candidates, but it appears that many family physicians are unlikely to recommend an IUD. This could be attributable to a number of factors, including reliance on outdated, restrictive eligibility criteria; misunderstanding of current information; and physician attitudes or misconceptions.\(^2\)\(^-\)\(^4\)

Responses about ectopic pregnancy may reflect a misunderstanding of current information. A pregnancy that occurs with an IUD in place is more likely to be an ectopic than a pregnancy in the general population. However, since the IUD is so effective at preventing all pregnancies, overall a woman using an IUD has a significantly decreased risk of experiencing an ectopic pregnancy.

Reliance on outdated criteria may explain why few family physicians would recommend an IUD for a woman with a remote history of either sexually transmitted infection (STI) or pelvic inflammatory disease (PID). While there was an increased risk of infection due to the faulty Dalkon Shield in the 1970s and 1980s, with the IUDs currently available in the United States there is an increased risk of PID only during the first 20 days after insertion (thought to be due to STI present at time of insertion). Women who have experienced an STI or PID within the previous 3 months should not be offered an IUD; women with a more remote history of STI or PID can safely use an IUD.

The low response rate is the main limitation of our study, yet it does fall within the range of published physician survey studies. While response bias is a concern with suboptimal response rate, due to the relative homogeneity of physician groups, non-response bias may be less of an issue in this study than in layperson studies. Additionally, we did not ask the actual frequency with which respondents recommend IUDs. Therefore, the responses we gathered are theoretical and may not reflect the reality of these family physicians’ actual practice.

To decrease unintended pregnancy, clinicians who care for women of reproductive age should present their patients with all of the medically appropriate contraceptive options. Yet the majority of family medicine residents have little experience with IUDs during their training.\(^5\) Clinician education, both during training and with CME, should include updates on contraceptive methods, including IUDs. Additionally, we must look for alternative ways to change family physicians’ attitudes and misconceptions about IUDs.

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Acknowledgments: This study was funded by a private foundation that wishes to remain anonymous.

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vice obligations through the Health Professions Scholarship Program (HPSP). The primary outcome of interest was the overall prevalence of professional badmouthing experienced by medical students in each of these environments. We also compared the primary source of badmouthing (specialty, level of training—resident/faculty, type of school—public/private; osteopathic/allopathic; military/civilian). Basic descriptive statistics were used along with crosstabs, Kruskall-Wallis rank and non-parametric Mann-Whitney group comparisons.

**Results**

The overall response rate was 52% (n=418). Individually, 64 of 156 (41%) of USU students responded. A total of 354 of 649 (55%) HPSP students responded; 115 from public allopathic schools, 100 from private allopathic schools, 13 from public osteopathic schools, and 124 from public osteopathic schools. Overall, most medical students, whether USU or HPSP, were exposed to some element of professional badmouthing during their medical school experience. Figure 1 provides a comparison of exposure to badmouthing by source and location. The prevalence of professional badmouthing of primary care specialties was 87% by non-primary care residents and 75% by primary care residents. Slightly fewer attending physicians engaged in badmouthing of primary care specialties.
ry care (78% by non-primary care and 62% by primary care). Nearly 20% of medical students reported that exposure to non-professional criticism impacted their choice of specialty. Primary care, general surgery, and obstetrics-gynecology were the most common victims of professional badmouthing.

**Discussion**

Students are influenced by the culture of the institutions in which they train. Our findings confirm that students are commonly exposed to professional badmouthing across the spectrum of US medical school types. We found that students at a federal medical school are frequently exposed to badmouthing as are students at civilian medical schools. While the relatively low response rate limits the strength of comparisons between school settings, this finding was still surprising to us given the uniquely military environment of USU. Even though primary care, general surgery, and obstetrics-gynecology were the most commonly badmouthed specialties, we found that no medical discipline is completely immune from this unprofessional practice. Badmouthing is inconsistent with professional behavior at any level. Medical schools should discourage badmouthing by increasing awareness of how commonly it occurs, emphasizing that badmouthing detracts from interdisciplinary collegialism and by longitudinally exposing students to faculty who are trained to inculcate the ideals of professionalism in young learners. As medicine incorporates the patient-centered medical home, it should leave badmouthing behind.

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This Letters to the Editor column was edited by Joseph Scherger, MD, MPH