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Sociocultural Women's Health: SP Communication Skills Checklist (ALL Cases)

STUDENT NAME_____ **SPI NAME/CODE**_____ **DATE**_____

A. INITIAL ENCOUNTER:

Opening the Interview

1. **D ND** Addressed patient by name
   D = Used patient's first AND/OR last name appropriately
   ND = Did not use patient's name

2. **D ND** Introduced him/herself by name and role
   D = Used first name OR last name AND title
   ND = Used name only OR title only OR did not provide introduction

3. **D ND** Involved patient when discussing reason for visit (open OR closed ended verification)
   D = Asked what brought patient in OR verification (open or closed ended) of chart
   ND = No verification before asking patient questions

4. **D ND** Set an agenda for the interview
   D = Described what the structure of the interview would entail
   ND = Never described what the structure of the interview would entail

B. FACILITATING SKILLS ***(used continuously throughout interview):***

Conducting the Interview

5. **D NI ND** Conducted the interview in an organized manner
   D = All three of the following were present: logical progression, transition statements, efficient pacing
   NI = Interaction lacked one or two of the following: logical progression, transition statements, efficient pacing
   ND= Interaction lacked all of the following: logical progression, transition statements, efficient pacing

Questioning Techniques

6. **D NI ND** Used open & closed ended questions effectively
   D = Demonstrated a balance of open AND close ended questions
   NI = Used an imbalance of open AND close ended questions
   ND = Overwhelmed patient with close ended questions

7. **D ND** Avoided interrupting me
   D = No interruption(s) noted
   ND = Interruption(s) noted

8. **D ND** Avoided leading questions *(these suggest the proper or desired answer)*
   D = No leading questions were noted
   ND = Leading question(s) were noted

9. **D ND** Avoided multiple questions *(two or more questions presented to the patient at the same time)*
   D =No multiple questions were noted
   ND =Multiple question(s) were noted

Achieving Rapport and Responding to the Patient's Emotions

10. **D ND** Student's demeanor was appropriate for the situation.
    D = Student's demeanor was appropriate for the situation
    ND = Student's demeanor was inappropriate for the situation

11. **D ND** Elicited or explored patient's emotions (emotion-seeking)
    D = Elicited patient's emotions at any time during the interview
    ND = Never, or poorly, elicited patient's emotions during the interview

12. **D ND** Expressed understanding of patient's emotions (legitimizing)
    D = Expressed understanding and/or validated patient's emotions
    ND = Never, or poorly, expressed understanding and/or validated patient's emotions

13. **D ND** Reinforced positive behaviors (praising)
    D = Reinforced positive behaviors (praising)
    ND = Never, or poorly, reinforced positive behaviors

Verbal Skills

14. **D ND** Checked for accuracy during interview (paraphrasing)
D = Checked for accuracy at least once during the interview
ND = Never checked for accuracy during the interview

15. **D ND** Avoided inappropriate language (including slang and unexplained medical jargon)
D = Never used inappropriate language (slang/unexplained medical jargon) during the interview
ND = Used inappropriate language (slang/unexplained medical jargon) at any time during the interview

16. **D ND** Avoided false reassurances.
D = Never provided false reassurance to the patient
ND = Provided any false reassurance to the patient

17. **D ND** Avoided judgmental behavior (including tone, facial expressions and/or verbal statements)
D = Never exhibited judgmental behavior during the interview
ND = Exhibited judgment at any time during the interview

Non-verbal Skills

18. **D ND** Professional Attire/Presence

19. **D ND** Maintained appropriate eye contact
D = Eye contact was comfortable
ND = Eye contact was insufficient OR excessive

20. **D ND** Used effective body language (posture/proximity)
D = Appropriate posture AND appropriate proximity
ND = Lacked appropriate posture OR appropriate proximity OR both

