Physicians' Own Health—Some Advice for the Advisors

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Information about physicians' health and health practices is sparse and scattered. With a few exceptions, however—notably suicide and substance abuse—it appears that physicians' health and health-promotion activities are at least similar to those of the general public. In some areas, such as smoking cessation, physicians have far outstripped the general public. As physicians gain more insight into their own health and health habits, advice to patients can be realistic and effective. Indeed, several personal health activities, including immunization, have direct, salutary impacts on patient care. Physicians should analyze and change their own health practices as indicated and pay special attention to "high yield" health habits, such as seat-belt use.

(Clever LH, Arsham GM: Physicians' own health—Some advice for the advisors, *In* Personal health maintenance [Special Issue]. West J Med 1984 Dec; 141:846-854)

This special issue of the journal focuses on how physicians can help their patients promote health and prevent disease, but what about physicians' own health? Although not commonly recognized or discussed, physicians are people. They are people with unusual responsibilities and challenges, but basically people still. Do physicians have unique health problems? What information is available about physicians' health maintenance practices? Do some of these practices also affect patient care? What advice is available to improve physicians' health?

In this article we briefly review current literature, comment on health maintenance opportunities for physicians and, finally, offer the challenge of health-to-health combat with the Harvard Medical School Faculty.

Physician Life Expectancy and Mortality

Most information about physicians' lives and deaths is gathered by the American Medical Association (AMA) and includes reports, clippings and correspondence, often backed by death certificates. The most comprehensive study using this information calculated age-adjusted death rates and standardized mortality ratios (SMRs).[1] (An SMR is the actual versus expected number of deaths in relationship to a defined standard; an SMR of less than 100 suggests that the study population has a lower mortality than the comparison group, the United States white population.) This study showed that physicians have a two- to three-year longer life expectancy than their same-aged US counterparts and that life expectancy has improved substantially—at least for male physicians—since 1925 (and has improved more than that of white American men). Female physicians were shown to have a lower age-specific mortality than male physicians but a higher SMR. Thus, women physicians are "healthier" than male physicians, but less healthy than the US female population. Male physicians on the Pacific Coast and in New England had an 8% lower mortality than expected. SMRs of male physicians were found to vary by specialty: greater than 100 for those in general practice and pulmonary medicine, 96 for psychiatrists, 87 to 89 for internists and general surgeons, 72.5 for pediatricians and 64.8 for the lumped "other" specialties—primarily public-health oriented physicians and some subspecialists.[1] In contrast, a cohort study of more than 1,000 Harvard Medical School graduates found no differences in longevity among specialty groups.[2] Thus, life-span statistics are generally encouraging despite 1960 census data showing that physicians worked 55.5 hours per week, and 48.2 weeks per year compared with 40.4 hours per week and 44.5 weeks per year for all professionals.[2] Table 1 shows that except for arteriosclerotic vascular disease and for suicide, the causes of death for physicians do not differ greatly from those of the general population.

Interestingly, not only do physicians work more *hours* than others but they also work more *years* and therefore have a shorter retirement—3.1 years for physicians versus 7.8 years for the general population.[4] A recent Canadian study confirmed these population statistics: 93% of 58 surveyed physi-

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ABBREVIATIONS USED IN TEXT

AMA = American Medical Association
JAMA = *The Journal of the American Medical Association*
SMR = standardized mortality ratio

TABLE 1.—*Causes of Death in Physicians and the United States Population**

	Physicians in 5 States Percent	*US Population Percent*
ASCVD†	48.4	58.2
Cancer	21.6	20.9
Chronic lung disease	3.4	2.8
Suicide	2.4	1.3

*A study of 1,258 physician deaths in Arizona, California, Michigan, Oregon and Pennsylvania. Report of the AMA Council on Scientific Affairs, Report G(I-82), presented by William D. Dolan, MD, chair. From Dychtwald.[3]

†Heart disease, cerebrovascular disease and arteriosclerosis.

cians whose average age was 71 years were still in practice—72% involved in direct patient care—and 65% had no retirement plans.[5]

Suicide

The study of suicide in physicians has been marked by methodologic problems. It has long been suspected that suicides are underreported in AMA records and the AMA journal (*JAMA*). Indeed, Rose and Rosow showed that *JAMA* reports of California physician suicides listed only half of death certificate-proved suicides as "definite"; other causes were suspected, undisclosed, incorrect or omitted.[6] Valid conclusions are impeded by lack of age, sex and professional groups for comparison and, above all, inadequate numbers.[7-10] The following provisional conclusions can be drawn, however.

