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From the Chalkboards to the Hospital Wards: Demystifying the Third Year Clerkships

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From the Chalkboards to the Hospital Wards

Demystifying the Third Year Clerkships

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Class of 2016

Dedication:

This manual is dedicated to all of the fantastic clinicians, scientists, residents, allied health professionals, and support staff that have contributed to my growth as a medical professional and delivered excellent compassionate care to their patients. To my loved ones for their love and support, without which I would not be half the man that I am today. And to every patient that was brave enough to involve an inexperienced medical student in their care, demonstrate the patience required to answer my at times asinine questions at 5AM and for teaching me what no textbook could.

<i>Table of Contents</i>	<i>Page</i>
Introduction	1
How to Use the Guidebook	
Guidebook	
Miscellaneous Tips and Rules of Thumb	2
The Oral Presentation	4
Expectations for the Oral Presentation	5
Ideal Medical Student Attributes and Behaviors	6
Common Pitfalls of the Well Intentioned Medical Student	8
What Attributes Make a Medical Student Fun to Teach?	10
Does Verbalized Specialty Choice Affect My Evaluation?	12
Clerkship Directors ONLY	
Grading structure	14
What info can Residency Program Directors see?	
Attendings ONLY	15
What makes a medical student fun to teach?	
Ideal 'special topic' presentation	
Senior Housestaff ONLY	16
The art of asking to be dismissed for the day	
Best ways to contribute to patient care	
Appendix A: Respondent Statistics	17
Appendix B: Raw Survey Responses (available upon request)	
B1: Clerkship Directors	
B2: Attending Physicians	
B3: Senior Housestaff	

Introduction:

The Clinical Transitions Week for third-year medical students is intended to prepare students for the ill-understood transition to the hospital wards. Students are often left with lingering questions and uneasiness that they are told will be answered at a later time. This leaves students feeling anxious and lost as they struggle to process the mountain of new information that lies before them.

The psyche and confidence of a budding student doctor is fragile and vulnerable. Students are left to discover proper ward etiquette and clerkship-specific cultures in a trial-by-fire manner that can often leave a highly capable student discouraged if they are not able to understand and adapt to their role appropriately. This can hinder a student's desire to learn and engage on a clerkship, which can leave a student feeling jaded or despondent.

The transition to the third year clerkships is rife with expected and *unexpected* challenges. You are transitioning from a world where *your* education was the center of the universe to a place where the patient is the center of the universe. Your education, while highly valued, is not handed to you on a silver platter – you are expected to seek and self direct your learning where you are able. You will learn to navigate new world: the multiple Electronic Medical Record (EMR) systems while rotating at different institutions that introduce their own slew of challenges. Over the past two years you have learned to *speak* and *understand* the language of medicine. You will now learn how to *write* in the language of medicine efficiently and comprehensively.

This guide aims to dispel common myths that newly minted third year medical students have as they adapt to this transition.

How to Use this Guidebook

Targeted surveys were sent to Clerkship Directors, 34 attending faculty and 23 senior Housestaff representing the six core Third Year Clerkships. Their responses were summarized and compiled into this document. Where possible, answers were subdivided by specialty type. Where possible, responses that consistently appeared in multiple respondent's answers were bolded to denote this. This guidebook is intended to offer a broad representation of the opinions of many seasoned Housestaff and Faculty for medical student benefit, however, they do not represent the totality of opinions that exist amongst those groups.

General Tips and Rules of Thumb:

HOSPITALITY belongs in the HOSPITAL

In 2014, the Centers for Medicare and Medicaid Services (CMS) estimated that total private and public healthcare expenditure on United States healthcare system to be \$3 trillion dollars. If you couple this fact with the gravity of caring for the infirm, this makes healthcare the most important *service* industry in the USA. We are privileged to see and care for our patients – not the other way around. As medical students we have less to contribute to patient care *and* we take longer to accomplish anything making us inefficient overall. Patients are entertaining our, at times, asinine and repetitive questions in the early hours of the morning, letting us push on their tender spots, and allowing us to participate in their surgery not because you are contributing to their care but because they have an interest in training the next generation of physicians. Your patients will be infirm and afflicted with emotional/physical pain. No matter how seasoned or novice your patient is to the healthcare system their situation is still uncertain - be sensitive to that. Offer a drink of water or a warm blanket when appropriate and ALWAYS wish them well at the end of your encounters (i.e. I HOPE YOU FEEL BETTER). It's amazing how such a simple phrase can have such a significant impact on your patient rapport.

