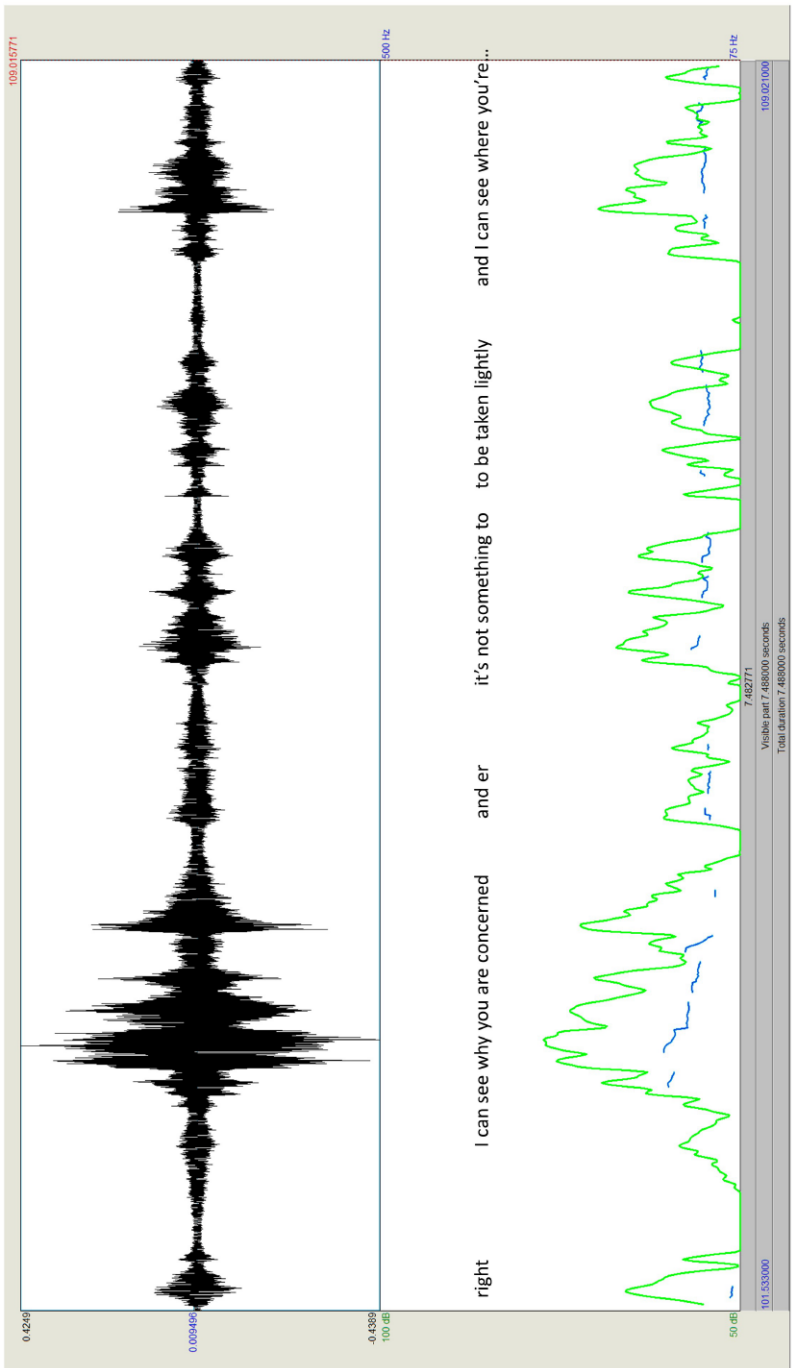

Figure 2: Prosodic and volume contour of an utterance by an unsuccessful candidate (upper line shows the rise and fall in volume; lower line shows the rise and fall in pitch)

of manner and attitude such as 'not engaging', 'not interested enough', 'a bit Olympian'. So perceived differences can rapidly lead to 'interpretive overdrive' as Blommaert and Rampton discuss:

> For much of the time, most of the resources materialised in any communicative action are unnoticed and taken for granted, but it only takes a slight deviation from habitual and expected practice to send recipients into interpretive overdrive, wondering what's going on when a sound, a word, a grammatical pattern, a discourse move, or bodily movement doesn't quite fit. There is considerable scope for variation in the norms that individuals orient to, which affects the kinds of things they notice as discrepant, and there can also be huge variety in the situated indexical interpretations that they bring to bear ('good' or 'bad', 'right' or 'wrong', 'art' or 'error', 'call it out' or 'let it pass', 'indicative or typical of this or that').
>
> (Blommaert and Rampton 2016: 37)

Such perceived differences can affect both overall emotional tone – whether the candidate sounds warm, involved, responsive and so on – and overall behavioural smoothness, i.e. whether the interaction progresses without jarring or uncomfortable moments or not (Erickson and Shultz 1982: 169–173). If both role-player and examiner share normative expectations about communicative resources but these are not shared with candidates – even at the most micro-prosodic level – the whole encounter may seem to have gone awry. This may lead to candidates being assessed as lacking compassion or disengaged, and doubts about how they can be trusted to be a caring professional are raised (see also O'Grady and Candlin 2013).

In a superdiverse context, where we are increasingly exposed to one another's different communicative styles – and no more so than in the health service – the ability to produce these phrases in a manner which sounds sincere to an overhearing examiner, in what is a simulated context, may not be an especial priority as a doctoring skill. Indeed, in superdiverse contexts, there is a strong argument for rethinking what the interactional environment of consultations looks like and whether local British normative expectations of expressing compassion or empathy can remain the dominant style of assessment. Deciding whether talk is empathic or not depends upon whether the observing examiner considers that the candidate's behaviour accords with what they consider empathy to be. The objectivity of standardised assessments is difficult to sustain when judgements such as 'empathic' depend upon an examiner's unavoidably subjective assessment of candidates' simulated behaviour towards simulated patients.

