

THE IMPACT OF LANGUAGE TESTING ON THE REGISTRATION OF IMMIGRANT DOCTORS

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Before non-English-speaking background doctors holding overseas qualifications can begin the medical and clinical examinations required to practise in Australia they must first pass an English language test. This has proved to be a severe hurdle for some language groups, in many cases delaying their progress and, in others, preventing significant numbers from proceeding to the medical and clinical examinations.

INTRODUCTION

In the debate over the admission of overseas trained doctors (OTDs) to Australian medical practice, a notable omission to date has been consideration of the part played by assessment of candidates' English language ability. Such an omission is strange, for with few exceptions a pass in the Occupational English Test (OET) is a mandatory requirement for overseas trained doctors qualified in non-English speaking background (NESB) countries an essential pre-requisite to their admission to the two gatekeeping tests of medical knowledge administered by the Australian Medical Council (AMC): the Multiple Choice Question (MCQ) and the Clinical examinations.

Assessment of English language ability has in fact exerted a major regulatory influence within Australia for decades not merely directly through the stalling or culling of candidates seeking an OET pass, but also indirectly, given the potential of inadequate English skills to affect MCQ and Clinical examination outcomes.[1] Within the contemporary period, moreover, English as a Second Language (ESL) assessment is becoming more rather than less significant, not only because of mounting political debate over OTDs' access to registration,[2] but because of the unprecedented number of migrant doctors now reaching Australia from NESB source countries.[3] While medical arrivals prior to 1981 were dominated by the UK and former Commonwealth countries characterised by strong exposure to English, by 1986-91 incoming doctors were drawn from an increasing range of NESB source countries, with China (after the UK) the second most prominent.[4] Reflecting this trend, by 1991-1995, the 10 most common countries of origin for OET medical candidates were (in order), India, China, the former USSR, Egypt, the Philippines, Sri Lanka, former Yugoslavia, Iraq, Hong Kong, and Bangladesh. The requirement to pass the Occupational English Test, for many such doctors, would represent a formidable barrier. In the present article we map the evolution of English language testing in relation to migrant doctors over the past 20 years, and analyse OET results from 1991 to 1995. Such an analysis has never previously been undertaken.

THE EVOLUTION OF LANGUAGE TESTING IN RELATION TO MIGRANT DOCTORS

The medical profession pioneered vocational English language testing in Australia, in somewhat notorious circumstances. As described in a previous article,[5] a benchmark study of medical protectionism in 1975 indicted the Australian Medical Association for its long-standing and implacable opposition to the entry of post-war East European medical refugees including its orchestration of a scare campaign designed to denigrate their professional worth.[6] A major basis of this exclusion was the application of a vocational English language test one lacking both formal validation and face validity, and primarily designed (according to a number of prominent academics) to keep the wog doctors out'. Devised by a professor from the faculty of medicine at the University of Melbourne, this test demanded analysis of passages of purple prose or nineteenth century literary criticism' and had an outrageously low pass rate. Sealed off from external scrutiny, it persisted until the early 1980s despite vigorous protests from OTDs effectively blocking the vast majority from registration, since it stood as the gatekeeper to the subsequent testing of medical knowledge.

By the early 1980s minor improvements had flowed from the involvement of the Council on Overseas Professional Qualifications (COPQ). However, there remained a persistent failure to recognise three critical things: that vocational English language testing is a complex and specialist task; that such testing must be based on proper research and validation; and that processes such as these require the allocation of adequate resourcing and time. According to Tim McNamara, now Associate-Professor in the Department of Linguistics and Applied Linguistics at the University of Melbourne, though the committee appointed by COPQ contained several eminent people,

(The two applied linguists) were not given a chance to do any proper test development... What happened was that they were flown to Canberra, and in an afternoon they were asked to construct a test... They were very frustrated about this... In the end they basically went on strike just dissolved themselves!)

Challenged to recognise the gravity of the situation, COPQ commissioned a group of experts in English for Specific Purposes (ESP) testing at the University of Lancaster in England to prepare a detailed report on procedures for conducting vocational ESL assessment of overseas qualified health professionals in Australia, including the principles on which such a test should ideally be based. Completed in 1986, this report recommended the preparation of an entirely new and appropriately validated test - one placing its prime emphasis on assessment of candidates' potential communicative competence within the Australian medical workplace. This represented a radical departure from previous practice. The resulting Occupational English Test was designed to test candidates' speaking, listening, reading and writing skills in linguistic contexts simulating the professional context.