There are several competing demands in the mind of a medical student:

- Collect patient data
- Conduct patient interviews
- Attend conferences, special lectures, training
- Observe procedures
- Study for the shelf examination
- Daily tasks for patient care etc.

With all of these competing demands sometimes students lose sight of the fact that there is a patient – a vulnerable and often scared human being – at the center of all of this. Your patients are not simply a means to an end for your education. Never blame them for their condition - respect them as individuals with a complex story and life circumstances that led them to this point today. Treat them with dignity and forgive minor annoyances – they're probably having a worse day than you are. Be human and practice empathic medicine.

Know your place:

It sounds blunt but it's important that this point is driven home and I think it is appropriate to be bluntly delivered from a medical student peer. Medicine is collegial but a hierarchy exists – and for good reason. The most important focus of the team is patient care. You and your education are important but will be prioritized appropriately. No matter how casual more senior members of your team are with you do not forget that there is a level of professionalism and respect that must ALWAYS be maintained. It is a common trap for students to become *too* casual. As a medical student, you lack the depth and breadth of clinical knowledge and experience to talk down to anybody – no matter how much you know about the molecular pathophysiology of a disease process. Respect and humility are essential qualities to be maintained throughout your training and in practice. Never undermine people especially in the presence of patients.

Common courtesy always has a place:

When working with any hospital staff (desk clerk, custodian, attending, nurse, etc.) take the time to introduce yourself. Use the phrases 'please' and 'thank you' generously. These people are not simply a means to an end. If someone helps you, in the smallest way – always say thank you. You will likely encounter them multiple times throughout your training and having a cordial relationship will pay innumerable dividends when you least expect it. And being nice to people is ... nice. Also, a tense relationship with hospital staff can make your life a living nightmare.

Oral Presentation:

If you ask a hundred attendings/residents about how to present a patient you're likely to receive 100 slightly nuanced answers that hover around a widely accepted standard. One general guideline is presented in the "Expectations for the Oral Presentation" section that you should become familiar with. In general, you will need to tailor your presentation to your audience's preference.

Tips:

Purpose: To briefly and effectively communicate the patient history, relevant physical examination findings, pertinent laboratory/imaging data with an interpretation and plan to the rest of the care team including residents, attending physicians, nurses, social workers and other allied health professionals caring for the patient.

Practice: Take the extra few minutes to go over your oral presentation by yourself – even if that means talking to yourself in the mirror in the bathroom before rounds. The overall goal is to effectively communicate the information and if that requires you to read from a paper then do it. However, you will impress your team members if you are able to *effectively* recite your presentation with minimal referencing of your notes. This shows you know your patient inside and out. This skill takes time and practice – start early and build up.

Observe: Listen to other student and resident presentations. Compare your style to theirs. Enlist what you like and avoid what you don't like.

Feedback: This comes in many forms. Sometimes team members will provide casual feedback and other times you will have to elicit formal feedback. Do not overdo feedback solicitation, as this can be off-putting.

Expectations for the Oral Presentation

(Learning and Demonstrating your Clinical Reasoning)

With permission from Chad R. Stickrath, MD

University of Colorado Denver

**adopted from Bradley A. Sharpe, MD UCSF*

Chief Complaint (2 seconds): What brought the patient to the hospital – EX: hemoptysis

- **Ask yourself: What are the top 5-7 possible diagnoses? Create your "Top 5"** (This does not need to be articulated verbally, but be prepared to list your Top 5 if asked)

History of Present Illness (HPI) (90 seconds)

- First Line: Descriptor sentence including age, pmh that is relevant to current state and their presenting complaint
- Paragraph 1: Chronological description of the patient's symptoms taking us from their baseline to their current presentation.
 - **Use paragraph 1 to ask yourself: Have my top 5-7 possible diagnoses changed, or reordered?**
- Paragraph 2: Review any other historical elements relevant to "The Top 5," including other symptoms, ROS, PMH, SH, etc..
 - EG for a patient presenting with cough: "Also of note, the patient reports that he spends many hours a week grooming his 12 pet pigeons." or "Also of note, the patient's father died at age 62 of mesothelioma and his brother has asbestosis."

PMH, Meds (30 seconds), SH, FH, ROS (20 seconds)

- It is important to efficiently present this "mid-section". Your presentation is not a regurgitation of your write-up. If pertinent to HPI, should have been included in HPI (don't repeat here). If not pertinent to HPI, present it if it will be pertinent during current hospitalization or will be on their problem list.

