PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	Spirituality and Religion in Residents and Inter-relationships with Clinical Practice and Residency Training: A Scoping Review
AUTHORS	Chow, Hsin Han Elisha; Chew, Qian Hui; Sim, Kang

VERSION 1 – REVIEW

REVIEWER	John Peteet Harvard Medical School, USA
REVIEW RETURNED	16-Sep-2020

GENERAL COMMENTS	This is a well described systematic review of an important subject. The findings are clearly described, the limitations appropriately acknowledged and the conclusions reasonable. The authors' English awkward in places.

REVIEWER	Bernard Mathieu Palliative and Supportive Care Service Lausanne University Hospital and University of Lausanne Switzerland
REVIEW RETURNED	06-Nov-2020

GENERAL COMMENTS	This paper aims to establish a systematic review of knowledge, skills, attitudes towards spirituality and religion and inter-relationships with patient care and psychological wellbeing in residency training. The authors announce to have followed the PRISMA 2009 checklist to do this systematic review. This question an important and growing topic in medicine. However, independently of comments and questions regarding the role of physicians towards spirituality and religion of the patients, I'd like to mention some limitations and problems related to the way this systematic review has been realized. Because I am not an English native speaker, I really apologize for the syntactic approximations and sincerely hope that my comments will be understandable for the authors and editors. First, the research question and objectives are not so clear in my opinion. The authors want to take into consideration too many aspects in this review, as we can see already in the title: knowledge, skills, attitudes towards spirituality and religion and how these dimensions are implemented in existing training programs for residents, how these elements are related with clinical practice, and also the psychological wellbeing of the residents themselves. At the end of the introduction, we do not really understand what the authors want to really consider and examine in this systematic review. The authors want to focus on too many parameters, and finally, it is difficult to identify the key

	messages from this systematic review. All the mentioned elements refer to specific aspects and would first deserve to be better defined, which would be useful for a more refined search strategy in the literature. For a systematic review, the more the research question is clear and concise, the best it is. Here, many terms figuring in the mentioned objectives at the end of the introduction are not included as keywords for the search strategy in the literature (attitudes, training, psychological wellbeing, etc.). Globally, the authors only take into account the keywords spirituality/religion and internship/residency. For example, the keywords referring to "training" are not considered, although this topic seems to be a key point in the introduction. A suggestion would be to add specific keywords in relation with the themes mentioned in the results section. The inclusion and exclusion criteria are not well explained and detailed (type of study, follow-up period considered, etc.), which makes difficult to understand the decisions taken in the PRISMA flowchart to reach the final 44 studies and also what type of studies they are. In table 1, some important characteristics of the studies considered are lacking, in particular the design of the studies (intervention, observational studies, etc.), the methods used, the outcomes considered and how they were assessed. Sometime they appear in the table, but not always and not systematically at the same place. The risk of bias for each study is also lacking. It is therefore difficult to have a clear idea of the studies retained in this review since they seem to be very different from each other and concern very varied medical contexts (psychiatry, palliative care, etc.). Again, a better clarification of the inclusion and exclusion criteria, and a definition of the themes would have helped the authors to better structure this table and facilitate the reading and the understanding of the results. For example, page1, it is difficult to understand why the outcome "knowledge of the chaplain" is included in both the themes 1 and 3. The theme "personal beliefs regarding SR in resident" refers sometimes to the religious confession (Piscitello and Martin, 2019) and sometimes to other concepts such as self-doubt, helplessness (Vicini et al., 2017) or spiritual wellbeing. Are all these concepts on the same level and do they really refer to personal beliefs in my opinion? Some scales included in the table (for example SWBS, p. 14) are missing at the end of the table. Before going further in the analysis of the results, I suggest to consider these essential points, particularly the inclusion-exclusion criteria and the objectives of this review (by focusing on a more specific topic, for example SR in the medical curriculum, how SR is introduced with the patients, associations between SR and professional satisfaction, depression or burnout, etc…) in order to improve it. I also advise the authors to follow more precisely the PRISMA checklist regarding the report of the methods and the results sections.