C. EDUCATION, MOTIVATION, NEGOTIATION:

Providing Information and Educating the Patient

21. **D ND** Explored patient's beliefs/perception of the problem or health-related issue(s)
D = Explored patient's beliefs, knowledge or perception about their health related issue
ND = Never explored patient's beliefs, knowledge or perception about their health related issue

22. **D ND** Clearly described medical information *(info delivered at the patient's level)*
D = Medical information presented was clear and understandable
ND = Medical information presented was unclear or difficult to understand

23. **D ND** Clearly described benefits from change and/or risks involved if change is not made
D = Benefits and/or risks associated with change presented were clear
ND = Benefits and/or risks associated with change were not presented OR were presented unclearly

Motivation and Negotiation

24. **D ND** Assessed patient's readiness for change

25. **D ND** Clearly described treatment options
D = Treatment options presented were clear
ND = Treatment options were not presented OR were presented unclearly

26. **D ND** Treatment option recommendations were appropriate for the situation.

27. **D ND** Negotiated a treatment plan cooperatively incorporating the patient's preferences

28. **D NI ND** Asked patient to summarize his/her understanding of the next steps
D = Actively asked patient to summarize his/her understanding of the next steps
NI = Passively asked patient if he/she understood the information provided about next steps
ND = Did not assess patient's understanding of the next steps at all

D. CONCLUSION:

Closing the Interview

29. **D NI ND** Summarized the interview *(history and exam when applicable)*
D = Provided a brief synopsis of important points of interaction
NI = Provided insufficient OR excessive detail
ND = Omitted a summary

30. **D NI ND** Asked for additional questions and/or concerns
D = Phrasing encouraged patient to ask questions or express concerns
NI = Phrasing discouraged me from asking questions or expressing concerns
ND = No opportunity provided

31. **D NI ND** Reviewed next step(s)
D = Clear
NI = Unclear
ND = Not addressed

32. **D NI ND** Closed interview *(closing salutation)*
D = Closing salutation was appropriate
NI = Closing salutation was awkward or disjointed
ND = No closing salutation was provided

33. As an SPI, how comfortable did you feel with this student overall (excluding medical content)?
☐ A = Extremely Comfortable
☐ B = Comfortable
☐ C = Neutral
☐ D = Uncomfortable
☐ E = Extremely Uncomfortable

ADDITIONAL COMMENTS:

Sociocultural Women's Health
SP Content Checklist-Case A

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

	History of Present Illness	Yes/ Asked	No/ Not Asked
1.	Onset of Irregular Bleeding		
2.	Frequency of Irregular Bleeding		
3.	Duration of Irregular Bleeding		
4.	Other associated symptoms (i.e. cramping, etc…)		
	Past Medical History		
5.	Hospitalizations		
6.	Surgeries		
7.	Other medical problems (i.e. diabetes, anemia, bleeding disorders, etc…)		
	Family History		
8.	History of similar issues in the family (mom died of cervical cancer)		
	Past OB/Gyn History		
9.	Menses History (i.e. age at onset, what is typical for you, etc…)		
10.	Sexual History (i.e. sexually active, number of partners, etc…)		
11.	History of STDs		
12.	History of abnormal Pap smear/pelvic exam results		
13.	Pregnancies		
14.	History of gynecological problems (i.e. fibroids)		
	Medications		
15.	Prescription		
16.	Over the Counter/Herbal Medications		
17.	Drug Allergies		
18.	Other remedies tried to alleviate the health issue		
	Social History		
19.	Family or primary relationship situation (i.e. marital status, children, etc…)		
20.	Patient's support system		
21.	Where patient is from		
22.	How members of family and/or support system manage female issues		
23.	Stressors/impact of health issue on pt's life		
24.	Life-style risk factors (i.e. smoking, alcohol use, drug use/abuse)		
25.	Assessed my beliefs surrounding my health issue (if it's not broken, don't fix it).		
26.	Assessed my understanding/fears surrounding my health issue (fear cervical cancer is hereditary, fear that Pap smears cause cancer (mistrust))		
27.	Acknowledges my ways of managing my health issues.		
28.	Avoided projecting his/her cultural values.		
	Health Education/Literacy		
29.	Assessed patient's understanding of physical exams/tests		
30.	Explained pelvic exam (what it is, what is done and why it's done)		
31.	Explained Pap smear (what it is, what is done and why it's done)		
	Next Steps/Plan		

