

NORC INTERVIEW STUDY

OF

A. C. S. PROFESSIONAL EDUCATION PROGRAM

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## PREFACE

This report describes the objectives and methodology of the NORC Interview Study of the American Cancer Society's professional education program, and presents a full set of tables showing the percentaged distribution of response to each question asked, broken down by specialists vs. non-specialists.

The purpose of the present report is to provide a basic "source book" for the results of the Interview Study, and to present, as promptly as possible, an overall summary of what the doctors believe and do with respect to the subjects inquired about.

Copies of the interview schedule used in this study are available from NORC or from the Director of Program Evaluation, Medical Affairs Department of A.C.S. Two earlier memoranda prepared by NORC are also available on request. One of these reports on the doctors' attitudes toward the A.C.S. monograph series, and the other compares the responses and characteristics of those physicians who failed to return the A.C.S. mail questionnaire with those who cooperated on that survey.

There remains a considerable opportunity for fruitful analysis of these interview data, and it is hoped that, as time and resources permit, one or more additional reports or memoranda may be forthcoming.

Paul B. Sheatsley  
Ann F. Brunswick

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## OBJECTIVES AND METHODOLOGY OF THE INTERVIEW STUDY

In late 1958, the American Cancer Society began a comprehensive evaluation of its Professional Education Program. In carrying out this program, the Society relies mainly on four media of communication with physicians: the bi-monthly journal, "CA--A Bulletin of Cancer Progress;" a series of monographs on various aspects of cancer; and films and exhibits shown at medical meetings.

Broadly speaking, the evaluation was aimed at finding out how important this program is to doctors, and how well it is being carried out. More specifically, the Society was interested in defining who are the readers of "CA" and the monographs and how these readers differ, if at all, from those who are reached in group settings by the films and exhibits; how effective is each of these types of materials in bringing doctors information about cancer, and what channels might be used so that the program could reach more physicians.

To collect the data needed to answer these questions, the Society selected a representative sample of 5,000 physicians throughout the United States and sent them a short-answer mail questionnaire. From this relatively large sample, they could get a measure of how many doctors received or attended the Society's materials, how successful the doctors considered the materials to be, the doctors' interest and knowledge concerning cancer, and other information relevant to the Society's program.

### Objectives of the NORC Interview Study

To supplement the results of the large mail survey, the Society asked NORC to conduct personal interviews with a small sub-sample of these 5,000 doctors. These personal interviews had four main objectives.

To avoid a low response rate, mail questionnaires must usually be brief. In contrast, the personal interview can hold the doctor's attention for as much as an hour and thus cover a wider range of subject matter. And through open-ended questions and interviewer-probes for the reasons for the doctor's replies, a fuller explanation of his point of view can be developed. Thus, one objective of the personal interviews was to amplify and clarify the check-list responses received on the mail questionnaire returns.

A second objective was to obtain data on a wider variety of matters than could be covered in the mail questionnaire: the size and nature of the doctor's practice, the frequency with which he utilizes certain detection and examination procedures recommended by the Society, his reading habits, his smoking habits, his hospital affiliations, etc. It was felt that background information of this type would help provide a meaningful interpretation of the basic data on exposure to and opinions about the Society's professional education materials.

Third, the personal interviews offered an opportunity to evaluate the possible bias resulting from non-response to the mail questionnaire. A representative sample of doctors who failed to return their mail questionnaires could be asked those same questions in the personal interview situation and their responses checked against the group who did reply. If major differences were revealed, the findings of the mail survey could be corrected to allow for the bias due to non-response.

And finally, the personal interviews permitted the Society to repeat certain questions which NORC had asked, on behalf of the Society, on a survey of similar doctors in 1955. Replication of these items four years later would provide a measure of any changes in physicians' opinions or behavior with respect to these matters.

#### The Sample Design

The 5,000 doctors to whom the ACS mail questionnaire was addressed were drawn from two sources. Approximately 1,400 names were provided by NORC. These were the doctors who were named by a representative sample of the adult U.S. population in 1955 as their "regular doctor" or the doctor they "would probably call" if they got sick.

The NORC list, though four years old, was peculiarly adapted to the interests of the Society because, essentially, it was a nationally representative list of active physicians in private practice. In contrast, any list of doctors obtained from medical directories or lists was likely to include large numbers of physicians who were not in private practice or who restricted their practice to specialties -- and it was the family doctor who was the principal object of study.

To provide the larger mail questionnaire sample desired, the NORC roster was supplemented by an additional 3,600 names drawn from up-to-date medical lists. These names were selected with probability proportionate to the distribution of the general population (not necessarily the physician population) with respect to community size and geographical region.

All of the doctors designated for personal interview, however, were drawn from the NORC list of 1,400. Operationally, this had the advantage of insuring the availability of trained interviewers at the indicated sampling points. Furthermore, by sampling from the same population as had constituted the 1955 NORC physician survey, the examination of opinion trends since that date would be facilitated.

It was determined that 150 personal interviews with non-responders to the mail questionnaire would be sufficient to establish the extent and nature of any non-response bias. Since a total of 600 interviews was provided for, the number of responders designated for personal interview was set at 450.

It should be noted that when the NORC roster was first sampled in 1955, the names had been weighted according to their frequency of mention by the public. Thus, a doctor named by more than one respondent as his regular physician had greater opportunity to fall into the sample than a doctor named only once. In the present survey, however, the sample of personal interviews was primarily designed to clarify the mail questionnaire data, and consequently required selection by the same method -- that is, the setting of quotas, based on general population, within each county or metropolitan area.

In actual practice, this method produced virtually the same effect as the more complicated weighting system. For example, the rural doctor had a greater opportunity than the city doctor to fall into the 1955 sample because he was more likely to be named as the regular physician of more than one respondent. But he also had more opportunity to fall into the present sample because in rural areas almost every listed doctor had to be interviewed in order to meet the quota for that community size, whereas in larger cities only a fraction of the list was required.

Of the 600 doctors originally designated for interview, 28 were found to be ineligible for the sample by reason of retirement, death or medical disqualification (osteopath, psychiatrist, etc.). These were replaced by other names drawn from the NORC roster in the same area.

#### The Interviewing

The interviewing was carried out by 98 interviewers in 67 counties and metropolitan areas throughout the United States. With minor exceptions, all interviewers were members of NORC's permanent national staff, and many of them had participated in the 1955 doctor survey. Each received, as part of his working materials on the present study, a 28-page manual of instructions on how to obtain and conduct the interview. Just prior to the interview, each doctor was sent a letter from the NORC Study Director, briefly explaining the auspices and purpose of the study and advising him that an interviewer would soon phone him for an appointment.

Interviewing was started in May 1959 and three-quarters of it was completed in that month. Field work continued into July, however, in order to give every assigned doctor the maximum opportunity to participate in the survey.

Of the originally designated sample, 86% were successfully interviewed. The following table shows the nature of the losses:

	<u>N</u>	<u>%</u>
Interview completed . . . . .	514	86%
Refused to be interviewed . . . . .	57	9
Away from home during time of survey. . . . .	10	2
Too sick to be interviewed. . . . .	8	1
Moved out of area . . . . .	6	1
Interviewer failure, no report. . . . .	5	1
	<u>600</u>	<u>100%</u>

The high completion rate was achieved primarily by two means. First, the interviewers were persistent but patient in seeking appointments. If a doctor could not see them one week, they thanked him and tried again the following week. They constantly stressed the importance of his interview and emphasized their willingness to meet him at any time and place most convenient to him.

If the doctor objected to being interviewed, or if the interviewer felt she was being deliberately put off, she filled out a form reporting the nature and circumstances of the difficulty. A personal letter from the Study Director, sent via special delivery mail, or a long-distance phone call, was then employed to answer the doctor's particular objections and to reassure him of the importance of his cooperation. Such letters and phone calls were successful in "converting" approximately 50 doctors who first refused to be interviewed.

In order to build up the number of cases to approximately 600, the 86 cases lost from the original sample were substituted for, and the final sample totaled 587 interviews.

#### The Questionnaire

The personal interview questionnaire was developed by NORC in consultation with the staff of the American Cancer Society's Department of Program Evaluation. It was pretested on a group of doctors in the New York area, some of whom had responded to the mail questionnaire while others had not. The final version of the schedule was cleared with medical personnel from the Society's staff.

It included 54 numbered items, many with one or more sub-parts, and the median time required for administering the interview was exactly 60 minutes. The particular questions asked can be grouped into the following general areas pertinent to the study's objectives.

Qs. 1-10: The first nine questions were a replication of key items from the mail questionnaire: exposure to and opinions about "CA," the monographs, films and exhibits provided by the Professional Education Program; attendance at medical meetings during the past year, and self-ratings of interest in and knowledge about cancer. These questions were asked only of non-responders to the mail questionnaire, so their answers could be compared with those of responders. A tenth question asked whether the mail questionnaire had been received, and if so, why it had not been completed.

Qs. 11-15, 29: Characteristics of the doctor's practice, such as size, specialization, type of patients, and the extent to which problems of cancer arise.

Qs. 16, 28: Opinions and impressions concerning people's report of symptoms to the physician, repeated from the 1955 survey.

Qs. 17-27: Opinions and practices with respect to medical examination procedures: general physical checkup, digital-rectal exam, proctoscopy, chest X-ray, breast self-examination, pelvic examination and Pap smear.

Qs. 35-38, 40-44: Details of exposure to and opinions about "CA," the monographs, cancer films and exhibits, plus overall opinions concerning the Society's Professional and Public Education Programs.

Qs. 21-BC, 39, 52: Opinion about the relationship between smoking and lung cancer, and information about the doctor's handling of the smoking problems of his patients.

Qs. 30-31, 33-34, 45, 48, 54: Professional affiliations and activities, including hospital association, journal reading, membership in medical societies, and activities in behalf of the American Cancer Society.

Qs. 32, 46-47, 49-51, 53: Personal characteristics, including: age, income, nationality, father's occupation, religion, date and place of medical schooling, service in armed forces, membership in community organizations, and leisure time activities.

#### Representativeness of the Sample

It has been noted that 14% of the original sample could not be interviewed, and that most of these doctors were substituted for in order to bring the total number of interviews to a level approximating 600. Analyses were made to determine whether these substitutions of more willing and more available doctors introduced any bias into the sample.

With the aid of medical listings it was possible to ascertain, for each doctor who could not be interviewed, his age, the size of community and geographical region in which he resides, and whether or not his practice is specialized. It was also known whether or not he had returned the mail questionnaire.

Application of a chi square test for homogeneity failed to reveal any differences beyond those attributable to chance between doctors who had not been interviewed and those who had -- although the somewhat higher interview loss rate among non-responders to the mail survey approached statistical significance. It may be concluded that the 14% loss from the originally designated sample and the subsequent substitutions did not significantly impair the representativeness of the interview survey sample.

It will be remembered, however, that responders to the mail survey were sampled in a 3:1 ratio (450 vs. 150) to the non-responders. The actual ratio of responders to non-responders was 3:2 (approximately 60%). Thus, in the ensuing tabulations each non-responder interview has been given a weight of 2 (counted twice) in order to compensate for this bias.

THE DOCTOR AND HIS PRACTICE

The NORC roster of physician names, which was sampled for purposes of the present study, is not representative of any specifiable group of physicians. Rather, it represents the doctor-half of a sample of patient-physician relationships, and consequently includes only those physicians who were considered by at least some of their patients to be their regular or general doctor in the year 1955.

This sampling design results in a preponderance of general practitioners in the sample, since few adults would consider such specialists as pathologists, radiologists, pediatricians, dermatologists, anesthesiologists, etc., as their regular physician.

It also results in a sample heavily weighted toward those physicians who have large general practices, and thus toward doctors who, in 1955, were between forty and sixty years of age -- since younger physicians, who were still establishing their practices, and older doctors, in the process of retiring, were less likely to be mentioned by the public as their regular doctor.

And since the roster is now four years old and has not been supplemented by names of younger physicians, the group has aged since it was first sampled in 1955. Thus, two-thirds of the doctors in the present sample are between the ages of 40 and 60; one out of five is 60 or older, and only 13% are under the age of 40.

The design retains, however, the advantages which led to its adoption four years ago. The sample is representative of those doctors to whom the general public first turns, and it is consequently a singularly appropriate group to question in a study of the American Cancer Society's professional education program.

The tables which follow this section are descriptive of the kinds of doctors sampled and the nature of their practice.

Summary

Sixty-one percent of the group say their practice is a general one, while 32 percent say their practice is concentrated in a specialty. The remainder specialize to some extent, but their replies have been grouped with those of the non-specialists in the tables to follow. Surgery, internal medicine, and obstetrics and gynecology (in that order) account for almost all of the specialties pursued.

In 1955, almost three-quarters of the sample, in contrast to the present 61 percent, defined themselves as general practitioners. It may be assumed that some of these have now completed specialty training, and since no younger doctors were added to the roster, the proportion of specialists has increased somewhat.

Two-thirds of the specialists say that the nature of their practice requires them to take an above-average interest in cancer; only 36 percent of the non-specialists say their practice requires such an interest.

The specialists interviewed also claimed a greater interest in cancer and a greater knowledge about cancer, "as compared with other doctors in the same type of practice," in their replies to the questions asked on the mail questionnaire. Forty-one percent of the specialists, as compared with 24 percent of the non-specialists, said they took more interest in the subject; 38% of the specialists, but only 15% of the non-specialists, claimed above-average knowledge.

Both specialists and non-specialists in the interview sample have been long established in their communities. More than half of the total group have practiced for more than 20 years in the same area. Only 13% have practiced in the community for less than 10 years.

The practice of the specialists is more likely to be concentrated among women. Seventy percent of the group say they treat more women than men or children; only 56% of the non-specialists treat mostly women. The practice of the specialist is also more likely to exclude children. Thirty-five percent treat only adults; only 4% of the non-specialists restrict their practice in this manner.

