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The view from over there: reframing the OSCE through the experience of standardised patient raters

Jennifer L Johnston, Gerard Lundy, Melissa McCullough & Gerard J Gormley

CONTEXT Ratings awarded by standardised patients (SPs) in UK objective structured clinical examinations (OSCEs) are typically based on humanistic (non-technical) skills and are complementary to clinician-examiner ratings. In psychometric terms, SP ratings appear to differ from examiner ratings and improve reliability. For the first time, we used qualitative methods from a constructivist perspective to explore SP experiences of rating, and consider how these impact our understanding of assessment.

METHODS We used constructivist grounded theory to analyse data from focus groups and individual semi-structured interviews with 38 SPs and four examiners. Inductive coding, theoretical sampling and constant comparison continued until theoretical saturation was achieved.

RESULTS Standardised patients assessed students on the core process of relationship building. Three theoretical categories informed this process. *The SP identity* was strongly vocational and was both enacted and reinforced through rating as SPs exerted their agency to protect future patients by promoting student learning. *Expectations of*

performance drew on individual life experiences in formulating expectations of doctors against which students were measured, and *the patient experience* was a lens through which all interactions were refracted. Standardised patients experienced the examination as real rather than simulated. They rated holistically, prioritised individuality and person-centredness, and included technical skill because the perception of clinical competence was an inextricable part of the patient experience.

CONCLUSIONS The results can be used to reframe understanding of the SP role and of the psychometric discourse of assessment. Ratings awarded by SPs are socially constructed and reveal the complexity of the OSCE process and the unfeasibility of absolute objectivity or standardisation. Standardised patients valued individuality, subjective experience and assessment for learning. The potential of SPs is under-used their greater involvement should be used to promote real partnership as educators move into a post-psychometric era. New-generation assessments should strive to value subjective experience as well as psychometric data in order to utilise the significant potential for learning within assessment.

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 INTRODUCTION

Standardised patients (SPs) have been used since the 1960s in training the health care professions.¹ Standardised patients have a particular role to play in assessment, in which their use overcomes many practical and ethical challenges associated with the use of 'real' patients.² The SP role within summative objective structured clinical examinations (OSCEs) has been defined as that of 'people with or without actual disease who have been trained to portray their own problems, or ones based on other patients, in a consistent manner for evaluation of clinical skills'.³

Most of the significant body of research on SPs^{4,5} has focused on psychometric issues, in keeping with the dominant perspective in the field of assessment. In this paper, we use qualitative methods from a constructivist standpoint to look in depth for the first time at the assessment process from the SP perspective, and consider how this information might be used to illuminate assumptions and reframe thinking about roles and procedures within assessment.

Patients as partners in assessment

Working in partnership with patients is a cornerstone of modern medical practice.⁶ This has not been reflected within medical education, in which there is a tendency to use patients as a passive resource rather than as active partners.⁷ In a 'parable' on modern medical education, Bleakley and Bligh vividly and succinctly describe how patient-centred learning has foundered on the rocks of objectification and external validation, and argue for movement towards medical education which focuses on the relationship between student and patient, rather than student and doctor.⁸ A recent addendum to *Tomorrow's Doctors* makes the position of the UK General Medical Council (GMC) clear: as in clinical practice, patient involvement must extend beyond the passive and encompass greater involvement in quality management and control processes.⁹

Nowhere is this issue more pertinent than in the field of assessment, where the classic conception of SPs' usefulness is based on standardising patient encounters^{10,11} to minimise variability.^{12,13} The introduction of SP ratings expanded the role of the SP,¹⁴ but through widely different interpretations. In some North American licensing examinations,

SPs are used in lieu of clinical examiners to assess technical skill,^{15,16} whereas in UK undergraduate medical education they provide a complementary global rating of communication skills and serve alongside a clinician-examiner who assesses clinical skill.¹⁷ The latter method will be the focus of this paper. In this setting it has been generally considered that further SP involvement would risk damaging the face validity of the OSCE assessment¹⁸ and thus patients remain comparably passive.

