MR) imaging and computed tomography (CT) scans, or to the specific task of taking a patient's history. Although RP2 indicated that criterion C2 was relevant, RP1 commented that although it was important it was not necessary in the major part of their work.

Similarly, the two participants representing occupational therapy expressed some reservations about section C of the checklist in their annotations, in particular the professional rather than client centred- approach that they perceived to be underlying the definition of C1:

Occupational therapy participant 1 (OTP1): "*We are client centred, and therefore the client is taking the leading role in the conversation. We may put in prompts to provide structure, but a lot of relevant information can be gained through an informal structure where the client tells you what they think is important*."

Occupational therapy participant 2 (OTP2): "*[It] can be more useful to allow the clients to tell their own story, in an order that is logical to them*."

OTP1 expands on her annotation relating to C1 in the interview:

> "*I mean, if you're coming at something from a client-centred perspective, uhm, it's sort of.. It's hard to explain, but.. That one actually made me stop and think about when I'm talking with patients.. Yes, I try to, I go in with a purpose of why I'm talking to the person and I tell the person what the purpose of the conversation is... It's not always logical, some of the assessments that we do is really just build on conversation and um, you know, it's not like we ask a series of questions…Probably logical sequencing was the thing that made me go like: oh, that's not quite, because to me, that speaks to being, not sort of formulaic, but you know what I mean? Like you have a certain logical sequence that you, like, first you talk about this, then you talk about that, then you talk about something else, and it just doesn't work that way often in practice*."

Both participants also signalled in their annotations that criteria C3 was not particularly relevant. OTP1 indicated that the definition of C3 was a poor fit with the needs of some of their clients, such as those with mental health issues:

OTP1: "*I think this would be more of a personal style than a regularly practiced skill. May not be suitable in all settings too: mental health clients would be likely to find this too directive*."

By contrast, OTP2 expressed that the communication techniques mentioned in C3 would be useful in dealing with clients with mental health issues. Her judgment of the criterion as slightly relevant related to the relatively minimal importance of these aspects of communication compared to other skills mentioned in the checklist:

OTP2: "*People with mental health issues have difficulties with processing and retaining information all these are useful strategies to assist with this. Although I don't feel it is as important as some of the earlier categories of communication skills*."

In summary, all of the criteria in section C of the checklist were endorsed by participants across six of the eight professions. While the participant from optometry had questioned the relevance of some of the definitions in section B, he verified the relevance of all of the criteria in section C. Again, however, as shown above, participants from radiography indicated that some of the definitions did not align well with the sorts of professional-patient interactions typically occurring in their field. Furthermore, those representing occupational therapy questioned the professional rather than client centred- approach that they perceived to be underlying the definition of some of the criteria in this section.

Section D of the checklist

Table 4, below, shows that although those representing occupational therapy and radiography found some of the criteria in section D, 'Information gathering', to be of only slight relevance, participants from the remaining six professions found all of the criteria relevant to their professions.

	D1	D2	D3	D4	D5
Medicine	R	R	R	R	R
Nursing	R	R	R	R	R
Optometry	R	R	R	R	R
Pharmacy	R	R	R	R	R
Occupational Therapy (1)	R	**S**	R	R	R
Occupational Therapy (2)	R	**S**	R	R	R
Physiotherapy (1)	R	R	R	R	R
Physiotherapy (2)	R	R	R	R	R
Radiography (1)	**S**	**S**	R	R	**S**
Radiography (2)	**S**	**S**	R	**S**	R
Speech Pathology (1)	R	R	R	R	R
Speech Pathology (2)	R	R	R	R	R

Table 4. Relevance of criteria related to 'Information gathering'.

Key:
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
R=relevant, S=slightly relevant, N=not relevant

Participants representing occupational therapy (OTP1 and OTP2) found most of the criteria relevant, but viewed criterion D2 to be of only slight relevance to their profession, as illustrated in their annotations:

OTP1: "*Somewhat relevant to OT – some of our assessments start with a series of closed question and then 'expand' on them as rapport has been built*."

OTP2: "*This is useful skill but not as essential as active listening and non-judgemental approach and valuing the person's story. I think if there are some difficulties with this it can be overcome with strengths in other aspects of communication*."

