Centre for Research in English Language Learning and Assessment

ASSESSING HEALTH PROFESSIONALS

Dr Lynda Taylor

Centre for Research in English Language Learning and Assessment

Policy and practice, issues and challenges

Dr Lynda Taylor

Acknowledgements

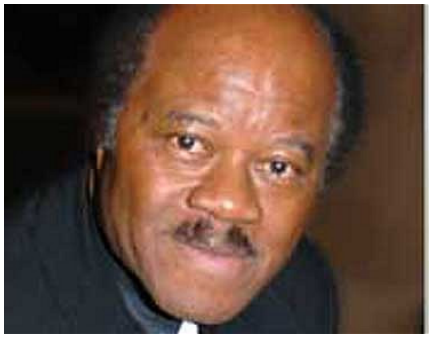
- John Pill: University of Melbourne, Australia
- co-author on 'Assessing Health Professionals' : Chapter 30 in *The Companion to Language Assessment* (2014) edited by A J Kunnan

Exactly 3 years ago….

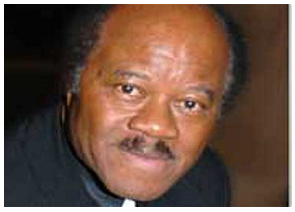
"The General Medical Council has condemned the 'gaping hole' in regulations which means clinical and language skills of European doctors cannot be tested …."

The Telegraph, 18 June 2010

The newspaper report followed a coroner's inquest…



The background story



Dr Daniel Ubani, 67, was banned from practising in Britain following serious errors which led to the death of David Gray, 70.

Ubani gave Mr Gray ten times the normal dose of diamorphine on his first shift providing GP out of hours cover in Britain. He had complained he was tired and was unfamiliar with the drug.

Assessing health professionals

- a highly complex and sensitive area
- not just a matter of policy and practice, nor of theory and research
- concerns professional and cultural competence as well as language competence
- touches upon ethical and moral questions
- as well as issues of public safety and personal professional development

Approaches to assessing International Medical Graduates (IMGs)

CRELLA
University of Bedfordshire

Differing approaches

Approaches can vary according to jurisdiction, e.g.

1. the United Kingdom
2. Australia
3. the United States of America

These areas helpfully illustrate 3 different approaches to assessing the language competence of health professionals (particularly doctors).

1.Policy and practice in the UK (i)

The UK's General Medical Council (GMC) = regulatory body for setting and maintaining standards for medical practice (e.g. registration of doctors). The GMC uses:

- a *general-purpose language test*
- a separate *test of professional competence*

NB variation according to country of origin/training, i.e. within EEA vs 'rest of the world'

1.Policy and practice in the UK (ii)

Minimum requirements set by GMC for the *general-purpose language test* (IELTS):

- Band 7 in each IELTS module (Ac Reading, Ac Writing, Listening and Speaking) at one sitting
- a 2-year limit (unless additional evidence provided)
- test result serves as an initial screening mechanism

Separate *test of professional competence* (PLAB):

- Part 1: CB tests of medical knowledge
- Part 2: OSCE – short clinical scenarios testing communication skills with various stakeholders

1.Policy and practice in the UK (iii)

Based on long-established procedures

- developed out of early collaboration in 1970s between linguists and medical experts to analyse language used by doctors, nurses and patients in British hospitals (TRAB)

Evolved into a 2-stage test (PLAB)

- (1) English lang. + (2) medical knowledge/comm. skills
- a growing role for IELTS for (1) from late 1990s

See Rea-Dickins, 1987, and Douglas, 2000.

2.Policy and practice in Australia (i)

The Medical Board of Australia's approach:

- a *specific-purpose language test* designed for medical and health professionals (covering 12 health professions)
- a separate *test of professional competence*

2.Policy and practice in Australia (ii)

Minimum requirements set for the *specific-purpose language test* (the Occupational English Test):

- Grade B (A-E) in each of 4 OET subtests (Reading, Writing, Listening and Speaking)

Separate *test of professional competence* (AMC certificate), e.g.

- CB MCQ test of medical knowledge
- a test of clinical and communication skills (involving observed interactions with standardised patients)

2.Policy and practice in Australia (iii)

OET derived from work in Australia in 1980s on assessing language in the workplace, esp. in healthcare context

- common test components for receptive skills of reading and listening
- profession-specific task-based tests of speaking and writing with an integrated dimension
- multitext reading task under time pressure since 2010

See McNamara, 1996, and Douglas, 2000, for more information.