Most of these physicians describe the economic status of their patients as about average for the community, but again there are differences between specialists and non-specialists. Forty-two percent of the former, but only 20% of the latter, say their patients are better off financially than the average; only 3% of specialists, but 13% of non-specialists describe their patients as worse off than most others in the community.

#### Hours Worked and Patients Seen

As would be expected, specialists spend less time on home calls to patients. Almost a quarter of them make no home visits at all, and two out of three devote fewer than five hours a week to such visits. In contrast, only one non-specialist in twenty avoids home calls entirely and almost half of them spend ten or more hours a week in this manner.

Specialists also spend less time seeing patients in their office. Half of them devote less than 30 hours a week to office visits, while only 31% of the non-specialists spend so little time in the office. On the other hand, the specialists devote more time to hospitalized patients. Practically all of them spend at least some time at the hospital, and one out of three devotes 20 or more hours a week to this part of his practice. Among non-specialists, only one doctor in five spends so much time visiting patients in the hospital.

In total, the average non-specialist works many more hours per week than his specialized colleague. Almost three-quarters of them say they spend 50 or more hours in an average week seeing patients, 43% spend 60 or more hours, and one G.P. in five works 70 hours or more. Only about half the specialists work as many as 50 hours a week.

Consistent with this, the general practitioner sees more patients in an average week than the specialist does. Half the specialists see fewer than 100 and only 10% see more than 200 in a week. Only a third of the non-specialists see fewer than 100 patients a week, and one in five sees more than 200.

But although somewhat more specialists see fewer than 1,000 different patients per year, there is no large difference in the total size of the average practice of the two groups. This presumably reflects the fact that the specialist is more likely to see a single patient only once or twice, while the non-specialist may see him at repeated times and for different conditions throughout the year.

#### Hospital Affiliations

Ninety-five percent of the general practitioners and 99% of the specialists have some hospital affiliation, but 39% of the former as compared with 21% of the latter have only one such affiliation. A quarter of the specialists are associated with four or more hospitals; only one G.P. in ten is in this position. The specialists are more likely (26% to 14%) to hold an appointment of "senior" or "chief", while the non-specialists (10% to 3%) are more likely to hold only a courtesy appointment.

All doctors were asked whether any of the hospitals with which they are affiliated maintain certain special cancer services. For four of the five services inquired about, better than three-fourths of the sample answered affirmatively.

Seventy-seven percent of the physicians said their hospital provides tumor treatment services, and 83% tumor diagnostic services; 84% said cytologic services were available, and 76% answered "Yes" to radiation therapy. For the fifth item, cancer registry, 57% replied affirmatively, 23% answered "No," and 20% did not know.

Forty-nine percent of the doctors interviewed said that all five of these services are available at one or more of the hospitals with which they are affiliated. For each of the five, specialists were more likely than non-specialists to answer affirmatively.

Asked about the frequency with which hospital meetings deal in any way with cancer, two doctors out of three say that fewer than half of them do. Twelve percent could not answer this question; 22% said that half or more of their hospital staff meetings are concerned in one way or another with cancer. Specialists did not differ from non-specialists in their replies to this question.

When cancer discussions do take place, they most frequently take the form of case studies or reports. Special lectures or papers, general cross-table discussion, and pathology reports or other data presentations are mentioned much less often.

### Medical Journals and Medical Associations

Ninety-nine percent of these doctors, both specialists and non-specialists, read at least one medical journal regularly. Half of them spend less than five hours a week on this activity; the other half spend five or more hours. And about half read fewer than four journals regularly, while the other half read four or more. General practitioners read just about as many journals, and spend just about as much time at it, as specialists do.

The journals read by these doctors were coded in some detail. The "Journal" of the A.M.A. of course heads the list. Four out of five G.P.'s and two-thirds of the specialists say they read it regularly. State and regional journals are read more widely by non-specialists (except the "New England Journal of Medicine"), while the specialty journals are naturally mentioned more often by specialists.

More than twice as many G.P.'s (26% to 12%) volunteered "CA" as one of the journals they read regularly. Indeed, among non-specialists, no single journal except "J.A.M.A." was mentioned as frequently.

When asked which journal they rely on most for information about cancer, 31% of these physicians referred to "J.A.M.A.", and "CA" was second with 19% (G.P.'s 23%, specialists 10%). Specialists often cited the "New England Journal of Medicine," "Surgery, Gynecology and Obstetrics" and other specialty journals.

Twenty-two percent of the physicians say they have worked with the American Cancer Society in some way at some time; 78% have not. But twice as many specialists as non-specialists answer "Yes" to this question. The most frequently cited activities are service on a committee or board, public speaking before professional or lay groups, and work in a cancer or tumor clinic.

Practically all of the doctors belong to A.M.A. or one of its state or county societies, and two-thirds of the specialists are members of a specialist society. Three-quarters of the specialists, but little more than half of the G.P.'s, belong to more than one medical society or association. One-third of the non-specialists are members of A.A.G.P.

A final question, designed to divide the sample according to their basic outlook toward medical practice, is included in this section. It asked, "Which would you say is more important -- for a physician to keep himself informed of new scientific developments, or to devote more time to his patients?" About a fourth of the doctors simply could not answer this, but the remainder divided fairly evenly. Thirty-five percent selected the first alternative, and 38% the second. Specialists were somewhat more likely than non-specialists to answer "Both" or "Don't know," and somewhat less likely to answer "Spend more time with patients."

II. THE DOCTOR AND HIS PRACTICE

T A B L E S #

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<u>1. Interest in cancer required by nature of practice (Q.29)</u>			
More than average . . . . .	36%	66%	46%
About average . . . . .	61	27	50
Seldom called on in practice. . . . .	3	7	4
<u>2. Interest in cancer as compared with others in same type of practice (Q.8-A)</u>			
Much more interest. . . . .	4%	14%	7%
More interest . . . . .	20	27	22
About the same. . . . .	70	53	64
Less interest . . . . .	1	2	2
Much less interest. . . . .	*	*	*
Don't know, no answer . . . . .	5	4	5
<u>3. Knowledge about cancer as compared with others in same type of practice (Q.8-B)</u>			
Much more knowledge . . . . .	2%	5%	3%
More knowledge. . . . .	13	33	20
About the same. . . . .	77	57	70
Less knowledge. . . . .	3	3	3
Much less knowledge . . . . .	-	*	*
Don't know, no answer . . . . .	5	2	4
<u>4. Length of residence in area (Q.11-A)</u>			
Less than 10 years. . . . .	6%	8%	7%
10-14 years . . . . .	16	14	15
15-19 years . . . . .	8	7	8
20-24 years . . . . .	12	10	11
25 years or more. . . . .	57	60	58
Don't live in area, just practice . . . . .	1	1	1
<u>5. Length of practice in area (Q.11-B)</u>			
Less than 10 years. . . . .	11%	16%	13%
10-14 years . . . . .	23	24	23
15-19 years . . . . .	12	10	11
20-24 years . . . . .	19	12	17
25 years or more. . . . .	35	38	36

Percentages are based on 399 interviews with Non-specialists and 188 interviews with Specialists. As described in the first section of this report (P.5), non-responders to the mail questionnaire were assigned a weight of 2 in both groups in order to give them their proper weight in the sample.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>F. Percent of patients who are men</b> <u>(Q.12-A)</u>			
None. . . . .	-%	16%	5%
Some but less than 20%. . . . .	15	9	14
20-29%. . . . .	40	10	30
30-39%. . . . .	33	31	32
40-49%. . . . .	9	23	13
50-59%. . . . .	2	9	4
60% or more . . . . .	1	2	2

**G. Percent of patients who are women**  
(Q. 12-A)

Less than 30% . . . . .	5%	1%	4%
30-39%. . . . .	22	7	17
40-49%. . . . .	26	14	22
50-59%. . . . .	23	22	23
60-69%. . . . .	17	30	21
70-89%. . . . .	7	10	8
90-100% . . . . .	*	16	5

**H. Percent of patients who are children**  
(Q.12-A)

None. . . . .	4%	35%	14%
Some but less than 10%. . . . .	6	25	12
10-19%. . . . .	16	22	18
20-29%. . . . .	23	7	18
30-39%. . . . .	29	7	22
40-49%. . . . .	14	2	10
50% or more . . . . .	8	2	6

**I. Practice consists mainly of:**  
(Q.12-A)

Men . . . . .	3%	3%	3%
Women . . . . .	56	70	60
Children. . . . .	12	2	9
Men and women . . . . .	8	19	12
Women and children. . . . .	11	2	8
All three equally . . . . .	10	4	8

**J. Economic status of patients as compared with average in area (Q.12-B)**

Better off than average . . . . .	20%	42%	27%
About the same. . . . .	66	55	62
Worse off than average. . . . .	13	3	10
Don't know. . . . .	1	*	1

K. <u>Doctor's practice is: (Q.13)</u>	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
A general practice. . . . .	89%	-%	61%
Concentrated in a specialty . . . . .	-	100	32
Both, can't say . . . . .	11	-	7

L. <u>Nature of specialty (Q.13-A)</u>	#		
Surgery . . . . .	5%	32%	13%
Internal medicine . . . . .	1	36	12
Obstetrics, gynecology, . . . . .	3	23	9
Pediatrics, . . . . .	1	3	2
Other . . . . .	2	13	6

M. <u>Proportion of practice falling within specialty (Q.13-B)</u>			
Less than half, . . . . .	4%	3%	3%
50-69% . . . . .	3	6	3
70-79% . . . . .	3	7	5
80-89% . . . . .	1	11	4
90-99% . . . . .	*	17	6
100% . . . . .	-	56	18

N. <u>Average number of hours per week spent on house calls (Q.14-A)</u>			
None, . . . . .	5%	23%	11%
Less than 5 hours . . . . .	23	43	29
5-9 hours . . . . .	24	14	21
10-14 hours . . . . .	18	9	15
15-19 hours . . . . .	9	6	8
20-24 hours . . . . .	13	2	9
25 hours or more, . . . . .	8	1	6
Can't estimate, . . . . .	*	2	1

O. <u>Average number of hours per week seeing patients in office (Q.14-B)</u>			
Less than 25 hours, . . . . .	22%	32%	25%
25-29 hours . . . . .	9	19	12
30-34 hours . . . . .	21	17	20
35-39 hours . . . . .	12	12	12
40-44 hours . . . . .	17	10	15
45 hours or more, . . . . .	18	9	15
Can't estimate, . . . . .	1	1	1

P. <u>Average number of hours per week seeing patients at hospital (Q.14-C)</u>			
None, . . . . .	8%	*%	5%
Less than 10 hours, . . . . .	29	22	27
10-14 hours . . . . .	28	27	28
15-19 hours . . . . .	13	16	14
20-24 hours . . . . .	13	15	13
25 hours or more, . . . . .	8	17	11
Can't estimate, . . . . .	1	3	2

# Multiple answers permitted as some doctors engaged in more than one specialty.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>Q. <u>Average number of hours per week seeing patients (total) (Q.14)</u></b>			
Less than 40 hours . . . . .	13%	22%	16%
40-49 hours . . . . .	15	27	19
50-59 hours . . . . .	29	26	28
60-69 hours . . . . .	22	19	21
70 hours or more . . . . .	21	6	16
<b>R. <u>Total number of different patients seen in average week (Q.15-A)</u></b>			
Less than 50 . . . . .	11%	18%	13%
50-99 . . . . .	22	32	25
100-149 . . . . .	26	27	26
150-199 . . . . .	17	7	14
200-249 . . . . .	10	6	9
250 or more . . . . .	10	4	8
Can't estimate . . . . .	4	6	5
<b>S. <u>Number of different patients seen during last year (Q.15-B)</u></b>			
Less than 1,000 . . . . .	12%	20%	14%
1,000-1,999 . . . . .	17	19	18
2,000-2,999 . . . . .	13	11	12
3,000-4,999 . . . . .	17	14	16
5,000-6,999 . . . . .	10	8	10
7,000-9,999 . . . . .	7	7	7
10,000 or more . . . . .	7	4	6
Can't estimate . . . . .	17	17	17
<b>T. <u>Number of hospital associations (Q.30-A)</u></b>			
None . . . . .	5%	1%	4%
One . . . . .	39	21	34
Two . . . . .	27	26	26
Three . . . . .	20	25	21
Four or more . . . . .	9	26	14
At least one but number unknown . . . . .	*	1	1
<b>U. <u>Nature of hospital appointment (Q.30-C)</u></b>			
Senior or chief . . . . .	14%	26%	18%
Active or associate . . . . .	68	69	68
Courtesy . . . . .	10	3	8
Other . . . . .	3	1	2
None . . . . .	5	1	4

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
V. <u>Does hospital provide tumor treatment services? (Q.30-D-1)</u> #			
Yes . . . . .	74%	82%	77%
No. . . . .	23	15	20
Don't know. . . . .	3	3	3
W. <u>Does hospital provide tumor diagnostic services? (Q.30-D-2)</u> #			
Yes . . . . .	80%	89%	83%
No. . . . .	17	10	15
Don't know. . . . .	3	1	2
X. <u>Does hospital provide cytologic services? (Q.30-D-3)</u> #			
Yes . . . . .	82%	89%	84%
No. . . . .	15	8	13
Don't know. . . . .	3	3	3
Y. <u>Does hospital provide radiation therapy? (Q.30-D-4)</u> #			
Yes . . . . .	72%	84%	76%
No. . . . .	28	16	24
Z. <u>Does hospital have cancer registry (Q.30-D-5)</u> #			
Yes . . . . .	53%	65%	57%
No. . . . .	24	22	23
Don't know. . . . .	23	13	20
AA. <u>Number of these services provided by hospital (Q.30-D)</u> #			
All five services provided. . . . .	44%	59%	49%
Four of them provided . . . . .	23	17	21
Three . . . . .	7	8	8
Two . . . . .	10	6	8
One . . . . .	8	5	7
None of them provided or don't know	8	5	7
BB. <u>Proportion of hospital meetings attended which are devoted in whole or in part to cancer (Q.31-A)</u>			
Less than 10% . . . . .	13%	12%	13%
10-19% . . . . .	22	22	22
20-29% . . . . .	19	18	19
30-49% . . . . .	12	14	12
50-74% . . . . .	12	13	12
75% or more . . . . .	11	7	10
Can't estimate. . . . .	11	14	12