To this end McNamara (the test designer) gathered data on the most frequent and complex communicative tasks encountered by NESB doctors surveying up to 40 who had passed the

previous English test, and were now enrolled in medical bridging courses. A key finding was the importance of communication within the doctor/patient consultation which formed the basis of Australian medical practice. Such consultations typically contained a range of communicative tasks eliciting information about symptoms, explaining illness, reassuring and counselling the patient data confirmed as standard through detailed analysis of the international literature, and systematic observation in clinical settings. On the basis of this research, McNamara made doctor/patient roleplays the central speaking task for the test, with speech samples assessed by expert raters for overall communicative competence against criteria such as fluency, breadth of vocabulary, clarity of speech and grammatical structures, with formal accuracy incorporated as only one of many relevant assessment criteria. On the basis of further research with Australian health professionals supervising NESB candidates in the field, McNamara inserted within each roleplay a communicative problem', reflecting the fact that in real life patients can be difficult and that unexpected complications can incapacitate NESB candidates dependent on ritualised medical interviews.

Four language tests in all had to be passed. The OET included occupation-specific test versions for each of the productive' language skills of speaking and writing in order to ensure face validity. By contrast, generic test versions were developed for the more passive' language skills of reading and listening based on tasks such as comprehension of a written medical text or understanding of a taped discussion relating to broader health issues. The pass level required for the OET was set at an advanced level of English (Australian Second Language Proficiency Rating 3) rather than the near native-speaker level of ASLPR 4 advocated by the medical profession. McNamara justified this on the grounds that the test was devised to assess candidates' readiness to proceed to the MCQ test, rather than directly into medical employment. Following a pass in the OET, the majority would confront a minimum of several more years of study and hospital based practice, during which English would inevitably be refined. When some senior AMC personnel voiced concern several years later that candidates with inadequate levels of English were still getting through, McNamara, together with several University of Melbourne colleagues, conducted a research project in which AMC examiners and experienced OET raters assessed a common group of candidates on the speaking tasks, only to find the medical professionals made marginally more lenient judgments. Concern on this issue partly died down.[7]

The Occupational English Test has now been used in Australia and at overseas posts for a period of more than eight years, almost completely unchallenged by the medical profession. Administered in turn by COPQ, the National Office on Overseas Skills Recognition (NOOSR), and the National Languages and Literacy Institute of Australia (NLLIA) (since 1991), it is highly regarded and considered an exemplar for ESP tests.[8] In terms of administration, the OET tests candidates from 11 health occupations twice a year. Roughly two thirds of candidates sit the test in Australia in capital cities or larger regional centres (on demand), having already entered the country through the Preferential Family or Humanitarian immigration categories. The test is also available in 38 to 42 countries overseas, where candidates sit at locations as diverse as Saigon, Dacca, Bonn and Islamabad after first demonstrating they possess a permanent Australian visa, or a number indicating that they are

currently being assessed as part of the migration process. The OET is primarily funded by candidates' fees (now \$275 in Australia, \$320 off-shore). To prepare for the test, the NLLIA provides candidates with detailed guide-lines, an information booklet and practice tapes. Within Australia current regulations allow candidates to attempt the test multiple times, paying \$40 to re-sit each failed section. However, since early 1995, overseas candidates have been required by the Department of Immigration and Multicultural Affairs to lodge a new migration application if they wish to re-sit one or more sections of the test within a period of less than twelve months. If twelve months or more have elapsed, candidates must re-sit the entire test (all four sections). This represents a critical problem for overseas candidates, as it necessitates recommencing the whole immigration process, including the payment of considerable application fees.

OET RESULTS FOR MIGRANT DOCTORS, 1991-1995

For this article, OET data from Australian and overseas test administrations were analysed for medicine candidates from 1991 to the end of 1995. In this context, a pass refers to candidates who gained an overall pass in the OET before the end of 1995, that is, they had passed all four sections of the OET, although not necessarily at one sitting.

In order to give an indication of the number and composition of potential OET medicine candidates, it is useful to look briefly at the number of doctors migrating to Australia in recent years. [Table 1](#) includes both general practitioners and medical specialists arriving as permanent migrants in the five years from 1989-90. Of the 2,469 doctors migrating to Australia, 30 per cent were born in English speaking countries. These doctors would have generally been exempt from sitting the OET, and those from New Zealand would also have gained automatic medical registration. Of the 70 per cent born in NESB countries, some would undoubtedly have received OET exemptions where their medical qualifications had been gained in an approved English speaking country. This situation would typically arise with doctors born in Commonwealth countries including those from India, Malaysia and Hong Kong who had studied in the UK. This means that 1,718 represents an upper limit of doctors migrating to Australia during this five year period who would be required to sit the OET. The exception here is doctors from China. Analysis of Census data indicates that 857 Chinese doctors were present in Australia in 1991 who had arrived over the years 1986-91, mostly as temporary English language students. They are not included in Table 1.