During the interview, OTP1 explained that although the skill of using open and closed questions was important, she perceived the sequencing indicated in the criterion definition as too rigid and as non-applicable to many professional-patient interactions in her profession:

"*Often times in OT assessments you start with stuff that's fairly specific, and then you move out to something that's a bit more broad. And especially in, again I go back to mental health I guess, sometimes it's safer to start with the really specific stuff, with the yes and no, and then you sort of go out into something that's a bit broader after that. So it's not so much that, I guess, my reaction to that was: yeah, you can go from open to closed, but you can equally go the other way if you need to work with your consumer…So it just comes down I guess to knowing your client… So it comes, a lot of it comes to judgment, which you can't capture in something like this, but I think uhm, the way it was stated was like, you know, you initially use open questions, then you move to closed questions, and I guess my reaction was: yeah, you can do that, but there are other.. Sometimes that's not the right way to go*."

Interview data showed that although both of the participants from radiography (RP1 and RP2) saw the communication techniques described in criteria D1 and D2 as useful skills that would be drawn upon in some instances in their professional practice, they each questioned the relevance of the two criteria on the basis that they are not routinely used:

RP1: "*Things like getting into more of the echoing and repetition and paraphrasing, um, we may have to do that initially, but not in a protracted way. So, it is, you know, and then closed questions versus open questions, something we teach the students here what to do and I think they need to, radiologists, need to understand and know the difference, but you know, they're not going to be sitting down with a patient for even 15 minutes. What they need to do is, in a very short space of time, in you know, 2 minutes or so, 2 or 3 minutes or so, is ask the right questions that will give you the right answers and it's quite tricky because if it's completely closed you get yes, no and we don't get the whole thing, if you have too open, then you hear the person's entire life history, for which you don't have time*."

RP2: "*Um, I guess, you know, I guess it depends on the depth that you would want. So for example, when I'm looking at D1, 'Facilitating patient's narrative with active listening techniques and minimising interruption', yes of course you would do that but not necessarily on a daily basis, for every procedure. And again, depending, for something like a CT exam or MR, you would ask them specific questions, they would often be closed questions, you know, have you ever had any surgical procedures, and then it would get to open questions after that, what type and those sorts of things, but it's.. You know, I look at this as being a more interview type that people would use in different professions, in different health professions*."

They each expressed that their concerns over criteria D5 and D4, respectively, were of a similar nature; while the descriptions of the communication techniques were viewed positively, they were thought to be relevant only occasionally rather than generally applicable.

As shown in table 5, below, although most of the criteria related to 'information giving' in section D of the checklist were endorsed by participants across the health professions, D7 was only slightly relevant according to representatives from occupational therapy and not relevant at all to radiography, according to both participants from that profession.

	D6	D7	D8	D9	D10
Medicine	R	R	R	R	R
Nursing	R	R	R	R	R
Optometry	**S**	R	R	R	R
Pharmacy	R	R	R	R	R
Occupational Therapy (1)	R	**S**	R	R	R
Occupational Therapy (2)	R	**S**	R	R	**S**
Physiotherapy (1)	R	R	R	R	R
Physiotherapy (2)	R	R	R	R	R
Radiography (1)	R	**N**	R	R	R
Radiography (2)	**S**	**N**	**N**	R	R
Speech Pathology (1)	R	R	R	R	R
Speech Pathology (2)	R	R	R	R	R

Table 5. Relevance of criteria related to 'Information giving'.

Key:
D6=Establishing what the 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
R=relevant, S=slightly relevant, N=not relevant

The representative from optometry (OP) and one of the radiography participants (RP1 and RP2) also questioned the relevance of D6, as shown below in the interview excerpts:

> OP: "*Again* [as with criteria B3]*, patients generally won't come in knowing they have an eye disease, they won't come in… Even if they have a family history of it, they actually don't know what it is. So 'I've got a family history of glaucoma, so I came in'. . I've never sort of felt that in optometry there is relevance in… at that point, asking the patient 'do you know why… Do you know what this condition is?' Generally we'd do it like: we're going to test, we'll do tests x, y, z, and we're doing these tests because glaucoma may affect this, or macular degeneration may affect this, or whatever it might be*."

> RP2: "*… It's not particularly relevant, it might be relevant when, you know, have you ever had the procedure done before, do you understand all that we're going to do for this, sort of verifying validating that they have understood and given an informed consent for the procedure that you're going to do…"*
> Researcher: "*Okay, so is it something that you would normally do, as a part of your routine?*"
> RP2: "*No, no*."

One of the occupational therapy participants, OTP2, also found criterion D10 slightly relevant, as described in her annotation:

"*This is useful but not essential skill for OT if other communication skills as described above are good this should be covered*."