Sociocultural Women's Health
SP Content Checklist-Case A

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

32.	Worked with me to develop a plan that incorporated my beliefs.		
33.	The plan we developed:		

Sociocultural Women's Health
SP Content Checklist-Case B

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

	History of Present Illness	Yes/ Asked	No/ Not Asked
1.	Onset of Irregular Bleeding		
2.	Frequency of Irregular Bleeding		
3.	Duration of Irregular Bleeding		
4.	Other associated symptoms (i.e. weight gain, hair growth, etc…)		
	Past Medical History		
5.	Hospitalizations		
6.	Surgeries		
7.	Other medical problems (i.e. diabetes, anemia, bleeding disorders, etc…)		
	Family History		
8.	History of similar issues in the family (cousin with infertility issues)		
	Past OB/Gyn History		
9.	Menses History (i.e. age at onset, what is typical for you, etc…)		
10.	Sexual History (i.e. sexually active, may ask what your def. of sexually active is).		
11.	Prior Pap smear/pelvic exam		
	Medications		
12.	Prescription		
13.	Over the Counter/Herbal Medications		
14.	Drug Allergies		
15.	Other remedies tried to alleviate the health issue		
	Social History		
16.	Family or primary relationship situation (i.e. marital status, who she lives with…)		
17.	Patient's support system		
18.	Where patient is from		
19.	How members of family and/or support system manage female issues		
20.	Stressors/impact of health issue on pt's life		
21.	Life-style risk factors (i.e. smoking, alcohol use, drug use/abuse)		
22.	Assessed my beliefs surrounding my health issue (gynecological exams too invasive; perception of sexual activity prior to marriage is unacceptable).		
23.	Assessed my understanding/fears surrounding my health issue (fear of infertility; pelvic exam doesn't disrupt virginity)		
24.	Acknowledges my ways of managing my health issues (discussing sensitive issues with family first).		
25.	Avoided projecting his/her cultural values.		
	Health Education/Literacy		
26.	Assessed patient's understanding of physical exams/tests		
27.	Explained pelvic exam (what it is, what is done and why it's done)		
28.	Explained Pap smear (what it is, what is done and why it's done)		
29.	Discussed hormone therapy/birth control as a treatment option.		

Sociocultural Women's Health
SP Content Checklist-Case B

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

	Next Steps/Plan		
30.	Worked with me to develop a plan that incorporated my beliefs.		
31.	The plan we developed:		

Sociocultural Women's Health
SP Content Checklist-Case C

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

	History of Present Illness	Yes/ Asked	No/ Not Asked
1.	Onset of Irregular Bleeding		
2.	Frequency of Irregular Bleeding		
3.	Duration of Irregular Bleeding		
4.	Other associated symptoms (i.e. cramping, etc…)		
	Past Medical History		
5.	Hospitalizations		
6.	Surgeries		
7.	Other medical problems (i.e. diabetes, anemia, bleeding disorders, etc…)		
	Family History		
8.	History of similar issues in the family (maternal grandmother died of ovarian cancer; father died of colon cancer)		
	Past OB/Gyn History		
9.	Menses History (i.e. age at onset, what is typical for you, etc…)		
10.	Sexual History (i.e. sexually active, number of partners, etc…)		
11.	History of STDs		
12.	History of abnormal Pap smear/pelvic exam results		
13.	Pregnancies		
14.	History of gynecological problems (i.e. fibroids)		
	Medications		
15.	Prescription		
16.	Over the Counter/Herbal Medications		
17.	Drug Allergies		
18.	Other remedies tried to alleviate the health issue		
	Social History		
19.	Family or primary relationship situation (i.e. marital status, children, etc…)		
20.	Patient's support system		
21.	Where patient is from		
22.	How members of family and/or support system manage female issues		
23.	Stressors/impact of health issue on pt's life (financial concerns)		
24.	Life-style risk factors (i.e. smoking, alcohol use, drug use/abuse)		
25.	Assessed my beliefs surrounding my health issue (health care important, but not always prioritized due to cost).		
26.	Assessed my understanding/fears surrounding my health issue (concerned about expense of tests)		
27.	Acknowledges my ways of managing my health issues.		
28.	Avoided projecting his/her cultural values.		
	Health Education/Literacy		
29.	Assessed patient's understanding of physical exams/tests		
30.	Explained pelvic exam (what it is, what is done and why it's done)		

