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Validating the OET, a specific purpose language test for health professionals, against OSCEs: A comparative discourse study of simulated clinical roleplay assessments

Abstract

The aim of this paper is to investigate from a discourse analytic perspective task authenticity in the speaking component of the Occupational English Test (OET), an English language screening test for clinicians designed to reflect the language demands of health professional-patient communication. The study compares the OET speaking sub-test roleplay performances of twelve doctors who were successful OET candidates with practice Objective Structured Clinical Examination (OSCE) roleplay performances of twelve International Medical Graduates (IMGs) preparing for the Australian Medical Council clinical examination. The premise for the comparison is that the OSCE roleplays can represent communication practices that are valued within the medical profession; therefore a finding of similarity in the discourse structure across the OET and the OSCE roleplays could be taken as supporting the validity of the OET as a tool for eliciting relevant communication skills in the medical profession.

The study draws on genre theory as developed in Systemic Functional Linguistics (SFL) in order to compare the roleplay discourse structure and the linguistic realisations of the two tasks. In particular, it examines the role relationships of the participants (i.e. the tenor of the discourse), and the ways in which content is represented (i.e. the field of the discourse) by roleplay participants. The findings reveal some key similarities but also important differences. While both tests inevitably fall short in terms of authentic representation of real world interactions, the findings suggest that the OET task, for a range of reasons including time allowances, training of test interlocutors, and the limits of contextual information provided to candidates, constrains candidate topic exploration and treatment negotiation, compared to the OSCE format. The paper concludes with proposals for modifying aspects of the OET task structure and administration in the interests of enhancing its capacity to elicit more domain specific language and communication skills.

Keywords: Occupational English Test, Objective Structured Clinical Examinations (OSCE), assessing languages for specific purposes, validity, discourse analysis, medical discourse, Systemic Functional Linguistics

1. Introduction

1.1 Authenticity in LSP testing

A goal of language proficiency testing for specific occupational purposes is to predict the 'real world' performance of a candidate based on evidence gained from a simulated context (Douglas, 2000, Basturkmen and Elder, 2004). Effective communication in the workplace for professional settings such as healthcare and aviation involves not only delivering a service but also ensuring that the service meets the industry registration standards and is safe for consumers, thereby reducing the risk of adverse or catastrophic outcomes. The stakes of testing language proficiency for specific occupational purposes are therefore high: for candidates seeking to gain entry into professional practice, for professional registration bodies, and for public safety. Test design should consequently seek to replicate salient aspects of communication in the professional setting so as to facilitate a judgment on the test-taker's language proficiency to participate effectively in the workplace. One consideration in this approach is authenticity (Douglas, 2001). Authenticity refers to the extent to which the test reflects the professional context, for example, in the test format, the nature of the language elicited from candidates and the assessment criteria against which performance is judged. Constraints due to the practicalities of test design and administration can affect authenticity and should be investigated in test validation studies (Lumley and Brown, 1996, Spence-Brown, 2001).

Only a few studies in LSP testing have examined the question of authenticity from the perspective of domain experts. Whether the assessment criteria of the speaking component of the Occupational English Test, a language screening test for overseas qualified health professionals (McNamara, 1996), resonated with the criteria of doctors for effective doctor – patient communication was the focus of Pill's study (Pill, 2013, Elder et al., 2012). Lumley and Brown's post-hoc validation study (Lumley and Brown, 1996) explored the extent to which the speaking component of the OET incorporated appropriate test content in the task as well as the authenticity of the interaction between the candidate and the simulated patient. The approach used in both studies provided opportunities to develop shared understandings with domain experts about the purpose, scope and limitations of LSP testing, as misunderstandings abound both within the field of language testing as well as in the professional domain (Pill and Woodward-Kron, 2012).

Domain expert perspectives on the authenticity of candidate performances, however, are limited in the extent to which they can inform understandings of the discourse features of these performances. Discourse analysis can offer new insights into the nature of communication in the testing context. McNamara (1997), for example, considers how discourse analytic research challenges the idea of oral test performance as a fundamentally psycholinguistic phenomenon, by uncovering the inherently social, interactive and jointly constructed character of the test encounter. A number of studies have questioned the extent to which direct speaking tests such as the widely used Oral Proficiency Interview mirror the features of natural conversation. Johnson (2001), for example, found that the distribution and allocation of turns in such interviews differed so markedly from what occurs in ordinary conversation as to cast doubts on the validity of this format as a means of predicting behaviours in a real world context. While discourse analytic approaches have become increasingly popular in the language testing field (McNamara, Hill & May, 2002), none to our knowledge has compared the discourse features of performance on a language test designed for specific occupational purposes with those displayed on assessment tasks used to predict professional performance in the target occupational domain. Comparative discourse analytic studies can yield insights into the communication tasks in each interactional setting. Such studies can therefore shed light on the nature of the construct captured in each case and its relevance to what is valued in the target domain.

