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The Professional Attitudes and Clinical Practices of Men and Women Generalists

SUMMARY

Data from a 1983–84 Quebec generalists' survey were used to compare the professional attitudes and clinical practices of women physicians with those of their male colleagues. The survey was conducted on a random sample of 736 Quebec generalists and achieved a 83.7% response rate. Analyses were performed separately for fee-for-service physicians and for salaried physicians working in local community health centers (CLSCs). Results showed more gender differences among fee-for-service physicians than among salaried physicians. Women in private practice were more likely than their male colleagues to value the multidisciplinary, social, and humanistic aspects of patient care. For their part, women salaried physicians reported being significantly more involved in the social and preventive dimensions of health care than their male colleagues. Important attitudinal differences were observed between fee-for-service and salaried generalists, regardless of gender. This study suggests that neither the medical training nor the organizational constraints of the work setting succeed in levelling off all gender differences. The findings also suggest that women physicians can help promote aspects of health care to which much importance has been attributed in recent years. (*Can Fam Physician* 1989; 35:59–63.)

RÉSUMÉ

On s'est servi des données obtenues par l'enquête menée en 1983-84 auprès des omnipraticiens du Québec pour comparer les attitudes professionnelles et les pratiques cliniques des femmes-médecins à celles de leurs collègues de sexe masculin. Un échantillon randomisé composé de 736 omnipraticiens du Québec ont participé à l'enquête avec un taux de réponse de 83.7%. Dans l'analyse, on a séparé les réponses obtenues des médecins rémunérés à l'acte de celles obtenues des médecins à rémunération fixe oeuvrant dans les centres locaux de services communautaires (CLSC). Les résultats ont révélé plus de différences entre les sexes chez les médecins à l'acte que chez les médecins à salaire. Les femmes en pratique privée, comparativement à leurs collègues mâles, ont exprimé attacher plus d'importance à la multidisciplinarité et aux aspects sociaux et humanistes des soins. D'autre part, les femmes travaillant à salaire s'impliquent significativement plus dans les dimensions sociales et préventives que leurs collègues mâles. On a observé d'importantes différences en termes d'attitudes entre les omnipraticiens à l'acte et les médecins à rémunération fixe, indépendamment du sexe. Cette étude suggère que ni la formation médicale ni les contraintes organisationnelles du milieu de travail ne réussissent à égaliser toutes les différences de sexe. Elle suggère aussi que les femmes-médecins peuvent contribuer à promouvoir certains aspects des soins auxquels on accorde beaucoup d'importance depuis quelques années.

Key words: general practice, physician attitudes, physician gender.

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THE LAST FEW DECADES have been marked by an important increase in the number of women entering medicine. In Quebec alone, the percentage of women physicians has doubled in the last 10 years to reach, in 1986, a high of 25.3% among generalists and 12.1% among specialists.¹ Since the proportion of women admitted to medical schools continues to grow, the number of women physicians may eventually reach or even exceed the number of men physicians. In 1987, women made up more than 40% of students enrolled in Canadian medical schools.² In Quebec, the proportion of women is even greater: more than half the medical student body is composed of women.²

The feminization of medicine may have a profound impact on the delivery of health-care services. Several studies have shown that women physicians differ from their male counterparts both on specialty choice and practice patterns. Indeed, women physicians were reported as more interested in primary care medicine and less attracted by surgery and subspecialties.^{1,3-6} Regarding practice patterns, women physicians were shown as more likely to work in urban centres and in institutional settings, to choose salaried practice,^{7,8} and to conduct a less diversified type of medical practice, spending proportionally more time than men in office care but being less involved in hospital and emergency care, home care, and administrative work.^{3,9,10}

However, not much research has examined the professional attitudes and clinical practices of women physicians. Research among freshman medical students showed that women tended to display more sensitivity to doctor-patient relationship, more general acceptance of patients' feelings, and more openness to the psychosocial aspects of medicine than their male colleagues.¹¹⁻¹⁴ Among se-

nior students, the results are somewhat less conclusive. While the results of the longitudinal study by Leserman¹³ showed that senior women students still placed more importance on social and psychological factors in health care, the study of Maheux and colleagues¹⁴ disclosed few, if any, gender differences among senior students relating to the importance given to the interpersonal, psychosocial, and preventive aspects of the physician's role.

All these studies were conducted on samples of medical students. Little is known about the professional attitudes and clinical practices of men and women physicians, once in practice. This study seeks to determine whether men and women physicians have different professional values toward health care issues debated in Quebec over the last 15 years. It also seeks to assess whether there are gender differences in physicians' clinical practices.

