科技部補助專題研究計畫成果報告
期末報告

分析台灣醫生性別與醫療環境內領導力和人道關懷的關係研究

計 畫 類 別 ： 個別型計畫
計 畫 編 號 ： MOST 107-2629-H-010-001-
執 行 期 間 ： 107年08月01日至108年07月31日
執 行 單 位 ： 國立陽明大學醫學系精神學科

計 畫 主 持 人： 范佩貞
共 同 主 持 人： 黃冠華、陳修聖、陳李魁
計畫參與人員： 碩士班研究生-兼任助理：曾國瑋
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中 華 民 國 108 年 10 月 30 日

中 文 摘 要 ： 背景：
國內外一些研究指出不同性別的醫生在領導力、病患溝通、及對病患汙名化或歧視程度有差異。以上因素之背後動機與環境影響複雜且重要，因為這些因素會影響醫生工作品質與病患福祉。
目標：
本研究就不同性別醫生的領導力與人道關懷因素，人道關懷主要包含醫生對精神病患的歧視和汙名化態度進行深入了解、探索分析文獻以及相關測量工具討論並做整理。
方法：
本研究進行國內外相關文獻全面性回顧，挑選具國際信效度的領導力與人道關懷各主題測量工具，做翻譯與評估分析整理，並搜尋整理以及評估國際醫學領導力以及反汙名化的醫學教育相關介入方案。
結果：
醫學教育在未來醫生的專業觀點、信念和態度的形塑上佔有至關重要的一席之地。然而精神病患者的污名化程度不僅普遍存在於公眾，在醫生和其他醫療衛生專業人員中也同樣存在。本研究針對醫學領導力與人道關懷中的疾病汙名化相關文獻、測量工具、介入方案作分析評估與建議。 並揀選建議醫學參與量表、精神疾病患者社區態度量表、對精神疾病患者的恐懼和行為意向量表、臨床醫生精神疾病態度量表、醫護人員心思開放量表、精神健康知識量表等相關議題的工具。
貢獻：
本研究對醫生領導力及對弱勢病患態度因素進行搜尋整理分析與研究，並做性別倡議與建議，推動性別平等，加強醫學專業之領導力與人道關懷，分析評述整理可提供社會與機構將對人才培養、教育訓練、資源分配、社會價值觀氛圍型塑等有利參考。

中 文 關 鍵 詞 ： 醫學領導力，疾病汙名化，性別差異

英 文 摘 要 ： Background:
Gender difference in leadership, patient communication, and stigma/ discrimination among physicians have been indicated. The motivations and contexts of the above factors are complex and crucial because these factors may affect physicians' work quality and patient well-being.

Objective:
This study aims to explore the leadership and humanistic care factors of physicians of different genders. The investigation of humanistic care mainly focuses on discrimination and stigma attitudes toward patients with mental illness. We aim to examine and evaluate various associated factors, search and evaluate relevant assessment instruments and intervention plans.

Methods:
This study conducts a comprehensive review of related

literatures, selects internationally relevant and effective leadership and humane care measurement tools, performs translation and evaluation analysis, and searches and evaluates international medical leadership and anti-stigma intervention programs.

Results:
Medical education plays a vital role in shaping the professional development, behaviors, and attitudes of "tomorrow's doctors". The stigma of mental patients is not only common in the public, but also among doctors and health professionals. This study analyzes and recommends measurement tools and intervention in medical leadership and humane care. Selected instruments include Medical Engagement Scale (MES), Community Attitudes Toward the Mentally Ill Scale (CAMI), Fear and Behavioral Intentions Toward The Mentally Ill (FABI), Mental Illness: Clinicians' Attitudes Scale (MICA), Opening Minds Scale for Health Care Providers (OMS-HC), and Mental Health Knowledge Schedule (MAKS).

Significance:
This study conducts research on doctor leadership and attitudes toward vulnerable patients, and promote gender equality and the profession's leadership and human care capability. The study results may benefi the society and institutions in formulating policies and programs as well as in improving health care personnel training, education quality, resource allocation, and societal values.

英文關鍵詞：Medical Leadership, stigma, gender difference

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（□期中進度報告/■期末報告）

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執行機構及系所：國立陽明大學醫學系精神學科

計畫主持人：范佩貞

共同主持人：陳李魁、陳修聖、黃冠華

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□出席國際學術會議心得報告

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中華民國 108 年 6 月 20 日

目錄

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第一章 摘要

第一節英文摘要

Background:
Gender difference in leadership, patient communication, and stigma/ discrimination among physicians have been indicated. The motivations and contexts of the above factors are complex and crucial because these factors may affect physicians' work quality and patient well-being.

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This study aims to explore the leadership and humanistic care factors of physicians of different genders. The investigation of humanistic care mainly focuses on discrimination and stigma attitudes toward patients with mental illness. We aim to examine and evaluate various associated factors, search and evaluate relevant assessment instruments and intervention plans.

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KEYWORDS: Medical Leadership, stigma, gender difference

第二節 中文摘要

背景：

國內外一些研究指出不同性別的醫生在領導力、病患溝通、及對病患汙名化或歧視程度有差異。以上因素之背後動機與環境影響複雜且重要，因為這些因素會影響醫生工作品質與病患福祉。

目標：

本研究就不同性別醫生的領導力與人道關懷因素，人道關懷主要包含醫生對精神病患的歧視和汙名化態度進行深入了解、探索分析文獻以及相關測量工具討論並做整理。

方法：

本研究進行國內外相關文獻全面性回顧，挑選具國際信效度的領導力與人道關懷各主題測量工具，做翻譯與評估分析整理，並搜尋整理以及評估國際醫學領導力以及反汙名化的醫學教育相關介入方案。

結果：

醫學教育在未來醫生的專業觀點、信念和態度的形塑上佔有至關重要的一席之地。然而精神病患者的污名化程度不僅普遍存在於公眾，在醫生和其他醫療衛生專業人員中也同樣存在。本研究針對醫學領導力與人道關懷中的疾病汙名化相關文獻、測量工具、介入方案作分析評估與建議。 並揀選建議醫學參與量表、精神疾病患者社區態度量表、對精神疾病患者的恐懼和行為意向量表、臨床醫生精神疾病態度量表、醫護人員心思開放量表、精神健康知識量表等相關議題的工具。

貢獻：

本研究對醫生領導力及對弱勢病患態度因素進行搜尋整理分析與研究，並做性別倡議與建議，推動性別平等，加強醫學專業之領導力與人道關懷，分析評述整理可提供社會與機構將對人才培養、教育訓練、資源分配、社會價值觀氛圍型塑等有利參考。

關鍵字: 醫學領導力，疾病汙名化，性別差異

第二章 報告內容

第一節 研究背景

前言

醫療環境中的性別與領導力傾向

台灣女性進入醫學院校的比例正不斷上升，中華民國醫師公會全國聯合會的統計報告顯示，截至 2016 年為止，台灣女性醫師人數佔總執業醫師的 19%[1]，由此可見，醫療勞動力的女性化程度日益提昇[2]。儘管如此，研究發現男女性醫師位居領導職位的差距依然存在[3]，如此引出亟需思考的問題，即女性醫生是否與其男性同事擁有相同機會？女性醫師在醫療職涯上是否遇到了阻礙，使其更有可能扮演次要的角色？研究顯示女性在醫學領域的領導地位仍然居於少數，不成比例，再者，在一固定時間內，女性醫生比男性晉升的可能性更小[4]。

美國研究顯示，性別歧視是醫學界妨礙 40%女性在職業進展的主要因素[5]，形成玻璃天花板效應，該效應可以被定義為「阻礙女性在企業中上昇至一定水平的隱形障礙」[6]，是由傳統的性別角色、醫療環境中的性別歧視現象、缺乏有效的教師指導制度而形成的，於是弱化了女性的領導能力與野心。

國外的醫學生研究發現[3]，女性醫學生對於擔任領導者較缺乏自信，相較於女性醫學生，兩倍的男性醫學生人數視自己在未來將處於領導地位，對於未來擔任領導者角色較具野心，且平均而言，男性醫學生對女性領導者抱持某些負面觀點。除非關於女性的負面觀點被消除、其自信心得到改善，否則女性將繼續面臨領導困難。自信需要從早期階段透過更多的反饋和指導來發展，醫學生的

觀點不僅需要藉由女性模範榜樣來加以改善，也需要去接觸更多成功的男性與女性領導者。再者，該研究中[3]的兩性醫學生都揭示了在醫學生社會中擔任領導角色的障礙，這顯示需要更多方的介入努力來確保所有的醫學生都有機會爭取早日的領導地位。

公開領導力的發展計畫需要整合納入醫學生和住院醫師的教育課程，以確保台灣醫療專業人才為領導角色做好準備。國外許多研究皆採用透過領導力介入措施使男女性的領導能力有所進展，甚至提昇個人對自身領導能力的自我意識。

醫學院內教育的現今趨勢聚焦於臨床、基礎和社會科學的整合[7]，這種改革通常伴隨著減少傳統教學課程時間，轉向強調小組活動，如問題導向學習（problem-based learning），讓學生在自我教導（self-instruction）和同儕合作學習中承擔更大的責任，如此小組環境的一個重要先決條件，是所有學生都可以在公平和安全的環境中表達自身想法，和實踐領導角色。不論性別、種族、國籍和社會經濟地位，所有學生都應該被賦權在小組環境中發揮領導作用[8]。研究指出[9]，領導者性別經常和該小組正執行的任務或指示相關，在一般情況下，男性醫學生作為小組領導者的比例明顯多於女性，特別是當小組任務不涉及複雜的社會互動。領導層中的性別偏見，經常來源於性別角色的刻板印象：即男性較具競爭性和侵略性，女性較具合作性[10]，具體來說，若小組活動以任務為導向，或者符合男性刻板印象，選擇男性作為領導者的可能性會顯著大於女性；若團體活動是社會合作性質，或者與女性刻板印象相關，則任何一個性別被選為團體領導者的可能性幾乎沒有差別[9-13]。有研究表明，其實女性有潛能成為組織變革更有效的領導者，因為女性傾向展現出變革型的領導作風（Transformational Leadership）[14]。

近幾十年來，女性在醫學院入學方面已有極大進步[1]，然而，在學術醫學底層的此進展似乎並沒有轉化女性成為終身教職人員、正式教授、學科主任和

院長人數等領導職位的相稱進展，擔任領導力時的性別偏見仍然是被廣泛指出的現象。在醫生群體中，倘若缺乏針對性的介入措施，關於領導力的性別偏見將會持續[8]。由此可知，醫學院長期性的頻繁且一貫的介入措施，可能是緩解性別偏見的重要因素，是可以鼓勵女性醫生、醫學生促進信心、肯定自己是領導者的重要因素。對於限制女性在學術醫學和其他醫學專業道路的職業發展，可達到重要作用。

醫師性別與既定印象

在與任何病人建立融洽關係時，醫療從業者的基本準則是具備關懷態度[15]。過去國內外明確針對醫師性別和污名化進行研究的文獻亟為匱乏，僅少數明確針對醫師性別和治療精神疾病患者時的性別實踐差異，提出以醫師性別為因素經常帶來的影響，即女性醫生傾向於促進更多與患者的公開交流，展現了建立更積極的醫患關係的行為[16-17]，花費更多的時間進行診斷諮詢，且更有可能去治療患有精神心理疾病的病人[18]，平均而言，在管理精神疾病如憂鬱症方面，女性普通科醫師（General Practice, GP）相較於男性醫師，較可能被評為具有關懷和傾聽態度，表現出較理想的溝通技巧，並且如同被調查的病人所預期，男性醫師較可能開出藥物處方治療，詢問比病人預期還更少的資訊，也較不會將病人推薦給專科醫生[19]。由於女性醫生平均希望花費更多的時間在諮詢討論中，相對而言，男性醫生平均希望追求做出快速的技術決策，因此顯得女性醫生更加具備關懷態度。澳洲的研究數據（大約 70,000 次諮詢）顯示，女性醫生通常會花費更多的時間在診斷病人身上[20]，該研究的因素分析說明，也可能是憂鬱症患者，特別是女性患者，會期望女性醫生較多的關心，如此的期望也會影響女性醫師的溝通互動實踐[21]。

過去研究反映出醫生的盡責程度，或者甚至是防禦性實踐（defensive practice），即醫生尋求避免不良的治療結果方面的性別差異，其中女性普通

科醫生（GP）較可能將其患者轉診給專科醫生。由病人所反應提出的缺乏適當照護，相對之下，比如較差的眼神接觸、打斷病人的言論、急於開立藥物處方等，似乎都反映出某些男性醫生實踐上缺乏關懷照護和同理心的狀況[19]。某些研究識別了醫生人際交往能力和實踐優先性的性別差異，如此差異不限於精神障礙的治療。加拿大的 GP 研究發現[22]，女性醫師傾向更加重視病人照護的心理社會因素；澳洲一項調查 113,000 GP 診所的研究發現[23]，女性醫師較有可能管理患者的心理問題；美國加州的研究表示[24]，醫師的性別被證明很有可能影響其溝通模式，而女性醫師普遍獲得較高的患者滿意度，此外，女性患者向男性 GP 醫生返診的可能性略為較低，尤其如果醫生將藥物作為唯一的治療選擇，女性患者的返診率會更低。由此可知，平均而言，病人似乎不僅受到男性醫生較少關懷照護，這樣的因素還會繼續影響患者如何在未來尋求治療管理。對於憂鬱症病人來說，一般疾病的診療長度對他們而言卻是處於急迫的時間壓力之下，因此病人會感覺無法充分披露問題，因而阻礙病人最佳化的利用醫療諮詢診療服務[25]。

當醫生將同理心、關懷和傾聽視為治療的優先事項時，任何差異性照護帶來的影響顯然值得注意，如果醫生的性別在任何實質程度上會影響對精神疾病患者的評估和管理，量化這些治療效果的差異性，將有助設計改善早期醫學教育的策略和工具[19]。

醫師性別與醫療執行傾向

綜觀過去國內外研究，已將醫生的溝通技巧與各種正面治療成果連結起來，包括病人和醫生的滿意度、更高的建議治療遵從度水平、改善的疾病控制的生理指標，以及提昇的身心健康狀況[26-28]，在此背景下，醫師性別的溝通方式差異也刺激了許多研究興趣。社會性別理論認為，性別差異是由個人特徵與廣泛的社會文化力量相互作用產生的[29]。研究發現，男性和女性醫師在醫療照

護的實踐模式上存在某種特定差異，女性醫師傾向於堅持採用臨床指南和實證本位服務（evidence-based practice）[30-32]、更頻繁地提供預防性諮詢和護理[33-40]、提供較多針對生理性別的篩檢服務[33]、使用較多以病人為中心的溝通[41-44]、促進較開放且平等的交流，相較於男性同行者提供病人較多的社會心理諮詢服務[43]，創造與男性醫生不同的治療環境[45-48]。病人通常會受到女性醫生的影響，傾向於更全面性地對話、有更積極的言論、討論更多心理資訊，也表達較高的夥伴建立關係[43]。儘管研究表明男性和女性醫師實踐模式，以及追求品質的過程方法的差異，事實上，男性和女性醫生的患者治療結果是否不同，在很大程度上是未知的[29]。

研究發現女性醫生的醫療診斷會涉及較積極正面的溝通言論，比如鼓勵患者、詢問較多心理問題、討論更多情緒因素，展現與病人建立合作夥伴關係的態度[32]，普遍比男性醫生更具同理心，在關懷、鼓勵、安定、降低支配地位和積極對話等方面，展現較多與病人融洽的建立行為，其醫療諮詢性質更加以患者為中心[33]。為理解男性和女性醫生之間的差異，過去研究對醫療諮詢時間進行廣泛研究，如加拿大和英國研究提醒[35-36]，在未考慮品質和性質的狀況下，診療諮詢長度上的時間差異，將導致男女性醫生的臨床活動率明顯不同。綜觀過去研究，女性醫生平均多花費 2 分鐘或多出 10％以上的病人諮詢時間，隨著醫生的時間和生產力壓力日益趨增，每次諮詢增加 2 分鐘其實代表相當大的負擔，女性醫師在每個病人身上所多花費看似微小的時間差異，將造成單一工作日內累積的的顯著差異，讓女性醫師較男性醫師晚約一小時下班[49]，從這樣的角度來看，女性醫師很可能在日常排程規劃落後於男性同事。該現象相符於其他研究所指出醫生在臨床活動中性別差異，儘管如此，基於各研究的異質性，以上數字必須謹慎解讀[29]。

醫師性別差異是需要被重視的議題[50]，因為性別溝通差異會與病人遵從度、滿意度、治療結果等相關。研究已發現，以病人為中心的溝通風格與病人遵從度、病人恢復力（patient enablement）[51]和更理想的照護效果間存在正面

關聯[52]。系統性文獻回顧表明，醫患共享決策的交流方式，會影響病人情緒健康、症狀消除和生理健康狀況[28,53]。然而，許多研究未考慮病人與其他醫療人員、護理人員、家人和朋友互動影響的治療成果，評估醫患溝通與治療結果關聯的研究也很少納入更廣泛的生理或社會決定因素[54]。

儘管有研究證據表明女性醫生可以提供更高品質的護理治療[16, 24, 30-33, 36-37, 39, 42, 44, 55]，也有研究認為，女性在撫養孩子的職業中斷、較高的兼職率，以及家庭和工作責任之間的許多折衷[56]，可能會損害女性醫生所提供的照護品質，以此正當化男性醫生獲得較高工資的現象[57-59]。女性醫生現在約占台灣醫師的五分之一[1]，隨著女性在醫學中的比例日漸趨升，關於男性和女性醫生是否運用相異的方式與病人溝通此長期問題是重要且及時的。醫患互動是健康與疾病的重要決定因素，透過適當的反污名化（anti-stigma）、領導力培訓等醫學教育介入，未來病人將可以從注重這些相互作用品質的醫師中受益[60]。

