if the authors assessed the interrater reliability used to assess the validity evidence, since their checklist was adapted from Beckman et al., which found kappa values ranging from –0.10 to 0.96 and was particularly poor for rating the Response Process criteria.

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In Reply to Roff and McAleer and to Loo and Byrne: We appreciate the interest in our article from Roff and McAleer and from Loo and Byrne. Here, we will attempt to clarify a few points.

First, we did not assess the interrater reliability of coding; however, in the few instances when there were differences, discussions took place until consensus.

Second, we hoped that readers would not interpret our comments as implying that job training in residency is not an educational pursuit. Instead, we wished to emphasize that residents have evolved from exclusively learners to trainees who are also employees with professional responsibilities.

Third, many of the articles that have cited Roff and colleagues’ Dundee Ready Education Environment Measure (DREEM) were excluded from the review because they did not meet inclusion criteria, which were carefully considered by the authorship team and appreciated during the peer review of our article. Only 45 articles about DREEM were published in English in peer-reviewed journals and provided new quantitative data from medical students or residents. Repeated citations of DREEM suggest that it fulfilled an unmet need since its development in the 1990s, and use of the DREEM may reflect the high esteem that the community has for the accomplishments in medical education at Dundee. For validity evidence for the tool were more robust and compelling, it may have been included in more studies.

Inclusion criteria also explain why the first article to mention the Postgraduate Hospital Educational Environment Measure (PHEEM)1 was not included in the review. Specifically, no quantitative data were in the article’s Results section, and thus validity evidence could not be established. Therefore, we elected to use the first publication of the PHEEM in which quantitative data were provided for the review.2

Finally, subsequent-use articles did not factor into the validity evidence scores that we generated. Instead, the score was calculated for each tool based upon evidence provided in the first publication with quantitative data. It is not unreasonable to suggest that subsequent publications may provide additional validation and that these may be a proxy for acceptability within the educational community. Another review could be conducted to investigate the entire body of validity evidence associated with each scale. Although it would be interesting to see if validity evidence is strengthened with subsequent publications, some threshold of evidence is needed in the first article presenting a new tool to justify publication. Additionally, if ample validity evidence is not provided in the initial publication, how might scholars and educators know whether the tool should be subsequently used or not?

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How Do U.S. and Canadian Medical Schools Teach About the Role of Physicians in the Holocaust?

To the Editor: Almost every aspect of contemporary medical ethics is influenced by the history of physician involvement in the Holocaust. Most notorious is the unethical research by Nazi doctors, which led to the Nuremberg Code, but physicians and their organizations played many other roles, including in rationalizing and implementing programs of forced sterilization and “euthanasia” of disabled individuals, and in developing, testing, and refining the killing, cremation, and camouflage technologies used in the death camps. This history informs modern debates about economic and social forces in medical practice, genetic testing and therapies, public health research and practice, physician involvement in prisoner interrogations and executions, end-of-life decision making, and many other issues.1–4

How Do U.S. and Canadian Medical Schools Teach About the Role of Physicians in the Holocaust?
Although teaching on ethics and professionalism is uniformly required in medical schools, it is not known whether or how medical students today learn this specific history. To address this, the Liaison Committee for Medical Education (LCME) included two new questions in its 2013 annual survey of U.S. and Canadian Medical schools: “Does the curriculum include required sessions that address the role of physicians in the Holocaust?” and a follow-up item on the teaching format(s) used. The methods of the survey, which is completed by every LCME-accredited medical school in the United States and Canada, are described in detail elsewhere. Responses to these questions reveal a stunning fact: Only 22 of 140 (16%) medical schools in the United States and Canada have any required curricular elements on the roles of physicians in the Holocaust, and half of these (11/22) teach this material using a lecture format only.

Of course, surveys are imperfect, and some schools might have underreported their required course work. Also, the LCME asked only about “required sessions,” which might not cover electives that address this history or spontaneous discussion of the topic during other sessions. Still, it appears that specific attention to arguably the most influential set of events in the history of professional ethics in medicine is required at only a fraction of U.S. and Canadian medical schools—and this despite a uniform requirement to teach ethics and professionalism.

Now that the LCME has documented this deficiency, the medical profession should be galvanized to ensure more focused attention to this history and its continuing relevance in training programs, such as by developing standardized curricular materials and fostering collaborations between medical schools and Holocaust resources such as museums. If the situation does not improve with voluntary efforts, the LCME should consider adopting more specific training requirements.

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