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Language proficiency and nursing registration

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ABSTRACT

This discussion paper focuses on English proficiency standards for nursing registration in Australia, how Australia has dealt with the issue of language proficiency, and the factors which have led to the establishment of the current language standards. Also, this paper will provide a comparison of the two language tests that are currently accepted in Australia (OET and IELTS), including the appropriateness of these tests and the minimum standards used. The paper will also examine the use of educational background as an indicator of language proficiency. Finally, communication-based complaints in the post-registration environment will be explored, and some discussion will be provided about why pre-registration measures might have failed to prevent such problematic situations from occurring.

What is already known about the topic

- Clear communication is essential to patient care and the healthcare team.
- Language difficulties among international nurses are seen in many countries.
- There are international variations in how language proficiency is addressed at a policy level for registered nurses.

What this paper adds

- This paper outlines how English language proficiency is assessed for nursing registration, focusing on the Australian context, explaining how the current standards were developed and how these compare to various other countries.
- This paper evaluates the language tests used in Australia, including their points of difference, and the validity of language tests for the nursing context, i.e. with language skills being a core pillar, rather than the sole contributor, of communicative competence.
- This paper evaluates the use of educational experience as a means to establish language proficiency in Australia, including the pros and cons of the educational pathway, the assumptions about language skills, and how this pathway can be used to avoid standardised language tests
- This paper examines the issue of language proficiency standards, focusing on the Australian context, and provides a discussion of the rationales, minimum requirements, drawbacks, and implementation of standards.

1. Language proficiency and nursing registration: discussion paper

Internationally, it is important to have language testing for both immigrant nurses and graduating international students who have studied nursing and wish to work in their country of residence. Proficiency testing of foreign nursing graduate's language has been a concern since the mid-1970s in the USA (Powers and Stansfield, 1985: 21–22). In Australia, language testing of overseas nurses has been in place since at least 2000 (Wickett and McCutcheon,

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2002: 47). Australia has a large migrant population, with 44% of the population either born overseas or having a parent born overseas (Xiao et al., 2014: 641). By 2007, approximately 15.5% of the nursing workforce were trained outside of Australia (Xiao et al., 2014: 641), and currently about 30% of international students with an Australian nursing qualification will enter the Australian nursing workforce (HWA, 2012: 51). English is not necessarily the first language of Australian nurses, so it is certainly a concern that there may be a language barrier between patients and healthcare providers which may contribute to poor health outcomes. This paper explores the English language proficiency standards found in Australia, evaluates the two methods used to demonstrate English language ability, and examines how post-registration language problems in the workplace have been regulated.

The Nursing and Midwifery Board of Australia (NMBA) is the single national body that governs the various State and Territory Nursing and Midwifery Boards. The NMBA registers nurses, develops standards, and handles complaints, among other duties. One of its main roles is to protect the public, so communicative proficiency is a prominent feature in the NMBA's (2010: 8-9) 'National competency standards for the registered nurse', particularly under sections 9.1, 9.2, 10.2, and 10.3. In the standards, the direct references to language and communication skills are (NMBA, 2010: 8-9):

- demonstrates the necessary communication skills to manage avoidance, confusion, and confrontation
- ensures that written communication is comprehensive, logical, legible, clear and concise, and that spelling is accurate
- communicates effectively with individuals/groups to facilitate provision of care
- uses written and spoken communication skills appropriate to the needs of individuals/groups.

Thus, Australian registered nurses are expected to have a range of effective communication skills which are appropriate to different contexts, and to possess good written and verbal skills that allow information to be conveyed to patients and to initiate/maintain rapport with others. A good grasp of English – especially grammar, syntax, vocabulary, and fluent spontaneous speech – is a prerequisite for these communicative skills to be possible.