醫生領導力的定義

一、 醫學領導力（Medical Leadership）[61]

醫學領導力是一套多元化的行為，由臨床醫生取決於病人照護，所預期能改善患者治療結果的行為。醫生大都提供高度客製化、基於個人的醫療服務，經常是表現情緒、同情和關懷的服務。醫生、病人和公眾擁有近似於隱性契約的東西，因此圍繞個人照護的處置仍然是醫療衛生系統的主要特徵。探討醫學方面的領導力時，存在某種矛盾，在於醫生認識到必須參與考慮更廣泛的醫療系統環境，而不損害至關重要的醫患關係如此的文化挑戰。政府為控制成本、提高患者安全性而執行的中央介入越來越多，影響到醫師的臨床自主性和專業價值，使得這一挑戰變得更加困難，甚至會導致醫療專業人員的異化（alienation），然而，醫學領導力仍是實現醫生全面積極參與執業的必要條件

[62]。醫學領導力的明確定義不容忽視，領導力的不當定義會造成醫生參與領導醫療體系時的混亂和出錯狀況。

領導關係涉及不止個人行為[63]，重點並非是展現單一非凡傑出的英雄，而是和許多其他人分享的分配過程。領導力在服務相關的行業如醫療界尤為重要，必須在與外部環境相關的部門職能、計畫方案中快速做出複雜決策。

儘管投資注入以及對品質和創新的追求，某些醫療衛生機構仍然面臨大幅改變的困難性，特別是政策和管理面的變化，這樣的專業官僚體系即由部分專業人士所主導的控制專業知識、確定組織安排的專業主義文化，會滲透機構內的決策和資源分配面向[64]。醫學界是個人專業精神的典範，每個醫療執業者在自我實踐中與病人一起工作，醫療決策的關鍵是基於評估每個病人的需求，為了決定照護需求，醫師必須保有一定的臨床自主權，因此，在專業官僚體系中，管理和行政層面對醫療專業人員的影響有限[65]。醫師領導者的概念，傳統上仰賴於個體臨床醫生的專業知識和能力，醫生對成本和結果的責任相對較小，臨床自主權是其職業認同的組成部分。相比之下，在重視高績效的醫療體系中，醫生會視自己為相關合作夥伴，將績效與計算和報酬支付連結，視責任為改善病人照護的工具，而非視為個人自主權的妨礙[66]，美國的山際健康照護聯盟（Intermountain Health）、維吉尼亞醫學中心（Virginia Mason）、馬約診所（Mayo Clinic）、凱薩醫療機構（Kaiser Permanente）和瑞典延雪平醫療健康中心（Jønkøping Health Region）即是該理念的典範。

作為個體醫師領導者與醫療領導力新模式之間的過渡性階段，英國國民保健署（National Health Service，NHS）特別關注醫生領導者的招聘和發展，賦予醫生在臨床服務的正式角色和責任等結構性改變。有鑑於在組織結構中為醫生建立正式的領導職位不足以確保轉變和改進，醫療領導力的發展將需要考慮到更全面的方法，必須基於醫療保健系統績效改善的證據，也基於在整個系統中

發展領導能力的有利環境的創造[67]。對於一線醫生和擔任正式領導職位的醫生之間的衝突，在美國凱薩醫療機構（Kaiser Permanente）中可以找到答案，無論是否擔任正式領導角色，所有醫生都應該被視為是領導者，其學習系統也可以因此建立[68]，美國其他許多醫療機構也有類似理念。

儘管個體醫生的優秀卓越是必要的，卻不足以保證良好的病人治療結果[69]。在過去十年中，領導公共服務的方式，已經從個人領導轉變為分布式領導（Distributed Leadership）和集體領導（Collective leadership）。分布式領導是指該領導力角色在整個系統或組織中的遍及程度，以便在不同層次的治理中應對挑戰；集體領導是指結合多樣化的專業知識，讓所有參與者以互補的方式共享領導角色。對醫療保健系統而言，所有醫生都是領導者[68]，因為臨床領導力會發生在病房和提供照護服務的所有微系統中，如此的新臨床領導力和醫療領導力模式，由美國的組織案例可知，在受薪醫師和由醫師領導的醫院組織中較容易獲得發展。

基於這些發現，在醫療組織系統中發展醫學領導力，會有三個重要面向[65]：

（1）建立正式的醫師領導職位

（2）建立各臨床和非臨床學科對各級組織領導力的一致認定的集體和分布式觀點

（3）確認領導力發展與組織策略、運作層面的明確改進目標相一致，並以醫療系統改進科學為基礎[70]

在過去傳統上，領導者和正式醫師領導者的發展過去只側重於以上第一面向，當今的領導力和醫療領導力的發展則應該注重在組織系統環境背景的以上共三個面向。

鑑於醫療行業日益複雜，對少數高層正式領導者來說，其面臨的挑戰和要求日益攀升，這是美國公司每年在領導力發展上花費共超過 130 億美元的原因[79]。建立組織的領導力將帶來明顯的優化區別，當領導力適當發揮在全面性的系統環境背景下，對於每個組織的文化、策略、流程和人員來說將會帶來獨一無二的影響。儘管個別領導者的發展十分重要，組織集體領導力的發展可能更為重要，這意味著正式和非正式的各級醫生領導者都承諾履行同樣的使命，朝著一致的方向前進[78]。

二、醫療環境內的人道關懷_反歧視或汙名化疾病

鑒於主持人專業與能力預算，本研究聚醫療環境內人道關懷主題聚焦於歧視或汙名化精神疾病。並因為精神疾病與其研究易受到汙名化與誤解，參考美國某些精神疾病社區研究以別名方式取名，所以本研究以人道關懷之大雨傘名稱包覆含括研究主題。

精神疾病患者有過早死亡的狀況[108-110]，其中一個原因是其獲得的醫療健康照護平均比沒有精神疾病問題的病人差[111]，例如，精神疾病患者的冠狀動脈血管成形比率、糖尿病住院率，以及血壓測量等基本評估比率，與沒有精神疾病的人相比之下低[112-115]，研究指出應理解導致這些不平等因素的迫切性，因為這些差距的潛在機制是醫療衛生專業人員對精神病患者的歧視，受到社會大眾對於精神疾病患者的污名觀點所影響[116-117]。

污名化涵蓋對某群體知識的欠缺（刻板印象）、負面態度（偏見），和實質的排斥（歧視）[118]，對於社會互動有負面影響。污名化也明顯阻礙病患治療的開始、延續和成果，損害國家經濟面向如就業機會、文化面向如社會關係

[119]。尤以在發展中國家，普遍大眾和某些精神心理專業人員仍視精神疾病患者為危險、難以預測和令人恐懼，寧願與精神疾病患者保持社會距離[120]。

污名化會對病人安全產生負面影響[135, 138]。加拿大最近一項研究透過調查員工態度、組織文化等因素，將污名化視為病人安全的一大障礙，並指出污名化會導致精神健康患者被邊緣化的事實[138]。擁有精神疾病史的人，提出時常會遇到阻礙其滿足生理照護需求的障礙，例如在尋求關於非精神健康問題的照護協助時，醫護人員較不重視其症狀[131, 133-135, 130, 132,]，在尋求非精神健康問題的照護協助時，也會得到較不理想的照護品質[130, 132, 139-141]，而這被認為是由於診斷治療過程中，生理症狀被醫療人員誤診為是由病人的精神疾病引起，造成診斷和治療方案的延誤[139]。

污名化會阻礙病患取得優質照護服務，所造成的後果包含了尋求醫療幫助的延宕、治療中止、不理想的醫患關係，以及較差的精神與生理照護品質等等所造成的障礙[123, 128-132]。病患所預期的來自醫療衛生專業提供者層面的污名化，更被認定是其不願意尋求精神疾病協助的一個關鍵因素[128-129, 131, 133-137] 。加拿大精神疾病學會（Canadian Psychiatric Association）進行的一項調查發現，79%的受訪者曾觀察到大眾針對病患的歧視原手經驗（first- hand experience），53%的受訪者曾注意到醫療服務提供者歧視精神疾病患者的現象[123]。

污名化的定義

精神障礙由嚴重的精神疾病引起，被社會上部份群眾描述為不具備能力達成人生目標，例如擁有合理收入的職業，或是和家庭同住一個屋簷下。研究論點提出，像這樣的精神疾病患者人生成就的達成，會受到公眾、個人對精神疾病的反應所妨礙，即污名化（stigma）[144]。

1. 精神疾病的污名化

「污名化」[145]該詞彙指涉針對性的生心理標誌，強調被污名化標記者的劣等之處。這個標誌可以是明顯針對生理的，如膚色，或微妙針對心理的，如同性戀或精神疾病；如此的道德污名至少在兩個層面上產生極其嚴重的影響，稱作公眾污名化（public stigma）和自我污名化（self-stigma）[146]。公眾污名化（public stigma）是大型社會群體一致表現對於某群體刻板印象的現象；自我污名化（self-stigma）是當人們內化公眾污名時，出現的自尊喪失與自我效能喪失。公眾污名和自我污名化之間的區別，對於理解、解釋和建立改變污名化的策略相當重要。

2. 精神疾病污名化的模型

目前大多數解釋精神疾病污名化現象的模型都是從基本行為科學出發的。解釋性模型可以分為三大類：

II. 個人認知模型（Individual cognitive models）：運用自然發生的認知結構來解釋污名化

III. 動機模型（Motivational models）：探討為什麼人們會污名化

III. 體制和結構模型（Institutional and structural models）：將社會制度和結構中的污名化和歧視經歷作為基礎

I. 個人認知模型（Individual cognitive models）

社會心理學家認為，人類認識世界的方式受到認知結構和過程的限制，個人認知模型（Individual cognitive models）描述人如何在心理層面形成和維持污名化相關過程。圖 1 概括了該模型的三個構成：刻板印象（stereotypes）、偏見（prejudice）和歧視（discrimination）。社會心理學家認為，刻板印象是大多數社會群體成員學習到的知識結構[147-152]，是對社會群體資訊進行分類特別有效的手段；刻板印象觀念被認為是「（社會的（social）」，因其代表社會集體加諸於某族群的一致概念；刻板印象是「高效的（efficient）」，因公眾可以迅速對有刻板印象的群體產生印象和期望[153]。如刻板印象這般的分類功能，是大眾

面臨日常生活中大量刺激的組織方法[154]。關於精神疾病的普遍刻板印象包括危險、無能和性格軟弱。正因為大多數人並不需要藉由同意或認同，即可擁有一套刻板印象[155]。

Figure 1、 精神疾病汙名化構成

（參考來源 Corrigan, P. W., Kerr, A., & Knudsen, L. (2005). The stigma of mental illness: Explanatory models and methods for change. Applied and Preventive Psychology, 11(3), 179-190.）

持有偏見者經常擁有負面的刻板印象（「沒錯，所有精神病患者都是暴力的！」），並產生負面的情緒反應（「精神病患者讓我覺得很害怕！」）[149,

[151, 156-158]。相對於刻板印象，偏見（prejudice）態度則涉及對評估性組成部分的同意程度[154, 159]。偏見基本上是認知和情感反應，嚴重時也可能會導致行為反應，即歧視（discrimination）[160]；附有憤怒的偏見會造成敵對的歧視行為，如傷害少數的弱勢族群[161]，阻礙患者接受精神照護服務，或者甚至利用刑事司法系統服務取代精神照護服務[162]。恐懼也可能導致歧視性迴避，如雇主不希望患有精神疾病的人在附近，所以不願意僱用他們。如圖 1 所示，根據公眾考慮公眾污名化（public stigma）或自我污名化（self-stigma 的差異，刻板印象（stereotype）、偏見（prejudice）和歧視（discrimination）的表現形式也會不同。

II. 動機模型（Motivational models）

動機模型（Motivational models）試圖解釋為什麼人們污名化，或污名化為施加污名者帶來的功能。文獻中指出三種動機：自我正當性（egojustification）、群體正當性（group-justification）和系統正當性（system-justification）[163]。精神分析學家說明自我正當性（egojustification）是當施加污名者的內部衝突被投射到被污名化的群體時，自我（self）會受到保護[164-165]，如此一來，污名化有助於施加污名者保護自尊免受個人失敗的影響。社會心理學家將自我正當性（egojustification）擴展到個人防禦機制之外，涵蓋任何透過將這些負面概念和行為投射到他人身上來反映自我、保護自我的思想、形象或行為的功能[166]。污名化的功能是為了避免潛在威脅到自己的身體或心理自我，藉由動機來避開社會認為有威脅性的危險，或合理化其基於群體的負面態度和歧視[167-168]。

群體正當性（group-justification）是指，外團體（out-group）的存在，如精神疾病患者，是用以支持內團體（in-group）的目標。從進化的角度來看，

污名化威脅到有效功能的外團體，有助內團體生存和基因延續的高度適應性[169]、增強凝聚力、防止污染、避免較劣等的社會交流夥伴[170]。

學者提出更廣泛的、超越自我或群體的污名化解釋[171-173]，認為刻板印象和偏見的發展是為了"加強系統"，即系統正當性（system-justification）— 無論是由於歷史事件、生物起源、公共政策，還是個人意圖，一旦一組事件產生特定的社會關係，所導致的安排都僅僅是因為它們的存在而被解釋和正當化。舉例而言，刻板印象如「精神病患者是暴力的，因此需要受控制」的觀念可能是源自於，或是用以正當化，建構並維持某些組織，這些組織會建議有精神疾病標籤的患者需要透過醫院和監獄來控制。儘管系統正當性（system-justification）有助於大眾認識當前群體之間的差異，卻未對系統的起源作出任何解釋。

III. 體制和結構模型（Institutional and structural models）

從認知和動機角度著眼於個人心理解釋層面，尚不足以為污名化問題提供完整的描述。藉由體制和結構模型（Institutional and structural models），污名化可以在影響制度、社會群體的歷史、政治和經濟等社會層面上被加以理解。例如美國為了更佳理解種族主義，民權活動家[174-175]和社會學家[176-182]指出，歧視會影響少數弱勢族群這樣的現象無法由個人的偏執與偏見行為的直接影響解釋，因此將個人層面的影響與體制結構原因劃分開來；體制性的歧視以其公共/ 私營機構居於權力位置的規定、政策和程序，刻意限制部分族群的權利和機會。

體制性歧視的影響在定義上是刻意的，是由一個機構頂部的強權人士明確地試圖透過如法律規範來削弱某些族群的機會[177,180-181,183]。體制性歧視是少數

人污名化行為和態度的直接結果，除此之外，結構性歧視的後果也影響甚遠地限制了少數群體成員的機會[177,184]。

研究發現，美國醫學生比其他國家的醫學生，在面對精神疾病患者時會展現出更正面積極的態度[185]。該研究結果反映了美國數十年來藉由許多宣傳倡導組織為消除污名化所作出的努力。這些反污名化的宣傳活動是由官方和醫療界共同主導，倡導即使是精神障礙疾病最嚴重程度的患者，也應該享有被尊重的權利，而且致力於讓病患能夠康復，過有勞動生產能力的生活，重新獲得在社區中有價值的角色。在美國廣泛流行的藥物行銷活動，和消費者直接的精神藥物廣告，對美國社會的污名化消除也產生影響。過去研究建議應該在文化、哲學和歷史的背景下理解國家社會的污名化狀況。

研究發現[196]，醫學生在專業求學過程中，對於非精神疾病如肺炎患者的態度有顯著改善，然而對精神疾病患者的態度卻僅有輕微轉變。研究建議在個人或職業層面上適當接觸精神疾病患者，會促成對精神障礙疾病患者更積極正面的態度[197]。醫學院校教師，包含教學醫院醫生的污名化態度，是造成醫學生對精神疾病和精神醫學負面態度的重要因素之一。國外一項橫跨調查英國、歐洲、亞洲醫學院校教師的研究顯示，90%的醫學院校教師認為精神科醫師是醫學生的負面榜樣，84%的醫學院校教師認為精神病患者不適合在特定機構外接受治療，73%的醫學院校教師認為精神疾病患者令人情緒疲倦耗盡[198]。相比醫學生，醫學院校教師平均持有較大的污名化態度和較高的社交距離，如過往研究也發現年齡較大的族群會有相對高的污名化態度[199-200]，不過臨床學科教師比純學術教師展現出較少的污名化態度。

研究議題的重要性

簡言之，污名化態度已被證明與醫學生和教師的性別相關，也和學生的偏好專科、精神學科課程的完成度，以及教師的年齡、指導方式等因素相關[186]。

而綜觀國外多項研究結果，在醫學生完成如領導力、反污名化、精神醫學等課程的介入教育後，會展現對精神醫學和精神疾病患者更寬容的態度[201-202]。

即使台灣女性醫生比例正逐步攀升，女性相較男性醫生居於高級領導職位的比例卻無法直接對照[187-189]。平均而言，學術醫學的女性研究成果和成功申請到補助金的數量較少[190]，這些差異的解釋因素，包括撫養孩子的責任經常落在女性身上、女性接受的指導品質不佳，以及缺乏支持的各項不利環境因素[188,190]。但截至目前為止，關於醫生、醫學生性別和其領導力的研究十分有限[191-192]，此類性別研究可影響社會和醫學界對未來領導層的期望。

