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4. Achieving English proficiency for professional registration: The experience of overseas-qualified health professionals in the New Zealand context

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This study explores the experience of a group of overseas-trained health professionals in seeking to meet the English language requirements for registration.

ABSTRACT

This study explored the experience of a group of overseas-trained health professionals in seeking to meet the English language requirements for registration in New Zealand by enrolling in a specialised course at a university in Auckland. A major focus of the course was preparation for both IELTS and the Occupational English Test (OET), the latter being an ESP test developed in Australia for the assessment of health personnel. The study investigated factors influencing participants' choice of pathway to re-registration, as well as their study and test-taking strategies and test performance. It was based on interviews undertaken with 13 doctors, nurses and pharmacists who attended the course, supported by data from a journal kept by the course tutor, lesson observations, and an analysis of in-house and external assessment scores from a total of 20 students.

Findings revealed that participants initially tended to favour the OET on the grounds of its familiar content; however, in many instances, this perception changed after actual experience of the two tests and the realisation that neither is, in any real sense, a test of their ability to communicative effectively in clinical contexts. Over the course of the study, many participants came to see the advantages of IELTS, which included lower fees and the availability of preparatory courses and practice materials.

Factors affecting the likelihood of success in either test included entry-level proficiency, attitude to the tests, and participants' degree of acceptance of the rationale for the advanced level of English proficiency required by professional bodies. Also influential were their strategies for self-study and test-taking, personal attributes such as perseverance, confidence and the ability to self-assess realistically, the amount of financial and family support available to them, and the strength of their commitment to settling permanently in Australasia.

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Glossary of abbreviations

AMC	Australian Medical Council
AUT	Auckland University of Technology/AUT University
EHP	English for Health Professionals course at AUT, 2007
NZMC	New Zealand Medical Council
NZREX	New Zealand Registration Exam
OET	Occupational English Test
OTD	overseas trained doctors
UNHCR	United Nations High Commissioner for Refugees
USMLE	United States Medical Licensing Examination

1. INTRODUCTION

Since the 1990s, numerous professional registration bodies in New Zealand have adopted English language requirements for overseas-trained medical personnel seeking registration in this country. There is usually more than one way in which applicants can demonstrate their proficiency in the language, either through an acceptable score in a recognised English test or some form of exemption on the basis of previous English-medium education or professional experience in an English-speaking environment. However, increasingly, the dominant way in which the minimum standard of English proficiency is defined is in terms of an IELTS score. The standard requirement for several registration agencies, such as the Medical, Dental and Pharmacy Councils, is an overall score of at least 7.5 in the Academic module, with no individual band score of less than 7.0.

There are various reasons why IELTS has emerged as the primary test for this purpose.

- IELTS is well established in New Zealand as the preferred measure of English competence for international students applying for admission to tertiary institutions, and for immigration applicants in the skilled and business migrant categories.
- As a result of its use for education and immigration purposes, IELTS preparation courses are routinely offered by language schools throughout the country (see Read and Hayes, 2003), and IELTS band scores have become a *de facto* common currency among ESOL professionals for describing students' English levels (Read and Hirsh, 2004).
- In addition, IELTS is available at test centres worldwide, administered under standard and increasingly secure conditions.
- Unlike its major international competitor, TOEFL, IELTS has always included an assessment of all four macro skills, including a face-to-face interview for speaking.

On the other hand, there are ways in which IELTS is not entirely suitable for assessing the English proficiency of qualified professionals.

- It is still primarily designed as a test for those undertaking academic study or training programs and is not specifically intended to assess the communication skills required in particular professions.
- As far as we are aware, there has been no large-scale study to validate the use of IELTS scores for professional registration purposes.
- In the band score range of 7 and above, which is typically targeted by professional registration requirements, IELTS provides a somewhat less reliable measure of proficiency – at least in Listening and Reading – than in Bands 4-7.
- IELTS is often seen as unfair by overseas-trained professionals, not only because of its lack of specific-purpose content, but also because of provisions such as 1) the need to wait three months before repeating the test (a rule that has been relaxed only recently) and 2) the need to repeat the whole test each time rather than only previously failed modules.

In Australia and New Zealand, an alternative measure designed specifically for the health professions is the Occupational English Test (OET). In its present form, the OET was developed in 1988–89 by Tim McNamara under contract to the Australian Government (McNamara, 1996) to assess the English proficiency of overseas-trained health professionals as a first step towards provisional registration to practise in Australia. Although most of the candidates are doctors, dentists and nurses, there are versions of the test for nine other professions as well: dietetics, occupational therapy, optometry, pharmacy, physiotherapy, podiatry, radiography, speech pathology and veterinary medicine. The OET

testing program is currently managed by the Centre for Adult Education in Melbourne, in conjunction with the Language Testing Research Centre at the University of Melbourne. In 2007 the test was administered on four dates at 40 locations worldwide, including Auckland, Palmerston North and Christchurch in New Zealand.

The OET is a specific-purpose language test (Douglas, 2000), in the sense that the test tasks were designed on the basis of an analysis of language communication needs in the medical workplace and the test content draws on a variety of health-related topics. As in IELTS, there are separate tests for the four skills. The Listening and Reading sections, which are common across all 12 professions, require comprehension of oral and written texts on health topics, including a recording of a simulated consultation between a health professional and a patient in the case of the Listening test. In the Writing section, candidates write a response to case notes, usually in the form of a referral letter, whereas the Speaking section involves two role plays with an interviewer, who plays the part of a patient. The input material for these latter two sections of the test is specific to each discipline. Further details of the OET testing program can be found at www.occupationalenglishtest.org.

In the New Zealand context, the OET is accepted by the Dental, Nursing, Pharmacy and Veterinary Councils (among others) as an alternative means of satisfying their English language requirement for overseas-qualified professionals. The test used to be recognised by the Medical Council for international medical graduates as well, but the Council has changed its policy in favour of accepting only IELTS. Nevertheless, taking the OET is still an option for overseas doctors resident in New Zealand who are considering an application for registration in Australia rather than in this country.

Thus, the present study was motivated by our interest in exploring the relative merits of IELTS and OET as instruments for assessing the English proficiency of health professionals. We chose to undertake the investigation by working with a group of immigrants taking a specialised English language course designed to address their needs at a tertiary institution in Auckland. One of our original goals – to make a direct quantitative comparison of performance on the two tests – proved not to be feasible for reasons to be discussed later, but we achieved our other objectives of developing rich profiles of this representative group of candidates for the tests from the health professions and exploring language assessment issues within the broader context of the efforts by these people to adjust to their new lives in New Zealand.

2. LITERATURE REVIEW

There is a small but growing number of published works on the language needs of health professionals from non-English-speaking backgrounds who migrate to one of the main English-speaking countries with the intention of practising there. A significant theme in the literature is the mismatch between the perceptions of medical professionals and language specialists as to the nature of communication in the health professions. For instance, in their review of the research on doctor-patient communication, Ong et al (1995) covered a whole range of behaviours that doctors exhibit as they interact with their patients in clinical settings, including the ability to create a good interpersonal relationship, to facilitate a meaningful exchange of information and to engage in joint decision-making with patients about treatment. The centrality of doctor-patient communication to effective clinical practice is now generally acknowledged (Silverman, Kurtz and Draper, 2005), as is the need to build skills that promote a collaborative partnership between medical professional and patient (a *patient-centred* or *relationship-centred approach*). The specific communication skills that constitute patient-centred management are presented in summary form in the authoritative Calgary-Cambridge framework (Kurtz, Silverman, Benson and Draper, 2003), a variation of which was used by the medical communication specialist to assess the role play performances of participants in the present study. The criteria that comprise this framework cover the medical professional's ability to establish initial

rapport, identify reasons for the consultation, explore the presenting problem(s), provide structure to the consultation, use appropriate non-verbal behaviour, develop rapport, provide the correct amount and type of information, achieve a shared understanding that incorporates the patient's perspective, share decision-making and close the session appropriately.

Although, obviously this communication involves the use of language, it is a much broader conception of communicative competence than the linguistically-oriented one that applied linguists and language teachers are familiar with. The theme is taken up in an assessment context by Jacoby and McNamara (1999), who point out that in Australia, the registration of overseas-trained health professionals is set up as a two-stage process, whereby their English language proficiency is first assessed by means of the Occupational English Test and then their professional communication skills are evaluated quite separately as part of the assessment of their clinical competence. This raises questions about the validity of the rating criteria for the OET tasks, and indeed whether the tasks themselves elicit the range of behaviours that will allow good judgments to be made about the ability of the candidates to communicate effectively in an English-medium medical workplace. Jacoby and McNamara argue that more research is needed into the "indigenous" assessment criteria employed by professionals to better inform the design of specific-purpose language tests in the health sciences and other professional fields. One implication is that, despite the fact that the OET incorporates simulated performance tasks with a medical focus, it may not be any more valid than a general proficiency test like IELTS in assessing the communication skills of health professionals.

This issue is at least implicit in a number of studies which have investigated the use of English language tests in medical contexts. In Australia, Chur Hansen et al (1997) studied how the language competence of undergraduate medical students related to their ability to conduct a simulated consultation in a clinical setting. Although students from a non-English-speaking background were significantly more likely to achieve an unsatisfactory result in the language screening test the researchers used, language background was not so strongly related to performance in the clinical interview. The key indicator of the ability to perform well in the interview was fluency of speech, which was not directly assessed by the screening measure.

The importance of oral proficiency was confirmed in a larger US study conducted by the Educational Commission for Foreign Medical Graduates (ECFMG) (Boulet et al, 2001). The ECFMG uses standardised patients (lay people trained to represent patients with common clinical conditions) not only as interlocutors but also as raters in the Clinical Skills Assessment (CSA) for foreign doctors. The CSA ratings for spoken English correlated much better with the interpersonal skills ratings than with other components of the clinical assessment. In addition, the CSA doctor-patient communication ratings correlated moderately (r= .69) with the overall score in TOEFL. This could be interpreted both as evidence of the validity of the spoken English ratings by the standardised patients and also an indication that TOEFL could be an acceptable screening measure for foreign doctors, despite the fact that at the time of the study it did not include a speaking section.

However, a small study at a US university by Eggly, Musial and Smulowitz (1999) revealed some limitations of general English proficiency tests in the assessment of medical communication skills. The researchers administered the Test of English for International Communication (TOEIC) and the Speaking Proficiency in English Assessment Kit (SPEAK) to 20 international medical graduates, as well as obtaining various measures of their performance in clinical settings. Although these graduates all achieved high scores on the English tests, there were strong indications from ratings by both colleagues and patients that many of them had significant language weaknesses in their work as medical residents.

Despite such concerns, as noted in the introduction to this report, IELTS has been widely adopted as a measure of English proficiency for health professionals, which raises the question of how the required scores on the Test should be determined. There are established procedures in the field of educational measurement to set standards of performance on a proficiency test by pooling the judgements of carefully selected and trained experts in the relevant field. A recent application of the standards-setting methodology involving the use of IELTS in the health sector can be found in the study by O'Neill et al (2007) to determine the minimum passing scores for internationally educated nurses in the US. Based on the recommendations of the expert panel, the Examination Committee of the National Council of State Boards of Nursing set an overall band score of 6.5, with a minimum of 6.0 in each module. It is worth noting that this is a little lower than the standard set by the Nursing Council and other registration bodies in New Zealand.

In addition to the research involving testing and assessment, there are some published accounts of ESP courses which have been developed to meet the oral communication needs of health professionals from non-English-speaking backgrounds in the United States. An early example is Graham and Beardsley's (1986) description of a course for a small group of pharmacy students at the University of Maryland. The course was based on a number of key speech functions such as asking for information, reassuring, requesting and directing, which were illustrated by means of videotapes and live demonstrations and then practised in role plays. More recently, Hoekje (2007) gave an account of the ESP courses developed at Drexel University for international medical graduates. Hoekje emphasises that the linguistic and cultural complexity of medical discourse in contemporary American society creates a range of challenges for doctors from other countries, even when their general English proficiency is quite advanced. One specific source of misunderstanding (also highlighted by Graham and Beardsley) is the use of lay terms and especially slang expressions by patients to refer to symptoms and medical conditions. Hoekje argues that there is a significant role for ESP teachers in dealing with such language concerns, while acknowledging that broader cultural issues are involved in medical communication.

In the New Zealand context, Hawken (2005) reported on the evaluation by overseas-trained doctors of a training program they participated in to prepare them for registration and practice in this country. The professional development phase of the program included work on medical language and, although they were not asked specifically to comment on the language component, the respondents recorded a significant increase in their level of comfort in communicating with New Zealand patients, once they moved to a clinical attachment. In the context of the same Overseas Doctors Training Program, Wette and Basturkmen (2006) analysed the feedback that the doctors received from the preceptors (medical instructors) on their performance in role plays. The results showed that the preceptors either ignored many language errors and difficulties or referred to them only in a general way that was not helpful for the doctors in knowing how to improve their language use. The authors argue that there is a role for language teaching specialists in identifying key structures and vocabulary, as well as common formulaic expressions which are the linguistic realisations of the medical communication skills that the overseas doctors are expected to demonstrate.

