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Original Article

Development of Interview Skills Using Clinical Simulation in Speech-Language Therapy

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ABSTRACT

Objective structured clinical evaluation (OSCE) is a type of clinical simulation that has significantly changed how clinical interview skills are developed, specifically regarding anamnesis and communication. However, there is little evidence of its use in speech-language therapy. The purpose of this work was to analyze the use of formative OSCE as a pedagogical strategy to teach clinical interview skills in the second year of a Speech-Language Therapy program. This is a quantitative and analytical-relational study with a quasi-experimental, pre-post design. The sample included 17 students from the Speech Therapy program at Universidad Andres Bello. Clinical interview skills were evaluated using an observation scale and a self-efficacy scale, both before and after the formative OSCE. Three observation checklists were applied during the interview: anamnesis, clinical judgment, and communication. Finally, students completed a survey on their perception of the OSCE methodology. All participants showed improvements in their clinical interview skills and their levels of self-efficacy. The differences in anamnesis and communication were statistically significant ($p<0.05$). Similarly, they expressed high levels of satisfaction with the methodology. In conclusion, formative OSCE favors the development of anamnesis and communication competencies in speech-language therapy students, in addition to increasing their self-efficacy in these areas. Furthermore, the participants expressed a high degree of satisfaction with the method.

Keywords:
Simulation Training; Patient Simulation; Objective Structured Clinical Evaluation (Osce); Speech-Language Therapy; Interview as Topic

Desarrollo de habilidades de entrevista usando simulación clínica en fonoaudiología

RESUMEN

La evaluación clínica objetiva estructurada (ECOE), es un tipo de simulación clínica que ha provocado cambios destacados en el desarrollo de habilidades para realizar entrevistas clínicas, específicamente en anamnesis y comunicación. Sin embargo, existe escasa evidencia sobre su utilización en Fonoaudiología. El propósito de este trabajo es analizar la utilización del ECOE formativo como una estrategia pedagógica para enseñar habilidades de entrevista clínica en el segundo nivel formativo de Fonoaudiología. Este estudio es de naturaleza cuantitativa y analítico-relacional, de diseño cuasi experimental, antes y después. La muestra incluyó a 17 estudiantes de la Carrera de Fonoaudiología de la Universidad Andres Bello. Se evaluó la entrevista clínica empleando una escala de observación y una escala de autoeficacia, tanto antes como después del ECOE formativo. Durante la ejecución, se aplicaron tres pautas de observación: anamnesis, juicio clínico y comunicación. Finalmente, los estudiantes completaron una encuesta de percepción respecto a la metodología de ECOE. Todos los participantes mostraron mejoras en sus habilidades para realizar entrevistas clínicas y en sus niveles de autoeficacia, siendo estadísticamente significativas las diferencias en anamnesis y comunicación ($p<0,05$). Asimismo, manifestaron altos niveles de satisfacción con la metodología utilizada. Se concluye que el ECOE formativo favorece el desarrollo de competencias en anamnesis y comunicación en estudiantes de la Carrera de Fonoaudiología, además de incrementar su autoeficacia en estas áreas. También manifestaron un elevado grado de satisfacción con el método utilizado.

Palabras clave:
Simulación; Paciente Simulado; Evaluación Clínica Objetiva Estructurada; Fonoaudiología; Entrevista Clínica

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INTRODUCTION

The acquisition of competencies in professional training requires pedagogical strategies that foster integrated theoretical, practical, and behavioral development in students (Mantilla et al., 2021). In this context, clinical simulation emerges as a methodology that substitutes real experiences through supervised scenarios that evoke or replicate fundamental aspects of the real world in a fully interactive manner (Gaba, 2004). It stands out from other methodologies (Bartlett et al., 2021), both because it leaves room for error without the risk of adverse consequences for the patient and because it allows for a rapid generalization of competencies to various contexts (Gaba, 2000, 2004; Hewat et al., 2020; Maran & Glavin, 2003). Numerous studies have shown significant impacts of simulation on theoretical learning (Quigley & Regan, 2020), communication (Bartlett et al., 2021), interdisciplinary collaboration, and stress reduction (Farrés Tarafa et al., 2015; Okuda et al., 2009; Penman et al., 2021; Quigley & Regan, 2020).

These benefits have led to the development of the Objective Structured Clinical Examination (OSCE), which assesses a broad range of competencies using diverse methodologies and simulated work scenarios (Casey et al., 2009). Anamnesis, clinical judgment, and communication skills are some of the competencies with the greatest professional impact; they are also the most likely to be evaluated and enhanced through the OSCE (Boursicot et al., 2021).