在英國，為了深入探討本議題，英國前任首席醫務長利安·唐納森（Liam Donaldson）在 2009 年曾為全國女性成立工作小組來調查這些性別問題[188]，其研究報告識別了造成女性於領導進展的障礙，並提出改善現狀的建議，以鼓勵女性擔任領導職位[193]許多女性醫生在職業生涯與家庭生活的選擇上仍然存在著重大衝突，以權衡工作與生活的平衡。除了個人限制，如關注家庭生活或缺乏領導野心外，其他更多無形障礙正影響女性醫生的職業生涯，如人際網絡（networking）和傳統（tradition）因素，缺乏來自部門主管和同事的職業指導和諮詢，造成阻礙女性醫生流動性的玻璃天花板效應[194]，另外，工作投入時間、資源來源、由論文發表數量或外部補助金額度來衡量的生產率等，也是解釋領導職位性別差距的因素[58]，成為阻礙女性在醫學社會位居領導位置的障礙

過去醫學生的研究顯示[2]，男女性醫學生都強調了在醫學課程中嵌入領導力教育培訓的重要性，醫學教育需要更加重視醫學院內醫學和其後各級的指導（mentoring）、模範榜樣（Role Model），以及領導意識教育的注入。

I. 醫療環境內領導力培訓計畫

加州大學柏克萊分校有開發該校的醫師領導力計畫[195]，強調醫生的領導力及其在新興的醫療保健服務環境、社區健康實際需求中的重要性，透過該計畫提供醫學生具體的理解，規定醫學生參與者將開發出成為有效領導者所需的工具，並加以發揮作用。該計畫涵蓋主題如下：

1. 醫師領導力（Physician Leadership）：使醫生發揮領導能力的策略和機會

2. 加強作為領導者的有效性（Strengthening Your Effectiveness as a Leader）

3. 擴張影響力（Expanding Your Impact）：領導團隊和組織

4. 執行案例與傳遞願景（Making Your Case and Communicating Your Vision）

5. 實現目標（Achieving Your Objectives）：權力、影響力和談判藝術

6. 展現與眾不同的能力（Making a Difference）：成為醫療專業領域的變革領導者

醫學領導力的發展是一個社交過程，讓參與者單獨和以團隊方式面對挑戰，共同努力推進任務，朝一致目標前進。醫生的領導風格和方法可以有所不同，如僕人式領導力（Servant Leadership）的醫療文化領導風格，強調建立社區、以病人為中心的承諾、致力於同理心、意識和管理工作的成長[203]。投資領導力發展的案例，是期望參與者帶來的回報。參與被定義為人們在組織使命中的心理投入程度，該程度會造成對於目標的酌情努力。在醫療界，應用組織心理學中的「組織公民行為（Organizational Citizenship Behavior，OCB）」，可以使醫療機構以有限的資源進行競爭與品質提昇，有助提昇生產力，並且改善病人滿意度、增加醫生同事之間的協調性、降低人員流動率、提高組織適應性和盈利能力[204-205]。領導力發展藉由鼓勵承諾、提供肯定、成長和發展機會，這些激勵因素可以透過協調一致的領導力與組織設計來實現，將直接影響醫生領導者的參與。

II. 醫療環境內反歧視或反污名化介入培訓計畫

研究發現[196]，醫學院校教師，包含教學醫院醫生的污名化態度，是造成醫學生對精神疾病和精神醫學負面態度的重要因素之一。國外一項橫跨調查英國、歐洲、亞洲醫學院校教師的研究顯示，90%的醫學院校教師認為精神科醫師是醫學生的負面榜樣，84%的醫學院校教師認為精神病患者不適合在特定機構外接受治療，73%的醫學院校教師認為精神疾病患者令人情緒疲倦耗盡[198]。相比醫學生，醫學院校教師平均持有較大的污名化態度和較高的社交距離，如過往研究也發現年齡較大的族群會有相對高的污名化態度[199-200]，不過臨床學科教師比純學術教師展現出較少的污名化態度。

綜觀國外多項研究結果，在醫學生完成如領導力、反污名化、精神醫學等課程的介入教育後，會展現對精神醫學和精神疾病患者更寬容的態度[201-202]。此外，醫學教育如醫學心理學和醫患溝通等教育課程能帶來正面效果，醫學生透過從中獲得臨床相關主題的資訊，可以獲得能力比如與服藥不遵從、或急性精神病患者溝通交流。藉由在介入教育期間獲得更多自尊和勝任能力，如此可以提高醫學生在處理患者方面的舒適感。美國研究發現[206]，除了醫學教育的因素，醫學生對精神疾病患者的態度，也受到接觸程度和社會文化的顯著影響。

第二節 研究目的

鑒於以上，本研究擬探索台灣醫生的性別領導力與人道關懷、溝通能力的影響因素，檢視性別差異。本研究將深入分析台灣醫生的領導力因素，分析是

否男性相對女性，擁有顯著較高的比例與信心擔任小組領導者，並研究性別的領導力傾向，是否與其污名化態度、人道關懷等傾向相關。

歸納以上，本研究計畫有下列欲深入研究的問題方向:

一、本研究不只是要闡明醫生領導力的傾向，更要追究其深入原因，及醫生認為實習醫院與學校教育對其領導力的影響，以及對社區醫療的精神疾病健康的看法。

二、我們的質性研究議題，是經過文獻搜尋與整理設計，包括但不限於美國加州大學柏克萊分校醫學院等領導力發展計畫的指導原則，並加強設計與創新，以適合使用於台灣的醫生。設計過的開放式問題將是使受試者不單是協助研究、提供未來醫學教育內指導與輔導領導力時的規劃設計與參考，更是因為這些問題的刺激與協助，將提升受試者醫生對其領導者角色的反思、體認、與覺察、個人生活與事業規劃解剖、個人醫師專業角色的形塑與認同、生活及工作的問題解決思考、及提醒對於社區健康與國家發展納入個人生涯規劃的考量當中。

本研究之創新點尤其在於是把社會污名化元素隱藏與融入質性開放式的問題中，等於已經不只是單純研究領導力此重要議題，而是在研究中就開始進行了心理層面的介入方案，以刺激受試者對於領導力、溝通能力、同理心、反污名化態度及生活品質等重要因素的再反思。本研究主題最理想的狀態應該是以長期追蹤的方式以進行本研究之後測，但因為最後申請只拿到一年部分補助，希望在這個計劃開始下，我們能持續未來各種追蹤與介入，以為台灣醫療照護之困境略盡棉薄之力。

第三節 研究方法

原本計畫多年的工作但因只獲得一年的部分補助，所以本研究主要以搜尋國內外中文與英文相關文獻，相關工具搜尋整理確認測試，針對主題討論問卷適宜性進行篩選，進行彙整分析制作系統性文獻回顧表，以作為日後若有更多經費發展後續相關計畫的準備。

本研究首先進行了文獻以及相關測量工具整理，從文獻搜尋針對醫學領導力、醫療環境內人到關懷，以及反汙名化等議題資料蒐集與文獻整理、就測量以上主題的工具進行謹慎嚴謹的評估與篩選，進行工具的測試，並翻譯相關資料與工具，與原作者聯繫得到授權，輸入資料、撰寫報告與論文。

本研究質性研究部分議題要經過文獻搜尋與整理與設計，使醫生受試者不單是協助研究，也提供未來醫學教育內指導與輔導領導力時的規劃設計與參考，更是因為這些問題的刺激與協助，將提升受試者醫生對其領導力、人道關懷的反思、個人生活與事業規劃解剖、問題解決、及提醒對於社區健康與國家發展納入個人生涯規劃的考量當中。

質性訪談分析以NVivo（QSR International）軟體，對會談記錄討論建立領導力以及對精神疾病患者人道關懷態度得分高者訪談之逐字稿進行編碼。依據受訪者之資料參考Labov的敘說分析法，將受訪資料談及教學、行動、評價以及解決方法等主題進行分類，為避免無法呈現受訪者主觀感受與內在的事件，並將增加兩個主題融入（1）男女臨床教師教學經歷與專業的歷程（2）男女住院醫生學習經歷與專業的歷程，以做對於影響與內在因素之探討。後續之醫學臨床領導力實踐是否受到介入課程之影響，以及台灣醫療制度與環境等結構性因素也是本計畫之要點，因為要能夠增進教學成果的實用性，必須正視這些關鍵影響，而這也是解決當前限制的研究方向，所以在質性訪談問題時也會納入相關問題。

第四節 研究結果

I. Systematic Literature Review 系統性文獻整理

篇名 Topic	作者 Author	作者單位 Institution	期刊 Journal	刊登時間 卷數頁數 Publication	論文目的主題 Study Design	樣本 Sample Size	方法 Methods	結果 Results	結論 Conclusion
Gender Differences in Physicians' Financial Ties to Industry: A Study of National Disclosure Data	Susannah L. Rose, Ruchi M. Sanghani, Cory Schmidt	Department of Bioethics, Cleveland Clinic, Cleveland, USA	PLoS One	2015; 10(6): e0129197	Academic literature extensively documents gender disparities in the medical profession with regard to salary, promotion, and government funded research. However, gender differences in the value of financial ties to industry have not been adequately studied despite industry's	all practicing physicians in the United States (n = 747,603)	This study analyzed publicly reported financial relationships among 747,603 physicians and 432 pharmaceutical, device and biomaterials companies. Demographic and payment information were analyzed using hierarchical regression models to determine if statistically significant gender differences exist in physician-industry interactions regarding	In 2011, 432 biomedical companies made an excess of $17,991,000 in payments to 220,908 physicians. Of these physicians, 75.1% were male. Female physicians, on average, received fewer total dollars (-$3,598.63, $p<0.001$) per person than men. Additionally, female physicians received significantly lower amounts for meals (-$41.80, $p<0.001$), education (-$1,893.14, $p<0.001$), speaker fees (-$2,898.44, $p<0.001$), and sponsored research (-$15,049.62, $p=0.05$). For total dollars, an interaction between gender and institutional reputation was statistically significant, implying that the	Female physicians receive significantly lower compensation for similarly described activities than their male counterparts after controlling for key covariates. As regulations lead to increased transparency regarding these relationships, efforts to standardize compensation should be considered to promote equitable opportunities for all physicians.

					increasing contribution to income and research funding to physicians in the U.S.		financial ties, controlling for key covariates.	differences between women and men differed based on industry's preference for an institution, with larger differences at higher reputation institutions.	
Analysis of Gender Equity in Leadership of Physician-Focused Medical Specialty Societies, 2008-2017	Julie K. Silver, Reem Ghalib, Julie A. Poorman	Department of Physical Medicine and Rehabilitation, Harvard Medical School, USA	JAMA Intern Med	2019; 179(3):433-435	The long-standing underrepresentation of women among medical academic leaders (deans, chairs, and professors) is well documented. However, little is known about trends in medical society leadership. Because tenure in society leadership positions contributes to academic advancement and provides opportunities	physicians from 39 societies s listed in the 2016 Physician Specialty Data Report	This cross-sectional study identified 1 major physician-focused medical society for each of the 43 specialty groupings listed in the 2016 Physician Specialty Data Report. The authors selected the largest and/or most influential society in the field. Groupings for internal medicine/pediatrics, neonatal-perinatal medicine, pediatric cardiology, and pediatric hematology/oncology (4 of 43 groupings) were	Between 2008 and 2017, presidential leadership was held predominantly by men, with men serving as presidents in 82.6% of years (322 of 390 years) vs women serving as presidents in 17.4% of years (68 of 390 years). Women were underrepresented overall but were significantly underrepresented in 2015 in terms of the percentage of women among society presidents vs the percentage of women among active physicians (15.4% vs 34.0%; P = .01). The Society of Critical Care Medicine, American Society of Neuroradiology, American Psychiatric Association, and American Geriatrics Society had the highest number of years with women presidential leaders (4-6 of 10 years;	Society leadership has a role in academic advancement, and leaders may exert considerable influence on their organizations and specialties. Finding of sustained underrepresentation of women within the critical post of society president highlights a challenge to achievement of gender equity in medicine that persists today. Barriers to equitable representation of women within societies may have affected

					to influence both the organization and the medical specialty, it is crucial to begin examining the demographics of society leadership.		then excluded because physicians in these specialties generally belong to the American Academy of Pediatrics (AAP). The primary outcome measures were years of presidential leadership attributed to men and women. To minimize some lack of independence across years, which is even greater for societies using 2-year presidential terms (4 of 39 societies; Table), data were collected for a 10-year period (2008-2017), allowing for a minimum of 5 election cycles. For 38 societies, presidents' names were assigned to the year of	Table). In contrast, 10 societies had 0 of 10 years with women presidential leaders. To gain perspective on the representation of women in top leadership roles, data on presidents from each society were compared with the representation of women among active physicians in the respective specialty grouping in 2015. The study was limited to this single comparison because the Association of American Medical Colleges workforce data were not reported in consistent specialty groupings or at consistent intervals during the study period, and society membership information generally was not publicly available. Equitable or better representation (positive differences) was found in 10 societies. However, gaps (negative differences) were found in 29 societies, with the 5 largest gaps (>30%) found in the American Academy	women's ability to ascend to presidential leadership, though the study has data only for selected societies and no data on internal processes used during selection of presidential leaders. Results suggest that efforts to improve diversity and inclusion may have been more successful in some societies than in others. Therefore, societies must prioritize examination and mitigation of disparities in the inclusion and support of members and report both challenges and successful strategies.

							election. For the AAP, which changed the start of its presidential term from fall to January in 2014, presidents elected before 2014 were assigned to the year following election.	of Dermatology, American College of Obstetricians and Gynecologists, College of American Pathologists, American Association of Clinical Endocrinologists, and AAP.	
Gender Differences in Leadership Positions Among Academic Nuclear Medicine Specialists in Canada and the United States	Saba Moghimi, Kiran Khurshid, Sabeena Jalal	Department of Medicine, University of Toronto, Canada.	AJR Am J Roentgenol	2019; 212(1):146-150	The primary objective of this study was to compare gender representation in academic and leadership positions among faculty members in nuclear medicine in Canada and the United States. The secondary objective was to study the influences to account for the existing disparity in academic	237 faculty members	Using the Fellowship and Residency Electronic Interactive Database (FREIDA) and Canadian Resident Matching Service (CaRMS), the authors created a database of faculty members in nuclear medicine. For assessment of academic performance, the h-index, number of publications, number of citations, and years of active	The academic ranks of 237 faculty members were used for analysis; of this group, 16.95% of associate professors were female. Women were less frequently represented in higher academic ranks, and women were also less frequently represented in leadership ranks (13.6% female vs 86.4% male). The h-index was comparable across genders.	Female nuclear medicine specialists are underrepresented in academic and leadership positions compared with their male counterparts. This difference in numbers is unlikely to be because of academic performance given that both genders had comparable academic performance metrics in this study. The results show the need for

					nuclear medicine.		research were extracted using Scopus.		devising strategies to promote diversity in academic and leadership positions across nuclear medicine specialists.
Women deans' perceptions of the gender gap in American medical deanships	Humberstone E	School of Education, Johns Hopkins University, Baltimore, USA.	Educ Health (Abingdon)	2017; 30(3):248-253	Women account for 16% of deans of American medical schools. To investigate this gender gap, female deans were interviewed about the barriers facing women advancing toward deanships.	8 women deans from AAMC Central, Southern, and Western regions	The author conducted semi-structured interviews with eight women deans. Interviews were analyzed using provisional coding and sub coding techniques.	Four main themes emerged during the interviews: (1) the role of relationships in personal and career development, (2) leadership challenges, (3) barriers between women and leadership advancement, and (4) recommendations for improvement. Recommendations included allocating resources, mentorship, career flexibility, faculty development, updating the criteria for deanships, and restructuring search committees.	The barriers identified by the deans are similar to those found in previous studies on female faculty and department chairs, suggesting limited improvement in gender equity progress.
Identifying a gender leadership and management gap in EU	E Kuhlmann, P Ovseiko, M von Knorring	Karolinska Institutet, LIME, Medical Management Centre,	European Journal of Public Health	2017; 27(S3)	Women's participation in medicine and the need for gender equality in	four large European centres: Charite´ – Universita¨ts medizin	An explorative comparative design is used, taking the case of four large European centres:	The percentage of female medical students and doctors in all four countries is now more balanced, but women remain significantly under-	Setting gender balance objectives exclusively for top-level decision-making bodies may not

academic health centres: Ellen Kuhlmann		Sweden			healthcare are increasingly recognised, yet little attention is paid to leadership and management positions in large publicly-funded academic health centres. This study aims to explore and compare the representation of women in leadership and management in European academic health centres.	Berlin (Germany), Karolinska Institutet (Sweden), Medizinische Universita¨t Wien (Austria), and Oxford Academic Health Science Centre (United Kingdom)	Charité – Universitätsmedizin Berlin (Germany), Karolinska Institutet (Sweden), Medizinische Universität Wien (Austria), and Oxford Academic Health Science Centre (United Kingdom). Material includes public statistics, website information, unpublished data from HR Departments, and an interactive workshop of the authors.	represented among senior doctors and full professors. All four centres have made progress in closing the gender leadership gap on boards and other top-level decision-making bodies. While country-specific differences related to the welfare state models remain relevant, there are similar trends: gender inequality is stronger within academic enterprises than within hospital enterprises, and stronger in middle-management than at the top level. These novel findings reveal fissures in the 'glass ceiling' effects at top-level management, while the barriers for women shift to middle-level management and remain strong in academic positions.	effectively promote a wider goal of gender equality. Academic health centres should pay greater attention to gender equality as an issue of organisational performance and good leadership at all levels of management, with particular attention to academic enterprises and newly created management structures.
How does physician gender	Hao Xue, Gordon Liu,	School of Economics and Manageme	Lancet	2018; 392: S66	Studies in high-income countries have found that	309 primary providers who received 412	This cross-sectional study used standardised patients to assess	In unadjusted comparisons, female providers completed 0·76 (95% CI 0·05–1·47) more	This study finds that female providers prescribe fewer

influence primary care quality? evidence from a standardised patient audit study in China	Yaojiang Shi	nt, Northwest University, China			female physicians exhibit better performance than their male counterparts. However, it is largely unclear whether these findings are influenced by case and patient mix bias. The study aimed to objectively assess differences in clinical practice and treatment between female and male primary care providers in rural China.	visits from standardised patients in township health centres in rural areas of three provinces in western, central, and eastern China	provider performance in clinical practice, yielding objective performance measures free from case and patient mix bias. All providers were visited by standardised patients who were trained to consistently present three disease cases. Clinical process was graded against checklists based on national and international guidelines of recommended questions and exams to be performed. Assessment of treatment considered the appropriateness of medicine dispensed and referrals made, as well as the types and quantity of medicines	clinical checklist items on average than male providers, representing an increase of 15% over the mean number of checklist items completed by male providers (5·04 items). Female providers were also 15 percentage points (95% CI 0–30) more likely to give appropriate treatment than male providers (38%). Although, there was no significant difference in unadjusted comparisons (43% for female providers and 41% male providers), female providers prescribed significantly fewer unnecessary or harmful medicines such as antibiotics than male providers after controlling for facility fixed effects and other provider characteristics (–21 percentage points, 95% CI −41 to −2).	unnecessary or harmful treatments in primary care than male providers in rural China after controlling for potential sources of bias. No difference between female and male providers was found for other measures of clinical process quality after adjusting for observable characteristics.

							dispensed.		
In their own words: describing Canadian physician leadership	Snell AJ, Dickson G, Wirtzfeld D	Psychologist and Researcher, Canada.	Leadersh Health Serv (Bradf Engl)	2016; 29(3):264-81	This study compiles statistical data to describe the functions and responsibilities of physicians in formal and informal leadership roles in the Canadian health system. This mixed-methods research study offers baseline data relative to this purpose, and also describes physician leaders' views on fundamental aspects of their leadership responsibility.	689 physicians	A survey with both quantitative and qualitative fields yielded 689 valid responses from physician leaders. Data from the survey were utilized in the development of a semi-structured interview guide; 15 physician leaders were interviewed.	A profile of Canadian physician leadership has been compiled, including demographics; an outline of roles, responsibilities, time commitments and related compensation; and personal factors that support, engage and deter physicians when considering taking on leadership roles. The role of health-care organizations in encouraging and supporting physician leadership is explicated.	The baseline data on Canadian physician leaders create the opportunity to determine potential steps for improving the state of physician leadership in Canada; and health-care organizations are provided with a wealth of information on how to encourage and support physician leaders. Using the data as a benchmark, comparisons can also be made with physician leadership as practiced in other nations.