These linguistic expectations have been formed as a result of an ongoing problem of poor language skills impeding the provision of quality health care. In one Australian study, internationally-educated health professionals with linguistically-diverse backgrounds expressed how communication issues negatively affected patient care and the general working atmosphere (Clayton et al., 2014: 4). Another Australian study found that immigrant nurses' language and communication issues placed stress on healthcare teams (Xiao et al., 2014: 646). Similar problems were reported in a review of the Canadian healthcare environment which found that internationally qualified nurses' language and communication issues were the greatest challenge faced by employers and that communication barriers caused frustration and confusion among staff and patients (ANMC, 2009: 14). In the UK, changes were made to increase language proficiency standards after public consultation, British Council evidence, and patient lobby groups who sought better English language proficiency requirements for nurses, since poor English was found to be a safety risk to patients' health (Smith, 2009: 5).

Currently, proof of English language skills is required as one element of the application for nursing registration in Australia (NMBA, 2014a: 1). This requirement applies to both native and non-native English speakers and those trained to be a nurse in either Australia or overseas countries. In setting language proficiency standards, the NMBA (2011a: 1) assert their commitment to best practice regulation and protection of the public by ensuring that its practitioners have effective English language skills. The current language standards were formed as a result of community and professional consultation, and were guided by the desire to be fair and reasonable but also safe (NMBA, 2011a: 2). The guiding principles include (NMBA, 2011a: 2):

- an ability to implement the registration standards effectively
- the establishment of a rigorous registration standard that can be understood easily
- national consistency and alignment, where possible, with the registration standard on English language skills of other National Boards
- the protection of the public.

The result is that Australia recognises two main methods of establishing English language proficiency for nursing registration: having an extended educational background conducted in the English language, or through an English language proficiency test. Once registered with the national body, a nurse will typically interview for employment, and commence working without further linguistic induction being provided by the workplace.

There are three exceptions to the need to demonstrate English language proficiency. The first is for applicants who have previously held, or currently hold, nursing registration in Australia (NMBA, 2014a: 2). The second is for applicants who hold current registration as a nurse in New Zealand, which has a special agreement in place (NMBA, 2014a: 2). The third is for applicants who can provide compelling evidence of their language proficiency that shows it is equivalent to the required standard (NMBA, 2014a: 3). It is unclear whether this pathway has ever been used by the NMBA, although this clause does allow future latitude in policy for atypical or unusual applications to be successfully processed.

In the next section, we will look at language testing (including overseas comparisons), the differences between the tests, and the appropriateness of these tests.

2. Language tests

Standardised language tests are objective, applicable across time, place, and individuals, and are not prone to the problem of significant score variation between assessors. Standardised language tests satisfy the principles of being

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easy to implement, having transparent scores, and allowing comparison across individuals, professional entities, and national bodies. Two language proficiency tests are accepted in Australia: the academic version of the International English Language Testing System (IELTS) and the Occupational English Test (OET). Currently in Australia, applicants must obtain either a minimum of 7.0 in each band of the IELTS (academic) test, or a minimum of B in each band of the OET sub-tests (in one sitting of either test). The qualifying test score must be gained within two years of applying for nursing registration. A test result older than two years can be used if the applicant has maintained continuous practice as a nurse in a recognised country, or if they have been continuously enrolled in any program taught and assessed in English in a recognised country. This two-year period has been adopted from other language test practices in the USA and France, and has been regarded as generous in comparison to Australia's immigration policy of accepting only test results which are 12 months old or less (Smith, 2009: 7). In the following paragraphs, the IELTS test will be discussed, followed by an overview of the OET test.

3. IELTS

The IELTS test was designed to measure English for general academic or training purposes (Ingram, 2004: 18). The test is comprised of four language-skill sub-tests: reading, writing, speaking, and listening, and the results are expressed in half-band increments, ranging from 0 (did not take the test) to 9 (expert user). To obtain a score of 7 out of 9 for IELTS in reading or listening, the candidate usually needs to answer 75% of the test questions correctly (IELTS, 2014). If this figure is couched in terms of risk, a successful candidate may incorrectly answer 25% of the questions, which is quite a high rate of error/inability. Furthermore, error rates between band scores are not equally incremental. Exploratory research by Müller (forthcoming) suggests that written error rates may be exponential, finding that IELTS scores of 6.0, 6.5, and 7.0 equate to 206 errors, 96 errors, and 35 errors per 1000 words, respectively.

