A Sense of Calling and Primary Care Physicians’ Satisfaction in Treating Smoking, Alcoholism, and Obesity

Nicotine dependence, obesity, and alcoholism respond to treatment by primary care physicians, but research suggests established treatment protocols are rarely used.1,2 It may be that physicians shy away from addressing these multifaceted, often obdurate conditions because they find that treating them is unsatisfying.3,4 We use the results of a national survey of primary care physicians to examine correlates of physician satisfaction in treating these conditions. We hypothesized that physician satisfaction would be lower for physicians who believe patients are responsible for these conditions and who are dissatisfied with their careers. We hypothesized that treatment satisfaction would be higher for physicians who view medicine as a calling.

Methods. The data are from a national mail survey of 1504 US primary care physicians (those with a primary specialty of general internal medicine, family medicine, or general practice, and with no secondary specialty) who were 65 years or younger. The survey was conducted from 2009 to 2010. The overall response rate was 63% after excluding 77 primary care physicians who had invalid addresses or were no longer practicing. Data were weighted to represent the population of US primary care physicians. A more detailed description of the research design is presented elsewhere.5 Outcome measures were questions about how much personal satisfaction physicians experience when taking care of patients with alcoholism, obesity, and nicotine dependence. With respect to predictors, physicians were asked to indicate for each condition to the extent to which the condition resulted from choices for which patients are responsible. Career satisfaction was measured as agreement or disagreement with the statement, “If I had it to do over again, I would not choose medicine as a career.” Finally, physicians were asked whether they agree or disagree with the statement, “For me, the practice of medicine is a calling.” We used separate multivariable logistic regression models to estimate independent effects of patient responsibility, physician career satisfaction, and practice of medicine as a calling on each of the 3 conditions. Physician specialty, sex, age, race/ethnicity, region, immigration status, religious affiliation, and importance of religion were also included as covariates in the models.

Results. Physicians were most satisfied with treating nicotine dependence (62% experienced “some” or “a lot” of satisfaction), followed by obesity (57% experienced “some” or “a lot” of satisfaction) and alcoholism (50% said they experienced “some” or “a lot” of satisfaction; P <.01 for all comparisons). Multivariable analyses (Table) showed that physicians who indicated that medicine was a calling were significantly more likely to report satisfaction treating each condition (nicotine dependence, adjusted odds ratio [AOR], 1.9; obesity, AOR, 1.9; alcoholism, AOR, 1.6). Those dissatisfied with medicine as a career were significantly less likely to report satisfaction treating nicotine dependence (AOR, 0.7) and alcoholism (AOR, 0.6). Physicians who believed that the patient was responsible for the condition were significantly less likely to report satisfaction treating alcoholism (some vs no responsibility, AOR, 0.3; a lot vs no responsibility, AOR, 0.3).

Comment. This study is limited in that data were generated by physician self-reports. In addition, nonresponders may differ from responders in ways that bias the results. Also, causal direction cannot be determined from cross-sectional data such as these. Future research should examine the relationship of physicians’ sense of calling, their career satisfaction, their attribution of responsibility for the disorders to patients, and their satisfaction in treating the disorders to the actual implementation of treatment plans for these 3 common

medical disorders that have such important health consequences.

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COMMENTS AND OPINIONS

Additional Ways to Diminish the Deleterious Effects of Red Meat

W e read with great interest the article by Pan et al1 discussing the results of 2 prospective cohort studies addressing the issue of red meat consumption and mortality. The authors found a positive correlation between red meat consumption and an increased risk in total cardiovascular disease (CVD) and cancer mortality. They also proposed the substitution of other healthy protein sources to lower mortality risks due to CVD and cancer.

Red meat is a major source of protein and other micronutrients in large populations around the world; therefore, it would not be easy to replace it with other (may be more expensive) dietary sources. We would like to stress that there might be additional ways to diminish the deleterious effects of red meat rather than avoiding it. Red meat might undergo enhanced lipid peroxidation in the stomach, which serves as an endogenous bioreactor2,3; this process leads to the massive production of lipid peroxidation end products (eg, organic peroxides, reactive aldehydes) that in turn, may gain access to the blood circulation. Many of these deleterious compounds are also carcinogens and strong oxidants and might contribute to development of CVD and cancer.

We have demonstrated that the coconsumption of red wine rich in polyphenols with red meat can significantly decrease the stomach oxidation process of the meat products and prevent the absorption of meat-derived aldehydes to the plasma.4 Recently, we also demonstrated...