Physician leadership in e-health? A systematic literature review	Keijser W, Smits J, Penterman L	Faculty of Behavioral, Management and Social Sciences, University of Twente, The Netherlands.	Leadersh Health Serv (Bradf Engl)	2016; 29(3):331-47	This paper aims to systematically review the literature on roles of physicians in virtual teams (VTs) delivering healthcare for effective "physician e-leadership" (PeL) and implementation of e-health.	44 papers	The analyzed studies were retrieved with explicit keywords and criteria, including snowball sampling. They were synthesized with existing theoretical models on VT research, healthcare team competencies and medical leadership.	Six domains for further PeL inquiry are delineated: resources, task processes, socio-emotional processes, leadership in VTs, virtual physician-patient relationship and change management. To date, PeL studies on socio-technical dynamics and their consequences on e-health are found underrepresented in the health literature; i.e. no single empirical, theoretic or conceptual study with a focus on PeL in virtual healthcare work was identified.	E-health practices could benefit from organization-behavioral type of research for discerning effective physicians' roles and inter-professional relations and their (so far) seemingly modest but potent impact on e-health developments.
The effect of physician gender on length of patient consultations: observational findings from the UK hospital setting and synthesis					This study investigated the effect of physician gender on consultation length in UK hospital outpatient clinics and compare this, through meta-analysis, with previous studies outside the UK.	174 observations of outpatient consultations with 10 hospital specialists (consultants) from different specialties in two UK hospital trusts.	Observational data on clinic times were analysed and findings were combined in a meta-analysis with existing studies investigating the effect of physician gender on consultation length. Clinic times were recorded and analysis of	No statistically significant difference was found in the length of consultations for male and female doctors in these UK hospital settings. When pooled with existing studies, consultations with women doctors were found to be approximately two minutes longer than with men ($p = 0.01$).	Findings from this analysis of clinic consultations in the UK National Health Service do not support previous studies, which were undertaken predominantly in North America and primary care settings. Overall, meta-analysis suggests doctors' gender may influence

with existing studies							consultation length was undertaken with physician gender as a covariate. Data were then synthesised through meta-analysis with 10 existing studies in this field.		consultation length. Gender differences in communication should be considered in training clinicians and in overall clinical practice.
Gender, power and leadership: the effect of a superior's gender on respiratory therapists' ability to challenge leadership during a life-threatening emergency	N Pattni, MD Bould, MA Hayter	Department of Anaesthesia, Guys and St Thomas' NHS Foundation Trust, UK	British Journal of Anaesthesia	2017; 119(4): 697-702	Effective communication within teams is crucial, especially in crisis situations. Hierarchy gradients between team members can contribute to communication failures and are influenced by many factors. The effect of gender on team performance has not been well studied. The objective	29 respiratory therapists	Respiratory therapists were recruited to take part in a high-fidelity simulation of can't-intubate can't-oxygenate scenarios. They were randomized into two groups, either assisting a male or a female anaesthetist in managing an airway crisis during which the anaesthetist made incorrect clinical decisions. Two independent raters scored the performances using the modified	Twenty-nine subjects completed the study. The median best challenge score when the staff anaesthetist was female was 4 (3–5 IQR [2–6 range]) compared with 3 (3–3[0–3]) for challenges to a male anaesthetist (P=0.017). The median of the total challenges against a female staff member 11 (7.3–14.8 [2–18]) was significantly higher compared with 4 (3.5–7 [2–11.5]) for a male staff (P=0.006).	The study showed a significant effect of superiors' gender on a respiratory therapist's ability to challenge leadership. A female staff anaesthetist was challenged more often and with greater assertiveness and effectiveness. This has implications for an educational intervention targeting the

					of this study was to examine the effect of the physician's gender on respiratory therapists' ability to effectively challenge clearly incorrect clinical decisions during a life-threatening crisis.		Advocacy-Inquiry Score (min 1, max 6).		ability to challenge a wrong decision by a supervisor and emphasizing the effect of gender on the willingness to speak up.
Physician gender and patient centered communication: The moderating effect of psychosocial and biomedical case characteristics	Dong Wook Shin, Debra L.Roter, Yong Kyun Roh	Department of Family Medicine & Health Promotion Center, Seoul National University Hospital, Korea	Patient Education and Counseling	2015; 98(1): 55-60	Literatur suggests female physicians have a more patient-centered communication style than their male counterparts; however, few studies have investigated how the biomedical or psychosocial	76 3rd year residents (50 male and 26 females)	Residents seeking board certification from the Korean Academy of Family Medicine participated in the 2013 Clinical Practice Examination by conducting two simulated patient (SP) interviews, one presenting a largely	Female physicians and their SPs engaged in more dialog than male physicians in both cases. Female physicians were more patient-centered than males for the psychosocial case ($t = -3.24$, $P < 0.05$), however, their scores did not differ for the biomedical case. In multivariate analysis, a significant interaction between physician gender	Case characteristics moderated the association between physician gender and patient-centeredness. Case characteristics need to be considered in future research on the association of

					nature of a patient diagnosis might moderate this relationship.		psychosocial case and the other largely biomedical. The interview recordings were coded with the Roter Interaction Analysis System (RIAS).	and case ($z = -3.90$, $P < 0.001$) similarly demonstrated greater female patient-centeredness only for the predominantly psychosocial case.	physician gender and the patient-centered communication, as well as in the tailoring of physician communication training.
Significance of gender in the attitude towards doctor-patient communication in medical students and physicians	Henriette Löffler-Stastka, Tamara Seitz, Sabrina Billeth	Klinik für Psychoanalyse und Psychotherapie und Postgraduate Education and Training Center, Medizinische Universität Wien, Ö sterreich	Wiener klinische Wochenschrift	2016; 128(17-18):663-668	Gender-specific differences in the attitudes towards doctor-patient communication among medical students and physicians were assessed.	150 medical students and 51 physicians from different departments	The association, attitude and experiences regarding doctor-patient communication were assessed with a series of tools and questionnaires.	Female doctors and students tended to describe the doctor-patient communication with positive attributes, such as “helpful”, “sentimental”, “voluble”, “sociable”, “gentle”, “yielding” and “peaceful”. Male students and physicians, on the other hand, described doctor-patient communication as “overbearing”, “robust” and “inhibited”. The most frequent associations females had with the term doctor-patient communication were “empathy”, “confidence”,	This study indicates a gender-dependent communication style influenced by stereotypes. At the establishment of communication training these differences should be taken into account, especially to strengthen male communication skills and improve their attitudes.

								“openess”, while the most frequent association of the male colleagues was “medical history”. Female doctors reported speaking about the psychosocial situation of the patient significantly more often and believed in higher patient satisfaction by sharing more information. Furthermore, they reported having longer conversations with a more equal partnership than their male colleagues. Compared to male students, female students were willing to take part in training their communication skills more often and had more interest in research about doctor-patient communication. Male medical students reported self-doubt during conversations with female patients, while one third of the male physicians talked	

								about “the power over the patient”.	
The influence of gender on the communication skills assessment of medical students	Chin-Chou Huang, Chia-Chang Huang, Ying-Ying Yang	Department of Medical Education, Taipei Veterans General Hospital, Taiwan	Eur J Intern Med	2015; 26(9):670-674	Opinions on the interaction between the genders of standardized patients and examinees are controversial. This study sought to determine the influence of gender on communication skills assessment in Eastern country.	5 medical students from a medical college in Taiwan	Participants were assigned to obtain informed consent from either male or female age-matched standardized patients. Their performance was rated by standardized checklist rating scores and global rating scores. Either male or female examiners rated their performance.	A total of 253 medical students (166 male students and 87 female students) were recruited. The checklist rating scores for students interacting with male standardized patients were significantly lower than the scores for interactions with female standardized patients (male examiners, P = 0.006; female examiners, P = 0.001). For male students, the checklist rating scores were significantly lower for male standardized patients than for female standardized patients (male examiners, P = 0.006; female examiners, P = 0.008). For male standardized patients, male students had significantly lower checklist rating scores than female students when rated by male examiners (P =	The gender of standardized patients influences communication skills assessment. In terms of checklist rating scores, female standardized patients seem preferable to minimize potential gender effects. In the best interest of students, global rating score may be preferable to checklist rating score, especially for male examinees.

								0.044). The global rating scores were similar except when female students interacted with male and female SPs and when rated by female examiners (P = 0.004).	
Communication skills of medical students during the OSCE: Gender-specific differences in a longitudinal trend study	Joachim GrafRobert SmolkaElisabeth Simoes	Medical Faculty Tuebingen Dean's Office for Students' Affairs, Germany	BMC Med Educ	2017; 17:75	Although significant differences in communication behaviour of male and female students are known, gender differences in the performance of students are still under-reported. The aim of this study was to analyse gender differences in communication skills of medical students in the	1027 medical students from Tuebingen University	In a longitudinal trend study based on seven semester-cohorts, it was analysed if there are gender differences in medical students' communication skills. The students (self-perception) and standardized patients (SP) (external perception) were asked to rate the communication skills using uniform questionnaires. Statistical analysis was performed by	Across all ratings in the self- and the external perception, there was a significant gender difference in favour of female students performing better in the dimensions of empathy, structure, verbal expression and non-verbal expression. The results of male students deteriorated across all dimensions in the external perception between 2011 and 2014.	It is important to consider if gender-specific teaching should be developed, considering the reported differences between female and male students.

					context of an OSCE exam (OSCE = Objective Structured Clinical Examination).		using frequency analyses and t-tests in SPSS 21.		
Interventions to reduce discrimination and stigma: the state of the art	Petra C. Gronholm, Claire Henderson, Tanya Deb	Health Services and Population Research Department, David Goldberg Centre, King's College, London Institute of Psychiatry, Psychology and Neuroscience, De Crespigny Park, UK	Soc Psychiatry Psychiatr Epidemiol	2017; 52(3): 249–258	There is a rich literature on the nature of mental health-related stigma and the processes by which it severely affects the life chances of people with mental health problems. However, applying this knowledge to deliver and evaluate interventions to reduce discrimination and stigma in a lasting way is a complex and long-term challenge.	35 studies (involving 4257 students)	This study conducted a narrative synthesis of systematic reviews published since 2012, and supplemented this with papers published subsequently as examples of more recent work.	There is evidence for small to moderate positive impacts of both mass media campaigns and interventions for target groups in terms of stigma-related knowledge, attitudes, and intended behaviour in terms of desire for contact. However, the limited evidence from longer follow-up times suggests that it is not clear whether short-term contact interventions have a lasting impact.	The risk that short-term interventions may only have a short-term impact suggests a need to study longer term interventions and to use interim process and outcome data to improve interventions along the way. There is scope for more thorough application of intergroup contact theory whenever contact is used and of evidence-based teaching and assessment methods when skills training is used for target groups.

Clinical decisions and stigmatizing attitudes towards mental health problems in primary care physicians from Latin American countries	Vistorte AOR, Ribeiro W, Ziebold C	Department of Psychiatry, Universidade Federal de São Paulo, Brazil	PLoS One	2018; 13(11):e0206440	The aim of this paper is to investigate how doctors working in primary health care in Latin American address patients with common mental disorders and to investigate how stigma can affect their clinical decisions.	387 physicians from Bolivia, Brazil, Cuba and Chile	Using a cross-sectional design, the study applied an online self-administered questionnaire to a sample of 550 Primary Care Physicians (PCPs) from Bolivia, Brazil, Cuba and Chile. The questionnaire collected information about sociodemographic variables, training and experience with mental health care. Clinicians' stigmatizing attitudes towards mental health were measured using the Mental Illness Clinicians' Attitudes Scale (MICA v4). The clinical decisions of PCPs were assessed through three clinical vignettes representing	A total of 387 professionals completed the questionnaires (70.3% response rate). The 63.7% of the PCPs felt qualified to diagnose and treat people with common mental disorders. More than 90% of the PCPs from Bolivia, Cuba and Chile agreed to treat the patients presented in the three vignettes. No significant difference was observed between the four countries in the scores of the MICA v4 stigma levels, with a mean = 36.3 and SD = 8.3 for all four countries. Gender ($p = .672$), age ($p = .171$), training ($p = .673$) and years of experience ($p = .28$) were unrelated to stigma. In the two multivariate regression models, PCPs with high levels of stigma were more likely to refer them to a psychiatrist the patients with depression (OR = 1.03, 95% CI, 0.99 to 1.07 $p<0.05$) and somatoform symptoms somatoform (OR = 1.03, 95% CI, 1.00	The majority of PCPs in the four countries were inclined to treat patients with depression, anxiety and somatoform symptoms. PCPs with more levels of stigma were more likely to refer the patients with depression and somatoform symptoms to a psychiatrist. Stigmatizing attitudes towards mental disorders by PCPs might be important barriers for people with mental health problems to receive the treatment they need in primary care.

							typical cases of depression, anxiety and somatization.	to 1.07, p<0.05) to a psychiatrist.	
Stigma towards mental illness among medical and nursing students in Singapore: a cross-sectional study	Sherilyn Chang, Hui Lin Ong, Esmond Seow	Research Division, Institute of Mental Health, Singapore, Singapore	BMJ Open	2017; 7(12): e018099	This study aims to assess stigma towards people with mental illness among Singapore medical and nursing students using the Opening Minds Stigma Scale for Health Care Providers (OMS-HC), and to examine the relationship of students' stigmatising attitudes with sociodemographic and education factors.	The study was conducted among 1002 healthcare (502 medical and 500 nursing) students during April to September 2016. The mean (SD) age of the participants was 21.3 (3.3) years, with the majority being females (71.1%). 75.2% of the participants were Chinese, 14.1% were Malays, and 10.7% were either	A cross-sectional study in Singapore was conducted. Factor analysis was conducted to validate the OMS-HC scale in the study sample and to examine its factor structure. Descriptive statistics and multivariate linear regression were used to examine sociodemographic and education correlates.	Factor analysis revealed a three-factor structure with 14 items. The factors were labelled as attitudes towards help-seeking and people with mental illness, social distance and disclosure. Multivariable linear regression analysis showed that medical students were found to be associated with lower total OMS-HC scores (P<0.05), less negative attitudes (P<0.001) and greater disclosure (P<0.05) than nursing students. Students who had a monthly household income of below S$4000 had more unfavourable attitudes than those with an income of SGD$10 000 and above (P<0.05). Having attended clinical placement was associated with more negative attitudes (P<0.05) among the students.	Healthcare students generally possessed positive attitudes towards help-seeking and persons with mental illness, though they preferred not to disclose their own mental health condition. Academic curriculum may need to enhance the component of mental health training, particularly on reducing stigma in certain groups of students.