Traditionally, the OSCE has been used as a high-stakes test. However, since the 2020 Ottawa Conference, there has been an emphasis on transitioning the OSCE toward formative assessment (Boursicot et al., 2021, 2023). This shift is primarily attributed to its potential to enhance learning processes through high-fidelity scenarios involving standardized or simulated patients (SPs) and the use of effective feedback (Behrens et al., 2018; Doyle et al., 2024). In Chile, reports from medical programs highlight its application for formative purposes in both in-person (Bozzo Navarrete et al., 2020) and remote formats (Jadue et al., 2023). These accounts underscore the educational and catalytic power of the OSCE, attributes that have been recommended to be considered and promoted since 2020 (Boursicot et al., 2021, 2023). Nevertheless, no studies have been found on its pedagogical effectiveness in other healthcare professions such as speech-language therapy, a gap that is also observed internationally (Bressmann & Eriks-Brophy, 2012; Quigley & Regan, 2020).

A review of the Latin American literature (indexed in Scopus, WOS, Scielo, LILACS, and PubMed) revealed only one report on the use of the OSCE as a teaching strategy and evaluation instrument in speech-language therapy. This study highlights statistically significant improvements in fourth-year students' skills (required for primary healthcare) after participating in formative OSCE sessions (Bustos et al., 2018).

The relevance of simulation in speech-language therapy lies in its capacity to enhance the development of clinical competencies that are essential for professional practice. Speech-language therapists must engage in activities that include prevention, diagnosis, and treatment for people with linguistic-communicative, articulatory, vocal, auditory, swallowing, and oral motor difficulties. Therefore, the clinician-patient interview, encompassing medical history, diagnostic hypotheses, and communicative interaction, is fundamental for achieving effective collaborative work with families, communities, and interdisciplinary teams (Bustos et al., 2018). In this context, clinical simulation using SPs emerges as a high-impact educational methodology for speech-language therapy programs due to its high fidelity to real-world scenarios, low economic cost, and extensive supporting evidence (Alinier, 2007; Levine & Swartz, 2008).

This study aimed to analyze the use of formative OSCE as a pedagogical strategy for developing clinical interview competencies in a Neurolinguistics course taught in the second year of a speech-language therapy program.

METHOD

The dataset analyzed in this article was previously collected and presented in the dissertation “Development of Clinical Interview Skills Through an Objective Structured Clinical Examination Experience in Speech-Language Pathology Students at a Private University in the Region, Concepción, Second Semester 2019,” defended by the main author at Universidad de Concepción, Chile (Aguilar, 2020).

A quantitative approach with a relational analysis was used. The study design was experimental, specifically pre-experimental, incorporating both pretest and posttest assessments. Students’ performances were evaluated before and after the implementation of the formative OSCE methodology.

Participants

The sample consisted of 17 speech-language therapy students who were enrolled in a Neurolinguistics course. They were selected through non-probabilistic convenience sampling.

Students who did not participate in at least 75% of the course-related activities were excluded.

Assessment Instruments

The ability to conduct a clinical interview was assessed using an observation scale, specific to clinical interviews, and a self-efficacy scale, both administered before and after the formative OSCE. During the OSCE implementation phase, the clinical interview was divided into three components: anamnesis, clinical judgment, and communication. As a result, separate checklists were developed and used for each component of the clinical interview. At the end of the process, students completed a perception survey to rate their level of satisfaction with the OSCE methodology. All assessment tools were designed by the researcher and validated by a panel of five experts.

Clinical Interview Observation Scale

The clinical interview was evaluated using an observation scale with numerical grading across three levels (1 = not achieved; 2 = partially achieved; 3 = achieved). The primary goal of this scale was to detail the level of development of the clinical interview skills. The instrument comprised 16 items divided into three categories: Anamnesis (5 items), Clinical Judgment (4 items), and Communication (7 items).

Clinical Interview Self-Efficacy Scale

The students' self-efficacy associated with their clinical interview skills was assessed using an appraisal scale with numerical grading across three levels (1 = not achieved; 2 = partially achieved; 3 = achieved). This scale was applied both before and after the formative OSCE. Like the observation scale, it covered Anamnesis (5 items), Clinical Judgment (4 items), and Communication (7 items), totaling 16 items to evaluate the students' perception of their ability to conduct clinical interviews.

Perception Survey

Students' perceptions of the OSCE methodology were assessed using a Likert-type scale with four response options (1 = strongly disagree; 2 = disagree; 3 = agree; 4 = strongly agree). This scale was administered after the formative OSCE. The instrument included five dimensions: Teaching and Learning Methodology (5 items), Competency-Based Planning (4 items), Procedure (5 items), Satisfaction (5 items), and Material and Human Resources (4 items), amounting to a total of 23 statements regarding the methodology and the level of satisfaction with it.

