The Objective Structured Clinical Examination and student collusion: marks do not tell the whole truth

R Parks, P M Warren, K M Boyd, H Cameron, A Cumming, G Lloyd-Jones

Objective: To determine whether the marks in the third year Objective Structured Clinical Examination (OSCE) were affected by the collusion reported by the students themselves on an electronic discussion board.

Design: A review of the student discussion, examiners’ feedback and a comparison of the marks obtained on the 2 days of the OSCE.

Participants: 255 third year medical students.

Setting: An OSCE consisting of 15 stations, administered on three sites over 2 days at a UK medical school.

Results: 40 students contributed to the discussion on the electronic discussion board. The main points raised were perceived inequity between students who did, or did not, have prior knowledge of the station content, and the lack of honesty and professionalism of their peers. Most contributors claimed to have received, or knew of others receiving, prior knowledge, but none confessed to passing on information. No significant difference (p = 0.16) was observed in the overall mark for the OSCE on day 1 (mean 390 (SD 37)) and day 2 (mean 397 (38)). On day 2, marks were considerably greater for four stations and markedly lower for three stations. It was not obvious why collusion should affect these station marks. A clear indication of the effects of collusion could only be obtained from a single subsection of an individual station (pathology) where 82 students on day 2 incorrectly gave the diagnosis from day 1.

Conclusion: Marks do not provide a sound inference of student collusion in an OSCE and may mask the aspects of professional development of students.

Higher education institutions are paying increased attention to academic dishonesty among their students. Although cheating under any circumstances is a serious regulatory matter, its importance on courses leading to professional status is arguably greater. The General Medical Council states that doctors should be honest and trustworthy; so a question mark hangs over the suitability of any student found guilty of cheating for entry into the profession. Because little is known about the career trajectories of students who transgress ethical codes, a link between student dishonesty and future professional lapses cannot be assumed, however plausible the association may seem. Limited evidence from self-reported data from engineering students in the US points to an association between cheating in high school or college and in the workplace. Universities therefore experience dilemmas when dealing with instances of cheating in medical schools.

For obvious reasons, it is difficult to estimate the frequency of occurrence of clandestine behaviour such as cheating. On a limited evidence base, cheating among medical students appears to be neither new nor confined to particular cultures, although the introduction of information technology, cultural norms and mismatches between student and faculty perceptions have been claimed as contributory. In the main, reports either describe specific incidents or depend on self-reported data from questionnaire surveys that reflect student experience and intention. In some studies, the frequency of observations of cheating, or intentions to cheat, increased with seniority, suggesting that increasing experience of medical school is accompanied by the development of more relaxed peer norms towards academic misconduct.

In 2000, the BMJ reported the management of a student caught cheating during a clinical finals examination at a London medical school. Among the many responses was an anonymous confession, from “recent graduates” of a UK medical school, describing collusion on a major scale in relation to an Objective Structured Clinical Examination (OSCE). Students had gained sight of a marking sheet 2 days before the exam and disseminated the information, enabling recipients to revise selectively for the OSCE. A greater number of merits and distinctions were awarded that year, although cheating under any circumstances is a serious regulatory matter, its importance on courses leading to professional status is arguably greater. The General Medical Council states that doctors should be honest and trustworthy; so a question mark hangs over the suitability of any student found guilty of cheating for entry into the profession. Because little is known about the career trajectories of students who transgress ethical codes, a link between student dishonesty and future professional lapses cannot be assumed, however plausible the association may seem. Limited evidence from self-reported data from engineering students in the US points to an association between cheating in high school or college and in the workplace. Universities therefore experience dilemmas when dealing with instances of cheating in medical schools.

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than their peers. From this arises the claim that a trend for a rising score in a cohort reflects a potential breach of exam security and, conversely, that finding consistent scores over time indicates that no major violation of exam security has occurred. The alternative view, that advance information can disadvantage candidates, resulting in lower marks over time, is considered, but features less prominently. If information about content has the potential to either advantage or disadvantage a candidate, then inferences relating to trends in overall marks of the peer group to collusion become unreliable. Even consistent mean marks over time cannot be taken to indicate that exam security has been maintained. Detecting breaches of test security, particularly at the individual level, becomes difficult, if not impossible, under these circumstances. In addition, a focus on marks has seemingly diverted attention from the ethical implications of collusion and its potential significance for the development of professionalism in undergraduate students.

**AIMS**

Against this background, we describe a critical incident that occurred in a UK medical school, in which student collusion at a third year OSCE was seen on a staff–student electronic discussion board. We consider the incident to be of wider relevance and interest owing to the many issues that it raises for students, teachers and educational institutions, in which the OSCE format is used in the assessment programme.