1.2 This study

This study examines International Medical graduate (IMG) candidate performances in the speaking component of the OET, which is an English language proficiency test for health professionals from non-English speaking backgrounds, and compares these performances to IMG candidate performances in practice oral clinical skill roleplays conducted in preparation for the Australian Medical Council's (AMC) clinical examination. This examination comprises Objective Structured Clinical Examinations (OSCEs) and forms part of the standard pathway to medical registration for IMGs, that is, medical professionals who have undertaken their primary medical studies outside of Australia (see editorial by Elder, this issue). As in the speaking component of the OET, the OSCEs involve roleplays between the doctor (the candidate) and a professional simulated patient, that is, an actor role-playing a patient. The research questions are:

- How similar is the discourse structure as manifest in task performance of successful OET candidates to that of the practice doctor-patient OSCE roleplays performed by

non English speaking background (NESB) IMG doctors in preparation for the Australian Medical Council's clinical examination?

- How similar is the management of communication tasks in the interaction which occurs in the two assessment contexts?

The study is a qualitative investigation of the OET's congruence with a criterion measure, the OSCE, which, while necessarily different in purpose from the OET, is accepted by the health profession as representing valued communication practices in the Australian workplace. A finding of similarity in the discourse structure and task management across the two assessment contexts could be taken as supporting the validity of the OET as a tool for eliciting communication skills relevant to the test's intended purpose.

2. Assessing clinical communication skills in the professional setting

Doctors' communication tends to be assessed via performance testing in order to allow examiners to observe test takers applying content knowledge and clinical skills, including communication skills. Performance testing in the form of objective structured clinical examinations, abbreviated to OSCEs (Harden et al., 1975), is used extensively in summative tests in Western medical schools and in specialist medical trainee examinations. Simulation is therefore a familiar training and assessment format for many students and doctors, although this may not be the case for IMG doctors trained in non-Western medical schools (Dorgan et al., 2009). OSCEs involve professional simulated patients playing a semi-scripted role, which will include clinical information such as features of the presenting complaints as well as psycho-social information. They are timed interactions, observed by an examiner who assesses the candidate performance. In some instances such as in the U.S. but not in Australia, the simulated patient also assesses an aspect of the candidate's performance such as the candidate's language and communication skills (Rothman & Cusimano, 2000, 2001; Van Zanten et al., 2003, 2005). OSCEs are widely accepted as an appropriate means of assessing the quality of clinical interaction of future doctors with patients. OSCEs can thus be seen as a strong representation of the values and requirements of the medical profession with respect to clinical interaction. While the best site for observing how these values are enacted is likely to be the actual workplace setting, difficulties of access and the variability that exists within workplace settings and patients make this an impractical option.

3. Methodology and methods

3.1 Methodological framework

This study examines i) the discourse structures of NESB IMG doctor-patient practice roleplays and of OET medical candidate performances, and ii) the management of communication tasks, including challenges and concerns, in the interactions by both groups of candidates. The analytical approach is genre analysis as developed within Systemic Functional Linguistics (SFL), a theory of language use in context (Halliday, 1994). An SFL approach to the analysis of test discourse has been advocated by Chapelle (2012, p. 28) as a useful way of connecting language and context for LSP test validation purposes. Genre analysis emphasises the interdependence of a text's purpose and its linguistic realisations (Martin 1992, 1997). Genre is viewed as "a staged, goal-oriented, purposeful activity in which speakers engage as members of our culture" (Martin, 2001, p. 155). In the current study, using genre as a tool to analyse the candidates' roleplays of doctor-patient interactions allows for a macro-level examination of the text structure and schematic stages, and for analysis of how the two interactants (simulated patient, doctor candidate) achieve their goals in the interaction.

3.2 Study design and setting

To examine the authenticity of LSP test candidate performances, a comparative study design was adopted. The professional setting was practice OSCE roleplays of NESB IMG doctors preparing for the clinical examination of the Australian Medical Council, a hurdle requirement for medical registration of IMG doctors in Australia. The OSCE practice roleplays were carried out in the context of voluntary workshops for IMGs conducted at the University of Melbourne as part of a research and development project between May and October 2011 [Woodward-Kron et al., 2014][1]. Four roleplay scenarios were adopted from the AMC clinical examination specifications. These were: alcohol history, chronic pain management, sexual history, and depression. The workshops adopted the AMC test format of OSCE 'stations' (encounters with different patients in different rooms with different examiners) of eight minutes' duration; participant roleplays were video-recorded. Twelve role-play interactions from the first workshop were analysed. The twelve IMG doctors in the workshop had all passed an English language proficiency test, that is, either the OET or IELTs, used as the first step on the pathway to professional registration. In Australia,

[1] The project, entitled X, was unrelated to the Australian Research Council project described in the introductory editorial (Elder, this issue)

registration requirements include successful completion of a knowledge test in the form of a multiple choice examination, followed by a clinical examination, which is mostly assessed via objective structured clinical examination (OSCE) stations with simulated patients. Candidates preparing for their clinical examination, once they have passed the English language test and knowledge examination, can gain provisional registration and work under supervision. Participants in the workshops were all from non English-speaking backgrounds and came from a range of countries, including India, Iran, China and countries in Eastern Europe. Most participants were employed as Hospital Medical Officers with limited medical registration while others were seeking clinical work. The actors, all from English-speaking backgrounds, were professional simulated patients who regularly participated in the Medical School's OSCE assessments. There were different actors for each of the OSCE stations. None of the stations incorporated a physical examination component.

