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National Ambulatory Medical Care Survey: Terrorism Preparedness Among Office-Based Physicians, United States, 2003–2004

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Abstract

Objectives—This investigation describes terrorism preparedness among U.S. office-based physicians and their staffs in identification and diagnosis of terrorism-related conditions, training methods and sources, and assistance with diagnosis and reporting.

Methods—The National Ambulatory Medical Care Survey (NAMCS) is an annual national probability survey of approximately 3,000 U.S. nonfederal, office-based physicians. Terrorism preparedness items were added in 2003 and 2004.

Results—About 40 percent of physicians or their staffs received training for anthrax or smallpox, but less than one-third received training for any of the other exposures. About 42.2 percent of physicians, 13.5 percent of nurses, and 9.4 percent of physician assistants and nurse practitioners received training in at least one exposure. Approximately 56.2 percent of physicians indicated that they would contact state or local public health officials for diagnostic assistance more frequently than federal agencies and other sources. About 67.1 percent of physicians indicated that they would report a suspected terrorism-related condition to the state or local health department, 50.9 percent to the Centers for Disease Control and Prevention (CDC), 27.5 percent to the local hospital, and 1.8 percent to a local elected official's office. Approximately 78.8 percent of physicians had contact information for the local health department readily available. About 53.7 percent had reviewed the diseases reportable to health departments since September 2001, 11.3 percent had reviewed them before that month, and 35 percent had never reviewed them.

Keywords: bioterrorism • medical education • preparedness • ambulatory care

Introduction

In response to the terrorism incidents of September 2001, the Office of the Assistant Secretary for Planning and Evaluation (OASPE), Department of Health and Human Services, requested that the National Center for Health Statistics survey a nationally representative sample of U.S. physicians' offices on their preparedness for treating patients in the aftermath of terrorist attacks. OASPE provided funding to add several relevant questions to the 2003 and 2004 NAMCS. Information about strengths and limitations of terrorism preparedness in physicians' offices is crucial for planning how terrorism preparedness funding may be used to improve the domestic defensive posture.

Methods

NAMCS is an annual survey of U.S. nonfederal, office-based physicians, excluding anesthesiologists, radiologists, and pathologists. The survey reports on trends in utilization within the physicians' outpatient practices. A multistage survey design is used, with the frame constructed from 112 geographic primary sampling units and physician practices within those

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units. A sample of 3,000 physicians per year was selected in both 2003 and 2004 from the masterfiles of the American Medical Association and the American Osteopathic Association. The data were weighted according to the inverse probability of selection, with an adjustment for nonresponse. Therefore, estimates are considered representative of similar office-based practices across the entire Nation. Of 2,007 in-scope physicians sampled in 2003, 1,114 responded to the induction interview. Of 1,961 in-scope physicians sampled in 2004, 1,121 responded. The total response rate for both years was 56.3 percent, representing about 311,000 physicians per year nationwide. Descriptive analyses were performed using SUDAAN 9.0.1 software, with significant differences among frequencies defined as nonoverlapping 95 percent confidence intervals (1).

Terrorism preparedness items were added to the 2003 and 2004 NAMCS as part of the physician induction interview (see the description of the items below). Data were collected by U.S. Census Bureau field representatives by means of face-to-face interviews with the physicians. Additional information on data collection and response to the 2003 through 2004 NAMCS has been published (2). Excerpts from the questionnaire related to terrorism preparedness can be found in the "Technical Notes."

Physicians (allopathic or osteopathic) were asked whether they or their staff had received special training since September 2001 in the identification and diagnosis of several terrorism-related diseases or conditions. Staff included the physicians as well as physician assistants, nurse practitioners, registered and licensed practical nurses, and other staff employed by physicians. The diseases or conditions included smallpox, anthrax, plague, botulism, tularemia, viral hemorrhagic fever, viral encephalitis, and chemical and radiological exposures.

Physicians were also asked questions concerning the following areas:

- Where they would turn for assistance in diagnosing patients with unusual symptoms suggesting a terrorist-related condition.
- Whom they would contact to report a terrorism-related disease or condition.
- If they had contact information for the local health department readily available in their offices or primary practice sites.
- Whether they had reviewed the list of reportable diseases in their state or local jurisdictions since September 2001.