# Percentages based on doctors with one or more hospital affiliations.

CC. Form in which cancer discussions take place (Q.31-B)	#	Non-Specialists	Specialists	All Doctors Interviewed
Case study of hospital patient. . . . .		62%	64%	63%
Special paper or lecture. . . . .		24	23	24
General discussion. . . . .		17	18	18
Any one or all three of above . . . . .		14	17	15
Reviews of hospital data. . . . .		17	23	19
Mention of films, slides. . . . .		9	6	8
Don't attend hospital meetings. . . . .		2	2	2

DD. Number of hours per week spent reading medical journals (Q.33-A)				
Less than 2 hours . . . . .	10%		6%	8%
2 hours . . . . .	18		16	17
3 hours . . . . .	15		14	15
4 hours . . . . .	11		11	11
5 hours . . . . .	10		14	11
6 hours . . . . .	8		10	9
7 hours . . . . .	10		5	8
8 hours or more . . . . .	16		21	18
Can't estimate. . . . .	2		3	3

EE. Number of journals read regularly (Q.33-B)				
None. . . . .	1%		1%	1%
One . . . . .	5		3	5
Two . . . . .	16		14	16
Three . . . . .	23		29	25
Four. . . . .	27		23	25
Five. . . . .	11		17	13
Six . . . . .	11		9	10
Seven or more . . . . .	6		4	5

FF. Names of journals read regularly (Q.33-B)	#			
J.A.M.A. . . . .	79%		68%	76%
American Journal of Medicine . . . . .	6		10	7
New England Journal of Medicine . . . . .	13		23	16
Southern Medical Journal. . . . .	5		2	4
Other state, regional journals. . . . .	42		24	37
Surgery, Gynecology & Obstetrics. . . . .	9		20	13
Am. Journal of Ob/Gyn . . . . .	3		12	6
Obstetrics & Gynecology . . . . .	4		12	6
American Journal of Surgery . . . . .	3		7	4
Annals of Surgery . . . . .	2		7	3
Archives of Internal Medicine . . . . .	1		6	3
Annals of Internal Medicine . . . . .	1		18	6
Journal of Pediatrics . . . . .	2		2	2

(continued)

# Many doctors mentioned more than one.

	<u>Non- Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>FF. (continued)</b>			
Pediatrics. . . . .	17	17	17
Geriatrics. . . . .	2	3	2
G.P. . . . .	10	4	9
Post-Graduate Medicine. . . . .	3	6	4
Medical Clinics of North America. . . . .	7	3	6
Surgical Clinics of North America . . . . .	3	12	6
Journal of Intl. College of Surg. . . . .	2	3	3
Other specialist journals . . . . .	18	48	27
CA . . . . .	26	12	22
The Cancer Bulletin . . . . .	4	3	4
Medical Economics . . . . .	17	13	16
Modern Medicine . . . . .	19	10	16
Medical Times . . . . .	5	*	4
M.D. . . . .	4	-	3
Medical Digest. . . . .	4	2	3
Scope . . . . .	2	1	2
Misc. publications. . . . .	25	22	24
None . . . . .	1	1	1

**GG. Journals relied on most for cancer information (Q.34)**

J.A.M.A. . . . .	35%	23%	31%
American Journal of Medicine. . . . .	2	3	3
New England Journal of Medicine . . . . .	5	10	6
Other state, regional journals. . . . .	7	4	6
Surgery, Gynecology & Obstetrics. . . . .	4	12	6
Am. Journal of Ob/Gyn . . . . .	1	6	2
Obstetrics & Gynecology . . . . .	2	7	3
American Journal of Surgery . . . . .	1	3	2
Annals of Surgery . . . . .	1	3	2
Archives of Internal Medicine . . . . .	1	3	1
Annals of Internal Medicine . . . . .	1	6	2
Geriatrics. . . . .	1	2	1
G.P. . . . .	8	-	6
Post-Graduate Medicine. . . . .	3	3	3
Medical Clinics of North America. . . . .	6	1	4
Surgical Clinics of North America . . . . .	4	7	5
Other specialist journals . . . . .	4	17	7
CA . . . . .	23	10	19
The Cancer Bulletin . . . . .	4	2	3
Medical Economics . . . . .	1	2	1
Modern Medicine . . . . .	3	2	3
Other publications. . . . .	7	9	8
Don't know, all of them, etc. . . . .	17	23	19

# Multiple answers permitted.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>HH. Past work with A.C.S. (Q.45-A)</b>			
HAVE WORKED WITH A.C.S. . . . . .	17%	33%	22%
Served on committee . . . . .	5	12	7
Served on board . . . . .	5	13	8
Speaker before public group . . . . .	10	16	12
Speaker to professional group . . . . .	2	10	5
Engaged in publicity for cancer . . . . .	1	3	1
Worked in cancer clinics. . . . .	2	5	3
Other medical activities for cancer . . . . .	1	2	1
Miscellaneous activities. . . . .	1	3	2
NEVER WORKED WITH A.C.S. . . . . .	83	67	78
<b>II. Length of time since last work with A.C.S. (Q.45-B)</b>			
Within last year. . . . .	8%	17%	11%
1-2 years ago . . . . .	2	4	3
3-5 years ago . . . . .	4	4	4
Over 5 years ago. . . . .	3	8	4
<b>JJ. Medical organizations belonged to (Q.48-A)</b>			
AMA, county, state societies. . . . .	99%	97%	98%
Specialist societies. . . . .	24	69	38
A.A.G.P. . . . .	34	6	25
International societies . . . . .	5	10	7
American College (Phys., Surg.). . . . .	7	37	16
Other . . . . .	9	13	10
None. . . . .	1	-	*
<b>KK. Number of medical organizations belonged to (Q.48-A)</b>			
None. . . . .	1%	-%	*%
One . . . . .	46	24	39
Two . . . . .	36	39	37
Three . . . . .	15	26	19
Four or more. . . . .	2	11	5
<b>LL. Ever held office in any medical organization? (Q.48-B)</b>			
Yes . . . . .	46%	53%	48%
No. . . . .	54	47	52
<b>MM. Which is more important? (Q.54)</b>			
Keep informed of med. developments . . . . .	34%	35%	35%
Devote more time to patients. . . . .	42	31	38
Both, can't say . . . . .	24	34	27

EXPOSURE AND REACTIONS TO THE A.C.S. PROGRAM

Four out of every five doctors, specialists and general practitioners alike, report that they are familiar with "CA--a Bulletin of Cancer Progress." But where almost half of the non-specialists who are familiar with "CA" consider it "very often helpful" in providing cancer information, only one out of three specialists consider it so. And twice as many specialists as non-specialists (25% vs. 13%) feel that "it does not add very much" to what they learn about cancer from other sources.

Most frequently cited by both groups of doctors as the reason they find "CA" helpful is the up-to-date information it carries. This was mentioned by three of every ten doctors familiar with the publication. Approximately one doctor in five of those familiar with it cited its value as a specialized reference tool.

Better than one in five of the non-specialists, but only half that number among the specialists, referred to the material on diagnosis and symptomatology as helpful. One doctor in seven singled out for mention the information on therapeutic procedures, and an equal number commented favorably on "CA's" concise method of presentation.

Critics of "CA" most often felt that it duplicates information already provided elsewhere. One out of every five specialists (21%), but only 7% of the GP's, is of this opinion.

Monographs\*

Specialists (65%) are more likely than non-specialists (51%) to report familiarity with the ACS monograph series. But among those familiar, the two groups do not noticeably differ in their ratings of the monographs' usefulness as a convenient source of cancer information.

Almost half of those familiar with the series say that they "usually" get information from the monographs that they do not find conveniently elsewhere, and more than a third feel that they "sometimes" do. Only 13% say the monographs "hardly ever" bring them information which is not conveniently found elsewhere.

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\* A more detailed analysis of this subject is presented in the NORC memorandum, "Summary of Findings from Interview Study of Doctor Attitudes toward A.C.S. Monographs," dated October 23, 1959.

When doctors who said they find the monographs useful were asked to give an example, almost half of them (46%) were unable to specify any particular instance. The largest single group of replies, offered by 23%, referred to the convenience and conciseness of these publications, and their suitability as a reference source.

Three-quarters of the physicians familiar with the monographs could volunteer no way in which they could be made more useful, and no one idea was mentioned by more than a few doctors.

### "The Complete Physical in the Doctor's Office"

On the ACS mail questionnaire, doctors were asked to rate the importance of preparing new material on a number of topics. Of the five subjects listed, the most popular appeared to be "The Complete Physical in the Doctor's Office," which 73% of the responding doctors rated as "very important" and another 20% as "moderately" or "of some" importance. Doctors were questioned further on this subject in the course of the personal interview.

When asked what type of material they would like to see in such a monograph, about one-fourth of both specialists and GP's could offer no specific suggestions, and another one-fourth disclaimed any interest in the subject. The latter group expressed the view that every doctor knows how to give a physical exam and that in any case material on the subject is readily available elsewhere.

But about one doctor in five said he would like to see an up-to-date listing of just what a complete physical should include, as a checklist to guide his own procedure. Another 20% would welcome material on diagnostic techniques and symptomatology. Eight percent specified information on the pelvic exam or Pap smear; 7% spoke of laboratory procedures, and 4% suggested material on proctoscopy or rectal examination.

Asked directly and specifically how much need there is for new materials on the subject, the doctors who were interviewed were somewhat less enthusiastic than the responses to the mail questionnaire had indicated. Only one in five felt there was a "great need;" 38% said there was "some need," and 37% answered "hardly any need." Almost all of the latter group repeated their view that doctors already have this know-how or that the information can readily be found elsewhere.

Of those who felt the need for new materials on "The Complete Physical," almost half gave as their reason that doctors need reminding of the importance of such examinations and should be encouraged to do a thorough job. About a third of the group placed their emphasis on the availability of new diagnostic techniques and the need for doctors to keep abreast of current developments.

### "Cytology in Cancer Diagnosis"

On the mail questionnaire, almost two-thirds of the responding doctors rated new materials on cytology as "very important" and almost all of the others accorded it at least "some" importance. When asked during the personal interview how much need there is for such information, one fourth of the physicians (26%) said there was a great need, 32% answered "some need," and 29% said "hardly any need." One doctor in eight (13%) was unable to estimate the need for such materials.

Asked what sort of information they would like to see in a monograph on the subject, one third of the doctors expressed no interest at all, usually on the ground that cytology should be left to the pathologist. Fourteen percent would like information on how to take the specimen or prepare the smear; 11% on interpretation or diagnosis from the smear, and 10% expressed a desire for up-to-date information generally.

The desire to "keep up with the field" is also the most frequently cited reason of those who feel a need for new materials on the subject. They point out that many doctors are unaware of recent developments in cytology. Others say that too many physicians have a limited view of cytologic procedures and do not recognize their full range of use.

But 23% of all doctors reject the need for new materials on the ground that "This is the pathologist's job, not mine." They give such replies as:

"I leave that to the laboratory. It's been years since I looked through a microscope"

"It's a specialized field. Only a few doctors would be interested. Those who do cytology interpret for the rest of us"

### Films of Cancer

Films most often mentioned as having been seen during the year preceding the interview were those on cancer of the breast (reported by 14% of the doctors) and cancer of the cervix-uterus (mentioned by 10%). Forty-nine percent of the GP's and 42% of the specialists (46% of all doctors) said they had seen no films on cancer during the year.

Among those who had seen any films at all, hospital staff meetings were reported as the most frequent occasion. Forty percent of the group had seen one or more films in this context, and 30% had viewed them at national, state or regional medical meetings. The third most frequent place of exposure to cancer films was specialist society meetings (specialists), and local and county meetings (non-specialists).

Doctors had some difficulty specifying just what they especially liked about the films. More than half either expressed a vague general approval ("The whole thing was excellent," "I liked all of it") or answered non-committally: "Nothing special," "It was just the general story of cancer," "Most of it I already knew."

Of specific features mentioned, the most frequent references were to the manner of presentation rather than to content. Thus, doctors spoke of the "beautiful technicolor," the "clear pictures," the fact that it was "well edited" or "easy to absorb."

The second largest category of response referred to the value of the film for laymen, in providing reliable information about cancer and dispelling fear. These replies indicate that the doctors were not distinguishing between professional films and those used in the general public education program. (The question asked simply about "films on the subject of cancer.")

It was frequently hard to tell, also, whether doctors were referring to an A.C.S. film or to one produced independently or by some other group. Thus, the responses to these questions refer to cancer films in general and cannot necessarily be taken as specific commentary on the films provided by the Society's professional education program.

Criticisms of the films were even more difficult to elicit than specific points of praise. Ninety-four percent of the GP's and 83% of the specialists could mention nothing about the films which they "didn't like so much." The most frequent complaint of the specialists was "I didn't learn anything, it had nothing new to say."

Almost all doctors (86%) who had seen a cancer film during the year agreed that more doctors should see them. When asked how this might be brought about, they recommended showings at hospital staff meetings, at national and state meetings, and at local and county meetings, in that order.

#### Cancer Exhibits

More specialists (71%) than non-specialists (58%) reported having seen a cancer exhibit during the preceding twelve months. National, state or regional medical meetings most often provided the forum; 43% of all doctors saw an exhibit at one of these meetings. One out of five specialists (22%) viewed an exhibit at a meeting of his specialist society, while 10% of the non-specialists reported seeing them at AAGP meetings.

As in the case of films, doctors were generally unable to offer specific comments of praise or criticism with respect to the exhibits they had seen. Three-quarters of them (73%) could not specify anything they particularly liked about them, and 88% could think of nothing they did not like.