Procedures

1. Training of SPs and Examiners Participating in the OSCE

Standardized patients (SPs) were trained in a 4-hour session held four weeks prior to the OSCE. This session was led by the researcher and a nursing professor certified in clinical simulation. The SPs were portrayed by final-year speech-language therapy students in their internship stage. During the training, four clinical scenarios were analyzed: one to assess participants' clinical interview skills before and after the intervention, and three for the formative OSCE scenarios. The session focused on reviewing patient dialogues and their characteristics (physical, psychological-emotional, and behavioral). Emphasis was placed on ensuring a standardized representation of cases so that participants encountered a consistent level of symptom complexity across clinical scenarios. The training concluded with role-playing cases and feedback provided by the instructors. The SPs were certified for their participation in this methodological innovation and the training received as SPs.

During the four weeks leading up to the OSCE, examiners practiced delivering effective feedback through video analysis and role-playing exercises.

2. Educational Intervention

The educational intervention consisted of four stages: Preparation, Pre-Intervention, Formative OSCE, and Post-Intervention.

2.1. Preparation Stage

Four weeks before the OSCE, second-year speech-language therapy students were provided with written materials on clinical interviews, aphasia, and communication.

2.2. Pre-Intervention Stage

Four weeks later, each student conducted a clinical interview with a standardized patient (SP) portraying a case of Broca's aphasia, without prior training in anamnesis, clinical judgment, or communication. The purpose of this activity was to diagnose the students' baseline competency in conducting clinical interviews.

Following the clinical interaction, each participant completed the clinical interview self-efficacy scale. The video recording was analyzed by two evaluators: the researcher and the nursing instructor certified in clinical simulation.

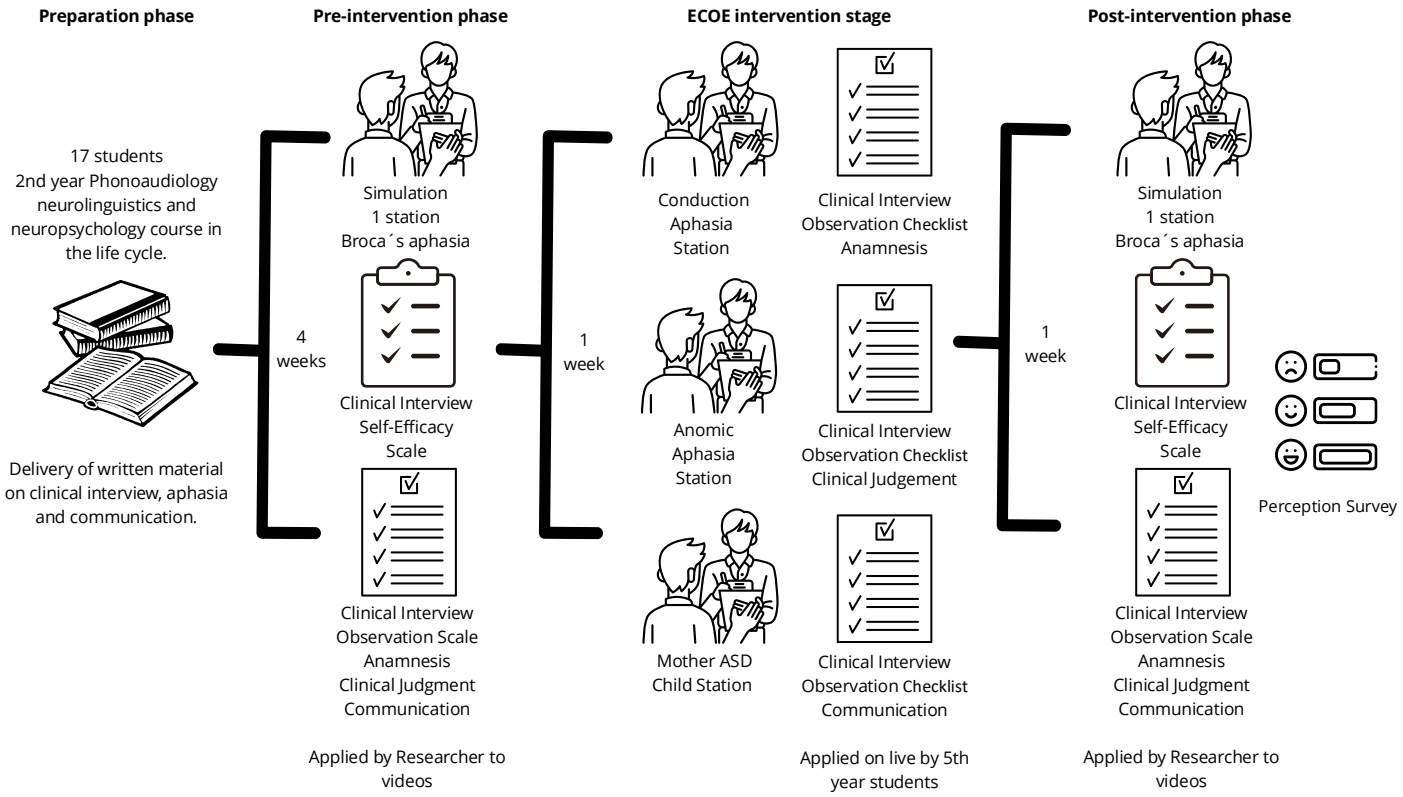

Figure 1. Summary of key milestones in the educational intervention.