Results

Training

Training was received for anthrax by 40.7 percent of either physicians or their staffs, and by 40.2 percent for smallpox—frequencies that were significantly larger than those of training for other exposures. Training was received for chemical exposures by 32.6 percent of either physicians or their staffs, for viral encephalitis by 28.9 percent, for botulism by 28.5 percent, for radiological exposures by 28.5 percent, and for plague by 27.8 percent. Training was received for viral hemorrhagic fever by 25.4 percent of physicians or their staffs and for tularemia by 25 percent—frequencies that were significantly less than those of training received for anthrax, smallpox, and chemical exposures (Figure 1).

A breakdown of training frequencies for each of the nine exposures by individual clinician types is presented in Table 1. Overall, 42.2 percent of physicians received training in at least one exposure (2), but only 13.5 percent of nurses and 9.4 percent of physician assistants and nurse practitioners received such training. The percentages for all three groups were significantly different from one another (Figure 2). A breakdown of these percentages by practice characteristics is presented in Table 2.

Among clinicians who received any training, physicians were trained for a mean of 6.0 of the nine exposures, physician assistants and nurse practitioners for 5.3 of the exposures, and nurses for 4.8 of the exposures. There were no significant differences by practice characteristics, with the exception of some regional variations for physicians, physician assistants, and nurse practitioners (Table 3).

Diagnostic assistance

Diagnostic assistance would be sought from state or local public health officials by 56.2 percent of physicians,

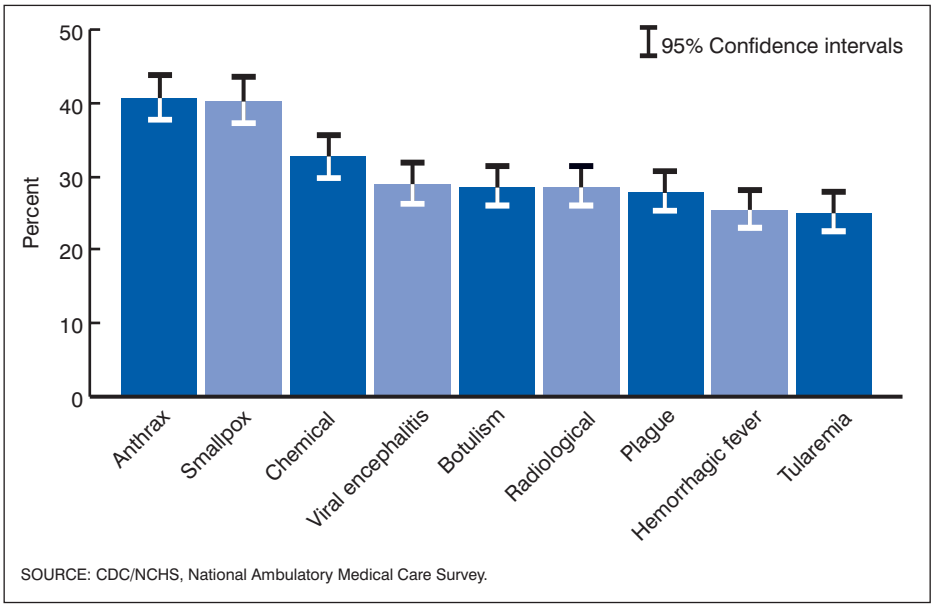

Figure 1. Percentage of physicians or their staffs trained in the identification and diagnosis of terrorism-related exposures: United States, 2003–2004