Another local program that addresses this issue to some extent was developed at Unitec Institute of Technology for nursing students with English as an additional language (Malthus, Holmes, and Major, 2005). The course materials were based on a discourse analysis by Victoria University of Wellington researchers of authentic nurse-patient interactions recorded in a hospital ward. The researchers emphasised the amount of social talk that the nurses engaged in to develop rapport and empathy with their patients. The students had the opportunity to view sample recordings as the basis for discussion of such speech functions as expressing politeness, mitigating directives and dealing with complaints.

The English course for health professionals that is the focus of the present study was similar to these others in that it sought to develop the language resources needed by the class members to engage effectively in medical communication in the New Zealand environment. However, it also had a strong emphasis on preparation for the Occupational English Test (OET). Thus, it was an appropriate context for us to investigate our research questions.

1. How do health professionals seeking re-registration in an English-speaking country view IELTS and the OET as measures of their English language proficiency?

2. What factors affect the choice of a particular pathway (IELTS or OET) to meeting the English proficiency requirement for professional re-registration in New Zealand?

3. What factors influenced both the English language development and test performance of a group of health professionals in an *English for Health Professionals* course?

3. THE STUDY

3.1 Setting

The research was conducted at Auckland University of Technology (AUT) in New Zealand. The School of Languages at AUT has been a leading provider of ESOL courses for migrants and refugees in the Auckland region for many years, and courses for health professionals are well established and resourced. Data for this study were collected from the course leading to the *Certificate in English for Health Professionals*, which ran from May to September 2007. It was a part-time course of 120 hours over 15 weeks. Instruction took place during two four-hour sessions per week, both of which were taught by the collaborating tutor on the project.

A number of funded places on the course were available for those who met the criteria for a Tertiary Education Commission (TEC) study grant. An overseas medical qualification and an advanced level of English were listed as pre-requisites for entry to the course. Twenty-three students were enrolled in the course in 2007 – 10 doctors, 10 nurses and three pharmacists. Most originated from Asian and Middle Eastern countries.

The course outline listed the specific oral interaction, listening, reading and writing skills needed by overseas trained medical professionals to enter the New Zealand medical workforce. These included understanding lay medical terminology, managing a health care consultation, reading and extracting information from relevant texts, taking notes from oral and written texts, writing letters of referral, using appropriate vocabulary and grammatical forms, and pronunciation skills. According to this information, the main aim of the course was to assist students to prepare for the OET, with IELTS preparation strategies also being offered.

Course attendance, while initially good, declined as the course progressed. Six students left during the course: four to take up full-time jobs; one because she obtained the required band 7.5 average on IELTS; and one for health reasons. Others began to attend less regularly due to work commitments, ill health or family responsibilities. Some students on the course were the sole earners in their families, and were therefore prepared to take up any reasonable job offer.

3.2 Design

The general aim of the project was to investigate how the IELTS Test functioned as an English language proficiency measure for professional registration purposes in New Zealand compared with other measures (the OET, internal course test scores and achievement-based assessments). More specifically, it aimed to explore professional and personal factors influencing the language development and communicative performance of immigrant health professionals in New Zealand. The study had a quantitative element, represented by in-house test scores and other measures of English proficiency. This was complemented by various forms of qualitative evidence to provide a rich description of the participants' backgrounds, current communicative ability, their efforts to meet the English language proficiency requirement for their professions, and choices regarding pathways to registration.

3.3 Participants

The two researchers visited a class session at the beginning of the course and explained the project. All health professionals in the class were invited to participate at two levels: by agreeing to make their test scores and role play performances available for the research or by agreeing to this and to being interviewed up to three times during the course. Out of the 23 health professionals in the class, 20 gave their consent to the first level of participation (10 doctors, seven nurses and three pharmacists), and 13 members of the class were interviewed at least once.

3.4 Data-gathering procedures

To investigate the research questions, data were gathered from a variety of sources, which are explained in the sections below.

3.4.1 Interviews

The core component of the data-gathering comprised three semi-structured interviews with members of the class carried out by Rosemary Wette during the period of the study. Each interview lasted 20 to 30 minutes. The first round of interviews took place just after the course began in May 2007, and the second towards the end of the course in August. They were usually scheduled in the hour before class, and were conducted face-to-face in a room adjacent to the classroom. They were audiotaped and later transcribed for analysis. The third round of interviews was carried out by phone in March and April of 2008, and the researcher took detailed notes on participants' responses immediately after each conversation. The schedules for all three interviews are set out in Appendix 1.

At the beginning of the course, nine members of the class agreed to be interviewed. The first interview gathered information about participants' language learning and medical backgrounds, their use of English in the medical workplace in their home countries, and their decision to migrate to New Zealand. They described what they believed to be their strengths and weaknesses in communication, and outlined their expectations for the EHP course as well as their short- and long-term study and career plans.

By the second round of interviews, one person had left the course (Doctor G), and two new participants had volunteered for interview (Pharmacist M and Nurse N). In this case, the interviewees were asked to compare IELTS with the OET in terms of cost, degree of difficulty, and appropriateness as a test of English language proficiency for the purposes of professional registration, as well as drawing any other points of comparison they considered relevant. Information was sought about how much progress participants thought they had made on the course, and what they planned to do (or had already done) to prepare themselves for IELTS or the OET. Their perceptions were elicited regarding current attitudes in the general population and media in New Zealand towards overseas trained health professionals. They also commented on the information and guidance made available by the New Zealand registration body for their professions. This second interview was longer for the two new participants, as it also covered the topics of the first interview.

For the third interview, 10 of those who participated in the first two interviews were able to be contacted by telephone, along with two others from the larger group of participants (Nurses O and Q). In addition, less formal conversations took place when several participants contacted the researcher by email and phone to discuss their exam results and pathway choices, ask advice about how to access IELTS and OET practice materials, or to arrange for reimbursement of their IELTS fee.

Information relevant to the study was therefore gathered through at least one interview with 13 of the 20 study participants: seven doctors, three pharmacists and three nurses.

3.4.2 Observations

As well as an initial visit by both researchers to the classroom to explain the project, Rosemary Wette visited on three occasions during the course for a total of six hours to observe class activities. A number of shorter visits were made to arrange interview appointments with class members and to collect assessment data from the course tutor. Lesson observations were recorded in the form of field notes, and these provided input for the interviews and for a general description of the course. During part of the second and third visits, the researcher played the patient role in simulated health care interviews which enabled her to get to know the participants and the course curriculum, build trust and rapport with the teacher and class members, and show appreciation for the involvement of both in the project.

3.4.3 Teacher journal

The course tutor (Patsy Deverall) kept a journal during the course as a general record of the teaching program, with particular attention to incidents and insights relevant to the research questions guiding the study. Topics covered in her journal included her personal theories of practice, teaching the four skills, assessment and feedback. While she commented throughout the journal on the progress of individual students, she refrained from mentioning the three who were not participants in the research.

3.4.4 Assessment information

At the beginning of the course, students completed in-house tests of writing, grammar, vocabulary, listening (dictation) and reading. The results of these tests for participating students were recorded as pre-course measures. The tutor conducted mid-course and end-of-course assessments to measure student achievement on the course and provide information for the award of the AUT certificate. These assessment results also formed part of our research data.

The researchers had access to videotaped simulated patient role play assessments in which 10 participants (five doctors, one pharmacist and four nurses) carried out medical interviews in their professional roles. These were part of the exit assessments for the course. These 10 role plays were assessed by the course tutor and the two project researchers. The course tutor assessed participants against a grid of 19 criteria that covered interview structure (eg opening, closing, taking a history, summarising) and communication skills (active listening, questioning, transition signals, ability to establish rapport, grammar, vocabulary, body language). She also gave written feedback comments. The researchers made notes on areas of skill and areas needing improvement as they watched each role play, then discussed their feedback to reach a consensus.

A further assessment was made by a New Zealand doctor who is a registered general practitioner, psychotherapist and medical educator trained in the assessment of communication in health care contexts. His background includes several years as a senior lecturer in the Department of General Practice at the University of Auckland Medical School organising communication skills workshops for groups of doctors, nurses and medical students, and four years as a teacher/facilitator on the professional development component of the government-funded Overseas Trained Doctors (OTD) Bridging Program from 2001 to 2004. He assessed recorded role plays of 10 participants in the present study against a set of eight criteria for medical communication that had been adapted from the widely-known Calgary-Cambridge framework (Kurtz et al, 2003) for use on the OTD program. These criteria

assessed ability to establish and develop rapport; establish the patient's concerns; explore and clarify from a medical perspective; explore physical, social and psychological factors; provide structure to the consultation; share decision-making, and show sensitivity to the patient's views.

Participants were encouraged to take both the OET and the Academic module of IELTS as close as possible to each other and to the time when they completed the course. Those who did so were reimbursed for the cost of the IELTS Test.

3.4.5 The data set

Given the variable patterns of attendance during the course and participation in the research, a complete set of data was obtained from just one of the 20 participants. Details of data collected from each participant are presented in Table 1.

3.5 Data analysis

Test scores and assessment results were collated. These provided information for the profiles of study participants and facilitated comparisons with other students in the class.

The videotaped assessments were reviewed by the course tutor, the researchers, and by the medical communication expert. Key features of each candidate's performance were described. The course tutor worked from a list of criteria that emphasised language, while the medical assessor commented generally on language and more specifically on issues of medical communication using the set of criteria indigenous to medical professionals. The researchers commented on language and on communication in the medical context from a lay/patient perspective.

N-Vivo 7 qualitative data management software was used to improve the consistency with which themes of interest and relevance to the study were coded. The content of entries in the teacher journal was grouped by theme. Data gathered from these sources as well as from the class observations were used to construct rich descriptive profiles of 11 of the participants (five doctors, three pharmacists and two nurses) to highlight the complexity of the factors influencing the pathway choices and performance of overseas-trained health care professionals seeking re-registration in an English-speaking country.

Number	Name	Interviews	Sat IELTS	Sat OET	Entry test scores	Exit test scores	Assessed role plays
1	Doctor A	3	✓	✓	I	✓	✓
2	Doctor B	3	✓	✓	✓	✓	✓
3	Doctor C	3	✓	✓	I	X	X
4	Doctor D	3	✓	X	✓	X	X
5	Doctor E	3	X	X	X	✓	✓
6	Doctor F	2	X	X	✓	I	X
7	Doctor G	1	X	X	✓	X	X
8	Doctor H	0	X	X	X	I	X
9	Doctor I	0	X	X	✓	I	✓
10	Doctor J	0	X	X	X	X	✓
11	Pharmacist K	3	✓	✓	✓	X	X
12	Pharmacist L	3	X	✓	✓	I	X
13	Pharmacist M	2	✓	✓	I	✓	✓
14	Nurse N	2	✓	X	X	X	✓
15	Nurse O	1	X	✓	✓	✓	✓
16	Nurse P	0	X	X	X	X	✓
17	Nurse Q	0	X	X	✓	✓	✓
18	Nurse R	0	X	X	✓	✓	X
19	Nurse S	0	X	X	✓	X	X
20	Nurse T	0	X	X	✓	X	X

Key
I data incomplete
X data not available (e.g was not present for the test, did not sit the exam)
✓ data available and complete

Table 1: Data from health professionals participating in the study

4. FINDINGS

4.1 The English for Health Professionals (EHP) course

This section presents information about the content of the EHP course curriculum and the instructional strategies employed by the course tutor to develop participants' proficiency in the four skills, grammar and pronunciation. Information was gathered largely from her journal, as well as from course documents and researcher observations of several lessons.

4.1.1 Curriculum content and teaching strategies

Speaking/role plays

The course tutor noted that, while all students benefited from role play practice, the ones who made better progress were those who actively sought and were willing to accept error correction, and were sufficiently confident to participate fully in the interactions. With regard to feedback on role plays, she tried to achieve a balance between candour and sensitivity. She believed that while feedback should support students' emerging confidence, less proficient students also needed to be made aware of grammar, vocabulary and pronunciation weaknesses if these interfered with communication. The approach she most often used was to focus on one or two types of language error, while at the same time making a comment on overall content. Issues related to the patient-centred approach in medical communication were also sometimes mentioned. Students commented that too much feedback was "overwhelming" and that they would have preferred to receive the comments individually and in private. The course tutor further noted the importance of social interaction in the classroom, and of active learning by class members. She believed that a number of obstacles prevented successful implementation of this approach, including the age and preferred learning style of the health professional. Educational background was also an impediment if it had been one in which, as a rule, content was transmitted by the teacher to a relatively passive class.

Listening

Weekly sessions were scheduled in the language laboratory. These provided opportunities for students to progress their skills by listening to, and completing, worksheets based on taped radio discussions and lectures on medical topics. Although copies of tapes listened to in the language laboratory could be borrowed for independent study, only half the students in the class took up this opportunity. Furthermore, the tutor reported that only a minority of the class completed the set listening assignment over the mid-course break, and few used resources from the AUT self-access learning centre. While this may have been because of paid work and family commitments, the tutor expressed disappointment at the desire of most students to focus almost exclusively on exam-type practice tasks, to the extent that they were less than enthusiastic about any other kinds of activities, such as listening to lectures or radio discussions on health issues.