The LSP study setting was the speaking sub-test component of the OET. The OET format is a roleplay interaction with an interlocutor. The test taker assumes his/her professional role, in this case, that of a doctor, while the interlocutor plays the role of the patient or the carer/relative of a patient. The roleplay scenarios are developed in consultation with health professional informants; these roleplays generally require the doctor and patient to negotiate an aspect of the patient's care. The speaking performances are audio recorded and are five-minute interactions with the patient/interlocutor monitoring the timing. The patient/interlocutor receives procedural training from the OET Centre. As OET candidates undertake the examination in different localities, the interlocutors in this study are different for each candidate performance.

The OSCE practice roleplays, while serving a different purpose from those of the OET, were deemed to be an appropriate point of comparison as they involve a simulated patient or interlocutor. The OSCE clinical tasks are non-specialist, as the AMC examination is considered the equivalent in skill level to first year post medical school training.

Ethics approval for the IMG study was granted by the Medical Education Unit Human Ethics Advisory Group, University of Melbourne. The OET Centre gave permission for de-identified candidate audio-recordings to be used in the study.

3.3 Data - roleplays

Table 1 provides the four roleplay prompts or 'stems' used in the IMG workshop. The roleplay tasks are referred to in the results as depression history, female simulated patient [DepFP], alcohol history, male simulated patient [AlcMP], sexual history, female simulated patient [DisFP], chronic pain, female simulated patient [BacFP].

Table 1 Data - OSCE doctor roleplays

Roleplay scenario	**Candidate codes male (M), female (F)**
The patient is a 26-year-old female accountant who has come to a clinic because she wonders whether she might need vitamins to get more motivated. The doctor's task is to take a focused history and make an initial diagnosis. [DepFP]	01M, 02M, 03M, 04F
The patient is a 44-year-old man who has come to the clinic because his girlfriend is worried about his alcohol intake. The doctor's task is to take a targeted history and explore the patient's understanding of the effects of alcohol on his health and life. [AlcMP]	05F, 06M, 07M,
The patient is a 33-year-old woman presenting with a vaginal discharge. The doctor's task is to take a targeted history and suggest a treatment plan. [DisFP]	08F, 09M, 10M
The patient is a 42-year-old female nurse who has been having back pain for a few years. The doctor's task is to take a targeted history and suggest a management plan. [BacFP]	11M, 12M

The audio-recorded OET speaking test performances used in this study were part of a larger database used in Phase Two of the study reported in Elder et al. (2013) (and see also O'Hagan et al., Paper 3, this issue). Of this dataset, twelve successful speaking performances by medical candidates were randomly selected for analysis on the grounds that these candidates were most likely to display valued features of medical interaction. All the selected performances had received scores indicating the candidate's language proficiency was at or above the minimum level acceptable for professional practice. Summaries of the prompts for the roleplays are provided in Table 2. The roleplays were transcribed following the transcription conventions in Eggins and Slade (1997).

Table 2 Data - OET candidates and roleplays

Roleplay scenario	**Candidate codes Male (M), Female (F); Candidate (Can), Patient (Pat)**
A 32-year-old with cystic fibrosis carrier status wishes to start a family and presents for advice and reassurance.[Cys]	01CanF/PatF, 02 CanM/PatM, 03CanM/PatF
A 40-year-old single parent presents seeking advice and reassurance having experienced a 'panic attack' a couple of days previously. [Pan]	04CanF/PatM, 05CanF/PatM, 06CanF/PatF
A patient in his/her late forties with recent constipation and blood in stools presents with concerns about bowel disease. [Col]	07CanM/PatF, 08CanF/PatM,
A 20-year-old amateur sportsperson presents in pain following a shoulder	09CanF/PatF,

injury during a football match the previous day. [Mus]	10CanF/PatF
A 32-year-old with acne since high school has recently started oral retinoid therapy and presents to find out why it appears not to be working. [Der]	11CanF/PatF, 12CanM/PatF,

3.4 Analytical procedure

The generic structure analysis of the roleplays was guided by the process outlined in Eggins and Slade (Eggins and Slade, 1997), and by a study of an interactive intra-professional clinical spoken genre (Prior and Woodward-Kron, 2014). The labelling of the stages was informed by aspects of the six-function model of medical communication (de Haes and Bensing, 2009), which includes tasks such as information gathering, information provision, decision making, and responding to patient emotions. The delineation of stages was guided by the discourse-semantic and language features of each stage. The analysis of the lexico-grammatical features associated with the schematic stages focused on the register variables of *field*, the content or activity, and *tenor*, the role of the interactants. The analysis of the *field* of discourse provides a means of examining information gathering and information provision, as identified in the six-function model (de Haes and Bensing, 2009). The *tenor* analysis focuses on how the roles of doctor and patient are played out by the interactants including the status relations and affect dimension. The register variable of the discourse of *tenor* intersects with the model's functions of fostering the relationship, decision making, and responding to emotions.

4. Results

The findings are reported first for the generic features of the OSCE doctor practice roleplays; a brief discussion of variation between candidate performances is also given. This is followed by the results for the corresponding aspects of the OET candidate performances. Next, the OSCE and OET performances are compared for the register variable of the field of the discourse, then for the tenor of the discourse.