We aim to:

- describe the incident, its management and consequences for the school;
- challenge the view that trends in overall means or station marks, derived from sequential OSCE sittings, provide a sound basis for the presence or absence of collusion; and
- discuss ethical issues arising out of collusion from student and staff perspectives.

Because this paper relates to events in real time, which do not conform easily to the predetermined character of a research study, the following structure has been chosen:

- a description of the incident in context;
- a description of the staff response to the incident; and
- an analysis of OSCE marks.

**CRITICAL INCIDENT**

**OSCE implementation**

In all, 255 third year students sat for a summative OSCE consisting of 15 stations of 10 min each. The exam was conducted at three different sites over 2 consecutive days, resulting in three sittings per day at each site. Table 1 describes the individual station tasks and any intended variations between days 1 and 2. Marking sheets were standardised and the standard for scores was set using the Angoff method.

Students taking the OSCE on day 1 were explicitly advised not to pass on information about the exam to students at later sittings. Steps were taken to avoid successive groups of candidates talking to one another, although it was impossible to prevent day 1 and 2 students communicating during the assessment period.

**Electronic discussion board**

The medical school runs a series of password-protected, electronic discussion boards, organised by year of study, which are accessible to staff and students in the school. Less than 2 h after the end of the day 2 OSCE, students initiated a discussion about collusion between day 1 and 2 students, which continued until the publication of results 12 days later. Nearly 40 students contributed, about three quarters of whom remained anonymous.

The main topic was the perceived lack of equity between those students who had, and had not, received insider information about OSCE content. Students without insider information argued that colluding students retained an advantage over the rest of their colleagues, which devalued the achievements of honest students and the assessment process. There was concern that honesty was not being rewarded. Several posts criticised their peer’s dishonesty and its potential effect on professionalism and future practice. Although students reported either receiving insider information themselves or knowing of someone who had, no one confessed to conveying information. Those receiving insider information disclaimed any advantage, but others reported studying relevant electronic learning resources and memorising names of drug in the interim. Clearly, collusion had occurred between students sitting the OSCE on the same day, as well as on different days.

**Staff response**

Under the circumstances, staff thought it imperative to respond to events, as the electronic discussion board is publicly accessible to the entire school. Although students who use the facility may elect to remain anonymous, staff reserves the right to uncover the identity of any student who fails to maintain proper standards. Staff associated with the

<table>
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<tr>
<th>Table 1</th>
<th>Description of the Objective Structured Clinical Examination stations in order of question consistency between days 1 and 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Station blueprint</td>
<td>Station task</td>
</tr>
<tr>
<td>Gastrointestinal system</td>
<td>Physical examination</td>
</tr>
<tr>
<td>Locomotor system</td>
<td>Physical examination</td>
</tr>
<tr>
<td>Cardiovascular system</td>
<td>Physical examination</td>
</tr>
<tr>
<td>Respiratory system</td>
<td>History taking</td>
</tr>
<tr>
<td>Locomotor system: diagnosis and management</td>
<td>Video</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>Prescribing for different scenarios on medicines sheet</td>
</tr>
<tr>
<td>Ethics</td>
<td>Discuss smoking cessation during pregnancy</td>
</tr>
<tr>
<td>Practical skills</td>
<td>Connecting intravenous fluids</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Diagnosis from written scenario and interview about alcohol consumption</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>Basic life support</td>
</tr>
<tr>
<td>Pathology</td>
<td>Written Q and A on specimens</td>
</tr>
<tr>
<td>Anatomy</td>
<td>Written Q and A on scenarios and specimens and x rays</td>
</tr>
<tr>
<td>Microbiology</td>
<td>Written Q and A on cultures, x rays and treatment</td>
</tr>
<tr>
<td>ECG</td>
<td>Written Q and A on interpretation of electrocardiograms</td>
</tr>
<tr>
<td>Radiology</td>
<td>Interpretation of x rays</td>
</tr>
</tbody>
</table>

ECG, electrocardiogram; Q and A, questions and answers.
OSCE vigorously debated appropriate responses to the incident. Reprimanding students who had admitted receiving advance information was considered, but was narrowly rejected on the following grounds. Firstly, no student had admitted passing on information and these students were arguably as guilty as those who received information. Also, students would probably not divulge the names of informants. Secondly, the discussion board thread probably represented only the tip of the iceberg and the collusion may have been more widespread. Further problems arose from the interpretation of electronic interaction: without clues of non-verbal behaviour, irony and sarcasm are difficult to differentiate from factual statements.