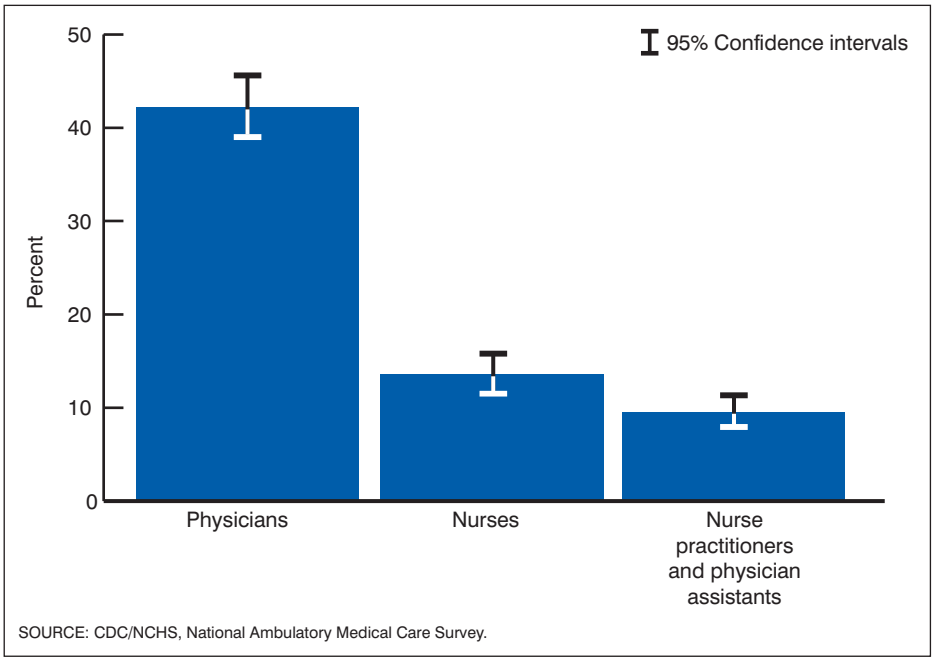

Figure 2. Percentage of physician office staff trained in the identificatin and diagnosis of at least one terrorism-related exposure: United States, 2003–2004

which is significantly more frequent than diagnostic assistance sought from CDC or other federal agencies (49.0 percent) and colleagues or consultants (44.6 percent). Furthermore, assistance in diagnosing symptoms potentially related to terrorism would be sought significantly more frequently from state or local health officials, federal agencies, or colleagues than from the Internet (16.3 percent), medical associations (16.0 percent), medical journals (13.5 percent), medical textbooks (13.2 percent), or other sources (14.6 percent) (Table 4).

Reporting practices

The leading agencies to which physicians indicated that they would report a suspected terrorism-related condition included the state or local health department (67.1 percent), CDC (50.9 percent), and the local hospital (27.5 percent). These frequencies were significantly different from one another and from less frequently mentioned agencies (Table 5).

Contact information for the local health department was readily available (e.g., posted, speed dial, or rolodex) in 78.8 percent of physicians' offices. Primary care physicians had this contact information available more frequently than medical or surgical specialists. Physicians with 3 to 10 managed care contracts had contact information more frequently than those with no managed care contracts (Table 6).

The list of diseases reportable to health departments had been reviewed by 53.7 percent of physicians since September 2001 and by 11.3 percent before September 2001, whereas 35 percent had never reviewed the list (this includes the 5 percent who did not respond to the question). The information had been reviewed since September 2001 by primary care physicians more frequently than by medical and surgical specialists, by rural physicians more frequently than by urban physicians, and by physicians with 3 to 10 managed care contracts more frequently than by those with none. Physicians practicing in the South had reviewed the list of reportable diseases prior to September 2001 more frequently than physicians practicing in the West, but there were no regional differences in physicians having reviewed this information since September 2001 (Table 7).

Discussion

The frequencies of training of medical office physicians and their staffs in the management of terrorism-related diseases are quite low. Although this report shows that physicians who had received any bioterrorism training at all had covered two-thirds of the exposures, only about 4 of every 10 physicians were in that category. A previous report using NAMCS data presented a more specific analysis with respect to the training of physicians themselves and the characteristics that predict the likelihood that this training occurs. When all physicians in the sample were taken into account, they had received training in only about three of the nine exposures (3). In comparison to the NAMCS office-based physicians, hospital-based clinicians had received terrorism response training more frequently. In the 2003 through 2004 Bioterrorism Supplements to the National Hospital Ambulatory Medical Care Survey, about 88 percent of nurses, 75 percent of staff physicians, and 47 percent of physician assistants and nurse practitioners working in hospital outpatient departments and emergency departments had received training in at least 1 of 10 terrorism-related biological, chemical, or radiological diseases or conditions (4).