4.1 Genre structure and generic features of OSCE IMG practice roleplays

The twelve OSCE roleplays displayed an identifiable generic structure of:

Opening^
Statement of Concern^Exploration of Condition^
Discussion of Diagnosis, Treatment and Investigation^

Closing

in response to the examination stem or prompt. The caret symbol ^ indicates how the stages are sequenced in relation to each other.

The *Opening* functions to foster the relationship and seek information about the reason for the visit. It includes introductions and ritualistic greetings. The doctor initiates the interaction. The *Statement of Concern* is the reason for the visit provided by the patient. These statements tend to be brief, incorporating affective elements, e.g. *driving me mad, a bit out of sorts,* and vague, non-medicalised language, e.g. *a sort of discharge.* The *Statement of Concern* tends to incorporate a request expressed in non-medical terms e.g. *I'd like to get it cleared up; I just thought I might need some vitamins or something*.

The phase *Exploration of Condition* functions for the doctor to gather information and for the patient to provide information. Doctor initiated information seeking follows a pattern of questioning to elicit initially the symptom complex, then broadening to psycho-social aspects. Language features in the doctor turns include Wh-interrogatives, polar interrogatives with exchange units including the sequence 1) doctor initiated question, 2) patient response and 3) doctor confirmation, as in the repetition of *sharp* in the following excerpt:

D = = gotten a bit worse, alright. Um, have you noticed - um, about the pain first, so um can you say - can you describe a bit more about the pain?

P Um… just kind of sharp

D Sharp pain [10 Dis M]

Patient responses tend to be brief with few turns incorporating extended clause complexes. Temporal information and gradation, e.g. *worse, better*, featured in both doctor and patient turns while technical terms featured in the doctors' speech, e.g. *urination, systemic body*, as well as euphemistic language, e.g. *private area*. Cohesive elements between turns were infrequent, with the doctors relying on '*you mentioned that'* to refer to previous information. Mitigating statements, such as *if that's alright with you*, were used to introduce more sensitive questions and topics. Affective elements, e.g. *difficult, worrying*, featured in patient information-giving and doctor acknowledgment statements.

The *Discussion of Diagnosis, Treatment and Investigation* phase functions for both interactants to negotiate and work towards treatment decisions. While this phase was

dominated by the doctor providing information as a sequence of activities, e.g. *I'm going to look at your liver, do some blood tests*, the patient was an active participant questioning judgments and seeking information. Negative patient statements, such as '*I don't really think that I drink too much'*, contributed to protracted decision making. Verbal processes in the doctor statements such as *discuss* featured as part of attempted collaborative decision making while the doctor recommendations tended to feature high obligation in modalised statements, e.g. *you need to, you have to,*.

The *Closing* phase concludes the interactions. It is signalled non-linguistically by the bell (timekeeping) and can be accompanied by ritualistic farewells and thanks.

Table 3 shows the generic stages with sample excerpts for each stage.

Table 3: Generic stages of the OSCE IMG simulated doctor-patient interview

Generic stages	**Examples [various cases]**
Opening: Foster the relationship; seek reason for visit	D: Hi Mr. [ ], how are you? P: Yeah I'm good = = D: = = My name is [ ] I'm one of the doctors. Er how can I help you today? [06AlcM]
Statement of concern: reason for consultation	P: Yeah um I'm feeling a bit out of sorts actually, um I think I might have an infection, or something, I've got a sort of discharge. [08DisF]
Exploration of condition: gather clinical & psychosocial information in a systematic way to inform differential diagnosis, management	[excerpt] D: Do you feel tired all the time, or do you feel tired a particular time of the day? P: I'm just tired all the time, yeah, sometimes I go to bed at 10.00 so I can get lots of sleep and I'm still tired D: Do you have a good sleep in the night? P: I get to sleep ok yeah but I'm I wake up early before it's light== D: ==ok P: And I toss and turn and then I end up getting up early and trying to study== D: Apart from the study is anything else bothering you? [01DepM]
Discussion of Diagnosis, Treatment and Investigation both interactants negotiate treatment decisions	D: Alright…so if you think it is difficult to stop drinking…are you looking for some help or… P: I don't really think that I drink too much. D: Alright P: And um I'm fit and yeah…I don't have anything wrong with me D: Ok, can I just probe…underline what I've understanding P: Yeah, go for it. D: You've been drinking 12-15 years already, and if you drink everyday you can develop some disease like liver disease and this can [influence?] your future kids, if you are going to have kids. Umm…probably what I'd like to do is just to check your blood P: Hmm [yes] [continued] D: Hmm alright ok. So hopefully you have good health. P: Yeah sure. Do you think I drink too much? D: Ah I think if you drink on a regular basis and you attempt to think about it probably it could be like a habit and it could go to dependency…we call it alcoholism… so it is best to probably check it and to discuss probably. I would like if your girlfriend is really worried to see a social worker and to discuss …so…how about it? P: Umm…I'm not really sold. D: Ah..alright P: I'm not really sold at all. [05AlcF]
Closing	[bell rings]

Table 4 shows the variation between the candidate performances in terms of the schematic stages. There was little variation between candidates in the opening stages in terms of number of turns and which speaker took the interactional initiative. Two candidates, candidate 01, and candidate 09 attempted to progress the interaction to the Discussion of Diagnosis, Treatment and Investigation phase but the patient questioned the findings, resulting in the need for the doctor to gather further information. Time pressures curtailed functional stages, e.g. for candidate 01, with only two candidates managing a closing phase in the interaction.