						Indians or of other ethnicity.			
Stigma of addiction and mental illness in healthcare: The case of patients' experiences in dental settings	Mario A. Brondani, Rana Alan, Leeann Donnelly	Faculty of Dentistry, University of British Columbia, Vancouver, Canada	PLoS One	2017; 12(5): e0177388	This study aims to explore the ways in which stigma is experienced in healthcare and dental settings by patients with a history of addiction and mental illness.	25 residents from two community treatment centres in Vancouver, Canada	Audio-recorded, semi-structured interviews with a purposefully selected convenience sample of residents from two community treatment centres in Vancouver, Canada were conducted. The interview guide contained questions about experiences while seeking health and dental care and was based on an existing framework of labeling, stereotyping, exclusion, discrimination, and power imbalance. Interviews were transcribed verbatim for coding and	Twenty-five participants between 23 and 67 years of age were interviewed; 17 were males. Most had a self-reported history of depression combined with use of alcohol and crack-cocaine; most of them only sought dental care for emergency purposes. Textual analysis of more than 300 pages of transcribed interviews revealed that participants perceived stigma when they were negatively stereotyped as 'unworthy', labeled as 'different', excluded from the decision-making process, discriminated against, 'treated unfairly', and felt powerless when interacting in the heath and dental care systems. Conversely, positive experiences were characterized by empathy, reassurance and good communication, which were empowering for patients.	When associated with stigma, mental illness and addictions have negative implications for accessing health and dental care. From the participants' perspectives, it seems that the lack of understanding about their life conditions by the healthcare professionals was the origin of stigma. The authors suggest that an increased social awareness of these health issues be enhanced among current and future health and dental care professionals to help improve care experiences for this

							thematic analysis.		marginalized population.
Prejudice in Perceptions of Physicians?: The Influence of Race and Gender on Evaluations of Medical Errors	N. Derek Brown Larry R. Martinez, Michelle "Mikki" R. Hebl	Department of Psychology, Portland State Universit, USA	J Gen Intern Med	2018; 33(6): 807-808	Little is known about prejudicial attitudes patients have toward physicians. Past research shows that physicians commonly face discrimination, and although Asian physicians constitute the largest ethnic minority population of practicing physicians, there is no research that examines their experiences with discrimination explicitly. Asian professionals are subject to both positive and negative	482 adults	This study recruited 482 adults (59% female) using Amazon's MTurk.6 Participants were randomly assigned to view one website and one incident report that altered to manipulate physician ethnicity (White vs. Indian), gender (male vs. female), and medical error severity (major vs. minor error). The study assessed participant evaluations of the physician with questions about patient care characteristics ($\alpha = .86$) and the appropriateness of various consequences that could be "taken	The mean age of participants was 37.09 ($SD = 12.54$) and 77% of participants were White/Caucasian. Table 1 provides means, standard deviations, reliabilities, and correlations of the variables included in the analyses. There were no differences in care quality perception or suggested consequences for severe errors between race and gender groups (Table 2). For all groups, patient care perceptions were more negative and consequences for major errors were more severe compared to minor ones ($F(2,473) = 38.97$, $p < .001$). For minor errors, there was no difference between patient care perception or desired consequences for White or Indian men or Indian women. However, White women were viewed more positively in terms of their provision of patient care ($F(1, 474) = 4.77$, $p < .05$, $\eta 2 = .01$) compared to	The results suggest that evaluations of physicians are not only linked to the severity of the error committed, but also to physician gender and race. Indian physicians were rated no differently than White male physicians, despite having sufficient power to detect an effect. Results also revealed differential evaluations for White female physicians in comparison to White male, Indian male, and Indian female physicians, though only for minor errors. Specifically, white female physicians were

					stereotypes, such that they are categorized as high-achieving (e.g., intelligent, successful), yet also perpetually foreign and never accepted into the American milieu. This research examined how patient biases can influence evaluations of physicians as a function of physician race, gender, and severity of a medical error.		against the physician" ($\alpha = .89$). We compared mean differences based on participant impressions as a function of error severity and physician ethnicity and gender (MANOVA) and assessed for potential relationships between physician demographic characteristic and suggested consequences using regression analysis (Hayes' PROCESS Macro Model 4). An a priori power analysis (with $\alpha = .05$ and power = .95) revealed an adequate sample size to detect differences in effect sizes as small as .025.	other physicians, evaluated as a group ($M = 4.24$, $SD = 1.08$). Similarly, White women were treated more leniently in terms of suggested consequences ($F(1, 474) = 4.52$, $p < .05$, $\eta 2 = .01$) compared to the other physicians ($M = 2.94$, $SD = 1.32$). For major errors, there were no differences based on race or gender. In the multivariable model, the study found that the leniency for White female physicians could be explained by the perception that White women have greater ability to provide care following a minor error, $b = -0.19$ ($SE = 0.09$), 95% CI $[-0.40, -0.02]$.	rated as better caretakers and elicited the least severe sanctions (despite equivalent performance). The study data suggest that physician race and gender may be instrumental in an individual's evaluation toward physicians, above and beyond what may be deserved based on their performance alone. The results highlight the pernicious effects of racial and gender stereotypes in the doctor–patient relationship, which can translate to large-scale consequences (e.g., pursuing malpractice lawsuits). This research reveals that in order to

									manage equitable hospital climates, in which being female or being non-White does not yield career disadvantage, research must continue understanding biases of patients and physicians that hinder effective medical care.
Medical Students' Exposure to the Humanities Correlates with Positive Personal Qualities and Reduced Burnout: A Multi-Institutional U.S. Survey	Mangione S, Chakraborti C, Staltari G	Sidney Kimmel Medical College of Thomas Jefferson University, USA	J Gen Intern Med	2018; 33(5):628-634	This study aims to test the hypothesis that medical students with higher exposure to the humanities would report higher levels of positive physician qualities (e.g., wisdom, empathy, self-efficacy, emotional appraisal, spatial skills), while	739 medical students from five U.S. medical schools	An online survey was conducted. All students enrolled at five U.S. medical schools during the 2014–2015 academic year were invited by email to take part in the online survey. Students reported their exposure to the humanities (e.g., music, literature, theater, visual	In all, 739/3107 medical students completed the survey (23.8%). Regression analyses revealed that exposure to the humanities was significantly correlated with positive personal qualities, including empathy ($p < 0.001$), tolerance for ambiguity ($p < 0.001$), wisdom ($p < 0.001$), emotional appraisal ($p = 0.01$), self-efficacy ($p = 0.02$), and spatial skills ($p = 0.02$), while it was significantly and inversely correlated with some components of burnout ($p = 0.01$). Thus,	This study confirms the association between exposure to the humanities and both a higher level of students' positive qualities and a lower level of adverse traits. These findings may carry implications for medical school recruitment and curriculum design.

					reporting lower levels of negative qualities that are detrimental to physician well-being (e.g., intolerance of ambiguity, physical fatigue, emotional exhaustion, and cognitive weariness).		arts) and completed rating scales measuring selected personal qualities.	all hypotheses were statistically significant, with effect sizes ranging from 0.2 to 0.59.	
Associations between emotional intelligence, empathy and personality in Japanese medical students	Abe K, Niwa M, Fujisaki K	Medical Educational Development Center, Gifu University, Japan	BMC Med Educ	2018; 18(1):47	It is known that empathic communication is important for physicians to achieve higher patient satisfaction and health outcomes. Emotional intelligence (EI), empathy and personality in medical students predict	357 1st year medical students from 2008 to 2011 at one medical school in Japan	Students completed self-report questionnaires comprising three validated instruments measuring EI: Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF), empathy: Jefferson Scale of Physician Empathy- student version (JSPE)	Pearson Correlations showed weak association between TEIQue-SF and JSPE. TEIQue-SF and NEO-FFI showed positive correlation for E and C, and strong negative correlation for N and weak positive correlation for A and O. Weak positive correlation between JSPE and the NEO-FFI were observed for E and A. Although effect sizes were small, N, A and empathy were significantly higher in females (unpaired t-test). However,	In the study population of 1st year medical students, females had significantly higher N, A and empathy scores than males. Medical students' N score was strongly negatively associated with EI. Empathy was weakly associated with EI and A. However, when controlling gender

					students' individual disposition and their emotional and empathic perceptions. This study aimed to investigate: 1) The association between empathy, EI and personality, and 2) Gender differences in the association between empathy, EI and personality.		and personality: NEO-Five-Factor Inventory (NEO-FFI), which explores 5 dimensions of personality Neuroticism (N), Extraversion (E), Openness to experience (O), Agreeableness (A), and Conscientiousness (C).	hierarchical multiple-regression analysis when controlling for gender and personality showed no association between EI, empathy and gender. A, TEIQue-SF and N were found to make small contributions in respect of predictions for JSPE. Personality contributed significantly to the prediction of TEIQue-SF. N had the largest independent negative contribution ($\beta = -0{,}38$).	and personality in regression analysis, gender did not affect EI and empathy, rather personality is the most important factor. Findings indicate that N is a major factor that negatively affects EI. It is important to mitigate N using thoughtful training, taking into account students' personalities, to reduce N.
Female specialists in intensive care medicine: job satisfaction, challenges	Felicity H Hawker	College of Intensive Care Medicine of Australia and New Zealand, Australia	Crit Care Resusc	2016; 18(2):125-31	Women are under-represented in the intensive care medicine (ICM) specialist workforce. This study aimed to better understand the challenges	127 female fellows of the College of Intensive Care Medicine (CICM) of Australia and New Zealand	All female fellows of the College of Intensive Care Medicine (CICM) of Australia and New Zealand were surveyed using an online questionnaire. The study was approved by the	The response rate was 80.3% (127/158). The median age bracket was 40-45 years, and 118 respondents were practising ICM, 85 full-time in a tertiary intensive care unit. Eighteen were ICU directors and 23 were CICM-appointed supervisors of training. Sixty-five women were	The participation and satisfaction rates of women working in the ICM specialist workforce are encouraging. Although challenges exist, women contemplating a career in ICM

and work–life balance					these women face so they can be considered in the training and support of ICM specialists.		Cabrini Human Research Ethics Committee. Thirty respondents with children volunteered to complete a second questionnaire.	mothers, and 70% returned to full-time work after their maternity leave. Child care was most commonly undertaken by family members or a nanny. Overall, 81% were satisfied with their experiences, but 37% felt they had been disadvantaged because of their sex. Fewer women with leadership roles felt disadvantaged. Their major challenges included the on-call work affecting child-rearing and family life, sexism in the workplace and difficulties with academic advancement.	should see it as achievable and rewarding.
The influence of role-modeling on clinical empathy of medical interns: A qualitative study	Nahid Ahmadian Yazdi,Shoaleh Bigdeli,Seyed Kamran Soltani arabshahi	Center For Educational Research in Medical Sciences (CERMS), Iran University of Medical Sciences, Iran	J Adv Med Educ Prof	2019; 7(1): 35-41	Clinical empathy ascertains the quality of doctor-patient relationship and entails beneficial outcomes for both parties. Role-modeling is a major	14 medical interns and 6 clinical professors from Iran and Ardebil universities of medical sciences	In this qualitative conventional content analysis, semi-structured individual interviews were conducted with 14 medical interns and 6 clinical professors. The participants were selected by purposive sampling. All	Data analysis led to the emergence of a theme called role-modeling, and two subcategories: "advertent role-modeling" and "inadvertent role-modeling". Advertent role-modeling included "influenced by the charismatic personality of professors", "critique of faculty members' communicative behaviors with patients", and	Role-modeling was the main theme of the present study. To improve clinical empathy skills, particular attention should be paid to role-modeling. Informing clinical professors and medical students on role-modeling,

					factor in promoting clinical empathy skills of medical students. The study attempted to explain the importance of role-modeling in clinical empathy of medical interns. It was also intended to obtain a better and more profound understanding of the subject based on the experiences of medical interns.		interviews were recorded, transcribed, and analyzed. Trustworthiness, credibility, and confirmability of the data were confirmed.	"observation of the faculty members' performance". Inadvertent role-modeling included "crystallization of human values in communication behaviors" and "compliance with hierarchical behavior".	strengthening students' empathetic behaviors by role model professors, and recruitment of professors with strong communication skills are among the recommended strategies of this study.
Effects of doctors' empathy abilities on the cellular	Ningxi Yang, Han Xiao, Wei Wang	Department of Epidemiology, School of Health	Patient Prefer Adherence	2018; 12: 1305-1314	The empathy of doctors is closely related to patients' outcomes. This research	175 prostate cancer patients who were treated at five hospitals in	Data on the empathy of doctors and the demographics, disease condition, stigma, self-	At the three time points, all three psychological indicators of the patients were statistically significant. Among the immune indices, only the	Doctors' empathy affected the NK subset in advanced prostate cancer patients and was related to

immunity of patients with advanced prostate cancer treated by orchiectomy : the mediating role of patients' stigma, self-efficacy, and anxiety		Sciences, Wuhan University, Wuhan, China			aimed to examine whether patients' stigma, self-efficacy, and anxiety mediate the relationship between doctors' empathy and cellular immunity in patients with advanced prostate cancer treated by orchiectomy.	north China	efficacy, and anxiety of patients were collected. Patients' psychological indicators and cellular immunity were measured at admission, after 14 days, and after 3 months. The variance analysis test was used to compare the immune indices at the three time points. At T3, a multivariate linear regression model was used to analyze the factors that influenced the immune index. Pearson correlation analysis and structural equation modeling were used to examine the relationships among patients' stigma, self-efficacy, anxiety, and cellular	change in the percentage of NK cells (NK subset) was statistically significant, while the changes in the percentages of CD3+, CD4+, CD8+, and B cells were not statistically significant. The doctors' empathy showed negative relationships with patients' stigma and anxiety and a positive relationship with patients' self-efficacy. Patients' stigma and anxiety were negatively associated with NK subset, while patients' self-efficacy showed a positive relationship with NK subset. Anxiety was positively related to stigma and negatively related to self-efficacy. Therefore, the effect of the doctors' empathy on the patients' NK subset was mediated by the patients' stigma, self-efficacy, and anxiety.	the patients' stigma, self-efficacy, and anxiety. In addition, anxiety directly affected stigma and self-efficacy. Thus, medical staff should focus on improving their empathy toward patients. Interventions that focus on patients' anxiety, stigma, and self-efficacy may be helpful to improve immunity.

							immunity and doctors' empathy.		
Reducing Mental Illness Stigma through Unconscious Bias-Informed Education	Javeed Sukhera, Saad Chahine	Western University, Canada	MedEdPublish	2016; 5(2)	Mental illness stigma can have disastrous consequences for patients, families and healthcare organizations. Unconscious bias informed education seeks a systematic approach to addressing implicit biases in healthcare providers by promoting awareness and understanding in order to promote compassion and empathy.	146 third year students from a Liaison Committee on Medical Education accredited Canadian Medical School, who were enrolled in the third year psychiatry clerkship rotation	After a 1 hour intervention, third year medical students who were enrolled in the third year psychiatry clerkship rotation completed a demographic form, (pre/post) a shortened mental illness implicit association test (IAT) and the Brief Mental Illness Attitudes Scale (BMIAS).	For the IAT, the majority (51.4%) of participants demonstrated a bias that mental illness was associated with dangerousness. A paired samples t test of BMIAS scores found no significant change in pre and post scores on Responsibility subscale. There was a statistically significant improvement in the in the Traits subscale from pre (n=87, m=5.15, sd=0.87) and post (n=87, m=5.62, sd=0.71), t(86)=5.16 $p<0.001$. The brief seminar had a statistically significant impact on student attitudes towards patients with traits of individuals with psychiatric illness.	These findings indicate that mental illness stigma is an important issue in medical education and that unconscious bias-informed education may provide an effective method to reduce stigma.
Physicians' self-assessed empathy levels do not correlate	Monica Oliveira Bernardo	Radiology Department–Faculty of Medicine,	PLoS One	2018; 13(5): e0198488	This study aims to investigate: 1—the relationship	945 patients and 51 physicians from two clinics (one	This is an observational study which enrolled 945 patients and 51	No significant correlation was observed between total self-assessed empathy and patients' perceptions. There was a small	The lack of correlation between self-assessed empathy levels and

with patients' assessments		Catholic University of São Paulo, Brazil			between physicians' self-assessed empathy and patients' measures of physicians' empathy; 2 – Environmental factors that could influence patients' perceptions; and 3 –the correlation between two widely used psychometric scales to measure empathy from the perspective of patients.	private, one public) located in the same multi-specialty medical center in Sorocaba, São Paulo, Brazil	physicians from radiology, clinical, and surgical specialties. The physicians completed the Jefferson Scale of Physician Empathy (JSE) and the International Reactivity Index (IRI), and patients completed the Consultation and Relational Empathy scale (CARE), and the Jefferson Scale of Patient's Perceptions of Physician Empathy (JSPPPE).	correlation (r = 0,3, P<0,05) between the sub-dimension Perspective Taking-JSE and JSPPPE. JSPPPE and CARE had a positive and moderate correlation (0,56; p<0,001). Physicians' gender and sector influenced the JSPPPE score. Sector, medical specialty and the nature of the appointment (initial versus subsequent) influenced the CARE measure.	patients' perceptions suggests patients be included in the process of empathy evaluation.
Association between emergency physician self-reported empathy and	Wang H, Kline JA, Jackson BE	Department of Emergency Medicine, Integrative Emergency Services, John Peter Smith Health,	PLoS One	2018; 13(9):e0204113	This study aims to evaluate the association between physician self-reported empathy and after-care instant patient-	41 ED providers with 1,308 patients	A prospective observational study was conducted in a tertiary care hospital ED. The Jefferson Scale of Empathy (JSE)	Emergency Medicine (EM) residents had the lowest JSE scores (median 111; interquartile range [IQR]: 107–122) and senior physicians had the highest scores (median 119.5; IQR: 111–129). Similarly, EM residents had the lowest percentage	This study provides evidence of a positive association between ED provider self-reported empathy and after-care

patient satisfaction		USA			to-provider satisfaction among Emergency Department (ED) healthcare providers with varying years of medical practice experience.		was used to assess provider empathy. An after-care instant patient satisfaction survey, with questionnaires regarding patient-to-provider satisfaction specifically, was conducted prior to the patient moving out of the ED.	of "very satisfied" responses (65%) and senior physicians had the highest reported percentage of "very satisfied" responses (69%). There was a modest positive association between JSE and satisfaction (RR = 1.04; 95% CL: 1.00, 1.07).	instant patient-to-provider satisfaction. Overall higher empathy scores were associated with higher patient satisfaction, though minor heterogeneity occurred between different provider characteristics.
Stigma and attitudes towards mental illness: Gender differences in a sample of Italian medical students	M.Pascucci, M.La Montagna, D.Di Sabatino	Institute of Psychiatry, University of Foggia, Department of Clinical and Experimental Medicine, Italy	European Psychiatry	2017; 41:S739	Stigma in mental illness is characterized by discrimination towards people affected by mental disorder. Consequence of the paradigm "stigma-injury-discrimination	339 Italian medical students	A total of 339 Italian medical students completed a cross-sectional survey, in Rome and Foggia (Italy). The Italian version of Community Attitude towards the Mentally Ill test (CAMI) was adopted to analyze the students' attitudes.	There is a substantial difference among the attitudes towards mental disorders in female and male students. Female students have obtained less stigmatizing results in 9 of the CAMI test items ($P < 0.05$), in Benevolence ($P = 0.001$) and Social Restrictiveness subscales ($P = 0.043$) and in the total score ($P = 0.013$).	These results are in line with those achieved in scientific literature, confirming that women tend to show more humanitarian attitude towards the mentally ill. Even in the original article of the validation of the CAMI test, the authors found better attitudes in

