

## Sample submission 1A

All four authors of the gospels wrote with specific objectives in mind. They had their respective target audiences and they focused on different characteristics of Christ, resulting in a biased representation.

In order to understand the messages of each of the gospels one needs to understand the background of each individually. To whom was the book originally addressed? What are the objectives or the

emphases, which the writers have chosen to elaborate to their reader? Answering these questions leads to a better understanding of the differences between the gospels and their purpose. This paper will analyze the differences between the Passion narratives in the Synoptic Gospels while also focusing on how these differences help produce the Lukan portrayal.

First we will compare the passion narratives in the gospels.

Understand Luke's intentions and overall message. Very

differences in each author's account. We can begin discussing

12 disciples at the last supper. The monologue is very similar

several verses at the end, in which Jesus says "you are those who have stood by me in my trials. And I confer on you a kingdom, just as my father conferred one on me, so that you may eat and drink at my table in my kingdom and sit on thrones judging the twelve tribes of Israel" (Luke, 22:27-30). By adding these verses Luke represents Jesus as the prophet of God. More importantly he also established Jesus' authority over the future kingdom. Luke's underlying message is much more significant though. By adding this, Luke is establishing a future kingdom attainable by all people, not just Jews, through Jesus Christ. It is a strong message for all future Christians, giving them hope that they too can attain a part in the coming kingdom.

When comparing Luke and Matthew's interpretation of Jesus' trial, both authors emphasize a different part of Jesus' person. In Matthew, the governor asks Jesus, "are you the King of the Jews?" (Matt. 27:11) while in Luke the chief of priests and teachers of the law asks Jesus, "are you the Son of

Sample Submission 1A  
and 1B (see next page)

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## Sample submission 1B

Name

Course

Instructor

Date

### *Introduction*

All the gospel writers wrote with specific objectives in mind. They have their respective target audiences as well as different emphases as to the different aspects of the person of the Christ. Matthew had the Jewish people as his target, while John, the broader audience which are Gentiles mainly. Mark and Luke also have their own audiences; the aimed target of the first are Romans, while the latter's recipient was an individual named Theophilus (Constable 2000 p5). In order to understand the application of the narratives and the messages of each of the gospel writer, which are usually similar (especially the synoptics), one needs to understand the background of each gospel. To whom was it originally addressed? What are the objectives or the emphases which the writers have chosen to elaborate on their readers? These are some of the important and helpful questions that the student may find beneficial in his/her study of the gospels.

This paper's focus at hand is to compare Mark's record with Luke's record pertaining to an instance in Jesus' life when he came to his own hometown in Nazareth. What are the differences, if there are any, between the two records? Moreover, what are the reasons for discrepancies? Are there aspects of Jesus' person that both writers simply wanted to stress. As is often pointed out by scholars, the seeming contradictions within the three gospels (Mark, Luke) can be explained only by taking the three documents as the accounts of three eyewitnesses – with each focusing on specific angle – intent on reporting what they

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## Sample submission 2A

With mortality of more than 30,000 people in the United States and approximately 1 million worldwide each year, suicide has become one of the leading causes of death. Many risk factors have been identified in the past few decades (i.e., demographic, psychological and biological), with hopelessness, anhedonia, impulsiveness, and reactivity being the most prevalent psychological symptoms. With the increase in psychological distresses in modern society, many would ultimately suffer episodes of major depression, or major depressive disorder (MDD), which in turn may prompt individuals to seek escape by taking his or her own life (Nock, Borges, Bromet, Cha, Kessler, & Lee, 2008).

Among the aforementioned risk factors, biological predispositions have been the focus of the research communities in the past two decades. Strong links have been established between the deficiencies or abnormalities in various neurotransmitters (i.e., serotonin, norepinephrine, dopamine,  $\gamma$ -aminobutyric acid, peptide neurotransmitters, and trophic factors) and the diagnosis of MDD and suicide (Parsey, et al., 2006). While researchers have yet to identify the genetic loci for suicide in molecular genetic studies due to the complex nature of the phenotype, substantial amount of evidences had consistently suggested that suicidal behavior involve disruptions in the functioning of the inhibitory neurotransmitter serotonin (Nock et al., 2008).