2.3. Formative OSCE

One week later, the students participated in the OSCE. They completed three stations focused on clinical interactions—anamnesis, clinical judgment, and communication—and one theoretical written station. Each station was allocated a total of 5 minutes, with 4 minutes dedicated to interaction with the SP and 1 minute for feedback. The first three stations consisted of one SP with conduction aphasia, one with anomic aphasia, and a caregiver of a patient with Autism Spectrum Disorder (ASD). The fourth station consisted of a written clinical case involving sensory transcortical aphasia. Feedback for participants was provided by final-year speech-language therapy students who were in their clinical internship stage. This feedback was based on the observation checklists for anamnesis, clinical judgment, and communication that were used in the first three stations.

2.4. Post-Intervention Phase

One week after the OSCE, the students were invited to conduct an individual interview with a patient exhibiting Broca's aphasia. As in the pre-intervention phase, the video recording of this activity was subsequently analyzed by the same two evaluators using the clinical interview observation scale.

After the interview, participants once again completed the clinical interview self-efficacy scale (the same instrument used in the pre-intervention phase) and a perception survey regarding this pedagogical innovation. Finally, each participant received a detailed written report of their performance in their clinical interview competencies, sent via personal email. Figure 1 summarizes the primary achievements of the formative OSCE.

Statistical Analysis

Initially, a descriptive analysis was conducted for the variables included in the sample. This process involved examining absolute and relative frequencies for categorical variables. For numerical variables, measures such as the mean, standard deviation, minimum, and maximum values were calculated.

For the perception survey, self-efficacy scale, and observation checklists, Cronbach's alpha coefficient was calculated to determine the internal consistency of the factors. Scores were presented in terms of their mean, standard deviation, minimum, and maximum values.

To assess differences in the results obtained before and after the formative OSCE, the non-parametric Wilcoxon test for related samples was applied. Statistical analyses were conducted using Stata SE 16 software.

Ethical Considerations

The Scientific Ethics Committee of the Faculty of Medicine at Universidad de Concepción approved this research. Participation by students was confidential and voluntary. Participants signed an informed consent form that outlined the study's objectives, procedures, required time commitment, and their right to receive a personal performance report. Furthermore, the research ensured equitable treatment for all participants, safeguarding against the exploitation of any vulnerable groups.

RESULTS

Differences were detected in the analysis of the pretest results between both evaluators. For Evaluator 1 (the researcher), the area of highest performance was communication, with a score of 45.5%. In contrast, Evaluator 2 (a nursing instructor specializing in simulation) identified the highest performance in anamnesis, with a score of 49.5%. However, both evaluators agreed that the area of lowest performance was clinical judgment, with scores of 30.0% and 36.0%, respectively. These findings are detailed in Table 1, providing a clear overview of strengths and areas for improvement before the intervention.

Table 1. Descriptive analysis of student performance in the pretest of the clinical interview according to the evaluators.

	Checklist	α	M ± SD	Min	Max	%
Evaluator 1	Anamnesis	0.62	1,72 ± 0,38	1.00	2.20	36.0
	Clinical	0.65	1,60 ± 0,42	1.00	2.50	
	Judgment					30.0
	Communication	0.89	1,91 ± 0,40	1.00	2.33	45.5
Evaluator 2	Anamnesis	0.61	1.99 ± 0.38	1.40	2.60	49.5
	Clinical	0.71	1.72 ± 0.51	1.00	2.50	
	Judgment					36.0
	Communication	0.76	1.89 ± 0.38	1.17	2.33	44.5

N = 17

Regarding the posttest assessment, Evaluator 1 indicated that communication has the highest performance, with 60.0%, while Evaluator 2 considered that anamnesis showed a higher performance, with 77.0%. Both evaluators agreed that the worst performance was found in the clinical judgment competency, with 43.5% and 56.5%, respectively. The posttest results are detailed in Table 2.

Table 2. Descriptive analysis of student performance in the posttest of the clinical interview according to evaluators.