Table 4: Schematic stages of OSCE IMG roleplays – 8 minutes

Schematic Stages	01 DepM FP	02 DepM FP	03 DepM FP	04 DepF FP	05 AlcF MP	06 AlcM MP	07 AlcM MP	08 DisF FP	09** DisF FP	10 DisM FP	11 BacM FP	12 BacM FP
Opening	8*	3	5	3	5	3	5	1	1	3	5	1
Statement of Concern	1	1	1	1	1	1	1	3	1	3	1	4
Exploration of Condition	40 1 20	72	13	50	59	82	50	54	40 19 44	114	65	41
Discussion Diagnosis, Treatment and Investigation	1	3	11 6 11	23	11 5 6	53	13	36	3	5	8	9
Closing	-	4	9	-	-	2	-	-	-	-	-	
Total turns	**71**	**83**	**56**	**76**	**86**	**141**	**69**	**94**	**108**	**125**	**79**	**55**

* no of speaker turns

4.2 Genre features and schematic structure of OET candidates' performances

A discernable schematic structure was evident in the twelve OET candidate roleplays. The unfolding of the interaction reflected the genre's discursive purpose, namely, for the participants to explore the simulated patient's presenting concern and to negotiate treatment and investigation options. The generic stages of the OET candidates' simulated doctor-patient interview were:

Opening^

Statement of Concern^

Exploration of Condition^ [Explanation of Condition]^

Discussion of Diagnosis, Treatment and Investigations^

Closing

[ ] represents an optional stage. Table 5 shows a role-play showing with generic stages.

4.2.1 Speech function and linguistic realisations of the schematic stages

The *Opening* functions to foster the relationship. In this stage interactants used ritualistic greetings, provided names, and one of the participants either gave or sought information about the purpose of the visit. In contrast to the OSCE role-plays in which the doctor commenced the interaction, the interactional initiative for the greetings as well as for seeking/providing information was taken by the doctor or the patient interlocutor.

The *Statement of Concern* is the reason for the visit provided by the patient. The patient's statement contained narrative features such as temporal information and everyday language for medical symptoms, e.g. *at work, a couple of days ago, um, I was feeling, um I was getting hot and cold flushes*, as well as affective elements, e.g. *feeling really weird.* The patient's description of concern frequently included medicalised elements: technical language such as *shortness of breath, heart palpitations* and nominalisations such as *sweating, disorientation*. The statement could include a mitigated request for information, e.g. *So I <u>just</u> wanted to find out what that might be.*

The phase *Exploration of Condition* functions for the doctor to gather information and for the patient to provide this information. 'Wh' interrogatives featured such as *How did it happen?*, and polar interrogatives e.g. *Any chest pain?* as well as interrogatives seeking specific information such as temporal information, severity, and so on. As well as information seeking, the doctor sought to clarify and confirm information, with repetition of the patient responses occurring frequently. Affective elements occurred in both speaker turns.

The *Explanation of Condition* phase is an optional element. The doctor maintained the interactional dominance throughout this phase: speech function elements were mainly statements with a causative dimension (*so*) as well as affirmatives, e.g. *Do you understand* to check comprehension. Lexicogrammatically, this phase featured conditional (*if)* and concessive clauses (*but*) as well as modal elements to discuss probabilities. In some instances, a *Diagnostic* sub-phase appeared as optional with technical language and a 'naming' process, e.g. *generalising anxiety disorder, which we can call it* with minimal input other than backchannels by the patient.

The *Discussion of Diagnosis, Treatment and Investigations* phase functions for both interactants to negotiate and make decisions about treatment. As in the OSCE roleplays, this phase was dominated by the doctor providing information as a sequence of processes, e.g. *maybe we're going to do some blood test.* The participants were primarily the doctor or other members of the medical profession as Actor, e.g. *specialist, I, we.* These clauses were interspersed with interrogatives seeking affirmation from the patient: *Is that ok?* Strong obligation featured in recommendation statements as well as repetition for emphasis: *I highly recommend that you do it.* Patient speech functions included statements of affect, e.g. *gee that's a concern.* While some turn-taking occurred to reach agreement, there was little disagreement (e.g. *no, that's not the case*), thus allowing the candidate to reach a consensus with the patient.

The *Closing* phase signalled the end of the interaction and was initiated by either speaker to affirm the decision made in the previous phase. It included formulaic farewells, thanks, with the occasional evaluative statement from the patient. Table 5 provides an example for each generic stage.