Accordingly, this article is an effort in providing a brief review which is based on a few selective research journals in the past to demonstrate how serotonin and suicide is related, and why selective serotonin-reuptake inhibitors (SSRIs) has become the first line of defense in preventing suicide and the remission of MDD.

It is well established in the research community that serotonin plays an essential role in the regulation of sleep, appetite, body temperature, blood vessel tone, secretion of specific hormones and in the perception of pain, therefore affecting a wide range of physiological states

Sample Submission 2A  
and 2B (see next page)

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**Comment [TS1]:** APA Style, name all the authors

**Comment [TS2]:** Researchers have not identified genetic loci for suicide in molecular genetic studies in light of the complex nature of the phenotype - Plagiarism from **Suicide and Suicidal Behavior**

1. Matthew K. Nock<sup>1</sup>,  
2. Guilherme Borges<sup>2,3,4</sup>,  
3. Evelyn J. Bromet<sup>5</sup>,  
4. Christine B. Cha<sup>1</sup>,  
5. Ronald C. Kessler<sup>6</sup> and  
6. Sing Lee<sup>7</sup>  
Epidemiol Rev (2008) 30 (1): 133-154.  
doi: 10.1093/epirev/mxn002. First  
published online: July 24, 2008

**Comment [TS3]:** The biologic factors most consistently correlated with suicidal behavior involve disruptions in the functioning of the inhibitory neurotransmitter serotonin - Plagiarism from **Suicide and Suicidal Behavior**

1. Matthew K. Nock<sup>1</sup>,  
2. Guilherme Borges<sup>2,3,4</sup>,  
3. Evelyn J. Bromet<sup>5</sup>,  
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information about risk factors for suicidal behaviors. We do not distinguish between studies conducted in different countries, given that the risk factors reported have been consistent across virtually all countries examined. Given that there is a large and ever-expanding body of literature on risk factors for suicidal behaviors, we provide a summary of only the strongest and most consistently reported factors.

**Demographic factors.** Demographic risk factors for suicide include male sex, being non-Hispanic White or Native American (in the United States), and being an adolescent or older adult. Demographic risk factors for suicidal behaviors (in the United States and cross-nationally) include being female, being younger, being unmarried, having lower educational attainment, and being unemployed (25–28, 40, 68). The differences in male:female ratio are often attributed to the use of more lethal suicide attempt methods, greater aggressiveness, and higher intent to die among men (34, 69). As mentioned above in connection with India and China, the gender-specific lethality of methods may vary cross-nationally. The other demographic factors mentioned (younger age, lack of education, and unemployment) may represent increased risk for suicidal behaviors associated with social disadvantage, although the mechanisms through which these factors may lead to suicidal behavior are not yet understood.

**Psychiatric factors.** The presence of a psychiatric disorder is among the most consistently reported risk factors for suicidal behavior (25, 47, 70–74). Psychological autopsy studies reveal that 90–95 percent of the people who die by suicide had a diagnosable psychiatric disorder at the time of the suicide (75), although this percentage is lower in non-Western countries such as China (76, 77). Mood, impulse-control, alcohol/substance use, psychotic, and personality disorders convey the highest risks for suicide and suicidal behavior (25, 34, 47, 70, 71, 78–81), and the presence of multiple disorders is associated with especially elevated risk (25, 47, 80, 82).

**Psychological factors.** Researchers have begun to examine more specific constructs that may explain exactly *why* psychiatric disorders are associated with suicidal behavior. Several such risk factors include the presence of hopelessness (83–85), anhedonia (49, 86), impulsiveness (70, 87–89), and high emotional reactivity (86, 87, 90), each of which may increase psychological distress to a point that is unbearable and lead a person to seek escape via suicide (88, 91–93).