Reading

As with listening, the course tutor stated that many students failed to see the need to expand their reading interests beyond exam practice materials to broader health issues and beyond; for example, only three completed out-of-class reading tasks set for the mid-course break. Although accustomed to answering short-answer and multiple-choice questions in their medical studies, students appeared largely unaware of how this differed from the reading and test-taking strategies required for an assessment of English language proficiency. In the OET, close reading of the text is necessary to answer difficult multiple-choice items, whereas in IELTS locating the answers to True/False/ Not Given items involves a scanning strategy.

Grammar

Feedback from students during the first part of the course was that grammar exercises done in class were too difficult. The tutor therefore noted that more complex grammatical structures needed to be

broken down into components and taught separately. The writing and speech of many students showed that mastery of key structures (eg question forms) and functions (eg making empathetic responses, giving advice, negotiating options) was less than secure.

Vocabulary

Students' vocabulary of medical and lay-medical terms was expanded in a number of ways. They practised improving their ability to guess words from context through vocabulary tasks connected with each of the written texts they read. Additional practice was linked to the OET Speaking paper (matching lay-medical and technical terms, use of phrasal verbs, colloquial "patient" language) and the Writing exam (through formal language appropriate to the letter of referral eg *admitted to, mitigated by, diagnosed with, discharged from*).

Pronunciation

Pronunciation was a major difficulty for quite a few students in the class. Although tutor feedback on assessed role plays almost invariably drew students' attention to the fact that their speech might well be unintelligible to New Zealanders, attempts to persuade them to attend a pronunciation class running concurrently at AUT were largely unsuccessful.

Writing

The tutor commented that the text type used in her diagnostic assessments and in the OET (ie, a letter of referral) was specialised in nature, therefore it tended to reveal more about students' familiarity with the type and with the medical content of the letter than their ability to write grammatically accurate sentences and paragraphs. She wondered if a more general topic and text type might therefore be preferable as a diagnostic tool. She further noted that in practice, letters of referral were not always so formal or lengthy, and were seldom written by pharmacist and nurses. She concluded, however, that the letter of referral provided invaluable practice in writing in a neutral tone and formal register, and that it was possible to draw comparisons between it and the IELTS Academic Writing task.

Cultural content

The tutor believed that it was important that the content of spoken and written texts was sourced in the New Zealand health system (radio talks, written health information texts, common presenting complaints) to increase learners' familiarity with the local context. She noted that although issues of cultural safety and the particular needs of Maori and Pasifika patients are of considerable importance in New Zealand, they were given less emphasis in the course and in role play feedback than she would have liked because of the need for feedback to focus on students' immediate language needs and weaknesses. She expressed disappointment, however, at the somewhat apathetic or even dismissive attitude of some members of the class towards the needs and difficulties of these groups in New Zealand society.

4.1.2 Lesson observations

The focus for the first of the two weekly sessions (Mondays) was on writing and listening, while the second emphasised speaking and reading (Thursdays). One of the researchers observed three lessons in the early part of the EHP course.

Students were actively involved in the three lessons observed. In the first (Monday), a large part of the time was taken up with activities to prepare the students for the writing task in the OET, which involves composing a letter of referral. Thus, there was a cloze-type task to complete the blanks in a sample referral letter; discussion of the structure of this kind of letter; and practice in transferring information from case note form to a complete letter of referral. Other activities in the first lesson included matching lay expressions with medical terminology, identifying question forms in the medical interview, and grammar and punctuation exercises. In the second and third lessons (Thursdays), role play practice took place in which students took turns playing the role of health care professional while the simulated patient role was taken by the researcher. Students were assessed

according to a set of criteria that included their questioning technique, management of the stages of the consultation, responses to feedback from the patient, ability to express empathy and their body language. In addition, attention was paid to linguistic features such as the clarity of their speech, use of transition signals and their knowledge of lay medical terms. The course tutor observed the role plays and gave verbal feedback on particular language errors. The medical content of the role play was also discussed.

4.1.3 Course assessment

Students completed diagnostic tests on entry to the course. Achievement-based assessments took place at the midway point and at the end of the course, as set out in Table 2. Comparisons between different students in the class and between the internal and external assessments of IELTS and OET were limited by the fact that a complete data set was not available. The achievement of individual students on the course is discussed in the descriptive profiles (See 4.2.)

Assessment	Entry test	Mid-course test	Exit test
Listening	short dictation – medical content	radio talks and self-access materials (not assessed)	note-taking on two radio discussions (medical)
Reading	OET sample text	IELTS and OET reading tasks (not assessed)	text (medical content) and 10 x multi-choice questions
Writing	report on an adverse workplace medical event	a learning journal (not assessed)	letter of referral
Speaking	none	doctor-patient role play (recorded)	doctor-patient role play (recorded)
Vocabulary	from frequency lists (2000, 5000 and 10,000) and the academic word list	None	none
Grammar	42-sentences: verbs, articles, rel. pronouns, prepositions	None	none

Table 2: Assessment evidence from the EHP course

4.2 Profiles of five doctors

Before presenting profiles of some of the doctors on the course, it is necessary to give some background on the process of registration for overseas-qualified doctors, as established by the Medical Council of New Zealand. After meeting the English language proficiency requirement for registration through IELTS, the doctors are required to pass a written assessment of their medical knowledge. Previously this was an exam set in New Zealand and known as NZREX Written (NZREX being the New Zealand Registration Examination). However, the Council now recognises three overseas exams instead: Steps 1 and 2 on the US Medical Licensing Exam (USMLE); Part 1 of the UK Professional and Linguistic Assessments Board (PLAB) exam; or the MCQ exam of the Australian Medical Council). Doctors' clinical skills are then assessed through NZREX Clinical, which uses an Objective Structured Clinical Examination (OSCE) format to assess core clinical competencies and communication skills such as taking a medical history, explaining a diagnosis, treatment or type of medication, and negotiating a mutually agreed management plan. Examiners are looking for evidence of the ability to listen actively, understand the presenting problem from the patient's perspective, and the ability to communicate well with patients in a variety of situations, irrespective of the patient's gender, race, religion or sexual orientation (Medical Council of New Zealand, 2007).

Personal information and data collected from the five doctors profiled for the study are presented in Table 3.

Name	Gender	Country of origin	Interviews	Role plays
Doctor A	female	Sri Lanka	1, 2, 3	✓
Doctor B	female	China	1, 2, 3	✓
Doctor C	male	India	1, 2, 3	X
Doctor D	female	Sri Lanka	1, 2, 3	X
Doctor E	male	Afghanistan	1, 2, 3	✓

Table 3: A summary description of Doctors A–E

4.2 1 Doctor A

Doctor A is a general practitioner who, after completing her medical studies, worked in hospitals in her native Sri Lanka for more than 10 years before travelling to the Netherlands to complete an MSc in Public Health. Although English was the medium of instruction during her study for all of these qualifications, Sinhalese was the language of the medical workplace and this, she believed, impeded the development of her speaking and listening abilities in English. Since arriving in New Zealand in 2003, she has worked as an elderly care assistant, and is currently a technician in a medical laboratory. Her husband, who is also an unregistered overseas-trained doctor, would prefer to return home to Sri Lanka.

Doctor A first took IELTS in July 2005, gaining an average band score of 7, with a 6 in Reading as her lowest score. In the first interview, she reported noticing an improvement in her performance after using the various strategies for reading that she had learned in class, and as a result of the extra study she had put in after class in the university library, where there was a range of IELTS practice materials. She believed that her difficulties in the 2005 IELTS Reading module had been due to poor time management strategies, as she had found that in order to understand some more difficult paragraphs of the exam texts she had been obliged to read more slowly, and she had therefore been unable to complete the test.

By the time of the second interview in August, Doctor A had taken the IELTS Test again, this time achieving scores of 7 for the Speaking and Reading modules, 7.5 for Listening and 5.5 for Writing, with an overall band of 7.0. She was particularly surprised and disappointed at the score for Writing, since she had achieved band 8 in 2005. She again attributed her relatively poor performance in this exam to poor test strategies, as she had chosen to write in pencil rather than pen so that she could make corrections, but it had turned out to be a time-consuming strategy. She also felt that, because of her 2005 scores, she had chosen to focus on reading in her exam preparation and had spent relatively little time on the other three skills.

Doctor A reported in the second interview that her plans for meeting the English language requirements for registration had changed, and that since the Australian Medical Council allowed doctors to delay sitting their English exam until after the written medical papers, she was considering this as a more suitable pathway for herself. Despite this decision, she stated that since strategies for sitting the OET had been part of the content of the EHP course, she planned to attempt this test before the end of the year to make use of what she had learned. She admitted to having only a very general idea about how the two tests compared.

Doctor A went on to take the OET in December, 2007, receiving a C grade for Writing and a B grade for the other three sections. In March 2008 she reported that her preferred pathway was still to pass the AMC written exam in New Zealand before moving to Australia and attempting to meet the English language requirement through the OET. She was undecided about which English test would give her the best chance of success: she felt that IELTS was the more achievable goal, since only her writing was below the required standard (and this because of poor strategy choice on that particular occasion), and because the test fee was much lower. If, on the other hand, she found she was able to re-sit only the Writing paper, she stated a preference for the OET option. (In fact, this assumption held by a number of participants that they could re-sit one paper in OET is incorrect, or no longer correct. Sub-clause 5 of Clause 3.0 of the National English Language Proficiency Requirement for International Medical Graduates explicitly states that examination results "must be obtained in one sitting" if seeking registration in Australia, where a minimum grade of B in each of the four components of the OET is accepted as an alternative to IELTS.)

Although she was not present for all the diagnostic and exit tests for the EHP course, scores for Doctor A were above the class average, especially in the vocabulary assessments. Her performance in a doctor-patient interview role play was assessed to be at the level of a good pass in the OET by the course tutor, although a small number of errors in verb tense forms and pronunciation were pointed out. On viewing the same role play, the two researchers noted a number of language errors, and also a lack of clarity and an absence of transition signals in the explanations about the cause of the patient's complaint. They felt that the management plan lacked a coherent structure, which would make it difficult for the patient to follow the advice and instructions offered.

This same performance was evaluated by the medical communication specialist as below a passing grade (4/10), with the exception of the criterion of "establishing rapport", which was judged satisfactory (5/10). The weakest part of Doctor A's performance, in his opinion, was against the assessment criterion of ability to "provide a clear structure to the consultation" (3/10). The specialist noted a need for improvement in these main areas: English language; consultation techniques (clarifying and providing clear explanations); and in adopting a patient-centred approach, which he believed was lacking in the consultation.

The culture of patient-centred care in medical workplaces in New Zealand was relatively new for Doctor A, as in Sri Lanka "patients hardly ask questions and they don't argue, they accept whatever things you tell them". However she reported having few difficulties adapting to this requirement for more detailed explanations and negotiations, since she had had opportunities to practise when discussing procedures with patients in her job at a diagnostic medical laboratory.

She suspected bias in media reporting of any medical errors in New Zealand hospitals, with a tendency to blame foreign doctors irrespective of the particular cause of the problem. She stated that she would very much like to see some more open communication between overseas trained doctors and the Medical Council. She would also like to have seen the government-funded bridging course for overseas trained doctors re-established, having heard from fellow Sri Lankans who had attended the course and were now in the medical workforce that it had been successful in helping overseas trained doctors to gain registration in New Zealand. She also believed that the Medical Council should check the credentials of the institutions where overseas doctors had received their training against the lists of approved providers compiled by the World Health Organisation, with a view to automatically re-registering some overseas trained doctors. The requirement that all doctors pass local written and clinical examinations was, in her opinion, "just wasting our energy and resources".

4.2 2 Doctor B

Doctor B studied for her medical qualifications in China in the second intake of students admitted after the end of the Cultural Revolution. She reported that she had received four lessons a week of English at school (almost exclusively focused on reading and grammar), but that there had been very few

opportunities to use English in her work as a hospital doctor in China, particularly before foreigners began to visit the country. Since arriving in New Zealand nine years ago, she had attended a general purpose integrated skills English course at AUT at the upper intermediate level, and had been helping in her husband's real estate business (the client base of which was largely Chinese) and acting as a volunteer health care interpreter for new migrants in her local area.

At the time of the first interview, Doctor B's experience with IELTS was limited to having taken the General Training module for immigration purposes in 1998 (she received an overall band score of 5.5). She had never attempted the OET. Although she admitted knowing relatively little about either exam, she believed that a key advantage of the OET was that it was possible to re-sit only those papers in which the required grade had not been achieved, which she felt in her own case would be advantageous since her proficiency in listening and reading was greater than in speaking and writing (as noted on the previous page, this assumption about re-sitting one part of the test was incorrect). She believed that a further advantage of OET was that texts and tasks were medical in nature, whereas topic content in IELTS could be selected from any academic area, making it difficult to prepare for the examination. She also stated that she was well aware of the difficulties she would personally face in overcoming the other two obstacles to registration in New Zealand, namely the NZREX written and clinical examinations.

