Perceptions of Family Practice Residents Regarding Health Care and Poor Patients

James H. Price, PhD, MPH, Sharon M. Desmond, PhD, Frank F. Snyder, MD, and Sanford R. Kimmel, MD
Toledo, Ohio

The purpose of this study was to assess residents' beliefs about the poor. Residents from eight different Ohio residency programs completed the questionnaire (N = 130). No significant differences were found in beliefs about the poor based on resident age, year of residency training, size of the community in which the resident was raised, and percentage of low-socioeconomic-status patients cared for. Most residents perceived the welfare system as lacking; 83 percent agreed the poor are caught in a "cycle of poverty," 82 percent agreed welfare benefits cause the poor to be dependent upon the system, and 48 percent believed indigent women become pregnant and have babies so they can collect welfare support. Conversely, only one in four residents believed that most poor people become poor as a result of lack of effort on their part, and one in five believed that society is coddling the poor.

The majority of residents believed that poor patients are more likely than others to miss appointments without canceling (73 percent), more likely to be late for appointments (51 percent), and less knowledgeable about their illnesses (80 percent). One in four residents believed that poor patients tend not to appreciate the work of physicians and nurses, and 43 percent claimed that the poor are more difficult patients. The majority of residents believed that the poor are unlikely to practice preventive health behaviors (72 percent) or to be compliant with their medical regimen (60 percent). Finally, 41 percent believed that poor patients usually care less than others about their own health status.

Family physicians more than ever need to be aware of the health care needs of indigent people for several reasons. First, in 1983, 35.5 million people, or 15 percent of the population, fell below the US Census Bureau's poverty line and were classified as indigent,[1] the highest level of poverty in the United States in almost 20 years. Second, because of poor health status, poor patients are likely to make more physician visits per person per year.[2] Third, because family physicians are more likely than other specialties to settle in small towns and inner cities, they are likely to be more geographically available to indigent patients.[3] Finally, since family physicians are perceived as being more accessible and humanitarian than other physicians, they are more likely to be perceived by low-income patients as preferred caregivers.[4] Thus, family physicians are more likely to be called upon to exercise the imperative of all physicians, to help provide equitable and quality health care to the poor.

The purpose of this study was to examine one factor that may affect the quality of health care provided indigent patients, namely, family practice residents' beliefs about the poor. Several questions were specifically examined: (1) What are residents' perceptions of the poor in general? (2) How do residents perceive their relationships with poor patients? (3) What are residents' perceptions of health care provided the poor? (4) Do residents' perceptions of the poor differ based on various background items such as age, year of residency, size of the community in which the resident was raised, and percentage of low-socioeconomic-status patients seen?

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From the Department of Health Promotion and Human Performance, University of Toledo, The WW Knight Family Practice Center, The Toledo Hospital, and the Department of Family Practice, Medical College of Ohio, Toledo, Ohio. Requests for reprints should be addressed to James H. Price, Department of Health Promotion and Human Performance, University of Toledo, Toledo, OH 43606.

METHODS

The subjects for this study were obtained from eight large family practice residency programs in the state of Ohio. A total of 162 questionnaires were mailed to the respective residency directors, who in turn distributed them to their residents. The anonymously completed questionnaires were returned by means of a self-addressed stamped envelope.

Based on a review of the literature on health care and the poor, a 42-item questionnaire was developed examining three components of residents' perceptions of the poor: 11 items concerning general beliefs about the poor, seven items concerning professional relations with patients who are poor, and 14 items covering health care for poor patients. Responses to these items were obtained with seven-point Likert-type scales (ie, strongly agree to strongly disagree). Ten other questions, mainly background items on the residents, completed the questionnaire. To encourage a high response rate, the questionnaire was designed to require no more than 15 minutes to complete.

A factor analysis was conducted on the responses to the questionnaire, and 90 percent of the items loaded on one factor. Thus, the instrument seemed to measure a single dimension, attitude toward the poor. To test the reliability of the questionnaire, both internal consistency and stability reliability were examined. A group of 28 senior medical students were administered the questionnaire on two occasions one week apart. The test–retest reliability was 0.79. Internal reliability was estimated by Cronbach's alpha and was found to be 0.88.