As mentioned above, criterion D7 did not align well with the perceptions of participants from occupational therapy and radiography. The two participants from occupational therapy explained their judgment of slight relevance for D7 in their annotations:

OTP1: "*Not a technique that's taught in training, but may be used in some settings as a matter of personal style*."

OTP2: "*interventions are not necessarily around information giving but rather experiential learning and supporting reflection on what worked and what did not and then adapting*."

Those representing radiography both agreed that D7 was not relevant to their profession, due to the time-limited nature of their interactions with patients:

RP1: "*Not too relevant as radiographers would not be involved in a sustained interview*."

RP2: "*The example is much more than we would be doing just because of the interactions we have*."

These participants disagreed, however, over the relevance of D8, with RP1 judging the criterion as relevant and RP2 not relevant. RP1 described the criterion in her annotation as follows:

"*This is very important as radiographers need to allay fears which can manifest themselves in patients not able to complete a procedure. Patients can be reticent to talk about this unless expressly asked to do so*."

RP2, by contrast, wrote that the criterion was not as applicable to radiography. As the following interview excerpt shows, although she sees the technique as valuable, she doesn't view it as part of a typical professional-patient interaction:

> RP2: "*We would want a patient to, we want to know about their feelings or any concerns they have, but again, it's at a level which wouldn't be as in-depth as with other professions*."
> Researcher: "*Okay, but would you routinely elicit those things from patients?*"
> RP2: "*It would depend. We wouldn't routinely do that*."

Participants across the remaining five professions endorsed all of the criteria related to 'information giving' as relevant. The participant from medicine and one of the physiotherapy participants suggested, however, that while the criteria reflect highly valued aspects of communication, they are not necessarily practiced by existing health professionals due to time restraints and other pressures. That the checklist represented 'ideal' or best practice in terms of communication rather than the realities of current practice across the professions was a theme that emerged through the general feedback on the criteria taken together provided by various participants in the interviews. This general feedback is detailed below.

General feedback on the checklist

In addition to reflecting on each criterion in the checklist individually, participants were also asked to consider how well the checklist in its entirety reflected the communication demands of professional-to-patient interactions in their particular professions. As noted above, there were profession-specific problems with some of the criteria in each section of the checklist. On the whole, however, feedback was very positive with participants indicating that the checklist was very comprehensive and generally reflective of the sorts of communication behaviours that are highly valued within their professions. Furthermore, all participants from the professions of medicine, nursing, physiotherapy (2 participants) and speech pathology (2 participants) indicated that they found all criteria across all sections of the checklist to be highly relevant.

One main theme that emerged, however, was that the checklist represented 'ideal' or best practice communication, as noted in relation to section D, above, which perhaps was not always manifest in current practice in the healthcare professions. This theme is illustrated in the interview extracts shown below:

Medicine: "*I think its very representative of an ideal communication between doctors and patients. And I guess I recognize that in practice it will often fall short of this, there'll be stresses like time and perhaps contextual things… this is definitely a beautiful well written, well thought out ideal communication skills. But whether any particular medical student or doctor will (a) remember them and (b) practice them, I think will be highly variable*."

Optometry: "*I think something like this, it's hugely relevant to getting optometrists to make sure that they're good communicators, prior to being able to see patients*."

Physiotherapy participant 2: "*I have to say while these are essential, I don't think a lot of our new graduates necessarily operate as fluently in these areas as on that checklist… there's best practice behaviour, and I just, unless people have training, especially because so much of it is cultural, lots of the information provided is very culturally embedded, so unless people have the opportunity to be educated on this as being priority in Australia, and being used as best practice, people might not be performing in assessment tasks*."

Radiography participant 1: "[in radiography] *there's one school of thought from a lot of clinical people, that say well, you know, because people rush in and out so quickly, we really don't have time to deal with these items of communication issues… it is something that tends to get perhaps not given the attention it should…I think almost universally in universities and schools, we would emphasize the importance of that communication. The reality, when you go out in the workplace, is definitely different*."

