Supp. Submission No. 64.1
(Overseas Trained Doctors)
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Suggested features of a test of English competence for health professionals in Australia

1. The guiding principle for the language testing of health professionals should be the need for competent administration of health services to patients in Australia.

2. The only reason to have a special test for health professionals is to cover the unique vocabulary and idiomatic language used in each area of the health professions as different from general English usage. For doctors trained overseas there should be additional professional development points for further language studies beyond OET or IELTS.

3. Candidates should not be required to pass all sub-tests (Listening, Reading, Writing, Speaking) simultaneously. There is no evidence of any benefit deriving from the requirement for simultaneity. Results should be cumulative to allow candidates time to improve on areas of language weakness (the opportunity for acquisition of language skills is more important than testing).

4. IELTS 7.0 will become (in July 2011) the standard for immigration. Immigrating doctors who have satisfied the immigration requirements will presumably not be required to sit further language tests, but this would defeat the purpose of having a language test that recognises the special language needs of doctors. The benefits deriving from having a focussed English test should be recognised.

5. The results of each test should be published, including, at a minimum, the total number of candidates at each centre and the test results at each level and the rates for different cohorts –doctors, dentists, nurses, etc.

6. Any limitation to the validity period of an English Test should be related to the period it would take to complete the entire registration process. The validity period should not be used if applicants are hindered by non-availability of Medical Tests (for example, MCQ, Clinical). There may be valid reasons for applying a limited validity period to language test results obtained outside Australia, but there is no evidence of much deterioration of language skills in people who are living and working in Australia. Any skill that is not used can become blunted, and this applies equally to Australian-educated people. Nothing is achieved by adding further obstacles that in most cases are caused by delays in the system or excessive waiting times.

7. Any occupational English test should be oversighted by a government agency or at least supervised by a government agency if placed hands of a private organisation. Administration of tests must not be allowed to be in the hands of untrained persons. Language testing cannot be completely objective, so there has to be flexibility, which demands highly-trained assessors. Assessors should be pre-tested for a basic understanding of medical and health issues and to assure accuracy in marking.

8. The profession should have input into the content and requirements of an occupational English test and also to the regulating authority that sets the requirements. This should be in collaboration with a group of language testing experts (and could include Prof. Tim McNamara, originator of the OET Test), the Language Test and Resource Centre at the University of Melbourne (currently involved in parts of the OET), and experienced language assessors familiar with English for Special Purposes.

Doone Lamb and David Lamb – April 2011

Suggested specific requirements for English sub-tests

The tests of Listening, Reading, Writing and Speaking need to be:

- realistic
- practical
- patient-needs centred
- cognisant of current technology
- sensitive to our multi-cultural society

Listening

T he listening subtest could comprise a recording of an interview between a health professional and a patient, and a reading, in lecture form, on a health-related topic. Short listening tests that could include consultation extracts between a doctor and an NESB (non-English-speaking background) patient. There needs to be coverage of a range of patient ages and situations, such as teenagers (for example, about sex matters), doctors advising about drug use, or the problems of elderly citizens. The test should include the use of numbers, proportions and relativities such as used in dosages or statistics.

Reading

The reading subtest could comprise, firstly, a set of questions or a 'cloze' test (fill-the-gap) that tests word form, grammatical construction, and vocabulary relevant to the health profession and to conversations with patients. The second part should be a text that includes conversational language, some academic language appropriate to the medical profession, and the use of numbers, probabilities and graphs. A computer test could include texts from a patient history, current medical guidelines, planned tests, treatments or medications and a set of questions that tests understanding of the written material.

Writing

The writing subtest could recognise the realities of modern non-verbal communication, but should also test the candidate's ability to construct a formal text on a given health related topic using appropriate vocabulary and correct grammatical form. Part of the writing test could be computer-based and could include, for example, short messages to colleagues, safety instructions, notices to cover special situations or similar, every day short texts and SMS messages, or notes for patient files.

Speaking

The speaking subtest could comprise two role-plays.
1. A doctor-patient (or member of patient's family), and,
2. A doctor-colleague conversation (another doctor, nurse, physiotherapist etc).

These would allow an emphasis on register, the ability to use language at different levels and appropriate to the situation. The speaking test could include leaving a telephone message. Interlocutors must be well trained and competent.
Assessment for speaking should be performed by one English assessor and one Health Professional and/or a person who is representative of patients.

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