In the UK model, SPs are trained to limit their assessment to communication, professionalism and empathy. Clinician-examiners are responsible for assessing clinical competence and their assessment is regarded as the reference standard.^{19,20} The primary role of the SP is still to provide standardisation; the rating role is secondary. Global ratings provided by SPs are added to examiner scores and make a small contribution to a student's overall mark.

Differences in rating

Psychometric evidence suggests SPs rate students differently from examiners, and that adding SP scores increases overall reliability.¹⁸ In Homer and Pell's study, SP ratings correlated positively with examiner scores, but the small effect size suggested that the ability of one of these variables to predict the other was low.¹⁸ Other studies have found a similarly weak correlation between SP and examiner scores,²¹ and similarly concluded that the two groups score candidates differently.²²

Few studies have examined what actually takes place during the rating process and there is limited information on why or how SPs might rate students. One study, which looked at how SPs, doctors and lay people rated students in OSCEs, concluded that scoring was a complex process with significant inter-rater variability, even between raters of the same group, and suggested that SPs looked for qualities that differed from those sought by doctors or lay people.²³ Another study acknowledged that SP marks arise from a complex process of reflection, encompassing issues of content and communication. Standardised patient raters are thus not objective observers, but, rather, represent active participants in the examination process.²⁴

This unique perspective, based on SP experience, provides a 'third eye' on the assessment process and it is this aspect that we set out to investigate, looking in depth at the process from this viewpoint

for the first time. This is important for several reasons: because the patient voice is often too quiet in medical education research; because the SP constitutes one-third of the core triad in an OSCE station, and because the uniqueness of the SP's position, which lies somewhere between that of the lay person and that of the professional, offers potentially profound insights for learning and teaching through the medium of assessment. Spencer *et al.*²⁵ identified a pressing need for research into patient involvement in education as a prerequisite for developing true partnership; understanding the SP discourse can promote such partnership and demonstrate how to further professionalise the involvement of SPs in assessment.²⁶ Furthermore, by examining implicit social processes in assessment, we may move beyond a dependence on psychometrics alone towards a deeper understanding that will influence the next generation of assessments.

We felt a qualitative approach was needed to explore these issues to the required depth and so we set out to explore the process of how SPs award global scores in OSCEs using constructivist grounded theory.

METHODS

Theoretical perspective

The project was underpinned by a social constructionist epistemology. Hence, knowledge and meaning are co-constructed rather than discovered, and the inter-subjectivity of the researcher and research participants is acknowledged. Within this framework, true objectivity is neither the aim of the research nor even considered possible; rather, we aim to achieve a deep understanding of possible constructions of meaning within the data.

Constructivist grounded theory was chosen as a method of analysis that aligned with our theoretical perspective and was particularly suitable for studying processes.²⁷ This is a methodology which aims to develop a deep understanding of the phenomenon strongly rooted ('grounded') in empirical data. Of note, theory in this sense is not of a positivist, predictive nature, but, rather, represents a way of laying open the implicit discourse by conceptual rendering of the data. Grounded theory promotes the voice of research participants by naturalistic coding which remains close to the original data as it interprets the participants'

experience. In this respect, it offers an ideal methodology for exploring the process by which SPs award marks and thereby improving our understanding of a group that has frequently been the subject of research but whose voice has rarely been heard.

Study setting

The study was conducted at Queen's University Belfast (QUB), where the undergraduate medical programme follows a 5-year integrated curriculum. An SP programme has been running since 2006. In it, members of the public from a wide range of age, gender and socio-economic groups are selected and trained for teaching and assessment purposes.