[\[Table 1\]](#)

The data on OET candidates show that, between 1991 and 1995, 2,079 overseas trained doctors sat the OET at least once. (See [Table 2](#).) Of these, 1,640 attempted it in Australia and 439 at various Australian overseas posts. On the assumption that many NESB doctors arriving in Australia attempt the OET reasonably soon after arrival (within a year or two), the narrow margin between the number of OET candidates in Australia (1,640) and the number of NESB doctors entering the country (1,710) over this five year period may suggest that most of those needing to pass the OET for registration purposes are in fact attempting to do so.

[\[Table 2\]](#)

Again, the Chinese are the exceptions since most of the 1986-91 arrivals have only recently gained permanent residence status. Prior to this they were not eligible for English language training courses, including enrolment in intensive OET preparation programs.[9] There is also evidence from the 1991 Census which suggests that some hundreds of other recently-arrived NESB doctors have delayed entry to the OET process for more than two years. The 1991 Census data showed that over 2,000 doctors who arrived between 1986 and 1991 were not practising by 1991. Aside from the Chinese, none of the 28 Vietnamese doctors, only 11 per cent of the Poles, and 12 per cent of the Filipinos were employed as professional doctors.[10]

So does the OET delay or prevent OTDs from reaching the real medical registration hurdles the MCQ and clinical examinations? For a significant proportion, the answer is yes. In terms of overall pass rates, 78.3 per cent of 1991-95 medicine candidates had passed the OET by the end of 1995. Over half had sat the OET only once and passed it. However, the remaining 42.6 per cent had either sat the OET more than once, or they had failed and not attempted it again by the end of 1995. Interestingly, overseas candidates were less likely to re-sit the OET than Australian candidates. This may be due to the high local cost of sitting the OET in many countries and the infrequency of local test administrations a trend likely to be confirmed from 1995 by the requirement for those failing the test to recommence the whole migration process. Even in Australia, very few persisted with more than two attempts, although the highest number was seven by one extremely stubborn candidate who eventually gained a pass.

Test location in Australia or overseas is highly significant in determining the OET's effects and outcomes. As shown in [Table 3](#), candidates sitting the OET in Australia had significantly higher pass rates than those sitting it at overseas posts. Candidates in Australia presumably have had greater opportunity to learn English through casual contact and through formal English training, including participation in bridging programs and special OET preparation classes. Only 19 per cent of OET candidates in Australia had not passed by the end of 1995. Most of these candidates will presumably sit the failed sections again and many will eventually pass. The OET's power of exclusion or delay in the registration process therefore seems to be operating more strongly at overseas posts, prior to entry to Australia. This will be less of an issue in future since the 25 point penalty imposed since mid 1995 on doctors seeking Independent or Concessional selection will limit the numbers taking the OET overseas.

[\[Table 3\]](#)

So who exactly is sitting the OET and who is passing it?

Two variables are available from the OET data to assist in identifying where OET candidates originate from country of training and first language. Unfortunately, country of training was not available for nearly a quarter of the candidates. However, results by country of training

appear to correspond reasonably well to the more reliable indicator of first language. More than 90 different languages were listed by OET candidates. The ten most common are shown in [Table 4](#).

[\[Table 4.\]](#)

The largest language group were the Indian subcontinent languages, including Hindi, Singhalese, Tamil and Bengali. As a whole, this group had a higher than average pass rate and a lower than average number of attempts, even though they were less likely to already be in Australia. Speakers of Hindi, Tamil and Punjabi were however much more likely to pass than those speaking Urdu or Bengali, no doubt reflecting the less widespread use of English in Pakistan and Bangladesh compared to India and Sri Lanka. Chinese speakers were the second most common group of candidates, but had a relatively low pass rate. Again, there were significant differences within the overall group, most notably between Cantonese speakers (74 per cent pass rate) and Mandarin speakers (45 per cent pass rate). This disparity reflects the huge English skills gap between candidates trained in China (59 per cent of whom passed despite almost all being resident in Australia) and candidates trained in Hong Kong (85 per cent of whom passed, though two-thirds were overseas). Vietnamese speakers showed a similar pattern to Mandarin speakers, with only a 64 per cent pass rate even though over 90 per cent were already in Australia. These results imply some delays in the movement of the large numbers of Chinese doctors recently granted permanent residence status through the accreditation process.

