LETTERS TO THE EDITOR

To the Editor:—We were interested in the article by Turnbull, et al., which called attention to the need to improve the evaluation of students on clinical rotations.¹ Their method of “clinical work sampling” is intriguing for it proposes that the unit of evaluation change from the clerkship to the case; efforts to establish the utility of this approach are worthwhile.² However, the authors describe current undergraduate in-training evaluation methods as “...neither effective, accountable nor educational.”¹ This overlooks a body of published evidence on a method of student evaluation that is reliable, valid, and educational.

At the Uniformed Services University, the internal medicine clerkship includes a descriptive evaluation method that describes student progress as growing independence from Reporter to Interpreter to Manager/Educator (known as R-I-M-E).³ We incorporate this descriptive evaluation framework into formal evaluation sessions first introduced into our clerkship by Noel.⁴ These sessions are held every three to four weeks at all sites during our twelve-week clerkship. A trained, on-site clerkship director meets with the instructors working with students currently on the clerkship. They discuss each student for fifteen minutes, citing areas of strength and areas in which to improve. During the meeting, the on-site director provides feedback to the instructors on their observations and comments and works with teachers to develop actions for helping the student achieve the “next step.” After the session, this clerkship director meets with each student in a formal feedback session to discuss the evaluations and further develop the plan of action. The timing of the meetings ensures (and documents) that evaluation occurs and that students receive formal feedback *at least* three times during their clerkship. The amount of time we spend on evaluation *during* the clerkship is similar to the time most clerkship directors spend *after* the clerkship.⁵

Using this evaluation method, we have achieved a high level of assessment reliability, sufficient for high-stakes decisions, during the clerkship.³ We have previously demonstrated an enhanced ability to identify students with insufficient knowledge,⁶ unprofessional behavior,⁷ and those students who will receive low ratings from their internship directors.⁸ Recent studies have shown the feasibility of implementing this system at another institution.⁹

This method of evaluation is also educational. Because we meet regularly with both instructors and students, we reinforce clerkship goals, limit grade inflation, and achieve inter-site consistency. Program and clerkship directors might be especially interested in how the system can provide on-going development of teaching skills for housestaff and faculty.¹⁰

Altogether, we meet our obligation to the student through clear goals, inter-site consistency, and timely feedback. We are also accountable to society by improving the ability to identify students with deficiencies and tailoring interventions for remediation.

Much more research is needed, and Turnbull and colleagues have addressed an innovative way to deal with the unit of evaluation during clinical clerkships. It may prove especially valuable in settings where a large number of teachers has limited or intermittent contact with a student. We wanted to draw

attention to the fact that there currently exists a method of in-training evaluation during clinical clerkships that is reliable, valid, feasible, credible with students and teachers, effective, accountable, and educational.—**PAUL A. HEMMER, MD, THOMAS JAMIESON, MD, and LOUIS N. PANGARO, MD, Uniformed Services University-EDP, Bethesda, Md.**

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In reply:—Thank you for giving us the opportunity to respond to the letter by Doctors Hemmer, Jamieson and Pangaro about our study.¹ The “R-I-M-E” approach to in-training evaluation provides an excellent descriptive format to guide evaluators and learners. Equally, the formal implementation of this framework, three or four times throughout a 12-week clerkship is a significant improvement over programs that already exist. We are in agreement that: evaluations should be more frequent than once per rotation, these assessments should be formative, multiple observers should be used when collecting evaluation information, and that they should have some level of psychometric integrity (i.e., are reliable and valid). The areas where I believe our work diverges from the work cited is that their unit of analysis is not clearly identified as the patient interaction, but rather a short interval of training. The studies cited provide modest evidence to support the validity of this approach; this needs to be more extensively investigated as suggested by the authors. The reliability of these measures should also extend to a formal generalizability study where all potential

sources of error could be considered. Equally, claims of educational effectiveness require supporting evidence in terms of outcomes. This would be an important next step for the authors to consider.

We believe that the work described in the letter to the editor is a helpful addition to our understanding of in-training evaluation. We look forward to more extensive studies which could potentially combine the approach described with that of a clinical work sampling approach.—**J. TURNBULL, MD, J. MACFAYDEN, MD, C.**

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