Involving patients in the summative assessment of medical students

Summary

The need for standardisation in medical students' summative assessments has resulted in many medical schools working solely with simulated patients (SPs) in their final assessment before graduation; an instance of the tussle between standardisation and validity experienced throughout health profession's education. In this study, we report on the involvement of real patients in summative Objective Structured Clinical Examinations (OSCEs) in this institution, inviting educators outside our institution to consider the practice. We offer our experience and empirical evidence of this simulation-based practice, based on institutional ethnographic examination of the involvement of real patients in summative OSCEs from this undergraduate medical school in the United Kingdom. Our critique demonstrates the merits of this approach, as an assessment environment closer to the real clinical environments where these soon to be doctors interact in a more authentic way with real patients and their illness experiences. We balance this against the extra work required for all involved and suggest the biggest challenge for educators interested in trying this practice is in the reorientation work required for both Faculty and students who are institutionalised to expect standardisation above all in assessment. We advocate for involving real patients in summative OSCEs and hope that readers may feel compelled and empowered to foster this shift in mindset required to introduce this practice into their assessments.

Contact Details

Prof Gerard J Gormley g.gormley@qub.ac.uk
Dr Grainne P Kearney g.kearney@qub.ac.uk
Dr Jennifer L Johnston j.l.johnston@qub.ac.uk
Dr Kathy M Cullen k.cullen@qub.ac.uk
Prof Nigel D Hart n.hart@qub.ac.uk

Module Title/ Subject Area

Final MB – Clinical assessment

Class size

51+

Description (including literature review) | What was done?

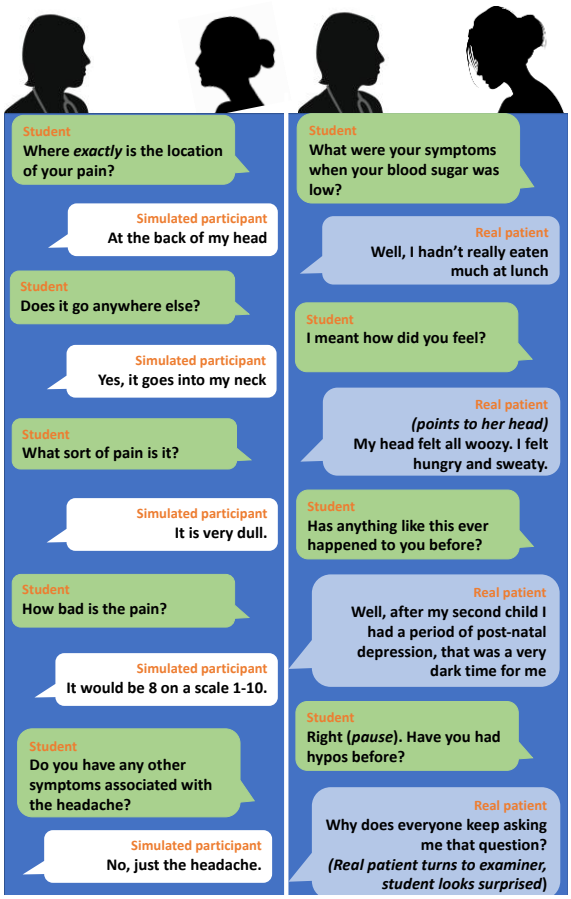
Objective Structured Clinical Examinations, better known as OSCEs have molded and morphed to secure their place as a ubiquitous form of assessment throughout health profession's education (HPE). Drawing upon many cornerstones of simulation – including SP methodology (SPs referring interchangeably to simulated patients, standardised patients, or simulated participants – hereafter referred to as SPs), concepts of scenario design and use of manikins – OSCEs are in effect constructed forms of reality that facilitate judgement on individual's competencies. In the shift towards a competency-based model in

HPE, the sustained emphasis on an outcomes-based approach to teaching and assessment [1] ensure OSCEs continue to dominate summative assessments internationally, albeit with variations in delivery.

In their AMEE guide, Khan et al define OSCEs (through their consolidation of definitions in the literature) as “An assessment tool based on the principles of objectivity and standardisation” [2]. Traditionally OSCEs involve patient roles being played by SPs, and authors have previously advocated that SPs should be actively involved in the co-construction of simulation scenarios depicting consultations [3], common practice described in the literature [4, 5]. Working with SPs in OSCEs is within the expressed spirit of commitment to standardisation. This discussion feeds in to a wider but prevailing criticism of OSCEs around perceived lack of authenticity [6], a feeling of being far removed from real clinical practice and patients. Many have warned of the potential unintended outcomes of highly simulated set ups [7, 8]. Bearman and Ajjawi [9] described exclusion of real patients from OSCEs but a move is growing momentum where real patients can be involved in co-creation of learning materials [10].