The use of IELTS around the world allows a direct comparison of the differing standards across countries (see Table 1). While countries such as Australia, New Zealand, the Republic of Ireland, and the UK have a single national governing board which enforces the standards, each state or province in Canada and the USA sets its own standard, although they may take guidance from a national body's recommendations. Table 1 below reflects the variations in minimal IELTS standards.

When reforming the Australian language proficiency standards for nursing registration in 2009, as mentioned previously, consistency with other national boards was sought (NMBA, 2011a: 2). Thus, Australian health profession boards, such as the Medical and Dental Boards, acted as referral points for changes to the IELTS requirements (Smith, 2009: 4). The policies of the UK, Ireland, Canada, USA, and New Zealand were also cited when reforming the Australian standards (ANMC, 2009: 14-18). In 2007, the UK's Nursing and Midwifery Council (NMC) introduced a minimum IELTS test score of 7 across all four sub-bands (Smith, 2009: 5), and this move was one contributing reason given for Australia's adoption of the same standard (ANMC, 2009: 40). The raising of the New Zealand standards in 2009, which required IELTS 7.0 in all sub-tests, was also cited as a contributing factor (ANMC, 2009: 15; Smith, 2009: 9). Matching the New Zealand standard was of particular importance because a discrepancy could have threatened the Trans-Tasman Mutual Recognition partnership which allows free and automatic movement of nurses for registration between the two countries. Indeed, the only current difference between Australia and New Zealand's IELTS standards is that New Zealand recognises sub-test scores across multiple sittings of IELTS within a single year, whereas Australia does not.

It is important to note at this point that the IELTS test makers themselves recommend that 7.0 is only 'probably acceptable' as a minimum entry point to linguistically-demanding health courses, whereas a score of 7.5 is deemed 'acceptable' for the field, with some certainty (IELTS, 2013: 13). Arguably, a minimum standard should not fall below 7.5 if it is meant to be suitable for registered nurse practice in a clinical setting, as compared to entry into an education environment which has more support and lower consequences for poor communication skills. However, the author has not yet found evidence that nursing bodies in Australia have considered the IELTS test-makers' recommendations.

4. OET

In Australia, the alternative language proficiency test to IELTS is the health-specific Occupational English Test

Table 1
Minimum IELTS requirements for nursing registration across the major English-speaking countries.

Country	Overall IELTS	Reading	Listening	Speaking	Writing
Australia	7.0	7.0	7.0	7.0	7.0
Canada[a]	7.0	6.5	7.5	7.0	7.0
New Zealand	N/A[b]	7.0	7.0	7.0	7.0
Republic of Ireland	7.0	6.5	6.5	7.0	7.0
UK	7.0	7.0	7.0	7.0	7.0
USA[c]	6.5	6.0	6.0	6.0	6.0

[a] i.e. Ontario, British Columbia, Alberta, New Brunswick.
[b] An overall score is not applicable because sub-test scores can be gained across multiple attempts of the test, thus making the aggregate score of any single test redundant.
[c] National recommended standard adopted by many states.

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(OET). The OET is comprised of four language sub-tests: reading, writing, speaking, and listening. It was designed by linguists in consultation with expert health professionals, and involved an occupation analysis and direct observation for the formation of tasks, after which the commonalities between health profession tasks were observed and incorporated into the materials for testing (OET, 2009: 3). The test also has nursing-specific writing and speaking components. The results range from bands of E to A ('low' to 'very high' level of performance). An OET B score in a sub-test represents a level of performance which involves fluent accurate English sufficient for professional needs (OET, 2007a: 11). Unlike IELTS, OET does not provide an overall average score, only sub-test results. Typically, in order to obtain a B in OET reading, 65% (weighted) of the answers need to be correct (OET, 2007b). If this figure is couched in terms of risk, then a successful candidate may incorrectly answer 35% (weighted) of the test questions. However, unlike IELTS, OET uses a ranking system for the listening and reading sub-tests which is indexed against population performance on the speaking and writing sub-tests, so these percentages are not definitive. Nevertheless, as was found for the minimum standard for IELTS, there is a generous margin for error in linguistic skills among applicants seeking nursing registration in Australia.