If patients also shared the same communicative expectations, there would be some case for arguing that all candidates should be able to draw on the same set of resources. However, the superdiverse patient populations which are characteristic of so many urban areas require a level of communicative flexibility that is not designed into standardised exams – indeed, it would be

something of an oxymoron. These exams do not assess whether candidates, whatever their background, are able to manage this level of flexibility in consultations in settings of linguistic diversity. Standardised role-players tend to use a local British way of speaking and so monolingual UK graduates are not judged on whether they can carry out an effective consultation in linguistically challenging situations, with patients from different linguistic/cultural backgrounds. Such standardisation also means that IMGs, many of whom consult regularly in another expert language, have no opportunity to display this linguistic and cultural knowledge, which may be so valuable in everyday practice. In sum, simulations also raise questions about the fairness of assessments and how proportionate they are in an increasingly diverse society where there is no one right way of showing interpersonal effectiveness (Atkins *et al.* 2016).

5 Conclusion

The simulated consultation is a highly standardised genre, and in attempting to assess candidates' clinical skills it comes up against the untameable quality 'empathy'. Even if empathy were not assessed, the OSCE-type exam raises as many questions as it answers once we look outside the psychometrics of reliability and most types of validity. Since the institutional frame of these exams overrides any local relationship work, the consultation cannot be experienced as real and instead may depend, in part, on acting skills. Even though candidates can be trained to simulate the examined consultation, there are still several aspects of it which escape from the real. These include the powerful positioning of the role-player and the interactional evidence that they have opportunities to claim this power and asymmetry at a micro level (Atkins forthcoming). In addition, there is a lack of everyday contextual features such as the 'voice' of the computer in shaping the interaction and in eroding some of the modelled features of interpersonal skills, such as amount of eye contact (Swinglehurst *et al.* 2012).

Together with the tricky business of assessing the real through the unreal, the increasing focus on the soft interpersonal skills, and more especially empathy, raises serious questions about what empathy is, if it can be experienced and if so how, in a standardised exam setting. Here, relationship building over time and the deep values inherent in building capability (Fraser and Greenhalgh 2001; Bleakley 2003) are outsourced to an externally timed case where surface skills are voiced so that they can be monitored and assessed. And, to go one step further, there is the matter of whether 'true empathy' (Halpern 2003) is a necessary moral requirement of being a doctor at all.

Tied into these concerns is the issue of fairness. OSCE-style exams are talk-heavy, requiring more voiced empathy phrases and more interactional work to

inoculate them against sounding formulaic and insincere. Under the intense gaze of the examiners, a candidate whose style of communicating is likely to be somewhat different from theirs is under particular pressure. Small differences can have large consequences. And IMGs feel the weight of the water, which others may swim through more freely and lightly. At the same time, the diversity of communicative practices, typical of so many family and hospital practices today, are difficult to assess in such exams, again leading to concerns about whether things being equal means that they are fair.

Linguistic ethnography (LE), the approach used in the research illustrated here, drawing on sociolinguistics and anthropology (Copland *et al.* 2015), can also feel the weight of difference when used in medical settings. These methodologies can be viewed with scepticism by non-sociolinguists: since people talk and interact all the time, knowledge about language, communication and even culture can seem self-evident or simply uninteresting; also, there seems little space for such research in positivistic and psychometric paradigms where the notion of 'small is beautiful' (Schumacher 1973) is squeezed to the periphery. For sociolinguists, like IMGs, there is much hard discursive work to be done. We need to engage with the medical paradigm, which expects generalisations from big data, by tracing the source of small events and difference to wider social forces and theories through close contextual analysis (Burawoy 1998; Mitchell 1983; Small 2009). For example, we can analyse an intonation contour in the ever widening context of coded typical exam phrases, examiner feedback, interpersonal skills as designed into the exam, institutional systems of assessment, current medical discourses, performance and sociolinguistic theories of language use and difference, and feminised and equality discourses, as the examples above suggest.

A study such as this has value only if its practical relevance is clear and if it contributes, to whatever extent, to re-setting the terms of the debate about 'language' in OSCE-type exams. In the UK, this has involved us in long-term relationships with various institutions that teach and assess postgraduate medical professionals. There is, also, a wider debate around standardisation in increasingly pluralistic societies and how institutions address the challenges of face-to-face assessments in a globalised context. Chris Candlin in the 1970s was one of the first applied linguists to study the medical consultation when, in the UK, society was becoming increasingly diverse. And, more recently, with his associates, he was a significant voice in using close interactional analysis to enhance assessment and teaching practices (O'Grady and Candlin 2013). In the twenty-first century, this early work looks all too prescient, and the recent work increasingly timely, as we grapple with what it means to be professionally competent with a patient population from everywhere.

Appendix: Transcription conventions

CAN	Candidate's speech
RPL	Role-player's speech
PPP:	Pause
(0.8)	Pause timed to tenth of a second
(.)	Pause of less than (0.2) seconds
·hhhh	Inhalation
er::m	Extended word/sound
bi-	Unfinished word/sound
→	Level intonation
xxx	Inaudible sound
≈	Latched speech (first part)
+≈	Latched speech (second part)
[ ] [ ]	Overlapping speech

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