					” is the social exclusion of these patients and the denial of their rights. This study aims to study the attitudes of medical students towards psychiatric patients. The study analyzes gender differences in a sample of Italian medical students towards mental illness.				women in all subscales, with the exception of Social Restrictiveness subscale (that in the analysis also correlates with the female gender).
Stigmatization towards the mentally ill: Perceptions of psychiatrists, pre-clinical and post-clinical rotation	Hendri-Charl Eksteen, Piet J Becker, Gian Lippi	Department of Psychiatry, Faculty of Health Sciences, University of Pretoria, South Africa			The aim of this study was to determine whether stigmatizing attitudes towards the mentally ill differ according to the level of knowledge about psychiatric		This study was carried out by assessing psychiatrists (n = 68), pre-clinical (n = 194) and post-clinical (n = 354) medical students' attitudes towards the mentally ill using the Mental Illness: Clinicians'	Participants in the three groups had statistical significant different levels of stigma with a decline in scores as being more exposed to psychiatry. Familiarity with mental illness was associated with less stigma. Participants who had friends or family members who suffered from mental illness or they themselves suffered from a mental illness had less	More exposure to mental health–related issues are needed not only in communities but also in medical schools. Medical students need to be targeted for educational intervention because they are the future doctors who might pursue

medical students					illnesses and whether the level of exposure towards the mentally ill plays a role in stigmatizing attitudes.		Attitudes (MICA) scale. The scale is scored on a Likert scale with higher scores indicating higher levels of stigmatization.	stigma.	psychiatry as their field of choice. Stigma against psychiatry as a medical profession should also be addressed. If psychiatry is to be respected as a medical profession, mental illness–related stigma interventions need to be put in place to raise awareness about the negative impact of stigma.
The influence of gender and other patient characteristics on health care-seeking behaviour: a QUALICOPC study	Ashley E. Thompson, Yvonne Anisimowicz, Baukje Miedema	Dalhousie University Family Medicine Teaching Unit, Dr. Everett Chalmers Regional Hospital, Canada	BMC Family Practice	2016; 17:38	Canadians' health care-seeking behaviour for physical and mental health issues was examined using the international Quality and Cost of Primary Care (QUALICOPC) survey that was conducted in 2013 in	7260 patients across 10 Canadian province	This study used the cross-sectional Patient Experiences Survey collected from 7260 patients in 759 practices across 10 Canadian provinces as part of the QUALICOPC study. A Responsive Care	Patients' self-reports indicated that there were gender differences in health care-seeking behaviour, with women reporting they visited their primary care provider to a greater extent than did men for both physical and mental health concerns. Overall, patients were less likely to seek care for mental health concerns in comparison to physical	This study confirms the gender differences in health care-seeking behaviour advances previous research by exploring in detail the variables predicting differences in health care-seeking behaviour for men and

					Canada.		Scale (RCS) was constructed to reflect the degree of health care-seeking behaviour across 11 health conditions. Using several patient characteristics as independent variables, four multiple regression analyses were conducted.	health concerns. For both women and men, the results of the regressions indicated that age, illness prevention, trust in physicians and chronic conditions were important factors when explaining health care-seeking behaviours for mental health concerns.	women. The variables were better predictors of health care-seeking behaviour in response to mental health concerns than physical health concerns, likely reflecting greater variation among those seeking mental health care.

II. 問卷搜尋整理結果以及翻譯

1. 醫學參與量表（Medical Engagement Scale，MES）

研究顯示醫學參與和醫院的組織績效正相關，MES 根據其概念性前提而開發，即醫學參與對於醫療服務的根本性改革與改進至關重要。MES 評估不同人際和系統方法如何影響醫生作為領導者的參與度。

2. 精神疾病患者社區態度量表（Community Attitudes Toward the Mentally Ill Scale，CAMI）

CAMI 包括四個分量表：權威（authoritarianism）、仁愛（benevolence）‘’

社會限制（social restrictiveness）和社區精神健康意識形態（community mental health ideology）。CAMI 測量醫生視精神疾病患者需要強制性醫療處理、基於人道原則的同情觀、限制其社會功能的觀念，以及其在社區的接受和融合等程度。

3. 對精神疾病患者的恐懼和行為意向量表（The Fear and Behavioral Intentions Toward The Mentally Ill，FABI）

評估與精神疾病患者保持社交距離的相關行為意向的測量工具。

4. 臨床醫生精神疾病態度量表（Mental Illness: Clinicians' Attitudes Scale，MICA）

MICA 是用以評估醫師的態度，包括其對精神疾病的看法和知識。該量表還涉及揭示精神疾病診斷、區分精神和生理健康，以及表達對精神疾病患者的關懷。

5. 醫護人員心思開放量表（Opening Minds Scale for Health Care Providers，OMS-HC）

OMS-HC 評估醫護人員對精神疾病的污名化程度。其中有五個維度：1）康復 Recovery 2）社會責任 Social responsibility 3）社會距離 Social distance 4）其他概念（危險性、誤診）5）揭示 Disclosure。

6. 精神健康知識量表（Mental Health Knowledge Schedule，MAKS）

MAKS 是用以評估對污名化相關精神疾病知識的測量工具。

1. 醫學參與量表（Medical Engagement Scale，MES）

1=非常不同意 Strongly Disagree 2=不同意 Disagree 3=中立 Neither Agree nor Disagree 4=同意 Agree 5=非常同意 Strongly Agree a）醫療衛生組織的評估 Level of Endorsement by Health Organisations b）醫務人員團隊的評估 Level of Endorsement by Medical Staff Groups c）責任管理層的評估 Level of Endorsement by Managerial Responsibility d）隸屬專科機構的評估 Level of Endorsement by Specialty Affiliation	1	2	3	4	5
Generally, in this organisation . . . 一般來說，在這個組織中…					
1. We try new things rather than hold on to the status quo. 我們嘗試新事物而不是堅持現狀。					
2. I have regular involvement with the leadership team within my speciality. 我經常參與並擔任專科中的團隊領導者。					
3. I have the information needed to understand the financial consequences of the decisions I make. 我會充分掌握所需資訊，以了解我所作決定的財務後果。					
4. I feel able to provide the best care to patients within the resources available. 我有能力在可用資源範圍內為病人提供最好的照護。					
5. I am able to keep up to date and informed about changes in plans and policies. 我能夠及時掌握最新情況，並了解計畫和政策的變化。					
The working arrangements in this organisation . . . 這個組織的工作安排…					
1. Support close working between the service team and medical staff to resolve issues. 支持服務團隊和醫務人員的緊密合作，以解決問題。					

2. Promote leadership, innovation and change as an intrinsic part of the medical role. 提昇領導力、創新和變革，以其作為醫療角色的內在組成。
3. Facilitate my opportunities to discuss quality, safety and performance with Senior Managers, including the Chief Executive (formally or informally). 促進我與高層管理者（包括正式或非正式行政長官）討論品質、安全和績效的機會。
4. Help me engage in personal training and professional development programs. 幫助我積極參與個人培訓和專業發展計畫。

4. 臨床醫生精神疾病態度量表

（Mental Illness: Clinicians' Attitudes Scale，MICA）

1=非常同意 Strongly Agree 2=同意 Agree 3=有點同意 Somewhat agree 4=不太同意 Somewhat disagree 5=不同意 Disagree 6=非常不同意 Strongly disagree 說明：針對 16 個問題，請只勾選右方其中一個方框作出回應。 這裡的精神疾病是指精神科醫生所視的病人個人情況。	1	2	3	4	5	6
1. I just learn about psychiatry because it is in the exam and would not bother reading additional material on it. 我讀精神醫學只是因為考試，不會額外花時間去讀考試範圍以外的資料。						
2. People with a severe mental illness can never recover enough to have a good quality of life. 患有嚴重精神疾病的人，無法恢復到足夠擁有良好生活品量的程度。						
3. Psychiatry is just as scientific as other fields of medicine. 精神醫學擁有和其他醫學領域一樣的科學性。						
4. If I had a mental illness, I would never admit this to any of my friends because I would fear being treated differently. 如果我發現自己患有精神疾病，我絕對不會向任何朋友承認這一點，因為害怕以後會受到不同的待遇。						
5. People with a severe mental illness are dangerous more often than not. 患有嚴重精神疾病的人通常比較危險。						
6. Psychiatrists know more about the lives of people treated for a mental illness than do family members or friends. 精神科醫生比精神疾病患者的家人或朋友還更了解該患者的生活狀況。						

7. If I had a mental illness, I would never admit this to my colleagues for fear of being treated differently. 如果我發現自己患有精神疾病，我絕對不會向任何同事承認這一點，因為害怕以後會受到不同的待遇。
8. Being a psychiatrist is not like being a real doctor. 當精神科醫生不像是當一個真正的醫生。
9. If a consultant psychiatrist instructed me to treat people with a mental illness in a disrespectful manner, I would not follow their instructions. 如果一位精神科顧問引導我去用不尊重的方式治療精神疾病患者，我不會按照他們的指示行事。
10. I feel as comfortable talking to a person with a mental illness as I do talking to a person without a physical illness. 我和精神疾病患者說話時感到自在，就像和一般人說話一樣。
11. It is important that any doctor supporting a person with a mental illness also assesses their physical health. 任何在治療精神疾病患者的醫生，也評估患者的生理健康，是相當重要的。
12. The public does not need to be protected from people with a severe mental illness. 公眾不需要被保護於嚴重的精神疾病患者。
13. If a person with a mental illness complained of physical symptoms (such as chest pain), I would attribute it to their mental illness. 如果精神疾病患者抱怨身體症狀（如胸痛），我會將其歸因於精神疾病。
14. General practitioners should not be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist. 不應該期望全科醫生對有精神疾病症狀的人進行徹底評估，因為他們可以將患者轉介給精神專科醫生。
15. I would use the terms ‘crazy’,‘nutter’, ‘mad’ etc. to describe people with a mental illness who I have seen in my work. 我會用“瘋狂”等類似詞彙來形容我在工作中見過的精神疾病患者。
16. If a colleague told me they had a mental illness, I would still want to work with them. 如果有同事告訴我他患有精神疾病，我仍然願意和他一起工作。

5. 醫護人員心思開放量表

（Opening Minds Scale for Health Care Providers，OMS-HC）

1=非常不同意 Strongly Disagree 2=不同意 Disagree 3=中立 Neither Agree nor Disagree 4=同意 Agree 5=非常同意 Strongly Agree	1	2	3	4	5
1. I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness. 比起治療精神疾病患者，治療生理疾病患者時我感覺更加自在。					
2. If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain or headache), I would likely attribute this to their mental illness. 如果精神疾病患者抱怨有身體症狀（例如噁心、背痛或頭痛），我很可能會將其歸因於他/她的精神疾病。					
3. If a colleague with whom I work told me they had a managed mental illness, I would be just as willing to work with him/her. 如果同事告訴我他/她患有精神疾病，我會和以前一樣願意與他/她合作。					
4. If I were under treatment for a mental illness I would not disclose this to any of my colleagues. 如果我正在接受精神疾病治療，我不會向任何同事透露這一點。					
5. I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace. 如果我的醫療服務提供者和我的工作沒有關係，我會比較有可能尋求精神疾病的幫助。					
6. I would see myself as weak if I had a mental illness and could not fix it myself. 如果我患有精神疾病，將會變得很虛弱，無法靠自己獨立解決。					
7. I would be reluctant to seek help if I had a mental illness. 如果我患有精神疾病，我將不願意尋求幫助。					
8. Employers should hire a person with a managed mental illness if he/she is the best person for the job.					

雇主應聘用精神疾病患者，如果認為他/她是最適合的該工作的人員。
9. I would still go to a physician if I knew that the physician had been treated for a mental illness. 如果我知道某位醫生曾接受過精神疾病治療，我仍然會去找他/她看醫生。
10. If I had a mental illness, I would tell my friends. 如果我有精神疾病，我會告訴我的朋友。
11. It is the responsibility of health care providers to inspire hope in people with mental illness. 醫護人員有責任去激發精神疾病患者的希望。
12. Despite my professional beliefs, I have negative reactions towards people who have mental illness. 儘管我擁有專業理念，我仍對精神疾病患者持有負面觀感。
13. There is little I can do to help people with mental illness. 我無法幫助精神疾病患者。
14. More than half of people with mental illness don't try hard enough to get better. 超過一半以上的精神疾病患者不夠努力改善自身狀況。
15. People with mental illness seldom pose a risk to the public. 精神疾病患者很少對公眾構成風險。
16. The best treatment for mental illness is medication. 精神疾病的最佳治療是藥物治療。
17. I would not want a person with a mental illness, even if it were appropriately managed, to work with children. 即使一個精神疾病患者有受適當管理，我也不想讓他/她和小孩一起合作。
18. Healthcare providers do not need to be advocates for people with mental illness. 醫療服務提供者不需要為精神疾病患者提供支持。

III 質性研究結果與相關文獻理論整理

性別差異與工作內待遇

多項研究指出醫生執業的副產品包括會產生不滿情緒和職業倦怠。為成為醫療界的領導者，男女性醫生都應認識到創造可持續職業的重要性，以提供工作職業滿意度、工作與生活間的平衡（work-life balance）[80]。更重要的是，工作環境中的公平性[81]與員工是否會產生不滿情緒和職業倦怠有關，可是目前高度工作消耗和薪資不平等的現象依然存在[82-83]，且女性相對男性的收入不平等現象仍然普遍，不論住院醫生、研究人員和各專科主治醫生。

研究顯示，專科差異、全兼職身份和實踐類型等因素未能解釋這樣的收入差距[84-86]。性別差異的解釋因素包含了談判技巧、加入組織人際網絡的機會，以及內隱或明確的性別偏見和歧視[4, 87-91]。

性別收入差距也普遍被認為是玻璃天花板效應的結果[90-91]，女性晉升的公平性障礙，包括缺乏合作性的環境，和缺乏成功實現工作與生活間平衡的模範榜樣[89, 91-93]。令人驚訝的是，幾個研究發現醫療環境中的女性領導者所面臨的性別收入差距更為嚴重，雖然這種性別收入差距在其他精英行業的領導者中也很普遍[94-95]。

女性醫生不將薪酬作為優先考量的相對傾向，解釋了性別收入差距的一大部分。在考慮工作滿意度時，較多男性將高薪酬列為其中的優先考量，這與男性實際上有較高收入的狀況直接相關；相對而言，較少女性會將高薪酬列為優先考量，也解釋了女性的較低收入[80]。過往經驗觀察到，因受制於文化規範，優先考量甚至會受到討論財務事項時的性別差異的影響，如此規範會隱約准許雇主在相同或類似工作上給予女性比男性還低的薪酬。女性在起薪、加薪相對男性處於劣勢的原因，可能是因為較少談判，或談判效果較不佳。而

當女性與雇主談判薪酬時，也有研究發現會較容易導致負面觀感和意想不到的負面後果，比如失去社交網絡、好感度下降，甚至失去工作錄取機會[96-99]。

一般來說，生產力與收入成正相關，但這並未完全解釋性別收入差距[80]。研究數據表明，平均而言，女性與被期望產生較少薪酬的工作特徵有關，例如，與男性相比，女性醫生較常兼職、從事學術、兒科，不太常擔任領導者，呈報的計費次數更少。再者，過往某些分析可能低估了男女性的收入差距，因為未納入兼職身份的附帶損失、未全面性計算考慮與高生產率相關的激勵薪酬。許多女性醫生在晚上工作的時間相較白天工作時間更高，然平均工資卻更低，顯示夜間工作的報酬可能需要調整，以反映其獨特的負擔和責任[100]。

儘管臨床工作大多數是以可衡量的方式支付報酬，領導者工作支付報酬的方式卻可能受到某些無形因素的影響，如聲譽、談判能力和信心，讓女性相對於男性處於不利位置[4, 94-95, 101-103]。綜觀過去研究所建議，醫療界必須有意識地提倡公平性，相稱地將女性公正晉升到和其男性同儕擁有同樣薪資的領導地位，應該是克服無形性別偏見最有效的方法之一[92]。因素如內隱偏見、談判差異、社交網絡和指導輔導機會[104-105]，也會導致男女性醫生的報酬差異。