Physical Exam (60 seconds)

- We are most interested in hearing about:
 1. Pertinent positive and negative findings associated with your "Top 5"
 2. Other significant (abnormal) findings

Diagnostic Tests (20 seconds)

- Same as the physical exam:
 1. Pertinent positive and negative findings associated with your "Top 5"
 2. Other significant (abnormal) findings

Assessment and Plan (1-2 minutes)

- Recap sentence, similar to opening sentence of HPI
- Then, follow with a prioritized problem (not diagnosis) list (ie: Cough, not Pneumonia as the problem)
- Each problem:
 1. Recap best highlights from H&P
 2. Give prioritized "Top 5" diagnoses
 3. Explain the evidence supporting (and refuting) the development and ordering of your "Top 5"
 4. Describe plan: diagnostic studies completed, or to-do and therapeutic plan

Ideal medical student behaviors and attributes

Clerkship Directors said:

- **Knows patients and is invested in them.**
- **Prepares** for cases and presentations
- **Organized, succinct and coherent presentations**
- **Show strong humanist traits**
- Diligent, **engaged, interested** in your education but remember *the patient comes first*.
- The best students are **hard working**, make **clear assessments** about patients' disease states and care, are social and pleasant, and show strong humanist traits.
- Thorough bedside assessments, organized and succinct presentations, focused reading, supportive team player

Attendings said:

- **Enthusiasm – for learning and engaging in patient care**
- **Find pertinent research articles to your patient that can be shared during rounds**
- **Read before cases so that you can learn and engage in the case**
- **Practice empathy – act like a person and treat patients like real people. Be human!**
- **Obtain data for the team that assists in patient care**
- **Learn your patient better than anyone else on your team**
- **Practice humility – it goes a long way**
- Advocate for your patient
- Practice excellent patient communication skills
- Inquisitive
- Remember what the attending has taught to you or the team
- Become an integral team member- coordinate with nurses, therapists, other services and your own team to provide awesome patient care
- Look up answers to questions that come up on rounds and give brief teach back points to the team. This shows engagement - *don't wait to be assigned a question/topic*.
- Volunteer to take on more patients (show that you are willing to challenge yourself. There is a fine balance - don't bite off more than you can chew as this will reflect poorly on you)
- Review pertinent *preclerkship* material prior to starting and read pertinent textbook level material throughout the clerkship
- Ask your residents: how can I help you today?
- Hard-working
- Punctual
- Stay after essential work has been completed and find helpful ways to contribute – ex: talk to lonely patients, take patient outdoors for a walk

Ideal medical student behaviors and attributes (cont'd)...

Senior Housestaff said:

- **Good team player**
- **Positive attitude, enthusiasm**
- **Prioritize patient care**
- **Be the eyes/ears of the team (you have more downtime than they do) – seek out information about your patients. See your patients at least twice a day. Go with them to procedures/imaging**
- **Look up articles, present new information at rounds**
- **Actively engage in patient care**
- **Invest in your training/learning actively – don't be a bystander**
- **Always available to participate in anything that is happening**
- **Proactive**
- **Follow up labs, talk to family**
- **Know everything about your patient**
- **Look up anatomy/steps in an operation beforehand**
- **Strive to come up with a management plan for the patients problems and issues**

Common pitfalls of the well-intentioned medical student:

Clerkship Directors said:

- **Failing to take a stand and make a formal assessment of what is wrong with a patient or what should be done for their care.**
- Not visible or vocal on team and avoid being overly-aggressive/eager at the same time.
- Dishonesty - if you don't know something, say that you don't know.
- Not being present when needed.
- Over studying individual patients at the expense of broad based understanding of material.
- Unfocused presentations.
- Lack of proaction in identifying ways to contribute.
- Seeing too few patients.

Attendings said:

- **Disinterest/apathy: learning any medicine will make you a better doctor.**
- **Over-confidence**
- Asking for TOO MUCH feedback. Don't irritate people.
- Not being present both physically or mentally. This applies to rounds or when their patients are being taken for procedures.
- Not knowing their patients
- Not listening to feedback
- Prioritizing their needs over those of the patients
- Trying to outshine the residents or stepping over your co-medical students
- Coming to team meetings ill prepared to discuss their patient
- Doing the minimum
- Taking it personally when an attending corrects you – you are a student and this is called teaching.
- *Missing on opportunities to do 'extra things':* if you can play piano or guitar, volunteer to share these skills and abilities as they can both enrich the therapeutic milieu and leave a lasting impression with the attendings.
- Thinking you need to know everything about everything – this can cause undue anxiety.
- Not receptive or responsive to feedback

Common pitfalls of the well-intentioned medical student (cont'd)...

