Appendix C

Assessment of Spoken English (Russell, 2006)

This can be used for all types of spoken medical communication including inter-professional and doctor-patient interactions. The scale refers exclusively to the techniques of Spoken English, and not to the appropriateness of content, other than in the selection of suitable vocabulary. Note that even native speakers can use technically non-fluent speech (eg ‘uh’, pauses, etc) but this is usually not noticed as the rhythm, pitch etc are not awkward or hesitant.

Generally the standard to keep in mind is: Is the speech such that it significantly interferes with communication (ie the transfer of meaning and/or information between two or more speakers)? If so, this scale may help in focusing on the specific language problem which can then be addressed.

Rate as follows:

- A Very Poor
- B Poor
- C Adequate
- D Good
- E Excellent (Native speaker level)
- F N/A (Either not observed or can’t judge)

Intelligibility of speech

- Accent (articulation of speech is understandable)
- Rate (too fast, too slow, natural rhythm)
- Audibility (too loud, too soft)
- Fluency (hesitations, fragmentation, unnatural pauses)
- Grammar and sentence structure (You don’t have to work to understand what is being said, or re-arrange sentences in your mind)
- Correct verb tense, word order, etc
- Facility with colloquial English (speech doesn’t sound awkward or formulaic)
- Uses conventions of speech appropriately (introductions, transitions, social statements such as ‘thank you’)

Vocabulary appropriate and extensive (including colloquial English)

Context (can adapt speech pattern to situation such as patient interview, report on a ward round, etc)

- Speech significantly and frequently interferes with communication
- Speech sometimes interferes with communication
- Speech does not interfere with communication