Australian
Medical Council Limited

AHPRA Public Consultation: English Language Skills Registration Standard

BACKGROUND

The Australian Medical Council (AMC) notes that the current English language proficiency standard for the registration of medical practitioners (IELTS Band 7 Overall and in all 4 components of the language assessment) is derived from the national standard for English language proficiency adopted by the State and Territory Medical Boards in 2005. This standard was accepted following an extensive review by the Medical Boards and in recognition of the importance of language proficiency as a key component of effective communications, itself a factor in ensuring patient safety.

Prior to the 2005 decision to adopt the English language proficiency standard for all International Medical Graduates (IMGs), an English language proficiency standard had been a pre-requisite for eligibility to sit the national screening examinations for IMGs seeking non-specialist registration since these examinations were first implemented in 1978. Initially the proficiency test was a language test developed and administered by the Horwood Language Centre of the University of Melbourne (this evolved into the current Occupational English Test [OET]). There were no provisions for exemptions.

In 1989/90, at the request of the Commonwealth Government, the AMC established provisions for exemptions to be granted to IMGs who had completed their primary and secondary education in countries where English was a “first” language or an official language. In 1998, due to limited access to the OET test at that time, the International English Language Testing System (IELTS) developed and administered by Cambridge University was adopted as an alternative to the OET. This decision was based in part on advice received from the General Medical Council of the UK regarding the English language proficiency standard applied to the Professional and Linguistic Assessment Board (PLAB) test that was administered by the GMC for non-EU medical practitioners seeking registration in the UK.

Since access to and completion of the OET could significantly delay an IMG commencing the AMC examination, the AMC was asked by the Commonwealth at various times to allow IMGs to commence its examinations without meeting the language proficiency standard, providing that they had satisfied that standard by the time they qualified for the AMC Certificate and applied for registration. This arrangement was finally abandoned when it was found that IMGs who had not satisfied the English language proficiency standard prior to taking the AMC examination experienced difficulty understanding the instructions for the MCQ examination. In the most extreme case the AMC was contacted by an Australian Embassy requesting permission to engage an interpreter to translate the instructions on the MCQ examination booklet to a group of IMGs.

STANDARDS AND PROFICIENCY LEVELS FOR MEDICINE

In the period between 1978 and 2004, when English language proficiency was a requirement for the AMC examination (and that of its predecessor), various standards and proficiency levels were applied.

Initially, the required standard was defined in terms of the Australian Second Language Proficiency Standards - Level 3 (ASLPR3) which was defined as “Minimum Vocational Proficiency”. Passing standard results for the OET were reported in 3 bands (A / B / C grade passes). It was also possible for a candidate for the OET to complete the requirements of the test in multiple sittings. As a result, a candidate could present for and pass each of the 4 components (Listening / Speaking / Reading / Writing) in separate attempts with a significant delay between the first and the final attempt. In the case of candidates with borderline results (C grade passes), a proficiency level could deteriorate between the first attempt and finally passing the OET overall. This became apparent to the AMC when clinical examiners began reporting that they found IMGs who had passed the OET were unable to follow the examiners’ instruction or to communicate effectively with the patients in the examination. In effect when these borderline language test candidates finally appeared for the AMC clinical examination they were being tested for their English ability rather than for their clinical knowledge and skills. In 1999, the AMC resolved that the deterioration of proficiency in IMGs with borderline results meant that it would only accept A or B grade passes at the OET and would no longer recognise C grade passes. Although this decision by the AMC was opposed by some language assessors, a number of other health professions that relied on the OET for language proficiency testing adopted a similar policy regarding the C grade passes.

When the IELTS test of English language proficiency was adopted by the AMC in 1998, the required standard was a score of 7 overall and not less than 6.5 in any of the 4 components of the test. This was the standard adopted by the GMC for its PLAB examination. In 2004/05 the Medical Boards sought independent advice on the proficiency levels required for registration purposes and resolved to adopt an IELTS standard of 7 overall and not less than 7 in all 4 components of the test. The A and B grade passes in the OET were also accepted by the Medical Boards for registration purposes.

EXEMPTIONS AND ALTERNATIVES

The provision for exemptions from the English language proficiency standard for the AMC examinations was developed in 1988/89 at the request of the National Officer of Overseas Skills Recognition, a body established by the Commonwealth and operating through the then Department of Employment, Education and Training. At the time it was argued that the English language proficiency test (now the OET) represented an artificial barrier to IMGs and could result in lengthy delays (up to 2 years or more in some cases) before these IMGs could present for the AMC examination and obtain registration in Australia. Since a number of IMGs came from English speaking countries or had been educated in English, it was argued that exemptions should be available to IMGs who could demonstrate that their proficiency had been tested or established prior to their arrival in Australia.