	Checklist	α	M ± SD	Min	Max	%
Evaluator 1	Anamnesis	0.60	2.13 ± 0.37	1.40	2.80	56.5
	Clinical	0.62	1.87 ± 0.41	1.50	2.50	
	Judgment					43.5
	Communication	0.76	2.20 ± 0.38	1.00	2.67	60.0
Evaluator 2	Anamnesis	0.65	2.54 ± 0.32	2.00	3.00	77.0
	Clinical	0.71	2.13 ± 0.64	1.00	3.00	
	Judgment					56.5
	Communication	0.80	2.19 ± 0.39	1.17	3.00	59.5

N = 17

For all purposes, student clinical interview performance was superior in the posttest compared to the pretest. The Wilcoxon test was applied to determine whether these differences were statistically significant. The results indicated that, for both evaluators, the improvement in performance in anamnesis and communication was statistically significant. However, although the improvement in clinical judgment, as assessed by both evaluators, did not reach statistical significance, the probability of Type I error (p) was very close to the conventional significance threshold ($p<0.05$). The results are presented in Table 3.

Regarding the reliability of the self-efficacy scale in the pretest and posttest measurements, it was observed that communication exhibited good reliability in the pretest ($\alpha=0.83$), but this decreased to an insufficient level in the posttest ($\alpha=0.59$). In response to this decrease, item 1 ("respects formal aspects: greeting, introduction, farewell") was removed, and the score was recalculated using only the remaining items. The results of this analysis are presented in Table 4.

Table 3. Comparison between students' performances in the pre and posttest stages of the clinical interview, according to the evaluators.

	Checklist	Z	p
Evaluator 1	Anamnesis	-3.416	<0.001***
	Clinical Judgment	-1.745	0.081
	Communication	-3.418	<0.001***
Evaluator 2	Anamnesis	-3.602	<0.001***
	Clinical Judgment	-1.949	0.051
	Communication	-3.209	0.001**

N= 17; *: p<0.05; **: p<0.01; ***: p<0.001.

Table 4. Descriptive analysis of self-efficacy in the clinical interview as reported by students.

	Checklist	α	M	SD	Min	Max	%	Z	p
Anamnesis	Pretest	0.67	2.13	0.46	1.00	2.80	56.5	-2.791	0.005**
	Posttest	0.60	2.45	0.38	1.80	3.00	72.5		
Clinical Judgment	Pretest	0.61	1.91	0.51	1.00	2.75	45.5	-0.335	0.738
	Posttest	0.68	1.93	0.56	1.00	2.75	46.5		
Communication[1]	Pretest	0.83	2.29	0.61	1.00	3.00	64.5	-2.03	0.t043*
	Posttest	0.75	2.50	0.42	1.50	3.00	75.0		

N= 17; 1 without considering item 1; *: p<0.05; **: p<0.01; ***: p<0.001.

The level of satisfaction associated with each indicator was obtained by calculating the means of the responses. Reliability ranged from α=0.60 to α=0.84, which was considered adequate for research in four of the five indicators, as well as in the overall satisfaction scale (α=0.73). However, the resources indicator showed a reliability of α=0.44. A discriminating capacity analysis was conducted, identifying that item 1 had a negative correlation with this indicator. Consequently, this item was removed from the scale calculation, which increased the reliability to α=0.63.

The results indicate a high level of satisfaction in all aspects. The elements that received the highest ratings, on a scale of 1 to 4, were the method and the resources, while the procedure received the lowest rating. These results are presented in Table 5.

Table 5. Descriptive analysis of student satisfaction with the formative OSCE methodology.

Theme	α	M	SD	Min	Max
Method	0.67	3.85	0.24	3.4	4
Competency-Based Education	0.74	3.75	0.31	3	4
Procedure	0.84	3.62	0.50	2	4
Satisfaction	0.60	3.73	0.34	3	4
Resources*	0.63	3.86	0.27	3	4
Overall Satisfaction	0.73	3.76	0.18	3.26	4

N = 17; * without item 1.

DISCUSSION

The students' ability to conduct a diagnostic interview, which involves anamnesis, clinical judgment, and communication skills, was assessed before and after the formative OSCE. Significant changes were observed only in anamnesis and communication, while clinical judgment showed no variations. This could be attributed to the low level of training in evaluation and diagnosis among second-year speech-language therapy students. Previous

research has shown improvements in anamnesis competence in medical students (Jadue et al., 2023), as well as in communication skills in both nursing (Farrés Tarafa et al., 2015) and medical students using the OSCE methodology (Farrés Tarafa et al., 2015; Fernández-Quiroga et al., 2017; Levine & Swartz, 2008; Sogi et al., 2007). These results differ from studies in speech-language therapy where improvements were observed in clinical judgment, but not in communication (Moineau et al., 2018; Zraick et al., 2003). It is noteworthy that improvements in anamnesis and communication were achieved in 3 weeks of intervention; this aligns with the findings of Fernández-Quiroga et al. (2017), who report advances in communication in sixth- and seventh-year medical students after 3 simulation sessions. These results may be explained by the possibility of repetition (Gaba, 2004), the use of SPs, and the delivery of effective feedback at each OSCE station (Behrens et al., 2018; Doyle et al., 2024; Ferrando-Castagnetto et al., 2019; Hernández Gutiérrez et al., 2017; Pugh et al., 2018).