REVIEWER	Francisca Rego Faculty of Medicine, University of Porto, Portugal
REVIEW RETURNED	12-Jan-2021

GENERAL COMMENTS	Dear authors, This paper is an important work on a major and not sufficiently studied issue: Spirituality and its interface with medicine, namely its training, skills and attitudes from residents. I believe the title it is a little bit confusing, too long with many variables. The abstract is clear and balanced, however the methods part is incomplete. Please add the search strategy (keywords, database, selection criteria), total number of articles found and the final number of articles included in the review. The introduction is clearly explained, the authors do a clear distinction between spirituality and religion , clearly describing the main issues in clinical practice and education related to these concepts. A systematic review is a rigorous form of conducting research, and therefore, in order for it to be repeated, there is a need to further describe the methodology and procedures done: Methods: needs to include eligibility criteria (inclusion and exclusion criteria); date of search on date base; and quality assessment of studies and data extraction (e.g. how was data extraction done (manually; software...) ; how were the differing opinions regarding articles' relevance were solved among the authors.) The authors included only one database. The recommend number for searching databases may range from 2 to 4 electronic databases at minimum. Is there a specific reason for including just one database? I would recommend to include at least one more database into your study. In the results section, the second paragraphs (line 24-36) should have the references of the respective studies (e.g. The majority of the papers were conducted in the USA (39/44, 88.6%) - reference the studies that were developed in the USA). Also, careful when introducing certain measures. For instance what does it mean to score high on religiosity. Are the variables/definitions of spirituality and religiosity the same in all the studies included in this review? There is a need to standardize the way you present your data: e.g. "four" or "4"; (39/44, 88.6%) or 16(36.4%) or (29.5%) - present always the same way. The discussion and conclusion section are clear. It would be relevant to further discuss the professional's self awareness, importance and professional/personal boundaries when addressing spirituality, as well as the relevance of addressing patient spirituality for patients (e.g. promoting patient dignity and autonomy by integrating their spiritual needs into the care plan). I suggest the reading of these studies: - Post SG, Puchalski CM, Larson DB. Physicians and patient spirituality: professional boundaries, competency, and ethics. Ann

	Intern Med. 2000 Apr 4;132(7):578-83. doi: 10.7326/0003-4819-132-7-200004040-00010. PMID: 10744595. - Levin JS, Larson DB, Puchalski CM. Religion and spirituality in medicine: research and education. JAMA. 1997 Sep 3;278(9):792-3. doi: 10.1001/jama.278.9.792. PMID: 9286846. - Puchalski CM, Lunsford B, Harris MH, Miller RT. Interdisciplinary spiritual care for seriously ill and dying patients: a collaborative model. Cancer J. 2006 Sep-Oct;12(5):398-416. doi: 10.1097/00130404-200609000-00009. PMID: 17034676. - Rego F, Nunes R. The Interface between Psychology and Spirituality in Palliative Care. Journal of Health Psychology. 2019. 24(3):279-287: DOI: 10.1177/1359105316664138. - Rego, F., Pereira, C., Rego, G., Nunes, R. The Psychological and Spiritual Dimensions of Palliative Care: A Descriptive Systematic Review. Neuropsychiatry, 2018, 8(2), 484–494. - Rego, F., Rego, G., Nunes, R. Moral agency and spirituality in palliative care. Annals of Palliative Medicine, 2020, 9(4),2286-2293. DOI: 10.21037/apm-19-436. - Balboni M., Balboni T. Do Spirituality and Medicine go together? Harvard Medical School Bioethics Journal, 2019. Finally, Table 1 is very interesting and clear. It would be relevant to add the reference number of each study so the reader can consult the table while reading the results section.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

1. “This is a well described systematic review of an important subject. The findings are clearly described, the limitations appropriately acknowledged and the conclusions reasonable. The authors' English awkward in places.”

   REPLY: We are very thankful for the positive comments and have attempted to edit the manuscript for language issues in this revision.

Reviewer: 2

1. “First, the research question and objectives are not so clear in my opinion. The authors want to take into consideration too many aspects in this review, as we can see already in the title: knowledge, skills, attitudes towards spirituality and religion and how these dimensions are implemented in existing training programs for residents, how these elements are related with clinical practice, and also the psychological wellbeing of the residents themselves. At the end of the introduction, we do not really understand what the authors want to really consider and examine in this systematic review. The authors want to focus on too many parameters, and finally, it is difficult to identify the key messages from this systematic review. All the mentioned elements refer to specific aspects and would first deserve to be better defined, which would be useful for a more refined search strategy in the literature.

