

Are OSCEs Truly Inclusive? Examining Their Potential to Exclude Diverse Learners

Abstract

Aim

This discussion paper aims to critically explore how Objective Structured Clinical Examinations (OSCEs) effectively and inclusively measure clinical competence in healthcare education. This paper highlights how current designs and implementation may inadvertently disadvantage students from diverse backgrounds.

Background

OSCEs are a fundamental aspect of clinical healthcare education, intended to support an objective and standardised assessment of clinical competence. However, evidence suggests tensions regarding equity, cultural bias, performativity, and inauthenticity. Consequently, students from diverse backgrounds may be disproportionately penalised due to hidden curricula and inflexibility in assessment design which does not allow for varied methods of demonstrating competence. This paper critically examines the lack of inclusivity within OSCEs, and the potential for them to become a gatekeeping tool, reinforcing structural inequalities.

Design

This discussion paper draws on literature on healthcare education, assessment theory and cultural competence to support a critical exploration of objectivity and inclusivity in OSCEs.

Methods

OSCEs often rely on narrow or implicit cultural norms and definitions of professionalism which are Anglocentric and neurotypical in nature, this may unfairly disadvantage students from diverse backgrounds.

Results

Reasonable adjustments and inclusion considerations are often lacking in OSCE assessments, exacerbating inequalities and undermining widening participation efforts.

Conclusion

Current OSCE design requires further scrutiny to ensure alignment with inclusive pedagogical principles and to avoid perpetuating structural barriers in healthcare education. Recommendations within this discussion paper support educators in the creation of more equitable and culturally responsive assessment strategies to ensure that they authentically assess clinical competence across a diverse student body.

Introduction

Objective Structured Clinical Examinations (OSCEs) are widely used in healthcare education to assess students' clinical, communication, and decision-making skills (Miller, 1990). They are designed to simulate real-world clinical scenarios, allowing students to demonstrate their competence in a structured and standardised manner. OSCEs aim to provide an objective and reliable assessment of clinical skills, ensuring that students meet the required professional standards before progressing in their training.

However, their structure and implementation raise significant concerns about fairness, equity, inclusivity, and cultural competence (Kumagai & Lypson, 2009; Tervalon & Murray-García, 1998). Like all examinations they have the potential to promote learning-by-rote. As identified by Tai et al (2022), assessment in higher education should be designed in such a way that it enables students to achieve and demonstrate capability in an equitable manner and that students from widening participation backgrounds are not disadvantaged because of characteristics or abilities extraneous to the competencies under scrutiny.

This paper critically examines how OSCEs may disproportionately disadvantage students from diverse backgrounds due to embedded biases, inflexible criteria, and a failure to reflect the realities of patient-centred care in a global context.

Cultural Norms and Expectations: Hidden Curricula

OSCEs frequently operate within hidden curricula that privilege Western cultural norms, implicitly disadvantaging students from diverse backgrounds (Hofstede, 2011; Hafferty, 1998). The hidden curriculum refers to the unspoken norms, values, and expectations embedded in healthcare education that shape professional identity and student experiences, often reinforcing dominant cultural perspectives (Hafferty & Franks, 1994). This raises a crucial question; are OSCEs truly measuring clinical competence, or are they assessing performativity, cultural conformity and rote learning?

Assessment criteria often include subjective elements that favour communication styles typical in Western healthcare settings (Norcini & McKinley, 2007). Scoring systems can be unreliable, with assessors unconsciously favouring students whose behaviours align with their own cultural norms (Hauer et al., 2021). The lack of transparency in these expectations calls into question the validity and reliability of OSCEs as an equitable assessment tool.

Expectations regarding politeness, such as the mandatory use of "please" and "thank you" are frequently included in OSCE marking criteria (Geeky medics n.d.) and illustrate the Anglocentric and neurotypical leanings of many OSCEs. These in addition to the implicit requirements embedded in OSCEs, such as specific greeting styles or gestures, further exacerbate inequities. These expectations create unnecessary barriers for students and undermine the purported objectivity of the assessment process (Ginsburg et al., 2003).

There is little empirical evidence suggesting that these behaviours directly impact clinical effectiveness, yet they continue to be weighted heavily in assessments. This raises a fundamental concern, are OSCEs assessing genuine patient care capabilities or reinforcing arbitrary cultural expectations? In a similar way, Western expectations regarding eye contact assume a universal interpretation of confidence and empathy (Sholl et al., 2017). However, cultural psychology research challenges this notion, highlighting that in some cultures, avoiding direct eye contact is a sign of deference and respect (Kumagai & Lypson, 2009). Penalising

students based on these biases demonstrates a failure of OSCEs to distinguish between professional competence and performativity which potentially disadvantages those from diverse cultural or neurodivergent backgrounds.

Bias in Scenarios

Many OSCE scenarios typically assume a Western biomedical framework, disregarding alternative healthcare perspectives and global variations in patient expectations (Tervalon & Murray-García, 1998). Research highlights that international students can often struggle not because of a lack of competence but due to unfamiliarity with localised healthcare practices (Sholl et al., 2017). This represents a fundamental flaw in OSCE design, privileging familiarity with systems over true medical knowledge and skills.