Senior Housestaff said:

- **Overconfidence or too aggressive – being a gunner.** There's a fine line between being spot on vs. over the top.
- **Arrogance – well meaning students who learned something on another rotation should not disagree with a resident or attending.** However, it's okay to ask questions and seek clarification
- **Asking so many questions that it becomes annoying.** There is a delicate balance between showing interest and being over the top.
- **Disinterested - we get it, you want to go into ortho.** You won't match ortho if you don't ace your medicine shelf, so pay attention!
- **Not knowing enough about their patients**
- Taking too much responsibility in an aim to please nature
- Recognize that residents are exhausted and spread thin – patient care takes priority
- Not prepared for the OR
- When we say you can go home, you really can go home. No need to linger!
- Copying and pasting progress notes.

How much of your evaluation is affected by their verbalized specialty interests?

Clerkship Directors said:

- None - specialty interest is not a factor. Students should not feign specialty interest
- Disinterested students are negatively perceived. This doesn't mean you have to pretend you're going to work in my specialty, it means you should show me that you understand that what I am trying to teach you is valuable to your training – even if you're going to work in a different field.

Attendings said:

10 of 15 Attending Physician respondents stated unequivocally that the student's stated specialty choice does not influence their evaluations.

Additional Attending comments include:

- **None.** Most of the best students aren't interested in Reproductive Medicine. They are all over the map. But when they are smart and motivated and know what they want, you know they will be good at whatever they pursue.
- Internal Medicine is a broad and welcoming rotation. I truly treat students no differently based on their future field of interest. I think most medicine physicians are of the opinion that ALL doctors need a great internal medicine base -- no matter what specialty they may end up in. Hypertension and diabetes affect all patients! The most important thing for students is to approach the rotation with an open mind and willingness to learn. You might be surprised by how much you enjoy your medicine rotation -- even if you're a future surgeon.
- **Only a little**, mainly just with the portion of the evaluation that asks for their promise in our particular field - knowing they are interested makes us feel like they would do better in the field
- **Zero.** Nonetheless, students should go into each rotation with an open mind because they may be pleasantly surprised to discover a new passion.
- **Not at all.** However, you may get closer scrutiny if you declare interest in the field.
- **Not at all** as long as they are present and interested in the clerkship they are currently in.
- I actually do not ask them what specialty they want to pursue to avoid this potential conflict. I try not to let it sway me anyway. From my way of thinking, the better all the different types of doctors understand how their colleagues think, the better off our patients and the profession is.
- **Not at all** – I don't care as long as they don't show lack of interest in learning
- Consciously -> 0% Subconsciously -> ???
- A student does not get higher grades from me by saying they want to go into Reproductive Medicine. I like truthful responses so I can help tailor a student's experience toward things that may be of interest or help them understand the importance of Reproductive Medicine to their future specialty
- **Not at all** to be honest. My approach is really similar - as long as they demonstrate they want to learn and be present, that's what matters
- If a student is not interested in my specialty, I do not think that this negatively impacts my evaluation of the student as long as the student is an enthusiastic learner. I think this is, in part, because physicians of all specialties give better care if they are comfortable with and knowledgeable of psychiatry so I am equally enthusiastic teaching someone headed into a career in Orthopedic Surgery and someone already leaning towards Psychiatry. I will admit that students

interested in older patient or psychiatry usually energize me a little more but I do not think I upgrade them. I might even hold them to a slightly higher standard.