About a decade ago, IELTS was the preferred language test in Australia because it was offered in more locations and with more frequency than the OET. Since then, the OET has increased the number of venues and the frequency of testing. Furthermore, IELTS was accepted for immigration, but OET was not; however, this has now changed over the last few years. When setting the minimum standard score for OET in Australia, consistency with other professions and countries was sought. As such, the Australian Dental Council's OET language requirements were examined (ANMC, 2009: 17–18). Since OET is only accepted in Australia and New Zealand for nursing registration, the New Zealand standards were also examined. Their standard was a 'B' in all sub-tests, allowable across multiple sittings within one year. Australia adopted the requirement of attaining a 'B' in all sub-tests, but all had to be gained in one sitting, possibly because the scoring system of each version of the OET test uses ranking percentages which vary according to each cohort's performance in the writing and speaking sections (even though this rationale was not stated explicitly by the ANMC).

5. Differences between IELTS and OET

In terms of the differences between IELTS and OET, the first lies in the contrasting vocabulary demands of each test. The IELTS candidate must have vocabulary across a wide variety of topics, e.g. agriculture, aquaculture, criminal punishment, real estate pricing, architecture, frog reproduction, soundwaves, food additives, and so on. The vocabulary demands of IELTS are similar to other language tests such as the TOEFL. In contrast, the OET demands are narrower and more occupation-specific: candidates must be familiar with the vocabulary of common diseases, taking patient histories, discussing health-related issues, interpreting health-related research, and so on. Thus, at the level of vocabulary alone, the differences are quite stark.

The second main difference between IELTS and OET can be seen in the type of tasks included in the sub-tests, particularly in speaking and writing. For example, in IELTS speaking, the candidate typically needs to answer questions about their personal background (e.g. hometown, hobbies, schooling, etc.), provide a monologue of personal opinion on a generic topic (e.g. a favourite relative, an enjoyable party, holiday preferences, etc.), and give opinions about a social issue or event (e.g. public holidays, the role of technology in education, community events, employer qualities, etc.). This type of personalised and opinionated communication may not be suitable in a professional setting. In comparison, OET speaking is nursing-specific, and includes two role-play discussions with a mock patient/carer, requiring the candidate to elicit information, provide explanations, give reassurance, negotiate meaning, and generally engage in an appropriate manner expected of a nurse. Quite large differences can also be found in the writing sub-tests of IELTS and OET. IELTS writing requires the interpretation of information found on a graph/diagram/table on a generic topic, and a short essay usually giving an opinion or argument on a generic subject. On the other hand, OET writing is nursing-specific and typically requires the candidate to write a referral letter for a patient using data from patient notes.

Fewer differences between IELTS and OET are found in the reading and listening sub-tests. IELTS has three reading tasks based on different generic topics, using multiple choice, gap-fill, heading matching, and true/false/not given answer formats. OET has two reading tasks based on health-related topics, using a gap-fill answer format about a number of text extracts in the first task and a multiple-choice answer format about two complex readings in the second task. The IELTS listening sub-test is based on two conversations (one paired, one in a group) about social needs, and two information-giving monologues (e.g. a lecture), using multiple-choice or gap-fill answer formats (in text or table form). OET listening has two parts based on a consultation between a patient and a health professional and then a monologue (e.g. lecture), using gap-fill answer formats (in notes, text, or table formats). Thus, the main differences are the greater focus on note-taking in OET and the type of communicative exchange/topic being listened to.