Table 5: Generic stages of the OET simulated doctor-patient interview

Generic stages	**Example – Candidate 06: Panic attack roleplay**
Opening: fosters the relationship	D: Hello, I'm Dr []. It's very nice to meet you. P: Nice to meet you. D: Can I have your name please? P: My name's Marie. D: Marie alright. How can I help you today?
Statement of Concern: provides reason for visit.	P: Okay, um, just er at work, a couple of days ago, um, I was feeling, um I was getting hot and cold flushes, um, I was (like) having shortness of breath, heart palpitations, ah sweating, and um, disorientation. So I just wanted to find out want that might be.
Exploration of Condition: gathers information in order to inform a management plan and provisional diagnosis.	D: Alright, and so could you tell me more about your problem, how – how did – how did it happen? P: Um, well, I was at work, um, I don't know, maybe I was a little bit worried, um, at work, because my contract is coming up for renewal, um, and I don't really get on very well with my boss. So, you know I was little bit worried about that and it kind of happened D: Did you have any chest pain, or palpitations? P: Yeah, I was having like heart palpitations. D: Heart palpitations, okay. And um… um did – did you have um similar attack before? P: Um no I've never had it before. [continued]
Diagnosis [sub phase]: provides initial clinical judgment pending investigations	D: So I think what you have is just, um, ah, is a condition called panic attack, and it's – I think because it – your work is very stressful and your like – it'd be very – yeah it must be hard for you to um, you know, and support you children on your own P: Mm
Discussion of Treatment & Investigations: make decisions about treatment and investigations	D: Yeah, and I think, I really think your work um has an effect on your condition, so, and um, the – the thing is, don't be um, that's not a condition that () to be a lot about, um, you – you should be fine if you take – you know if you make some changes to your lifestyle, and take a few weeks off your work, and yeah, take up some activities that you enjoy.

	P: Mhm D: And you will be better. P: Okay. D: [Pause – 5 secs] And um, if you need a medical certificate, for – for your work then I'd be more than happy to write you – to give you a medical certificate… And I'll uh, and there's some uh relaxation techniques that I'm going to uh, that I'm going to um advise you to um practice P: Mhm D: Yeah and… and here's – and I have brochures about some um relaxation center P: Mhm D: And I really recommend you to contact them, so you can learn um, how to relax yourself, and enjoy your life and I'm sure that they will uh help you. That they will help you with that. P: Okay. Alright. Well I might give that a try. Alright
Closing: terminates consultation	D: So um, do you have any ques – more questions? P: Um, no, I think I'm okay, yes. D: Um yeah, if – if you have any questions or if you have anything that concern you please come back and see me again. P: Okay. Alright, thank you.

The generic features and structure analysis show the dominant discourse patterns of the OET doctor-patient interaction. Table 6 shows the variation of the twelve candidate performances for presence of generic stages. The sequence of *Opening^Statement of Concern^Exploration of Condition* predominated in the twelve performances with some variation in the unfolding of the discourse. Several candidates revisited the *Opening* phase in order to elicit missing information due to the patient interlocutor taking the interactional initiative in the *Opening* and moving directly to the *Statement of Concern*. Another minor difference between candidates was the unfolding of the *Exploration of Condition*: some candidates used an illocutionary act to conduct or make reference to a [fictive] physical examination as part of the *Exploration of Condition*, an aspect which also occurred in several of the OSCE interactions:

The optional phase, *Explanation of Condition*, appeared in the two role-play scenarios in which the condition was named in the roleplay prompt (cystic fibrosis, panic attack). A candidate-initiated explanation of the condition dominated this phase. The following phase, *Discussion of Diagnosis, Treatment and Investigations*, featured in all performances with recursion of previous phases in only three of the twelve interactions. All performances included a *Closing* sequence with the exception of one performance, which was terminated by the patient at the conclusion of the previous stage.

Table 6: Schematic stages in the OET candidate performances – 5 minute guideline

Schematic Stages	01 Cys	02 Cys	03 Cys	04 Pan	05 Pan	06 Pan	07 Col	08 Col	09 Mus	10 Mus	11 Der	12 Der
Opening	1*	7	2	2	12	5	1	1	3	2	2	16
Statement of Concern	1	7	32	1	6	1	3	1	1	1 2	1	1
Exploration of Condition	6	4		28	36	26	42	8	2 4 20	22	4	16
Explanation of Condition	18	4 13	22	2 4	-	-	-	-	-	-	-	-
Discussion of Diag., Treatment & Investigations	6	18	44	25	29	12	19	28	24	7 4 44	15	29
Closing	2	2	11	4	12	6	2	-	6	6	6	3
Total turns	**34**	**55**	**111**	**66**	**95**	**50**	**67**	**38**	**60**	**89**	**28**	**65**
Length min	4.4	6.10	6.44	6.29	6.55	4.56	5.00	4.25	5.42	8.21	5.48	5.16

* no of speaker turns

Table 6 shows the marked difference in the number of turns between the interactants in the candidate performances to achieve the functional stages. There is also a marked difference in the length of each role-play despite the five-minute guideline monitored by the interlocutor in the role of patient, with more than four minutes' difference between the shortest performance, candidate (08), and the longest, candidate (10). Despite these differences, the OET candidate role-play performances have a clearly discernible schematic structure that the doctor candidates orient to in order to carry out the required tasks. The genre structure is largely similar to that of the practice OSCE performances with the exception of the *Closing* phase which is mostly absent from the more rigorously timed IMG interactions.