   For a systematic review, the more the research question is clear and concise, the best it is. Here, many terms figuring in the mentioned objectives at the end of the introduction are not included as keywords for the search strategy in the literature (attitudes, training, psychological

wellbeing, etc.). Globally, the authors only take into account the keywords spirituality/religion and internship/residency. For example, the keywords referring to "training" are not considered, although this topic seems to be a key point in the introduction. A suggestion would be to add specific keywords in relation with the themes mentioned in the results section."

REPLY: We have taken this comment into consideration and have amended the title as well as a description of the type of review undertaken. It has now been changed to a scoping review to better reflect our efforts and the broad themes we hoped to cover in this review, i.e. three main areas, namely a) the personal aspect, (b) clinical practice, and (c) residency training. We have also cited the methodology of the Joanna Briggs Institute for scoping reviews, and the six steps of Arksey and O'Malley methodological framework for conducting scoping reviews updated by Levac et al. to reflect the process which we have undertaken from the beginning more accurately.

2. The inclusion and exclusion criteria are not well explained and detailed (type of study, follow-up period considered, etc.), which makes difficult to understand the decisions taken in the PRISMA flowchart to reach the final 44 studies and also what type of studies they are.

   REPLY: We have elaborated on the inclusion and exclusion criteria.

   "*The inclusion criteria are as follows: a) sample must include those in residency training, b) article must examine issues relating to residents' SR at a personal level, and/or its influence on clinical practice, and/or SR in residency training, c) article must be published in English. Studies were excluded if a) they were systematic reviews, case reports, opinion articles, or dissertations, b) focused only on undergraduate medical students, or c) discussed SR issues only from the perspective of the patient or caregiver."* (See Materials and Methods, Paragraph 2, Lines 5 to 11)

3. "In table 1, some important characteristics of the studies considered are lacking, in particular the design of the studies (intervention, observational studies, etc.), the methods used, the outcomes considered and how they were assessed. Sometimes they appear in the table, but not always and not systematically at the same place.

   REPLY: We have included the design of the studies, the outcomes considered, and how they were assessed as additional columns in Table 1.

4. The risk of bias for each study is also lacking. It is therefore difficult to have a clear idea of the studies retained in this review since they seem to be very different from each other and concern very varied medical contexts (psychiatry, palliative care, etc.).

   REPLY: As this has been changed to a scoping review, the risk of bias and quality assessment for studies included will not be conducted in accordance with the PRISMA recommendations for scoping reviews.

   "*As the aim of our scoping review was to provide an overview of the topic of RS in residency, a formal assessment of the quality of studies was not performed, as is typical with most*

scoping reviews.[25]" (See Materials and Methods, Paragraph 4, Lines 11 to 13)

5. Again, a better clarification of the inclusion and exclusion criteria, and a definition of the themes would have helped the authors to better structure this table and facilitate the reading and the understanding of the results. For example, page1, it is difficult to understand why the outcome "knowledge of the chaplain" is included in both the themes 1 and 3. The theme "personal beliefs regarding SR in resident" refers sometimes to the religious confession (Piscitello and Martin, 2019) and sometimes to other concepts such as self-doubt, helplessness (Vicini et al., 2017) or spiritual wellbeing. Are all these concepts on the same level and do they really refer to personal beliefs in my opinion?

   REPLY: We have re-organised the main themes which are examined in this review, and have restructured Table 1 according to the three themes (personal aspect, clinical practice, residency training)

6. Some scales included in the table (for example SWBS, p. 14) are missing at the end of the table.

   REPLY: We have now added Spiritual Well-being Scale (SWBS) in the Abbreviations.

7. I also advise the authors to follow more precisely the PRISMA checklist regarding the report of the methods and the results sections.

   REPLY: In this revised manuscript, we have made reference to the PRISMA checklist for scoping reviews and presented our findings accordingly.

Reviewer: 3

1. I believe the title it is a little bit confusing, too long with many variables.

   REPLY: We have amended the title to better reflect the nature and primary aims of our review.

2. The abstract is clear and balanced, however the methods part is incomplete. Please add the search strategy (keywords, database, selection criteria), total number of articles found and the final number of articles included in the review.

   REPLY: We have added the search strategy, total number of articles found, and final number of articles included in the review. This can be found both in-text (Materials and Methods and Results sections), as well as the accompanying PRISMA chart in Fig. 1.

3. The introduction is clearly explained, the authors do a clear distinction between spirituality and religion, clearly describing the main issues in clinical practice and education related to these concepts.