Sociocultural Women's Health
SP Content Checklist-Case C

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

31.	Explained Pap smear (what it is, what is done and why it's done)		
	Next Steps/Plan		
32.	Worked with me to develop a plan that incorporated my beliefs.		
33.	The plan we developed:		

Sociocultural Women's Health
SP Content Checklist-Case D

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

	History of Present Illness	Yes/ Asked	No/ Not Asked
1.	Period is a week "late"; LMP 5 weeks ago		
2.	Negative home pregnancy test 3 days ago		
	Past Medical History		
3.	Hospitalizations		
4.	Surgeries		
5.	Other medical problems (i.e. diabetes, anemia, bleeding disorders, etc…)		
	Family History		
6.	History of similar issues in the family (maternal grandmother died of ovarian cancer)		
	Past OB/Gyn History		
7.	Menses History (i.e. age at onset, what is typical for you, etc…)		
8.	Sexual History (i.e. sexually active, number of partners, etc…)		
9.	History of STDs		
10.	Prior Pap smears/pelvic exams		
11.	Pregnancies		
12.	History of gynecological problems		
	Medications		
13.	Prescription		
14.	Over the Counter/Herbal Medications		
15.	Drug Allergies		
16.	Other remedies tried to alleviate the health issue		
	Social History		
17.	Family or primary relationship situation (i.e. marital status, children, etc…)		
18.	Patient's support system		
19.	Where patient is from		
20.	How members of family and/or support system manage female issues		
21.	Stressors/impact of health issue on pt's life (financial concerns)		
22.	Life-style risk factors (i.e. smoking, alcohol use, drug use/abuse)		
23.	Sexual Behaviors (unprotected sexual intercourse)		
24.	Assessed my beliefs surrounding my health issue (personal beliefs/sexual practices in direct conflict with familial beliefs).		
25.	Assessed my understanding/fears surrounding my health issue (concerns re: confidentiality; no knowledge of need for regular gynecological exams)		
26.	Acknowledges my ways of managing my health issues (seeking out help despite concerns).		
27.	Avoided projecting his/her cultural values.		
	Health Education/Literacy		
28.	Assessed patient's understanding of physical exams/tests		

Sociocultural Women's Health
SP Content Checklist-Case D

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

29.	Explained pelvic exam (what it is, what is done and why it's done)		
30.	Explained Pap smear (what it is, what is done and why it's done)		
31.	Educated patient regarding safe sex practices		
	Next Steps/Plan		
32.	Worked with me to develop a plan that incorporated my beliefs.		
33.	The plan we developed:		

Sociocultural Women's Health: Student Self-Assessment—Communication Skills (ALL Cases)

A. INITIAL ENCOUNTER:

Opening the Interview

1. **D ND** Addressed patient by name
   D = Used patient's first AND/OR last name appropriately
   ND = Did not use patient's name

2. **D ND** Introduced myself by name and role
   D = Used first name OR last name AND title
   ND = Used name only OR title only OR did not provide introduction

3. **D ND** Involved patient when discussing reason for visit (open OR closed ended verification)
   D = Asked what brought patient in OR verification (open or closed ended) of chart
   ND = No verification before asking patient questions