The great majority of the Chinese are likely to take up their English language and bridging course entitlements to the full preparing to take the OET before proceeding to the next stage of the pre-registration process. This hypothesis is confirmed by current Australian Medical Council data, which shows 69 new Chinese candidates registered for the October 1996 MCQ test, in addition to just 12 repeat candidates from the previous administration.[11]

The Middle East was the third area to be strongly represented in the OET, with 15.2 per cent of all candidates giving Arabic as their first language, and another 3.7 per cent listing other common Middle Eastern languages, including Turkish, Kurdish and Persian. Arabic speakers had a relatively high pass rate but were more likely than average to have sat the OET more than once. Speakers of other Middle Eastern languages had a much lower overall pass rate and a higher average number of attempts. Like the Chinese and Vietnamese speakers, only a quarter to a third of candidates speaking Arabic or other Middle Eastern languages were women. One of the more interesting findings in this analysis was the large number of candidates claiming English as their first language 8.9 per cent overall. These candidates had trained in a range of mostly Commonwealth countries, including Papua New Guinea, Fiji, Singapore, India and even the UK. It is unclear why some were required to sit the OET, but interestingly, 11 per cent had not passed by the end of 1995. Sixty-nine per cent of this group were already inside Australia.

An examination of data on gender shows that just under half of the OET candidates (44.7 per cent) were female. Female candidates had a significantly higher pass rate than males, and a

slightly lower average number of attempts. (See [Table 5](#).) This explanation appears to be that more of the female candidates were already in Australia when they sat the OET and were therefore more able to take advantage of a broader exposure to English and formal English language training. Also, women were far less likely to have trained China, Vietnam or Middle Eastern countries, which (as noted above) generally had low pass rates. They came instead from India, Eastern Europe or ex-USSR countries, which show relatively high pass rates.

[\[Table 5\]](#)

CONCLUSION

The OET results for 1991 to 1995 indicate that mandatory English language testing prevents or significantly delays 42.6 per cent of NESB OTDs from proceeding to the second stage of the pre-registration process, the MCQ examination. Though the overall failure rate of 22 per cent is less acute than the 53 per cent experienced by NESB nurses,[12] this outcome is significant for a number of reasons.

Firstly, substantial numbers of OTDs find they are obliged to devote a considerable length of time during the initial settlement period to studying English not merely general English to an advanced level, but also specialist English for health professionals, such as offered in courses pioneered by the Moorabbin and Footscray TAFE colleges (in Melbourne) and the Universities of NSW and Sydney (in Sydney).

Secondly, although just over half the OTD candidates passed all four sections of the OET at a single sitting, the rest were further delayed by the need to wait six months at a time for the opportunity to re-sit failed sections a long and frustrating process, particularly for older candidates. Such timelags may be extreme for certain country of origin groups who are particularly disadvantaged in relation to English.

Thirdly, as a consequence of the above, substantial numbers of OTDs appear to become demoralised about their prospects of gaining registration (if in Australia), or drop entirely out of the skilled migration application process (if at an overseas post). It is possible that many OTDs may not sit at all. This hypothesis is supported by the data reported above which show that hundreds of migrant doctors who arrived between 1986 and 1991 (other than the Chinese) do not appear to have shown up in the OET candidate figures.

The profound importance of English has recently been confirmed by the Australian Medical Council, which from July 1997 will integrate a further assessment of communicative competence in its Clinical examination, this time handled by the medical profession.[13] The justification for this new barrier is concern over the possible use-by' date of the OET that some candidates' ESL skills will have declined long before they reach the end stage of the pre-registration process. Accordingly, candidates will be assessed by a bank of 16 examiners for appropriate language, non-verbal, verbal, interpersonal' skills, while examining patients across a range of clinical settings. Inevitably this process will see more contenders delayed,

and more knocked out should they fail to pass within the statutory three year period. Professional registration will remain a tough path for NESB doctors to follow one bracketed at the start and the finish by a rigorous testing of English.

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12. A more detailed analysis of OET data in relation to migrant nurses and doctors will be

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Back to [Back to Contents Vol. 4 No. 3](#)

Back to [People and Place Home Page](#)