

CENTER FOR DISEASE PREVENTION & EPIDEMIOLOGY • OREGON HEALTH DIVISION

PHYSICIAN COUNSELING FOR CARDIOVASCULAR DISEASE

CARDIOVASCULAR disease (CVD), the leading cause of death in the United States, caused 960,592 deaths nationally in 1995¹ (41.5% of all deaths) and 10,898 deaths in Oregon (38.7% of all Oregon deaths).² Approximately 58 million persons in the United States (20% of the total population) have one or more types of CVD, which include high blood pressure, coronary heart disease, stroke, rheumatic fever or rheumatic heart disease, and other forms of heart disease. Behavioral risk factors for CVD and other chronic diseases include physical inactivity, a diet high in fat, overweight, and smoking.

The U.S. Preventive Services Task Force and the American Heart Association recommend that all primary-care providers offer their patients counseling to promote physical activity, a healthy diet, and smoking cessation as part of the preventive health examination.^{3,4} To characterize the provision of counseling by physicians about preventive health behaviors during office visits in 1995, data were analyzed from CDC's National Ambulatory Medical Care Survey (NAMCS). This report summarizes the results of that analysis, which indicates that a high proportion of office visits in 1995 did not include counseling for the prevention of CVD.

The analysis was restricted to the 29,273 office visits by persons aged 20 years and older who sought either a general medical or routine gynecologic examination. Visits excluded were those for examinations for illness or injury, school or employment, prenatal care, birth control consultation, assessment of specific organ systems, and follow-up or progress visits. Physicians participating in NAMCS were asked to complete a standardized survey. The sample was extrapolated to an estimated 40 million 1995 U.S. office visits.⁵

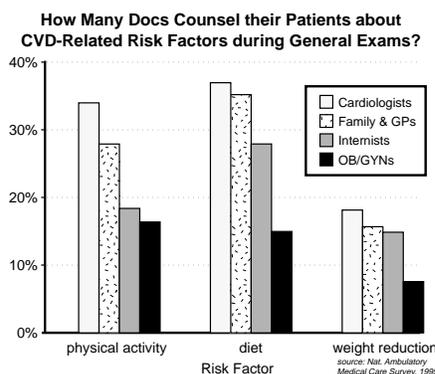
During 1995, 29.5% of office visits were with obstetricians or gynecologists, 26.3% with internists, 25.0% with family or general practitioners, 2.4% with cardiologists, and 16.9% with other specialists.

Physicians reported offering counseling about physical activity during 19.1% of office visits, diet during 22.8%, and weight reduction during 10.4% (see table). Counseling was reported more commonly for persons aged 50–64 years, for men than for women, and for non-Hispanic whites and Hispanics than for non-Hispanic blacks. The prevalence of reported counseling was lowest in the South and highest in the Midwest. Cardiologists and family or general practitioners were more likely than other specialists to provide counseling about physical activity, diet, and weight reduction (see figure). Among all respondents, 64% reported that their office visits included an assessment of smoking status; among current smokers, 41% of office visits included smoking cessation counseling.

Office visits for general medical and routine gynecologic examinations provide an important opportunity for physicians to counsel patients about reducing behaviors associated with CVD. However, the findings in this report indicate that, in 1995, high proportions of patient visits did not include such counseling. Although reported counseling rates were higher for visits to cardiologists than to other specialists, cardiologists accounted for only 2.4% of visits in 1995. The low prevalence of counseling among obstetricians and gynecologists—a group of physicians that accounted for almost one third of office visits in the survey—represents a substantial loss of opportunity. The lower prevalence of counseling among women may be,

in part, a result of a high proportion of women receiving care from obstetricians and gynecologists; however, when the analysis excluded these specialists, women were still less likely than men to receive preventive counseling. Although physically active persons often cite a physician's advice as a major motivating factor in their decision to become physically active,⁶ physician advice is related to physicians' attitudes about physical activity. In 1991, 59% of primary-care physicians believed that engaging in regular physical activity was very important for their patients, but only 24% reported that they would be able to modify patient behavior.⁷ The low proportion of office visits that included counseling about diet probably reflected physician attitudes about dietary advice.⁶ In 1988, 92% of internal medicine residents reported that a low-fat, low-cholesterol diet can effectively lower cholesterol levels, and 68% reported that they are responsible for providing dietary advice; however, 72% of physicians believed they were inadequately prepared to provide dietary counseling.⁸