   REPLY: We are thankful for the encouraging comments.

4. A systematic review is a rigorous form of conducting research, and therefore, in order for it to be repeated, there is a need to further describe the methodology and procedures done: Methods: needs to include eligibility criteria (inclusion and exclusion criteria); date of search on date base; and quality assessment of studies and data extraction (e.g. how was data extraction done (manually; software...) ; how were the differing opinions regarding articles' relevance were solved among the authors.) The authors included only one database. The recommend number for searching databases may range from 2 to 4 electronic databases at

minimum. Is there a specific reason for including just one database? I would recommend to include at least one more database into your study.

REPLY: We have elaborated on the details above, and have included one more database into our study (See Materials and Methods section).

5. In the results section, the second paragraphs (line 24-36) should have the references of the respective studies (e.g. The majority of the papers were conducted in the USA (39/44, 88.6%) - reference the studies that were developed in the USA).

   REPLY: We have included references of the respective studies as suggested.

6. Also, careful when introducing certain measures. For instance what does it mean to score high on religiosity. Are the variables/definitions of spirituality and religiosity the same in all the studies included in this review?

   REPLY: Not all studies (12 out of 44 studies or 27.3%) provide definitions of spirituality or religion. We have amended the places wherever mentioned that the religiosity refers to the scores on the SR ratings used.

7. There is a need to standardize the way you present your data: e.g. "four" or "4"; (39/44, 88.6%) or 16(36.4%) or (29.5%) - present always the same way.

   REPLY: We have standardized the format of presentation as best as possible.

8. The discussion and conclusion section are clear. It would be relevant to further discuss the professional's self awareness, importance and professional/personal boundaries when addressing spirituality, as well as the relevance of addressing patient spirituality for patients (e.g. promoting patient dignity and autonomy by integrating their spiritual needs into the care plan). I suggest the reading of these studies:
   - Post SG, Puchalski CM, Larson DB. Physicians and patient spirituality: professional boundaries, competency, and ethics. Ann Intern Med. 2000 Apr 4;132(7):578-83. doi: 10.7326/0003-4819-132-7-200004040-00010. PMID: 10744595.
   - Levin JS, Larson DB, Puchalski CM. Religion and spirituality in medicine: research and education. JAMA. 1997 Sep 3;278(9):792-3. doi: 10.1001/jama.278.9.792. PMID: 9286846.
   - Puchalski CM, Lunsford B, Harris MH, Miller RT. Interdisciplinary spiritual care for seriously ill and dying patients: a collaborative model. Cancer J. 2006 Sep-Oct;12(5):398-416. doi: 10.1097/00130404-200609000-00009. PMID: 17034676.
   - Rego F, Nunes R. The Interface between Psychology and Spirituality in Palliative Care. Journal of Health Psychology. 2019. 24(3):279-287: DOI: 10.1177/1359105316664138.
   - Rego, F., Pereira, C., Rego, G., Nunes, R. The Psychological and Spiritual Dimensions of Palliative Care: A Descriptive Systematic Review. Neuropsychiatry, 2018, 8(2), 484–494.
   - Rego, F., Rego, G., Nunes, R. Moral agency and spirituality in palliative care. Annals of Palliative Medicine, 2020, 9(4),2286-2293. DOI: 10.21037/apm-19-436.
   - Balboni M., Balboni T. Do Spirituality and Medicine go together? Harvard Medical School Bioethics Journal, 2019.

   REPLY: We are thankful for the list of useful readings and have added further discussion on the issues suggested.

   "*SR is an important part of clinical care, and its successful integration is dependent on the physician's self-awareness of his/her own SR, as well as the careful delineation of professional and personal boundaries when handling SR issues during clinical encounters. Respecting the patient as an individual and providing holistic care involve taking into account their SR beliefs while also being mindful of the possibility of coercion due to the power differential that is inherent in the physician-patient relationship.[73] Although the pressure to*

blur the boundaries between the professional and personal sphere often comes from patients, research suggests that many patients desire to have prayer as an adjunct to conventional medical treatment rather than an alternative or substitute.[73] This indicates that many patients are aware of the need for medical treatment, and physicians should be cautious of swinging to either extreme by unintentionally touting RS practices as a cure for diseases, or being dismissive of patients who appear to be strongly religious/spiritual. Hence, there is a need to enhance the physician's self-awareness of such boundaries and to train them on ways to navigate discussions on SR with sensitivity from the beginning of residency. In addition to these aims, healthcare professionals should also be encouraged to approach issues of SR with the aim of empowering the patient.[74] By assuming the role of a spiritual advocate, physicians can promote patients' moral agency and maintain the centrality of patients' concerns throughout the course of illness and treatment.[74]" (See Discussion, Paragraph 2)

9. Finally, Table 1 is very interesting and clear. It would be relevant to add the reference number of each study so the reader can consult the table while reading the results section.