The increase in self-efficacy levels during the clinical interview observed in the students after participating in the formative OSCE is consistent with studies showing a positive correlation between self-efficacy and simulation experience using SPs (Fernández-Ayuso et al., 2018; Ward et al., 2015).

The data indicate that students experienced a high level of satisfaction with the educational innovation. They underscore the usefulness of this methodology in professional training and its alignment with the course objectives. This aligns with other research analyzing this variable in nursing and medical students (Alarcón M., 2013; Farrés Tarafa et al., 2015; Ferrando-Castagnetto et al., 2019), as well as speech-language therapy students (Díaz et al., 2013; Hewat et al., 2020; Quigley & Regan, 2020). In this research, the best-rated indicators were the educational strategy and the resources used. In contrast, the procedure indicator received the lowest rating. This result could be due to the low score given by students regarding the time available in each OSCE scenario. Many of them expressed that the time was insufficient to interact with the SP and receive feedback from the examiner (final-year student). This is consistent with what has been observed in nursing students (Alarcón M., 2013).

The results of this research indicate that applying the formative OSCE methodology with SP facilitates the development of skills in anamnesis and communication in speech-language therapy students, a finding that has no precedent in the existing literature.

The educational impact of the OSCE is reflected in its promotion of two competencies that are essential for the professional training of speech-language therapists: anamnesis and communication skills. These skills are crucial for ensuring a strong relationship with the patient and their context, as well as with the rest of the professional team. This leads to higher-quality evaluation and therapy processes, characterized by high levels of commitment to the goals set and a strong relationship between speech-language therapists and their patients, based on effective communication.

Limitations

Several factors may have limited the scope of the results of this study, including the sample size, the number of stations, and the use of dichotomous checklists. Therefore, it is recommended to increase the number of participants and OSCE stations, as well as to include a control group to provide more certain evidence of the effectiveness of this methodology. Additionally, it is advisable to allocate more time at each station for simulation and feedback. Regarding the type of instrument, it is recommended to use evaluation scales or performance rubrics rather than dichotomous observation checklists, as they allow for a gradual analysis or an analysis by levels of achievement, and promote effective student feedback. In the same vein, it is pertinent to consider the use of standardized instruments for the Chilean population, such as the Communication Assessment Tool (CAT), which allows the SP to assess the student's communication skills (Armijo-Rivera et al., 2021). Finally, it is suggested to avoid theoretical stations with brief-response questions, such as the fourth station in this study, as they do not require the deployment of clinical skills that could be developed through the formative OSCE methodology.

CONCLUSIONS

Clinical simulation, in its formative OSCE version, significantly contributes to the development of essential competencies for conducting clinical interviews in speech-language therapy, particularly in the areas of anamnesis and communication. Furthermore, this methodology promotes an increase in the self-efficacy levels of students regarding their ability to conduct clinical interviews. Lastly, a high degree of satisfaction is observed regarding the use of the formative OSCE as a pedagogical strategy for teaching clinical interview skills.

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APPENDIX 1. Survey on Perception of the OSCE Methodology

To optimize methodological aspects in education, I am conducting a study with the primary objective of gathering your opinion on the experience of simulation with standardized patients through a formative Objective Structured Clinical Examination (OSCE). Therefore, I request your honest and objective participation. Your responses will be confidential. Please mark with an (x) the box that best represents your perception of clinical simulation.

	Strongly Disagree	Disagree	Agree	Strongly Agree
I. TEACHING AND LEARNING METHODOLOGY *The experience working with a simulated patient…*				
1. Allowed me to improve my understanding of the topics covered.	1	2	3	4
2. Allowed me to understand the relevance of the topics discussed.	1	2	3	4
3. Has helped me integrate theory with practice.	1	2	3	4
4. Is a useful learning method.	1	2	3	4
5. Is beneficial for professional training.	1	2	3	4
II. COMPETENCY-BASED PLANNING *The experience working with a simulated patient…*				
1. Is coherent with the purpose of the course.	1	2	3	4
2. Allowed me to improve my medical history skills.	1	2	3	4
3. Allowed me to improve my diagnostic hypothesis skills.	1	2	3	4
4. Allowed me to improve my communication skills.	1	2	3	4
III. PROCEDURE				
1. The procedure had a clear organization.	1	2	3	4
2. The assigned time was enough to carry out the proposed activities in each station.	1	2	3	4
3. Doubts were resolved promptly by the team.	1	2	3	4
4. The feedback provided facilitated learning.	1	2	3	4
5. The instructors and teaching assistants are proficient in the methodology.	1	2	3	4
IV. SATISFACTION				
1. The experience with the simulated patient was motivating.	1	2	3	4
2. I would like clinical simulation to be formally included in the syllabus of this course.	1	2	3	4
3. I would like to continue using clinical simulation to learn other content throughout the program.	1	2	3	4
4. The simulation has improved my clinical competencies.	1	2	3	4
5. The experience with clinical simulation has been satisfactory.	1	2	3	4
V. HUMAN AND MATERIAL RESOURCES				
1. The number of instructors and teaching assistants was enough to successfully carry out the activity.	1	2	3	4
2. The teaching assistants acted as facilitators of learning.	1	2	3	4
3. The spaces were adequate to achieve the objectives.	1	2	3	4
4. The furniture was suitable for the proposed activities.	1	2	3	4

Observations and/or additional comments

APPENDIX 2. Clinical Interview Self-Efficacy Scale.