When doctors did make any specific favorable remarks, they most often cited the "attractive display" or "clear manner of presentation." In terms of content, the materials relating to diagnosis and symptomatology were most often mentioned:

"Those nodules on the lung -- you have to decide cases like that every week"

"Models showing lesions were very effective"

Four out of five doctors (79%) who have seen an exhibit during the year believe it would be a good idea for more doctors to see them. This is somewhat less than the proportion of film-viewers who urged a broadening of the film audience. Specialists who have viewed either recommend films and exhibits to other doctors in equal proportions (84%, 83%). General practitioners who have seen films, however, are more likely to recommend them for wider showing (88%) than are GP's who have seen exhibits to recommend the exhibits (77%).

First on the list of places recommended for showing exhibits were hospitals and medical centers (21%):

"Some doctors don't get to meetings, so they should be shown in their hospitals where they work"

"Keep one room at the hospital available to doctors at all times and show exhibits there"

Regular national and state medical meetings and, somewhat less often, county and local meetings were also recommended as places where exhibits could be shown more often.

#### Current Emphasis on Cancer at Medical Meetings

Three out of every four doctors (74%) say they are satisfied with the present emphasis on cancer at medical meetings in general. One in five (21%) feels there is not enough emphasis on cancer. Only 2% believe there is too much emphasis.

Asked at what kinds of medical meetings more emphasis would be desirable, the doctors had no special type in mind. Hospital staff meetings, national and state, local and county, and "all kinds of meetings" received about the same number of replies.

Answers were similarly divided concerning the kind of program or materials needed to lend the desired emphasis. Most frequently urged (but by only 23% of those desiring more emphasis) were case history presentations, while 17% of the group would like more discussion of diagnosis and symptomatology.

"Case presentation dealing with early diagnosis"  
"They ought to emphasize outstanding symptoms that mean cancer"

Aspects of cancer treatment and cure were next most often cited:

"Show five year cures, ten year cures"  
"Newer types of treatment for the general practitioner"

Specialists more often urged material on research experiments and new developments generally, and they also expressed a greater desire for emphasis on diagnostic techniques.

Over a fourth (26%) of these doctors recommending more emphasis on cancer at medical meetings suggested a greater use of films, while 23% proposed more lectures or papers read by specialists. Eleven percent recommended the use of specimens or exhibits.

#### Opinions About the Professional Education Program

More than nine out of every ten physicians interviewed (93%) either "approve" or "strongly approve" of the Society's information program for doctors. Four percent were undecided about it and only 3% expressed any degree of disapproval.

Almost half (46%) of the doctors base their approval on the educational value of the program, either as a contribution to medical information about cancer or, in some cases, as a unique or outstanding resource for such information:

"This is the only way they have to learn about cancer properly"  
"Because I can't think of any other way of doing it"  
"It is an integral part of cancer medical education"

One doctor in five (21%) found the program valuable for its up-to-date information on new developments and research:

"You learn all the new developments and it helps keep you up to date on it"  
"They're keeping us in touch with the latest in the research field"

Fourteen percent credited the professional education program with having increased interest in and awareness of cancer generally, and 12% cited its influence on early detection and diagnosis in particular.

"It keeps a serious problem before us"  
"Really reminds doctors of the cancer situation and makes them more alert to search for cancer in the physical examination"

Eleven percent of the physicians interviewed praised the concise, convenient or reliable presentation of the ACS materials:

"Well prepared and presented material. It's interesting to the physician so he is likely to read it"

"It's the easiest way for us to get the information"

"It presents the latest information in a very ethical manner"

Of those who approve of the program, "CA" is mentioned by both specialists and non-specialists as its most important feature. But 45% of the GP's and only 31% of the specialists rank "CA" ahead of the monographs, the films and the exhibits. Monographs are ranked first by 25% of the specialists and 19% of the non-specialists, and the latter group accord the films an equal ranking (19%). Exhibits are rated most important by only 7% of all doctors, while 13% said "They are all important" or could not decide.

Asked which of the four media of presentation is least important, the doctors answered consistently with their former replies. Thirty-six percent chose the exhibits, 14% the films, 14% the monographs, and only 6% mentioned "CA." Thirty percent of the sample could not answer this question.

#### Opinions About the Public Education Program

Somewhat fewer doctors approve of the Society's public education program than approve of the professional education program. Whereas 93% voiced a favorable view of the latter, only 82% approve of the efforts to educate the public. Still, only 12% of all doctors expressed any degree of disapproval, and only 4% -- one physician in 25 -- raised strong objections. General practitioners (14%) are more likely to disapprove of the public education program than are specialists (7%).

The most often mentioned value of the program, referred to by one doctor in every four, is that it has encouraged people to see a doctor about their symptoms instead of putting it off:

"It makes people cancer-minded and sends them to the doctor early"

"Patients come in sooner now when they think they may have cancer"

"People may go to a meeting or read something, and then come in because of unusual symptoms, when they wouldn't have come before"

Fifteen percent singled out the program's success in educating the public to recognize cancer symptoms, and 11% spoke favorably of its emphasis on regular preventive checkups. A smaller group credited the program with encouraging a better attitude on the part of the public toward medical care and medical practitioners, while 22% of all doctors simply referred generally to the educational value of the program.

Six percent of the physicians interviewed (one in 16) specifically commended the Society for its moderate or "intelligent" approach to public education:

"They do a good job of informing people without creating panic"

"Their intellectual approach is better than getting hysterical"

But 23% of all doctors say that the program arouses public fears and anxiety about cancer, and this is by far the most frequent reason for disapproval. The same sentiment is sometimes voiced by doctors who generally approve of the program but who regard the arousal of fear (at least in some patients) as an undesirable by-product of the effort to educate the public.

Thus, some doctors qualify their over-all approval of the program with remarks like:

"However, sometimes the people become panicky and we have to treat cancer phobia rather than cancer itself"

"But it can be pushed too hard so that it frightens people"

A small portion of those who object to the program (2% of all doctors) claim that at least some people have become so fearful of cancer that they are afraid to visit their doctor.

Nevertheless, only 8% of the total sample stated that the danger of cancer has been exaggerated or that people have been made to worry unnecessarily.

III. EXPOSURE AND REACTION TO THE A.C.S. PROGRAM

T A B L E S

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>A. <u>Familiarity with CA (Q.35)</u></b>			
Familiar with CA. . . . .	82%	80%	82%
Not familiar with it. . . . .	18	20	18
<b>B. <u>How helpful is CA? (Q.35-A)</u> #</b>			
Very often helpful. . . . .	46%	33%	42%
Sometimes helpful . . . . .	39	40	39
Doesn't add much to other sources . .	13	25	17
Don't know. . . . .	2	2	2
<b>C. <u>Why is CA helpful or not helpful (Q.35-B)</u> #</b>			
Helpful material on diagnosis . . . .	22%	11%	18%
Helpful material on treatment . . . .	15	12	14
Latest information on new techniques.	31	28	30
Good for reference, review. . . . .	17	22	19
Concise, brief, saves time. . . . .	14	14	14
Miscellaneous ways it is helpful. . .	8	2	6
Little or no help in treating cases .	-	2	1
Too academic, specialized . . . . .	2	1	2
Repeats material available elsewhere.	7	21	11
Unnecessary, waste of money . . . . .	1	1	1
Miscellaneous criticisms. . . . .	4	6	5
Vague critical replies. . . . .	1	4	2
Don't read it, not my field . . . . .	8	2	6
Don't know, can't say . . . . .	14	12	14
<b>D. <u>Ways in which CA could be made more useful (Q.35-C)</u> #</b>			
Less material on uncommon type cases.	17%	17%	17%
Make it less technical. . . . .	2	-	2
More on diagnosis, treatment. . . . .	4	4	4
Less detail, make it shorter. . . . .	6	2	5
More new material, less repetition. .	1	3	2
More case histories . . . . .	1	1	1
Get wider distribution of CA. . . . .	*	3	1
Index material for reference. . . . .	3	3	3
Discontinue it, use money elsewhere. .	2	3	3
Miscellaneous suggestions . . . . .	12	13	12
Can't think of any ways . . . . .	74	71	73

# Percentages based on number familiar with CA.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>E. <u>Kinds of doctors thought to be most interested in CA (Q.35-D)</u></b> #			
All doctors, every doctor . . . . .	28%	25%	27%
General practitioners . . . . .	45	36	42
Surgeons. . . . .	30	38	38
Internists. . . . .	15	12	14
Obstetricians, gynecologists. . . . .	9	13	10
Pathologists, radiologists. . . . .	11	6	10
Gastroenterologists, proctologists . . . . .	1	3	2
Researchers, teachers . . . . .	2	4	3
Young, progressive doctors. . . . .	1	2	1
Miscellaneous . . . . .	6	9	7
Don't know. . . . .	6	10	7
<b>F. <u>Familiarity with A.C.S. monographs (Q.36)</u></b>			
Familiar with monographs. . . . .	51%	65%	55%
Not familiar with them . . . . .	49	35	45
<b>G. <u>Frequency of helpfulness of monographs (Q.36-A)</u></b> #			
Usually provide new material. . . . .	47%	50%	48%
Sometimes do. . . . .	39	30	36
Hardly ever do. . . . .	12	15	13
Don't know. . . . .	2	5	3
<b>H. <u>Examples of helpfulness (Q.36-B)</u></b> ##			
Material on diagnosis, causation. . . . .	4%	3%	4%
Material on treatment: surgery, etc.. . . . .	3	3	3
Monograph on breast cancer. . . . .	9	6	8
Monograph on cancer of cervix . . . . .	4	3	4
Monograph on thyroid, throat cancer. . . . .	2	3	2
Monograph on other specific sites . . . . .	19	15	17
Concise, useful as reference. . . . .	22	24	23
Complete, specific, detailed. . . . .	7	3	6
Miscellaneous. . . . .	2	6	4
Useful but can't give example . . . . .	47	44	46
<b>I. <u>Ways in which monographs could be made more useful (Q.36-C)</u></b> #			
Simpler, less technical . . . . .	2%	1%	2%
Shorter, more concise . . . . .	7	3	6
More new material, less repetition. . . . .	4	6	5
More or better illustrations. . . . .	4	2	4
More of them, publish more often. . . . .	4	5	4
Distribute them more widely . . . . .	3	5	4
Discontinue them, use money elsewhere . . . . .	1	1	1
Miscellaneous suggestions . . . . .	6	9	7
Can't think of any ways . . . . .	72	73	73

# Percentages based on number familiar.

## Percentages based on number who say they usually or sometimes are helpful.

J. Information desired in monograph on  
"Complete Physical in Dr.'s Office"  
(Q.37-A)

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
Vaginal, pelvic exam, Pap test. . . . .	6%	11%	8%
Proctoscopic, rectal exams. . . . .	3	7	4
Laboratory procedures: cytology . . . . .	7	7	7
General cancer diagnostic techniques. . . . .	12	9	11
Diagnostic techniques in general. . . . .	10	8	9
Checklist of items in complete exam. . . . .	19	16	18
How to educate public on need for exam. . . . .	2	2	2
Educate doctors on need for exams . . . . .	2	4	2
Miscellaneous suggestions . . . . .	5	8	6
Don't know, can't think of any. . . . .	24	25	24
Not needed, doctors know all this . . . . .	24	25	25

K. Degree of need for new materials on  
"Complete Physical" (Q.37-B)

Great need. . . . .	22%	14%	20%
Some need . . . . .	37	40	38
Hardly any need . . . . .	37	37	37
Don't know. . . . .	4	9	5

L. Reasons for need or lack of it(Q.37-C)

Not enough material on this . . . . .	2%	1%	1%
Other material not adequate . . . . .	2	2	2
Need for up-to-date material. . . . .	19	16	18
Doctors need reminding on this. . . . .	26	26	26
Needed to help diagnosis, detection . . . . .	3	1	2
Need a standardized routine . . . . .	2	4	3
Need to educate patients on it. . . . .	4	4	4
Miscellaneous reasons it's needed . . . . .	1	1	1
Doctors know all about this . . . . .	24	25	25
Doctors won't change their routines . . . . .	3	5	3
Other material available on it. . . . .	10	8	9
There's nothing new to report . . . . .	2	3	2
Misc. reasons it's not needed . . . . .	1	-	*
Don't know, no reason . . . . .	10	13	11

M. Information desired in monograph  
on "Cytology" (Q.38-A)

How to take specimen, prepare smear . . . . .	15%	14%	14%
Interpretation, diagnosis . . . . .	11	13	11
Photographs, pictures, slides . . . . .	5	4	5
How to do it yourself, in office. . . . .	4	3	4
The uses of cytology. . . . .	5	7	6
Reliability of the technique. . . . .	5	9	6
New information generally . . . . .	9	13	10
Miscellaneous suggestions . . . . .	2	5	3
No interest, nothing. . . . .	34	33	34
Don't know. . . . .	19	13	17

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>N. Degree of need for new materials on "Cytology" (Q.38-B)</b>			
Great need. . . . .	27%	24%	26%
Some need . . . . .	33	31	32
Hardly any need . . . . .	28	30	29
Don't know. . . . .	12	15	13
<b>O. Reasons for need or lack of it (Q.38-C)</b>			
Need simple, summarized info. . . . .	9%	5%	7%
Doctors not aware of its value,uses . . . . .	7	18	11
Needed for general education. . . . .	19	15	18
Need info. on new developments . . . . .	21	20	21
Miscellaneous reasons it's needed . . . . .	3	1	3
Doctors already know about this . . . . .	10	21	13
This is the pathologist's job . . . . .	24	21	23
Misc. reasons it's not needed . . . . .	4	2	4
Don't know, no reason . . . . .	12	8	11
<b>P. Cancer films seen in last year (Q.40)</b>			
Film on breast self-examination . . . . .	13%	15%	14%
Film on cancer of cervix,Pap smear. . . . .	11	10	10
Film on cancer of colon, rectum . . . . .	3	3	3
Film on lung cancer . . . . .	7	6	6
"You and the Patient" . . . . .	*	-	*
Film on cancer in general . . . . .	3	4	3
ACS public education film . . . . .	4	6	4
Miscellaneous ACS films . . . . .	12	12	12
Non-ACS cancer film . . . . .	3	4	4
Don't know, can't describe. . . . .	16	21	18
No cancer films seen in last year . . . . .	49	42	46
<b>Q. Where cancer films were seen(Q.40-A) #</b>			
National,state,regional meetings. . . . .	31%	28%	30%
County, local medical meetings. . . . .	19	7	15
AAGP or state GP chapters . . . . .	3	-	2
Specialist society meetings . . . . .	4	17	8
Hospital staff meetings . . . . .	40	42	40
American or local cancer soc.meetings . . . . .	4	9	6
Grad. or post-grad. medical assembly . . . . .	2	2	2
Non-professional meetings . . . . .	9	12	10
Miscellaneous places. . . . .	2	2	2
Don't know, can't remember. . . . .	5	5	5