One third of U.S. adults are overweight, and the low prevalence of counseling for weight reduction (10.4%) indicates that most overweight adults are not being counseled about weight reduction.⁹ Physician counseling about weight reduction should include advice about weight maintenance for all adults and caloric restriction and increased physical activity for persons who are overweight. Barriers to physician counseling include time constraints, lack of reimbursement, and lack of professional training.¹⁰ To promote counseling by all healthcare providers, training programs for physicians should increase emphasis on preventive counseling. In addition to medical schools, such training should be provided in residencies, other postgraduate programs, continuing medical education, and by professional organizations. Increasing enrollment in managed-care programs highlights the opportunities for counseling for prevention of CVD and other disease-prevention and health-promotion activities in such programs.



Who Gets Counselled

	Subject of Counseling		
	Physical Activity %	Diet %	Weight Reduction %
Age Group			
20-34	18.9	20.1	7.9*
35-49	15.9	17.7	10.5
50-64	23.8	29.5	15.1
65+	18.2	23.2	8.0
Sex			
Men	23.0	26.6	12.0
Women	17.5	21.2	9.7
Race**			
White, non-Hispanic	19.7	23.1	10.3
Black, non-Hispanic	13.0*	21.5	10.9*
Hispanic	19.9*	20.3*	11.9*
Region			
Northeast	20.2	23.2	10.2
Midwest	22.3	25.7	14.4
South	14.3	15.7	5.8
West	21.4	29.7	12.9
Total	19.1	22.8	10.4

*Estimates should be interpreted with caution because of small numbers.

**Numbers for other racial/ethnic groups were too small for meaningful analysis.

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**Escherichia coli O157:H7—
 Surveillance Notes**

ON JANUARY 28, a 6-year-old from Washington County and an 8-year-old from Coos County both began to feel sick with stomach cramps and diarrhea. Both soon developed bloody stools, and *E. coli* O157:H7 was subsequently cultured from both. These two cases, the first in Oregon in 1998, broke the longest streak of O157-free days (44) in Oregon since reporting for the dreaded infection began in 1990. The previous record of 40 O157-free days was set in 1992.

O157 infections are seasonal. In Oregon, over 50% of the non-outbreak cases occur in the months of July, August, and September. From 1991-97, only 32 of 667 non-outbreak cases (4.8%) occurred in January or February.

The reasons for the seasons are not well understood, although many factors may contribute. People may be more apt to barbecue or otherwise handle meat under less controlled circumstances in summer. Ambient temperatures are usually higher, meaning that bacteria would be more likely to multiply in food left out of the refrigerator (or left in a picnic basket).

More “high-risk” foods may be eaten in the summertime. And there is good evidence to suggest that (for whatever reason) cattle may be more likely to excrete O157 in the summertime, meaning that meat and other foods might be more likely to be contaminated.

The two children did not know each other, and investigation revealed no epidemiological link between them. Subsequently molecular analysis of the isolates found them to be quite distinct, suggesting that the coincidence was just that. Overall, incidence has been quite stable in Oregon for the past 3 years, with about 100 cases reported each year. This is a great improvement over 1992 and 1993, but there is always more progress to be made.

**A Death with Dignity
 Demands Rules**

THE DEATH with Dignity Act requires the Health Division to “make rules to facilitate the collection of information regarding compliance with the Act.” Emergency rules outlining the reporting requirements for physicians have been in place since November. A hearing will be held March 20, 1998 at 2 PM, Room 120C at 800 NE Oregon Street in Portland prior to the adoption of permanent rules. Persons who want to give oral testimony may do so at that time. Written comments will be accepted prior to that time, and should be sent to: Dr. Grant Higginson, Health Officer, Oregon Health Division, 800 NE Oregon St., Portland 97232. The last day for public comment is March 27. For a copy of the proposed permanent rules (which are the same as the emergency rules), contact Mellony Bernal at 503/731-4000, or visit our web site: <http://www.ohd.hr.state.or.us> (“What’s new?”).