OSCEs were introduced into medical education after concerns were expressed about perceived variability for students in assessment (using methods referred to as Long cases) [11]; so in combination with a desire for more objective clinical assessments, the scene was set for the introduction of OSCEs from the 1970s [12, 13]. The majority of medical schools introducing OSCEs around the end of the 20th century in the UK replaced real patients with SPs, but the medical school where this study took place, deliberatively continued to involve a small number of real patients in their summative OSCEs as a hybrid model alongside SPs, under the leadership of Clinical Academics.

Depicted in the infographic, we present composite accounts from the study of interactions of students with SPs, and for comparison, interactions with real patients in OSCEs. Composite accounts are “accounts constructed by the researcher that are built from the corpus of data collected (e.g., interviews, observations, and texts).” [14]. These composite accounts are based on GK’s ethnographic data, from her field notes taken whilst observing during the OSCEs combined with interviewees’ experience of being involved in OSCEs as Faculty, examiners, and students (see Methodology for more details). Whilst they are presented here almost as transcripts, some editing has been applied for them to work in this format. We used these composite accounts to begin our critique of these interactions. (Figure 1 from published article).



Motivation and Aims

The purpose of this article is to offer our experience and empirical evidence on the involvement of real patients in summative OSCEs in an undergraduate medical school in the UK, the practical application of which we hope is transferrable internationally. This is not to say that SPs cannot also be patients in their own right but on the day of an OSCE, they take on a role that they have been trained for and briefed in, as an increasingly professionalised group [15, 16]. More broadly, we detail an instance of the ongoing tussle health professions educators face on a daily basis, balancing a need to deliver standardisation against a desire for authenticity, and offer readers a description of the work involved in striving towards some real patient involvement. An institutional ethnographic examination is presented here detailing the merits of this approach, tampered alongside the challenges it brings, with the intention of encouraging a change in mindset to normative OSCE practices.

Methodology

This article is derived from a study which used institutional ethnography [17, 18, 19] as the approach to inquiry to critically examine OSCE practices. Institutional ethnography (IE) is a complex, critical qualitative theory/methodology, conceived by Dorothy Smith drawing on her reading of Marx's materialism and her experiences in the feminist movement. The focus in the IE approach is on what people actually do on the ground as their 'work'; it then moves to investigate where this work is organised from in a governing sense - the 'institution'. With roots in activism and social justice issues, it has been widely used to study health care settings but is gaining momentum in HPE (see [20] for more detail on this approach and its potential applications in HPE). When using IE, researchers reflexively declare the standpoint that they are taking in the study at the outset.

In the early stages of an IE study, it is not known which threads of inquiry the researcher will take up. Whilst the crux of this research was a problematisation of the dominance of standardisation in OSCE practices and how this traces back to the overruling demand for accountability, a vibrant and unexpected thread that developed through the study was a critique of the involvement of real patients in summative OSCEs.

GK, an academic General Practitioner (GP), spent the academic year 17/18 collecting data on summative OSCEs (the final clinical assessment prior to students graduating) in the medical school where she worked. Data collection in this study involved many hours of ethnographic observation of the work involved in OSCEs; observing the team that planned, delivered and later reviewed the OSCEs and well as the work of the students, newly qualified doctors, examiners and SPs involved in these OSCEs. Observations were recorded as fieldnotes; for example, there were 32 hours of observation during the OSCEs themselves. Alongside this, the researcher interviewed these people both formally and spoke to them more informally about what they were doing and how they knew to do it, (17 interviews in total). In addition, the research team analysed the texts identified by participants during observations and

interviews as texts they used in their OSCE work, these included texts produced within the medical school such as mark sheets and texts more widely available, such as from the regulatory body. Data collection and analysis was iterative, focused on what people did as their work and how they knew to do it i.e., what roles texts played in their work. The study had full ethical approval (Ref: 17. 29v2).

Successes | Challenges | Lessons Learned

We found that real patients bring an experiential, lived perspective beyond that of a disease to OSCEs, this is the motivation for working alongside them in this context. Real patients, in their unscripted way, describe their illness in the way that they personally make sense of it. Their stories develop the rich tapestry of uncertainty and non-standardised messiness that clinicians learn from and work in.

Students spoke at length about how consulting with real patients in their assessments felt "natural" or "normal". Students talked of feeling more relaxed with real patients, describing reactive dialogue which contrasted with their consultations with SPs where they admitted to thinking mostly about what their next question would be. One student described how they adjusted their usual OSCE tactic of trying to ask as many questions as quickly as possible as they "worried that these [real] patients have given up their afternoon" and might find such common OSCE practices "strange." Students admitted how they set aside their usual worries in OSCEs of appearing "too nice and too familiar" which they equated with appearing as if they were stalling. They likened their interactions with real patients in OSCEs to being "on a ward, you're like, 'how are things and how are you today?' And you chat to patients to make them feel more comfortable." Whilst the students talked of making the real patients feel comfortable, they inadvertently described their own increased ease within the assessment. Students and real patients laughed (genuinely) together at times in these assessments, on a day where more negative student emotions tended to be more notable. Students contrasted this with their interactions with the SPs, "so even though the actors are good, it's not representative of how you would conduct yourself on the ward maybe." OSCEs with real patients allowed students to demonstrate more closely how they would be in the workplace, as demonstrated in this quotation where a student stated that "It's not an OSCE when it's a real patient".