- Male physicians probably have twice the annual suicide rate of the white male population.[6]
- Female physicians probably have slightly more than triple the annual suicide rate of the US white female population.[8,9]
- No real inference can be drawn from suicide rates by specialty because of small numbers.
- Other professionals, including dentists, pharmacists and chemists, probably have substantially higher annual suicide rates than physicians.[6,7]

A recent British study based on government statistics showed the SMR for suicide in physicians younger than 65 to be more than three times that of the general English and Welsh male population but 1/5 that of pharmacists. Unmarried female physicians had an SMR 2½ times greater than the general unmarried female population but 1/5 that of female pharmacists.[11] These dramatic statistics warrant further investigation. Steindler proposed that many precursors of suicide in physicians parallel those of the general population: "depression, prior suicide attempt, alcohol and drug abuse, financial troubles, death of a close relative in childhood, death of a relative, and impaired physician health."[12] He also suggested that "professional isolation by specialty or geography, marital discord, unrealistic expectations of one's self and one's ability to cure disease, and the emotional battering of being confronted with [the] daily prospect and often actuality of pain and death" were additional problems faced by physicians.

Personal Health Practices

In three recent publications the broad spectrum of physicians' personal health practices was surveyed.[13-15] Indeed, readers of the *WJM* can compare their habits with those of the Harvard Medical School faculty by taking the self-test at the end of this article (see Figure 1). Good health habits practiced by physicians include dietary moderation, seat-belt use, temperate drinking habits and avoidance of tobacco smoking. According to one 1977 study, 21% of physicians in the United States smoked cigarettes; 14% of physicians in Massachusetts smoked in 1978. This compares favorably with the 39% of men in the US who smoked during that time.[14] A Massachusetts study of physicians and attorneys showed that 50% of physicians versus 40% of attorneys practiced dietary restrictions, such as reduced fat, salt and calories. Also, more physicians than attorneys used seat belts; 3% of physicians and 9% of attorneys reported drinking problems; gardening, not often an aerobic effort, was reported as the commonest recreational physical activity by both groups.

As seen above, the few studies of across-the-board physician health maintenance practices have included information about seat belt use. These data are pertinent because (1) the US Department of Transportation's National Highway Safety Administration estimates that the average American has a one in three chance of suffering a disabling injury from an automobile collision during his or her lifetime, and (2) it is estimated that the risk of serious injury or death can be reduced by more than half by simply wearing seat belts every time a person drives or rides in a car. Regular use of safety belts would reduce yearly traffic deaths by at least a third to a half.[16] Fortunately, seat-belt use by drivers in West Coast cities increased from 14% in 1981-1982 to 20% in 1983. This improvement is more than twice the 2.6% average change in cities nationwide (Calvin Burkhart, Regional Administrator, Region IX, National Highway Traffic Safety Administration, written communication, May 1984). Physicians in the West may parallel the 73% of Massachusetts physicians who buckle up.[13] Surely, physician use of seat belts is consistent with findings that directly correlate educational level and other "good" personal health practices—such as, nonsmoking and regular visits to a dentist—with seat-belt use.[17]

Smoking Habits

Physicians have given up smoking at a rate higher than any other professional group.[18,19] The proportion of internists smoking cigarettes decreased from 60% in 1945 to 22% in 1967 and 17% in 1975.[20] Sachs surveyed 594 of 2,207 American pulmonary disease specialists at the 1983 American Thoracic Society Annual Meeting; 4.6% said they smoked cigarettes and 7.4% a pipe or cigars.[21] Among California physicians, the percentage of cigarette smokers has declined from about 53% in 1950 to about 10% in 1980.[22] For other American men, the percentage of smokers has declined only from 53% to 39%. Enstrom chose to use this "natural experiment" to study mortality trends among California physicians who stopped smoking compared with the general public. He studied the mortality of a cohort of more than 10,000 California male physicians from 1950 through 1979 and found

that the SMR for lung cancer among California male physicians, compared with American white men, declined from 62 in 1950-1959 to 30 in 1970-1979. There were similar declines for other diseases related to smoking, such as ischemic heart disease (106 to 71); bronchitis, emphysema and asthma (62 to 35) and for other smoking-related cancers of the esophagus, buccal cavity and respiratory system (100 to 63). For causes of death not strongly related to smoking, the SMR remained relatively constant. These data are generally consistent with a similar study of British physicians.[23,24] Interestingly, Enstrom also compared mortality patterns among all physicians with a subgroup of 1,180 Loma Linda University medical graduates, assumed to be nonsmoking Seventh Day Adventists. The overall SMR declined from 84 in 1950-1959 to 67 during 1970-1979 for all physicians, but only from 62 to 56 for Loma Linda graduates. This suggests that the decrease in mortality from lung cancer and ischemic heart disease among California physicians was largely due to smoking cessation. While other factors may account for the decline in mortality from ischemic heart disease (such as improvement in other health habits), they are not likely to have had a substantial impact on mortality from lung cancer.