承上總結，女性醫生現在約占台灣醫生的五分之一[1]，隨著女性在醫療環境中的比例日漸趨升，關於男性和女性醫生在工作中的各種待遇與付出品質，包括是否運用相異的方式與雇主或病人交涉，以及不同溝通方式是否影響到自己或病人待遇...，是我們需要探索的問題。不管男女性別，在工作中得到公平待遇，有助減輕對工作的不滿及倦怠，提升人道關懷與醫患互動溝通品質，則更有助台灣醫療品質的提升。因此，透過適當的領導力培訓介入，或許將有助醫生在與雇主或病人交涉溝通等方面提升能力，更讓未來病人將可以從注重這些領導品質的醫生中受益[60]。

領導力與生活品質的關係

多項研究指出醫師執業會產生的不滿情緒和職業倦怠，為成為醫療界的領導者，男女性醫生都應認識到創造可持續職業的重要性，以提供工作職業滿意度、工作與生活間的平衡（work-life balance）[80]，更重要的是，以提倡在醫療工作環境中的公平性[81]，然而目前高度工作消耗和薪資不平等的現象依然存在[82-83]，女性相對男性的收入不平等現象仍然普遍存在，包括住院醫師、研究人員和各專科主治醫生。

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往某些分析可能低估了男女性的收入差距，因為未納入兼職身份的附帶損失、未全面性計算考慮與高生產率相關的激勵薪酬。與女性更常見的其他工作模式也強調了性別報酬的不平衡。許多女性醫生在晚上工作的時間相較白天工作時間更高，然平均工資卻更低，顯示夜間工作的報酬可能需要調整，以反映其獨特的負擔和責任[100]。

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一、醫師參與和領導力

參與是指相互依賴的動態結構，處於不斷變化的狀態，取決於環境以及個人所採取的改進或損害的行動。這是獨立個體對於工作的心理承諾，透過一系列能證明參與的行為來展現，從而引導至組織或系統性的貢獻結果。確切而言，醫師參與是醫師與工作環境條件之間的互動關係而調解的心理狀態，透過結構、政治和文化框架，每個框架可以賦予或削弱其權力[71]。

醫生在醫療衛生系統內各種不同的工作角色下積極堅定的參與，有助達成：

（1）個人確保按照專業標準和個人道德執行病人照護；在此第一級，醫師都會良好參與。

（2）與醫療衛生界的其他機構合作，來確保照護的適宜性、改善以患者為中心的照護品質、提昇持續性的效率，以及定義工作條件；在此第二級，醫師的參與是有限的。

醫師參與為一個雙向的社會過程[62,72]，其中組織必須透過設置環境條件和過程，回報個體醫生對高品質照護的參與，從而鼓勵醫生持續參與。鼓勵參與的兩個維度包含在醫學參與量表（Medical Engagement Scale，MES）中：組織機會 — 促使醫生更積極地參與領導和管理活動的文化條件、個人能力 — 加強認知的個人賦權、應對新挑戰的信心，和提昇的自我效能[72-73]。創造組織機會將激勵醫生，提供領導力的學習機會，使醫生有能力接受這些組織機會，促進其參與機會，最終落在如圖 2 所示的右上象限；提供組織機會是期望優化品質，由組織提供醫生領導能力計畫，將有益於提昇醫生能力。

Figure 2、 醫學參與模型（Medical Engagement Model）

（參考來源 Spurgeon, P., Barwell, F., & Mazelan, P. (2008). Developing a medical engagement scale (MES). International Journal of Clinical Leadership 16, 213-223.）

回顧關於醫師參與的障礙與推動因素文獻[74]，領導力是參與的關鍵，是促進參與的推動因素，兩者實際聯繫是雙向的，即醫生領導者是參與和發展領導力的有力推進者[71]。吸引醫生參與並擔任領導角色，是醫療界有效改革的核心要素，換句話說，由高層領導者主導，提供並邀請醫生參與領導力發展計畫，會激發醫生的參與和其對領導力的興趣。美國的山際健康照護聯盟（Intermountain Health）、馬約診所（Mayo Clinic）、凱薩醫療機構（Kaiser Permanente）、維吉尼亞醫學中心（Virginia Mason）、倫敦的聖約瑟夫醫療保健中心（St. Joseph's Health Care）和加拿大的渥太華醫院（Ottawa Hospital）都是很好的例子，由高層領

導促使醫師早期參與，讓醫生在發展計畫中學習領導技能，藉由擔任領導力角色，加上各組織層面的改革措施，有助促成非凡的照護品質和員工滿意度。

二、 評估過去領導力發展計畫

大多數組織未良好制定醫生領導力發展計畫結果的評估體系；至於已良好制定品質改進計畫的組織，認為其嵌入式的醫師領導力發展計畫是品質改進計畫的一部分，因此領導力計畫成果會被廣泛評估進品質改進成果。事實上，不同的領導力發展計畫是不同的開放系統，在活動、計畫、人員和組織之間具有互動性和連通性，這意味著必須注意到參與者除了會從領導力發展計畫中受益，也會經歷許多非計畫的刺激[75]。開放系統的觀點假設可預測性和不可預測性都發生，因此，領導力發展計畫結果的評估調查，應當被視為一個「發現」的過程，而不是「成功」的證明；另一方面，領導力發展是複雜的心理和社會過程，領導力發展計畫的設計過程的其中關鍵部分，是決定將要測量什麼樣的變化，因為在動態、不斷變化的環境背景下，將領導力成果與具體計畫聯繫起來進行評估，其實具有一定難度，由此可知，先確定預期和測量的變化水平是相當重要的[76-77]。領導力發展計畫期望個人層面的變化將促成組織、系統和社會層面的結果皆發生變化，不過從個人層面轉向組織層面或系統層面的結果，會進一步增加評估領導力發展計畫的複雜性。

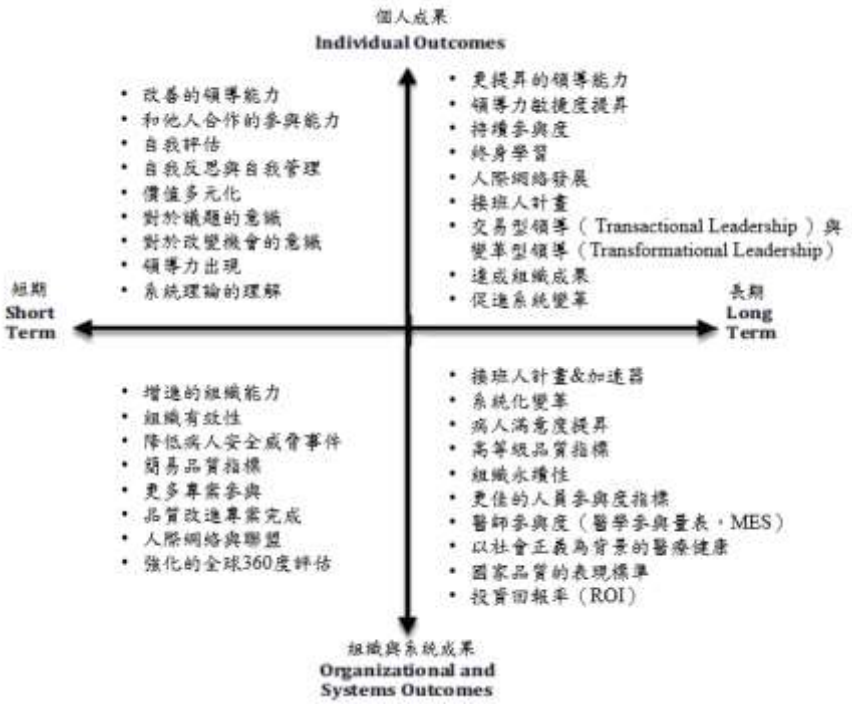

Figure 3、 領導力預期成果

（參考來源 Meehan, D., & Reinelt, C. (2007). Leading edge promising practices in leadership development: Scan prepared by LLC for the Packard Foundation. Unpublished manuscript.）

在新興的開放系統中，計畫的某些成果需要先被預測，因此在領導力計畫的前期發展時刻先制定結果和評估工具十分關鍵[76]。圖 3 與圖 4 是醫療系統試圖定義個人、組織或系統層面的短期和長期領導力結果[76]。建立領導力發展計畫時，將領導力模型整合納入組織所有發展工作和人力資源流程、評估和語言是非常重要的[78]。

Figure 4、 馬約診所領導模式（Mayo Clinic Leadership Model）

（參考來源 Meehan, D., & Reinelt, C. (2007). Leading edge promising practices in leadership development:Scan prepared by LLC for the Packard Foundation.）

三、改變醫生領導力和污名化傾向的可能性與方法

污名化在醫療保健方面的有害影響，已促使醫療衛生組織在解決這一問題方面必須發揮領導作用[123, 207-212]，在加拿大，越來越多的研究機構提出在醫療環境中減少污名化的前瞻性策略，藉由質性和理論模型，強調以文化變革為目標來消除污名化的重要性，使用持續的綜合方法，從外向和內向的雙重角度，即前述的（Public Stigma）與自我污名化（Self-Stigma），來針對污名化的消除，致力於提供強而有力的領導力支持[209,213]，藉由實踐模型，強調強制性或激勵性參與，將消除污名化的標準納入醫院和其他認證過程，作為把關照護品質的關鍵實行措施[213-214]。

研究已識別在醫療環境中有效消除污名化的關鍵因素[215]，這些因素的有效性在於其能夠在多大程度上解決上文所述的污名化問題[213]，其中因素包括了（1）醫學教育、（2）介入措施、（3）以人為本、以康復為導向照護模式：

（1） 醫學教育

透過與醫學教師密切交流討論專案和補助金事項，教師指導和同儕活動可以正向影響男女性的醫學同儕關係，促成公平的職業晉升，建立起具有學術、臨床生產力的同事網絡[216-217]。教師指導方案、輔導諮詢、人際網絡聯繫，以及支持性的合作夥伴，有助於加強女性醫生的軟技能，實現工作與生活間的平衡。此外，創造醫學院校管理水平的多樣性是有利的，因為男性和女性領導者有不盡相同的決策、解決問題和評估情況的方式，因此組織應該努力在管理層面上創造多元化的男女性領導者。

透過醫學教育，幫助醫療專業提供者明白「如何說」和「如何做」，確保計畫參與者推崇以人為本的行為，並充分利用社交接觸（social contact）[215]。社交接觸是指，直接聆聽有精神疾病經驗的人在經過培訓後所講述其疾病經驗與康復的過程，以及在醫療體系中的親身經歷，此跨職業的醫學教育方法，是消除醫療環境中污名化的關鍵策略[215,218-219]，不同於典型的醫療提供者與病人的互動接觸模式。在社會接觸方法中，有精神疾病史的人與其作為患者，更應該作為教育者[210, 219-221]，該方法已經被證明可以消除刻板印象、減少焦慮、加強同理心、建立人際關係，並且促進對於康復的理解[219-221]。

（2） 介入措施

介入措施包括打破迷思與聚焦轉變性的學習重點，以針對修正無意識的偏見，糾正可能對照護產生負面影響的錯誤觀念[209,215,222]。

在國外有越來越多直接與醫療專業服務提供者合作的計畫[210, 221-232]有效的模式包括基於工作坊的介入措施、基於能力的介入措施，和密集的社交接觸介入措施。加拿大的一個工作坊計畫展現了振奮人心的成果，即安大略中央地方衛生一體化網絡（Ontario Central Local Health Integration Network）所開發的一項 2 小時面對面的「理解污名化計畫（Understanding Stigma）[224-225]」，該計畫涵蓋了旨在增加知識、能力和意識的教育內容，和旨在改變行為的行動導向內容，以及一或多個社交接觸內容。藉由前測、後測和後續追蹤的計畫設計，以及醫療照護提供者開放思維量表（Opening Minds Scale for Health Care Providers scale，OMS-HC），在相異的醫療環境中對不同的醫療受眾進行了多種評估，該量表專門用於評估醫療專業提供者對精神疾病患者的態度和行為意向[127]。評估結果顯示，在 3 個月、6 個月的追蹤期間，伴隨著推進介入措施（booster session）的實施，醫療人員的態度和行為意向均有顯著的後測改善[224-225]。

密集的社交接觸模式，即醫療服務提供者在長時間軸上的多個時間點接觸患有精神疾病史的康復者，以了解其生活和經歷[210,221,231]。使用 OMS-HC 的評估顯示，這種模式能夠有效地改善醫生態度和行為意圖，並長期維持這些改善。社交接觸的獨立和合作性質，可以為醫療服務提供者、醫學教育工作者提供強而有力、正面積極的變革性學習體驗[210,231]。

（3） 以人為本、以康復為導向醫療照護模式

醫療組織藉由強調精神疾病的康復力，展現醫療專業提供者在該過程中所發揮的具影響力的角色和作用[215]；以人為本、以康復為導向的照護模式，透過更為充分的實踐，是消除污名化至關重要的因素[233-235]。

以人為本、以康復為導向照護模式的介入重點在於行為改變，旨在提高醫生對精神疾病的信心、舒適度和理解力，視精神疾病本質上是可治療的和可管理的[213,215]。英國的成人心理健康實踐支持計畫（Adult Mental Health Practice Support Program）[223,228,232,236]，教導有輕度-中度憂鬱和焦慮患者的醫生和其他的醫療專業服務提供者一套自我管理的認知行為工具，其目的是透過改善醫療人員和患者的互動，來有效消除污名化，提昇與精神疾病患者合作的信心與能力[223]。英國該計畫的評估顯示，醫生指出該計畫明顯改善了病人照護，不僅病人對抗憂鬱藥處方的依賴減少，醫生也認為病人有能力維持其工作或重新開始工作[223]。在加拿大的同一計畫下的隨機對照研究，也發現強勁的改善，與常規治療（treatment-as-usual（TAU））相比，醫生的信心和能力有了顯著的提昇，其持有的社會距離（social distance）也顯著減少[223,232]，6 個月後追蹤病患的病人健康問卷（Patient Health Questionnaire，PHQ-9）中的憂鬱指數顯著降低，再者，與 TAU 相比，抗憂鬱藥處方的開立水平也顯著降低[232]。

加拿大的專業心靈（The Working Mind，TWM）計畫目前使用在加拿大的醫療機構中[232]。該前瞻性計畫由加拿大政府相關計畫所推行開發，主要目的是幫助消除精神疾病的污名化、增強醫生韌性（resilience）、促進計畫參與者儘早尋求心理健康問題的協助[212, 232,

[237]。初步評估結果顯示，該計畫在改善態度、鼓勵人們尋求幫助、提高應對壓力和挑戰性事件的就緒方面有顯著效果[238]。

學校與醫學教育歷程的影響

介入措施能產生短期正面效果，但其持續作用的證據仍需透過長期研究追蹤，過去研究表明進一步將反污名化、領導力介入措施整合到醫學教育課程中的必要性。

根據調查結果，英國在 2008 年由慈善組織再思精神疾病（Rethink Mental Illness）主導的「吶喊污名化活動（Stigma Shout）」，透過對近 4000 名經歷精神照護服務的民眾進行調查，確認醫療專業人員為亟需改變的重要群體之一[239]，該調查顯示精神疾病患者指出歧視經驗的共同來源是醫療專業人員[240-241]，這強調了識別以及針對需求較高的群體進行精神衛生相關教育的重要性，因此，其後再思精神疾病組織繼續在英國醫學教育界與醫學生、護理學生共同執行反污名的「醫學教育不歧視（Education Not Discrimination，END）」活動[242-244]，以理解醫學教育培訓對其心理健康相關知識、態度、預期行為和同理心的影響。

藉由社交接觸（social contact），醫學生面對有使用過精神心理治療服務者的言論，會以更積極的態度回應，因為透過理解病人的觀點，轉變了學生的態度，並且提供以往正規教育未提供的以精神、心理健康為主題的見解。相較於純粹的教育介入，運用社交接觸聆聽曾接受過精神治療的人親口述說或演講其治療經驗，對醫學生的態度會產生顯著的影響[245]。許多研究結果證明，對精神心理疾病患者，如精神分裂症，持有較嚴重污名化態度的醫學生，會從這樣的反污名介入措施中獲益最多[246]。

當今關於本議題的研究趨勢，應針對如何維持醫學生的長期正面改善。首先，儘管充分的證據表明社交接觸（social contact）是有效的[244,247]，其中不同類型的介入內容仍會造成不同效果[248]；其次，如何透過推進介入措施（booster session）來維持長時間的收益，值得進

一步調查；再者，將反污名教育培訓和正規醫學教育整合起來，是以往許多研究所建議的方向。如果醫學生從他們的模範榜樣對象身上學習到對精神心理疾病患者的負面態度和行為，這將使如英國「醫學教育不歧視（Education Not Discrimination，END）」這樣的介入方案無法彰顯效果。這種潛在問題在醫學界基於學徒模式（apprenticeship model）的專業背景下，非常值得關注。如果醫學教育鼓勵醫生透過解決污名化和建立非歧視性的實踐模式來展現領導力，則可以更佳維持介入方案培訓的影響[249]。

在醫學教育中，指導教師制度的建立也是帶領領導力前進的方向，這涉及到高級和初級醫學專業人才間的人際關係，目的是提供醫學生具體建議和情感支持，並給予誠實的反饋[250]。指導教師是醫學生發展事業生涯的助力，現今對特定醫學生群體在學術環境、臨床環境中的指導計畫已發展成形，醫學生與指導教師分享計畫、設定共同目標，是向前邁出的一大步。成功的指導教師計畫會期望該教師和醫學生達成一致的目標和實踐，導師則應承擔讓學生保持在正軌上的責任。男性醫學生的指導教師應協助建立如何和女性平等分配責任方面益處的觀念。從組織的角度來看，現代管理提倡以模範榜樣帶領的領導模式，創造組織中信任和尊重的氣氛，傳達價值觀和目標[251]。