# Percentages based on number who saw one or more films.

	Non-Specialists	Specialists	All Doctors Interviewed
<b>R. Things liked about cancer films (Q.40-B) #</b>			
Clear, vivid, simple presentation . . . . .	21%	14%	19%
Emphasis on early diag., treatment. . . . .	5	5	5
Diag. procedures, exam. techniques. . . . .	9	8	9
Methods of treatment. . . . .	6	6	6
Importance of gen. physical exam. . . . .	*	2	1
Educates laymen, dispels fear . . . . .	14	12	14
Miscellaneous things liked. . . . .	4	1	3
All good, general approval. . . . .	23	31	26
Don't know, can't remember. . . . .	31	30	31
<b>S. Things not liked about cancer films (Q.40-C) #</b>			
Too detailed, technical . . . . .	1%	3%	1%
Not detailed, technical enough. . . . .	-	2	1
Poor narration, color, presentation . . . . .	1	3	2
Same old stuff, nothing new . . . . .	2	8	4
Miscellaneous things disliked . . . . .	4	6	4
Nothing disliked, liked it all. . . . .	25	27	26
Don't know, can't remember. . . . .	69	56	64
<b>T. Should more doctors see these films? (Q.40-D) #</b>			
Yes . . . . .	88%	84%	86%
No. . . . .	7	10	8
Don't know. . . . .	5	6	6
<b>U. How might this be done (Q.40-E) ##</b>			
Show them at national, state meetings. . . . .	24%	28%	25%
Show them at local, county meetings . . . . .	20	22	20
Show them at hospital meetings. . . . .	38	40	39
Put them on closed circuit TV . . . . .	4	-	3
Better facilities for exhibition at medical meetings . . . . .	-	3	1
Miscellaneous suggestions . . . . .	9	13	10
Don't know. . . . .	23	21	22
<b>V. Where cancer exhibits were seen (Q.41)</b>			
National, state, regional meetings. . . . .	42%	46%	43%
Local, county medical meetings. . . . .	9	6	8
AAGP or state GP chapters . . . . .	10	4	8
Specialist society meetings . . . . .	2	22	9
Hospital staff meetings . . . . .	6	6	6
American or local cancer soc. meetings . . . . .	1	3	1
Grad. or post-grad. medical assembly. . . . .	3	6	4
Miscellaneous places. . . . .	3	2	3
Don't know, can't remember. . . . .	3	3	3
No cancer exhibits seen in last year. . . . .	42	29	38

# Percentages based on number who saw one or more films.  
 ## Percentages based on number answering "Yes" to Q. 40-D above.

	Non- <u>Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>W. <u>Things especially liked about cancer exhibits (Q.41-A)</u></b> #			
Presentation, way it was displayed . . .	13%	11%	12%
Materials on diagnosis, symptoms. . .	12	8	10
Materials on examination techniques . . .	4	4	4
Materials on methods of treatment . . .	4	3	4
References to lung cancer exhibit . . .	2	1	2
Miscellaneous things liked. . . . .	1	1	1
All good, general approval. . . . .	24	30	26
Don't know, can't remember. . . . .	48	46	47
<b>X. <u>Things about exhibits not liked so much (Q.41-B)</u></b> #			
Too technical, too detailed . . . . .	2%	3%	2%
Exhibit otherwise not clear . . . . .	2	2	2
Nothing new, same old stuff . . . . .	6	4	5
Miscellaneous things disliked . . . . .	2	7	3
Nothing disliked, liked it all. . . . .	13	13	13
Don't know, can't remember. . . . .	76	73	75
<b>Y. <u>Should more doctors see these exhibits? (Q.41-C)</u></b> #			
Yes . . . . .	77%	83%	79%
No. . . . .	16	7	13
Don't know. . . . .	7	10	8
<b>Z. <u>How might this be done? (Q.41-D)</u></b> ##			
Show them at national, state meetings. . .	18%	17%	17%
Show them at local, county meetings . . .	17	9	14
Show them at hospital meetings. . . . .	21	21	21
Put them on closed circuit TV . . . . .	1	4	2
Put them in convenient, accessible locations wherever shown. . . . .	2	4	3
Advertise, publicize, then more. . . . .	4	4	4
Get doctors to attend more meetings . . .	20	15	18
Miscellaneous suggestions . . . . .	6	12	8
Don't know. . . . .	30	30	30
<b>AA. <u>Amount of emphasis on cancer at medical meetings in general (Q.42)</u></b>			
Too much. . . . .	3%	1%	2%
About right . . . . .	72	78	74
Not enough. . . . .	22	19	21
Don't know. . . . .	3	2	2

# Percentages based on number who saw one or more exhibits.

## Percentages based on number answering "Yes" to Q. 41-C above.

BB. <u>Kinds of meetings which need more emphasis on cancer (Q.42-A)</u>	Non-Specialists		All Doctors Interviewed
	#	Specialists	
National, state medical meetings. . . . .	17%	32%	21%
County, local medical meetings. . . . .	26	23	25
AAGP, meetings for G.P.'s . . . . .	3	14	6
Specialist meetings . . . . .	4	11	6
Hospital staff meetings . . . . .	30	30	30
Miscellaneous . . . . .	2	2	2
All medical meetings, all kinds . . . . .	30	20	27
Don't know. . . . .	3	2	3

CC. <u>Kinds of materials or program needed at meetings (Q.42-B)</u>	Non-Specialists		All Doctors Interviewed
	#	Specialists	
Case history presentations. . . . .	24%	23%	23%
Diagnosis, detection, danger signals. . . . .	19	14	17
Diagnostic, examination techniques. . . . .	5	14	7
Clinical, pathological findings . . . . .	7	2	5
Treatment procedures. . . . .	10	16	11
New research, new developments. . . . .	5	20	9
Whole program on one specific site. . . . .	9	2	7
Miscellaneous content . . . . .	11	2	9
General, round-table discussion . . . . .	17	5	13
Lectures, papers by specialists . . . . .	24	23	23
Pamphlets, written material . . . . .	2	2	2
Slides. . . . .	9	-	6
Specimens, Exhibits . . . . .	13	7	11
Films . . . . .	25	27	26
Television. . . . .	2	-	1
Show actual patients. . . . .	7	5	6
Misc. methods of presentation . . . . .	1	5	2
Don't know. . . . .	10	20	13

DD. <u>Attitude toward ACS professional education program (Q.43-A)</u>	Non-Specialists		All Doctors Interviewed
	#	Specialists	
Strongly approve. . . . .	44%	49%	45%
Approve . . . . .	50	44	48
Disapprove. . . . .	2	3	2
Strongly disapprove . . . . .	1	-	1
No opinion. . . . .	3	4	4

# Percentages based on number answering "Not enough" to Q. 42.

/ The first group of answers refer to desired content of programs, the second group refer to ways in which it should be presented. Some doctors answered in terms of content, some in terms of presentation, and many in terms of both.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>EE. Reasons for approval or disapproval (Q.43-B)</b>			
The info. is educational, useful . . .	36%	31%	34%
It's the only or best source of info.	10	16	12
Has increased interest, awareness . .	14	12	14
Has promoted early diagnosis. . . . .	13	10	12
Has informed drs. on treatment. . . . .	5	3	4
Provides up-to-date research info . .	22	20	21
Info. concise, authentic, convenient . .	11	13	11
Misc. reasons for approval. . . . .	2	3	2
Disapprove: info. available elsewhere.	2	1	2
Misc. reasons for disapproval . . . . .	4	6	5
Don't know, no special reason . . . . .	10	10	10
<b>FF. Most important part of program (Q.43-C) #</b>			
CA. . . . .	45%	31%	41%
Monographs. . . . .	19	25	21
Films . . . . .	19	17	18
Exhibits. . . . .	6	9	7
Don't know. . . . .	11	18	13
<b>GG. Least important part of program (Q.43-D) #</b>			
CA. . . . .	5%	10%	6%
Monographs. . . . .	16	10	14
Films . . . . .	13	14	14
Exhibits. . . . .	36	37	36
Don't know. . . . .	30	29	30
<b>III. Attitudes toward ACS public education program (Q.44-A)</b>			
Strongly approve. . . . .	39%	37%	38%
Approve . . . . .	42	49	44
Disapprove. . . . .	9	5	8
Strongly disapprove . . . . .	5	2	4
Don't know. . . . .	5	7	6

# Percentages based on number of doctors who approve of program.

Non-Specialists                      Specialists                      All Doctors Interviewed

II. Reasons for approval or disapproval (Q.44-B)

Encourages preventive checkups. . . . .	10%	11%	11%
Encourages earlier doctor visits . . . . .	26	23	25
Teaches people cancer symptoms. . . . .	15	13	15
Encourages better attitude. . . . .	8	7	7
Educates people generally . . . . .	22	19	22
Good approach, avoids hysteria. . . . .	4	12	6
Misc. reasons for approval. . . . .	3	2	3
Disapprove: it arouses fear . . . . .	19	23	21
Makes them afraid to see doctor . . . . .	2	1	2
It exaggerates the danger . . . . .	7	10	8
Public doesn't understand, act on it . . . . .	5	2	4
Makes people distrust doctor. . . . .	2	1	2
Misc. reasons for disapproval . . . . .	5	3	4
Don't know, no special reason . . . . .	5	8	6

BELIEFS AND PRACTICES WITH RESPECT TO CERTAIN DIAGNOSTIC PROCEDURES

Approximately one-fifth of the interview schedule was devoted to questions about the doctors' behavior and attitudes concerning various examination procedures recommended by the Society. These included preventive checkups, rectal examinations, chest X-rays, breast self-examination, pelvic exams and Pap smears.

Most of these questions had never before been systematically explored, and the data to be presented in this section consequently provide a uniquely valuable description of the present opinions and practices of a cross-section of medical practitioners.

General Physical Examinations

Ten percent of the specialists in the sample report that the nature of their practice does not require them to perform any general examinations. All of the non-specialists interviewed do at least one or two a month.

But the specialists who do give general examinations perform more of them than the GP's do. One-third of the specialists, but only a fourth of the non-specialists, perform as many as 75 per month. Thirty-eight percent of the general practitioners, but only 24% of the specialists, give fewer than 30 a month.

Doctors were asked how many of the general physicals they give are done because the patient has asked for a general checkup. The median estimate is 50%, though the range is a broad one.\* One doctor in five reports that fewer than 20% of his examinations are made on the initiative of the patient; one doctor in four says that three-fourths or more of his exams are made because the patient has asked for it. Non-specialists report a somewhat higher proportion of their exams to be done at the patient's request.

Over a third of the specialists (35%) give exams of one hour or longer, but only one non-specialist in five (21%) gives an exam of that duration. The median time reported by GP's was half an hour, by specialists 45 minutes.

That the specialist gives a more comprehensive general physical is indicated also by the proportion who include "routinely" each of twelve separate procedures inquired about. Except for auscultation of the chest and examination of the urine, which are performed equally often by both types of doctor, the specialists were more likely on each item to report routine performance.

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\* This and other estimates of medians in this section are approximations, since replies were grouped in the coding process. In this case, the median is toward the low end of the 50-59% interval.

Six of the twelve items were reported as routine by 80% or more of the general practitioners. They were auscultation of the chest (96%), palpation of various parts of the body (87%), complete medical history (87%), laboratory examination of the urine (87%), inspection of body orifices (86%), and visual inspection of the entire body surface (80%).

Three others are performed routinely by a majority of the non-specialists: pelvic examination (73%), digital rectal examination (68%), and laboratory examination of the blood (58%). The other three procedures are performed routinely by only a small proportion of GP's: chest X-ray (21%), proctoscopy (11%), and laboratory examination of the feces (4%).

Three out of every five general practitioners (58%) perform no more than eight of these twelve tests in their routine examinations. Of the specialists, three-fourths (75%) perform eight or more routinely, and almost two-thirds (64%) perform nine or more of the twelve. Only 7% of all doctors and 13% of the specialists routinely give as many as eleven of the twelve.

Three doctors in every four of those interviewed believe that all adults should get an annual checkup even if they are feeling all right. An additional 15% say it depends -- primarily on age. One doctor in nine expresses the view that such examinations are unnecessary unless the patient has some complaint.

While specialists and non-specialists believe about equally in the advisability of annual checkups, more specialists (72%) than GP's (61%) say they actually recommend the procedure to most of their patients.

#### Rectal Examinations

Asked to estimate the average number of digital rectal examinations they perform in a month, doctors gave a median estimate of approximately 40. Only about one in ten performs fewer than ten digital rectals a month and only 2% do none at all.

A sizeable majority of specialists (63%) say that the occasion for this examination is a routine part of the general physical, while a somewhat smaller majority of non-specialists (52%) perform the test in the absence of any complaint.

Two of every three doctors, including 65% of the GP's, say they perform proctoscopic examinations.\* Only 14% apply this test routinely; it is usually reserved for cases involving complaints or symptoms of the rectum or bowel (46%), or instances in which the digital examination indicates a need for proctoscopy.