In OSCEs, SPs are trained to rate students on humanistic (non-technical) skills by considering the statement 'I would be happy to come back and see this student again' and other statements anchored on a scale of 1–5 (Appendix S1, online). Standardised patients have the opportunity to practise this process and are given feedback by faculty staff and peers as part of their training. Within the OSCE itself, each SP participates in station-specific training prior to commencing the OSCE.²⁸

Standardised patients convey their score for recording by the examiner, either verbally or by holding up fingers. Calibration is allowed for the first four candidates. Standardised patients contribute 5–10% of the overall station checklist score.

Participants

Ethical approval was obtained from the school's research ethics committee. The study was carried out in accordance with the Declaration of Helsinki, including but not limited to there being no potential harm to participants. Written consent was obtained from all participants.

Standardised patients were recruited during OSCEs administered in 2011 and 2012. Initial sampling aimed to achieve maximum variation. Subsequent sampling was theoretical and used to confirm or disconfirm emerging themes. As part of theoretical sampling, follow-up data collection involved a mixture of focus groups and individual semi-structured interviews. Four individual interviews with examiners were included in this phase as a way of confirming the researchers' understanding of the role of examiners as it pertained to this research.

Data collection

A total of 38 SPs, plus four examiners, participated in seven focus group discussions and seven individual semi-structured interviews. Participant ages ranged from 18 years to 70 years; their length of experience as an SP ranged from 4 months to 8 years. Twenty-four SPs were female and 14 were male.

Interviews were conducted by researchers JLJ (a clinical academic) and GL (a postgraduate student and clinician), and were recorded, anonymised and transcribed verbatim. Neither MMcC nor GJG were directly involved with SPs, but they may have been known to individuals through their work as OSCE examiners.

Data analysis

Transcripts were coded line by line using grounded theory methods.²⁷ Analysis and data collection followed an iterative process in which memo writing, constant comparison and theoretical sampling continued until there was consensus that analysis had reached theoretical saturation. Coding was performed primarily by JLJ, with input and discussion from other members of the research team throughout, and theory was constructed by consensus within the whole research team.

RESULTS

Standardised patients made their assessment on the central task of relationship building and the student's ability to create confidence through the clinical encounter. Confidence for SPs meant the feeling that the student could be trusted with their stories and their bodies.

Three major theoretical categories inform this process: *the SP identity*; *expectations of student performance*, and *the patient experience*.

The SP identity

The key driver of SPs was the preparation of students for the future; thus enabling the student to become the best doctor possible, and ultimately allowing the SP to positively influence patient care. In this SPs saw themselves as patients, but also as patients' representatives. Their strong sense of vocation was the basis of a shared SP identity which influenced their interactions with students. SPs took

pride in their 'ordinariness', recognising that paradoxically it was this that allowed them to play a unique role in medical education, and emphasised their responsibility for providing a grounding influence:

'I'm just a Joe Bloggs from the street, just to give them that personal, you know, side to it... because I think from the minute you, you know, you could see a doctor they need to have that relationship... Anything we can do now is a small experience for what they're going out to, to come up against, so maybe some day in the future they might think, "Remember the day I did my such and such..."' (Interview 3, female participant)

The marking role of SPs allowed the expression of their vocational identity. Many SPs had previously given informal feedback to examiners and the provision of formal ratings represented external validation of their role. By rating students, their interactions and feedback were taken seriously at a stage of training in which they had potential to be meaningful:

'I was conscious that I was giving two students the lowest marks – because they were second years I felt they had the chance to improve and I thought if I don't do this consciously I'm not going to be helping them, I'm not going to be helping anybody.' (Focus group 5, female participant)

'What I would love to see is... when they are marking a third-year student and when they come back to do their fourth year, what's the data for that same student 1 year later, have they learnt anything?' (Focus group 2, female participant)

Standardised patients felt their contributions complemented those of examiners, and valued the individuality and range of the patient experience as strengths:

'You see 15 people from different walks of life are all saying the same thing, yes you were fine on diagnosis but you made me feel so uncomfortable because of x, y or z.' (Focus group 2, female participant)

'That illuminates the value we all play – that two different people tick all the [examiner's] boxes or the same boxes but one of them is outper-

forming the other in personal skills.' (Focus group 2, female participant)

Thus, SPs used the process of marking to enact their vocation (helping students learn, protecting patients) and to gain confidence in their identity being meaningful.