   REPLY: The references have been added accordingly.

We declare that the manuscript has not been published in whole or in part in any other journal and is not being reviewed for publication elsewhere. All co-authors have made substantial contributions to conception and design or analysis and interpretation of data, made substantial contributions to drafting the article or revising it critically for important intellectual content; and the manuscript has also been read and approved by all co-authors. All authors report no financial or other conflicts of interest related to the subject of this article. Thank you and best regards.

VERSION 2 – REVIEW

REVIEWER	Bernard, Mathieu Centre Hospitalier Universitaire Vaudois
REVIEW RETURNED	18-Mar-2021

GENERAL COMMENTS	I would like to thank the authors for having considered the several point mentioned in the first review of the article. This article has improved a lot. Shifting from a systematic review to a a scoping review is more congruent I think with the content and the aims of the authors. The fact to have pointed more clearly three main points (personal aspect, clinical practice and residency training) for this review makes the results much less vague, even if the scope remains quite large with these themes and all the aspects associated with each theme. Regarding the details of your research questions p.6: I wonder whether the "attitudes towards SR in clinical practice" should be rather placed in the next point "How does SR interact with clinical practice"? I also appreciate the adding and mention of the JBI methodology in the text, which gives more consistency and rigor to the scientific review process, and also the description of the six steps guideline of Levac et al. for conducting the scoping review. It makes the process much clearer now. Regarding this part, could the authors add the specific characteristics of a scoping review at the

	beginning of the “materials and methods” section? Thank you also for the clarification of the inclusion and exclusion criteria detailed in p.5-6. The table 1 of the results is better now with the differentiation of the three themes. Regarding the column “outcomes”, I doubt that this tittle is really appropriate and congruent with the content. As I can see, when looking at the details of each study for this part, it more refers to the “aims/goals of the study” with the methods used in brackets, than really the outcomes. If it was really about outcomes, they should be specifically mentioned, which is not the case currently (for example, for Rosendale and Josephson, it’s just indicated “pre and post training outcomes”). In addition, are all the studies categorized as “intervention” really intervention studies using a pre-post design (for example Hyidt et al.? Or does this term refer to a broader aspect, including for example the development of specific intervention (for example Vicini et al.)? What is understood with “observational” and “intervention” could be explained in the text. In the discussion part, I think that the authors should also discuss a little bit more the question of the role repartition and the frontier between the physicians and chaplains or spiritual assistants regarding SR in the hospital context. How far should the role of doctors go in relation to the spirituality of patients? When should chaplains take the lead? Given the increase of interdisciplinarity within hospitals, this issue also deserves to be addressed. Details: • p.5: “practicing” and not “practising” I guess. • Table 1: he size of the text is too large for the reference Saba et al.

REVIEWER	Rego, Francisca University of Porto
REVIEW RETURNED	01-Mar-2021

GENERAL COMMENTS	Dear authors, You explore a very relevant topic that should be more considered into the clinical practice. Regarding the manuscript: Please include the databases and keywords used on the methodology section in the abstract. Revise on materials and methods language errors: Keywords for the literature search included: ...(Resident* ... Please standardize the presentation of data. For example in some cases you use (39/44, 88.6%) and others you use (54.5%) and others you use none. Revise English language.

VERSION 2 – AUTHOR RESPONSE

Reviewer: 2

1. I would like to thank the authors for having considered the several points mentioned in the first review of the article. This article has improved a lot. Shifting from a systematic review to a

a scoping review is more congruent I think with the content and the aims of the authors. The fact to have pointed more clearly three main points (personal aspect, clinical practice and residency training) for this review makes the results much less vague, even if the scope remains quite large with these themes and all the aspects associated with each theme.

REPLY: We are thankful for the positive feedback.