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\* Interviewers noted some confusion over the meaning of "proctoscopic" in this question. Apparently some doctors interpreted it broadly to include allied instruments such as the anoscope, while others accepted the question literally.

Among the minority of doctors who do not practice proctoscopy, general practitioners are more likely to ascribe it to lack of equipment or lack of training and experience, while specialists more often explain that the occasion for it does not arise in their type of practice.

Practically every doctor who does not do proctoscopies himself refers his patients to another doctor for it. Only 1% of the total group of physicians neither do the examination themselves nor make referrals for it.

Two-thirds of all doctors interviewed endorse the principle of annual rectal examinations for all adults. Specialists (73%) are slightly more favorable to the idea than non-specialists (66%). Among both groups those who disapprove usually state that such frequent examinations are required only if there is some symptom or complaint, or only in the case of older persons.

#### The Chest X-ray

A large majority of physicians (77%) approve of the annual chest X-ray for all men over 45, and an additional 10% of all doctors approve if the patient is a cigarette smoker. There are no differences between specialists and non-specialists on these questions.

The minority of doctors who disapprove say most frequently that annual chest X-rays are needed only if there is some complaint, but another reason offered by large numbers is the danger of harmful radiation effects as a result of such frequent exposure. Among specialists, this reason is given more often than any other.

Two-thirds of all doctors who have adult male patients say they make a point of recommending annual chest X-rays to all, or to the smokers among them.

#### Breast Self-Examination

Eighty percent of both specialists and non-specialists answer affirmatively to the question, "Do you think all women should examine their own breasts once a month?", and 71% of both groups say they usually encourage their own patients to do this.

The majority of those who oppose breast self-examination express the belief that it causes undue worry and anxiety and in some cases gives the woman a neurotic concern about cancer.

### Pelvic Examinations

Almost half of all doctors with women patients (46%) report that "many" of them come in for an annual pelvic examination. Only 15% say this is "unusual."

Three-quarters of the physicians say that all women should have an annual pelvic examination, and 62% state that they make a point of recommending this to most of their patients. The one doctor in four who disapproves of the routine annual pelvic for all usually explains that the examination is not necessary in the case of young unmarried women.

Specialists, more often than non-specialists, say that many of their women patients come in for such exams, agree that all women should receive the examination annually, and state that they recommend it to most of their patients.

Doctors were asked to estimate the frequency with which they perform three specific procedures during a routine pelvic exam. The three were a digital vaginal examination, a cervical inspection, and a cervical smear. Five out of every six say they always perform the first two tests (83% and 85% respectively), but only 19% say they always take the smear.

Specialists, more often than general practitioners, report routine performance of all three procedures, but only a third of these always take the smear, and only 29% routinely include all three procedures when they do a pelvic. Only 12% of the general practitioners always include all three.

Fifty-seven percent of the total sample say that at least some of their women patients request the Pap smear, but 42% report that this is "unusual." Only 13% say that "many" of their patients make this request. Again, specialists report a somewhat higher frequency of requests than general practitioners do.

Specialists are also more likely to make a point of recommending the smear to most of their women patients. Over half of this group, but only a third of the non-specialists, say they do this.

Among both groups, those who do not recommend it routinely most often explain that they do so only if symptoms or some other indication suggests a need. The second most frequently offered reason is that their patients cannot afford this test routinely.

One doctor in five says he takes no Pap smears at all in an average month. More than half the specialists (51%), but only 36% of the general practitioners, take as many as ten per month.

Most of the specialists who take none explain that the need does not arise because of the nature of their practice; the non-specialists most usually say that they refer the patient elsewhere. Only 2% of the total group express lack of confidence in the reliability of the test and none of these are specialists.

Scarcely any doctors report dissatisfaction with the services available to them for interpreting cervical smears. Excluding those who never take any smears, only one doctor in fourteen (7%) voices any complaint.

IV. BELIEFS AND PRACTICES WITH RESPECT TO CERTAIN DIAGNOSTIC PROCEDURES

T A B L E S

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>A. <u>Average number of physical exams done in a month (Q.17-A)</u></b>			
None. . . . .	-%	10%	3%
1-9 . . . . .	9	6	8
10-19 . . . . .	14	5	11
20-29 . . . . .	15	13	15
30-49 . . . . .	14	17	15
50-74 . . . . .	17	11	15
75-99 . . . . .	9	12	10
100-199 . . . . .	11	16	13
200 or more . . . . .	6	5	5
Can't estimate. . . . .	5	5	5
<b>B. <u>Number of these which are requested by patient (Q.17-B)</u></b> #			
None. . . . .	3%	10%	5%
1-4 . . . . .	17	8	14
5-9 . . . . .	17	11	15
10-14 . . . . .	13	12	13
15-19 . . . . .	7	7	7
20-29 . . . . .	12	19	14
30-49 . . . . .	14	13	14
50-99 . . . . .	9	13	10
100 or more . . . . .	2	2	2
Can't estimate. . . . .	6	5	6
<b>C. <u>Proportion of all exams requested by patient (Qs.17-AB)</u></b> #			
None. . . . .	3%	10%	5%
1-19% . . . . .	20	15	19
20-29% . . . . .	12	13	12
30-49% . . . . .	10	16	12
50-59% . . . . .	23	16	21
60-74% . . . . .	4	8	5
75-99% . . . . .	15	9	13
100% . . . . .	13	13	13
<b>D. <u>Average time a general exam takes the doctor (Q.17-C)</u></b> #			
Less than 20 minutes. . . . .	9%	5%	8%
20-29 minutes . . . . .	17	12	16
30-44 minutes . . . . .	35	30	34
45-59 minutes . . . . .	16	17	16
60-74 minutes . . . . .	15	18	16
More than 75 minutes. . . . .	6	17	9
Can't estimate. . . . .	2	1	1

# Percentages exclude those specialists who do not do physical exams.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>E. <u>Complete medical history (Q.17-D-1)</u></b> #			
Taken routinely . . . . .	87%	95%	89%
On some patients. . . . .	11	4	9
Usually not at all. . . . .	2	1	2
<b>F. <u>Visual inspection of entire body surface (Q.17-D-2)</u></b> #			
Performed routinely . . . . .	80%	90%	83%
On some patients. . . . .	17	8	14
Usually not at all. . . . .	3	2	3
<b>G. <u>Inspection of body orifices(Q.17-D-3)</u></b> #			
Performed routinely . . . . .	86%	90%	87%
On some patients. . . . .	13	10	12
Usually not at all. . . . .	1	-	1
<b>H. <u>Palpation of breasts, neck, axillae, abdomen, genitalia, etc. (Q.17-D-4)</u></b> #			
Performed routinely . . . . .	89%	97%	91%
On some patients. . . . .	10	3	8
Usually not at all. . . . .	1	-	1
<b>I. <u>Auscultation of chest (Q.17-D-5)</u></b> #			
Performed routinely . . . . .	96%	96%	96%
On some patients. . . . .	4	3	4
Usually not at all. . . . .	*	1	*
<b>J. <u>Digital-rectal exam (Q.17-D-6)</u></b> #			
Performed routinely . . . . .	68%	83%	72%
On some patients. . . . .	30	16	26
Usually not at all. . . . .	2	1	2
<b>K. <u>Proctoscopy (Q.17-D-7)</u></b> #			
Performed routinely . . . . .	11%	17%	13%
On some patients. . . . .	55	61	57
Usually not at all. . . . .	34	22	30
<b>L. <u>Pelvic examination (Q.17-D-8)</u></b> #			
Performed routinely . . . . .	73%	84%	76%
On some patients. . . . .	25	14	22
Usually not at all. . . . .	2	2	2
<b>M. <u>Chest X-ray (Q.17-D-9)</u></b> #			
Performed routinely . . . . .	21%	36%	26%
On some patients. . . . .	60	49	57
Usually not at all. . . . .	19	14	17

# Percentages exclude those specialists who do not do physical exams.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>N. <u>Laboratory exam of blood (Q.17-D-10)</u> #</b>			
Performed routinely . . . . .	58%	73%	62%
On some patients. . . . .	32	25	30
Usually not at all. . . . .	10	2	8
<b>O. <u>Laboratory exam of urine (Q.17-D-11)</u> #</b>			
Performed routinely . . . . .	87%	86%	87%
On some patients. . . . .	11	12	11
Usually not at all. . . . .	2	1	2
Can't answer. . . . .	-	1	*
<b>P. <u>Laboratory exam of feces (Q.17-D-12)</u> #</b>			
Performed routinely . . . . .	4%	17%	8%
On some patients. . . . .	59	55	58
Usually not at all. . . . .	36	28	33
Can't answer. . . . .	1	-	1
<b>Q. <u>Number of these 12 procedures performed "routinely" (Q.17-D)</u> #</b>			
Less than five. . . . .	10%	5%	9%
Five. . . . .	7	3	6
Six . . . . .	10	8	9
Seven . . . . .	13	9	12
Eight . . . . .	19	11	17
Nine. . . . .	23	26	24
Ten . . . . .	12	25	16
Eleven or twelve. . . . .	6	13	7
<b>R. <u>Should adults get annual checkups even if they feel well? (Q.17-E)</u></b>			
Should get exam anyway. . . . .	73%	77%	74%
Not unless some complaint . . . . .	12	9	11
Depends . . . . .	15	14	15
<b>S. <u>Do you make a point of recommending regular checkups? (Q.17-F)</u></b>			
Recommend to most patients. . . . .	61%	72%	64%
Only to some patients . . . . .	22	14	19
Hardly ever recommend them. . . . .	5	5	6
Don't approve of checkups (Q.17-E). . . . .	12	9	11

# Percentages exclude the 10% of specialists who do not do physical exams.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>T. Average number of digital rectal exams performed per month (Q.18)</b>			
None. . . . .	1%	4%	2%
Less than 10. . . . .	10	6	9
10-19 . . . . .	18	7	15
20-29 . . . . .	11	11	11
30-49 . . . . .	14	17	15
50-74 . . . . .	16	12	14
75-99 . . . . .	7	7	7
100-149 . . . . .	12	12	12
150 or more . . . . .	8	16	10
Can't estimate. . . . .	3	8	5

<b>U. Under what circumstances is digital rectal performed? (Q.18-A)</b>			
Routinely . . . . .	52%	63%	55%
Rectal or bowel complaints, symptoms.	67	45	60
Genito-urinary complaints (male or unspecified) . . . . .	25	10	20
Female genito-urinary complaints, or as part of pelvic exam . . . . .	16	13	15
Misc. complaints: abdominal, etc. . . . .	12	11	12
When symptoms indicate (unspecified).	11	12	11
When history indicates need for it. . . . .	6	6	6
Routinely on older people . . . . .	9	6	8
Routinely on males. . . . .	7	6	7
Misc. circumstances . . . . .	3	4	3
Don't know, can't answer. . . . .	-	1	*
Don't give digital rectal exams . . . . .	1	4	2

<b>V. Do you do proctoscopic exams? (Q.19)</b>			
Yes . . . . .	65%	69%	67%
No. . . . .	35	31	33

<b>W. Under what circumstances is proctoscopy performed (Q.19-A)</b>			
Routinely . . . . .	11%	18%	14%
Rectal or bowel complaints, symptoms . . . . .	47	46	46
Misc. complaints: abdominal, etc. . . . .	7	8	7
When symptoms indicate (unspecified).	8	9	9
When history indicates need for it. . . . .	5	7	5
When digital exam indicates need. . . . .	11	8	10
With barium enemas . . . . .	1	3	1
Routinely on older people . . . . .	2	4	2
Misc. circumstances . . . . .	4	4	4
Don't know, can't answer . . . . .	1	1	1
Don't give proctoscopic exams . . . . .	35	31	33

	Non- <u>Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>X. <u>Reasons proctoscopy is not performed (Q.19-B)</u></b> #			
Not qualified to do it. . . . .	29%	18%	26%
Don't have equipment, facilities. . .	30	12	25
Don't have the time or help . . . . .	9	4	7
It's a job for a proctologist . . . . .	7	15	10
Refer them elsewhere(no reason given)	26	22	25
Use a different procedure instead . .	6	7	7
Have it done in hospital instead. . .	9	4	7
Need doesn't arise, outside my field.	1	31	10
Misc. reasons . . . . .	1	-	1
Don't know. . . . .	1	1	1
<b>Y. <u>Are patients referred elsewhere for proctoscopy? (Q.19-C)</u></b> #			
Yes . . . . .	96%	95	96%
No. . . . .	4	5	4
<b>Z. <u>Should all adults have annual rectal exam? (Q.20)</u></b>			
Yes . . . . .	66%	73%	68%
No. . . . .	33	27	31
Don't know. . . . .	1	-	1
<b>AA. <u>Reasons annual rectal exam is not necessary (Q.20-A)</u></b> ##			
Needed only if symptoms . . . . .	45%	36%	42%
Younger people don't need it. . . . .	30	34	31
Women don't need it . . . . .	6	3	5
Not enough time, facilities . . . . .	5	8	6
Too expensive for patient . . . . .	4	2	4
Incidence of disease not high enough.	12	8	11
Dr. should determine need for it. . .	4	7	4
Would upset, worry the patient. . . .	4	3	4
Misc. reasons . . . . .	2	3	2
Don't know. . . . .	2	2	2

# Percentages based on number who do not perform proctoscopic examinations.  
## Percentages based on number who oppose annual rectal examinations for all adults.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>BB. Should all men over 45 get annual chest X-ray? (Q.21)</b>			
Yes . . . . .	77%	77%	77%
No. . . . .	22	22	22
Don't know. . . . .	1	1	1