All of these diseases are rare in office practice. There were three total U.S. cases of plague in two states reported to CDC in 2004, attributable to contact with fleas or rabbits (5). As of August 25, 2006, there were 13 plague cases from four states reported in 2006, caused by contact with rabbits, rodents, dogs, and fleas. Prophylactic antibiotics were administered to at least 58 people who had contact with the patients. These cases compare with a median of seven plague cases per year reported to CDC between 1990 and 2005 (6). There were 134 cases of tularemia reported to CDC in 2004 from contact with arthropods, mammals, and lab cultures, and 133 total cases of botulism were reported, including those classified as infant, food borne, wound, and toxin injection sources. No cases of anthrax were reported, and only one case of

laboratory exposure to anthrax spores was reported (5).

The Health Resources and Services Administration initiated the Bioterrorism Training and Curriculum Development Program in 2003, awarding $22.3 million to 19 academic institutions to provide bioterrorism continuing education for health professionals and $4.2 million for health professional school curriculum development (7). However, funding levels have fallen since 2005, and the budget estimate for this program in fiscal year 2007 is about $12.4 million (8). A large gap exists between training for physicians and training for the other clinicians working in their offices. Because nurse practitioners and physician assistants see patients independently, with only later review by their collaborating or supervising physicians, the gap between these clinicians and the physicians is of concern. However, federal funding for bioterrorism training is not limited to physicians. The Bioterrorism Training and Curriculum Development Program reported training 26,004 nurses, 14,789 physicians, 2,737 nurse practitioners, and 1,113 physician assistants in fiscal year 2005 (7).

Diagnostic assistance tends to be requested from appropriate public health sources. Physicians are also likely to report these diseases to appropriate agencies, such as the health department or CDC. Of note is the small percentage of physicians who would report bioterrorism-related diseases to sources not usually capable of dealing with these reports, particularly the local medical association or local elected officials.

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Table 1. Percentage of office-based physicians, physician assistants and nurse practitioners, and nurses trained in the identification and diagnosis of selected terrorism-related exposures: United States, 2003–2004

Exposures	Physicians		PA[1] and NP[2]		Nurses	
	Percent	SE[3]	Percent	SE	Percent	SE
Anthrax	38.3	1.6	8.0	0.8	10.6	1.0
Smallpox	38.1	1.6	7.7	0.8	11.3	1.1
Chemical	29.8	1.4	6.4	0.8	8.7	0.9
Viral encephalitis	26.2	1.3	4.8	0.7	6.3	0.7
Botulism	26.0	1.3	4.9	0.7	6.0	0.8
Radiological	25.9	1.3	5.3	0.7	6.7	0.8
Plague	25.4	1.3	4.6	0.7	5.4	0.7
Viral hemorrhagic fever	22.7	1.2	4.4	0.6	4.9	0.7
Tularemia	22.4	1.3	3.9	0.6	5.0	0.7

[1]PA is physician assistant.
[2]NP is nurse practitioner.
[3]SE is standard error.

NOTES: Physician estimates based on unweighted n=2,235, corresponding to 311,170 physicians per year. PA and NP estimates based on unweighted n=1,990, corresponding to 276,147 office-based physicians with physician assistants or nurse practitioners per year. Nurse estimates based on unweighted n=2,056, corresponding to 284,730 office-based physicians with nurses per year.