Consistent with the theme that the checklist represented a 'best practice' model of communication, participants also viewed the checklist as a potentially useful pedagogic tool. For example:

Nursing: "*It's very well-structured, it's actually very well broken down and categorized to cover a range of areas where communication is so important. Um, patient's perspective, empathy, all of these aspects of communication that we actually teach undergraduate students in our own undergraduate program. And I thought this reflected, you know, both messages about communication very well. And it's in nice chunks, so for an international person to read this, they can actually look at it in small chunks and digest it and, you know, ask questions about it, so it helps them contextualize it if you like*"

Physiotherapy participant 2: "*I thought that checklist would be a very good one for us to teach our young ones about you know this way for them of understanding what's prioritised because it's put together really neatly…that's something I could have our first year students look at and think about their practice. I don't think it's just for people coming from overseas*."

The participant from pharmacy acknowledged that the checklist represented a comprehensive account of best practice communication, broadly speaking. She was concerned, however, that the criteria extended beyond the communicative demands of many of the typical interactions between pharmacists and clients. As a result, she envisaged that it would be difficult to incorporate all of the criteria into the speaking construct of test tasks replicating routine interactions:

"*My only, my main concern was whether, in doing a good job, whether you would always be able to actually demonstrate those things in a particular scenario… the thing is, if you develop a task that's something that's done quite regularly, like let's just say giving simple information on taking your medicine, if you do that sort of task, then if a candidate for example was given information about what they're expected to demonstrate during the task, then a scenario like that would end up with them doing something that would be totally unrealistic. We go way beyond what a reasonable person would actually do*."

Physiotherapy participant 1 (from the United Kingdom), consistent with the reservations expressed by the occupational therapy participants in relation to section C, reported above, saw the checklist as embodying a professional-centred approach to health care, rather than a client-centred approach:

"*A general observation is that the speaking test items do not overall reflect the more modern approach to health care practice in the UK, which seeks to operate (not always successfully I know), with health care profession working with patients and carers in partnership to achieve the goals which are important to the patient. The current items are very much health care professional led*."

Finally, the radiography participants both reiterated their reservations about specific criteria, detailed in the sections above, in highlighting that the particular nature of the professional-patient interactions that take place in radiography were not well represented by the definitions and examples provided in the checklist:

Radiography Participant 1: "*In each of those scenarios you're looking at maybe prolonged interviews with the patient or the client, whereas radiography has a different kind of scenario*."

Radiography Participant 2: "*I guess just what I wanted to get out, what we do varies a lot because there's a lot of different procedures that we can do, and some of them, and a lot of patients we would interact with, they can come in on an outpatient basis and be fairly healthy except for some minor problem, or the inpatient with complex problems and diseases. So we see a lot of different patients which maybe unlike, maybe unlike some other professions, but perhaps not, you know, so it varies a lot, the communication style that we need…I think one of the things that may be helpful would be providing examples that are more relevant to the radiography profession, I think that would be quite helpful for people*."

Discussion

As mentioned above under each sub-heading of the results section, the response from the twelve participants to the relevance of the checklist to each of their professional contexts was, for the most part, positive. Almost all of the criteria in sections A and B of the checklist were endorsed across the professions. 10 out of 12 participants found all four criteria related to section A, 'Relationship building', relevant to their professions and 9 out of 12 participants across six out of the eight professions found all three criteria related to section B, 'Understanding and incorporating the patient's perspective', relevant to their professions. All criteria in section C, 'Providing structure' and the first part of section D, "Information-gathering' were also verified by participants across six of the eight professions, while participants across five out of the eight professions judged all criteria under the heading 'Information giving' as relevant to their healthcare contexts. Table 6, below, provides a summary of these results.

Table 6. Relevance of checklist section across profession

Checklist section	All relevant	Slightly or not relevant
A: Relationship building	Medicine Nursing Occupational therapy Physiotherapy Radiography Speech pathology	Optometry Pharmacy
B: Understanding and incorporating the patient's perspective	Medicine Nursing Occupational therapy Pharmacy Physiotherapy Speech pathology	Optometry Radiography
C: Providing structure	Medicine Nursing Optometry Pharmacy Physiotherapy Speech pathology	Occupational Therapy Radiography
D1: Information gathering	Medicine Nursing Optometry Pharmacy Physiotherapy Speech pathology	Occupational Therapy Radiography
D2: Information giving	Medicine Nursing Pharmacy Physiotherapy Speech pathology	Occupational Therapy Optometry Radiography

Typically, as explained in the results section, judgments of slight or no relevance were motivated by perceptions that the communicative techniques and behaviours described in some of the criteria were not well aligned with the sorts of interactions most typical of a participants' health profession. This was evident in many of the comments of participants from occupational therapy, optometry and radiography. These participants, as well as the participant from pharmacy in her overall evaluation of the checklist, appeared to find aspects of the checklist too prescriptive and not sufficiently task and context sensitive. Participants from occupational therapy and radiography in particular, emphasized that communication can be highly variable, contingent on the type of consultation and the specific issues and needs of individual clients. At the same time, all of these participants endorsed the value of the skills embedded in the checklist. In addition, as noted in the general feedback section of the results, above, the array of skills defined in the checklist was viewed by many participants as representing a model of 'ideal' or best practice communication, rather than actual practice by already registered health professions.