4. **D ND** Set an agenda for the interview
   D = Described what the structure of the interview would entail
   ND = Never described what the structure of the interview would entail

B. FACILITATING SKILLS *(used continuously throughout interview):*

Conducting the Interview

5. **D NI ND** Conducted the interview in an organized manner
   D = All three of the following were present: logical progression, transition statements, efficient pacing
   NI = Interaction lacked one or two of the following: logical progression, transition statements, efficient pacing
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Questioning Techniques

6. **D NI ND** Used open & closed ended questions effectively
   D = Demonstrated a balance of open AND close ended questions
   NI = Used an imbalance of open AND close ended questions
   ND = Overwhelmed patient with close ended questions

Questioning Techniques (cont).

7. **D ND** Avoided interrupting the patient.
   D = Avoided interruption(s)
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8. **D ND** Avoided leading questions *(these suggest the proper or desired answer)*
   D = Avoided leading questions
   ND = Did not avoid leading question(s)

9. **D ND** Avoided multiple questions *(two or more questions presented to the patient at the same time)*
   D = Avoided multiple questions
   ND = Did not avoid multiple question(s)

Achieving Rapport and Responding to the Patient's Emotions

10. **D ND** My demeanor was appropriate for the situation.
    D = My demeanor was appropriate for the situation
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11. **D ND** Elicited or explored patient's emotions (emotion-seeking)
    D = Elicited patient's emotions at any time during the interview
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12. **D ND** Expressed understanding of patient's emotions (legitimizing)
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13. **D ND** Reinforced positive behaviors (praising)
    D = Reinforced positive behaviors (praising)
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Verbal Skills

14. **D ND** Checked for accuracy during interview (paraphrasing)
D = Checked for accuracy at least once during the interview
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15. **D ND** Avoided inappropriate language (including slang and unexplained medical jargon)
D = Never used inappropriate language (slang/unexplained medical jargon) during the interview
ND = Used inappropriate language (slang/unexplained medical jargon) at any time during the interview

16. **D ND** Avoided false reassurances.
D = Never provided false reassurance to the patient
ND = Provided any false reassurance to the patient

17. **D ND** Avoided judgmental behavior (including tone, facial expressions and/or verbal statements)
D = Never exhibited judgmental behavior during the interview
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Non-verbal Skills

18. **D ND** Professional Attire/Presence

19. **D ND** Maintained appropriate eye contact
D = Eye contact was comfortable
ND = Eye contact was insufficient OR excessive

20. **D ND** Used effective body language (posture/proximity)
D = Appropriate posture AND appropriate proximity
ND = Lacked appropriate posture OR appropriate proximity OR both

C. EDUCATION, MOTIVATION, NEGOTIATION:

Providing Information and Educating the Patient

21. **D ND** Explored patient's beliefs/perception of the problem or health-related issue(s)
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22. **D ND** Clearly described medical information *(info delivered at the patient's level)*
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23. **D ND** Clearly described benefits from change and/or risks involved if change is not made
D = Benefits and/or risks associated with change presented were clear
ND = Benefits and/or risks associated with change were not presented OR were presented unclearly

Motivation and Negotiation

24. **D ND** Assessed patient's readiness for change

25. **D ND** Clearly described treatment options
D = Treatment options presented were clear
ND = Treatment options were not presented OR were presented unclearly

26. **D ND** Treatment option recommendations were appropriate for the situation.

27. **D ND** Negotiated a treatment plan cooperatively incorporating the patient's preferences

Motivation and Negotiation (cont).