RESULTS

A total of 130 residents (80 percent) returned the questionnaire. Because of the high return rate, nonresponse bias was minimized, so very little threat was posed to external validity as it relates to Ohio family practice residents. A total of 101 men (78 percent) and 29 women (22 percent) responded. Ninety-four percent of the respondents were white; therefore, no further analysis was done in relation to race. The residents ranged in age from 25 to 43 years (mean 29.6 years, standard deviation 3.6 years). One third of the residents were in their first year of training, one third were second-year residents, and one third were third-year residents. Ninety-six percent of the residents were born in the United States. Thirty-six percent were Catholic, 41 percent were Protestant, none were Jewish, and 23 percent were of other or no affiliation. The size of the community in which the residents were raised was as follows: rural (n = 12); village, population 1,000 to 4,999 (n = 12); small city, population 5,000 to 24,000 (n = 34); medium city, population 25,000 to 99,999 (n = 25); large city, population 100,000 to 499,999 (n = 28); and major metropolitan area, population 500,000+ (n = 19). Ninety percent of the residents perceived they were raised in a middle-class family, while 5 percent thought they were raised in a lower-class family, and 5 percent perceived they were raised in an upper-class family. When asked what percentage of their current patient load was of low socioeconomic status, 47 percent answered less than one half and 53 percent claimed more than one half.

Four of the background variables were examined in relation to the residents' perceptions of the poor, including age, year of residency training, size of the community in which the resident was raised, and percentage of low-socioeconomic-status patients seen. Kruskal-Wallis nonparametric analyses of variance were conducted among pairs of these four variables to determine whether there were significant differences between groups. There was a significant difference between current year of residency training and percentage of low-socioeconomic-status patients cared for ($P < .05$). First-year residents reported seeing more patients of low socioeconomic status than did second- or third-year residents. There were no significant differences among the other pairs of variables. One-way analysis of variance (ANOVA) or analysis of covariance (ANCOVA), as appropriate, was calculated on the background variables with each of the belief statements on the questionnaire.

The residents' general beliefs about the poor are summarized in Table 1. Table 2 describes residents' beliefs concerning professional relations with poor patients. Approximately one third to two thirds of the residents believed the poor are likely to be difficult patients, late for appointments, and likely to miss appointments (Table 2). The majority of residents, however, did not perceive poor patients to be less friendly than most patients, nor did the majority perceive the poor as not liking physicians and nurses.

Items concerning health care provided to poor patients focused on three issues: (1) quality of care given, (2) the economy and health insurance, and (3) health behaviors of the poor. Sixty-two percent of the residents felt that the quality of care poor patients receive is not equivalent to the care all other patients receive (Table 3). Also, 45 percent agreed transferring patients from one hospital to another because of inability to pay is very common. Most residents (81 percent) believed millions of Americans are without any form of health insurance; one half felt that the poor are more likely to "take advantage" of the health care system, and 72 percent believed that a small deductible or copayment should be required to prevent this from occurring. Almost one half of the residents believed that the poor are likely to engage in preventive health

TABLE 1. GENERAL BELIEFS ABOUT POVERTY AND THE POOR (percent)

Item	Agree*	Neutral	Disagree
Government spending on poverty programs should be (greatly increased to greatly reduced)**	42	33	25
Welfare benefits cause the poor to be dependent on the system	82	8	11
Most poor people become poor as a result of lack of effort on their part rather than circumstances byond their control	28	24	49
Most poor people have been poor for a long time and will probably remain poor	67	16	17
The poor are caught in a "cycle of poverty" that perpetuates poor work habits and low self-esteem	83	10	8
Young women in poverty often get pregnant to have babies so that they can collect welfare support	48	23	30
The poor are usually minority patients (ie, black and Hispanic)	48	20	32
I think we are coddling the poor; most poor people live well on welfare	19	20	61
Most poor people prefer to stay on the welfare rolls	38	20	42
A person's poverty is frequently due to advantages squandered or opportunities they had and did not take	22	20	58

** Agree = 7, 6, or 5; neutral = 4; and disagree = 3, 2, or 1 on a 7-point scale.*

*** Scale for this item was greatly increased (agree) to greatly reduced (disagree)*

TABLE 2. PERCEIVED PROFESSIONAL RELATIONS WITH PATIENTS WHO ARE POOR (percent)

Item	Agree*	Neutral	Disagree
Poor patients tend to be less friendly than most patients	16	16	69
Poor patients are less likely than most to be able to understand directions given to them regarding their care	52	20	29
Poor patients often do not like physicians and nurses	14	20	67
Poor patients are most likely to be late for health care appointments	51	23	26
Poor patients are more likely to miss appointments without calling ahead of time to cancel	73	10	17
The poor are usually more difficult patients to deal with	43	20	37
Poor patients tend not to appreciate the work of physicians and nurses	28	16	57

** Agree = 7, 6, or 5; neutral = 4; and disagree = 3, 2, or 1 on a 7-point scale*

behaviors because free health care is provided, and agreed that poor patients usually care less about their own health status.