<b>CC. Reasons annual chest X-ray is not necessary for all men over 45 (Q.21-A) #</b>			
Needed only if symptoms . . . . .	44%	26%	38%
Dr. should determine need for it. . .	7	10	8
Not enough time, facilities . . . . .	4	2	3
Too expensive for patient . . . . .	9	4	8
Incidence not great enough. . . . .	9	16	11
Fluoroscope is sufficient . . . . .	3	4	3
Only if man is heavy smoker . . . . .	8	16	11
Would upset, worry the patient. . . .	3	4	3
X-rays not conclusive . . . . .	7	6	6
Danger of harmful radiation . . . . .	21	32	25
Once a year is too often. . . . .	5	4	4
Misc. reasons . . . . .	3	4	3
Don't know. . . . .	2	6	3

<b>DD. Should all men over 45 who smoke cigarettes get annual chest X-ray? (Q.21-B, asked of "No" group in Q.21)</b>			
Yes . . . . .	9%	11%	10%
No. . . . .	12	10	11
Don't know. . . . .	1	1	1

<b>EE. Do you make a point of recommending regular chest X-rays (Q.21-C asked of "Yes" groups in Qs. 21 &amp; 21-B) ##</b>			
Yes . . . . .	65%	68%	66%
No. . . . .	21	20	21
Don't approve of annual X-rays. . . .	12	10	11
No opinion. . . . .	2	2	2

<b>FF. Should all women examine their breasts once a month? (Q.22)</b>			
Yes . . . . .	80%	80%	80%
No. . . . .	19	18	19
Don't know. . . . .	1	2	1

# Percentages based on number who oppose annual chest X-rays for all men over 45.  
 ## Excludes 10% of the specialists who have no adult male patients.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>GG. Do you encourage your patients to do this? (Q.22-A)</b>			
Yes . . . . .	71%	71%	71%
No. . . . .	9	9	9
Don't approve of self-examination . .	19	18	19
No opinion. . . . .	1	2	1
<b>HH. Reasons breast self-examination is not necessary (Q.22-B) #</b>			
Needed only if symptoms . . . . .	2%	2%	2%
Makes them neurotic, anxious. . . . .	63	54	60
Self-exam is not adequate . . . . .	21	32	24
They may harm themselves. . . . .	9	2	7
Doctor should examine periodically. .	6	22	11
Can give false sense of security. . .	2	2	2
Once a month is too often . . . . .	19	20	19
Misc. reasons . . . . .	3	-	2
Don't know. . . . .	1	-	1
<b>II. Do many women come in for annual pelvic exam? (Q.23-A) ##</b>			
Many do . . . . .	43%	54%	46%
Some do . . . . .	41	34	39
This is unusual . . . . .	16	12	15
<b>JJ. Cervical smear (Q.23-B-1) ##</b>			
Always taken in pelvic exam . . . . .	14%	32%	19%
Almost always . . . . .	16	22	17
Sometimes taken . . . . .	49	25	42
Very seldom . . . . .	11	13	12
Never taken . . . . .	10	8	10
<b>KK. Digital-vaginal exam (Q.23-B-2) ##</b>			
Always taken in pelvic exam . . . . .	80%	89%	83%
Almost always . . . . .	10	7	9
Sometimes taken . . . . .	7	2	5
Very seldom . . . . .	2	1	2
Never taken . . . . .	1	1	1
<b>LL. Cervical inspection (Q.23-B-3) ##</b>			
Always performed in pelvic exam . . .	82%	92%	85%
Almost always . . . . .	10	5	9
Sometimes . . . . .	4	1	3
Very seldom . . . . .	2	1	2
Never . . . . .	2	1	1

# Percentages based on number who do not think it necessary.  
 ## Excludes the 7% of specialists who do not treat women.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
MM. <u>Number of these 3 procedures "always" included in routine pelvic (Q.23-B)</u> #			
None . . . . .	14%	14%	14%
One . . . . .	9	4	8
Two . . . . .	65	53	61
Three . . . . .	12	29	17
NN. <u>Should all women have annual pelvic exam? (Q.24)</u>			
Yes . . . . .	72%	83%	76%
No. . . . .	27	17	24
Don't know. . . . .	1	-	*
OO. <u>Do you make a point of recommending annual pelvics to patients? (Q.24-A)</u> #			
To most patients. . . . .	58%	70%	62%
Only to some patients . . . . .	10	10	10
Hardly ever recommend them. . . . .	4	3	4
Don't approve of annual pelvics . . . . .	27	17	24
Don't know. . . . .	1	-	*
PP. <u>Reasons annual pelvics are not necessary (Q.24-B)</u> ##			
Needed only if symptoms . . . . .	19%	10%	17%
Dr. should determine need for it. . . . .	1	3	1
Needed only for married women, older women, mothers. . . . .	72	54	68
Not enough time, facilities . . . . .	2	8	3
Women would object, wouldn't do it. . . . .	4	-	3
Incidence not great enough. . . . .	2	15	5
Makes them neurotic, anxious. . . . .	4	13	6
Once a year is too often. . . . .	2	-	2
Misc. reasons . . . . .	1	13	3
QQ. <u>Do many patients request the Pap smear? (Q.25)</u> #			
Many do . . . . .	11%	18%	13%
Some do . . . . .	41	50	44
It is unusual . . . . .	47	32	42
Don't know. . . . .	1	-	1

# Excludes the 7% of specialists who do not treat women.

## Percentages based on number who disapprove of annual pelvics for all women.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>RR. Do you make a point of recommending Pap smears to patients? (Q.26)</b>	#		
Recommend to most . . . . .	34%	53%	40%
Only to some. . . . .	46	34	42
Hardly ever recommend them. . . . .	19	13	17
Don't know. . . . .	1	-	1

<b>SS. Why are Pap smears not recommended to most women patients? (Q.26-A)</b>	##		
Recommend only if symptoms. . . . .	16%	6%	13%
Determine need for it by other means. . . . .	23	39	27
Only for older women. . . . .	14	14	14
Not enough time, facilities . . . . .	8	4	7
Patients can't afford it routinely. . . . .	22	21	22
Incidence not great enough. . . . .	3	2	3
Makes them neurotic, anxious. . . . .	3	2	3
Not convinced of value of test. . . . .	15	13	14
Refer this to specialist. . . . .	4	11	6
Misc. reasons . . . . .	5	2	4
Don't know. . . . .	7	5	6

<b>TT. Number of Pap smears taken in average month (Q.27)</b>			
None. . . . .	20%	20%	20%
Less than 5 . . . . .	29	13	24
5-9 . . . . .	14	11	13
10-19 . . . . .	19	18	18
20-29 . . . . .	8	12	9
30 or more. . . . .	9	21	13
Can't estimate. . . . .	1	5	3

<b>UU. Reasons for taking no Pap smears (Q.27-A)</b>	###		
Not qualified, don't know enough about it. . . . .	9%	4%	7%
Don't have facilities, lab. . . . .	14	9	12
It's a job for a specialist . . . . .	6	2	5
Refer them to hospital or lab . . . . .	20	15	19
Refer them to some other doctor . . . . .	26	26	26
Prefer a different technique. . . . .	15	-	10
Need doesn't arise, outside my field . . . . .	5	52	21
Costs too much. . . . .	6	-	4
Patients don't need them. . . . .	3	-	2
Misc. reasons . . . . .	5	-	4
Don't know. . . . .	2	-	1

# Excludes the 7% of specialists who do not treat women.  
 ## Percentages based on number who only sometimes or hardly ever recommend them.  
 ### Percentages based on number who take no Pap smears.

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
VV. <u>Satisfaction with services available for interpreting smears (Q.27-B)</u> #			
Satisfied . . . . .	91%	93%	92%
Not satisfied . . . . .	8	6	7
Don't know. . . . .	1	1	1
WW. <u>Reasons for dissatisfaction with services available (Q.27-C)</u> ##			
Costs are too high. . . . .			20%
Takes too long to get reports . . . . .			30
Inconvenience of mailing, of getting smears to the lab . . . . .			38
Have to send them away, no lab or pathologist nearby. . . . .			17
No confidence in the findings, pathologists differ. . . . .			28
Don't know or criticisms of Pap smear technique . . . . .			8

# Percentages based on number who take smears.

## Percentages based on number who are dissatisfied with service. There are too few such cases to report separately for non-specialists and specialists.

### SMOKING BEHAVIOR AND ATTITUDES

While the interview was taking place, just over a third (36%) of the doctors smoked, predominantly cigarettes (31%). But in reply to a question during the interview, 43% of the sample said they smoked cigarettes and another 5% replied that they smoked them occasionally. About a fourth of the doctors (23%) have never smoked, and three out of ten (29%) said they used to but have now given it up.

When the latter group was asked when they stopped, almost four out of ten, or 11% of the total sample, said they gave up cigarettes within the last five years, or since 1954. Only 7% of the total sample stopped smoking during the preceding 5-year period, 1950-1954; and only 11% of the total sample had quit smoking before 1950.

Thus, unless the rate at which people stop smoking accelerates with age, the figures indicate an unusual increase in the proportion of doctors who have given up cigarettes during the last five years.

Although equal numbers of specialists and non-specialists stopped smoking 10 or more years ago, 15% of the specialists but only 10% of the general practitioners have abandoned the habit during the last five years.

### The Relationship Between Smoking and Lung Cancer

One-third of all doctors, specialists and non-specialists alike, believe that cigarette smoking "definitely" is "a major cause" of lung cancer. Almost another third say it "probably" is, so that a total of 64% of the physicians interviewed affirm a causal relationship. Twenty-two percent say it is probably or definitely not a major cause, while 14% express no opinion.

Seven out of ten doctors say that at least some of their patients ask for advice about smoking. Such questions are unusual for only 29% of the sample.

And a third of the doctors say they routinely advise their patients to reduce their smoking or to give it up. Only 8% say they rarely advise against smoking, the majority (58%) reporting that they do so in some circumstances.

The circumstances most usually mentioned are infections or diseases of the upper respiratory tract. Other conditions for which abstinence from smoking is often recommended are chest and lung conditions, heart and cardio-vascular disorders, and gastro-intestinal conditions.

V. SMOKING BEHAVIOR AND ATTITUDES

T A B L E S

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>A. <u>Behavior during interview (Item F)</u></b>			
Doctor smoked cigarette . . . . .	33%	26%	31%
Doctor smoked cigar . . . . .	3	2	2
Doctor smoked pipe. . . . .	3	3	3
Doctor didn't smoke . . . . .	61	69	64
<b>B. <u>Do you smoke cigarettes? Did you ever? (Qs. 52, 52-A)</u></b>			
Yes, regularly. . . . .	44%	40%	43%
Yes, occasionally . . . . .	6	5	5
No, but used to smoke then. . . . .	27	33	29
Never smoked cigarettes . . . . .	23	22	23
<b>C. <u>How long ago did you stop? (asked of those who used to smoke) (Q.52-B)</u></b>			
Less than 3 years ago . . . . .	7%	11%	8%
3 or 4 years ago. . . . .	3	4	3
5 to 9 years ago. . . . .	6	8	7
10 or more years ago. . . . .	11	10	11
<b>D. <u>Is cigarette smoking a major cause of lung cancer? (Q.39-A)</u></b>			
Definitely is . . . . .	32%	33%	33%
Probably is . . . . .	30	32	31
Probably not. . . . .	14	12	13
Definitely not. . . . .	11	6	9
Don't know. . . . .	13	17	14
<b>E. <u>Do patients ask your advice about smoking? (Q.39-B)</u></b>			
Many do . . . . .	29%	34%	30%
Some do . . . . .	42	37	41
This is unusual . . . . .	29	29	29
<b>F. <u>How often do you advise them to cut down or give up smoking (Q.39-C)</u></b>			
Routinely . . . . .	32%	39%	34%
Sometimes . . . . .	60	53	58
Hardly ever . . . . .	8	8	8

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
G. <u>When do you advise this? (Q.39-D)</u> #			
Upper respiratory conditions. . . . .	63%	42%	57%
Lower respiratory conditions. . . . .	39	36	38
Heart, cardio-vascular conditions . . . . .	38	32	36
Vascular, circulatory conditions. . . . .	18	23	20
Loss of weight, lack of appetite. . . . .	9	8	9
Gastro-intestinal conditions. . . . .	29	37	31
When it's causing damage (general). . . . .	3	4	3
Whenever patient seems receptive. . . . .	4	5	4
Heavy smokers, pack a day or more . . . . .	19	22	20
Misc. circumstances . . . . .	16	16	16
Don't know. . . . .	1	3	1

# Percentages based on number who do not advise it routinely.

BACKGROUND CHARACTERISTICS

The first section of this report broadly sketched the professional activities of the sample of doctors who were interviewed on this study. The present section describes their social and demographic characteristics, and the scope and nature of their leisure-time activities.

These latter items were intended to serve a double purpose in the interview schedule. First, they were designed to provide additional information about the sample, thus rounding out the picture of the audience to whom the Society's professional education program is addressed. And secondly, they were to serve as independent variables in the analysis, in the expectation that some of them might explain differences in the doctors' exposure to the program's materials and in their attitudes and professional practices.

It is to be hoped that some of these analyses can be made in the future. Meanwhile, we present here a brief summary of the sample's "background characteristics."

Social and Demographic Characteristics

As might be expected of a mature group of physicians with large practices, the income of these doctors is quite high. Only one in ten told the interviewer he netted less than \$10,000 from his practice during the preceding twelve months, and the majority (51%) placed their income at \$20,000 or more.

Specialists, of course, earned more than non-specialists. One-third of the specialists earned \$30,000 or more, one-third earned between \$20,000 and \$30,000, and only one-third netted less than \$20,000 during the year.

Only one doctor in 25 expresses disappointment with his income, and the lower paid GP's are as likely as the specialists to say they are satisfied with what they are earning.

The sample is overwhelmingly white (96%), male (99%) and native-born (88%). It was reported earlier that only 13% are under 40 years of age, and 20% have passed the age of 60. Two out of three (64%) are Protestant, one in five is Catholic, and 13% are Jewish. Three percent have no religious preference.

Fourteen percent of the sample are sons of physicians, and a total of 29% say their father was engaged in a profession. The fathers of another 25% were business owners or managers. Fifteen percent are sons of farmers. Fewer than a third say their fathers were employed in white- or blue-collar labor.