The exemptions provision immediately became controversial for the AMC. The AMC sought advice from the authors of the ASLPR scales for language proficiency and on the basis of that advice adopted a policy of recognition based on primary and secondary education in a country where English was a “first” language. The applicant for exemption was required to provide evidence assessment in English language at secondary level. This policy proved difficult to administer as arguments frequently arose about the nature of the secondary education and testing of language proficiency. In some cases IMGs had completed the

Cambridge University overseas O-level and A-level programs with qualifications in English literature but not language. Similarly, IMGs were trained in South Africa, which was English speaking, but their secondary education was delivered in Afrikaans not English.

When the Medical Boards adopted the national standard in 2005, it was agreed to limit the exemptions to a group of recognised countries, including Canada, New Zealand, Ireland, South Africa, the UK and the United States. This immediately removed the problem of interpreting the variations in English language testing that had been experienced with the more lenient AMC exemptions policy.

OBSERVATIONS

The AMC would like to make the following observations regarding the English standard for registration and testing English language proficiency

1. Purpose of the English Standard

It is clear that language proficiency is an important contributing factor to effective communication. However, a test of English language proficiency is not a test of communication skills or ability. If the purpose of the English standard is to ensure a minimum operational capacity to function in a predominantly English-speaking environment, it may be possible to allow some flexibility in the definition of the standard and its application. If the purpose is to establish a minimum level of communications ability, a different type of testing or a combination of tests will be required that specifically address effective communication between a medical practitioner and other health professionals, patients and their families.

2. Definition of the Standard

The history of English language proficiency testing for medical registration in Australia shows a wide variation in the definition of the standard for these tests. In terms of the current standard (IELTS 7 overall and 7 in the 4 components), it has been argued that this standard is too severe and acts as a barrier to IMGs entering the medical workforce. On the other hand, at least one Specialist Medical College attempted to implement a higher overall standard of 7.5 for the assessment of overseas trained specialists because of concerns relating to communication.

In 2004/05 a Sub-committee of the AMC's Joint Medical Boards Advisory Committee was briefed by the IELTS administrators on the standard required for a score of 7 in each of the components of the test. It was noted at the time that the IELTS module used for the purposes of registration was the academic module and that the level of proficiency required for the Reading and Writing components was quite challenging, even for native speakers. Given that the type of reading and writing expected of a registered medical practitioner in the context of current medical practice is not likely to require a high level of academic proficiency in these components, consideration could be given to accepting a slightly lower performance standard (6 or 6.5) in these components. Listening and Speaking remain critical to the effective functioning of a medical practitioner and to patient safety. Accordingly, the AMC considers that the standard for these two components should not be lowered.

(The AMC was recently advised that the GMC is proposing to increase the standard of its English proficiency test to an overall IELTS score of 7.5 on grounds of concerns about patient safety.)

3. Achieving the Standard in Multiple Attempts

The provision for a candidate to complete the requirements of the English language proficiency test in multiple sittings has been raised on a number of occasions and was in place for some time in the 1990's. As outlined above, the AMC's experience with candidates who had completed the English test over multiple sittings raised serious concerns about the validity of the test result, especially with borderline candidates. Although it understands the motivation for advancing the prospect of testing over multiple attempts, it does not consider that this would be in the best interests of the individual IMG or the broader community in the long term. However, the AMC does recognise that there may be circumstances where a candidate has achieved sound scores in all but one component of an English test and could be allowed to re-sit a single component to complete the English language proficiency requirements.

4. Period of Test Validity

The AMC considers that the period of test validity (shelf life) is a matter for the test developers/administrators to determine. The experience with the AMC clinical examinations has demonstrated the extent to which language proficiency, especially speaking, can deteriorate over time. This is a particular problem if the IMG concerned is not operating in an English speaking environment. At the same time the AMC recognises that the current two-year limit on test validity set by IELTS and others, poses a problem for IMGs because of the time delay between commencing an assessment process for registration purposes and finally applying for registration with AHPRA. The AMC would support relaxing the two year limit, where an individual IMG can demonstrate that they have been operating or working in an English-speaking environment. This would also depend on the standard of performance achieved in the original test.

CONCLUSION

It is evident that the current English standard for registration presents a challenge for many IMGs seeking registration in Australia. It is also apparent that there is some scope for flexibility in applying the standard, but this should not be at the expense of compromising the validity of the test result, especially in relation to the components of Listening and Speaking which are critical to safe and effective clinical practice.

The AMC also recognises that language proficiency is not itself evidence of communications ability. It considers that in the longer term alternative options for assessing or establishing communications skills and ability should also be explored as a requirement for registration.

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