In the second interview, Doctor B outlined her preferred pathway to registration, which was to take advantage of a new regulation in Australia allowing doctors to sit the AMC written exam before meeting the English language requirement, and she stated that preparing for this exam was her current priority. Her rationale for the choice of this pathway was that preparing for the exam would bring her into contact with health-related language, which would in turn improve her chances of success in the OET. The main benefit of the EHP course was, in her opinion, the knowledge she had gained about the two tests, particularly the OET, as well as improvements in her ability to communicate in medical contexts. At the time of the third interview in March 2008, she reiterated her intention to sit either IELTS or OET prior to attempting the AMC exams, but had no definite idea of when this might happen. She was not employed, but helped out in her husband's real estate business and in the Chinese community on a voluntary basis.

In diagnostic tests for the course, her marks were slightly above the class average across the four skills, and her exit test score for reading was well above average. Her role play performance in a doctor-patient interview was assessed to be at the level of a good pass in the OET by the class teacher, although two weaknesses were noted: in the accuracy and detail of questions in the history-taking phase, and in the degree of empathetic feedback in responses to patient statements. The two researchers commented on weaknesses that they had identified in asking questions and in establishing rapport with the patient by responding to clear statements of concern. The assessment of Doctor B's performance by the medical communication specialist was that it was not of a passing standard (scores between 2 and 4/10). Particular weak points identified included language fluency (2/10), consultation technique (3/10), rapport (4/10), providing a coherent structure (3/10) and having a patient-centred approach (4/10). However, the assessor observed that Doctor B appeared to be familiar with the subject of the consultation from a clinical perspective.

Doctor B was critical of the Medical Council's lack of assistance with re-registration, and stated that she would very much like to see the government-funded bridging course re-established, even if it had to be funded through fees levied from course participants. She was also of the opinion that a medically-oriented English language test (similar to the OET) should be used to meet the English language requirement. The emphasis on patient-centred management in the EHP course was relatively new to her, since this aspect of clinical care was not explicitly discussed in her previous training or working life. She believed, however, that the underlying attitude of Chinese medical professionals towards patients was similar, in that good communication between doctor and patient was strongly emphasised.

She thought that media coverage in respect of overseas trained medical professionals was not particularly well informed, as it tended to confuse communication difficulties with lack of clinical expertise. Only recently, she reported, had she read any reports that acknowledged the extent to which New Zealand relied on experienced overseas trained medical professionals in the local medical workforce.

4.2.3 Doctor C

Doctor C studied for his medical qualification in an English-medium university in India. After working in his home city for 15 years, he qualified as an ear-nose-and-throat specialist and worked in a teaching hospital for a further eight years. In his professional life in India, English had been needed for all in-service training seminars as well as for communicating with some patients. Since arriving in New Zealand in September 2001, he had been registered as unemployed. Over that period he had completed a training course to become (but not worked as) a care giver, supervised intellectually handicapped workers, worked as a technician in Fiji and spent three months working in a medical laboratory in Australia.

In 2000 he had gained an overall band 6.5 in the IELTS General Training module before migrating to New Zealand. The following year he had taken the Academic module, with results of band 7 in all skills except Reading, for which he had scored band 5.5. His third experience of IELTS was in April 2007, where he again scored 7 for all skills apart from Reading, which this time was assessed as band 6.5. Although he said it was difficult for him to account for his poor performance in the Reading component of the Test, he had felt rushed, and believed that “to finish the paper you have to guess”. He also stated that, in his opinion, True/False/Not Given questions on a reading passage are “weird because they involve guess-work, and don’t allow candidates to write answers in their own words”. He had attended an IELTS preparatory course before taking the IELTS Test in 2007, but found it difficult to follow the advice he was given with regard to test-taking techniques for the Reading paper, which had been to look for key words, supporting words and parallel expressions, and then go step by step. He felt that, as a fluent speaker of English, his difficulties in the Reading paper lay not with understanding the content of the texts, but with the types of questions he was required to answer.

By the time of the second interview, Doctor C had also sat the OET, achieving a grade of A for Speaking, B for Listening and Writing, and C for the Reading component. Comparing IELTS with the OET, he had found both Speaking and Writing tests relatively easy and, while the medical content of the OET Listening test made it “a bit difficult and a bit fast”, as an experienced doctor he had been able to comprehend the content of the spoken text. Reading had proved difficult in both exams. He said he found it hard to identify any real points of difference between the two exams in terms of difficulty, skills tested and thinking processes required during the testing process.

In the course of his second interview, Doctor C affirmed that he would sit both IELTS and the OET again in the near future. By way of preparation, he was working his way through commercial IELTS preparation texts as well as the training materials provided by the OET Centre; although**,** having already worked through all of these in preparation for the earlier test, he was not quite sure how to go about revising for the re-sit. He was critical of the lack of training materials for the OET, and also of the fact that the types of questions used in sample tests did not mirror those used in the test itself.

In her journal, the course teacher expressed concern over the difficulties that Doctor C, as a well-qualified surgeon in his fifties with a particular status and position in his home country, appeared to be having with the immigration experience. As the course progressed he attended less regularly, and she noted that he appeared unwilling to accept teacher feedback on his writing errors and role play performances. In July he left the course to take up a full-time job in the health centre where he was employed.

At the time of the second interview, Doctor C's plan was to apply, as soon as the English language requirement had been met through either IELTS or the OET, for registration to practise in a rural area in Australia, since he had heard that it was possible to do this without having passed the AMC written and clinical exams. However, by the third interview in March 2008, these plans had changed. He had decided not to re-sit the OET, largely because of cost, and had in the meantime attempted IELTS for the fourth time, achieving 8.5 for Speaking, 7 for Listening and Writing, and 6.5 for Reading. At that time he expressed an intention to sit IELTS again, but seemed uncertain as to how he might go about improving his reading score, apart from working through more sample materials. From July 2007, when he left the EHP course, he was working full-time.

No test score information is available from the EHP course for this doctor apart from a diagnostic writing task, in which was assessed as being well above the class average.

Doctor C had had no difficulty with the emphasis on patient-centred management, as this had also been the approach in his working contexts in India. He stated that he would like to see the government-funded bridging courses reinstated as a way of giving doctors information about the local medical context. He believed that this kind of course existed in Australia, but that it was quite expensive.

4.2.4 Doctor D

Doctor D was born and educated in Sri Lanka, but completed her medical qualifications in Cuba, therefore in the Spanish language. After her internship, she returned to Sri Lanka and, as an overseas-trained doctor, was obliged to pass a medical registration exam in English. She worked in the outpatient department of a rural hospital, and in the neonatal, oncology and paediatric units of several hospitals in Colombo. She then married, started a family and in 2001 accompanied her husband to Japan so that he could complete a doctorate in environmental science. She learned Japanese and taught English. Since arriving in New Zealand in 2005, she has worked as a caregiver and, more recently, as the activities coordinator in a small private hospital for the elderly.

Her first experience of IELTS was taking the General Training module (band 6.5 overall, with 7.5 for Speaking, 7 for Listening and Writing, 6.5 for Reading) for immigration purposes. She recalled that, in this first experience of the Test, she had found it difficult to complete the Reading paper in the allotted time. At the time of the first interview in June, 2007 she was preparing to sit the Academic module by spending weekends working through practice materials in the AUT library, with particular attention to practice reading tests. By the second interview in September, she was able to report a successful result in the Test, as she had been able to achieve band scores of 7.5 for Listening and Speaking, and 7 for Reading and Writing. Her strategy for preparing for the exam had been to spend two months working through more than 20 books of practice examination texts for the Listening and Reading papers, as well as listening to radio broadcasts of talks and interviews. For the Speaking exam, she and a friend had held practice discussions on as many of the 200 topics identified in one IELTS training book as they could manage, and for the Writing paper she had prepared some 25 essays on topics that she thought might appear. She had not memorised these essays, but rather used them to help her think of suitable introductions, conclusions and key points.

Doctor D was mentioned several times in the course tutor's journal as an extremely diligent student with very high initial English language proficiency who completed extra out-of-class practice tasks, asked questions during and after the lesson, and generally viewed IELTS as a chance to learn more and to improve her English rather than as a barrier to be overcome. In comparison with the rest of the class, she was more confident and fluent as a reader with experience of reading different types of texts. She was one of a small group of students who tried hard not to lose confidence, and was sufficiently interested in language learning beyond the requirements of the IELTS Test to take up any available learning opportunities.

After meeting the English language requirement of the New Zealand Medical Council, Doctor D went on to pass the NZREX Written exam in April 2008, and reported in the third interview that she was studying for the NZREX Clinical exam, which she planned to sit in September 2008. Because of work and family responsibilities, her exam revision took place only in the evenings and weekends when she studied in the medical library at the University of Auckland. Her husband was unemployed; therefore it was not possible for her to give up her job in order to study full-time. Although very familiar with much of the content of the textbooks, she commented on the fact that recent developments in medicine meant that she needed to update her knowledge in a number of areas.

She felt that one of the main benefits of the EHP course was the opportunities it provided for practising a more patient-centred approach to the doctor-patient interview through role plays in class. She contrasted this with the more paternalistic doctor-patient relationship in her home country, where patients seldom voiced opinions or asked questions of the doctor and where the majority were, she believed, less well-informed about medical matters compared with patients in New Zealand. She also appreciated the instruction she had received on the course in how to write a letter of referral. Her achievement on diagnostic tests for the course showed that she achieved the highest or second-highest scores across the four skills in this group of 18 students. As she left the course on achieving IELTS 7.5 in July, no exit test information is available for Doctor D.

Doctor D was aware of media reports about the shortage of doctors and nurses in New Zealand due to the exodus of large numbers of personnel to Australia and elsewhere, and that there were a significant number of overseas-trained doctors experiencing difficulties meeting the New Zealand registration requirements. She was of the opinion that a bridging program was needed to help some of these doctors pass the NZREX exams, and that loans (repayable when doctors were in paid employment) should be available for course fees.

4.2.5 Doctor E

Doctor E came to New Zealand from Afghanistan. He began learning English at the age of 12, however, instruction focused on grammar, with little practice in speaking or writing. In 1986 he went to India to begin his medical studies, which were conducted in English. After qualifying as a medical practitioner in 1995, he worked in a number of departments in a private hospital, but was not eligible to undertake training to become a specialist under the agreement between the two nations that had allowed him to study in India. As well as his first language (Pashto) he speaks Dari and Arabic, and was obliged to learn Hindi and Punjabi in order to speak to patients. While working, he used English to keep up to date with new developments in medicine published in print and online, and also to speak with colleagues. With patients, he spoke Hindi most of the time, but sometimes English or Punjabi. He came to New Zealand as a refugee (under New Zealand's quota of UNHCR-mandated refugees) in March 2007, and enrolled in the EHP course at AUT almost directly after completing the compulsory six-week orientation program. At the time of the interviews he was unemployed.

At the first interview, he outlined his plan for re-registration, which was to meet the English language requirement through IELTS, and then to study for the USMLE Part 1 and Part 2 examinations. He was aware, however, that achieving the standard needed to pass the medical exam would not be easy, and that he had difficulties both in writing grammatically correct English, and in understanding the fluent speech of New Zealanders. He also believed that, on the basis of practice tests done on the EHP course, he might have difficulties completing the Reading paper in the allotted time. He had received feedback from the class teacher that his rate of speech was often too rapid for him to be readily understood. Although he had no experience of sitting either IELTS or the OET, he had a preference for the OET on the grounds that it is possible to re-sit individual papers (although this assumption was incorrect), and because of its medical content. He felt that, while IELTS might be an appropriate test for students planning to enter university to study English literature, for example, it was not suitable as a requirement for medical professionals as it did not test knowledge in medical and scientific contexts, and what it did test was irrelevant to communication in these domains. He was also critical of the cost

of all the registration exams in view of the limited financial resources of many overseas-trained doctors.

He realised, however, that he would be obliged to sit IELTS if seeking registration in New Zealand and that, as a recently arrived refugee, he would need to wait at least three years before he was eligible for a New Zealand passport. At the time of the second interview in August 2007, he had a firm plan to take IELTS and had begun to look at some training materials in the AUT library. By the time of the third interview in February 2008, however, he reported that he had decided to enrol in a full-time English course at AUT for the first semester, and to delay his first attempt at IELTS until July 2008.

As he entered the course a little late, no diagnostic test information is available for this doctor. On exit, the class teacher assessed his writing as at a satisfactory standard and his performance on a doctor-patient role play as also good in respect of explanatory content and reassurance, but less than satisfactory in amount of eye contact with the patient and pronunciation. Her feedback advised Doctor E that his very rapid pace of speech and misplaced sentence stresses made him extremely difficult to understand.