Table 2. Number and percentage of office-based physicians, physician assistants and nurse practitioners, and nurses trained in the identification and diagnosis of at least one terrorism-related exposure, by selected practice characteristics: United States, 2003–2004

Exposures	Physicians			PA[1] and NP[2]			Nurses		
	N[3]	Percent[4]	SE[5]	N	Percent	SE	N	Percent	SE
All physicians	311,200	42.2	1.7	276,100	9.4	0.9	284,700	13.5	1.1
Specialty									
Primary care	153,700	49.5	2.2	133,700	13.4	1.5	138,300	17.9	1.7
Surgical	84,500	31.9	2.1	76,800	5.6	1.1	78,800	9.2	1.3
Medical	73,000	38.8	3.0	65,600	5.5	1.2	67,600	9.2	1.8
Metropolitan statistical area									
Urban	275,000	41.4	1.7	245,500	9.0	0.9	251,500	11.9	1.2
Rural	36,200	48.6	5.2	30,600	12.2	2.7	33,300	25.1	3.3
Region									
Northeast	66,600	48.6	3.0	58,600	10.3	2.0	59,900	10.2	1.7
Midwest	69,400	41.3	3.9	61,200	9.6	1.9	64,300	16.4	2.2
South	105,000	39.3	3.1	92,800	8.6	1.4	95,600	15.1	2.2
West	70,200	41.4	2.9	63,600	9.5	1.9	64,900	11.2	2.5
Managed care contracts									
None	42,700	30.5	3.6	39,000	*2.9	1.4	39,300	4.9	1.5
1–2	34,700	44.8	4.0	31,100	12.9	3.0	32,500	18.5	4.3
3–10	121,500	44.3	2.5	105,300	9.4	1.5	109,900	14.6	1.7
More than 10	112,200	43.6	2.4	100,800	10.7	1.4	103,100	13.9	2.0
Practice size									
Solo	111,500	35.7	2.5	101,400	3.1	0.8	104,300	6.9	1.1
Partner	36,700	45.4	3.6	32,300	12.9	2.6	33,100	11.7	2.3
3–5 physicians	83,600	47.2	2.8	71,800	12.1	1.8	74,200	17.7	2.4
6–10 physicians	46,100	44.6	3.7	41,600	13.9	2.7	42,700	17.1	3.0
11 or more physicians	33,300	44.5	3.8	29,000	14.1	3.4	30,500	22.3	3.8

* Figure does not meet standards of reliability or precision (unweighted sample size less than 30, or relative standard error greater than 30 percent).
[1]PA is physician assistant.
[2]NP is nurse practitioner.
[3]N is the weighted number of physician offices having each type of clinician per year.
[4]Percent is the number of physician offices with training for each type of provider divided by the total number of offices that employ each type of provider.
[5]SE is standard error.

Table 3. Mean number of terrorism-related exposures for which selected clinicians who work in practices of office-based physicians have received training in identification and diagnosis, by selected practice characteristics: United States, 2003–2004

Characteristic	Physicians				PA[1] and NP[2]				Nurses			
	N[3]	Mean	SE[4]	95% CI[5]	N	Mean	SE	95% CI	N	Mean	SE	95% CI
All physicians	131,300	6.0	0.1	5.8–6.3	25,900	5.3	0.3	4.7–5.9	38,300	4.8	0.2	4.4–5.3
Specialty												
Primary care	76,000	6.0	0.2	5.6–6.3	18,000	5.3	0.4	4.5–6.0	24,800	4.7	0.3	4.2–5.3
Surgical	26,900	6.1	0.2	5.6–6.6	4,300	5.6	0.6	4.5–6.7	7,300	5.2	0.5	4.3–6.2
Medical	28,400	6.2	0.3	5.7–6.7	3,600	5.2	0.7	3.9–6.6	6,200	4.8	0.6	3.6–5.9
Metropolitan statistical area												
Urban	113,700	6.1	0.1	5.8–6.4	22,100	5.5	0.3	4.8–6.1	30,000	4.8	0.3	4.3–5.3
Rural	17,600	5.7	0.4	4.9–6.5	*	*	*	* *	8,300	5.1	0.5	4.1–6.1
Region												
Northeast	32,300	5.6	0.3	5.1–6.2	6,000	5.4	0.6	4.3–6.5	6,100	4.5	0.5	3.6–5.4
Midwest	28,600	5.6	0.3	5.0–6.2	5,900	6.3	0.6	5.0–7.6	10,500	5.7	0.4	4.8–6.6
South	41,200	6.2	0.2	5.8–6.6	7,900	4.1	0.4	3.3–4.9	14,400	4.3	0.3	3.7–5.0
West	29,100	6.7	0.2	6.2–7.2	6,000	6.0	0.7	4.7–7.3	7,200	4.9	0.5	3.8–5.9
Managed care contracts												
None	13,000	6.1	0.5	5.2–7.0	*	*	*	* *	*	*	*	* *
1–2	15,500	6.1	0.4	5.4–6.8	*	*	*	* *	6,000	5.0	0.6	3.9–6.2
3–10	53,800	5.9	0.2	5.6–6.3	9,900	5.6	0.5	4.6–6.6	16,100	4.6	0.4	3.9–5.4
More than 10	48,900	6.1	0.2	5.7–6.5	10,800	5.0	0.4	4.2–5.7	14,300	4.9	0.4	4.2–5.6
Practice size												
Solo	39,800	6.2	0.2	5.8–6.7	*	*	*	* *	7,200	4.2	0.5	3.4–5.1
Partner	16,700	5.7	0.4	5.0–6.4	4,200	4.8	0.6	3.6–6.0	3,900	4.0	0.6	2.7–5.2
3–5 physicians	39,500	5.9	0.2	5.4–6.3	8,700	5.4	0.5	4.5–6.3	13,100	5.3	0.4	4.5–6.1
6–10 physicians	20,500	6.1	0.3	5.5–6.8	5,800	5.7	0.6	4.4–7.0	7,300	5.2	0.5	4.3–6.2
11 or more physicians	14,800	6.2	0.4	5.4–7.1	*	*	*	* *	6,800	4.7	0.7	3.3–6.1