3.Policy and practice in the USA (i)

The US Medical Licensing authorities require all practitioners to follow a similar pathway in order to practise medicine:

- a *test of professional competence with an integrated language assessment*

NB Same assessment applied regardless of where initial training was delivered or what language it was delivered in

3.Policy and practice in the USA (ii)

United State Medical Licensing Examination (USMLE):

- 3 'Steps' - Step 1 and 2 to access residency/graduate training, Step 3 after 1st year of residency
- Step 2 Clinical Skills examination similar to the UK and Aus tests (i.e. clinical encounters with standardised patients, but also trained as raters)
- integrated (rather than separate) language assessment
- assessment criteria: *data-gathering; communication and interpersonal skills; spoken English proficiency*
- also CB tests of clinical knowledge and skills

3.Policy and practice in the USA (iii)

A move in the 1990s/early 2000s away from

- using separate English language proficiency measure, e.g. TSE / TOEFL
- only testing doctors qualified outside USA /Canada

More attention to using performance tests of clinical and communication skills involving patients

Comparing the approaches

- Can a *general-purpose* language test provide sufficient evidence of the range of language skills required by a health professional?
- Can a *specific-purpose* language test ever be specific enough?
- Is a single holistic score based on *spoken English proficiency alone* an adequate measure*?*

Key issues and challenges

LSP tests: 3 'problematic' aspects

- Authenticity
- Specificity
- Inseparability

(Douglas, 2001)

The issue of 'authenticity'

- advantage of simulating tasks and content from the workplace in a test – 'feeling at home'
- positive impact on preparation materials and courses?
- generates appropriate expectations?

BUT….

- tensions because a test cannot fully replicate the workplace
- potential mismatch between linguistically-oriented assessment criteria and authentic performance criteria of the workplace
- the balancing of a 'stronger' vs 'weaker' performance test
- the capacity of language professionals to act as health professionals when assessing outcomes

The issue of 'specificity'

- 'general-purpose' vs 'specific-purpose' testing tools for assessing health professionals - a matter of degree?
- the desirability of sampling relevant content and tasks from the domain of interest

BUT…

- the risk of certain groups being/feeling disadvantaged or disaffected if text topic is not specific enough to their discipline
  - e.g. paediatric intensive care nurse given a writing task about home visits to elderly
- the balancing of a 'stronger' vs 'weaker' performance test
- representation of local/national characteristics within the profession, e.g. idiomatic expressions, brand names, procedures for certification

The issue of 'inseparability'

- how far can language knowledge and use be separated from other types of knowledge and their application – in theory or practice
- can they be 'parceled out', or are they 'inextricably entwined'?
- if the former – use of a general, decontextualised lang prof measure may make good sense
- if the latter - the importance of collaboration between language specialists and content experts

A further important consideration

Practical considerations and constraints, eg:

- availability of test centres
- frequency of test administrations
- cost to test takers and other users
- test security and integrity
- results turnaround time
- support for test stakeholders
- public policy and government legislation

The dilemma (i)

"There can be a tension between selecting an established and widely available assessment tool that is recognized and benchmarked internationally, and creating a new test, tailored to a given context or health profession group and thus immediately relevant, but potentially costly to produce and maintain."

(Taylor and Pill, 2014)

The dilemma (ii)

"… workforce flows are managed by governments, and language tests and test providers inevitably become involved in legislation and public policy. Changes in the political, legal, or economic environment trigger policy changes, and political priorities can override language testing sensibilities."

(Taylor and Pill, 2014)

The dilemma (iii)

"Test users demand and expect a single, clear "answer", something language testers rarely want to provide. For their part, registration bodies face the complex task of balancing the management of public policy and risk while seeking to facilitate fair access and professional development opportunities for individual health professionals."

(Taylor and Pill, 2014)

Future directions?

CRELLA
University of Bedfordshire

Technology

- the need to recognise the growing use of **technology** in healthcare contexts
  - changing communication demands on health professionals with implications for reviewing/revising construct definition in this area?
  - opportunities for revised/innovative test delivery methods and approaches to their assessment?

Ethics and values

- the need to acknowledge a **rapidly growing dependence** in some parts of the world on recruiting healthcare workers from elsewhere in the world
  - a moral/ethical issue for all of us in terms of global equity and justice?
  - note also the problem of individual 'brain loss' (deprofessionalisation) for health professionals unable to practise in the receiving country

NS/NNS or 'novice/expert'

- the need to move beyond a 'deficit model' of language/communicative competence?
  - towards a more constructive role for assessment in the ongoing improvement of the language and communication skills of ALL practitioners in the particular contexts in which they work

Thank you for your attention

CRELLA
University of Bedfordshire