Recommendations

The aim of the study was to investigate the relevance of the proposed speaking checklist across the health professions currently served by the OET. As discussed above, in general, participants described the checklist as very comprehensive and generally reflective of highly valued communication behaviours within their professions. The lack of relevance of particular criteria in the checklist to some health professions, however, perhaps indicates a need for the development of profession specific definitions and examples for each criterion in each section of the checklist, as a means of better aligning the abstract communication skills labelled in the checklist to the real world communication demands faced by practitioners in the health professions served by the OET. Furthermore, the use of the proposed criteria as an assessment hurdle for overseas trained health professionals wishing to gain registration in an English speaking context raises questions of fairness, given that many participants described the checklist as an 'ideal' rather than a representation of actual communicative behaviour in their professional contexts. On the other hand, the utility of the checklist as a pedagogic tool to improve the communication skills of both overseas and locally trained health professionals was widely endorsed.

In light of the insights gained from this study, it is recommended that further investigations be conducted in order to:

- determine the feasibility of profession-specific versions of the checklist for occupational therapy, optometry, pharmacy, and radiography, with definitions of criteria and examples tailored to reflect current practice in each of the health professions. These four professions indicated some aspects of the checklist were only slightly relevant or not relevant.
- verify the extent to which criteria in the checklist are elicited by existing role play tasks, as well as the extent to which tasks need to be modified or reformulated to capture a broader speaking construct

Furthermore, on the basis of our finding that the checklist represented an 'ideal' model of spoken communication, rather than current practice in the professions, it is recommended that careful consideration be given to the fairness implications of including such criteria as a pre-registration requirement for professionals from non-English speaking backgrounds.

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Appendix A: Background questionnaire for expert informants

This questionnaire seeks to provide information about participants being interviewed for this study to inform consideration of how well their views represent those of their profession as a whole.

1. OET profession represented (select one):

☐Dentistry	☐Occupational Therapy	☐Podiatry
☐Dietetics	☐Optometry	☐Radiography
☐Medicine	☐Pharmacy	☐Speech Pathology
☐Nursing	☐Physiotherapy	☐Veterinary Science

2. Years of professional experience (select one):

☐1-5 years	☐11-15 years	☐20-25 years
☐6-10 years	☐16-20 years	☐26 years and more

3. Area(s) of professional experience at any time in your career to date (select all that apply):

☐practitioner	☐educator in a tertiary institution	☐administrator
☐supervisor of trainees in the workplace	☐examiner for a professional exam	☐staff member of professional/ registration body

How much experience do you have (for each question select one):

4. working with health professionals who have English as an additional language?

☐none ☐a little ☐some ☐quite a lot ☐extensive

5. supervising health professionals who have English as an additional language?

☐none ☐a little ☐some ☐quite a lot ☐extensive

6. working outside Australia in an English-speaking context?

☐none ☐a little ☐some ☐quite a lot ☐extensive

7. working outside Australia in a non-English-speaking context?

☐none ☐a little ☐some ☐quite a lot ☐extensive

8. Are you aware of details of the English language skills standard currently used by the Australian registration body/bodies for your profession?

☐Yes ☐No

9. Have you had any direct involvement in the registration process for members of your profession who have trained outside Australia and use English as an additional language?

☐Yes ☐No

If 'Yes', in what capacity?

_____

Appendix B: Checklist

Aspects of spoken communication relevant to health professional-patient interactions

The Occupational English Test (OET) is a specific-purpose language test for health professionals who have trained elsewhere and are seeking registration to practise in Australia. Changes to the OET speaking sub-test have been proposed (based on previous research) to maintain the test's relevance to the communicative demands of today's healthcare workplaces. This project seeks to collect information from practitioners and educators from all the health professions served by the OET to investigate whether these changes are viewed as relevant and appropriate for each profession.