* Figure does not meet standards of reliability or precision (unweighted sample size less than 30, or relative standard error greater than 30 percent).
[1]PA is physician assistant.
[2]NP is nurse practitioner.
[3]N is the weighted number of practices having each type of clinician per year.
[4]SE is standard error.
[5]CI is confidence interval.

NOTE: Means are based upon the clinicians who have received training in at least one exposure.

Table 4. Percentage of physicians who would seek assistance from selected sources for diagnosing symptoms possibly related to terrorism: United States, 2003–2004

Source	Percent	SE[1]
State or local health officials	56.2	1.7
CDC[2] or other federal agency	49.0	1.4
Colleague or consultant	44.6	1.9
Internet	16.3	1.2
Medical association	16.0	1.2
Medical journals	13.5	1.1
Medical textbook	13.2	1.0
Other	14.6	1.1

[1]SE is standard error.
[2]CDC is Centers for Disease Control and Prevention.

NOTES: Physician estimates based on unweighted n=2,235, corresponding to 311,170 physicians per year.
More than one source of diagnostic assistance could be reported.

Table 5. Percentage of office-based physicians who would report information about a patient with possible terrorism-related symptoms to selected agencies: United States, 2003–2004

Source	Percent	SE[1]
State or local health department	67.1	1.5
Centers for Disease Control and Prevention	50.9	1.5
Local hospital	27.5	1.3
Other state or local government agencies	11.4	1.0
Local medical association	9.1	0.9
Law enforcement	8.8	0.8
Other federal agency	7.0	0.8
Laboratory	5.4	0.7
Local political office	1.8	0.4
Other	7.3	0.7

[1]SE is standard error.

NOTES: Physician estimates based on unweighted n=2,235, corresponding to 311,170 physicians per year. More than one agency could be reported.

Table 6. Number and percentage of office-based physicians who have health department contact information readily available in their offices (e.g., posted, speed dial, or rolodex), by selected practice characteristics: United States, 2003–2004