Methodology

Data for the study reported here were collected from a representative sample of Quebec physicians as part of a mail survey conducted in 1983-84. The aim of the survey was to determine to what extent physicians' interest in various health-care themes advocated during the last 15 years in Quebec (such as patient involvement in health care, biopsychosocial approach, and humanization of care) varied according to their so-

ciodemographic background, their area of specialization, and the characteristics of their medical practice.

The survey was conducted by means of a mail questionnaire sent to a random stratified sample of 736 Quebec generalists. This sample was drawn from the population of 4488 generalists listed in the computerized files of the Federation of General Practitioners of Quebec as francophone, practising medicine in Quebec, and directly involved in the provision of patient care. Retired generalists or practitioners not providing direct patient care were thus excluded from the study. The sample was stratified on three variables: gender, post-doctoral training (mixed or rotating internship or residency training in family medicine), and type of practice (fee-for-service or salaried) for a total of eight strata. Simple random sampling was used within the eight strata of the sample. Of the 736 physicians selected in the sample, 392 were men, and 344 were women. The study achieved an 83.7% response rate. The high response rate was obtained by sending three follow-ups after the initial mailing of the questionnaire and by using the Dillman Total Design Method of implementing mail surveys.¹⁵

Comparisons between men and women generalists were performed according to the two types of general practice found in Quebec: private of-

Table 1
Quebec Physician Survey, 1983-84.
Professional Attitudes of Fee-for-Service and CLSC Generalists: Age-Adjusted Mean Scores by Gender

Professional ^a Attitudes	Fee-for-Service Physicians		CLSC Physicians	
	Men (n=184)	Women (n=147)	Men (n=136)	Women (n=147)
Multidisciplinary in health care	-.07	.25 ^b	.85	.76
Social components in health care	-.34	-.04 ^b	.15	.32
Illness as a potential source of personal growth	.02	.14	.34	.28
Patient involvement in health care	-.21	-.30	.31	.28

a. See Appendix for composition of attitude scales.

b. $p < .01$.

fice practice on a fee-for-service basis and salaried practice in local community health centres (CLSCs). CLSCs are publicly owned primary care centres that provide both medical and social services at the local community level.

Within each type of medical practice, men and women generalists were compared on their attitudes toward greater patient involvement in health care, illness as a potential source of personal growth, the social component in health care, and the multidisciplinary in health-care services. Men and women generalists were also compared on their reported clinical practices: namely, on the actions they take to allow the patient greater involvement in his or her own care; to account for social and preventive aspects of health care; and to ensure an interpersonal relationship of quality with the patient.

The attitudes and clinical practices of physicians were measured with multi-item scales. The item composition of the scales were validated through factor analysis. The scales were constructed from the factor score co-efficients. They are thus standardized variables (mean = 0, standard deviation = 1) ranging mainly from -3.0 to +3.0. The composition and reliability of the scales are given in the Appendix.

Since women surveyed were generally younger than their male colleagues, the results were controlled for the seven-year age difference be-

tween men and women generalists working on a fee-for-service basis (men = 40.3; women = 33.0) and the three-year age difference between men and women generalists in CLSC practice (men = 34.3; women = 30.9). Analysis of covariance was the technique used in analysing the data. Data were processed using the SPSS-X statistical software.

Results

As shown in Table 1, some differences were observed in the attitudes of men and women generalists. For fee-for-service physicians, the results showed that, compared to men, women expressed more positive attitudes toward the social and multidisciplinary components of health-care services. The differences were highly statistically significant ($p < .01$). There were, however, no differences in the attitudes of male and female generalists towards illness as a potential source of personal growth and patient involvement in health care.

In contrast to generalists working on a fee-for-service basis, men and women generalists working in CLSCs did not differ in their attitudes towards the multidisciplinary and social components of health-care services. Both groups favoured these two aspects of health care to a greater extent than did their colleagues in fee-for-service practice. Furthermore there were no gender-related differences in CLSC physicians' attitudes to illness as a potential source of person-

al growth and patient involvement in health care.

In the matter of clinical practices, some gender differences were observed (Table 2). While women physicians working on a fee-for-service basis gave more importance in their practice to humanization of health care than did their male counterparts, women physicians in CLSC practice reported being more involved in the social and preventive aspects of health care than were their male colleagues. Women physicians in both types of practice tended to score higher than their male colleagues as promoting patient involvement in health care. The results were not, however, statistically significant ($p > .05$).