The two researchers also noted this doctor's rapid and fairly expressionless way of speaking and a lack of dialogue between doctor and patient in the management phase. The medical evaluator assessed as satisfactory this doctor's exploration of the complaint from a medical perspective, his structuring of the consultation and his sharing of decision-making; he also felt Doctor E's level of language ability was acceptable (6/10). On the other hand, the evaluator judged one cause of the presenting complaint suggested by the doctor as medically flawed and culturally inappropriate. His notes for areas of improvement mentioned two main aspects: knowledge of New Zealand culture and complaints common in this country (such as campylobacter), and the need to adopt a more patient-centred approach. However, on the criteria of exploring and clarifying from a medical perspective, providing a clear structure to the consultation, ability to jointly negotiate a management plan and sensitivity to the patient's concerns, Doctor E's performance was judged to be at a satisfactory standard, and his overall score was a near-pass at 4.3/10.

With regard to patient- or relationship-centred management in New Zealand, Doctor E believed this was very similar to the culture of his workplace in India, partly because the chairman of the hospital had previously worked in the USA for many years. Using a patient-centred approach was therefore quite familiar to him.

Doctor E was of the opinion that the wealth of experience possessed by overseas-trained doctors, as well as their cultural and linguistic skills, was undervalued in a country where a considerable number of people were migrants from different cultures speaking languages other than English.

4.3 Themes from Doctors A–J

This section of the report outlines themes that emerged from the five profiles above and from additional sources of information, namely test scores from four other doctors (F, G, H and I), two interviews with Doctor F, one interview with Doctor G and role plays from Doctors I and J.

4.3.1 Exam pathways for doctors

A number of patterns were evident from the profiles of Doctors A–E and two others (F and G). Doctors C and D focused mainly or exclusively on meeting the English language requirement through IELTS, and stated that they were prepared to take the Test as often as necessary to achieve their goal of a 7.5 overall band score. Doctor A attempted both tests, but failed to meet the required standard in the Reading component in each case. Doctor C also had difficulties with reaching the standard in Reading and, in four attempts made between 2001 and 2008, had managed to increase his score in the IELTS Reading module from band 5.5 to 6.5, which fell short of the required band 7. At the time of the last interview, he was planning to attempt IELTS again unless it was possible to sit only the Reading component of the OET. Doctors B, E, F and G did not sit either test during the period of the

study, and at the final interview, Doctor E announced that he had decided to take a full-time course in English for one semester before making his first attempt at IELTS.

Doctors A, B, C, E and F made statements comparing IELTS with the OET. While they felt that IELTS was the more affordable test and the one for which preparatory courses and a range of materials were available, they had a preference for the OET on account of its medical content. Doctor C, who took both tests during the period of the study, believed that there were few real points of difference between the two.

4.3.2 English language proficiency

Assessments of role play performance were available for Doctors A, B, E, I and J. While evaluations by the researchers, class tutor and medical specialist showed some consistency, the first two assessments focused on language and communication from a patient's point of view, while the third assessor looked at the role play from a medical communication perspective. The specialist in this area evaluated the consultation technique of all five doctors as below the required standard for NZREX in respect of having a clear structure and a patient-centred approach, both of which are core communication skills in clinical practice in New Zealand.

The doctors themselves assessed their own strengths and weaknesses in terms of the four macro-skills, often as a result of the scores or grades they had received on IELTS and the OET. Reading and writing appeared to be the most challenging of the four skills for the group as a whole in terms of their ability to achieve the required levels in the tests.

4.3.3 Influences on exam success

Interviews with the five doctors suggested a number of factors that may impact on the likelihood of succeeding in IELTS and the OET. These include determination and perseverance, confidence, family and financial support, commitment to settle in Australasia, the existence of a well-defined plan of test preparation strategies and a clear pathway to registration, as well as the ability to accurately evaluate own strengths and weaknesses. Examples of doctors demonstrating these positive factors were the strong motivation, diligence and pragmatism of Doctor D, and the realistic self-assessment of Doctor E.

4.3.4 Patient-centred management

With regard to the three doctors who were interviewed and whose role plays were assessed by the medical communications expert (Doctors A, B and E), the first two admitted that they were not very familiar with patient-centred management, while the third stated that he was. None of the three, however, scored well on this criterion in their role plays, which suggests that they had yet to learn the subtleties of a relationship-centred approach and the ways in which it differed from a more authoritarian, information-centred approach. The course tutor's journal entries observed that doctor-centred approaches appeared to be the norm in many of the countries represented by students in the class. A number of doctors had reported to her that, for cultural and other reasons, including lack of resources, consultations were usually very short and patients did not ask questions about the diagnosis or treatment options.

4.3.5 Views of the New Zealand context

Six doctors (A–F) voiced opinions about the way the New Zealand media reported on overseas-trained doctors in New Zealand, and the amount of information and support provided by the New Zealand Medical Council. These opinions were almost uniformly negative. They felt that media coverage undervalued the contribution of overseas doctors to the local medical workforce, regarded their skills and qualifications as inferior to those of locally trained medical professionals, and tended to equate the communication difficulties they sometimes experienced with a lack of clinical expertise.

4.4 Profiles of three pharmacists

Personal information and data collected from the three pharmacists profiled for the study are presented in Table 4.

Name	Gender	Country of origin	Interviews	Role plays
Pharmacist K	female	Malaysia	1, 2, 3	X
Pharmacist L	male	Palestine	1, 2, 3	X
Pharmacist M	female	China	2,3	✓

Table 4: Pharmacists K–M

4.4.1 Pharmacist K

Pharmacist K comes from Malaysia, where she began learning English in her primary school years. Her training in pharmacy took four years, and she noted in the first interview that, while textbooks were in English, students completed their written work in Malay. After a one-year internship, she worked in Malaysia as a qualified pharmacist for seven years, during which time she reported that she had had few opportunities to practise speaking English. She came to New Zealand with her husband in early 2007, and at the time of the study was working as a retail pharmacist assistant.

Her first experience of IELTS was when, like a number of other medical professionals in the group, she sat the General Training module for immigration purposes. On that occasion she achieved band 7 in Reading and Speaking, 6.5 in Listening and 6 in Writing. By the second interview in August 2007, she had taken IELTS again, this time achieving band 8.5 for Reading, 8 for Listening, 7 for Speaking, and 6 for Writing. Pharmacist K prepared for this second attempt at the Test by taking a short intensive preparatory course and by working in the AUT library every Saturday to use desk copies of test preparation materials. At that time she stated that she had lost some confidence in her ability to reach the required standard through IELTS, and would not attempt the Test again until she felt more prepared, which she thought would not be for several months. For that same reason (and also because of the expense of test fees), she postponed the date on which she would first attempt the OET.

When asked at the first interview to compare the two tests, she was of the opinion that the OET would probably be easier on account of its more familiar medical content (a letter of referral), but that the standard of writing required would be similar between the two tests. The existence of IELTS preparation materials and training courses was one clear reason for her preference for that test as a pathway to registration, as was the cost of the Test, which was roughly a third of the fee for the OET. At the time of the second interview, she had just enrolled in a 12-week online course through a local institute of technology in the belief that getting feedback on her writing was essential if she was to improve her IELTS score. The course tutor noted that Pharmacist K was keen to take up any available learning opportunities on the EHP course by doing extra independent learning tasks and by asking questions of the teacher after class.

In February 2008 Pharmacist K sat the OET, achieving a Grade B in Listening, Speaking and Writing, and a Grade A in Reading, thus meeting the English language requirement for registration in New Zealand. At the third interview, she outlined the next steps on her pathway, which involved applying to the Pharmacy Council for registration, sitting two clinical exams, having her qualifications from Malaysia assessed and undertaking an internship of six months or one year before full registration would be given.

Commenting on how the two tests compared, she found them very similar in terms of difficulty, although she believed that the OET Listening paper had been more demanding as a result of the amount of medical terminology, while its Writing paper had been easier for her because she was much more familiar with how to write a letter of referral than the data commentary and essay texts required for IELTS.

Although only entry test scores are available for this pharmacist, her performance on vocabulary, grammar, listening, reading and writing were all well above the class average, and similar to, or slightly above, the scores achieved by Doctor D (who passed IELTS with a band 7.5 average during the period of the study). As she left the course in August, no role play feedback was available.

At the time of the first interview, Pharmacist K was working as an assistant in a retail pharmacy. She felt confident that her professional knowledge of pharmacy was very solid, although initially she had had to familiarise herself with products that were different from those sold in Malaysia. She was somewhat less confident about her ability to communicate with clients without any difficulty. She was aware from her work as a pharmacy assistant that occasionally New Zealanders had difficulty understanding her accent, and that she did not always understand the words they used, although generally speaking, she believed she was able to communicate satisfactorily when giving advice and information about over-the-counter products. Two months later, when the second interview took place, she had left the course to take up a job as a technician for a company supplying injectible forms of morphine, nutrition and other preparations, while still retaining her job as a retail pharmacy assistant on a part-time basis.

With regard to recent media coverage about overseas-trained medical professionals, she believed that New Zealanders were “still a bit sceptical about the abilities of foreign trained professionals” despite there being personnel shortages in many health care sectors, including pharmacy.

She was disappointed that the Pharmacy Council had set their English language requirement at the level of band 7.5 overall since, in her opinion, that placed too strong an emphasis on English language proficiency compared with professional qualifications and experience, which she felt should carry more weight in a registration process involving experienced pharmacists from overseas. She also regretted the unavailability of bridging courses, workshops and supervised practice options to assist pharmacists seeking registration.

4.4.2 Pharmacist L

Pharmacist L is a Palestinian who has, in his own words, “been all my life living like a refugee”. He described having settled for varying lengths of time in Saudi Arabia, Jordan and South Africa before coming to New Zealand in 2004. He gained his qualification as a pharmacist from Jordan, and while courses were taught in Arabic, he studied from English language textbooks. After graduating in 1997, he worked for five years in Saudi Arabia and lived illegally in South Africa before migrating to New Zealand with his family under the points system.

At the time of the first interview, he was employed as a security guard. He had no experience of studying English in a class, and was reliant on self-study and the little speaking practice he gained through his job to help improve his English. He had never taken either IELTS or TOEFL, and at that time was interested in making inquiries about retraining as a pharmacist through university study. At the first interview, he mentioned that he had already approached the University of Auckland for a

place on the Bachelor of Pharmacy course for 2008, and was about to file an application for admission to the university. He was hoping to be credited with the first three years of the five year degree so that he could begin his studies in Year 4. He had no doubts about his professional competence and ability to give sound advice to clients, but was less confident about whether his accent would always be readily understood by New Zealanders.

Although at the first interview, he said he knew little about either IELTS or the OET, by the time of the second interview, Pharmacist L had formed the opinion that the OET would be easier on account of its medical content, particularly the writing (the letter of referral) and speaking tests (a doctor-patient interview). Another advantage of the OET in his opinion was that it was possible to re-sit single skill components over a two-year period. He judged his weakest English language areas to be reading and vocabulary, and although he was pleased to have the opportunity to practise working with exam-type texts and tasks on the EHP course, he was uncertain whether his reading ability was actually improving. Feedback from the course tutor indicated that his performance on practice tasks was of a satisfactory standard. He scored well on a diagnostic writing task; however, his marks for entry tests in grammar, listening and exit tests for listening, reading and writing were significantly below the class average and, in the course tutor's opinion, not of a standard that would meet the English language requirement through either IELTS or the OET. Tutor feedback on a mid-course role play was generally positive, but pointed out a number of grammar and pronunciation errors. No role play information was available for Pharmacist L.

With regard to the patient-centred approach to dealing with pharmacy customers, he distinguished between those with prescriptions, to whom no other options could be offered, and those who came for advice without prescriptions. This second group was very much more common in the Middle Eastern countries where he had worked, since it was a cheaper option, and required a patient-oriented approach so that treatment could be negotiated.

Like many others in this study, Pharmacist L felt that, while they had come to New Zealand through points gained from their medical qualifications, the requirements for registration in New Zealand were extremely stringent, particularly the IELTS score of 7.5 needed to meet the English language requirement. Like others, he also regretted the absence of a bridging course to assist overseas-trained professionals through this process and, in view of shortages of medical personnel in this country, found this lack of support inexplicable.

Pharmacist L was contacted again in February 2008. He reported that he had sat the OET at the end of 2007, achieving two C grades and two D grades. He also said that he had accepted a place to study for a Bachelor of Pharmacy degree at the University of Otago. After taking two summer courses, he had been placed in Year 2 of the five-year degree program.

4.4.3 Pharmacist M

Pharmacist M completed her pharmacy qualification in China in 1989 and worked as a hospital pharmacist for 13 years (attending a university class for some period during that time to improve her English) before coming to New Zealand in 2003. English was not used during her studies, nor did she have any opportunities to use English during her working life in China. After arriving in New Zealand in 2003, she completed a qualification as a pharmacist technician at AUT and worked in several retail pharmacies in Auckland.