DISCUSSION

Perceptions of the poor tend to shape both the way professionals treat the poor and the policy alternatives they support regarding poverty. A significant portion of the residents (82 percent) believed welfare benefits cause the poor to be dependent on the system, and more than one third believed most poor people prefer to stay on the welfare rolls. Wilson and Aponte[5] have reviewed a variety of factors associated with urban poverty and have concluded that most studies have found Aid for Families with Dependent Children has had a small (but significant) negative effect on labor force participation. O'Neill[6] has reported that about one half of the women starting welfare do not stay on it beyond one year. If the women who stay on welfare are followed over time, about 70 percent will accumulate more than two years on welfare, whereas one in four will be on welfare ten years or longer.

Almost one half of the residents supported the statement "Young women in poverty often get pregnant to have babies so that they can collect welfare support." In April 1985 the *Los Angeles Times* interviewed 2,444 people, including an oversampling of 272 individuals who met the federal guidelines for poverty.[7] They found 48 percent of the respondents also believed poor young women often have babies in order to collect welfare. In addition, 64 percent of the respondents who lived in poverty said poor women often have babies to become eligible for welfare. Recent research, however, has found that level of welfare benefits does not have a significant impact on the fertility of unmarried black or white women, and modestly increases the likelihood of separation and divorce.[8]

Approximately one fourth of the residents believed most poor people are poor because they are lazy and that

TABLE 3. PERCEPTIONS OF HEALTH CARE FOR POOR PATIENTS (percent)

Item	Agree*	Neutral	Disagree
Free health care for the poor causes the poor to be less motivated to engage in preventive health behavior	52	18	31
Medicare and Medicaid programs have taken care of most of the health needs of the poor	25	15	61
The quality of care that poor patients receive is equivalent to the care that all other patients receive	28	11	62
Poor patients usually are not willing to make payments toward their medical bills	42	23	36
The poor are usually not compliant with their medical regimens	60	15	25
Poor patients are usually less knowledgeable about their illnesses than the general population	80	12	9
The poor are less likely than the nonpoor to practice preventive health behaviors	72	12	16
There are millions of Americans who are without any form of public or private health insurance	81	10	10
The practice of transferring patients from one hospital to another because those patients do not have a means of paying for their care is very common	45	16	39
The poor are more likely to attempt to "take advantage" of the health care system	48	22	31
Poor patients usually care less about their own health status	41	21	39
Assisting the poor in becoming well is a waste of medical care, since they will be back again soon with another health problem	7	9	84
Anyone who is poor and does not have health care simply does not use the Medicaid or Medicare programs that are available to them	10	16	74
To keep the poor from abusing the health care system, they should be required to pay a small deductible or copayment for the health services they receive	72	16	13

** Agree = 7, 6, or 5; neutral = 4; and disagree = 3, 2, or 1 on a 7-point scale*

most poor live well on welfare. These residents are espousing a belief that most poor persons "deserve" to be poor. In reality, many of the poor become caught up in a "culture of poverty" that perpetuates poor work habits, low self-esteem, inadequate nutrition, and chronic illness, which result in dependency on the system. A young adult reared in poverty is three times more likely to set up a poverty household when compared with a young adult reared in nonpoverty homes.[5] The perception that adults willingly go on welfare as an easy means of earning a living seems to ignore that only in certain circumstances can intact families, single adults, and childless couples be eligible for any of the three major welfare programs: Aid to Families with Dependent Children (AFDC), Social Security Income (for the aged, blind, and disabled), or Medicaid. Furthermore, 40 percent of those living in poverty are under the age of 18 years.[9]

Almost one half of the respondents believed that the poor are usually minorities (ie, black and Hispanic). In reality, two thirds of those below the poverty level are white and only one fourth are black.[1] Yet blacks are three times more likely to be poor than are whites, 35 percent vs 11.5 percent, respectively. Residents may have perceived blacks as constituting the majority of the poor because blacks are likely to make up a much greater portion of urban poor.[10] Most of the residents in this study practice in an urban area; hence, they are likely to encounter a greater number of poor patients who are black.