Discussion

This study examined the professional attitudes and clinical practices of a representative sample of men and women generalists practicing in Quebec. Physicians in fee-for-service and in CLSC practice were considered separately.

Among practitioners working on a fee-for-service basis, a number of gender differences were observed. Compared to men, women had more favourable attitudes to multidisciplinary in health-care services and to the psychosocial aspects of patient care. They also showed greater concern for humanization of care in their medical practice. These results corroborate previous studies of medical students.^{11,12} They tend to indicate that women keep at least some of their characteristics as they advance from medical students to medical practitioners, and that neither the medical training nor the work setting leads to a complete levelling of gender differences. These results suggest that the feminization of the medical profession can promote aspects of care that have been judged essential to ensure a high quality of medical care.¹⁶

Whereas women practitioners working on a fee-for-service basis valued the multidisciplinary, psychosocial and humanistic aspects of patient care more than did their male counterparts, these gender differences were not present among CLSC physicians. Closer examination of the results indicates that both men and women give more importance to these aspects than do their colleagues

Table 2
Quebec Physician Survey, 1983-84.
The Clinical Practices of Fee-for-Service
and CLSC Generalists: Age-Adjusted Mean Scores by Gender

Clinical ^a Practices	Fee-for-Service Physicians		CLSC Physicians	
	Men (n=172)	Women (n=143)	Men (n=130)	Women (n=145)
Patient involvement in health care	-.12	.05	-.01	.16
Social/preventive dimensions of health care	.11	.17	.20	.44 ^c
Humanization of health care	-.04	.14 ^b	.07	.17

a. See Appendix for composition of clinical practice scales.

b. $p < .05$.

c. $p < .01$.

in the private sector. These results clearly show that type of practice is an important variable to control when examining the relationship between physicians' gender and professional attitudes and practices.

Several factors may explain why men and women physicians working in CLSCs form a more homogeneous group. First, it is likely that there is a selection effect. In other words, CLSCs attract physicians who, independently of gender, share the same interest in a biopsychosocial approach to health care. Secondly, the organization of the CLSCs may contribute to the maintenance or development of attitudes and clinical practices consistent with the health-care ideology supported by CLSCs. A final reason may be that the proportion of women physicians is higher in CLSCs than in private practice, and that when they are in the majority, women may have an influence on the attitudes and clinical practices of their male colleagues. Indeed, women constitute more than half the physician body working in CLSCs, while they make up only about 20% of general practitioners as a whole. This argument is supported by Kanter's theory.¹⁷ According to this theory, a majority of women in an organization creates attitudinal and behavioural modifications among members of the organization. Some gender differences remain, however, since women physicians allow significantly more importance in their practice to the social and preventive dimensions of health care than do their male counterparts.

To what extent women physicians will continue to differ from their male colleagues is unknown. Answers to this question are needed to predict the impact on medical practice of the medical profession's feminization. Some argue that gender differences will persist and perhaps even increase as more and more female role models participate in medical training.^{13,18} Others suggest, on the contrary, that the long "cohabitation" of men and women in medical school will help to reduce gender differences in medical practice.^{19,20} All agree that more research is needed to determine how this important sociodemographic change in the medical profession will affect medical practice and the delivery of health-care services. ■

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References

1. Contandriopoulos AP, Fournier MA. *Les effectifs médicaux au Québec. Situation de 1972 à 1986 et projection pour 1990*. Corporation professionnelle des médecins du Québec, 1987.
2. Ryten E. Enrolment in Canadian faculties of medicine, 1987-88. *Forum* 1987; 21(1):1-4.
3. Bobula JD. Work patterns, practice

characteristics, and incomes of male and female physicians. *J Med Education* 1980; 55:826-33.

4. Weisman CS, Levine DM, Steinwachs DM, Chase GA. Male and female physician career patterns: specialty choices and graduate training. *J Med Education* 1980; 55:813-25.

5. Adams EK, Bazzoli GJ. Career plans of women and minority physicians: implications for health manpower policy. *J Am Med Women's Assoc* 1986; 41, 1:17-20.

6. Bowman M, Gross ML. Overview of research on women in medicine: issues for public policy makers. *Public Health Reports* 1986; 5:513-21.

7. Wunderman LE. Female physicians in the 1970s: their changing roles in medicine. In: Glandon GL, Shapiro RJ, eds. *Profile of medical practice*. Chicago: American Medical Association, 1980.