2. Regarding the details of your research questions p.6: I wonder whether the “attitudes towards SR in clinical practice” should be rather placed in the next point “How does SR interact with clinical practice”?

   REPLY: We hoped to explore residents’ personal attitudes towards SR in clinical practice with the first question (e.g whether they approve/disapprove of the idea), while the second question is targeted at their actual behavior and practices in clinic (e.g whether they actively enquire about SR-related issues regardless of their personal stance/attitude towards the matter).

3. I also appreciate the adding and mention of the JBI methodology in the text, which gives more consistency and rigor to the scientific review process, and also the description of the six steps guideline of Levac et al. for conducting the scoping review. It makes the process much clearer now. Regarding this part, could the authors add the specific characteristics of a scoping review at the beginning of the “materials and methods” section?

   REPLY: Specific characteristics of a scoping review have been added at the beginning of the Materials and methods section.

   “*A scoping review is useful in exploring the literature broadly to identify the evidence available on a particular topic.[25]”*

4. The table 1 of the results is better now with the differentiation of the three themes. Regarding the column “outcomes”, I doubt that this tittle is really appropriate and congruent with the content. As I can see, when looking at the details of each study for this part, it more refers to the “aims/goals of the study” with the methods used in brackets, than really the outcomes. If it was really about outcomes, they should be specifically mentioned, which is not the case currently (for example, for Rosendale and Josephson, it’s just indicated “pre and post training outcomes”).

   REPLY: We have changed the heading to “Aims of study” as suggested.

5. Are all the studies categorized as “intervention” really intervention studies using a pre-post design (for example Hyidt et al.? Or does this term refer to a broader aspect, including for example the development of specific intervention (for example Vicini et al.)? What is understood with “observational” and “intervention” could be explained in the text.

   REPLY: The definition of “observational” and “intervention” type studies have been clarified in Materials and methods.

   “*Studies were classified as intervention studies if they sought to evaluate the impact of any SR-related training in residency. Those seeking to examine the attitudes, behaviours, or skills of residents in relation to SR issues would be classified as observational studies.”* (See Materials and methods, Paragraph 4, Lines 9-12)

6. In the discussion part, I think that the authors should also discuss a little bit more the question of the role repartition and the frontier between the physicians and chaplains or spiritual assistants regarding SR in the hospital context. How far should the role of doctors go in relation to the spirituality of patients? When should chaplains take the lead? Given the increase of interdisciplinarity within hospitals, this issue also deserves to be addressed.

   REPLY: We have added an elaboration on this point.

   "*In the context of greater interdisciplinary collaboration in patient care, the issue of whether the physician or chaplain should take the lead in addressing SR would have to depend on an understanding of the background and needs of the patient, rapport of the patient with the members of the multidisciplinary team, comfort and SR related competency of the physician and wider system factors such as institutional and cultural norms."* (See Discussion, Paragraph 4, Lines 16-21)

7. Details:
   - p.5: "practicing" and not "practising" I guess.

     REPLY: We have amended the spelling.

   - Table 1: The size of the text is too large for the reference Saba et al.

     REPLY: It has been amended accordingly.

Reviewer: 3

1. Please include the databases and keywords used on the methodology section in the abstract.

   REPLY: We have done so.

2. Revise on materials and methods language error: Keywords for the literature search included:

   REPLY: We have checked the sentence and these are the terms used for literature and database search for relevant articles to be included within this review.

3. Please standardize the presentation of data. For example in some cases you use (39/44, 88.6%) and others you use (54.5%) and others you use none.

   REPLY: Presentation of data has been standardized. All include number of papers out of 44, and percentage.

   "*Of the **44 papers, 24 (54.5%)** reported data related to Theme 1, **18 (40.9%)** reported data related to Theme 2, and **35 (79.5%)** contained data related to Theme 3*."

   "*In terms of specialties included, the most frequent were Family Medicine (**13/44, 29.5%)**, Psychiatric **(13/44, 29.5%),** and Internal Medicine **(11/44, 25.0%)** residency programs*."

We declare that the manuscript has not been published in whole or in part in any other journal and is not being reviewed for publication elsewhere. All co-authors have made substantial contributions to conception and design or analysis and interpretation of data, made substantial contributions to drafting the article or revising it critically for important intellectual content; and the manuscript has also been read and approved by all co-authors. All authors report no financial or other conflicts of interest related to the subject of this article. Thank you and best regards.