Characteristic	N[1]	Percent	SE[2]	95% CI[3]
All physicians	311,200	78.8	1.2	76.4–81.1
Specialty				
Primary care	153,700	85.6	1.7	82.0–88.6
Surgical	84,500	73.0	1.9	69.2–76.5
Medical	73,000	71.5	2.6	66.2–76.3
Metropolitan statistical area				
Urban	275,000	77.8	1.3	75.1–80.2
Rural	36,200	86.9	3.2	79.4–92.0
Region				
Northeast	66,600	76.9	2.6	71.4–81.6
Midwest	69,400	77.2	2.7	71.5–82.0
South	105,000	80.7	1.9	76.6–84.2
West	70,200	79.6	2.7	73.9–84.4
Managed care contracts				
None	42,700	68.9	3.6	61.4–75.6
1–2	34,700	82.3	3.1	75.4–87.6
3–10	121,500	82.4	1.7	78.9–85.5
More than 10	112,200	77.7	2.2	73.1–81.6
Practice size				
Solo	111,500	75.2	2.1	71.0–79.0
Partner	36,700	78.3	3.3	71.0–84.1
3–5 physicians	83,600	83.4	2.1	78.9–87.1
6–10 physicians	46,100	79.2	2.8	73.1–84.2
11 or more physicians	33,300	79.5	3.3	72.2–85.3

[1]N is the weighted annual number of office-based physicians.
[2]SE is standard error.
[3]CI is confidence interval.

Table 7. Percent distribution of office-based physicians who last reviewed the list of reportable diseases before September 11, 2001, since that date, or not at all, according to selected practice characteristics: United States, 2003–2004

Characteristic	Reportable diseases reviewed									
	Before September 2001				Since September 2001			List not reviewed		
	N[1]	Percent[2]	SE[3]	95% CI[4]	Percent	SE	95% CI	Percent	SE	95% CI
All physicians	311,200	11.3	0.9	9.6–13.2	53.7	1.5	50.8–56.6	35.0	1.5	32.2–38.0
Specialty										
Primary care	153,700	12.9	1.4	10.3–16.0	61.4	2.0	57.5–65.1	25.7	1.9	22.2–29.6
Surgical	84,500	11.6	1.3	9.3–14.4	46.1	2.4	41.5–50.8	42.3	2.3	37.8–46.9
Medical	73,000	7.5	1.3	5.3–10.5	46.2	2.9	40.6–51.9	46.3	2.9	40.7–52.1
Metropolitan statistical area										
Urban	275,000	11.8	1.0	10.1–13.9	51.9	1.6	48.8–55.0	36.3	1.6	33.2–39.4
Rural	36,200	7.1	2.2	3.8–12.7	67.1	4.3	58.3–74.9	25.8	3.9	18.9–34.3
Region										
Northeast	66,600	10.2	1.9	7.1–14.6	50.5	2.8	45.0–56.0	39.3	3.1	33.4–45.4
Midwest	69,400	10.9	1.6	8.1–14.5	50.6	3.1	44.5–56.7	38.5	3.6	31.8–45.7
South	105,000	15.3	2.0	11.9–19.5	55.6	2.9	49.9–61.1	29.1	2.7	24.2–34.6
West	70,200	6.6	1.2	4.7–9.4	56.9	2.9	51.1–62.5	36.5	2.8	31.1–42.2
Managed care contracts										
None	42,700	9.3	2.0	6.1–14.0	44.6	3.8	37.3–52.1	46.1	3.8	38.8–53.6
1–2	34,700	8.9	2.0	5.8–13.6	56.0	4.2	47.6–64.0	35.1	4.0	27.7–43.3
3–10	121,500	9.8	1.3	7.6–12.6	57.1	2.1	52.8–61.2	33.2	2.2	28.9–37.7
More than 10	112,200	14.3	1.9	11.1–18.4	52.8	2.4	48.0–57.5	32.9	2.4	28.4–37.7
Practice size										
Solo	111,500	13.3	1.7	10.3–16.9	49.6	2.4	45.0–54.2	37.2	2.4	32.6–42.0
Partner	36,700	12.6	2.2	8.8–17.7	50.3	4.0	42.5–58.2	37.1	3.8	30.0–44.7
3–5 physicians	83,600	10.6	1.7	7.7–14.4	56.2	2.5	51.3–61.1	33.2	2.5	28.6–38.2
6–10 physicians	46,100	8.9	1.8	6.0–13.1	58.6	3.6	51.5–65.4	32.4	3.5	26.1–39.5
11 or more physicians	33,300	8.2	2.3	4.7–13.8	58.0	4.4	49.3–66.2	33.9	4.2	26.1–42.6

[1]N is the weighted annual number of office-based physicians.
[2]Percent is percentage of office-based physicians who last reviewed the list of notifiable diseases.
[3]SE is standard error.
[4]CI is confidence interval.