8. Ogle KS, Henry RC, Durda K, Zivick JD. Gender-specific differences in family practice graduates. *J Fam Pract* 1986; 23, 4:357-60.

Appendix

Professional Attitude Scales

Degree of agreement or disagreement on a four-point scale with the following statements:

1. Multidisciplinary in health care

A multidisciplinary approach favours better quality of care.

I prefer to function alone rather than on a multidisciplinary team.

I consider that there are more disadvantages than real advantages to multidisciplinary work in the health field.

In my view, too much importance is attached to multidisciplinary in the health field.

(Alpha coefficient = 0,81)

2. Social components in health care

The expenses of curative care should be lowered in favour of preventive care.

For many health problems, the psychosocial approach is preferable to the biomedical approach.

It is high time several health problems were demedicalized.

The biological sciences are more useful to the study of health than the psychosocial sciences.

(Alpha coefficient = 0,58)

3. Illness as a potential source of personal growth

There are good things as well as bad things in having an illness.

I do not see anything very positive in the fact of having an illness.

Illness can often be a source of personal growth.

(Alpha coefficient = 0,76)

4. Patient involvement in health care

It is important to ensure that the patient understands his health problem as much as possible.

I would rather the patient understand less than more about his illness.

It is preferable not to give the patient too much information on his illness so as not to worry him.

It is essential that the patient have a good understanding of his illness.

9. Ellsbury K, Schneeweiss R, Montano DE, Gordon KC, Kuykendall D. Gender differences in practice characteristics of graduates of family medicine residencies. *J Med Education* 1987; 62:895-903.

10. Maheux B, Dufort F, Lambert J, Berthiaume M. Do female general practitioners have a distinctive type of medical practice? *Can Med Assoc J.* 1988; 139:737-41.

11. Kaufman-Cartwright L. Conscious factors entering into decisions of women to study medicine. *J Social Issues* 1972; 28:201-15.

12. Streit-Forest U. Caractéristiques psycho-sociales d'un groupe d'étudiants en médecine à l'entrée à la faculté. *Union médicale du Canada* 1980; 109:1569-77.

13. Leserman J. *Men and women in medical school: how they change and how they compare.* New York: Praeger (special studies), 1981.

14. Maheux B, Dufort F, Béland F. Professional and sociopolitical attitudes of medical students: gender differences re-

considered. *J Am Med Women's Assoc* 1988; 43:7376.

15. Dillman DA. *Mail and telephone surveys: the total design method.* New York: John Wiley and Sons, 1978.

16. Engel G. Need for a new medical model: a challenge for biomedicine. *Science* 1977; 196:129-36.

17. Kanter RM. Some effects of proportion on group life: skewed sex ratios and responses to token women. *Am J Sociology* 1977; 82:965-90.

18. Ernst R, Yett DE. Physicians' background characteristics and their career choices: a review of the literature. *Medical Care* 1984; 41:1-36.

19. Elliot CM. Women physicians as workers. *J Am Med Women's Assoc* 1981; 36, 3:105-8.

20. Eisenberg C. Similarities and differences between men and women as students. *J Am Med Women's Assoc* 1981; 36, 2:45-50.

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For reducing the risk of recurrent transient ischemic attacks or stroke in men who have had transient ischemia of the brain due to fibrin platelet emboli. At present there is no evidence that ASA is effective in reducing transient ischemic attacks in women, or is of benefit in the treatment of completed strokes in men or women. ASA has been shown to be effective in reducing the risk of morbidity and death in patients who recently have suffered a myocardial infarction.

For reduction in the adhesive properties of the platelets in patients with diseased arteries, artificial blood vessel shunts and heart valves, and in patients with spontaneous platelet aggregation syndromes. Prophylaxis of venous thromboembolism after total hip replacement in men.

CONTRAINDICATIONS: Salicylate sensitivity, active peptic ulcer.

WARNINGS: ASA is one of the most frequent causes of accidental poisoning in toddlers and infants. Tablets should be kept well out of the reach of children.

