June 27, 2000

Protocol

FoodNet Physician Survey 2000

Project Title

Physicians as Food-Safety Educators: A knowledge, attitudes and practices survey

Objectives

$ To determine the knowledge, attitudes and practices of physicians as food-safety educators

$ To identify possible barriers that prevent physicians from being food-safety educators

Background

Foodborne Illness

Each year, foodborne pathogens account for an estimated 76 million illnesses in the United States (Mead). A wide variety of foodborne pathogens, including Salmonella, Escherichia coli O157:H7, Listeria monocytogenes, Clostridium botulinum, and caliciviruses, cause syndromes ranging from mild diarrhea to life-threatening septicemia. Two groups at highest risk for serious foodborne disease include pregnant women and immunocompromised persons. In response to the high incidence and potential serious sequelae of foodborne disease and the concern that people may not be aware how to prevent such illness, the Centers for Disease Control and Prevention developed educational fact sheets with simple food-safety guidelines.

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Physicians as Food Safety Educators

In addition to pathogen control efforts at production and distribution levels, public education about safe food preparation, storage, and handling is an important component of foodborne disease prevention. Given that physicians are often consulted about and dispense advice on a variety of health-related issues, it is of interest to assess their current role as food safety educators. Although no literature exists on the status of physicians as food-safety educators, there is an abundance of recent research that focuses on the role of physicians as nutrition educators (Kottke, Peiss, Tersbakovec, Shirley).

Physicians are targeted as nutrition educators for the following four reasons: 1) Physicians have contact with approximately 80% of the population during a given year (Hiddink); 2) people are most likely to change their behavior if they have recently experienced an illness or see themselves as at-risk (van Weel); 3) people value physicians over dieticians as key sources of nutritional and food safety information (Hiddink, Worsley); and 4) nutrition education programs involving one to three minute “pep talks” by physicians, followed by provision of self-help materials, are as effective as 30 minute counseling sessions from dietitians in changing food eating behavior (Shirley, Peiss).

Although physicians agree that they should act as nutrition counselors, few actually provide food-related advice to their patients (Kottke). Past surveys of physician knowledge, attitudes and practices have attempted to determine why this is so. In one study, the perceived absence of risk
in patients was the primary reason for physicians not providing nutritional advice (Kottke). Other important barriers preventing physician from acting as nutrition educators identified in surveys include a perceived lack of patient interest in diet changes, expectation of patient non-adherence to recommendations, lack of knowledge based on nutrition, lack of time, perceived lack of influence on patients, no interest in the effects of diet on health, and a perceived lack of ability to advise, treat, and prevent nutrition-related diseases (Kottke, Hiddink, Worsley).

Given the high incidence of foodborne illness in the United States and the lack of information on the role of physicians as food-safety educators, [we] propose a survey of physicians who serve patient groups that are at highest risk of some foodborne disease to determine their general knowledge of foodborne disease prevention, attitudes and perceptions as food-safety educators, and practices currently being used to educate patients on food-safety.

**Study Design and Methods**

**Study Sites**

The following FoodNet sites, under the Emerging Infections Program, will participate in the distribution and collection of physician surveys: California, Connecticut, Georgia, Maryland, Minnesota, New York, Oregon, and Tennessee.

**Personnel**

Each FoodNet site will have a primary appointed person to distribute and collect surveys to physicians in the state.
**Study Population**

Obstetricians, oncologists, nephrologists and infectious disease physicians, as identified by FoodNet sites through state licensing offices or medical specialty organizations, will be solicited as participants of the physician survey.

**Enrollment Criteria**

A survey participant must be a physician licensed through the state in which the survey is completed. Additionally, the physician must work in a practice that serves high-risk patients (i.e. obstetrics, oncology, nephrologists, and infectious disease physicians) and actively practice at least eight hours a week.

**Sample Size**

Each of the eight participating FoodNet sites will be expected to enroll a minimum of 100 eligible physicians for the survey, providing an estimated total of 800 physician participants in the study.

**Survey Content**

The survey is a five-page written document containing questions on food-safety counseling practices, perceptions of physicians as food-safety educators, physician specialty and training, practice setting (solo, group, health care maintenance organization), and patient demographics (Appendix 1, pages 8-13).
Survey Distribution and Collection

Beginning September 2000, questionnaires will be mailed to physicians (as identified under Study Population and Enrollment Criteria) along with a cover letter with confidentiality agreement and informed consent form. Because the survey presents less than a minimal risk to participants, a signed consent form will not be required. If a physician does not respond within one month, he or she will be mailed a follow-up letter and another copy of the questionnaire. If there is no response the following month, FoodNet sites will attempt to call the physician twice in a final attempt to recruit participants. Collection of questionnaires will continue from September to December, 2000.

Upon receipt of completed questionnaires from participants, each FoodNet site will enter their own data and send the completed data sets to FoodNet at the Centers for Disease Control and Prevention (Atlanta, Georgia) for analysis.

Informed Consent

Consent for participation, in the form of a written, one-page document, will be included with the mailed survey. Because the survey presents less than a minimal risk to participants, a signed consent form will not be required. (Appendix 2, page 14).

Confidentiality Agreement

In accordance with the Privacy Act of 1974 (Public Law 93-579) individuals asked to provide information for the survey used in this protocol will be informed of the reason for collecting the
information and how the information will be used. Participants will be notified that their participation is voluntary through a written statement attached to the survey (Appendix 2, page 14). All information will be kept confidential as permitted by law. Names and identifiers will not be entered into computer records sent to the CDC and will not be included in any published materials related to this study. All records will be kept in a secure location to which only study personnel will have access.

Data Analysis

Data analysis will be led and completed by FoodNet personnel at the Centers for Disease Control and Prevention (Atlanta, Georgia). Analysis of the data will be completed using SAS. Results from the physician survey will be distributed to FoodNet sites and physician participants.

References


Mead PS, Slutsker L, Dietz V, McCaig LF, Bresee JS, Shapiro C, Griffin PM, and Tauxe RV. Food-Related Illness and Death in the United States. Emerging Infectious Diseases 1999; 5 (5):