Staff recognised that targeting the students who contributed to the discussion would make scapegoats of a few, whereas others, perhaps many more, would evade censure. Instead, they chose to post a response to all third year students on the electronic discussion board, dealing with some of the students’ misconceptions about the implementation of the OSCE, recognising the inequity of the situation and promising to work towards a form of implementation that reduced opportunities for collusion to uphold the honest students. It was emphasised that the policy of non-disclosure of exam content would continue to remain an offence under the current assessment regulations.

RESULTS ANALYSIS
In the light of the student discussion, we reviewed the OSCE marks. The mean and SD for each day, differences in means (day 2—day 1) and the 95% confidence interval for the difference were calculated for the overall mark and the marks for each station (table 2). The day 1 and 2 marks were compared using the two sample t test (SPSS V.13). Although multiple comparisons were carried out, a Bonferroni correction was considered to be inappropriate because of the lack of independence of the overall mark and the station marks. Caution is therefore required when interpreting the reported p values.

The small increase in the mean overall mark between days 1 and 2 was not significant at the 0.05 level. For individual stations, roughly half showed significant differences between the average marks on the two days. It was impossible to attribute these findings to collusion, however, because other influences contributed to the average station mark. These included variations in examiners, student ability and case specificity arising from the participation of different patients at different sittings.19 Secondly, analysis of the results from all students sitting the exam on a specific day reflects an average effect for the class. If only a few students colluded then the effect would be masked by the results from the large majority who did not. Thirdly, collusion can affect the mark positively or negatively and the overall effect is diluted when considering the average values. Finally, the mark for an individual station was the sum of multiple sections, each of which may have been affected in opposite ways by collusion. For instance, a student may only lose or gain 2 marks out of 40 for a specific item. Thus, analysis of the marks for individual stations was not reliable for detecting or quantifying collusion.

We therefore decided to look in detail at the marks from those stations where examiners had commented spontaneously, without prompting by staff inquiries, that they had suspicions of collusion for their particular station (Communication skills, Pathology).

Communication skills
Examiners of the Communication skills station commented verbally to one of the authors (GL-J) that they had noted that day 2 students were offering the day 1 diagnosis, despite changes to the station scenario. Attempts to analyse the component items of the Communication skills answer sheets were foiled because the marks awarded for supplying the correct diagnosis were aggregated with marks for other aspects of the student-simulated patient interaction. It was therefore not possible to either support or refute the examiners’ assertions of collusion.

Pathology
We were alerted to possible collusion in the Pathology station by the examiners’ formal feedback comments, which were posted on the third year website. The examiners stated that “It seems possible that collusion was a confounding factor in day 2 answers to the second part of the question. The histology picture changed from tuberculosis on day 1 to squamous carcinoma on day 2.”

At this station, the scenario, questions and marking schedule were unchanged on days 1 and 2; only the photomicrograph specimen was changed (day 1 tuberculosis...

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Table 2 Total and stations scores for days 1 and 2