28. **D NI ND** Asked patient to summarize his/her understanding of the next steps
D = Actively asked patient to summarize his/her understanding of the next steps
NI = Passively asked patient if he/she understood the information provided about next steps
ND = Did not assess patient's understanding of the next steps at all

D. CONCLUSION:

Closing the Interview

29. **D NI ND** Summarized the interview *(history and exam when applicable)*
D = Provided a brief synopsis of important points of interaction
NI = Provided insufficient OR excessive detail
ND = Omitted a summary

30. **D NI ND** Asked for additional questions and/or concerns
D = Phrasing encouraged patient to ask questions or express concerns
NI = Phrasing discouraged me from asking questions or expressing concerns
ND = No opportunity provided

31. **D NI ND** Reviewed next step(s)
D = Clear
NI = Unclear
ND = Not addressed

32. **D NI ND** Closed interview *(closing salutation)*
D = Closing salutation was appropriate
NI = Closing salutation was awkward or disjointed
ND = No closing salutation was provided

Sociocultural Women's Health
Student Self-Assessment Content Items-Case A

Student _____

SPI Code_____

Date_____

Check if the you asked about or discussed the following:

	Social History	Done	Not Done
1.	Family or primary relationship situation (i.e. marital status, children, etc…)		
2.	Patient's support system		
3.	Where patient is from		
4.	How members of family and/or support system manage female issues		
5.	Stressors/impact of health issue on pt's life		
6.	Life-style risk factors (i.e. smoking, alcohol use, drug use/abuse)		
7.	Assessed pt's beliefs surrounding her health issue (if it's not broken, don't fix it).		
8.	Assessed pt's understanding/fears surrounding her health issue (fear cervical cancer is hereditary, fear that Pap smears cause cancer (mistrust))		
9.	Acknowledges pt's ways of managing her health issues.		
10.	Avoided projecting your cultural values onto the patient.		

Sociocultural Women's Health
Student Self-Assessment Content Items-Case B

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

	Social History	Done	Not Done
1.	Family or primary relationship situation (i.e. marital status, who she lives with…)		
2.	Patient's support system		
3.	Where patient is from		
4.	How members of family and/or support system manage female issues		
5.	Stressors/impact of health issue on pt's life		
6.	Life-style risk factors (i.e. smoking, alcohol use, drug use/abuse)		
7.	Assessed pt's beliefs surrounding her health issue (gynecological exams too invasive; perception of sexual activity prior to marriage is unacceptable).		
8.	Assessed pt's understanding/fears surrounding her health issue (fear of infertility; pelvic exam doesn't disrupt virginity)		
9.	Acknowledges pt's ways of managing her health issues (discussing sensitive issues with family first).		
10.	Avoided projecting your own cultural values.		

Sociocultural Women's Health
Student Self-Assessment Content Items-Case C

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

	Social History		
1.	Family or primary relationship situation (i.e. marital status, children, etc…)		
2.	Patient's support system		
3.	Where patient is from		
4.	How members of family and/or support system manage female issues		
5.	Stressors/impact of health issue on pt's life (financial concerns)		
6.	Life-style risk factors (i.e. smoking, alcohol use, drug use/abuse)		
7.	Assessed pt's beliefs surrounding her health issue (health care important, but not always prioritized due to cost).		
8.	Assessed pt's understanding/fears surrounding her health issue (concerned about expense of tests)		
9.	Acknowledges pt's ways of managing her health issues.		
10.	Avoided projecting your own cultural values.		

Sociocultural Women's Health
Student Self-Assessment Content Items-Case D

Student _____

SPI Code_____

Date_____

Check if the student asked about or discussed the following:

	Social History		
1.	Family or primary relationship situation (i.e. marital status, children, etc…)		
2.	Patient's support system		
3.	Where patient is from		
4.	How members of family and/or support system manage female issues		
5.	Stressors/impact of health issue on pt's life (financial concerns)		
6.	Life-style risk factors (i.e. smoking, alcohol use, drug use/abuse)		
7.	Sexual Behaviors (unprotected sexual intercourse)		
8.	Assessed my beliefs surrounding my health issue (personal beliefs/sexual practices in direct conflict with familial beliefs).		
9.	Assessed my understanding/fears surrounding my health issue (concerns re: confidentiality; no knowledge of need for regular gynecological exams)		
10.	Acknowledges my ways of managing my health issues (seeking out help despite concerns).		
11.	Avoided projecting his/her cultural values.		