Expectations of student performance

Expectations were the benchmark used to assess candidates, and were of two types: those arising from personal experience, and those reflecting societal expectations of doctors. Expectations were pre-conceived but their impact could be modified by environmental factors relative to the examination; for example, SPs were more lenient with junior students, but compared senior students against the standard of the qualified doctors whose ranks they would soon join. Assessment of students was considered easier at history-taking stations compared to examination stations. considered the assessment of students to be easier at history-taking stations than at examination stations:

'It does depend on the level of the student because the young ones don't have the same social skills and that can really affect them.' (Focus group 5, female participant)

Standardised patients' ideas of *the good doctor* drew heavily on individual experience. In particular, past experiences in health care informed the qualities they valued and tried to promote:

'I mean we all have a practice and we all favour a certain doctor and it is usually because it's their manner, you know that they will give you the time that you want and they will listen, whereas there are others who are dismissive... so we all make that sort of subconscious decision as to who we like to go to and who we avoid like the plague.' (Focus group 2, female participant)

In general, a good doctor was considered to be able to appreciate the individuality of the patient experience:

'I think first of all if they make eye contact with you and they show some sort of recognition of you as a person...' (Focus group 6, male participant)

'Body language, overall aura, general impression, if she's in a rush... you know like, here's another

one, how many of these people do I have to see before I get a tea break?' (Focus group 3, female participant)

However, good communication alone was insufficient and the perception of technical competence was crucial to the building of confidence:

'At the end of the day if I wanted to see a doctor again I would have to make up my mind, is he competent in what he is doing? Will he be able to cure me?' (Focus group 2, female participant)

Standardised patients expected candidates to accept the commonly defined social role of the doctor, as they accepted the patient role. Thus, it was important that candidates presented themselves as doctors rather than as students and behaved in keeping with expectations of a doctor. Demeanour, dress and paralanguage were all important from the moment the student entered the station:

'They need to be neat and tidy... some of them look like they're ready to go out for the night.' (Focus group 6, male participant)

'You're acting as a doctor now and we're acting as patients – we're not looking for them to act as students any more.' (Focus group 4, female participant)

Candidates were also expected to display professional control of their emotions, in keeping with social rules governing doctor–patient interaction. Examination nerves, over-familiarity and being overly emotional all negatively affected relationship building and resulted in a loss of confidence which could not be overlooked:

'You can't have a doctor examining you and be [ing] a bit flaky...' (Focus group 4, male participant)

'You're not looking for a friend as such, you're looking for a competent person.' (Focus group 4, female participant)

Students from outside the UK, who had difficulties with English or whose demeanour SPs perceived as culturally dissonant, had particular difficulty in establishing an effective relationship:

'Their whole attitude can be very deferential and therefore they may appear to do less well than others, but it's just, you know, a function of their

upbringing and the way that they relate to people, so I think that's a bit of a problem. Particularly some of the girls, they're very sort of meek and mild...' (Focus group 2, female participant)

Notably, however, although meeting socially influenced expectations was important, individual expectations of the good doctor took precedence:

'I had a student who didn't look particularly good, he had long hair tied back in a plastic band and he didn't look particularly tidy, but he had amazing bedside manner, rapport and empathy.' (Focus group 6, female participant)

The patient experience

Standardised patient interactions were rooted in the patient experience, leading to key differences in outlook and understanding. SPs did not just compare their patient experience with real life: their experience was real, not simulated, in physical and emotional terms. They replicated demanding scenarios and underwent repeated examination, continually building relationships which had the potential to elicit genuine emotion or physical discomfort.