4.3 Field of discourse: content and activities

There were similarities as well as differences in the field of discourse between the IMG and OET performances. In the IMG practice OSCEs, the field of discourse was an expert medical practitioner conducting a professional interaction with an expert simulated patient, who reported symptoms as well as associated psycho-social concerns. There were multiple doctor-initiated topic areas to explore the symptom complex, and psycho-social aspects. Patients adopted non-medical, vague language to explain their symptoms and to make requests. In contrast, the doctors tended to adopt more technical

language such as *urination, voiding, menses* to refer to everyday processes when exploring the symptom complex and providing information.

Similarly, the field of discourse for the OET candidate doctors was an expert (medical) practitioner conducting a pragmatic interaction; however, the interlocutor patient discourse had several noticeable discourse patterns. The first has to do with the language choices a number of the OET interlocutors made to state their concerns; namely, they used medicalised language featuring technical terms, e.g. *cystic fibrosis, genetic testing,* and nominalisations, e.g. *shortness of breath, palpitations, disorientation*, rather than everyday language (c.f. *feeling short of breath, my heart was racing, I was disoriented*). Several interlocutors adopted a more narrative approach; however, the gathering of information task was largely managed by the doctor using targeted questions to elicit aspects of the symptom complex, including duration and site. A second aspect of the OET doctor-initiated discourse was its limited scope in terms of topic focus, both medical and psycho-social. Gathering of symptom information tended to be brief with few requests for elaboration to assist in describing a symptom. A third aspect was the limited complexity of the language used in terms of nominal group structure as well as clause structure. Simple nominal groups with little or non-specific pre or post-modifying information dominated, e.g. *different medications,* while nominal groups with elaborated pre or/and post modifiers, as in *very mild face washers,* were rare. Several OET doctor candidates verbalised their clinical reasoning by discussing causation whereas vague language featured in other candidates' explanations, e.g. *something like that (03); anti-depressants or something like that (05).*

4.4 Tenor of discourse in the IMG OSCEs and OET candidate performances

The analysis of the tenor of discourse yielded some broad similarities between the two sets of performances; there were also considerable differences. For the functions of fostering the relationship and responding to emotions, the tenor features were largely limited to exchange structure patterns in which patient concerns were acknowledged by the doctor but not further explored. Another similarity was the high degree of obligation in modalised statements in the doctors' recommendations in the *Discussion of Diagnosis, Treatment and Investigations* phase. Both sets of performances included extended turns by the doctor with high obligation, e.g. *you need to get help*; *I highly recommend you …,* evaluative language, e.g. *very important*, as well as repetition of these elements.

The role relationships of the OET candidate/doctor and interlocutor/patient in the twelve interactions were multifaceted: the status of the doctor as a professional was foregrounded by both the patient and doctor by using the title 'Doctor' or variant in the *Opening* phase (e.g. *hello doctor; I'm Doctor …; I'm your visiting doctor*) and by the patient in the *Closing* phase, whereas the patients in the OSCE roleplays used informal language and mostly did not address the doctor by name or title. In both interactions the doctors tended to guide the discourse through the stages of *Exploration of Condition^Discussion of Diagnosis, Treatment and Investigations* to reach the interactional goals. The patient interlocutors in the OET performances, however, played significant roles in initiating phases as well as managing and extending the discourse. In ten of the twelve interactions the patient took the interactional initiative in the *Opening* phase, and in several performances they signalled the closing of the interaction. They requested services as well as extended the interaction through complication statements with affective elements mainly in the *Explanation of Condition* and *Discussion of Treatment and Investigations* phases, for example.

P It's going to be a little bit complicated for me
D To go through the treatment?
P Yeah, I think
D Look, we can arrange it, you don't have to join and go every day to support group, or spend a long time, if you went few times only in the week and learn the techniques, and you can do it at – yourself, it could take a bit, um, longer time, but you need help
P Okay
D Because on your own you will not be able to fight it all. You need to get help to get through this. So it's very important to – to see a psychiatrist and support groups.
P I see.
D [continued]
P I might be able to cope with it.
D Yes, you'll be able to cope with it, and be able to make it – uh if it happens, shorter in time so it won't go so far, twenty minutes or thirty minutes, because you will know, when you start to hyperventilate, what to do, and what to keep your mind away from your feeling of whom you're, um, you know, from your um, frightened feelings, () so
P Okay.
D Yeah.
P Well, thank you very much.
Thank you. [Pan04]

In this and all examples in the OET data, despite patient statements expressing initial concern about treatment suggestions, the interaction is a form of polite consensus with patient input limited mainly to affirmative statements, e.g. *yes,* and agreement, e.g. *alright, okay*. This is in contrast to interactional patterns in the same phase in the IMG OSCEs, where there was discord and extended negotiation and challenges as well as negative polarity (see Table 3).