Her initial experience of IELTS was also in the General Training module, taken for immigration purposes in 2003. At that time she scored band 5.5 overall. Since her arrival in New Zealand she had taken another English language course and sat the IELTS Academic module, achieving an overall band 5.5 this time as well. In her opinion, her present difficulties were all with aspects of spoken English. She admitted that she could understand "only about 80 per cent" of what customers said, and that she had difficulties with the vocabulary and grammar she needed to give advice and explanations.

Based on practice IELTS tests undertaken on the course, she had found the reading tests challenging, and was doubtful about whether she would be able to reach band 7.5 in the foreseeable future. In addition to the EHP course, she had also enrolled in a part-time IELTS preparatory course to get feedback on completed practice tests. She believed that she was improving, "but quite slowly, and quite slowly is not what I want". Like others in the study, she stated a preference for being able to re-sit only those components where the required standard had not been met, and for an exam with medical content. For those reasons she preferred the OET as a test of English language proficiency.

Her plans at the time of the second interview were to sit IELTS in September and the OET in November of 2007. By the time of the third interview in March 2008, she reported having taken both tests towards the end of 2007, achieving band 6 for Listening, Reading and Writing on IELTS and band 6.5 for Speaking. On the OET she had achieved grade C for all four papers. At that interview she stated that, with regard to the two tests, "neither is easier" and that she would need to study more before attempting either exam again. For this reason, she had selected IELTS as her preferred pathway, since she believed it was the more "learnable" test in that preparatory courses and a wealth of materials for self-study were available, while for the OET very few practice materials existed.

Only exit test scores were available for Pharmacist M. These show her proficiency over the four skills to be significantly lower than other participants on the EHP course (eg Doctor D and Pharmacist K) who were able to meet the English language requirement through either IELTS or the OET during the period of the study. The course tutor noted, however, her conscientiousness and eagerness to learn from the course. Exit role play performance feedback from the tutor emphasised her pronunciation difficulties with particular words and with forming conditional sentences, but praised her questioning techniques and empathetic approach. The assessment by the researchers noted a number of grammar errors and, while generally good, a confusing explanation of the difference between viral and bacterial infections. Her role play performance was evaluated by the medical communication expert as being below the standard of a pass (4/10) in respect of language, ability to elicit and understand the patient's perspective, ability to explore physical, social and psychological factors in the presenting complaint, and ability to jointly negotiate a management plan. Other aspects of her performance were judged to be of a passing standard (6/10): ability to establish rapport, to explore and clarify the presenting complaint, to clearly structure the consultation, explain the diagnosis and provide understanding. Her ability to reflect the patient's concerns and to encourage the patient to participate was assessed as a borderline pass (5/10). The medical expert noted that she had difficulties with the pronunciation of some words and in giving clear explanations. Overall, his assessment was that she was at the standard of a borderline pass (5/10).

Adopting a patient-centred approach to pharmacy customers was something new for Pharmacist M, as in China she had mainly communicated with fellow medical professionals in a hospital pharmacy setting. While she found it more challenging, as "you need to have more knowledge of medicine, what is useful, what's the side effect", she considered this new approach more stimulating – "you use your brain to do your work" – and beneficial to the patient.

She was aware of media attention to the issue of overseas-trained medical professionals in New Zealand, and that there was a general preference by the New Zealand public to be seen by a locally trained doctor, nurse or pharmacist. She said she would also like to be able to study on a bridging course for pharmacists, "because we have the background, we have the experience, we just need the chance".

4.5 Themes from Pharmacists K–M

Themes to emerge from the profiles of the three pharmacists attending the course are outlined in this section of the report.

4.5.1 Exam pathways

All three pharmacists in the study stated similar reasons to those of the five doctors interviewed with regard to their preference for the OET as a pathway to meeting the English language requirement: familiarity of medical content in Reading and Listening texts; medical task types in the Speaking and Writing papers; and the possibility of repeating just the particular papers that fell short of a B grade, rather than the whole exam (now possible only for pharmacists). On the other hand, they considered the availability of practice materials and training courses to be a significant advantage of choosing the IELTS pathway.

Two pharmacists (K and M) sat both tests in their attempt to reach the required standard. Pharmacist K met the English language requirement through the OET, and was of the opinion that the main differences between the two tests were that OET Listening was more demanding on account of the medical terminology used, and the OET Writing task (a referral letter) was easier for an experienced medical professional than the standard IELTS Writing tasks. Pharmacist M selected IELTS as her preferred pathway, realising that she needed more formal study of English to improve her reading ability, and that a test she could prepare for very thoroughly by working through a quantity of practice materials would suit her better. Pharmacist L, on the other hand, did not take either test, but opted to qualify to practice in New Zealand by studying for a degree in pharmacy at a local university.

4.5.2 English language proficiency

Interviews sought information about what the three pharmacists considered to be their own strengths and weaknesses. While they all expressed complete confidence in their own professional knowledge, they had reservations about their ability to communicate with ease with customers in all situations, and identified difficulties with grammar, vocabulary and pronunciation. Pharmacist M was also concerned about her reading ability in English.

4.5.3 Influences on exam success

Only one of the three pharmacists (K) met the English language requirement during the period of the study. Factors contributing to this included her level of English proficiency on arrival in New Zealand (around band 6.5 overall); her ability to persevere in the face of failure to achieve the required standard at the first or second attempt on IELTS and/or the OET; her readiness to spend a considerable amount of time and effort preparing herself for the tests by attending English language courses as well as studying independently; and the quantity of practice in speaking English that she gained through her employment in a retail pharmacy. While Pharmacist M displayed similar perseverance and diligence and employed similar strategies, her weaker initial proficiency (band 5.5 overall) made the task of reaching the required standard significantly more difficult.

Although Pharmacist L expressed confidence in his professional knowledge base and the qualification he had studied for in Jordan, his English proficiency was at a lower level than most of the rest of the class. This appears to be one factor in his decision to re-do his academic qualification in pharmacy rather than spend time trying to meet the required standard in IELTS or the OET. He explained this decision by saying that he considered it preferable to spend several years studying in his subject area, as he might well need to spend a similar amount of time studying for one or other of the English language tests. He also believed that, since he intended to settle in New Zealand, having a local qualification would benefit his career in the long term.

4.5.4 Patient-centred management

Both Pharmacists K and M were working in retail pharmacies at the time of the study, and so were well aware of the need to understand customer concerns and negotiate treatment options. While Pharmacist K stated that this was not dissimilar from the way interactions were conducted in Malaysia, both Pharmacists L and M (from China and the Middle East) said that the approach was very different from the one used in their home countries.

4.5.5 Views of the New Zealand context

Although they admitted to not being very well informed about public and media opinion on the topic of overseas-trained medical professionals in New Zealand, the general perception of these three pharmacists was that many New Zealanders were sceptical of their professional and communication abilities, a situation not helped by periodic media reports of professional misconduct or incompetence by a very small number of the large group of overseas-trained professionals who are working in New Zealand (40% of the total workforce: Medical Council of NZ, Survey of the NZ Workforce in 2006).

4.6 Profiles of two nurses

Personal information and data collected from the two nurses profiled for the study is presented in Table 5.

Name	Gender	Country of origin	Interviews	Role plays
Nurse N	female	Guatemala	2, 3	✓
Nurse 0	female	China	3	✓

Table 5: Nurses N and O

4.6.1 Nurse N

Nurse N was both a nun and a trained nurse in her native Guatemala, and had worked for more than 25 years in different parts of the country before arriving in New Zealand in 2003. At some time in the past she had also studied medicine for two years, but family circumstances had forced her to abandon these studies. She had a specialist nursing qualification in paediatric oncology, and in 2003 was awarded a scholarship to study English at San Francisco State University. While there, she was offered homestay accommodation in New Zealand and took up the opportunity to come to this country to improve her English. She has since decided to settle here, and has worked for four years as a health care assistant in a hospice, a job that she began as a volunteer before transferring to her present position. She stated that this is a job she particularly likes.

She judged her strongest skill to be speaking and her weakest writing (in particular spelling), which she believed also affected her ability to achieve a good score in listening comprehension tests. Although quite prepared to do the necessary study to meet the English language requirement for registration, Nurse N was feeling somewhat frustrated about the fact that, after 27 years of experience including four years in New Zealand, she was unable to work as a registered nurse, commenting that "now is too long, it is getting too long".

Her initial experience of taking the IELTS Academic module was in Guatemala in 2005, when she achieved band 5.5 overall. More recently, she sat the test in February 2007, this time obtaining band 8 for Speaking and 5.5 for the other three skills. Nurse N took IELTS for the third time at the beginning of December 2007 with these results: band 8 for Speaking, band 7 for Reading and Writing and 6.0 for the Listening paper. At the very end of December, she attempted IELTS yet again and scored band 5

on all four papers. When interviewed in March 2008, Nurse N was feeling disappointed and somewhat disillusioned with IELTS as a pathway to registration, particularly since she had studied hard and worked through quantities of practice materials throughout December. As a result of this lack of success with IELTS, she stated at the third interview that she now planned to try the OET and, she had re-enrolled in the EHP course for 2008 to have access to practice tasks and materials for that exam.

As she had begun attending the EHP course after the starting date in 2007 and was not officially enrolled, no entry or exit test scores were available for Nurse N. Feedback by the class tutor on her role play test at the end of the course noted a number of grammatical errors and lack of knowledge of empathetic responses. A clear, coherent structure was also considered to be lacking in the management phase. The two researchers made similar comments, and while they noted that she had a warm manner and an ability to listen attentively, her role play performance offered little in the way of a clear diagnosis or negotiation of a clear management plan. The medical communication assessor rated Nurse N's overall language ability as below a passing standard (3/10). He commented positively on her warm personality and assessed as satisfactory the information she gave about the diagnosis (5/10), as well as her exploration of the presenting complaint from a medical perspective and the overall structure of the consultation (6/10). Nevertheless, he felt that her general level of language proficiency was inadequate for the task of giving clear information, and that her manner in the interview was directive and non-patient-centred. He was of the opinion that she needed to improve her knowledge of medical complaints common in New Zealand and of nursing interview techniques. His overall score was 4/10.

4.6.1 Nurse O

Although she did not take part in the first two interviews, Nurse O volunteered to participate in the third post-course interview. She is from China, and at the time of the study was working as a health care assistant at Auckland City Public Hospital.

She first sat OET in September 2007, achieving Grade C for Writing and D grades for the other three skills. On her second attempt in November 2007, she achieved C Grades for Listening, Speaking and Writing, and a D Grade for Reading. At the time of the post-course interview in March 2008, she had just taken the OET for the third time, but no longer felt confident in her ability to pass this test. She listed both advantages and disadvantages of the OET: while its content was medical, therefore more familiar to nurses, and it was possible for candidates to re-sit individual papers, very few practice materials were available and, at $A750, the OET was a much more expensive test. She was also disappointed that, having practised writing letters of referral using the sample materials for guidance, the actual task in the exam was a set of written instructions and advice to a patient.

Entry test scores for Nurse O were below the class average for vocabulary, listening, reading and writing; however, her score for the entry grammar test, exit reading and speaking tests were assessed as at a satisfactory or passing grade. With regard to her exit role play test, comments made by the class tutor pointed out that she needed to find less blunt ways of questioning, to use transition signals at particular points of the interview and to pronounce key medical terms clearly and correctly. The two researchers for this study noted these points as well as a lack of empathy and spoken fluency and unclear pronunciation of certain words. The medical communication expert's evaluation of Nurse O's role play was that it was considerably below a passing standard. On the criteria of establishing the patient's concerns and understanding the patient's perspective, exploring and clarifying from a medical perspective and exploring physical, social and psychological factors, she scored at the bottom of the scale (0/10). On other criteria, including the ability to establish rapport, provide structure to the consultation, explain a diagnosis and jointly negotiate a management plan, her scores were also poor (2/10). Her overall language ability was assessed as marginal (4/10). The expert's advice to Nurse O was that she needed to develop the necessary emotional maturity and professional manner to be able to understand the patient's concerns. Her overall score was 1.5/10.

4.7 Themes from Nurses N–T

This section of the report outlines two themes to emerge from the two profiles above and from other sources of information: test scores from four other nurses (Q, R, S and T) and role plays from Nurses P and Q.

4.7.1 Exam pathways

Although Nurses N and O chose different pathways to registration (the former through IELTS and the latter through the OET), neither was successful in meeting the standard of English required for the nursing profession during the period of the study. At the third interview, each stated an intention of trying an alternative pathway in the hope that it would offer a better chance of success. Class test scores and feedback from role plays by all assessors suggested that, at the time of the study, the English proficiency of all six nurses was not at the level of IELTS band 7.5 or OET Grade B. Like their classmates in the other two professions, they were attending the course to improve their proficiency in English but their main test preparation strategy appeared to be to work through as many practice exam papers as possible.

Nurse Q was interviewed only once, in April 2008. At that time she stated that she was working as a care giver and that she would try to meet the English language requirement through the OET as a "more familiar, therefore easier" option compared with IELTS.

4.7.2 English language proficiency

Entry and exit test scores for Nurses O P, Q, R, S, and T showed that, on the whole, their English proficiency was average to below-average compared with the rest of the class, and generally weaker than most of the doctors and pharmacists.