Despite being trained to focus on humanistic aspects, experienced SPs provided a holistic assessment of their experience which included technical aspects of the student's performance. They were unable to unlearn technical knowledge they had picked up, incorporating this in their assessment, and thus unable to separate out technical and humanistic aspects within their patient experience:

'If they are very wishy-washy trying to bluff their way, I mean... would you want to see that person as a doctor again?' (Focus group 1, male participant)

Aspects of the consultation which faculty staff considered to be technical had different meanings for SPs. Hand-washing, seen by examiners as a basic technical skill and a 'soft' mark, was an important communicative act which symbolised that the candidate had moved on from the last patient and was fully attending to the current relationship. Examination was similarly interpreted as an act of communication:

'You're like, "Ah no, wash your hands" – you want to scream at them...' (Focus group 3, female participant)

'All the time in all the stations I would always give them an extra raise in the mark if they take the time and trouble to just say if you are experiencing pain in any part of your body where they are about to examine...' (Focus group 2, male participant)

Students could sometimes fail to recognise the veracity of the SP experience, and focused on their relationship with the examiner rather than on that with the patient. The impact of this mismatch of agendas was disproportionately large in causing feelings of dehumanisation:

'Do you remember the ad that used to be on television of all the babies coming out on a conveyor belt? Well, we're not like that, we're all individuals and that's what they are going to meet in real life.' (Focus group 1, male participant)

'For the next three minutes you're not a person anymore – they're not interested in you – they've taken a break and they are thinking of what's going to happen next and sometimes you can cut the atmosphere with a knife when they're standing looking all round them – looking everywhere but you.' (Focus group 3, male participant)

The need to prevent just such interactions with future patients strengthened the SPs' sense of identity and fuelled their vocational drive:

'If you are a simulated patient you are expecting something like that, but in a real-life situation that would be 10 times worse.' (Focus group 3, female participant)

The theory in summary

The vocational identity of the SP is the SP's driver for accepting the rater role, informs subsequent interactions and is ultimately strengthened by the rating process (Fig. 1). Expectations of performance arise from individual experience and are used as the benchmark by which candidates are judged as they engage with the SP in the core process of relationship building. The patient experience underpins the rating process and results in a holistic assessment of performance and a different outlook on the OSCE process.

DISCUSSION

The SP experience within OSCEs is visceral and more complex than has been generally understood.