While there are some differences between IELTS and OET, the fact remains that they also have important points of convergence–they both test grammar, sentence construction, vocabulary, and spelling. They test the ability to understand different accents at various rates of speech, to produce coherent spoken and written language, to search for facts and content, and much more. These are core skills which underpin both academic pursuits and professional activities. Thus, while it is clear that the OET tasks and content is certainly more suited to English language proficiency testing for nursing registration, IELTS remains useful. In a report by Merrifield (2008: 28), it was concluded that IELTS may have been designed for academic purposes but it could also play a role in demonstrating English language skills for professional

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activities, with most professional organisations deeming it satisfactory for that purpose. Both tests ascertain core language competencies which support good clinical communication. Furthermore, regardless of whether the candidate passes IELTS or OET, they will need to develop and adapt their language to suit the communicative requirements of each professional specific context encountered after they gain registration.

6. Appropriateness of language tests

Some criticism has been made of the use of language proficiency testing for nursing registration because there is not always a clear link between linguistic skills and future clinical communication skills. However, such criticisms are based on a misunderstanding of what the language tests are designed to achieve, the factors that underpin clinical communicative skills, and the role of the individual in adapting and improving their language to meet the needs of the clinical environment. This is borne out in a number of studies which have indicated that registered nurses who have passed an English language test (IELTS or OET) feel that it did not adequately establish their ability to perform clinical communication tasks. For example, Xiao et al. (2014: 646) observe that a language proficiency test is not a guarantee of communicative success in a clinical setting. In one Australian study, even though migrant nurses had met the minimum language standards (it was unspecified if this was through educational history or IELTS/OET), these nurses were reported as being unable to understand the needs of their patients either clearly or completely enough to provide appropriate care and medication (Clayton et al., 2014: 5). Similarly, in an Australian thematic analysis of interviews with nurses who have English as a Second Language (ESL), these nurses expressed their amazement at how, despite passing the IELTS/OET standards, they still had difficulties with language and it greatly affected their participation in the hospital context (O'Neill, 2011: 1123). These nurses reported that they struggled with basic communication and conversation with patients, and they were generally concerned that their English posed a risk to their patients' care and safety (O'Neill, 2011: 1124).

Such criticisms are not particularly surprising. This is because core language ability is a necessary, but not the only, condition for successful clinical communication to occur. Even English monolingual speakers may not make a successful transition to good clinical communication. In the case of IELTS, the role of the test is to assess *readiness* to start university studies rather than to predict future performance (Cambridge ESOL, 2004: 15). By extension, IELTS is a snapshot of the applicant's language skills, rather than how well they will adapt to the clinical workplace, where further attention to communicative growth will certainly be required. Similarly, OET was not primarily designed to measure professional or cultural competence (Pill and Woodward-Kron, 2011: 107). Indeed, it is explicitly stated by the OET creators that the test was not designed to measure non-linguistic factors such as professional competence; rather, it focuses only on English language proficiency (McNamara, 1996: 106). Arguably, the nursing-related tasks of OET provide the greatest opportunity for candidates to demonstrate their linguistic readiness to enter the clinical setting. What is established by these tests, however, is that the candidate has the necessary foundational skills to produce and comprehend English at a sufficient level to begin the long and continuing journey of developing their clinical communication skills. Having a language skills standard ensures that potential registered nurses commence with the same minimum core language skills.

