programs or other research and service activities for fear of being penalized with a depreciating Step 1 score.

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References

New Medical Student Performance Evaluation Standards: Laudable but Inadequate

To the Editor: The Association of American Medical Colleges’ recent Medical Student Performance Evaluation (MSPE) recommendations1 propose a revamped MSPE that organizes evaluative performance data in a clear and concise format, with standardized reporting across institutions. Inclusion of grading and ranking distributions, and clear articulation of the assessments that make up such measures, enhances transparency. Moreover, we applaud the inclusion of Accreditation Council for Graduate Medical Education core competency performance data, as well as the exclusion of United States Medical Licensing Examination scores, which affords candidates discretion in releasing scores. In sum, there is much to like in the new MSPE recommendations. Unfortunately, the recommendations do not address the grading and ranking variability they lay bare.

In a recent study of U.S. medical schools,2 the percentage of students receiving the top grade in any clerkship ranged from 2% to 93%. Similar “extreme variability” is seen in student ranking categories, with the top category containing 3% to 39% of students at different institutions.3 Lower grade and ranking categories display even greater between-institution variability. Even with improved transparency, how can residency program directors appropriately compare students from different institutions whose grades and ranks represent drastically different performance percentiles?

Most concerning, if no statistically valid way to compare such measures exists, what heuristics are programs using? In our interactions with students across diverse institutions, many have voiced these or similar concerns. Students from institutions with stringent grading distributions are especially vocal in their concern for inequity. Thus, while the MSPE recommendations may better expose underlying between-school variability, they ultimately fail to address the fundamental challenge: nonstandardization in grading and ranking.

As institutions move toward competency-based milestones and entrustable professional activities, we hope grading will be reevaluated entirely. In the meantime, we urge national standards for grading and ranking students that are rooted in statistically valid approaches for comparing candidates. Grading is not a new challenge; there are clearly no easy solutions. Yet, to ensure fairness in the residency application process and help program directors evaluate candidates, it is time to explore national standards.

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References

Assessment in Medical Education Focuses Too Narrowly on Test Scores

To the Editor: For a profession that is often viewed by the public as defining the cutting edge of science, we in medicine have been paradoxically skeptical of change. This reluctance is aptly observed in the archaic methods that we employ in assessing the performance of trainees.

Although our profession is slowly adopting multifactorial assessment techniques, the pinnacle of early-career achievement remains a series of numerical scores on examinations that rely predominantly on the recitation of memorized facts. Not only is this an ineffective way to judge a clinician’s aptitude, it can be counterproductive to developing excellent physicians.

One of my most respected mentors once challenged me to identify the difference between educational activities that are required to obtain test scores, and those that will help develop me into a valued and respected contributor to my field. While there is some overlap, these paths are, by and large, independent of one another. Today I try to impress upon medical students the importance of not ignoring the latter for the sake of the former.

The day-to-day practice of medicine in today’s Information Age is exquisitely reliant on critical thinking and complex problem solving—skills that are not focused on, or readily assessed, in our formal education. Moreover, our obsession with testing facts is ultimately futile, as there exists an overly abundant and ever-increasing body of knowledge that no individual will ever be able to master. A focus on memorizing as much information as possible yields only disciples who can regurgitate facts verbatim. This was of course a crucial skill for doctors in the not-so-distant days of limited access to information. Today there is much more utility in being able to define a problem, either to recall or otherwise quickly access the information needed to solve it, and to employ critical evaluation skills to assess the success of one’s interventions—and, crucially, to be able to know when to change course.

As long as admission to competitive training positions relies largely on rote recall ability, the educational system is
robbing our trainees of valuable time and mental bandwidth which could be spent developing them into excellent thinkers and doers. I trust that the latter is ultimately the direction that our profession wants to embrace.

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Clinical Skills in the Age of Google: A Call for Reform and Expansion of the USMLE Step 2 CS

To the Editor: The past year has seen the rise of a movement devoted to ending the United States Medical Licensing Examination Step 2 Clinical Skills (CS) exam. Cited reasons have focused on the expense, limited accessibility, and questionable psychometric properties of the exam. Indeed, the $1,275 exam is offered in only five cities and has a 96% first-time pass rate.1 Nonetheless, calls for its termination are shortsighted and misdirected.

Current trends point to medicine's ongoing and inevitable transformation into a bona fide service profession. Remuneration models and evaluation metrics that heavily weigh patient satisfaction increasingly tie physicians and hospitals to a domain largely driven by patient–clinician rapport.2 In addition, the epidemiological shift toward chronic disease means that medicine will increasingly center on long-term therapeutic alliances. This paradigm will render the patient–physician interaction important for clinical outcomes, as well as for processes of care. Moreover, my generation's virulent individualism promises to magnify the import of my short career as a medical student, my labels with shocking accuracy has forced me to reconsider my priorities for the preclinical years.

Despite its growing importance, critical assessment of approaches to patient–physician interaction has lagged. While clinical science is subjected to empirical evidence, patient interaction is still largely taught at the bedside.

Admittedly, there is little evidence to suggest that Step 2 CS, in its current form, advances the goal of fostering better patient–physician communication. However, at the very least, it forces medical schools to adhere to a minimal set of universal criteria in teaching communication. Step 2 CS needs reform and medical education needs a test like the Step 2 CS more than ever. It is dangerous to weaken medical licensure at a time of rapid change and upheaval.

References

Incorporating Formative Assessments Into the Preclerkship Lecture

To the Editor: Dedicated professionals—musicians, athletes, artists—constantly self-evaluate, ritualistically probing, targeting, and improving weaknesses before presentation of their work. Similarly, in clerkship rotations, medical student knowledge and skill are continually examined and improved through active problem solving and faculty-posed questions (“pimping”) before summative evaluations. In contrast, preclerkship course work has historically lacked such formal, daily tools for ongoing self-assessment and improvement before cumulative examination. For remedy, medical educators have increasingly recognized the value of student-centric learning, and several recent initiatives, such as the flipped classroom, problem-based learning, and team-based learning, have capitalized on the growing body of supportive pedagogical evidence. While we applaud these and other learner-oriented adaptations to preclerkship education, the primary mode of instruction generally remains didactic, with inquiry-based learning sequestered to occasional discrete activities. For continued improvement sans curricular overhaul, we suggest furnishing the lecturer-centric modality with diagnostic, educative, and reflective assessments antecedent, concomitant, and subsequent to classroom instruction. Such formative assessments might include prelecture reading quizzes; in-class polling; daily, weekly, and monthly postinstruction quizzes; and challenging extension questions.

Although most formal studies evaluating formative assessments are subject to methodological recrimination, education literature as a whole continues to showcase improved outcomes, particularly in concept understanding, application, and retention.3 Moreover, formative assessments can direct educators toward struggling individuals or reveal classwide misconceptions, and we informally find formative assessments highly favored among learners. Crucial for the preclerkship student, the provision of abundant, personalized, and real-time feedback encourages greater meta-awareness for more potent study. By varying context and presentation medium, formative assessments can also promote content mastery over apparent familiarity attained from rote rehearsal of lecture materials.

We reason that greater incorporation of formative assessments would provide improved scaffolding for preclerkship learning while still preserving conventional curricular architecture, easing the onus on faculty to engineer improvements. To counter student apprehension and accentuate learner benefit, these assessments could be graded with minimal weight or for completion. Ultimately, we call for increased integration of platforms in the lecture regime that support the continued development of problem-solving ability. By such inclusions, we believe that medical educators will be better equipped to instruct preclerkship students in large settings and consequently elevate testing outcomes, clerkship readiness, and the learner.

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