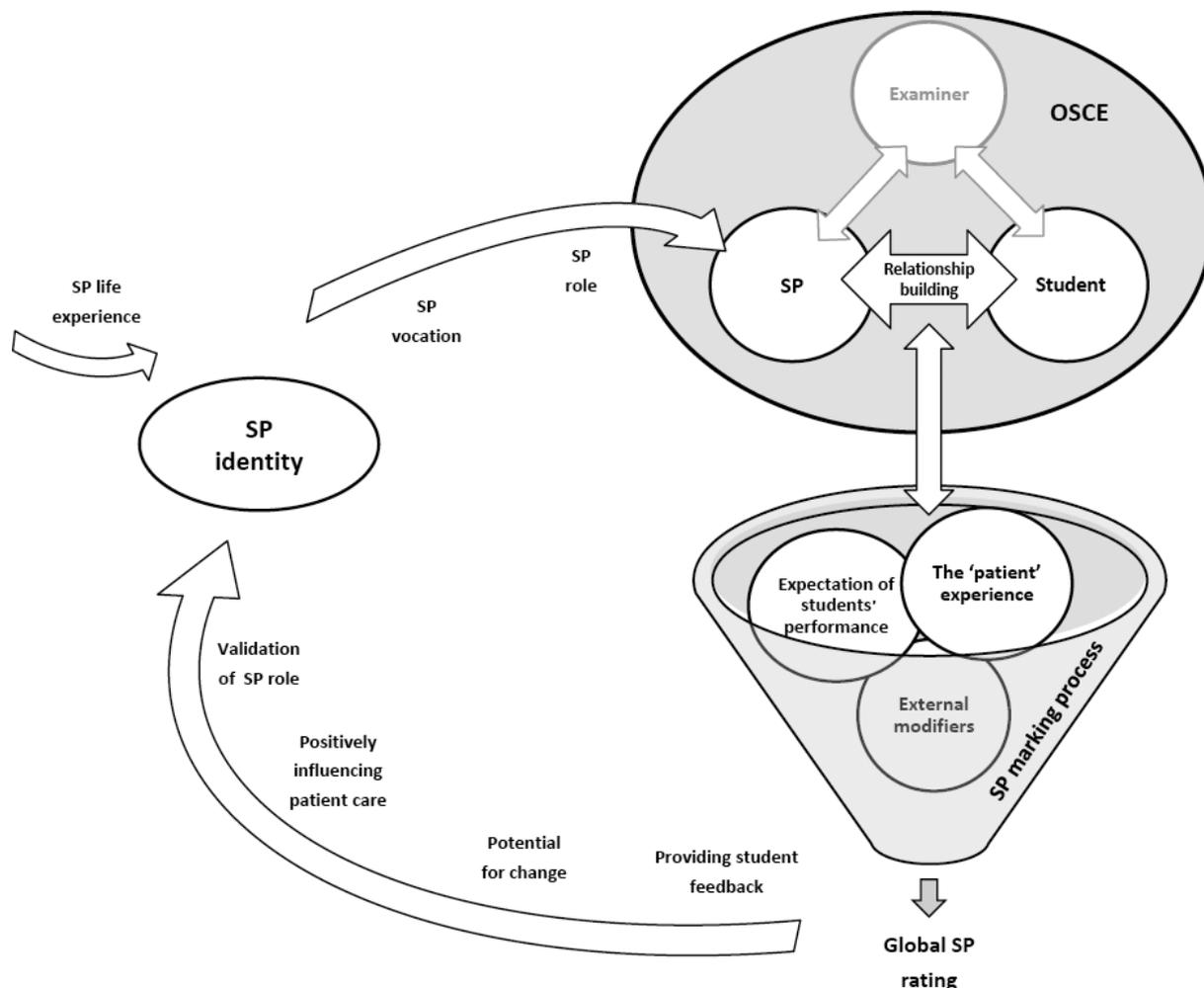


Figure 1 Schematic representation of how standardised patients (SPs) rate candidates in objective structured clinical examinations (OSCEs)

These new insights into the SP discourse can be used to reframe assumptions about the OSCE process and facilitate critical thought about its future direction.

Positioning SPs within the OSCE framework

The SP represents one-third of the core OSCE triad of examiner, SP and candidate, and thus SPs are important stakeholders. They are highly motivated, professionalised and have the ability to be critical of medical interactions in a way that real patients, because of their dependent position, may not be able to. They have been traditionally considered as lay people, but, as demonstrated here, they occupy a third space and by virtue of their training and experience become a kind of 'expert patient', a term used in clinical medicine to describe an empowered and knowledgeable patient.²⁹ Within

OSCEs, SPs quietly pursue their agenda as patient advocates, resisting a subordinate role within the hegemony of the clinician-as-examiner, and exert their agency to influence student learning in a way that extends beyond the current conceptualisation of the OSCE as simply a reliable summative assessment.¹³

Standardised patient ratings result from a holistic assessment based on the patient experience. In rating students, SPs are trained to focus on humanistic aspects of the student's performance and to ignore the technical aspects, which are the domain of the examiner. However, compliance with the first instruction makes the second impossible because SP ratings are inextricably linked with the attributes and experiences of the individual; assuming that it is possible to deconstruct this experience without losing something of its meaning is reductive and

over-simplistic. In this study, technical knowledge picked up by SPs (mirroring the democratisation of knowledge in the real world) became part of their rating because examination was a form of communication and the perception of technical skill a keystone of confidence.