In regard to professional relations with poor patients, the majority of residents perceived poor patients as more likely to be late for appointments or to miss appointments, and less likely to be able to understand directions regarding their care. Deyo and Inui,[11] in a review of the literature on dropouts and broken appointments, confirmed that almost every study finds low socioeconomic status significantly correlated with broken appointments. Also, since most individuals who live in poverty have limited formal education, it would not be surprising that most would have more difficulty in understanding directions regarding their care. Because many poor patients are not well educated, physicians must exercise special effort when communicating with these patients.

A majority of the residents did not perceive the quality of care of poor patients to be equivalent to the care all other patients received. Many residents agreed patients are commonly transferred from one hospital to another because of their inability to pay. There has been a growing body of research concerning patient dumping. Patient

dumping can be defined as denial or limitation of medical services for economic reasons resulting in the patient being referred elsewhere.[12] Studies have found that the transferred patients are almost always without insurance or are on Medicaid, and inordinate numbers are minorities.[13,14]

The majority of residents correctly believed that millions of Americans are without any form of health insurance; this is true of possibly as much as 15 to 20 percent of the population.[15] About one quarter of the residents believed Medicare and Medicaid programs have taken care of most of the health needs of the poor. Evidence indicates, however, that although the largest group of Medicaid recipients are eligible through AFDC (68 percent), they accounted for only 36 percent of total Medicaid spending in 1983.[15] Link et al[16] have shown that not so great a percentage of black needy as white receive Medicaid. This lack of insurance has been credited, in part, for over 1,000 "excess deaths" that occur each week among black Americans.[9]

Approximately one half of the residents believed that the poor are more likely to "take advantage" of the health care system, and almost three fourths believed that abuse of the health care system would be greatly reduced by requiring the poor to pay a small deductible or copayment. Whether a group is overutilizing or underutilizing health care services can be assessed only in relation to the need for such services, which can be derived, in part, from the incidence of illness and injury among those groups. Davis and colleagues[17] have claimed, "If health care services are to be allocated equitably by need, the poor should be using more health services than the nonpoor." A national survey of utilization of health care services in 1985, however, did not find significant differences among those who visited physicians between low-socioeconomic-status individuals and those who earned $35,000 or more per year when comparing number of physician visits made by these two groups.[18] Furthermore, patients who were of low socioeconomic status were 50 percent less likely to have visited a physician during the past two years than those with incomes of $35,000 or more. The poor are known to have more chronic health problems than the nonpoor. Thus, it may be hypothesized that to require them to have copayments or deductibles would most likely decrease utilization rates but increase the severity of the health problems once they are brought to the attention of health professionals. The result might likely be greater health care costs, more disability, and less participation in the workforce.

The majority of residents perceived poor patients as less knowledgeable about their illnesses, less likely to engage in preventive health behaviors, and less likely to be compliant with their medical regimens. Since most poor patients are those with less education, one may expect poor patients would be less knowledgeable about their illnesses.[19] A recent review on preventive health behaviors has confirmed that lower socioeconomic level subjects are less likely to engage in common preventive health behaviors.[20] There is no research, however, to show that low socioeconomic level individuals value health any more or less than other groups.

Overall, the majority of these residents had positive attitudes toward the poor and health care. One fourth to one third, however, held negative perceptions, which is a relatively large percentage of residents, given the issue involved. One would hope that physicians would not hold negative attitudes toward the poor. These negative perceptions might be communicated to patients, thereby resulting in patients feeling their physician does not value them. Feeling unvalued in turn might cause the patient to fail to comply with recommended treatment or follow-up care, resulting in impaired quality of care for the poor.

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Commentary

Debra L. Roter, DPH
Baltimore, Maryland

Unlike the ideal prototype of the physician,[1] "real" physicians are much like the rest of us in their general prejudices and stereotypes of the poor. The above study of physicians' attitudes toward poor patients by Price and colleagues[2] adds to a small body of research contributing to this disappointing, but not unsuspected, finding. Even in light of these findings, however, one still might question whether in practice a physician's professionalism will prevail over prejudicial attitudes.