**Biologic factors.** Family, twin, and adoption studies provide evidence for a heritable risk of suicide and suicidal behavior (94–99). Much of the family history of suicidal behavior may be explained by the risk associated with mental disorders (100); however, some studies have provided evidence for familial transmission of suicidal behavior even after controlling for mood and psychotic disorders (101). Researchers have not identified genetic loci for suicide in molecular genetic studies in light of the complex nature of the phenotype (102, 103) but instead have searched for biologic correlates of suicidal behavior that may arise through gene-environment interactions (104–109). The biologic factors most consistently correlated with suicidal behavior involve disruptions in the functioning of the inhibitory

neurotransmitter serotonin. Persons who die by suicide have lower levels of serotonin metabolites in their cerebrospinal fluid (110–113), higher serotonin receptor binding in platelets (114, 115), and fewer presynaptic serotonin transporter sites and greater postsynaptic serotonin receptors in specific brain areas such as the prefrontal cortex (101, 116), suggesting deficits in the ability to inhibit impulsive behavior (101, 117). Notably, however, similar deficits in serotonergic functioning are found in other impulsive/aggressive behaviors such as violence and fire-setting (118) and appear to be nonspecific to suicide.

**Stressful life events.** Most theoretical models of suicidal behavior propose a diathesis-stress model in which the psychiatric, psychological, and biologic factors above predispose a person to suicidal behavior, while stressful life events interact with such factors to increase risk. Consistent with such a model, suicidal behaviors often are preceded by stressful events, including family and romantic conflicts and the presence of legal/disciplinary problems (72, 76, 119, 120). The experience of persistent stress also may explain why persons in some occupations, such as physicians (121), military personnel (122–125), and police officers (126), may have higher rates of suicidal behavior; however, this increased risk may be explained by the demographic and personality characteristics of people who select such occupations (125, 127). More distal stressors, such as perinatal conditions and child maltreatment, also have been linked to

## Sample Submission 2B

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being reported in May and June) (145–148). Improvement in the ability to predict suicidal behavior through the continued identification of specific risk factors represents one of the most important directions for future studies in this area.

## Protective factors

Protective factors are those that decrease the probability of an outcome in the presence of elevated risk. Although formal tests of protective factors are rare in the suicide research literature, several studies of factors associated with lower risk of suicidal behavior have yielded interesting results. Religious beliefs, religious practice, and spirituality have been associated with a decreased probability of suicide attempts (149–152). Potential mediators of this relation, such as moral objections to suicide (153) and social support (154), also seem to protect against suicide attempts among persons at risk. Perceptions of social and family support and connectedness also have been studied outside the context of religious affiliation and have been shown to be significantly associated with lower rates of suicidal behavior (155–159). Being pregnant and having young children in the home also are protective against suicide (160, 161); however, the





# Langone Medical Center

**UNIVERSITY NEPHROLOGY ASSOCIATES**

Charles E. Langs, M.D.  
David T. Liu, M.D.  
Jeffrey J. Michael, M.D.  
Joseph M. Weisstuch, M.D.

July , 20

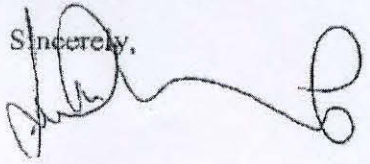
RE:

Sample Submission 3A  
See also 3B (next page)  
  
Faculty submitted medical documents  
that were forged by student.

To Whom It May Concern:

is a patient under my care. He suffered a concussive injury to his right temple on 7/21/2011. He had persistent headaches and dizziness through 7/26/2011. Please excuse his absence during this period.

Please contact me if any questions arise.

Sincerely,  




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July 20

RE:

Sample Submission 3B

See also 3A (previous page)

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