As with Nurses N and O, feedback on interview role plays by the medical communication specialist for Nurses P and Q was that their overall language ability was below a passing standard, (2/10 for both nurses). He believed that none had been able to demonstrate adequate knowledge of the presenting complaint in their role plays (all of which were common health problems in the New Zealand context). While Nurse P scored an average of 2.6/10 over the eight criteria, Nurse Q achieved an average of only 1.3/10. The course tutor and researchers commented on a number of English language weaknesses in the role play performances of these two nurses, including pronunciation, grammar, vocabulary and a general lack of accuracy and fluency in their spoken English.

4.8 Assessments of speaking/oral interaction ability

Now that we have described individual participants in some depth, it is useful to pool some of the assessment data. The study collected assessment feedback on participants' speaking/oral interaction ability from five different sources: the EHP course tutor, project researchers, medical communication specialist, IELTS and OET Speaking exam scores. A summary of this data is presented in Table 6.

	Course tutor and researchers	Medical communication specialist	OET	IELTS
1. Doctor A	*Tutor*: "Achieved" standard for OET; good passing standard. *Researchers:* English satisfactory; lack of clarity and structure.	4/10 average. Language 3/10. Weaknesses in English, consultation strategies and having a patient-centred approach.	B	7.0
2. Doctor B	*Tutor:* "Achieved" standard for OET; good passing standard; questioning and feedback responses need attention. *Researchers:* weaknesses in asking questions and establishing rapport.	3/10 average. Language 2/10. Severe weaknesses in English, consultation techniques and patient-centred approach poor; good medical knowledge of the presenting complaint.	DNS	DNS
3. Doctor E	*Tutor:* "Achieved" standard for OET; good in some communication skills and unsatisfactory in others; pronunciation unintelligible at times. *Researchers:* pronunciation, vocabulary and ability to establish dialogue with the patient all need improvement.	4.3/10 average. Language 6/10. Unfamiliar with the medical content of the complaint. Approach not patient-centred.	DNS	DNS
4. Doctor I	*Tutor:* "Achieved" standard for OET. No language errors noted. Needs to develop a closer rapport. *Researchers:* The most satisfactory role play from a language perspective, but some confusion over diagnosis.	2.4/10 average. Language 6/10. Overall, well below passing standard: lack of familiarity with patient-centred approach, the patient's cultural expectations re explanation of diagnosis and negotiation of a management plan.	DNS	DNS
5. Doctor J	*Tutor:* "Achieved" standard for OET; needs to improve ability to establish rapport through feedback responses. *Researchers:* poor rapport; did not give a diagnosis or negotiate a management plan.	2.2/10 average. Language 4/10. No emotional empathy; complete lack of familiarity with the patient's expectations; poor consultation techniques.	DNS	DNS
6. Pharmacist M	*Tutor:* "Achieved" standard for OET; good rapport established. Pronunciation of some words unclear. A number of grammar errors. *Researchers:* Language errors: plural and past tense endings, articles and prepositions omitted. Explanations not always clear.	5/10 average. Language 4/10. Friendly manner, but no eliciting of the patient's perspective. Pronunciation of some words and explanations of the presenting complaint were unclear.	C	6.5
7. Nurse N	*Tutor:* "Achieved" standard for OET; more work needed on vocabulary, pronunciation of some words and questioning techniques. *Researchers:* friendly manner and good listening skills. Not a patient-centred approach – no negotiation of treatment.	4/10 average. Language 3/10. Warm personality. Needs to improve overall fluency and ability to give information clearly; knowledge of the presenting complaint in this instance; using a methodical consultation technique	DNS	8 in Feb 2007. 8 and 5 in Dec 2007.
8. Nurse O	*Tutor:* "Achieved" standard for OET; improvement needed in pronunciation and a more sympathetic manner. *Researchers:* lack of empathy, fluency, ability to pronounce some words.	1.5/10 average. Language 4/10. Needs to develop emotional maturity, a more professional manner and the ability to show understanding of the patient's concerns.	C	DNS
9. Nurse P	*Tutor:* "Achieved" standard for OET. *Researchers:* Lack of structure to the consultation; did not appear confident. Grammar errors; lack of fluency.	2.6/10 average. Language 2/10. Good ability to reflect concern; poor language accuracy and fluency, familiarity with the medical aspect of the consultation; approach not methodical.	DNS	DNS
10. Nurse Q	*Tutor:* "Achieved" standard for OET; more work needed on pronunciation and questioning techniques. *Researchers:* Poor language resources (grammar, vocabulary, pronunciation); very hesitant manner.	1.3/10 average. Language 2/10. Poor comprehension from both a language and medical perspective; poor pronunciation, lack of familiarity with medical aspects of the consultation.	DNS	DNS

Table 6: Assessments of participants' performance in a medical interview role play, IELTS and OET test scores

Comparison of feedback given by the three assessors brought to light a number of points of interest.

- The course tutor, no doubt mindful of the need to give class members encouragement and to promote self-confidence, gave by far the most positive feedback on role play performances; however, her feedback identified few of those weaknesses that were noted by the medical specialist.
- Unsurprisingly, feedback from both the researchers and the course tutor focused on aspects of language and on medical communication as perceived by a lay person. Some comments from this perspective about each performance were also made by the medical specialist.
- The assessment scores given by the medical specialist against a similar set of criteria to those used for NZREX Clinical were much lower than those given by the course tutor. Whereas the latter assessed all 10 role plays as being at an "Achieved" standard for the OET, the highest scores given by the medical assessor were two borderline passes to Doctor E (4.3/10) and Pharmacist M (5/10). Other scores ranged from 1.3/10 to 4/10.
- The medical specialist's score for language ability was lower than his overall score on the medical communication criteria for six out of the 10 role plays (one to two points below), suggesting that many of this group of qualified health professionals still needed to learn more about how to convey their medical knowledge in English, and about the various strategies available for key consultation competencies such as being able to ask questions, show empathy and negotiate management options.
- In the four other role plays, participants' language scores were two or three points higher than their overall score (although still at best only a borderline pass), which perhaps indicates a good general proficiency in English, but lack of familiarity with particular medical complaints in the local context and with key components of a patient-centred approach.
- Only two of this group of participants took both IELTS and the OET; a further two sat one of these tests. A comparison of assessments from the two tests and the medical specialist's rating revealed a degree of discrepancy. Doctor A reached the required standard of English language proficiency through both the OET and IELTS, but was assessed at only 3/10 by the medical specialist, while Pharmacist M, who did not meet the proficiency standard on either exam, was assessed at 4/10. A similar small difference can be noted in respect of Nurse N (8 in IELTS, 3/10), while the two scores for Nurse O (C in OET and 4/10) were in agreement.

4.9 Achievement scores in IELTS and the OET

For these health professionals, their preference for IELTS or the OET varied during the course of the study; however, at any one time only one of the two tests was favoured by each person. As a result, just four participants took both IELTS and the OET within the same six-month period in 2007–08, providing very limited information about achievement on the two tests (presented in Table 7).
To the extent that any meaningful comparison can be made on such a small sample, it appears that the benchmark score of band 7.0–7.5 in IELTS can be equated to the "B" grade in the OET, while the "C" grade corresponds to IELTS 6.0–6.5. Those who obtained the two OET "A" grades received IELTS band scores of 8.5.

	IELTS Listening	OET Listening	IELTS Speaking	OET Speaking	IELTS Reading	OET Reading	IELTS Writing	OET Writing
Doctor A	7.5	B	7.0	B	7.0	B	5.5	C
Doctor C	7.0	B	8.5	A	6.5	C	7.0	B
Pharmacist K	8.0	B	7.0	B	8.5	A	6.0	B
Pharmacist M	6.0	C	6.5	C	6.0	C	6.0	C

Table 7: IELTS and OET scores in 2007–2008 for four health professionals

5. DISCUSSION

This section of the report reviews the three research questions in the light of the main findings of the study. It discusses implications of the research for health professionals, preparatory courses for health professionals and for IELTS and the OET.

5.1 Pathways to success in meeting the English language requirement

Research questions 1 and 2

The first research question inquired as to how health professionals seeking re-registration in an English-speaking country compared IELTS and the OET as measures of their English language proficiency, whereas the second question involved an investigation of the factors impacting on the participants' choice of a particular pathway to meeting the English proficiency requirement by means of one test or the other.

Interview statements by study participants provide clear evidence of their opinions on the advantages and disadvantages of IELTS and OET pathways, as well as recording changes in their preferences over the 10-month duration of the study.

Participants' opinions on the advantages and disadvantages of IELTS

Participants' opinions on the advantages and disadvantages of IELTS included the following points.

- At $NZ295.00, IELTS is a much cheaper examination than the OET ($A775.00).
- The availability of practice materials and preparatory courses providing advice in test-taking techniques make the IELTS Test more "learnable".
- IELTS Test content is not medical, nor are the Writing and Speaking tasks used in the Test in any way relevant to the participants' future professional practice.
- In the IELTS interview, candidates can be questioned on any topic by the examiner, who largely controls the direction of the interaction. This makes it somewhat different from the OET role plays.
- There is a requirement for all four modules of IELTS to be passed at a single sitting, and the whole test re-taken even if only one skill was assessed at below the required band 7.0. (This requirement has been relaxed for nurses who may now take one calendar year and more than one sitting to achieve scores of at least band 7 in all four IELTS papers – Nursing Council of New Zealand.)
- Doctor A, Pharmacist K and Nurse N expressed concerns about fluctuations in their scores (sometimes of more than one band for particular modules) on successive IELTS Tests taken within a reasonably short period of time. This could, of course, have been

because in their test preparation they concentrated on their weaker skill/s and in so doing they neglected those in which they had previously done well.

Participants' opinions on the advantages and disadvantages of the OET

Participants' opinions on the advantages and disadvantages of the OET included the following points.

- The medical content of texts in the Reading and Listening tests of the OET is familiar to them.
- The letter of referral is also familiar, especially for doctors, making it an easier text for health professionals to write well compared with an academic essay or data commentary.
- The medical interview is another familiar task, and the fact that the interlocutor takes the role of patient gives the candidate more scope to exercise some control over the direction of the interaction in the Speaking test.
- Not all four components of the OET need to be passed with grade B at a single sitting (although this flexibility now applies only to pharmacists and nurses, not to doctors applying to register in New Zealand).
- The Listening test of the OET is more demanding than the corresponding IELTS module on account of the medical terminology used in the text.
- The OET test is considerably more difficult to prepare for, owing to the lack of practice materials.

Despite the fact that most participants stated, at least in the first and second interviews, that they believed the OET to be a more achievable and in many ways easier test, patterns of exam-taking varied across the eight health professionals in the study who attempted one or both of the tests. Overall, IELTS emerged as the favoured pathway to meeting the English language proficiency requirement for the majority of study participants. During the period of the study, Doctor D and Nurse N took IELTS on multiple occasions but did not attempt the OET. Doctors A and K first attempted IELTS but were unsuccessful, and so they sat the OET several months later. Doctors C and M sat IELTS and OET at about the same time (Doctor C then switched back and attempted IELTS again). Pharmacist L sat the OET before deciding to re-do his pharmacy studies at university, while Nurse O attempted the OET three times without success. At the March 2008 interview, she stated an intention to take IELTS within the next six months.

From this evidence, it appears that the availability of practice materials and training courses for IELTS and its significantly lower cost may have outweighed its disadvantages for many in this group of health professionals. Evidence from the study also highlights the highly strategic and changeable stance of the participants towards the two tests. From interview statements, it is evident that they changed their opinions and test preferences over the course of the study as a result of actual experience (which in some cases contradicted their preconceived notions), degree of success in meeting the required level of proficiency on the first or second attempt at a particular test, the possibility of re-sits for individual test components, and the test fee.

Research question 3

The third research question explored factors influencing both the English language development and test performance of a group of health professionals in an *English for Health Professionals* course.

A number of influences appeared to determine the likelihood of success in IELTS or the OET, and from interview statements and the teacher's journal the profile of a "candidate more likely to succeed" emerges. It would seem that the chance of success increases if a health professional…

- can build on a solid skill base and knowledge of English, with extensive experience as a language learner and user
- is able to demonstrate self-confidence, perseverance and equanimity in the face of initial exam failure
- is able to devote sufficient time and effort to attending classes and to self-study (and has family support to assist with this), as well as being willing to access other available forms of assistance (eg peer support, library materials, online and face-to-face delivered courses)
- has a realistic view of their own strengths and weaknesses in English, and of what is required to reach the benchmark level of proficiency; as reported by the course tutor, those class members who hoped to achieve success within a few months through intensive practice on mock tests alone were less likely to succeed
- takes a broad view of the test, regarding it as an opportunity to improve English proficiency, rather than an unnecessary and resented barrier to registration or a one-off event to be prepared for in the most strategic manner possible
- is prepared to listen and read extensively beyond practice tests and health matters, and to take up all opportunities to interact with native speakers so as to build fluency and confidence
- becomes thoroughly familiar with the test format, and with test-taking techniques (eg the most effective type of reading and listening strategy for a particular task) and completes a quantity of practice test material
- appreciates that there are valid reasons for professional bodies to stipulate a high level of proficiency in English, eg issues of patient safety and the patient-centred approach to consulting that is considered best practice in health care workplaces in New Zealand.