第五節 討論

總歸而言，過去研究得出了與「醫生性別」這項因素相關的某種效應模式，這些性別差異強調了以病人為中心的領導力與溝通風格，激發醫生與患者的互惠交流，並反映出提昇參與度、舒適度和合作夥伴關係而後更加緊密的治療環境。

透過與醫學教師密切交流討論專案和補助金事項，教師指導和同儕活動可以正向影響男女性的醫學同儕關係，促成公平的職業晉升，建立起具有學術、臨床生產力的同事網絡[216-217]。教師指導方案、輔導諮詢、人際網絡聯繫，以及支持性的合作夥伴，有助於加強女性醫生的軟技能，實現工作與生活間的平衡。此外，創造醫學院校管理水平的多樣性是有利

的，因為男性和女性領導者有不盡相同的決策、解決問題和評估情況的方式，因此組織應該努力在管理層面上創造多元化的男女性領導者。

過去研究顯示[2]，醫學教育需要更加重視醫學院內醫學和其後各級的指導（mentoring）、模範榜樣（Role Model），以及領導意識教育的注入，因為領導力教育培訓有提升醫生個人工作滿意度與醫患溝通。身為具備國際前瞻性及遠見的醫學教育研究者，領導更多有關這方面的性別研究有其急迫性。尤其當女性醫師進入醫療行列成為勢不可擋的現在進行式與未來趨勢，這些差距將會造成越來越多與越來越嚴重的影響。

醫生性別差異造成的影響與許多現今確立的醫療、心理、行為和教育措施造成的影響程度相當[17, 68, 69]。本研究立場不表示大多數女性醫生皆以病患為中心，而男性醫生則非；男女醫生的溝通行為比男女比起差異，擁有更多共通之處。聚焦於發展具備領導力、自信、參與度、精神醫學知識、熟練溝通的兩性醫生，會促進達到理想的治療品質、時間效率和生產力，即使在有限時間內也能提供高品質、以病人為中心的醫療服務。確保兩性在醫學的領導力機會，將使醫生有能力透過自我意識（self-awareness）、自我監控（self-monitoring）和教育訓練等有意義的方式來持續改善消除醫療場域的污名化現象。

本研究認為，即使過往研究發現趨於一致的性別差異和影響，以性別之外，例如不同溝通方式來區分醫生群體，事實上是更恰當的。在醫療諮詢診斷過程中進行的醫患溝通，是病人接受治療時的不可或缺的組成要素，研究表明，醫患溝通與病人的滿意度、經驗、治療遵從度、對資訊的理解和治療健康結果等多項治療結果相關[27-28]。此外，醫患溝通會影響診斷諮詢長度，而後接續影響到醫生的臨床活動率，攸關目前國際上醫療衛生機構所強調的生產力和價值創造。如果男女醫生的確實溝通方式有所不同，將涉及到醫學教育的改革介入，應當針對男、女醫師調整教育培訓，和權衡其諮詢品質和數量的重要含意。

至於人道關懷例如精神疾病汙名化相關議題，精神疾病和藥物濫用失常發病率約佔全球187個國家非致死性疾病負擔的22.9%和總疾病負擔的7.4%[106]，與此同時，精神疾病患者

的污名化和負面態度持續構成社會和醫療體系發展的障礙，不僅抑制患者尋求服務的意願，也降低醫學生選擇成為精神專科醫生的意願。

此外，承上醫生性別在醫療照護、同理心、對弱勢病患關懷、及領導力方面過去研究多顯示有差異，本研究的文獻回顧研究也結論出，醫療專業人士對於病患暴力行為的理解，會連結不遵從服藥、缺乏社會支持或污名化本身有關，媒體報導和公眾則經常將其理解為違反社會秩序的不道德行為[121]。在新聞媒體中，精神疾病患者的攻擊和社會擾亂似乎成為常見詞彙，傳遞精神病患者會對社會構成危險的觀念，如此認知也出現在政府報告和官方統計中，作為精神病患者違反社會誠信的某種指標。這種以媒體為基礎的公開污名化的表達，會影響主流偏見，同時可能也受到主流偏見的影響，如此的污名化現象與以往醫生、醫學生的研究調查發現的負面態度相呼應，表明現階段大眾與醫療專業人員對精神疾病患者有限的社會接受程度，以及對其社會融合的鮮少支持[121]。

污名化也對醫療專業人員自願尋求幫助，或披露自身心理健康問題的意願產生內在影響，如此可能會導致過度依賴自我治療，原因在於污名化使醫療人員認定，若披露自身心理健康問題，可能會導致同儕支持程度降低，包括同事排斥和評斷，並增加其自殺風險[123-126, 142]。從一開始就不願意尋求幫助，可能會使醫療人員生產力下降，使同事加深刻板印象，施加更多的污名化，最終導致其更不願意進一步尋求幫助。鑑於精神疾病與任何工作場域的出勤率低落、生產力損失有關[143]，謹慎探討污名化和其影響顯得更加重要。

重視醫師健康和福祉的醫療組織文化，應致力於打擊病人照護中的污名化，對醫師、病人安全，以及財務底線也將產生正面影響。從組織文化、領導力和品質照護的角度來看待污名化問題，制定和實施相關的污名化標準和目標，並將其納入健康、安全和認證標準中，如台灣醫學教育學會，會是針對個人和組織層面污名化的有效消除改善，也將開始著眼於嵌入在醫療環境系統中的污名化結構問題。

根據研究，促進醫療專業人員態度改善的一個潛在可能性，是在醫學教育中培訓醫學生與醫生成為國家醫療衛生系統未來的領導者。不論醫生從事何種專科，面對精神疾病患者或其他相似可能會被汙名化的族群，採取更積極正面的態度，是一般民主國家領導者最基本的必備態度，可因而嘉惠可能受汙名化影響的病患，提升其治療過程與結果[118, 122]。

本研究深入了解醫生領導力的影響因素研究結果、與相關資料，可提供策略介入解決和改善的醫生領導者在性別差距的參考。深入探究與了解領導力的因素後，更重要是要設計人道關懷與溝通層面的實踐策略、消除醫療環境中的污名化現象、找尋醫學教育與學校歷程因應方法、提升學校輔導/ 指導性別領導力的系統、及加強女性醫療工作者的支持系統。此外，例如人際網絡、模範榜樣(role model)、社交接觸、精神醫學教育、醫學參與度、醫學院校內的領導機會相關資訊提供、相關課程的創新、提早與長期接觸某些被公眾污名化、自我污名化的精神疾病患者、領導力社團等課外活動都是國家社會、醫學院校與醫療院所可以介入的項目，以期縮減男女成為領導者職位的性別差距，進而逐漸減輕醫療環境中玻璃天花板效應的僵化問題。

本研究的文獻回顧研究也結論出，性別差異在醫學領導力議題上，是自始至終、從進入醫學院第一天到所有訓練完成後，都是存在的，領導更多有關這方面的性別研究有其急迫性。尤其當女性醫師進入醫療行列成為勢不可擋的現在進行式與未來趨勢，這些選擇差距將會造成越來越多與越來越嚴重的影響。因此，醫療教育體系應該要強化如何指引醫生適才適用、與適才適所，而任何國家或機構政策制定者，未來不只應該要關注性別在醫療領導力的重要性，更要在各方面提升性別平等與性別公平。

研究的貢獻

醫師不僅是台灣具有特殊貢獻的寶貴人才資源，其醫學專業的表現關係到整體社會發展的福祉。身為醫學教育研究推手，重視醫師個體與環境潛在的專科傾向因素分析，具有前瞻性與創新性。本研究將利於提升醫學教育素質全面性發展，更進而帶動優質的醫療照顧服

務。病人、社會、醫療專業、醫學教育政策制定與執行者，都會對未來醫生領導力有極大興趣，因為這與我們所有人未來的醫療照護與福祉息息相關。醫生如何對其成為領導者做出適合的決定，不只修關個人前途與生活，也影響國家實力與發展。醫生領導力和污名化程度對於個人與整體國家醫療照護系統，都至為關鍵。尤其在國家發生對某些病患持有污名化、刻板印象、歧視、偏見、差別治療的情況下，調整醫生的領導力和污名化傾向，是解決這個國家社會議題的核心。

即使台灣女性醫生比例正逐步攀升，女性相較男性醫生居於高級領導職位的比例卻無法直接對照[187-189]。平均而言，學術醫學的女性研究成果和成功申請到補助金的數量較少[190]，這些差異的解釋因素，包括撫養孩子的責任經常落在女性身上、女性接受的指導品質不佳，以及缺乏支持的各項不利環境因素[188,190]。許多女性醫生在職業生涯與家庭生活的選擇上仍然存在著重大衝突，以權衡工作與生活的平衡。除了個人限制，如關注家庭生活或缺乏領導野心外，其他更多無形障礙正影響女性醫生的職業生涯，如人際網絡（networking）和傳統（tradition）因素，缺乏來自部門主管和同事的職業指導和諮詢，造成阻礙女性醫生流動性的玻璃天花板效應[194]，另外，工作投入時間、資源來源、由論文發表數量或外部補助金額度來衡量的生產率等，也是解釋領導職位性別差距的因素[58]，成為阻礙女性在醫學社會位居領導位置的障礙。病人、社會、醫療專業、醫學教育政策制定與執行者，都會對未來醫生領導力有極大興趣，因為這與我們所有人未來的醫療照護與福祉息息相關。醫生如何對其成為領導者做出適合的決定，不只修關個人前途與生活，也影響國家實力與發展。因此，醫療教育體系應該要強化如何指引醫生適才適用、與適才適所，而任何國家或機構政策制定者，未來不只應該要關注性別在醫療領導力的重要性，更要在各方面提升性別平等與性別公平。本研究倡議與提出以上各研究問題，不只研究更提升此相關議題的社會關注度。

醫學教育在未來醫生的專業觀點、信念和態度的形塑上佔有至關重要的一席之地。然而精神病患者的污名化程度不僅普遍存在於公眾，在醫生和其他醫療衛生專業人員中也是如此。有鑑於截至目前為止，國外已有許多研究指出醫生、醫學生污名化態度的程度，以及醫生性別差異對於病人治療成果的影響，並且建議將污名化與醫生領導力發展計畫相結合。排除污名化相關的刻板印象、偏見、歧視，是醫學院校課程的應該要開發設計與修正評估。

本研究聚焦醫師在醫療系統領導力的發展，關注所有男女醫生的主要領導角色，以發揮醫療服務團隊中的領導才能和參與度。發展領導力的同時，為了解決醫學領域常見的性別在擔任領導職位上的差距，倡議設計在地化的介入訓練課程。本研究整理介入措施探討其對兩性醫生的長期影響，為醫師性別的領導力、反污名化態度以及溝通能力差距做出改善。

重視醫生健康和福祉的醫療組織文化，更應致力於打擊病人照護中的污名化，對醫生、病人安全，以及財務底線也將產生正面影響。從組織文化、領導力和品質照護的角度來看待污名化問題，制定和實施相關的污名化標準和目標，並將其納入健康、安全和認證標準中，會是針對個人和組織層面污名化的有效消除改善，也將開始著眼於嵌入在醫療環境系統中的污名化結構問題。

學術應用與其他方面貢獻

本研究之創新點尤其在於融入社會污名化元素，不只是單純研究領導力此重要議題，而是同時進行了心理層面探討，以刺激受試者對於領導力、溝通能力、同理心、反污名化態度及生活品質等重要因素的再反思。

本研究結合學術理論，並包括質性深入探究及加入隱藏式介入方案。針對醫療領導力與人道關懷的發展與變化，從醫生方面進行核心調查與分析，並結合資源分佈調查現況與評估，精進實證與科學化數據分析，確實達到學術與實際應用性貢獻。

第六節 本計畫已發表之論文

期刊論文

1. *Russell O Kosik, Lihong Fan, Angela P Fan, Xudong Zhao, Yunung Hsu, Selina S Lien, Dan Li, Christopher Lu, Yuanpeng Ren, Baisheng Jiang, Qi Chen* **Factors associated with specialty choice in Chinese medical students and residents: an exploratory cross-sectional**

study *The Lancet*, **(SCI) (Impact Factor: 59.10),** Vol. 394, S62, October, 2019

2. *Angela P Fan, Russell O Kosik, Lihong Fan, Xudong Zhao, Yunung Hsu, Selina S Lien, Dan Li, Yuanpeng Ren, Baisheng Jiang, Qi Chen* **Medical specialty distribution in China, 2009–17: a longitudinal examination** *The Lancet*, **(SCI) (Impact Factor: 59.10),** Vol. 394, S64, October, 2019

研討會論文

Angela Fan, Training General Practice Physicians for the Care of Elderly Population, Boao Global Health Conference, June, 2019

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107年度專題研究計畫成果彙整表

計畫主持人：范佩貞	**計畫編號：**107-2629-H-010-001-
計畫名稱：分析台灣醫生性別與醫療環境內領導力和人道關懷的關係研究	

成果項目					量化	單位	質化 （說明：各成果項目請附佐證資料或細項說明，如期刊名稱、年份、卷期、起訖頁數、證號...等）
國內	學術性論文	期刊論文			2	篇	1.Russell O Kosik, Lihong Fan, Angela P Fan, Xudong Zhao, Yunung Hsu, Selina S Lien, Dan Li, Christopher Lu, Yuanpeng Ren, Baisheng Jiang, Qi Chen Factors associated with specialty choice in Chinese medical students and residents: an exploratory cross-sectional study The Lancet, (SCI) (Impact Factor: 59.10), Vol. 394, S62, October, 2019 2.Angela P Fan, Russell O Kosik, Lihong Fan, Xudong Zhao, Yunung Hsu, Selina S Lien, Dan Li, Yuanpeng Ren, Baisheng Jiang, Qi Chen Medical specialty distribution in China, 2009–17: a longitudinal examination The Lancet, (SCI) (Impact Factor: 59.10), Vol. 394, S64, October, 2019
		研討會論文			1		Angela Fan, Training General Practice Physicians for the Care of Elderly Population, Boao Global Health Conference, June, 2019
		專書			0	本	
		專書論文			0	章	
		技術報告			0	篇	
		其他			0	篇	
	智慧財產權及成果	專利權	發明專利	申請中	0	件	
				已獲得	0		
			新型/設計專利		0		
		商標權			0		
		營業秘密			0		
		積體電路電路布局權			0		
		著作權			0		
		品種權			0		
		其他			0		
	技術移轉	件數			0	件	

		收入			0	千元	
國外	學術性論文	期刊論文			0	篇	
		研討會論文			0		
		專書			0	本	
		專書論文			0	章	
		技術報告			0	篇	
		其他			0	篇	
	智慧財產權及成果	專利權	發明專利	申請中	0	件	
				已獲得	0		
			新型/設計專利		0		
		商標權			0		
		營業秘密			0		
		積體電路電路布局權			0		
		著作權			0		
		品種權			0		
		其他			0		
	技術移轉	件數			0	件	
		收入			0	千元	
參與計畫人力	本國籍	大專生			4	人次	工讀生與研究助理協助文獻整理
		碩士生			1		研究助理協助文獻整理
		博士生			1		研究分析學習並參與未來計畫規劃與論文寫作
		博士級研究人員			0		
		專任人員			0		
	非本國籍	大專生			0		
		碩士生			0		
		博士生			0		
		博士級研究人員			1		參與計畫文獻整理與論文寫作
		專任人員			0		
其他成果 （無法以量化表達之成果如辦理學術活動、獲得獎項、重要國際合作、研究成果國際影響力及其他協助產業技術發展之具體效益事項等，請以文字敘述填列。）							

科技部補助專題研究計畫成果自評表

請就研究內容與原計畫相符程度、達成預期目標情況、研究成果之學術或應用價值（簡要敘述成果所代表之意義、價值、影響或進一步發展之可能性）、是否適合在學術期刊發表或申請專利、主要發現（簡要敘述成果是否具有政策應用參考價值及具影響公共利益之重大發現）或其他有關價值等，作一綜合評估。

1. 請就研究內容與原計畫相符程度、達成預期目標情況作一綜合評估
   ■達成目標
   □未達成目標（請說明，以100字為限）
   　□實驗失敗
   　□因故實驗中斷
   　□其他原因
   說明：

2. 研究成果在學術期刊發表或申請專利等情形（請於其他欄註明專利及技轉之證號、合約、申請及洽談等詳細資訊）
   論文：■已發表　□未發表之文稿　□撰寫中　□無
   專利：□已獲得　□申請中　■無
   技轉：□已技轉　□洽談中　■無
   其他：（以200字為限）

3. 請依學術成就、技術創新、社會影響等方面，評估研究成果之學術或應用價值（簡要敘述成果所代表之意義、價值、影響或進一步發展之可能性，以500字為限）
   本研究聚焦醫師在醫療系統領導力的發展，關注所有男女醫生的主要領導角色，以發揮醫療服務團隊中的領導才能和參與度。發展領導力的同時，為了解決醫學領域常見的性別在擔任領導職位上的差距，倡議設計在地化的介入訓練課程。本研究整理介入措施探討其對兩性醫生的長期影響，為醫師性別的領導力、反污名化態度以及溝通能力差距做出改善。
   本研究結合學術理論，並包括質性深入探究及加入隱藏式介入方案。針對醫療領導力與人道關懷的發展與變化，從醫生方面進行核心調查與分析，並結合資源分佈調查現況與評估，精進實證與科學化數據分析，確實達到學術與實際應用性貢獻。

4. 主要發現
   本研究具有政策應用參考價值：□否　■是，建議提供機關衛生福利部,
   （勾選「是」者，請列舉建議可提供施政參考之業務主管機關）
   本研究具影響公共利益之重大發現：■否　□是
   說明：（以150字為限）