Another criticism of minimum test score requirements is that they may be set too high. The principle is that every test has a certain degree of error, and a borderline competent person may be erroneously denied registration. An unnecessarily high standard unfairly blocks borderline applicants who may be clinically competent. In such cases, a lower minimum standard would give borderline applicants the benefit of the doubt and allow them to practise, even though this approach would also allow more incompetent passers to be registered. The principle of giving the benefit of the doubt to applicants can be found in the USA, where a low minimum IELTS score was adopted. The National Council of State Boards of Nursing (NCSBN) recommended a registration standard that uses an average of IELTS 6.5 and a minimum of 6 in any sub-test in the interest of benefiting borderline competent candidates, while also acknowledging that the lower individual subtest scores will result in a larger number of incompetent passers (O'Neill et al., 2007: 313). An immediate response to this position is to question how many incompetent passers are being allowed to practice on patients. Furthermore, what this position does not take into account is that the IELTS test-makers recommend a 7.5 for linguistically-demanding subjects such as health professions, so a score of 7.0 is already a concession. Finally, it is significant that all the countries originally surveyed in the NCSBN standard-setting process in 2007 have since raised their own IELTS entry standards (O'Neill et al., 2007: 311). To continue on this point, it is difficult to ascertain exactly how damaging a low entry standard can be for patient care because testing this proposition is fraught with both ethical issues and multiple confounding variables. However, we can draw analogies from the clinical performance of nursing students who commence with an IELTS of 6.5 (with at least a 6.0 in all bands), which is the entry criteria for starting most nursing degrees in Australia. The research shows that even though these students are guided and supervised throughout their course, they still struggle with clinical placements. Crawford and Candlin (2013a: 182) discuss how international students experience persistent problems with pronunciation, telephone exchanges, and medical jargon, and point to a lack of advanced English communication skills. In another paper, international students were found to have difficulties in speaking and listening with patients and colleagues (Crawford and Candlin, 2013b: 797). San Miguel and Rogan's (2012: 116) literature review of ESL students' clinical performance indicates problems with small talk, giving instructions to patients, explaining issues to patients, and using professional language. Donnelly et al. (2009: 204) describe international students' difficulties with charting, medication orders, and interactions with both patients and

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colleagues, while also pointing out the serious safety concerns that this causes for patients. It is not difficult to imagine that the registered nurse who has the same linguistic starting point would display similar problems with communication in their daily work with patients, especially since the registered nurse is further disadvantaged by not receiving the same level of support and supervision that a student receives. We can corroborate this conclusion by revisiting the observations of registered international nurses who had passed IELTS 7.0 or OET B requirements but were amazed at how their language still needed improving, how it impacted on the effectiveness of their communication in the clinical context, and their concern that their English posed a risk to their patients' care and safety (O'Neill, 2011: 1123-4).

7. Education

The second method of establishing language proficiency for Australian nursing registration is to have a sustained background of education undertaken in the English language. It is assumed that the applicant has demonstrated language ability through the successful navigation of (usually) senior high school or university. In Australia, applicants need to provide documentation showing a minimum of five years of education in a recognised country (NMBA, 2014a–d: 1). This five-year period can be comprised of attempted subjects with at least a pass grade, and can include periods of discontinuous study (whereas older English test scores require continuous study to remain current) (NMBA, 2014c: 3). Only two years of this educational experience needs to be devoted to nursing studies, with the other three years comprising of any type of tertiary, secondary, or vocational subjects (NMBA, 2014a–d: 1). The countries recognised by the NMBA for this educational criteria were initially the same as those the Australian government nominated in their waiver on English language tests for skilled migration applications, i.e. the recognised countries were the UK, the USA, Canada, New Zealand, and the Republic of Ireland (DIAC, 2010; DIBP, 2014). Since then, the NMBA (2014a: 2) has added South Africa as a recognised country for registration purposes.

Internationally, there is variation between countries on how language tests are waivered on the basis of educational background. Language proficiency test waivers can be found in the USA (a recommendation cited in NCSBN, 2011: 2) and Canada (Ontario and Alberta are examples), where being taught nursing in English is sufficient proof of language proficiency (sometimes a set amount of clinical practice hours is needed), and this was the case in Australia until 2008 (Smith, 2009: 9). In New Zealand, all internationally-qualified applicants (other than from Australia) must take a test of English language proficiency, even if they are monolingual English speakers (NCNZ, 2013: 8). It is assumed that those with sufficient English will only be disadvantaged by the time and cost to take the test itself, and the registering body will be protected by having an independently-verified record of each applicant's English ability.

