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REPLY

We thank Dr Atreja for making suggestions to improve the utility of quarter model for in-training assessment (ITA). He has suggested adding workplace based assessment (WPBA) to improve the applicability of the model.

While there are similarities between the two, there are important differences as well. ITA operates at the level of 'competence' (what the student is capable of doing) while WPBA operates at 'performance' (what the trainee actually does). ITA has been proposed basically for undergraduate medical students. Since undergraduates are not directly responsible for patient care, many of the tools used for WPBA are not applicable to them. At the postgraduate level; however, it is possible to use case based discussions (discussing the cases actually managed by the trainee and seeking justification for what had been done), DOPS and multisource feedback. In addition, sheer numbers will make it difficult to organize these types of assessments for undergraduates.

We do not agree with the contention that using more objective assessments will make such assessments more robust. There is enough literature support to tell that objectivity is not *sine-qua-non* of reliability or validity [1]. Expert subjective judgments can provide as much or sometimes even more reliable information about trainee performance [2]. The tools mentioned in the letter (mini-CEX, DOPS, MSF etc.) are very subjective compared to say OSCE - yet they have been accepted as highly useful in providing information about performance of the trainee. Since the purpose of ongoing assessment is to provide feedback to the trainee/students, reliability is not really as much of an issue as educational impact of such assessment. Conversely, subjectivity and individualized feedback is considered a strength of mini-CEX [3] which helps the trainees see cases from different perspectives.

The reasons for flawed implementation of internal assessment in our country are related to inability to make appropriate use of such assessments. Teachers hardly provide any feedback to the students to improve their performance and most such assessments end up as replica of conventional examinations without clarity of purpose. The solution lies in faculty development and letting the students experience the utility of formative feedback in helping them improve rather than using more objective assessments.

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Understanding Non-financial Conflicts of Interest

We read the article on 'Tackling Conflict of Interest and Misconduct in Biomedical Research' [1] with keen interest and would like to congratulate the author for succinctly emphasizing the utmost importance of competing interests in biomedical research. In this

regard, we would like to add that while financial conflicts of interest have been talked about more often and have been under increased scrutiny by regulatory bodies, the scientific world also needs to acknowledge and appreciate the non-financial conflicts of interest that frequently threaten the objectivity of biomedical publishing. In recent years, non-financial conflicts of interests have been highlighted [2,3] as potential influencers of biomedical research. Non-financial conflicts are poorly defined, heterogeneous and mostly

subjective, and hence inherently difficult to detect, acknowledge and control. They can exist anywhere in the chain of research, right from institutional review boards arbitrarily accepting/rejecting proposals based on personal relations to reviewers choosing to sit on papers of scientific competitors under the veil of blinded peer review. Often they can be as subtle as the religious [3] or moral beliefs of the reviewer or the 'academic self-interest' of the investigator [2]. In this connection, the instructions to authors [4] of Indian Pediatrics mention that, "conflicts can occur for other reasons, such as personal relationships, academic competition and intellectual passion." Interestingly; however, while there are regulatory guidelines for financial competing interests, non-financial conflicts of interests have remained a gray area, with utmost reliance placed on disclosure and subjective integrity of the authors, reviewers and editors. It is important to realize that such conflicts are intrinsic to research, and are mostly too

subjective and arbitrary to be readily quantified by an objective measure. Hence the need of the hour is the acknowledgement of their existence and sensitization of all concerned stakeholders about voluntary self-reporting/disclosure of any such existing conflicts.

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Recurrent Hemarthrosis : An Unusual Cause

A 7-year-old boy was brought to us with swelling of the right knee since 1 year of age. The swelling used to appear suddenly once every two months, would last for a few days and then gradually subside on its own. During the episode, the patient used to have severe pain in the knee joint and was not able to walk. There were no aggravating or relieving factors. There was no history of fever, trauma, bleeding from any other site or swelling of any other joint.

Examination revealed a child with a fluctuating, tender swelling on the medial aspect of the right knee joint (**Fig. 1**). Movements at the right knee joint were restricted. Further examination revealed a swelling on the medial aspect of the right foot, just in front of medial malleolus, fluctuant, non-tender, which used to decrease in size on raising the leg and used to blanch on pressure. The parents informed that this swelling was present since birth. Careful scrutiny also revealed that the affected limb was clearly hypertrophied and larger than the unaffected limb.

An MRI of the right lower limb was suggestive of a diffusely insinuating vascular malformation, haemolymphatic in nature, noted along the antero-medial aspect of the right leg with intra-articular extension and distension of the knee joint with mild joint effusion and evidence of intra-articular hemorrhage due to prior bleeds (**Fig. 2**).

Similar focal lesions were also noted on the dorsum and medial aspect of the foot. The vascular surgeon plans to thrombose the vascular supply of the intra-articular portion of the malformation to prevent the recurrent hemarthrosis which would otherwise eventually destroy the joint.

Klippel Trenaunay syndrome is a cutaneous vascular malformation that, in combination with bony and soft tissue hypertrophy and venous abnormalities, constitutes the triad of defects of this usually nonhereditary disorder [1]. However, interestingly, scattered reports are available in world literature that it may occasionally be inherited [2,3].



FIG.1. Right-sided hemarthrosis **FIG.2.** Intra-articular bleed