Student Name	**:**	
Date	**:**	

Describe how you felt during the recent clinical interview activity. Use the following criteria.

Achieved	3 points
Partially Achieved	2 points
Not Achieved	1 points

	A	**P/A**	**N/A**
I. ANAMNESIS ***Regarding my performance as an interviewer, I feel that…***			
1. I was able to ask questions to understand the reason for the consultation.	3	2	1
2. I was able to gather identification data: name, age, occupation.	3	2	1
3. I was able to gather personal information: family, social, psychological.	3	2	1
4. I asked about relevant medical history: personal and family.	3	2	1
5. I was able to gather information about the onset and current status of the condition.	3	2	1
II. COMMUNICATIVE DIAGNOSTIC HYPOTHESIS ***Regarding my performance as an interviewer, I feel that…***			
1. I carried out an informal task to assess language and communication.	3	2	1
2. I provided a general diagnostic hypothesis to the patient.	3	2	1
3. I explained the diagnostic hypothesis to the patient during the anamnesis.	3	2	1
1. I guided the patient on potential therapeutic options.	3	2	1
III. COMMUNICATION ***Regarding my performance as an interviewer, I feel that…***			
1. I respected formal aspects: greeting, introduction, farewell.	3	2	1
2. I used vocabulary appropriate for the patient's age and educational level.	3	2	1
3. I expressed my ideas clearly and in an organized manner.	3	2	1
4. I was able to ask and respond promptly during the interaction.	3	2	1
5. I used non-verbal resources to create a respectful environment: eye contact, facial expressions, body posture, prosody, conversational turns.	3	2	1
6. I summarized the information provided to the patient.	3	2	1
7. I asked the patient if they had any questions.	3	2	1

Observations and/or additional comments

APPENDIX 3. Clinical Interview Observation Checklist.

Student Name	**:**	
Evaluator Name	**:**	
Date	**:**	

Describe the student's performance using the following criteria.

Achieved	3 points
Partially Achieved	2 points
Not Achieved	1 points

EFFECTIVE COMMUNICATION CRITERIA	**A**	**P/A**	**N/A**
I. ANAMNESIS			
1. They ask questions to understand the reason for the consultation.	3	2	1
2. They gather identification data: name, age, occupation.	3	2	1
3. They gather personal information: family, social, psychological.	3	2	1
4. They ask about relevant medical history: personal and family.	3	2	1
5. They gather information about the onset and current status of the condition.	3	2	1
II. SPEECH-LANGUAGE THERAPY DIAGNOSTIC HYPOTHESIS			
1. They carry out an informal task to assess language and communication.	3	2	1
2. They provide a general diagnostic hypothesis to the patient.	3	2	1
3. They explain the diagnostic hypothesis to the patient during the anamnesis.	3	2	1
4. They guide the patient on potential therapeutic options.	3	2	1
III. COMMUNICATION			
1. They respect formal aspects: greeting, introduction, farewell.	3	2	1
2. They use vocabulary appropriate for the patient's age and educational level.	3	2	1
3. They express their ideas clearly and in an organized manner.	3	2	1
4. They are able to ask and respond promptly during the interaction.	3	2	1
5. They use non-verbal resources to create a respectful environment: eye contact, facial expressions, body posture, prosody, conversational turns.	3	2	1
6. They summarize the information provided to the patient.	3	2	1
7. They ask the patient if they have any questions.	3	2	1

Observations and/or additional comments

APPENDIX 4. Anamnesis Observation Checklist (OSCE).