One of the problems with recognising educational background as evidence of language proficiency is it assumes that international students gain language skills throughout their studies (recall that students can enter a nursing degree with a lower IELTS score than required for registration). In fact, O'Loughlin and Arkoudis (2009) found that the English skills of approximately one-third of students did not improve, or worsened, over the three years of their Australian degree. An earlier study in 2006 showed that at least one-third of graduated overseas students would probably be unable to fulfil the language requirements for their profession, despite obtaining visas to stay in Australia (Birrell, 2006: 53). There are also problems with the assumption that passing an English-medium course can only be achieved if the student already has adequate language proficiency (and by extension, sufficient language skills to support clinical communication). First, some degrees or educational qualifications require lower levels of language ability. Many degrees are not meaningfully related to the nursing profession (i.e. a software programming course) nor require the level of language proficiency necessary for nursing. Therefore, having the extra years of education may not demand or develop the level of language ability at a standard required for professional nursing practice, and yet it still counts for registration purposes. Second, it occasionally happens that some students cheat, e.g. have not written their own assessments. Especially for topics assessed using mostly essays or reports, cheating can be difficult for universities to detect (especially if students use methods which avoid detection from text-matching software). Furthermore, students may use editors to correct their assignments before submission.

Finally, a major problem with recognising educational background is that it allows people to actively avoid English proficiency tests. To do so, they only need to engage in further educational pursuits until the five-year requirement is met. This is an achievable measure for those with enough money and time to pursue this option, and may be attractive to those who have multiple failed attempts in language proficiency tests, since the individual gains both nursing registration and permanent residency in Australia. Thus, the use of educational experience to prove language proficiency is fraught with potential problems, perhaps more so than a standardised language test.

8. Reinforcing the standards after registration

In this section, we consider the situation where a registered nurse is found to have serious communication difficulties in the workplace. If we recall, the competency standards require registered nurses to have communication skills that prevent confusion, confrontation, or avoidance, and that their written and spoken skills are appropriate to the needs of others and facilitate the provision of care (NMBA, 2010: 8-9). Given the discussion above, it is possible to see how individuals may pass nursing registration prerequisites yet, in reality, lack the core language skills (i.e. through the educational pathway) or be unable to adapt to the clinical arena (i.e. despite passing a language test). Clinical communication skills

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involve far more than only the core linguistic ability established by language tests, and this problem is evident even among those competent monolingual English speakers who struggle with clinical communication.

Extending upon the problem already seen among nursing students, it is also possible that the language skills of the registered nurse can degrade after passing a language test, thereby contributing to future language difficulties in the workplace. Reasons for language degradation may include a lack of language maintenance practices, poor use of language development strategies, factors associated with the work or social environment, and other issues. In addition, patients and co-workers may contribute to the problem by not mentioning their difficulty in understanding the international nurse's language, so the issue is not brought to the awareness of that person. Instead, in the interest of politeness, others may feign comprehension, ignore the problem, and/or guess at intended meanings. The nursing standards, however, point out that others should not be placed in a disadvantageous situation because of an individual nurse's lack of proficiency, but the reality is that this standard is difficult to reinforce due to its social dimension. It is less likely that formal complaints will emerge at an individual level and more likely for calls for language proficiency to emerge at an anonymous general policy level or in research studies, and this may be why higher standards are often demanded before registration, rather than individuals undertaking the awkward and risky task of singling out a problematic person in the workplace.

In cases where communicative difficulty cannot be ignored, it may be addressed in a number of ways, such as in the workplace through an informal discussion with a supervisor, prompts from peers, etc. In some situations, the problem may be severe enough to attract a formal complaint from a patient, the patient's family, work colleagues, or independent reporting agencies. The NMBA has the power to investigate and make decisions regarding formal complaints made about registered nurses, and "can also decide, at any time, that an individual is not suitable to hold registration as a nurse or midwife if it believes that the individual's competency in speaking or communicating in English is not sufficient" (NMBA, 2014b: 2). In response to a communication complaint, the practitioner may be asked to undertake an English test and perhaps further training. A performance assessment may be carried out by an independent expert practitioner (AHPRA, 2013a). Evidence of communication difficulties may be gathered from patient records, reports from other practitioners, data from other sources, the patient and their family members, and from independent expert opinion (AHPRA, 2013b). The NMBA also makes it very clear in their English language standards documents and FAQs that they may test, or re-test, English language skills at any time (NMBA, 2014a: 2; NMBA, 2014b: 3; NMBA, 2014c: 2, 7; NMBA, 2014d: 2), with the basic position being: "The National Board reserves the right, at any time, to require any applicant for registration or renewal of registration to undertake a specified English language test" (NMBA, 2014c: 2). Thus, in Australia, there are mechanisms which allow language proficiency standards to be reinforced even after registration has been granted. Despite this, as mentioned in the previous paragraph, it is likely that a wide range of less obvious problematic communicative events that affect patient care do not progress to a formal complaint.