Personal Health Maintenance and Patient Care

Immunization

A number of physicians' personal health habits (good and bad) have direct impact on patient care. These include heavy drinking and abuse of other substances, stress and fatigue management and one rarely considered practice, immunization. To decrease the risk of teratogenesis and absenteeism, a number of agencies and institutions have recommended rubella screening and immunization of hospital personnel.[25] Reports have shown that only 20% of susceptible physicians have been immunized, compared with 53% to 66.2% of all employees.[26,27] The lowest vaccination rate (1 out of 11 susceptible) in the Los Angeles County/University of Southern California Medical Center report was among obstetricians and gynecologists; 31% of susceptible pediatricians allowed vaccination.[27] Experience with hepatitis B vaccine in hospitals has paralleled that of rubella.[28] Although 16% of physicians have serologic evidence of hepatitis B infection (thus showing that physicians *can* contract this potentially disabling, fatal disease), very few exposed physicians (house staff or attending) have been vaccinated. This not only leaves physicians susceptible to the disease, but also raises the possibility of physician-to-patient disease transmission.

Substance Abuse—Alcohol and Drugs

Because of concerns about patient care and personal and family tragedy, increasing attention has been paid to the problem of impaired physicians. Alcohol abuse and other drug dependence have been spotlighted as important elements. In the past, physicians were generally believed to be more susceptible to alcohol and drug abuse than the general population. Although large-scale reliable studies of these problems are not available, more and more studies of impaired physicians are being done.[29-32] In a recent study at the Mayo Clinic, 453 physicians attending a continuing education course were asked to fill out a self-administered alcoholism screening test; there was an 88% return rate.[33] The prevalence of serious alcohol dependence and actual alcoholism was 7% among physicians who did drink. This percentage is virtually the same as for a similarly surveyed general outpatient population.[34]

Drug abuse is still considered to be somewhat more prevalent among physicians than the general public.[29] A 20-year longitudinal follow-up study of 45 physicians and 90 controls showed that the use of tranquilizers, sedatives and stimulants was greater among physicians than among controls.[35] The regular use of sedatives was almost three times as great as for controls, and the regular use of tranquilizers was about twice as frequent, but not statistically significant. (The study showed no difference for alcohol use.) Data from the California Board of Medical Quality Assurance Treatment and Rehabilitation Program showed that large numbers of impaired physicians abuse drugs. Of 80 physicians in treatment programs, 31 were being treated for drug abuse, 18 for alcohol abuse, 13 for both alcohol and drug abuse and the remaining 18 for various combinations of mental or physical illness and substance abuse.[30] Encouragingly, an albeit incompletely controlled Mayo Clinic study found that the prognosis for favorable outcome was greater for physicians than for general patients, and that the prognosis was not related to the severity of the problem. Furthermore, and somewhat unexpectedly, they found that the physicians with drug addiction seemed to do better than those with alcoholism.[29]

Special Pressures and Responsibilities

If anything sets physicians apart from others, it is the special pressures and responsibilities that are intrinsic to the medical profession. Healthy responses to these demands may well determine a physician's ability to assure high-quality patient (and personal) care. McCue outlined several difficult areas.[36] Some, such as the need to deal with suffering (and sometimes inflict suffering), the need to allay patients' fears, the privilege of dealing with private aspects of a patient's body and life and the frequent presence of death, relate to emotional aspects for which our society has developed strong cultural codes and behavior. Other intrinsic demands derive from encountering situations for which physicians have not always been well prepared—such as "problem" patients—or with demands that are unrealistic—such as requests for certainty when only uncertainty is possible. Hilfiker explored the relative expectations of perfection that society (and physicians) have of physicians: no mistake allowed.[37] An illogical attitude of immunity to problems and diseases that may afflict others—what might be called the "physician invulnerability syndrome"—may prevent healthy coping. Some mental mechanisms—and a healthy sense of humor—help contend with problems medicine presents, but excessive denial is not beneficial.