In the IMG OSCE roleplays colloquial and euphemistic language featured in the simulated patients' speech but only to a limited extent in that of the doctors, who seldom took up the informal language used by the patient. Examples of colloquial language in patient speech include *I had a bit of a slip up [*referring to a sexual encounter*]; it [*referring to the alcohol*] usually just kicks out of me,* and *it's similar to the snot that you get with the colds as well* from the doctor. In contrast, formal language was used by the OET doctors throughout and also by the patient in most cases e.g. (*P) How are you sir?* As with the OSCE roleplays, colloquial language by the doctor was rare in the OET samples with the exception of *out of the blue*. Likewise, the patient interlocutors rarely used informal language with the exception of one patient: *hi doc, how you going?* and *good on you, thanks doc*.

5. Discussion

The findings of the generic structure analysis showed that the OET candidates oriented to a similar discourse structure to achieve their communicative goals, as did the doctors in the roleplay practice examination performances from the target context. The key communicative functions: fostering the relationship, gathering information, providing information, making decisions, and responding to emotions (de Haes and Bensing, 2009), were identifiable as intrinsic elements of the schematic stages of all the OET performances. This finding suggests that the OET candidate performances exhibit a reasonable degree of authenticity in the sense that they share important discursive features characteristic of IMG OSCE test performances in the professional setting. Other discursive similarities between the two sets of performances were exchange structure patterns whereby the doctor gathered information, and the monologic nature of information giving by the doctor with the high obligation aspect of the modalised recommendations.

In spite of these major similarities, the differences in the timing of OSCE and OET roleplays is noteworthy with 8 minutes provided consistently for the former and 5 minutes as a guideline for the latter. While it should be noted that each OET speaking test consists of two different role-play tasks, thereby providing candidates with additional opportunity to display their competence, the variability of timing across individual roleplay performances (from 4.4 to 8.2 minutes) is a reliability concern. Differences between the OSCE and OET roleplay performances were also apparent in the interactional patterns and lexicogrammatical choices adopted in the management of communication tasks in the two assessment contexts. These

differences emerged to an extent due to differences between the OSCE simulated patients' linguistic choices and interactional approaches to decision-making compared to those of the OET patient interlocutors. Unlike the IMG OSCEs, the OET patient interlocutor mostly used formal language as did the doctor candidate, as well as abstract language to describe the presenting complaint. This may have been influenced by the nature of the prompt materials provided to the interlocutor, a possibility which is worthy of further investigation given the well documented effect of task input on the language produced by test candidates (Fulcher, 2003). In contrast, colloquial language featured in the speech of the simulated patients in the OSCE throughout the interactions, perhaps a reflection of the OSCE participants' experience in the 'real world' of hospitals, where colloquial language may be more common as a dimension of rapport building. The scope of clinical topics also differed between the two sets of performances, with the OET candidates covering a narrower range of topics such as the symptom complex than was evident in the OSCE performances. This finding may be due in part to timing restrictions but also to the OET candidates' awareness that the clinical content is not assessed in the language test. The pattern of collaborative consensus evident in the OET performances may have also been partly due to a lack of contextual information provided for the interlocutors/candidates, which contributed to the truncated exchanges in the final phase of the interaction. Lack of detail in the OET prompt materials was also noted by Brown and Lumley (1996).

6. Conclusions and implications

This comparative discourse study examining the authenticity of the speaking component of an English language screening test, the OET, argues that the roleplay method of assessing communication skills in the target setting, in this case, doctor-patient communication, can represent the valued communication practices in the profession. Our finding that the similarity in the discourse structure and task management across the two assessment contexts, we suggest, supports the validity of the OET as a tool for eliciting communication skills relevant to the test's intended purpose. There are, however, important areas of divergence between the two types of roleplay performance which seriously detract from the OET's claim to be eliciting the language skills required of health professionals in the workplace and hence can be seen as a threat to test validity. We believe that these limitations can be at least partially remedied, firstly, by more careful vetting of OET prompt materials to allow the doctor candidate greater scope for probing of symptoms and for negotiation of treatment options and

hence for the deployment of occupationally relevant communication skills. Secondly, there is scope for more targeted training of the OET interlocutors along the lines of that provided to the simulated patients who participate in the OSCE roleplays. It is important that the OET interlocutors understand the importance of and are trained in the skill of challenging the doctor candidate in a way that will elicit a rich and relevant language sample for assessment purposes rather than simply facilitating candidates' completion of the roleplay in as smooth a manner as possible. (For stakeholder views on this unnaturally cooperative behavior on the part of the OET 'patient' see Macqueen et al., [Paper 7, this issue]). It also important, for the sake of fairness, that interlocutors adhere strictly to guidelines in relation to timing, even if this means dispensing with a neat conclusion to the encounter.

This study has several limitations. One possible limitation is that the OSCE performances were practice roleplays of IMG doctors preparing for their AMC clinical examinations rather than the actual assessed performances. As the assessed performances are not available for research purposes, it is not possible to determine what, if any, differences exist between the practice IMG roleplays analysed in this study and OSCE AMC simulations. A second consideration is that the OSCE IMG roleplays were by doctors who have undertaken their medical training outside Australia. Some of the participating doctors, notably those from non-Western backgrounds, may not have had communication skills training as part of their primary medical training; therefore, the ways in which these doctors approach the key communication tasks may differ from those trained in Western medical school settings. Further studies with locally trained doctors as the comparison group are necessary to explore this issue and corroborate the findings of the current research.

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