Instead of rejecting this subjectivity, SPs valued it for its capacity for learning, using their integrated perspective to promote a discourse based on person-centredness and individuality. Standardised patients are driven by the potential for student learning within each encounter; they invest in the examination physically and mentally to this end,³⁰ and the learning they promote involves not only content knowledge, but also elusive professional and consultation skills.

Reframing OSCEs for learning

For educators, although assessment is known to provide a powerful driver for learning,¹³ the OSCE is primarily a summative tool, and students have difficulty in seeing any value in the examination beyond the need to progress.³¹ Standardised patients have a different perspective and understand instinctively that assessment should be *for* and not *of* learning; indeed, this is the basis of their involvement. The summative emphasis amongst educators and students results in a strategic approach that fails to recognise the patient as an individual or take advantage of the potential within the patient role.

Despite their unique position, SPs' experience is still that of the patient, with all its attendant emotional and physical discomfort. It is this combined with the SPs' ability to give meaningful criticism that offers students potentially profound learning experiences through their interactions with SPs. This is explicitly expressed in GMC guidance, which notes that '...if patients remind students to wash their hands, put on gloves or explain their status, the message may be more powerful than when it comes from staff'.⁹ Clinical partnership with patients, which is such a defining feature of modern medical practice, should be reflected in medical education generally and in assessment specifically because of its potential to effect positive or negative learning.

Recasting the OSCE as a formative tool in this way raises specific issues for the curriculum and for the preparation of SPs, examiners and students for OSCEs. Students should be taught clinical communication with an emphasis on relationship building and person-centredness. Standardised patients noted par-

ticular difficulties in relationship building with non-UK students, and so it is particularly important that students are supported in their learning if differences in cultural norms make this more challenging. Professional communication teaching should also encompass examination and physical interaction as forms of more subtle communication. This is a higher consultation skill which is often overlooked, but the ability to combine process skills with content knowledge is essential for successful practice.³²

In terms of assessment itself, the artificiality of the examination and the consequent belief that the examination has no meaning beyond progression need to be addressed. In future, workplace-based assessment may supersede the use of OSCEs, but for the present we need to consider how best to develop existing frameworks. This may be achieved by writing OSCE stations that maximise the SP role and thus potential for relationship building, by rewarding the integration of content and process skills, and by making the examiner as unobtrusive as possible. These principles are already used successfully to assess UK postgraduate trainees in general practice (GP) because such skills are a core part of the GP curriculum,³³ but should be adapted for use with undergraduates.

Feedback is essential for learning, but giving detailed OSCE feedback to candidates is not customary at present. Offering SPs the chance to give qualitative comments or written feedback to candidates maximises the potential for learning within any given interaction.³⁴ Furthermore, this helps to cement the SP's status as someone deserving of the student's attention and empowers the patient within the assessment.

Reframing OSCEs from a constructivist perspective

Viewed from within the psychometric discourse that dominates the field of assessment, the key issues are objectivity, validity and reliability, as these are considered important sources of error.^{35,36} Thus, the unexpected and holistic nature of SP ratings might be considered problematic in terms of construct validity (i.e. that SPs are not measuring what they are expected to measure) and something which needs to be ironed out. However, approaching assessment from a constructivist viewpoint allows us to frame these issues differently. In looking beyond psychometric data we can use the data in a new way in a new way.