A longitudinal study of Case Western Reserve School of Medicine graduates found that the major dissatisfactions among physicians still related to time pressures but that several new sources of stress are being described—malpractice suits, having to give up certain aspects of medical work, the threat of physical harm and certain features of peer review.[38] Other new pressures include decreased autonomy, increased control (from new regulations), increased competition due to more doctors being trained, the emergence of greater roles for

other health professionals and decreased financial rewards.[39] On the other hand, medicine has many intrinsic rewards, pleasures and privileges that may help account for physicians' perhaps surprisingly good health.

Comments and Recommendations

Although information about health promotion for physicians and the general public is incomplete and inconclusive, some comments and recommendations are in order. Despite the special responsibilities that the practice of medicine creates, physicians still make conscious decisions about their lives based on their own personalities and assessment of benefits and costs, just as everyone does. The steps suggested for physicians will therefore be very similar to those that physicians can recommend to their patients.

- Assess where you are. What is the current state of your health? What are the factors in your life that contribute to your health or enhance the likelihood of disease?
- Consider your options based on your current health practices and your own values, personality and life. Here is where your own formula comes into play. Only you can find the balance between the pleasure you gain and the risk you incur—for instance, the principle of rotating dietary "toxins" will allow occasional indulgence.
- Once decisions are made, provide incentives and remove barriers to change habits. These are powerful tools. Just as you would with your patients, ask yourself what barriers exist in improving your health and think of ways that barriers could be reduced or eliminated. Ask yourself what things give you pleasure. Find ways to make those rewards contingent on the changes you are trying to accomplish—for example, turn on the radio *after* you have fastened your seat belt.
- Find ways to document the changes—jot progress on a graph and post it on a mirror. Overall, follow Watts's call to put personal health maintenance high on your professional agenda in order to help your patients[40] *and* put it high on your personal agenda in order to help yourself.

The following suggestions merit your consideration, at least:

- Get help when you need it. The "physician invulnerability syndrome" is a serious risk factor.
- Wear seat belts *every* time you drive or are a passenger. This is an easy, "low-cost" item.
- Stop smoking. In addition to the long-term gains resulting from smoking cessation, there are some short-term gains that may be important, such as less coughing and more breath.
- Get immunized against the hepatitis B virus if you come into contact with blood or blood-contaminated patient products. This is another easy, low-cost item, as are tetanus and rubella shots.
- Drink alcohol in moderation, if at all. The possible positive effects of small amounts[41-44] must be weighed against considerable negative consequences of excessive alcohol.[45] Also, avoid recreational drugs.
- Consider a form of aerobic exercise that you *enjoy*. If you do not enjoy it, it will be difficult to continue.
- Consider decreasing the cholesterol and saturated fats in your diet and increasing the vegetables, fruit and whole grains. Pasta is fine, garlic is great and olive oil is neutral.
- Consider developing interests outside of medicine that give you satisfaction. These can range from traditional hobbies to involvement in public life, which can contribute to the public health and certainly help manage professional pressures. Benjamin Rush may have set the tone for public service by American physicians. He was a signer of the Declaration of Independence, Surgeon General, Treasurer of the Mint and advocate for the rights and humane care of the mentally ill. Now as then, physicians can volunteer in underserved areas in the United States and abroad or as citizen members of governing boards of service, cultural and educational organizations. They understand the health implications of war and can inform the public; they can participate in debate about health care delivery and financing; they can encourage and be involved in planning for natural disasters. David Bates suggests two caveats for physicians-as-citizens: "The necessity of integrity and the avoidance of political polemic."[46]
- Finally, a word about retirement. Regardless of previously mentioned findings, some physicians do retire. Although this transition is a time of vulnerability, planning can be an enormous help. New activities can be a source of continued success and help maintain self-esteem. Important factors include fitness, freedom, finances, family, fun and flexibility. One helpful planning resource is a 129-item bibliography on physician retirement developed by the AMA Division of Library and Archival Services in 1980.

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See addendum next page.

Addendum

Figure 1.—Personal health practices—How do you compare to the Harvard Medical School faculty? (Excerpted from the June 1982 issue of *The Harvard Medical School Health Letter* © 1982 President and Fellows of Harvard College.[13])

PERSONAL HEALTH PRACTICES
HOW DO YOU COMPARE TO THE HARVARD MEDICAL SCHOOL FACULTY?

The following survey of personal health practices was just completed by 595 members of the Harvard Medical School faculty. Check the answers as they apply to you; then go on to see how you compare with those who preach as well as practice.