It needs to be noted that, while the motivation of the two participants who successfully met the required English proficiency standard during the period of the study was strongly instrumental, they did not embody all of the above attributes although they did each possess a number of them. Two additional influences that might well play a role in determining success in meeting the English requirement, and will no doubt become more critical once a candidate attempts the clinical examinations and supervised practice stages of re-registration, are mastery of the discourse of patient-centred management and commitment to following a clear pathway through the written and clinical assessment stages of the registration process.

The medical specialist's comments and evaluations of role play performances by 10 participants in the study emphasised a number of features common to the group, as all were assessed as borderline passes or below a passing grade on their communication skills in a sample medical interview. As well as knowledge of the medical content of the presenting complaint, the specialist's assessment scores and comments covered weaknesses in accuracy, fluency and intelligibility, questioning techniques, empathetic responses, clear explanations, and the ability to provide options for the management plan

and a coherent structure to the consultation. More importantly, due to language weaknesses or lack of knowledge, in his opinion none of the 10 participants demonstrated any real ability to establish rapport and implement a patient-centred approach to the consultation.

In the second interview for the study, participants' views of the New Zealand context with regard to the attitude of professional bodies, the media and public opinion were elicited, and it has to be said that these views were overwhelmingly negative. Almost without exception, participants believed that the benchmark of band 7.5 for IELTS was too severe and extremely difficult for any non-native speaker of English to achieve. They also felt they had received little encouragement or support from their professional bodies, none of which offered any kind of bridging course or supervised practice to help overseas-trained practitioners become acculturated to the New Zealand health care environment. Similarly, they felt that while the media were quick to publicise any medical errors or miscommunication involving overseas-trained personnel, their contribution to the New Zealand medical workforce and what they brought with them in terms of clinical experience and expertise, as well as their knowledge of at least two languages and cultures, went largely unrecognised. However, while all the participants in the study shared these views, some seemed more able to set these negative feelings aside in order to concentrate on the task of IELTS or OET preparation.

One further issue affecting preparations for IELTS or the OET was whether participants and their families were committed to staying and seeking registration in New Zealand, were planning to move to Australia to meet registration requirements through the OET or the AMC pathway, or were considering a return to their home country.

5.2 Limitations

We originally anticipated being able to obtain data from a number of participants who had taken IELTS and the OET more or less concurrently; however, only four participants in fact did this. As the New Zealand Medical Council no longer accepts the OET as an alternative to IELTS (although the Pharmacy and Nursing Councils do), the strategy of most health professionals in the study, as noted earlier, was to select one of the two tests as their preferred pathway and to attempt that test at least once before trying the alternative option.

One further difference between the intended and actual data sets is that, due to the transient and unsettled lives of many of the participants in the study and their need to earn a living, the data set of test scores is not complete: some participants came late to the course, left before the course finished and/or were absent for one or more assessments. It was therefore not possible to undertake the kinds of statistical analyses on in-house assessment results compared with external tests that we had originally intended.

A third difference is that we conducted interviews with more participants than originally planned (nine participants for the first interview, 10 for the second, and 11 for the third). We believe that this decision enhanced the qualitative data that we have presented for this project.

5.3 Implications

In this section we discuss implications of the study for candidates from a non-English speaking background seeking re-registration in an English-speaking country, for courses such as EHP that prepare health professionals for the OET and IELTS, and for these two tests.

As can be seen from the profiles of the 10 health professionals, they represented a range in terms of their current level of proficiency in English, attitude towards the task of achieving professional re-registration in New Zealand, knowledge of strategies for accessing support and resources, and personal attributes such as confidence, determination and diligence. Those who succeeded or came close to achieving their goals during the study period developed ability, knowledge and skill in most, if not all, of these areas.

Findings of the study also suggest that preparatory courses need to offer thorough, systematic teaching of the macro skills and areas of language weakness, rather than narrowly focusing on working through test preparation materials. While participants showed a strong preference for detailed study of texts and tasks relevant to medical contexts, some belatedly realised that both IELTS and the OET are assessments of English language skills in which their clinical skills as health care professionals count for little. To achieve the required scores, health professionals need to demonstrate that they are operating at the level of a very proficient user of English who makes only occasional errors in accuracy or appropriateness, which for many in this group would require a period of further study in general academic English of several months or even years, rather than a short period of intensive study of past examination papers.

As IELTS is not a specific-purpose test, health professionals who take IELTS are assessed according to the general rating criteria that are used with all candidates. IELTS examiners are not in a position to adopt “indigenous” criteria – in Jacoby and McNamara’s (1999) sense – that would reflect the particular requirements of communication in the health professions. In addition, it is not appropriate for IELTS Examiners to rate candidates’ spoken and written performance by reference to the minimum cut score that a candidate needs to achieve for professional registration – or for university admission, for that matter. This represents a limitation on the use of a relatively general proficiency test like IELTS to make decisions on the English language ability of candidates with respect to particular occupational purposes. In contrast, raters assessing candidates in a specific-purpose test like the OET can make more targeted decisions about whether someone has achieved the threshold level of performance represented by the cut score established for a particular profession.

It also needs to be acknowledged that achieving the English language proficiency standard for registration through IELTS or the OET provides only very limited evidence about whether a candidate is able to communicate effectively in health care contexts, and that mastering the subtleties of the discourse of patient-centred management (which also involves the ability to establish rapport with the patient and to understand informal “patient talk”) will almost certainly require further study and skill development (see Wette and Basturkmen, 2006).

This study has provided some evidence of differences between an assessment from a medical communication perspective and a language-based assessment (course tutor, researchers, IELTS and OET scores) and, on this evidence, it would appear that meeting the English language requirement for professional registration is no guarantee that a candidate will pass the communication skills component of a clinical registration exam such as NZREX. This raises a further question of how, in the absence of bridging courses to assist overseas-trained health professionals to develop the relevant language and communication skills (Lillis, St George and Upsdell, 2006), these abilities can be developed – either concurrently with a course preparing them for English language proficiency tests or immediately after these requirements have been met.

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6. CONCLUSION

Although participants pointed out a number of shortcomings of IELTS in their interviews and, at least initially, favoured the OET, by the end of the study period, a more balanced view of the two tests emerged, and the benefits of a more affordable fee and the availability of training courses and practice materials for IELTS became apparent to them. The perception that the OET was somehow easier also changed with test-taking experience. In addition, by the third interview many health professionals seemed to have realised that both IELTS and the OET are tests of English language proficiency, not of clinical knowledge and skill, and therefore the medical content of the OET became less important as a factor determining their choice of test.

Although scores were available from only four candidates, in all cases the IELTS benchmark of 7–7.5 was consistent with the OET standard of a Grade B. An assessment of participants' role play performance by a medical communication specialist drew attention to key components of effective communication that were beyond the scope of an assessment of English language proficiency. Thus, the two English language tests are probably best seen as sound screening measures that can identify the adequacy of the candidates' general proficiency in the language, but they are not necessarily good predictors of the ability of health professionals to handle the broader demands of medical communication in an English-speaking society such as New Zealand.

REFERENCES

AUT Knowledge Base, 2007, retrieved on 29 August 2008 from *Course information outline for Certificate in English for Medical/Health Care Professionals*. Available online at <http://intouch.aut.ac.nz/intouch/CourseInfo/knowledge_base/kb_sub.php?articleid=363§ionid=51>

Boulet, JR, van Zanten, M, McKinley, DW and Gary, NE, 2001, 'Evaluating the spoken English proficiency of graduates of foreign medical schools', *Medical Education,* vol 35, pp 767-773

Chur-Hansen, A, Vernon-Roberts, J, and Clark, S, 1997, 'Language background, English language proficiency and medical communication skills of medical students', *Medical Education,* vol 31, pp 259-263

Eggly, S, Musial, J, and Smulowitz, J, 1999, 'The relationship between English language proficiency and success as a medical resident', *English for Specific Purposes,* vol 18, pp 201-208

Graham, JG, and Beardsley, RS, 1986, 'English for specific purposes: Content, language and communication in a pharmacy course model', *TESOL Quarterly,* vol 20, pp 227-245

Hawken, S, 2005, 'Overseas trained doctors' evaluation of a New Zealand course in professional development', retrieved on 29 August 2008 from *The New Zealand Medical Journal* <www.nzma.org.nz/journal/118-1219/1584/>

Hoekje, B, 2007, 'Medical discourse and ESP courses for international medical graduates (IMGs)', *English for Specific Purposes,* vol 26, pp 327-343

Jacoby, S, and McNamara, T, 1999, 'Locating competence', *English for Specific Purposes* vol 18, pp 213-241

Kurtz, S, Silverman, J, Benson, J, and Draper, J, 2003, 'Marrying content and process in clinical method teaching: Enhancing the Calgary-Cambridge guides', *Academic Medicine,* vol 78, pp 802-809

Lillis, S, St George, I, and Upsdell, R, 2006, 'Perceptions of migrant doctors joining the New Zealand medical workforce', retrieved on 29 August 2008 from *The New Zealand Medical Journal* <www.nzma.org.nz/journal/119-1229/1844/>

Malthus, C, Holmes, J, and Major, G, 2005, 'Completing the circle: Research-based classroom practice with EAL nursing students', *New Zealand Studies in Applied Linguistics,* vol 11, pp 65-89

McNamara, TF, 1996, *Measuring second language performance*, London, Longman

Medical Council of New Zealand, *NZREX Clinical handbook for candidates 2008,* retrieved 28 August 2008 from <www.mcnz.org.nz/portals/0/nzrex/2008%20handbook%20for%20candidates.pdf>

National Policy Register, 2007, *National English language proficiency requirement for international medical graduates (Australia),* retrieved on 28 August 2008 from <www.nswmb.org.au/system/files/f52/o486//National%20Eng%20Lang%20Pol%20V%2017%20April%202007.pdf>

Occupational English Test, *Test information,* retrieved on 29 August 2008 from <www.occupationalenglishtest.org/Display.aspx?tabid=2411>

O'Neill, TR, Buckendahl, CW, Plake, BS, and Taylor, L, 2007, 'Recommending a nursing-specific passing standard for the IELTS examination', *Language Assessment Quarterly,* vol 4, pp 295-317

Read, J, and Hayes, B, 2003, 'The impact of IELTS on preparation for academic study in New Zealand' in *IELTS Research Reports 2003, Vol 4*, ed R Tulloh, Canberra, IELTS Australia, pp 153-205

Read, J, and Hirsh, D, 2004, '*English language levels for international students in tertiary institutions*', Final report to Education New Zealand on Export Education Levy Project E4

Silverman, T, Kurtz, S, and Draper, J, 2005, *Skills for communicating with patients,* Oxford, Radcliffe

Wette, R, and Basturkmen, H, 2006, 'The language difficulties of overseas trained doctors: Evidence from role plays' in *New Zealand Studies in Applied Linguistics,* vol 12, pp 64-77

APPENDIX 1: INTERVIEW GUIDES

Interview 1, June 2007

1. Can you please tell me about your language background?
   - How many years of English language learning have you had?
   - How many years have you lived in NZ (or any other English-speaking country)?
   - Have you sat any English language proficiency exams? (IELTS/TOEFL/OET)
   - What grades did you get?
2. Can you please tell me about your medical background?
   - What qualifications do you hold?
   - Where have you worked previously?
   - What kinds of jobs were you doing?
   - What are your goals for working in your particular area of health care in NZ?
   - What will you need to do in order to achieve those goals?
3. What do you think are your main areas of strength and weakness when you are trying to communicate in English in health care situations?
4. How do you think the EHP course will help you to overcome areas of weakness / prepare for the IELTS and OET examinations? (L/S/R/W)

Interview 2, August 2007

1. Could we start by talking about a little more about IELTS and OET? Have you/you have sat IELTS/OET before?
2. What do you think of the two exams – how do they compare?
3. What are your plans for sitting OET/IELTS in September/October? Definite?
4. And as far as the skills you need to prioritise – how are you going on the course? – do you think you are improving in the key areas for you?
5. What kind of feedback are you getting from Patsy? What does she think about your progress?
6. There's quite an emphasis on PCM (patient-centred management). I guess that could be quite a cultural thing – is it new for you in your experience as a medical professional?
7. And when you finish the course? What happens then?
8. There's been quite a bit of media coverage on OTDs recently – in newspapers and on television. What kind of impression does it give of OTDs (overseas-trained doctors)?
9. What do you think of the information and support provided for you by the Medical/Pharmacy/ Nursing Council of New Zealand?

Interview 3, March/April 2008

Topics covered in this telephone interview included:

- recent experiences sitting IELTS and/or OET
- perceived similarities and differences in the two examinations
- short-term and long-term plans with regard to registration
- current employment.

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