Examiners observing the students interacting with real patients in these assessments also used the words "normal" and "natural" to describe the atmosphere. For instance, one examiner described the interaction as a "normal consultation. I could actually see them consulting properly rather than acting in an exam situation. The examiners talked of observing what they considered to be real empathy between the student and the real patient, as the student tried to understand the actualities of the experiences of the person in front of them. One examiner contrasted this to what they often considered in OSCEs, that students were "acting empath."

We considered why the OSCEs with real patients were different to those involving SPs who are obviously also 'real' people and who may have patient experience themselves. Fundamentally, what we found

different about real patients is in how they describe their individual social knowledge of their personal illness. Whilst SPs may or could be real patients, in the context of an OSCE, once they are loosely scripted, trained, rehearsed and standardised in the way of the institution, they no longer draw on their social knowledge of illness. Real patients, through their random recruitment, lack of scripting, lack of training and lack of standardisation allow students to understand the sensuous actualities of living with illness rather having a biomedical disease.

We hope we have made a strong case for involving real patients in OSCEs. However, in describing the involvement of real patients in OSCEs in this medical school it is important to note that they were only involved in part of the assessment. Whilst many of those involved in organising OSCEs cited the involvement of real patients as rewarding in interview, they talked at length of the extra work, time and effort required to make it possible. In this institutional ethnographic study, we detail the work of involving real patients in OSCEs, revealing how much of this additional work pivoted on the perceived challenges to standardisation when involving real patients for all invested in these assessments. Therefore, a pragmatic article on this practice necessitates description of this extra work and how this medical school managed it. In IE terms, this work is considered to be unseen, not because it is not sanctioned within the medical school but because the time and effort involved is not represented in documentation around OSCEs.

In addition to the technical aspects of involving real patients but just as important is the extra work required in preparing the mindsets of all involved. We are aware that what we are promoting, involving some real patients in summative OSCEs, will substantially add to this workload as medical schools aim to ensure their processes satisfy the regulator wherever they are based and require a shift in thinking from the ground up, for all involved in OSCEs.

Scalability and Transferability

The stated purpose in our introduction of this article was to offer what we have learned through study and experience of involving real patients in summative OSCEs. We conclude involving real patients achieves a more naturalised and authentic assessment environment, closer to the real clinical environments for these soon to be doctors. These consultations with real patients, demonstrate in a more genuine way, how senior students interact and develop rapport with people rather than with checklists of symptoms, how they take the vast biomedical knowledge developed through their years in medical school and make it work for the individual in front of them. The non-standardised and non-institutionalised presence of real patients, still in the role as patients, help students demonstrate if they are real-world ready, prepared for the unscripted messiness and uncertainty of the real clinical practice they are currently learning in and are about to work in. The examiner quoted in the title of this article stated, “I could actually see them consulting properly rather than acting in an exam situation”: for them the presence of a real patient allowed for an authentic consultation moment, albeit in the surroundings of a standardised assessment.

OSCEs are a constructed phenomenon. We not only have the ability to change their destiny but perhaps even a moral obligation to address their shortcomings. Would the public expect student doctors to be certified on their interactions with real patients before they are granted a provisional license to treat

them? Some regulatory bodies are encouraging involving real patients [21] and their illness experiences in OSCEs; however we urge some caution. In times of increasing regulation throughout HPE, we need to be careful that any potential to make real patient involvement in OSCEs mandatory or any attempt to standardise real patients in OSCEs may defeat the individualism and realism that we have celebrated here. We must be careful that another wave of change in the form of increased regulation does not cause further 'cleansing' or sterilisation of how we deem medical students ready for the real world. This concern can be extended to real patients repeatedly being involved in OSCEs, could they equally become organised by a need to standardise and in time become a human role player themselves, a type of SP? We must think carefully about how we involve real patients at all possible points and remain true to their authentic voices, rather than succumb to the drive for their standardisation and professionalisation.

Involving real patients in summative OSCEs requires much more work than organising their attendance on the day. Appetite already exists among the simulation community for involvement of real patients in learning environments where they co-create SP scripts to make them more authentic or are involved in coaching SPs, or review of scenarios [10]. We see these co-created scripts, delivered by SPs to be the mainstay for more junior students in assessment but advocate alongside this practice for real patients themselves to deliver their own 'scripts' in summative assessments for senior students. The positive disruption real patients can bring to highly standardised assessments necessitates a major shift in thinking for those involved in OSCEs, a reorganisation of what they consider to be a success in assessment. The work involves changing heart and minds, but we advocate for finding ways to give it a go!

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Further Information/ Additional Resources

Citation for article:

Kearney, G.P., Johnston, J.L., Hart, N.D. *et al.* Revised paper ASIM-D-21-00055R1: "Consulting properly rather than acting": advocating for real patient involvement in summative OSCEs. *Adv Simul* **7,** 16 (2022). **https://doi.org/10.1186/s41077-022-00213-4**