1. Do you smoke cigarettes? Yes ☐ No ☐
   If so, how many a day?____ If not, are you a former cigarette smoker? Yes ☐ No ☐
2. Do you use tobacco in any other form on a daily basis? Yes ☐ No ☐
   If yes, what form? Pipe cigar snuff chewing tobacco
3. Do you use a sleeping pill more than three times a week? Yes ☐ No ☐
4. Have you had a routine health exam during the past two years? Yes ☐ No ☐
5. Do you use seat belts routinely? Yes ☐ No ☐
6. Do you use aspirin on a daily basis to protect against vascular disease? Yes ☐ No ☐
7. Do you usually take an antibiotic if you develop an upper respiratory infection? Yes ☐ No ☐
8. Do you jog or do equivalent aerobic exercise for 20 minutes (or more) at least three times a week? Yes ☐ No ☐
9. If practicing contraception, do you (or your partner) use contraceptive pills? Yes ☐ No ☐
10. If female, do you routinely perform self-examination of your breasts? Yes ☐ No ☐
    If male, do you routinely perform self-examination of your testes? Yes ☐ No ☐
11. Do you eat breakfast? Yes ☐ No ☐
12. Do you weigh more than 10 pounds above what you'd like to weigh? Yes ☐ No ☐
13. Do you take more than 2 alcoholic drinks a day? Yes ☐ No ☐
14. Do you restrict your consumption of red meat to 3 times a week or less? Yes ☐ No ☐
15. Do you try to maintain a high bran or fiber content in your diet? Yes ☐ No ☐
16. Do you drink coffee? If yes, how much?____ Yes ☐ No ☐
17. Do you restrict your egg intake to 3 per week or fewer? Yes ☐ No ☐
18. Does your household use margarine (as opposed to butter)? Yes ☐ No ☐
19. Do you visit your dentist for a check-up at regular intervals? Yes ☐ No ☐
20. Do you floss your teeth daily? Yes ☐ No ☐
21. Do you take vacations during which no work is done? Yes ☐ No ☐
22. Do you take a daily multivitamin? Yes ☐ No ☐
23. Do you ever make purchases in stores devoted exclusively to health foods? Yes ☐ No ☐
24. Do you use vitamin C to protect against colds? Yes ☐ No ☐
25. Do you take a laxative or enema if you do not have a bowel movement for 2 days? Yes ☐ No ☐

THE ANSWERS OF OUR FACULTY

Now that you've gone on record, here's how our faculty responded... along with a bit of commentary on each set of answers. (A description of how the survey was done and some further words on it appear in this month's Medical Forum.)

1. Do you smoke cigarettes? Yes 8% No 92%
   If not, are you a former cigarette smoker? Yes 38% No 62%

There's no question that doctors have not only read the warnings but have also seen the consequences "close up" among their patients with heart disease, cancer, and emphysema. Eight per cent still smoke cigarettes as compared with 32% of the general population. And only 13 of 49 reported smokers exceeded one pack a day. The number of *former* cigarette smokers — 34% of all responders — is also impressive.

2. Do you use tobacco in any other form on a daily basis? Yes 11% No 89%

Pipes had it over cigars by 3 to 1. No one chewed tobacco and 2 used snuff. So long as inhaling is avoided, the danger of lung damage is considerably reduced.

3. Do you use a sleeping pill more than three times a week? Yes 2% No 98%

While the low use of sleeping pills might suggest a high level of serenity, we've been at too many faculty meetings to believe that. More likely, it's a healthy desire to avoid drugs that can be habit-forming. The frequent use of some sleeping pills can even interfere with normal sleep patterns.

4. Have you had a routine health examination during the past two years? Yes 54% No 46%

We were surprised to find that so many have, given the common notion that doctors are the last ones to seek a routine check-up. As might be guessed, older individuals did so more frequently. Regular health exams were obtained by 41% of our faculty in their 30s, 54% in their 40s, 65% in their 50s, and 80% of those over 60.

5. Do you use seat belts routinely? Yes 73% No 27%

Hooray! While hardly perfect, the high rate of seat belt use is testimony that at least some common sense prevails in ivory towers. And our guess is that doctors who work in emergency rooms that receive auto accident victims approach 100% in *their* seat belt use.

6. Do you take aspirin on a daily basis to protect against vascular disease? Yes 7% No 93%

It has been proposed that aspirin taken in low dosage will prevent heart disease and strokes by inhibiting blood clotting. However, few of our faculty seem to act on what remains an unproven hypothesis.

