

Academic Dishonesty Among Dental Students in Southeast Iran

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Dear Editor,

Academic integrity is an essential component of professional formation in health sciences education. In dentistry, academic dishonesty is of particular concern as students' progress from classroom learning to patient-based clinical responsibilities, where records, signatures, attendance, and treatment notes are linked to competence and patient care. The fundamental values of academic integrity—honesty, trust, fairness, respect, responsibility, and courage—are directly relevant to dental professionalism (1).

We wish to highlight findings from an analytical cross-sectional survey conducted in May 2023 among third- to sixth-year dental students at Zahedan Faculty of Dentistry, Zahedan University of Medical Sciences, Iran. A census approach was planned, and all eligible students were invited; 293 complete, anonymous, self-administered questionnaires were analyzed, corresponding to an 88% response rate. Only complete returned questionnaires were analyzed; because the survey was anonymous, respondents could not be compared with nonrespondents. The questionnaire was adapted from previously published dental education studies of cheating behaviors; during this process, its face and content relevance were evaluated in relation to examination, assignment, attendance, and clinical documentation contexts. It covered demographic characteristics, 13 item-level perceptions of wrongdoing,

and self-reported misconduct, methods, motivations, and responses to peer cheating. Because the items represented heterogeneous behaviors rather than a single latent construct, no total score or internal consistency coefficient was calculated. Data were analyzed using descriptive statistics and Pearson's chi-square test, with $P < 0.05$ considered statistically significant; sparse subgroup findings were interpreted cautiously and were not regarded as stable subgroup estimates. The study was approved by the Ethics Committee of Zahedan University of Medical Sciences (IR.ZAUMS.REC.1402.092), and written informed consent was obtained.

Students' judgments of dishonest behaviors varied. Intentional falsification of treatment notes was most often rated as "very wrong" (61.8%), followed by taking an examination on behalf of a friend (49.5%) and forging an instructor's signature in a patient chart (43.3%). In contrast, asking students who had already taken an examination about its questions was rated as "not wrong" by 86.3% of participants. Unauthorized homework help was also frequently normalized: 70.0% considered giving such help "not wrong," and 72.0% considered receiving it "not wrong." Among students who responded to the cheating item ($n = 291$), 191 (65.6%) reported cheating at least once, whereas 100 (34.4%) did not. Self-reported cheating differed by academic year ($P = 0.001$): 28/60 third-year, 52/81 fourth-year, 51/78 fifth-year, and 60/72 sixth-year

respondents reported cheating. The most frequently reported method involved asking other students. The main reasons were fear of failure and the desire to obtain better grades; these reasons differed by academic year ($P = 0.003$), with fear of failure becoming more prominent in the higher academic years. Reporting peer cheating was also associated with academic year ($P = 0.001$). No perception item was significantly associated with sex.

These findings are educationally important because they reveal a gap between students' recognition of severe clinical falsification and their tolerance of peer-assisted or assessment-related misconduct. Similar patterns have been reported in dental and health professions education, where students may perceive the sharing of examination information or unauthorized collaboration as socially acceptable rather than dishonest (2-5). Consistent with previous dental studies, our findings reinforce the observation that students often distinguish between serious clinical dishonesty and behaviors perceived as common, low-risk, or peer-supportive. This distinction may reflect assessment pressure, a low risk of detection, unclear collaboration rules, and a hidden curriculum in which repeated minor violations are normalized through peer norms or inconsistent enforcement.

Potential COVID-19-related educational disruptions should also be considered. Although this survey was conducted after the main pandemic restrictions, recent experiences with remote learning, altered assessment formats, and increased digital communication may have blurred the boundaries between legitimate collaboration and unauthorized assistance. Future studies should examine digital and post-pandemic forms of misconduct rather than focusing solely on traditional examination cheating.

Dental schools should address academic integrity as a longitudinal educational competency rather than relying solely on punitive rules. These efforts should include defining acceptable collaboration, discussing the integrity of clinical documentation before students begin patient care, designing assessments that reduce opportunities for misconduct, and establishing confidential and fair reporting and remediation

pathways. Future intervention studies should evaluate structured integrity modules, honor-code or professionalism workshops, feedback based on clinical record audits, assessment redesign, and confidential reporting systems using outcomes such as perceived seriousness, self-reported cheating, reporting behavior, and documentation accuracy.

This study was limited by its single-center, cross-sectional design, reliance on self-reported data, inability to compare respondents with nonrespondents, absence of formal psychometric indices for the adapted item-level questionnaire, and potentially sparse cells in subgroup analyses. Nevertheless, the findings support targeted integrity education in dental curricula, particularly regarding peer-assisted misconduct, the sharing of examination information, and clinical documentation.

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