- I don't think the interest in my specialty really biases me too much. I am not there to promote my specialty. I think every rotation has something to teach, something to enrich the medical experience of caring for patients, no matter what specialty the student chooses. I think being enthusiastic and demonstrating genuine interest to learn is vital

Senior Housestaff said:

- Three respondents simply stated this has absolutely no impact on their evaluation of the student
- What matters in my evaluation is if the student demonstrates interest in the subject matter they are currently rotating on. You can be interested in Specialty X and still show up trying to learn some medicine, etc. I'll tailor teaching to what you think you're going to go into but either way medical school is about seeing everything. You will not be evaluated favorably if you disrespect the rotation that you are on.
- I don't expect students to want to pursue a career in Reproductive Medicine. I do expect them to be invested and recognize that this is a broad field, which can benefit any proposed field of interest. I ask what students want to go into so I can skew their teaching to their stated interests; this is the only reason.
- **This doesn't matter.** I'd rather people not lie to us. That being said someone who says they're interested in a different specialty and then pays little attention or puts little effort into the rotation because of this will get dinged. It's okay to say you're interested in something different as long as you still work hard on our rotation and recognize the value of what learning about or specialty can have to your future practice.
- **Not at all.** Of course I encourage everyone to consider surgery because I love it, but it isn't for everyone- that doesn't mean you can't learn a lot from the rotation- some of my best medical students were definitely not surgeons
- **Not at all.** If I have an ortho or gyn bound student that demonstrates interest in Internal Medicine (you can even say "I'm here to learn IM because I know how important it will be when I'm managing post-operative patients in the middle of the night") then we will grade you like a superstar. Put simply, show up with a good attitude, be eager and interested and it will take you far. I have often commented on this particular aspect in evaluations I have written (like, "fantastic attitude, great team player, its a shame we can't keep him/her in internal medicine - but our loss is ortho/gyn's gain")
- I teach them surgery to their interested field. I don't care if they want to go into surgery. But if they do then **I will expect them to know and read more.** Be honest about your field and ask the residents if they can teach their field to your future so you don't call foolish consults.
- It **does not affect my evaluation** at all, unless the student's lack of interest in the field leads to apathy and/or it becomes evident that the student isn't working hard.
- The specialty a student wants to go into **does not impact** my evaluation. I will try to tailor my teaching towards that specialty to keep it interesting for the student.

Clerkship Directors ONLY:

Briefly describe how Honors, Near Honors and Pass is determined in your clerkship? Is there a committee involved? How is the final distribution of students tabulated? (Current as of March 25, 2016)

Surgery:

Final scores are weighted in the following manner: clerkship evaluations (70%), shelf score (25%), and case presentations (5%)

Honors: >75th-80th %ile at discretion of clerkship director, Near Honors >60th %ile to 75th-80th %ile at discretion of clerkship director

No committee (only clerkship director)

Family Medicine:

Based on undisclosed numerical formula and qualitative comments. For Honors, also need to score above the mean on the final

Neurology:

75% of possible points awarded based on aggregate of faculty and resident subjective evaluations, 25% of points awarded based on Shelf score compared to national mean.

Students in a quarter are rank ordered by total points, top 25% get honors, next 15% get near honors, rest pass.

Internal Medicine:

Final scores are weighted as follows: Inpatient blocks (30% each). Outpatient block (20%) Shelf exam: (20%).

Honors: 75-99th %ile and must receive above mean on shelf, Near Honors: 60-74th %ile.

What information is made available to Residency Program Directors from Clerkship performances other than what is visible in the Dean's Letter (MSPE)?

Responses varied:

- Other information available upon request
- Overall grade but nothing other than what is MSPE
- None, unless the information is incorporated into a letter of recommendation from an attending on that clerkship
- Unsure

Attendings ONLY:

What attributes make a medical student fun to teach?

- **Enthusiasm, energetic personality, eager**
- **Genuine curiosity**
- **Remember preclerkship level material**
- The right blend of confidence and **humility**. Don't be timid.
- Asks interesting questions.
- Humor
- Reading about their patients
- Actively involving self in patient care
- Using your own unique personal qualities and applying them to patient care
- Presence and attentiveness when an informal lecture is being provided
- Quickly making changes in response to feedback from the attending.
- Volunteer to help with certain tasks so that the attending has more time to teach or mentor.

How would you describe an ideal 'special topic presentation from a medical student?

- The student is excited about the topic
- Succinct: 5-10 minutes maximum
- Evidence based – identify primary citations
- Focused – what is clinically relevant to care of patient on team
- Well organized
- The student chooses summary documents or recent publications

Senior Housestaff ONLY:

What is the most appropriate way to ask your resident to be dismissed for the day? Will that ever influence your evaluation negatively?