Consistent with their age, half of the sample received their M.D. prior to 1935, and since the sample was originally drawn in 1955, all have had their medical degrees since that time.

One out of five is a diplomate of an American board. Three-quarters of the diplomates identified themselves as specialists, but the other 24% said their practice is not restricted to their specialty.

Seventy-two percent of the specialists and 57% of the GP's have served in the medical corps of the armed forces.

The sample is national in its scope, conforming closely to the distribution of the general population within the four main geographic regions and four sizes of community.

#### Social, Community and Recreational Activities

The majority of both specialists and non-specialists say they like to discuss medical matters when with other doctors socially. But specialists seem to associate with other doctors during their non-working hours more consistently than GP's do. More non-specialists than specialists report that "hardly any" of the friends they see most often are physicians.

Three-quarters of the sample belong to one or more civic or social organizations in their community and a third of them have at one time or another held office in at least one of them. Over half belong to civic or service groups such as the Chamber of Commerce, Kiwanis, Rotary, the school board, United Fund, etc. Almost a third belong to the Elks, Masons, Shriners or other fraternal order or lodge.

Specialists belong to more organizations than general practitioners do, and are also more likely to have held office in them. Almost half of the GP's (48%) are members of only one organization or none, but two-thirds of the specialists (64%) belong to two or more. Specialists also more often report membership in a health-related organization such as A.C.S., Red Cross or local hospital association.

More than nine out of ten doctors (92%) read a newspaper every day, and the majority (57%) read three or more non-professional magazines regularly. Only 11% read no magazines. Most popular are "Time" and "Life", each mentioned by 36% of the sample, "Saturday Evening Post" (29%) and "Readers Digest" (20%).

Specialists and non-specialists read approximately the same number of magazines, but specialists are more likely to mention news magazines and "quality" magazines such as "Atlantic," "Harper's" and "Saturday Review."

The two types of physicians differ more widely in their book-reading habits. A third of the general practitioners read no (non-professional) book of any kind during the preceding year; only half as many specialists failed to read at least one book. And only a fourth of the GP's read more than six books, whereas 41% of the specialists read seven or more.

The movie-going habits of the two groups are almost identical. Seventy percent of the total sample attended at least one movie during the year, but only one doctor in ten exceeded the rate of one per month.

But 77% of the specialists, as compared with 54% of the GP's, attended a stage play during the year; 63% of the specialists but only 40% of the GP's attended an opera, ballet or concert, and 58% of the specialists but only 39% of the general practitioners visited an art gallery or museum during the year. Specialists also attended more sports events, though the differences are somewhat smaller on this item.

Practically all doctors report at least one hobby or outside interest. Outdoor sports (headed by fishing, golf, swimming or boating, and hunting, in that order) are mentioned most often, but one out of five gets his exercise gardening or attending to the yard. Photography, music and do-it-yourself activities are also mentioned by more than one doctor in ten.

VI. BACKGROUND CHARACTERISTICS

T A B L E S

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>A. Annual net income from practice (Q. 53-A)</b>			
Under \$10,000 . . . . .	11%	6%	10%
\$10,000-\$12,499 . . . . .	12	6	10
\$12,500-\$14,999 . . . . .	10	9	10
\$15,000-\$19,999 . . . . .	19	9	15
\$20,000-\$29,999 . . . . .	23	34	27
\$30,000 or more . . . . .	20	33	24
Not ascertainable . . . . .	5	3	4
<b>B. Satisfaction with income (Q. 53-B)</b>			
Very well satisfied . . . . .	58%	61%	59%
Fairly well satisfied . . . . .	36	35	36
Disappointed. . . . .	5	4	4
No opinion. . . . .	1	*	1
<b>C. Sex (Item D)</b>			
Male. . . . .	98%	99%	99%
Female. . . . .	2	1	1
<b>D. Race (Item E)</b>			
White . . . . .	96%	97%	96%
Negro . . . . .	4	3	4
<b>E. Age (Q. 46-A)</b>			
Under 40. . . . .	14%	12%	13%
40-44 . . . . .	13	15	14
45-49 . . . . .	18	25	20
50-54 . . . . .	24	17	22
55-59 . . . . .	12	10	11
60-64 . . . . .	7	15	10
65 or over. . . . .	12	6	10
<b>F. Nativity (Q. 46-B)</b>			
Born in U.S. . . . .	88%	89%	88%
France, Belgium, Switzerland. . . . .	3	5	4
Germany, Netherlands, Austria . . . . .	2	3	2
Russia, Poland, Baltic. . . . .	2	1	2
Born elsewhere. . . . .	5	2	4

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<u>3. Father's nativity (Q.46-C)</u>			
Father born in U.S. . . . .	66%	65%	65%
France, Belgium, Switzerland. . . . .	7	9	7
Russia, Poland, Baltic. . . . .	9	11	9
Germany, Netherlands, Austria . . . . .	5	7	6
Italy, Spain, Portugal. . . . .	5	3	5
Scandinavia . . . . .	2	1	2
Romania, Hungary, Greece, Balkans . . . . .	2	2	2
Father born elsewhere . . . . .	4	2	4

<u>H. Father's occupation (Q.46-D)</u>			
Professional, semi-prof. . . . .	27%	34%	29%
Farmer. . . . .	17	9	15
Business, managerial. . . . .	22	32	25
Clerical, sales . . . . .	8	8	8
Skilled labor . . . . .	15	12	14
Other blue-collar . . . . .	9	4	7
Service worker. . . . .	2	1	2
Father was doctor . . . . .	12%	17%	14%

<u>I. Religious preference (Q.46-E)</u>			
Baptist . . . . .	13%	6%	11%
Presbyterian. . . . .	15	15	16
Methodist . . . . .	15	19	16
Episcopalian. . . . .	8	12	9
Lutheran. . . . .	6	2	5
Other Protestant. . . . .	8	5	7
Catholic. . . . .	21	18	20
Jewish. . . . .	12	17	13
None. . . . .	2	6	3

<u>J. Year received M.D. (Q.47-A)</u>			
Before 1925 . . . . .	16%	22%	17%
1925-1929 . . . . .	12	10	11
1930-1934 . . . . .	22	19	21
1935-1939 . . . . .	13	20	19
1940-1944 . . . . .	19	20	20
1945-1949 . . . . .	9	6	8
1950-1954 . . . . .	4	3	4

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>K. <u>Diplomate of any American board? (Q.47-C)</u></b>			
Yes . . . . .	7%	47%	20%
No. . . . .	93	53	80
<b>L. <u>Ever serve in medical corps of armed forces? (Q.47-D)</u></b>			
Yes . . . . .	57%	72%	62%
No. . . . .	43	28	38
<b>M. <u>Geographic region of residence</u></b>			
East. . . . .	25%	26%	25%
Midwest . . . . .	31	22	28
South . . . . .	30	32	31
Far West . . . . .	14	20	16
<b>N. <u>Size of community</u></b>			
Large metropolitan area . . . . .	30%	33%	31%
Small metropolitan area . . . . .	32	47	36
Urban county. . . . .	20	14	18
Rural county. . . . .	18	6	15
<b>O. <u>Local organizations belonged to (Q.49)</u></b>			
Veterans, patriotic groups. . . . .	9%	3%	7%
Health-related organizations. . . . .	9	23	14
Civic or service groups . . . . .	50	55	52
Political or pressure groups. . . . .	2	1	2
Fraternal orders. . . . .	33	26	31
Church, religious groups. . . . .	10	10	10
Cultural, educational groups. . . . .	4	6	5
Social, sports, hobby groups. . . . .	23	33	26
None. . . . .	24	20	23
<b>P. <u>Number of organizations belonged to (Q.49)</u></b>			
None. . . . .	24%	20%	23%
One . . . . .	24	16	21
Two . . . . .	21	25	22
Three . . . . .	17	18	17
Four or more. . . . .	14	21	17
<b>Q. <u>Ever held office in them? (Q.49-A)</u></b>			
Yes . . . . .	29%	41%	33%
No. . . . .	47	39	44
Belong to none. . . . .	24	20	23

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>R. <u>Frequency of attendance at meetings (Q.49-B)</u></b>			
Attend regularly. . . . .	32%	41%	34%
Attend occasionally . . . . .	24	26	25
Hardly ever attend. . . . .	20	13	18
Belong to none. . . . .	24	20	23
<b>S. <u>Ever asked to take prominent part in local functions? (Q.50)</u></b>			
Yes . . . . .	62%	64%	63%
No. . . . .	37	35	36
Don't know. . . . .	1	1	1
<b>T. <u>Like to talk shop when with other doctors socially? (Q.32-A)</u></b>			
Yes . . . . .	56%	58%	57%
No. . . . .	43	40	42
Don't know. . . . .	1	2	1
<b>U. <u>Of best friends, how many are doctors? (Q.32-B)</u></b>			
Most are doctors. . . . .	14%	19%	16%
Some are doctors. . . . .	57	61	58
Hardly any are doctors. . . . .	29	19	26
Don't know. . . . .	-	1	*
<b>V. <u>Newspaper readership (Q.51-A)</u></b>			
Read paper every day. . . . .	91%	95%	92%
Almost every day. . . . .	4	3	4
Only occasionally . . . . .	5	2	4
<b>W. <u>Non-professional magazines read (by type) (Q.51-B)</u></b>			
News and business . . . . .	51%	64%	55%
Travel, geographic. . . . .	16	11	14
Sport, outdoor life . . . . .	18	13	16
Hobby, special interest mags. . . . .	13	11	12
General, family, home . . . . .	63	64	63
Quality or "intellectual" mags. . . . .	16	23	19
Miscellaneous . . . . .	9	9	9
Don't know. . . . .	1	2	1
Don't read any magazines. . . . .	13	8	11

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>X. <u>Most frequently read magazines (Q.51-B)</u></b>			
Life. . . . .	35%	40%	36%
Time. . . . .	32	44	36
Saturday Evening Post . . . . .	31	25	29
Readers Digest. . . . .	20	21	20
Newsweek. . . . .	14	21	16
U.S. News & World Report. . . . .	12	14	12
Look. . . . .	12	7	10
National Geographic . . . . .	12	4	9
Sports Illustrated. . . . .	8	8	8
<b>Y. <u>Number of magazines read (Q.51-B)</u></b>			
None. . . . .	13%	8%	11%
One . . . . .	14	14	14
Two . . . . .	16	21	18
Three . . . . .	25	24	25
Four. . . . .	16	17	16
Five. . . . .	10	10	10
Six or more . . . . .	6	6	6
<b>Z. <u>Number of non-professional books read in last year (Q.51-C)</u></b>			
None. . . . .	34%	17%	29%
1-2 . . . . .	17	13	15
3-4 . . . . .	13	18	15
5-6 . . . . .	10	11	10
7-12. . . . .	9	20	13
13-24 . . . . .	9	8	9
25 or more. . . . .	8	13	9
<b>AA. <u>Movies attended in last year (Q.51-D)</u></b>			
None. . . . .	31%	28%	30%
One . . . . .	11	14	12
Two . . . . .	12	15	13
3-4 . . . . .	14	14	14
5-6 . . . . .	12	9	11
7-12. . . . .	10	10	10
13-24 . . . . .	5	5	5
25 or more. . . . .	5	5	5
<b>BB. <u>Stage plays attended in last year (Q.51-E)</u></b>			
None. . . . .	46%	23%	39%
One . . . . .	11	13	12
Two . . . . .	14	17	15
3-4 . . . . .	11	22	14
5-6 . . . . .	8	11	9
7-12. . . . .	8	11	9
13 or more. . . . .	2	3	2

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<b>CC. Operas, ballets, symphonies, concerts attended in last year (Q.51-F)</b>			
None . . . . .	60%	37%	53%
One . . . . .	12	10	11
Two . . . . .	9	13	10
3-4 . . . . .	9	15	11
5-6 . . . . .	6	13	8
7 or more . . . . .	4	12	7
<b>DD. Art galleries, museums visited during last year (Q.51-G)</b>			
None . . . . .	61%	42%	54%
One . . . . .	13	16	13
Two . . . . .	14	20	16
3-4 . . . . .	6	12	8
5 or more . . . . .	6	10	9
<b>EE. Sports events attended in last year (Q.51-H)</b>			
None . . . . .	30%	22%	27%
1-2 . . . . .	17	17	17
3-4 . . . . .	14	10	13
5-6 . . . . .	11	13	12
7-12 . . . . .	12	24	16
13-24 . . . . .	11	12	11
25 or more . . . . .	5	2	4
<b>FF. Hobbies or interests (Q.51-I)</b>			
Hunting, shooting . . . . .	16%	14%	15%
Fishing . . . . .	32	20	28
Swimming, boating . . . . .	16	16	16
Golf . . . . .	21	32	24
Other athletic sports . . . . .	15	11	13
Gardening, flowers, yard . . . . .	18	23	20
Farming . . . . .	7	5	7
Music, Hi-fi . . . . .	11	13	11
Bridge . . . . .	4	3	3
Painting, wood-carving . . . . .	4	3	4
Reading . . . . .	8	10	9
Photography . . . . .	14	16	15
Do-it-yourself activities . . . . .	10	11	11
Travel, driving, work on car . . . . .	5	11	7
Television . . . . .	3	2	2
Misc. spectator sports . . . . .	5	2	4
Misc. interests . . . . .	10	10	10
Don't know . . . . .	1	*	1
No hobbies or outside interests . . . . .	4	5	4

	<u>Non-Specialists</u>	<u>Specialists</u>	<u>All Doctors Interviewed</u>
<u>GG. Attitude toward interview (Item H)</u>			
Very cooperative. . . . .	68%	72%	69%
Fairly cooperative. . . . .	24	20	23
Neutral, indifferent. . . . .	4	4	4
Somewhat hostile. . . . .	3	4	3
Very hostile. . . . .	1	-	1