<table>
<thead>
<tr>
<th>Station</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Mean differences (95% CI)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stations with questions consistent between days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal system</td>
<td>30.5 (4.4)</td>
<td>31.1 (4.7)</td>
<td>0.7 (0.4 to 1.1)</td>
<td>0.236</td>
</tr>
<tr>
<td>Locomotor system</td>
<td>28.8 (6.8)</td>
<td>28.0 (6.6)</td>
<td>-0.9 (2.5 to 0.8)</td>
<td>0.311</td>
</tr>
<tr>
<td>Cardiovascular system</td>
<td>30.4 (4.7)</td>
<td>28.5 (5.0)</td>
<td>-1.8 (3.0 to -0.6)</td>
<td>0.003</td>
</tr>
<tr>
<td>Respiratory system</td>
<td>29.4 (4.8)</td>
<td>29.7 (5.4)</td>
<td>0.4 (0.5 to 2.8)</td>
<td>0.206</td>
</tr>
<tr>
<td>Locomotor system: diagnosis and management</td>
<td>25.6 (5.8)</td>
<td>29.7 (5.4)</td>
<td>4.1 (2.7 to 5.5)</td>
<td>0.000</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>16.1 (6.0)</td>
<td>17.0 (6.8)</td>
<td>0.8 (0.8 to 2.4)</td>
<td>0.314</td>
</tr>
<tr>
<td>Ethics</td>
<td>27.8 (4.7)</td>
<td>27.1 (5.0)</td>
<td>-0.7 (1.9 to 0.4)</td>
<td>0.220</td>
</tr>
<tr>
<td>Practical skill</td>
<td>27.3 (6.1)</td>
<td>27.7 (6.4)</td>
<td>0.4 (1.2 to 1.9)</td>
<td>0.643</td>
</tr>
<tr>
<td><strong>Stations with questions partially changed between days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication skills</td>
<td>29.1 (5.4)</td>
<td>26.7 (5.5)</td>
<td>-2.4 (3.8 to -1.0)</td>
<td>0.001</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>30.0 (5.3)</td>
<td>32.0 (4.4)</td>
<td>2.0 (0.7 to 3.2)</td>
<td>0.002</td>
</tr>
<tr>
<td><strong>Stations with questions changed between days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>26.4 (6.4)</td>
<td>24.5 (5.3)</td>
<td>-1.9 (3.4 to -0.5)</td>
<td>0.010</td>
</tr>
<tr>
<td>Anatomy</td>
<td>19.7 (4.5)</td>
<td>24.0 (4.4)</td>
<td>4.3 (3.2 to 5.4)</td>
<td>0.000</td>
</tr>
<tr>
<td>Microbiology</td>
<td>19.6 (6.9)</td>
<td>20.8 (6.5)</td>
<td>1.1 (0.5 to 2.8)</td>
<td>0.179</td>
</tr>
<tr>
<td>ECG</td>
<td>26.4 (7.5)</td>
<td>26.2 (6.0)</td>
<td>-0.2 (1.9 to 1.5)</td>
<td>0.820</td>
</tr>
<tr>
<td>Radiology</td>
<td>24.1 (5.1)</td>
<td>23.6 (5.3)</td>
<td>-0.5 (1.7 to 0.8)</td>
<td>0.483</td>
</tr>
</tbody>
</table>

Data are given as means and (SD) unless otherwise specified.

ECG, electrocardiogram.
and day 2 squamous carcinoma). The number of correct and incorrect answers for the diagnosis given each day was counted, the results of which are summarised in Figure 1. The findings are congruent with collusion between day 1 and day 2 students.

**DISCUSSION**

These findings challenge the view that trends in overall mean or station marks, derived from sequential OSCE sittings, provide a sound assumption for the presence or absence of collusion. Instead, they support the later work of Colliver et al. in showing the need to examine specific station marks, derived from sequential OSCE sittings, on original mark sheet indecipherable.

Figure 1 Number of correct or incorrect answers for diagnosis given at the Pathology station on days 1 and 2. Day 1 “TB” correct, number giving the correct answer of tuberculosis; day 1 Incorrect, number giving any incorrect answer; day 2 “Ca” correct, number giving the correct answer of squamous carcinoma; day 2 “TB” incorrect, number giving tuberculosis as an incorrect answer; day 2 Other incorrect, number giving an incorrect answer other than tuberculosis; not available, script on original mark sheet indecipherable.

Some may criticise our conclusions on the grounds that the Pathology question preferentially tested knowledge rather than skills, as knowledge is easier to reproduce at short notice. There is some truth in this, but it is only partial. Although the OSCE is promoted as a skill-based assessment, skill must be constructed on, and integrated with, knowledge if it is to be of value in educating the safe, competent professional. Representing skills and knowledge as entirely different entities is unhelpful when, in reality, the relationship is far more complex. Furthermore, the anecdotal evidence from the Communication skills examiners shows how a station, perceived primarily as a skills test, becomes unacceptable. Otherwise, there is the danger that turning a blind eye, however unintentional, may encourage a culture in which unethical behaviour simply becomes unacceptable. Otherwise, there is the danger that turning a blind eye, however unintentional, may encourage the growth of undesirable norms in which peer group loyalty overtakes professional ethics. It is in this spirit that we report the incident, to publicise the uncertain effects of collusion in relation to OSCEs and to open a debate about these issues in relation to current OSCE implementation practices.

**CONCLUSION**

Although research examining the effects of collusion on OSCE marks has been conducted, there is little information about the nature of collusion and its ethical implications. An incident of collusion at a UK school showed that it could disadvantage students, although its effect on marks appeared to be limited. Honest students raised ethical concerns about cheating colleagues and the possible effect on their future professional practice. In the absence of any evidence against individual students, the school issued a public statement and has since modified the implementation of the OSCE to reduce opportunities for cheating. The potential influence of these issues on the development of social and cultural norms in medical school culture has been considered. In view of the global popularity of the OSCE format for assessing professional competence, these findings may have wider relevance.

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REFERENCES


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