- "So what's next for today?" This can negatively influence my evaluation of the student if the timing is bad or if it is too early in the day.
- Totally depends on the resident. And there's a huge difference between the team getting busy at the end of the day and not sending the students home at the right time vs. med studs trying to leave early in the day.
- "Is there anything else I can do to help?" The context matters though. If residents are slammed asking this question seems selfish to the pressures on the team.
- I appreciate a student who asks "what more can I do?" I find that different from "is there anything else I can do for you" because you sound more interested in helping than in leaving but most residents will still let you leave if there's nothing left to do. If you say "Can I go home now" and that is coupled with an overall pattern of being disinterested, that could affect your evaluation.
- Is there anything I can help you with?
- Ask if there is anything else that can be done to help the team
- I think all MS3s learn to ask "anything else you need from me today?" If you ask this more than, let's say, once a week, it will become painfully obvious that it is a pattern and your resident will start to bristle every time you ask this question. Rather than just asking if there's any other work you can do, just do the work! Then when it's finished, you can say "I wrote Mr X's DC summary (in a word document that I'll email you since it can't exist in the Epic space), it's now 5pm (thereabouts) and we are done admitting. Is it okay if I leave for the day?" That, in my mind, is a more proactive approach and demonstrates good teamwork without coming off as disingenuous (which is how the "anything else I can do?" question often sounds).
- "Is there anything I can help with?" If they are asking to leave before 4pm and there is still work it's probably not appropriate to leave
- "What else can I do to help?" (if the resident doesn't get the hint, ask again ~ 15 min later). Asking to be dismissed will negatively influence an evaluation if the student asks to leave when there is clearly still work to be done.
- Just ask if there's anything else for you to do, and if not I'll let you know! Definitely doesn't affect negatively.
- The classic "Is there anything else I can help you with?" seems like the best way. It does not negatively influence evaluations.

What is the most effective way for a medical student to contribute directly to patient care on *this* particular rotation?

Internal Medicine Senior Housestaff said:

- Develop a good relationship with your patients, dig through their charts and know minutiae, and read up on your patients!
- Be your patient's shadow. Go to the IR suite when they are getting a drain placed. Go to pathology to review the biopsy slides with the path resident. Go to the CT scanner and see how the tech protocols the study. Go to radiology afterward and have them read it. If you act like there's no such thing as an EMR (meaning you don't simply wait for a result to show up in Epic), you will learn so much more from each specialist and you will be able to bring that knowledge to your interns, residents, and on rounds. You will look like a superstar and you will have fun doing it!
- Get a great history, we often don't have time to get long histories
- By taking ownership of their patient, they will contribute significantly to the team.

Surgery Senior Housestaff said:

- Know your patients
- Follow a couple of patients beginning to end, stay engaged, be on top of things, know about issues before I do.
- Read all notes on the patients they are following and ask if they can help with the patient's care. Help out with notes, return pages, go see consults etc.
- Know everything about his/her patient. **Bring dressing supplies on rounds.** See patients during free time and report back any updates.

Reproductive Medicine Resident said:

- Know your patient, follow-up results, take initiative in learning about the patient's complexity

Psychiatry Resident said:

- Being on top of what's going on with your patients (consults that came in, lab/imaging results) and letting your team know

APPENDIX A:

Respondent Statistics:

Clerkship Directors: Pediatrics, Internal Medicine, Surgery, Neurology, Reproductive Medicine, and Psychiatry Clerkship Directors were all represented.

<u>ATTENDINGS</u>	<u>Internal Medicine</u>	<u>Pediatrics</u>	<u>Surgery</u>	<u>Reproductive Medicine</u>	<u>Neurology</u>	<u>Psychiatry</u>	<u>Total</u>
<i>Number Contacted</i>	7	9	6	7	1	3	34
<i>Number Responded</i>	6	0	1	4	1	3	15
<i>Response Rate</i>	86%	0%	14%	57%	100%	100%	44%
<i>Weighted</i>	40%	0%	7%	27%	7%	20%	

<u>RESIDENTS</u>	<u>Internal Medicine</u>	<u>Pediatrics</u>	<u>Surgery</u>	<u>Reproductive Medicine</u>	<u>Neurology</u>	<u>Psychiatry</u>	<u>Total</u>
<i>Number Contacted</i>	4	3	5	4	3	4	23
<i>Number Responded</i>	4	0	4	2	1	2	13
<i>Response Rate</i>	100%	0%	80%	50%	33%	50%	57%
<i>Weight</i>	31%	0%	31%	15%	8%	15%	

Comments: A satisfactory number of primary care physicians and specialists were represented across all disciplines of medicine. Unfortunately, pediatrics was not represented.