7. Do you usually take an antibiotic when you develop an upper respiratory infection? Yes 3% No 97%

So much for how we treat our own common colds. We hope that our readers will feel secure without antibiotics for theirs. (Chicken soup has a lower incidence of side effects.)

8. Do you jog or do equivalent aerobic exercise for 20 minutes (or more) at least three times a week? Yes 49% No 51%

Vigorous exercise is popular among faculty of all ages and both sexes. While "feeling good" and "looking good" are important reasons for exercise, the kind of exercise we asked about is also believed to promote cardiac fitness.

9. If practicing contraception, do you (or your partner) use contraceptive pills? Yes 5% No 95%

Of the two-thirds of our responders who practice contraception, the use of the pill by the female partner is strikingly low. One reason, given that 99% are beyond age 30, is that they have probably completed their families, making tubal ligations and vasectomies more acceptable. Also, vascular complications from the pill are higher in older females, an additional reason for seeking other measures.

10. If female, do you routinely perform self-examination of your breasts? Yes 72% No 28%
If male, do you routinely perform self-examination of your testes? Yes 36% No 64%

Early detection of these cancers leads to earlier treatment and a greater number of cures. Self-examination is easy. We'd like to see both men and women achieve 100% on this one.

11. Do you eat breakfast? Yes 78% No 22%

A point of interest for some, perhaps. It may not be crucial to start the day off with a good meal, but it may indicate a greater awareness of the importance of nutrition.

12. Do you weigh more than 10 pounds above what you'd like to weigh? Yes 29% No 71%

While 29% of our faculty are not as trim as they'd like to be, in most cases it's apt to be more a concern for appearance than for health. A few extra pounds are usually not a health hazard.

13. Do you take more than 2 alcoholic drinks a day? Yes 7% No 93%

Two ounces of alcohol a day may actually be beneficial, but more that this should be cause for concern.

14. Do you restrict your consumption of red meat to 3 times a week or less? Yes 44% No 56%

A surprising number of faculty restrict red meat consumption, probably because of evidence linking red meat consumption to bowel cancer, and possibly to avoid the animal (saturated) fat present in red meat.

15. Do you try to maintain a high bran or fiber content in your diet? Yes 41% No 59%

High fiber diets clearly help constipation. Some believe such diets also decrease the risk for bowel cancer by promoting more rapid evacuation of carcinogens from the colon.

16. Do you drink coffee? Yes 83% No 17%

Of those who drink coffee, 47% have 2 cups or fewer a day, 45% average 3 to 5 cups, and only 8% exceed 5 cups. Many of the health problems purported to be linked to coffee remain in question on careful study—but all would agree that too much coffee can cause jitteriness, palpitations, and insomnia.

17. Do you restrict your egg intake to 3 per week or fewer? Yes 79% No 21%

A surprisingly high degree of egg restriction, we thought, presumably due to concerns about cholesterol.

18. Does your household use margarine (as opposed to butter)? Yes 69% No 31%

Again, it's probably concern for cholesterol levels that prompts the use of margarine, which is high in polyunsaturated fat as compared to butter. Margarine is also less expensive.

19. Do you visit your dentist at regular intervals? Yes 84% No 16%

Good sense. Fewer root canal jobs, we hope.

20. Do you floss your teeth daily? Yes 41% No 59%

The greatest cause of tooth loss among adults is periodontal disease, not caries. And flossing should help remove the plaques that contribute to periodontal disease.

21. Do you take vacations during which no work is done? Yes 83% No 17%

Probably a healthy practice, but hardly an essential one. Several responders described their golf games as more work than play.

22. Do you take a daily multivitamin? Yes 14% No 86%

There's no real need for vitamin supplementation if one's diet is normal and special circumstances (e.g., pregnancy, digestive disorders) are not present.

23. Do you ever make purchases at stores devoted exclusively to health foods? Yes 25% No 75%

Many "health foods" are overpriced in respect to their true nutritional value. At times, they may produce a positive placebo effect of "feeling good."

24. Do you use vitamin C to protect against colds? Yes 14% No 86%

Few seem to believe that vitamin C really works. Or else they find that daily pill taking is more bothersome than a few days of sneezing and dripping.

25. Do you take a laxative or enema if you don't have a bowel movement for 2 days? Yes 3% No 97%

There's wide variation in bowel habits among normal people, and apparently few of our faculty believe the ads promoting medications to achieve "regularity."