We have demonstrated here that SP ratings represent a social construction that encompasses individ-

ual experience, expectations and attributes together with interpersonal and environmental interactions. This demonstrates the impossibility of reducing the complexity of rating to a list of descriptors, and thus offers an explanation for the improved reliability and validity of global scores over checklists³⁷ and an argument for the greater use of global scoring for all parties. Standardised patients' holistic manner of rating may also explain why psychometrics are improved by adding SP ratings to examiner scores because the inclusion of technical competence leads to overlap in the constructs rated by the examiner and SP.¹⁸

Rather than trying to eliminate difference, SPs relied on the 'normal distribution' of interactions with a large number of SPs in the examination. The variable and nuanced nature of such interactions at a microsocial level demonstrates how unfeasible it is to aim for absolute standardisation or complete objectivity.³⁸ In practice, we should work towards a system of assessment that recognises and uses diversity and subjective experience as sources of strength rather than weakness. Standardisation is possible only up to a point; thus the important question concerns not how every experience can be made identical, but, rather, where the parameters within which we are happy to accept variability should be drawn.

Despite evidence to the contrary regarding the acceptability of doing so, and its widespread use in North America,² within the UK it remains unacceptable to replace examiners with SPs in undergraduate OSCEs. However, as SPs incorporate some aspects of clinical skills within their assessment anyway, it makes sense to train them in the correct assessment of these aspects so that misconceptions about technical skills can be corrected. Standardised patients could then be used alongside clinician-examiners to assess technical as well as non-technical skills. After all, as it will be real patients who make assessments on the practice of tomorrow's doctors, it is imperative to work in partnership with patients in training these students today.³⁹

Limitations and theoretical sensitivity

To our knowledge, this is the first qualitative study of the kind looking in-depth at the role of SPs in assessment. In keeping with the principles of constructivist grounded theory,²⁷ we accept that our backgrounds as clinicians and educators, and our social constructionist research perspective are sensitising concepts.

We did not intend to produce a positivist theory, but, rather, to illuminate and explain the discourse underlying the role of SPs in OSCEs. The resultant theory is grounded in the empirical data and context in which it occurred (a single medical school in the UK). This is a strength of the study, but the fact that the present study, like other qualitative research, is contextually situated means it is not necessarily widely generalisable. However, we believe the findings are cogent and add important insights to the assessment process. As such, they are relevant to those working in similar contexts throughout health care education.

Interviews were conducted by JLJ and GL who, although they may have been known individually to SPs through their previous work as examiners, were not involved in administering the SP programme or the OSCE process. Participating SPs were aware that GJG, who was well known to SPs as the OSCE coordinator, and MMcC, who was closely linked with the Patients as Partners programme, were part of the research team.

We focused on the SP perspective in this study. A small number of examiners were interviewed to confirm assumptions made by the research team about their own perspectives as faculty staff because this issue arose in the middle stages of analysis. These results are presented as an integrated part of the abstract theory rather than separately. Further analysis of interactions within the OSCE triad will be the subject of a future project.

Directions of future research

Future research should consider exploring the experiences of students and examiners within OSCEs, and the ways in which they intersect. A similar study might look at the processes employed by clinician-examiners in comparison with those of SP raters. Qualitative research also has an important role to play in assessment research in exploring why and how psychometric phenomena are seen and thus in moving the assessment discourse into a post-psychometric era.

CONCLUSIONS

The process by which SPs award ratings offers new insights into both the SP experience and the nature of assessment. Standardised patients have a strong vocational identity, occupy a unique position as a form of 'expert patient' and base their ratings on

the process of relationship building. Understanding SP ratings leads not only to a greater appreciation of this experience, but underlines the potential for further work in partnership with patients for the benefit of medical education. Furthermore, it generates insights into the nature of assessment which help to reframe the OSCE as a social construction and provide evidence in support of a move away from reliance on psychometrics alone towards a greater appreciation of the value of individuality in assessment.

Contributors: J LJ contributed to the study design, and the acquisition, analysis and interpretation of data, and wrote the first draft of the paper. GL contributed to data acquisition and analysis and the critical revision of the article. MM contributed to the study design, data analysis and the critical revision of the paper. GJG contributed to the study conception and design, the analysis and interpretation of data, and the critical revision of the paper. All authors approved the final manuscript for submission.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article:

Appendix S1. Simulated patient rating of student performance in objective structured clinical examinations.

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