Student Name	**:**	
Evaluator Name	**:**	
Date	**:**	

MEDICAL HISTORY CRITERIA	YES	NO
BEGINNING OF THE INTERVIEW AND CONSULTATION REASON ***The student…***		
1. Greets the patient	**1**	**0**
2. Introduces themselves to the patient	**1**	**0**
3. Explains the session's objective to the patient	**1**	**0**
4. Asks the patient about their reason for consultation	**1**	**0**
IDENTIFICATION DATA		
1. The student asks the patient for their name	**1**	**0**
2. The student asks the patient for their age	**1**	**0**
3. The student asks the patient for their occupation	**1**	**0**
4. The student asks the patient for their education level	**1**	**0**
SOCIAL AND FAMILY BACKGROUND		
1. The student asks the patient about their family support network (family group)	**1**	**0**
2. The student asks the patient about their leisure activities	**1**	**0**
3. The student asks the patient about their previous emotional state	**1**	**0**
4. The student asks the patient about their previous personality traits	**1**	**0**
PERSONAL AND FAMILY MEDICAL HISTORY		
1. The student asks the patient about their linguistic-communication history	**1**	**0**
2. The student asks the patient about their family's linguistic-communication history	**1**	**0**
3. The student asks the patient about their personal medical history	**1**	**0**
4. The student asks the patient about their family medical history	**1**	**0**
DESCRIPTION OF THE CONDITION		
1. The student asks the patient about the start of their symptoms	**1**	**0**
2. The student asks the patient about the progression of their symptoms	**1**	**0**
3. The student asks the patient about the current state of their symptoms	**1**	**0**
4. The student asks the patient about previous therapy history	**1**	**0**
CLOSING OF THE INTERVIEW		
1. The student asks the patient about their recovery expectations	**1**	**0**
2. The student synthesizes the information gathered in the interview	**1**	**0**
3. The student asks the patient if they have doubts	**1**	**0**
4. The student says goodbye to the patient	**1**	**0**

Observations and/or additional comments

APPENDIX 5. Clinical Judgment Observation Checklist (OSCE).

Student Name	**:**	
Evaluator Name	**:**	
Date	**:**	

CLINICAL JUDGMENT CRITERIA	YES	NO
I. BEGINNING OF THE INTERVIEW AND CONTEXTUALIZATION ***The student…***		
1. Greets the patient	**1**	**0**
2. Introduces themselves to the patient again to contextualize the situation	**1**	**0**
3. Explains the objective of the session to the patient	**1**	**0**
4. Asks the patient about their current state, “How have you been?”	**1**	**0**
II. INFORMAL LANGUAGE AND COMMUNICATION ASSESSMENT		
1. The student asks the patient to name objects: at least 5.	**1**	**0**
2. The student asks the patient to describe item 1 from the Boston Naming Test.	**1**	**0**
3. The student asks the patient to follow instructions: at least 5.	**1**	**0**
4. The student asks for the repetition of stimuli: at least 5.	**1**	**0**
III. CLINICAL JUDGMENT: DIAGNOSIS AND REHABILITATION		
5. The student provides a general diagnostic hypothesis to the patient.	**1**	**0**
6. The student explains the diagnostic hypothesis to the patient.	**1**	**0**
7. The student provides guidance on therapeutic options to the patient.	**1**	**0**
8. The student refers the patient to other professionals if necessary.	**1**	**0**
IV. INTERVIEW CLOSING		
9. The student summarizes the information obtained during the session.	**1**	**0**
10. The student explains to the patient the realistic expectations for recovery.	**1**	**0**
11. The student asks the patient if they have any questions.	**1**	**0**
12. The student says goodbye to the patient.	**1**	**0**

Observations and/or additional comments

APPENDIX 6. Communication Observation Checklist (OSCE).

Student Name	**:**	
Evaluator Name	**:**	
Date	**:**	

EFFECTIVE COMMUNICATION CRITERIA	YES	NO
VERBAL ASPECTS OF EFFECTIVE COMMUNICATION ***The student…***		
1. Greets the patient.	**1**	**0**
2. Introduces themselves to the patient.	**1**	**0**
3. Explains the objective of the session to the patient.	**1**	**0**
4. Asks the patient for the reason for consultation.	**1**	**0**
5. Inquires about the evolution of the symptoms.	**1**	**0**
6. Formulates questions to clarify vague information.	**1**	**0**
7. Verbally facilitates the progression of topics.	**1**	**0**
8. Uses vocabulary appropriate to the patient's educational context.	**1**	**0**
9. Expresses ideas in an organized manner.	**1**	**0**
10. Respects conversation turns.	**1**	**0**
11. Provides the right amount of information required for the exchange.	**1**	**0**
12. Summarizes the information provided by the patient.	**1**	**0**
13. Emphasizes the most important elements of the summary.	**1**	**0**
14. Asks the patient if they have any questions.	**1**	**0**
15. Says goodbye to the patient.	**1**	**0**
NON-VERBAL ASPECTS OF EFFECTIVE COMMUNICATION ***The student…***		
16. Maintains eye contact with the patient.	**1**	**0**
17. Uses facial expressions to support verbal communication.	**1**	**0**
18. Uses hand movements to accompany verbal communication.	**1**	**0**
19. Adopts a body posture appropriate to the communicative situation.	**1**	**0**
20. Articulates words clearly and accurately.	**1**	**0**
21. Regulates vocal intensity according to the context (volume).	**1**	**0**
22. Uses melody and rhythm in speech (prosody).	**1**	**0**

Observations and/or additional comments