9. Conclusion

In Australia, the NMBA have sought best-practice regulation of English communication to ensure safe care for clients. Among the guiding principles are the ability to implement an easily understood standard that is effective and consistent with other registering bodies and to ensure the protection of the public as the main aim. However, the current system still has some problems, which are arguably due to language proficiency standards being set too low. While it is true that higher standards will occasionally disadvantage some borderline applicants who might otherwise be adequate communicators, the implication for nursing practice is it also better identifies those inadequate English users who would need to improve their language skills before they can enter the professional workforce and work with patients.

This is not to say that the currently-used language tests are without their own idiosyncrasies. There are differences in how the two language tests relate to the tasks of the nursing context, and there is a limitation of the tests to establish future clinical communication performance, including an inability to predict subsequent changes in, or degradation of, linguistic ability. Despite this, there are definite strengths to these language tests: they are objective, standardised, widely-used, allow for comparisons across populations, have clear scoring, and are easily implemented. It is difficult to imagine any suitable alternative methods of linguistic assessment that meet all these criteria. What is clear from this exploration of the issues is that acceptable scores should not be set lower than recommended by the test-makers, such as IELTS provides. The implication of accepting test scores which are too low is that it makes the testing process redundant, since they are not being given the chance to fully screen out inadequate language users.

The alternative to language testing, using educational background to indicate language proficiency, can also be problematic even though it, too, is easily implemented. The advantage of using this method is that it allows people from some native English-speaking countries to easily fulfil the criteria, but it also introduces a pathway where language tests can be avoided and makes a number of unfounded assumptions about language skills. If the educational pathway is used to establish English language proficiency, then a greater number of years of education, or a more specific type of educational experience, might be more reliable than the generalised short-term standard currently used. It is recommended that a higher requirement of five years of health-related studies, or a complete high-school education in an English-speaking country, might reduce some of the problems.

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Nonetheless, despite the effectiveness or ineffectiveness of the language-test or the educational-background pathways, the policy provisions allow for action to be taken after registration to address communication issues in the workplace. The NMBA can enforce a language test and/or a performance assessment upon an individual. A language test is particularly useful for the cases where it was initially bypassed in the registration process (by using educational experience as proof of proficiency). However, the practice of relying on people to report communication issues as a method of dealing with language proficiency has been argued to be problematic because of the social dimension involved in such reporting. Furthermore, if the test score accepted by the registering body is set too low, then a language test may not ensure that a reported individual has adequate linguistic ability. Once again, it is recommended that higher standards should be used because it allows greater certainty that the individual has adequate language skills and also ensures that the measurement instruments (tests) can do their job in discriminating poor language users from adequate language users. The implication for nursing practice is that higher standards benefit the patient.

To conclude, patient care is the key role of a nurse, and language barriers can contribute to poor patient outcomes. This paper has discussed the establishment of current language test standards in Australia and has made comparisons of how these standards conform or contrast to other countries. While clinical communication is an international concern, there is no consensus on policy or minimum thresholds. In Australia, there are two broadly-used methods of establishing language proficiency for nursing registration: a language test or educational experience. All countries use language tests as one option for demonstrating linguistic ability, and most countries allow an educational pathway as an alternative to taking a language test. The importance of setting high standards has been argued in this paper, explaining that a lower minimum standard allows a higher number of incompetent practitioners to work with patients. The paper also raises the possibility that the current standards across the globe may still be too low, and a reconsideration of the test-makers' own recommendations may need to be undertaken. Finally, it is clear that methods of establishing language proficiency are still not perfect, nor have they been perfectly implemented. Indeed, it is likely that language requirements will be an ongoing issue of debate for nursing registration.

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