NOTE: Row percentages add to 100 percent.

Technical Notes

Section II – INDUCTION INTERVIEW – Continued

26. This next set of questions deal with preparedness for bioterror events.

a. Have you or your staff received special training (e.g., in-service or other courses, CME, Grand Rounds, or self-guided study) since September 2001 in the identification and diagnosis of the following terrorism-related diseases/conditions?

☐ None –*SKIP to item 27a on page 14.*

	Type of personnel who received training. *Mark (X) appropriate columns* **OR** *mark (X) N/A box, if the physician's practice does not have this type of personnel.*			
	MD/DO	☐ N/A PA/NP	☐ N/A RN/LPN	☐ N/A Other
(1) Smallpox	1☐	2☐	3☐	4☐
(2) Anthrax	1☐	2☐	3☐	4☐
(3) Plague	1☐	2☐	3☐	4☐
(4) Botulism	1☐	2☐	3☐	4☐
(5) Tularemia	1☐	2☐	3☐	4☐
(6) Viral Hemorrhagic fever	1☐	2☐	3☐	4☐
(7) Viral Encephalitis (WNV, SLE, EEE, VEE, etc.)	1☐	2☐	3☐	4☐
(8) Chemical exposure	1☐	2☐	3☐	4☐
(9) Radiological exposure	1☐	2☐	3☐	4☐

b. Which methods of training were utilized for the diseases/conditions for which you or your staff received training?

(Mark (X) all that apply.)

1☐ Instructor-led course/workshop
2☐ Self-study course
3☐ Book or journal article
4☐ Other – *Please Specify* ➶

c. Who conducted the training?

(Mark (X) all that apply.)

1☐ Professional association (e.g., medical, physician assistant, nursing, and/or laboratory)
2☐ State or local public health department
3☐ Other state or local government agency
4☐ Federal agency
5☐ Hospital
6☐ Insurance organization
7☐ Private vendor
8☐ Other – *Please specify* ➶

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Section II – INDUCTION INTERVIEW – Continued

27a. Where would you turn for assistance in diagnosing patients presenting with unusual patterns of symptoms possibly related to terrorism?

(Mark (X) all that apply.)

1 ☐ CDC/Other Federal agency
2 ☐ Colleague/Consultant
3 ☐ Internet
4 ☐ Medical association
5 ☐ Medical journals/Peer-reviewed literature
6 ☐ Medical textbook
7 ☐ State/Local public health officials
8 ☐ Other – *Please specify*

b. If you believe that a patient under your care has acquired one of the diseases/conditions listed above, to whom would you report that information?

(Mark (X) all that apply.)

1 ☐ CDC
2 ☐ Other Federal agency
3 ☐ Laboratory
4 ☐ Law enforcement
5 ☐ Local hospital
6 ☐ Local medical association
7 ☐ Local political office
8 ☐ State or local public health department
9 ☐ Other state or local government agency (e.g., Office of Emergency Management)
10 ☐ Other – *Please specify*

Section II – INDUCTION INTERVIEW – Continued

28a. Is contact information for your local health department readily available in your office or primary practice site (e.g., posted, speed dial, or rolodex)?

1 ☐ Yes
2 ☐ No

b. When did your office last review the list of diseases defined as reportable in your state or local jurisdiction?

1 ☐ Before September 2001
2 ☐ Since September 2001
3 ☐ Not reviewed list

29. What is the preferred method in your practice for receiving updates about the prevention, diagnosis, therapy and reporting of terrorism-related conditions?

(Mark (X) one.)

PROBE for only one answer.

1 ☐ Conferences
2 ☐ E-mail
3 ☐ Facsimile transmission
4 ☐ Health Alert Network (HAN)
5 ☐ Other Internet – *Specify site*
6 ☐ Mail
7 ☐ Medical journals
8 ☐ News media (e.g., television, newspapers, etc.)
9 ☐ Professional specialty societies
10 ☐ Telephone

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