PRECAUTIONS: Administer salicylates cautiously to patients with asthma and other allergic conditions, a history of gastrointestinal ulcerations, bleeding tendencies, significant anemia or hypoprothrombinemia. Patients taking ASA daily are at an increased risk of developing gastrointestinal bleeding following the ingestion of alcohol. Caution is necessary when salicylates and anticoagulants are prescribed concurrently, as salicylates can depress the concentration of prothrombin in the plasma. Diabetics receiving concurrent salicylate-hypoglycemic therapy should be monitored closely, and reduction of the sulfonylurea hypoglycemic drug dosage or insulin requirements may be necessary. Caution is advised when prescribing ASA-containing medications to children and teenagers because of possible association with Reye Syndrome, a rare but serious illness. High doses (3g daily) of ASA during pregnancy may lengthen the gestation and parturition time. Salicylates can produce changes in thyroid function tests. Sodium excretion produced by aspirinolone can be decreased by salicylate administration. Salicylates in large doses are uricosuric agents, smaller amounts may depress uric acid clearance and thus decrease the uricosuric effects of other drugs. Salicylates also retard the renal elimination of methotrexate.

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Treatment consist of prevention and management of acid-base and fluid and electrolyte disturbances. Renal clearance is increased by increasing urine flow and by alkaline diuresis but care must be taken in this approach to not further aggravate metabolic acidosis and hypokalemia. Acidemia should be prevented by administration of adequate sodium containing fluids and sodium bicarbonate. Hypoglycemia is an occasional accompaniment of salicylate overdosage and can be managed by glucose solutions. If a hemorrhagic diathesis is evident, give vitamin K. Hemodialysis may be useful in complex acid base disturbances particularly in the presence of abnormal renal function.

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References:

1. Elwood PC, Cochran AL, Burr ML, et al: A randomized controlled trial of acetylsalicylic acid in the secondary prevention of mortality from myocardial infarction. *Br Med J* 1974; 1:436-40.
2. The Coronary Drug Project Research Group: Aspirin in coronary heart disease. *J Chron Dis* 1976; 29:625-42.
3. Breddin K, Low D, Lechner K, et al: Secondary prevention of myocardial infarction: comparison of acetylsalicylic acid, phenprocoumon and placebo: a multicenter two-year prospective study. *Thrombosis and Haemostasis* 1979; 41: 225-36.
4. Aspirin Myocardial Infarction Study Research Group: A randomized, controlled trial of aspirin in persons recovered from myocardial infarction. *JAMA* 1980; 243:661-9.
5. Elwood PC, Sweetman PM: Aspirin and secondary mortality after myocardial infarction. *Lancet* 1979; 2:1313-5.
6. The Persantine-Aspirin Reinforcement Study Research Group: Persantine and aspirin in coronary heart disease. *Circulation* 1980; 62:449-61.
7. A randomized trial of aspirin and sulfinpyrazone in threatened stroke. The Canadian Co-operative Study Group. *New Engl J Med* 1978; 299:53-9.
8. Demko DM, Luderer JR, Wakefield LK, et al: The effect of itazirigel and aspirin on the mucosa of the esophagus, stomach and duodenum of normal subjects. *J Clin Pharmacol* 1987; 27:916-20.
9. Stern A, Ward F: Similar gastric damage caused by a single low dose and regular doses of aspirin. Abstract, Annual Scientific Meeting 1988: Gastroenterological Society of Australia.
10. Lanza FL, Royer GL, Nelson RS: Endoscopic evaluation of the effects of aspirin, buffered aspirin and enteric coated aspirin on the gastric and duodenal mucosa. *New Engl J Med* 1980; 303:136-8.
11. Data on file, SmithKline Consumer Products.
12. Faigel DJ, Jakubowski JA, Stamper MJ, et al: Multiple doses of regular and enteric coated aspirin produces equivalent platelet inhibitory effects. *Curr Ther Res* 1986; 39:519-27.

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The patient should always make the final decision about his treatment.

It is often justifiable to hide information from the patient.

Certain decisions about treatment are too fraught with consequences to be left up to the patient.

I would like to see the patient adopt a critical attitude towards his treatment.

(Alpha coefficient = 0,77)

Clinical Practice Scales

The frequency with which the physician succeeds in doing the following things when meeting a patient. Four answers were provided ranging from "almost never" to "almost always".

1. Patient involvement in health care

If the patient is hesitant about medical recommendations, encourage him to ask for a second opinion.

Ask him to explain the prescribed treatment in his own words.

Encourage him to ask questions.

Give him sources of information about his health problem.

Encourage him to use resource persons other than those of your profession.

Explain to him that he must make the ultimate decision about his treatment.

(Alpha coefficient = 0,63)

2. Social/preventative dimensions of health care

Try to find out about the patient's circumstances.

Enquire about any personal problems that might be worrying the patient.

Promote healthy life habits in the patient.

(Alpha coefficient = 0,73)

3. Humanization of health care

Take your time with the patient.

Demonstrate warmth for the patient.