Challenges for Neurodivergent Students

The rigid structure of OSCEs can present specific challenges for neurodivergent students, raising the question of whether they measure competence or merely reward neurotypical performance patterns (Clouder et al., 2020). Whilst clinical practice does not follow a rigid structure, traditional OSCEs expect students to engage in scripted social interactions, using specific facial expressions and verbal cues to convey empathy (Davidson & Henderson, 2010). However, empathy is not confined to neurotypical expressions (Cascio & Racine, 2019). Penalising students who do not conform to these norms reflects an outdated, exclusionary perspective that ignores the breadth and diversity of effective communication strategies.

In a similar manner, timed OSCEs reinforce an approach that disadvantages students who process information differently (Govaerts & van der Vleuten, 2013) or indeed those who suffer from anxiety in high stakes situations. The assumption that quick responses equate to clinical proficiency is both unfounded and exclusionary (Lucey et al., 2020). A fairer model would recognise and accommodate different cognitive processing speeds rather than penalising those who do not fit into a narrow, neurotypical framework. If an assessment was authentically reflecting real clinical practice there are few scenarios which would require a rigid time structure and in reality, even experienced practitioners would take more time to perform clinical tasks depending on the case and presentation of the patient.

The OSCE environment, with bright lights, unfamiliar actors, and high-pressure conditions (from an individual assessment perspective as opposed to the pressure experienced in a clinical setting), can be distressing for students with sensory processing differences (Epstein, 2007). Research shows that high-stakes testing environments disproportionately impact neurodivergent individuals, yet accommodations remain rare in OSCEs (Clouder et al., 2020). This suggests that inclusivity is not merely an afterthought in OSCE design but a systemic failing.

The underlying assumption that there is a single correct way to demonstrate competence fails to reflect the realities of diverse patient care (Miller, 1990). This rigidity limits OSCEs' ability to assess the true breadth of clinical capability.

Widening Participation in Clinical Education and Building a More Diverse Healthcare Workforce

From an 'assessment for social justice' perspective (MacArthur, 2016), more inclusive assessment practices would allow institutions to support the agenda of expanding access to healthcare education and increasing diversity in the healthcare workforce which is a critical step toward addressing systemic inequities. OSCEs, as a key component of clinical education assessment, play a pivotal role in either enabling or obstructing this goal.

Widening participation initiatives seek to address barriers faced by students from underrepresented backgrounds, including those from lower socioeconomic groups, ethnic minority communities, and individuals with disabilities (Lucey et al., 2020). However, if OSCEs continue to favour traditional norms of clinical competence, they may inadvertently become a gatekeeping tool that prevents diverse candidates from progressing through training.

Creating a More Inclusive OSCE

A truly inclusive OSCE must reflect the diversity of the patient populations that students will serve. This means incorporating a broader range of cultural scenarios, ensuring assessments are free from biases that disadvantage students from marginalised backgrounds, and providing equitable support structures to enable all students to succeed (Tervalon & Murray-García, 1998).

A key recommendation would be to explore the option of using OSCEs differently, the value of using these in an assessment for learning approach or as a formative assessment in preparation for practice assessments. However in their current context there are recommendations to address these structural inequities discussed, OSCEs must undergo fundamental reform, rather than minor modifications (Lucey et al., 2020). The following are recommendations of actions to be taken by clinical academic staff involved in curriculum and assessment design to enhanced the inclusivity of OSCEs.

Cultural Awareness in Assessment

- **Explicit Criteria:** Clearly define what is being assessed to avoid hidden expectations (Ginsburg et al, 2003).
- **Assessor Training:** Implement rigorous cultural competence training to reduce unconscious bias (Tervalon & Murray-García, 1998).
- **Diverse Scenarios:** Incorporate patient cases from various cultural contexts to ensure broader applicability (Kumagai & Lypson, 2009).

Accommodations for Students:

- **Flexible Criteria:** Recognise and validate diverse ways of demonstrating clinical competence (Clouder et al., 2020). Consider methods such as self recorded video submission or more focus on assessment in clinical practice.
- **Sensory Support:** Provide tailored accommodations such as extended time, flexible environments, and advanced briefing (Davidson & Henderson, 2010).
- **Alternative Assessments:** Incorporate additional evaluation methods, such as reflective practice and longitudinal assessments, to supplement OSCEs (Govaerts & van der Vleuten, 2013).

Transparent and Fair Marking

- **Audit Criteria for Bias:** Regularly review and revise assessment rubrics to eliminate cultural and neurotypical biases (Hauer et al., 2021).
- **Student Feedback:** Actively involve students from diverse backgrounds in OSCE design and revision to identify barriers and propose solutions (Ginsburg et al., 2004).

While OSCEs are widely regarded as an essential tool for assessing clinical competence, their current design disproportionately disadvantages students from diverse backgrounds. The reliance on unspoken cultural norms, rigid assessment criteria, and inflexible structures raises serious concerns about fairness and validity. True inclusivity in OSCEs requires systemic change, not just minor adjustments, to ensure all students are assessed equitably. Without these critical reforms, OSCEs will continue to reinforce structural inequities rather than serving as a genuine measure of clinical competence (Epstein, 2007; Lucey et al., 2020).

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