The alarming reality is that a convincing literature exists to suggest that these negative attitudes indeed reflect disturbing behaviors in the clinical encounter. By using meta-analytic techniques to characterize the research literature describing physician-patient communication, patients' social class was found to be significantly associated with several elements of communication.[3,4] Patients of higher social classes receive more information, more positive talk, and more talk overall than patients of lower social classes. There is also evidence that the higher the social class of patients, the higher the quality of care, both technical and interpersonal, that they are likely to receive.[1]

Patient ethnicity or race is confounded with social class in most studies, and race is also related to several aspects of communication. White patients receive more information, less question asking, and more positive talk from physicians than do minority patients.[3] Moreover, white patients receive higher quality of care than black or Hispanic patients.[1]

Care setting may also act as an indicator of social class distinction in that poorer patients tend to use clinic services rather than private practice. In this regard, the meta-analysis revealed that private practice patients ask more questions than clinic patients and receive more information from their physicians and have significantly shorter visits overall.[3]

The pattern of results from the meta-analysis implies alternative provider styles of communication tailored to patients with different sociodemographic profiles. Taken together, the picture that emerges suggests that physicians are more "patient centered" when interacting with patients who are of higher socioeconomic status; that is, physicians talk more and give more information but ask fewer questions. There is also some indication that patients of higher socioeconomic status may be more active participants in the therapeutic process, their participation marked by more questions addressed to the physician. In contrast, when physicians are with patients of low socioeconomic status, they appear more "physician centered," that is, they are less informative and spend more time in directing the visit by asking the patient questions.

Some 30 years ago Pratt and associates[5] observed that clinic patients typically assume a passive stance during the medical encounter. While patient passivity may be less prevalent now than in the 1950s, indications are that it is only less so for the educated and affluent.[6] Patients of low socioeconomic status are still likely to adopt a passive stance in medical exchanges and to seem unconcerned to their physicians. Indeed, the communication cycle described in an earlier work by Pratt et al still rings true:

> . . . [W]hen a doctor perceives the patient as rather poorly informed, he considers the tremendous difficulties of translating his knowledge into language the patient can understand along with the dangers of frightening the patient. Therefore, he avoids involving himself in an elaborate discussion with the patient; the patient, in turn, reacts dully to this limited information, either asking uninspired questions, or refraining from questioning the doctor at all, thus reinforcing the doctor's view that the patient is ill-equipped to comprehend his problem. This further reinforces the doctor's tendency to skirt discussion of the problem. Lacking guidance by the doctor, the patient performs at a low level; hence, the doctor rates his capacities as even lower than they are.

Despite the diffidence of patients, however, there is little evidence that these patients are uninterested in their health. Waitzkin[7] notes in his study of social class and physician-patient communication that there were no class distinctions among patients in their desire for information; in fact, virtually all patients want more information than

they are likely to get from their physician. Expressing the desire for information, however, may be the problem. Patients of lower socioeconomic status appear more passive verbally and use different sociolinguistic patterns in the medical exchange than do more affluent patients.[8,9]

Physician insensitivity to differences in cultural expression and language use by poor patients can foster the incorrect impression that poor patients are not interested in matters of health, as is well documented by Price and colleagues.[2] These impressions result in the ironic reality that most physicians spend less time overall, and spend less informative time during the medical visit with just those patients who most need instruction, encouragement, and help. Since these visits tend to be plagued by more serious conditions, physicians may be unaware that they are failing their patients by inattention to patient information needs and by perpetuating a nonproductive passivity.

There may yet be reason for optimism. Physicians' communication skills in the medical interview have received growing attention over the past 20 years with most major medical schools now including at least one such course in their curriculum. Patient-centered interviewing has been the focus of much of this activity, with increasing emphasis on its clinical application and its positive effects for patient comprehension, compliance, and functional status.[10] Finally, several studies experimentally increasing patient participation in the medical encounter show promising results in terms of compliance and functional status.[11,12]

Recognition and confrontation of medicine's failure to the poor is the painful but necessary antecedent to remedy. The challenge that faces medicine is nothing less than the need to transform the traditional clinical model, which encourages and reinforces patient passivity, into a new, patient-centered model that maximizes patient resources in partnership with physicians in their own care.[13]

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Debra Roter is Associate Professor, Division of Behavioral Sciences and Health Education, Department of Health Policy and Management, Johns Hopkins School of Hygiene and Public Health, Baltimore, Maryland.