The assessment checklist provided here has been designed to reflect what is important in health professional–patient spoken communication. Four main categories have been identified (relationship building, understanding and incorporating the patient's perspective, providing structure to interviews with patients, and information gathering and giving), and a range of skills/behaviours within each category. Please **read through each of the communication behaviours/skills** described within each of the four main categories, and **comment on the relevance to <u>your</u> profession** of each of the behaviours/skills.

A. Relationship building

A1 Initiating the interaction appropriately (greeting, introductions)

Definition	**Relevance to your profession**
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. An effective example would be: *"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"*	

A2 Demonstrating an attentive and respectful attitude

Definition	**Relevance to your profession**
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. For instance: "*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"*	

A3 Demonstrating a non-judgemental approach

Definition	**Relevance to your profession**
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. An effective example would be: "*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.*"	

A4 Showing empathy for feelings/predicament/emotional state

Definition	**Relevance to your profession**
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. An effective example would be: *"I can see that your husband's memory loss has been very difficult for you to cope with".*	

B. Understanding & incorporating the patient's perspective

B1 Eliciting and exploring patient's ideas/concerns/expectations

Definition	Relevance to your profession
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. The health professional might need to ask directly as in *"Did you have any thoughts yourself about what might be causing your symptoms?"* or *"Was there anything particular you were concerned about?"* If expressed spontaneously by the patient, the health professional will need to explore this by saying for instance *"You mentioned that you were concerned about the effect the illness might have on your work, could you tell me more about that?"*	

B2 Picking up patient's cues

Definition	Relevance to your profession
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. Techniques for picking up cues would include echoing *"Something could be done…?"* or more overtly checking out statements or hints *"You used the word worried, could you tell me more about what you were worried about?"* or *"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

Definition	Relevance to your profession
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 An effective example might be: *"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…"*	

C. Providing structure

C1 Sequencing the interview purposefully and logically

Definition	Relevance to your profession
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

Definition	Relevance to your profession
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: *"Can I just check that I have understood you, let me know if I've missed something…."*. 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: "*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?"* or *"Since we haven't met before it will help me to learn something about your past medical history. Can we do that now?..."*	

C3 Using organising techniques in explanations

Definition	Relevance to your profession
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 forewarns the patient about which categories of information are to be provided e.g. *"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."* labelling in which important points are labelled by the health professional e.g. *"it is particularly important that you remember this…"* chunking in which information is delivered in chunks with clear gaps in between sections before proceeding repetition and summary of important points e.g. *"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"*	

D. Information-gathering and -giving

Information-gathering

D1 Facilitating patient's narrative with active listening techniques, minimising interruption

Definition	Relevance to your profession
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 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. Observable skills of active listening techniques include: • the use of silence and pausing • verbal encourages such as *um, uh-huh, I see* • echoing and repetition such as "*chest pain?"* or *"not coping?"* • 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

Definition	**Relevance to your profession**
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, such as yes or no, is expected. They limit the response to a narrow field set by the questioner. 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. Simple examples of these questioning styles are Open- *"tell me about your headaches"* More directive but still open - *"what makes your headaches better or worse?"* Closed - *"do you ever wake up with the headache in the morning?"* Examples of effective open questioning techniques would be: "*Start at the beginning and take me through what has been happening....."* or *"How have you been feeling since your operation...?"*	

D3 NOT using compound questions/leading questions

Definition	**Relevance to your profession**
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

Definition	Relevance to your profession
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: *"Could you explain what you mean by light-headed"* or *"When you say dizzy, do you mean that the room seems to actually spin round?"*	

D5 Summarising information to encourage correction/invite further information

Definition	Relevance to your profession
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: *"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?"*	

Information-giving

D6 Establishing initially what patient already knows

Definition	Relevance to your profession
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: *"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."*	

D7 Pausing periodically when giving information, using response to guide next steps

Definition	**Relevance to your profession**
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: *"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?"*	

D8 Encouraging patient to contribute reactions/feelings

Definition	**Relevance to your profession**
A further element of effective information giving is providing opportunities for to the patient to ask questions, seek 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: *"What questions does that leave you with - have you any concerns about what I have said?"*	

D9 Checking whether patient has understood information

Definition	**Relevance to your profession**
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 when they mean no to avoid looking stupid. A more effective method is to use patient restatement. An example of this would be: *"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."*	

D10 Discovering what further information patient needs

Definition	**Relevance to your profession**
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: "*Are there any other questions you'd like me to answer or any points I haven't covered?"*	