Pediatric Patients’ Satisfaction and Perceptions of Physician-Patient Interaction During Medical Visits

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Pediatric Patients’ Satisfaction and Perceptions of Physician-Patient Interaction During Medical Visits

by

Angela M. Slaymaker

Honors Thesis
Presented to the Faculty of Carroll College
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Bachelor of Arts

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This thesis for honors recognition has been approved for the Department of Communication Studies.
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Abstract

Unlike many current studies involving children and adolescents, this study focuses on the pediatric patient's view of his or her physician and medical visit. This is important to improving techniques, communication, and approaches used with children and adolescents during a medical encounter. Fifty-five pediatric patients ages 5 to 18 were recruited following their medical visit in the pediatric department of a large clinic. Quantitative and qualitative data were collected from a satisfaction questionnaire and open-ended interview questions. Quantitative results suggest that pediatric patients are generally satisfied with their medical visits. Results from the qualitative data indicate that pediatric patients highly regard communication issues—both interpersonal and general—with their physicians, as well as view the practical features involved with a medical visit as being important.
Chapter 1

Pediatric Patients’ Satisfaction and Perceptions of Physician-Patient Interaction During Medical Visits

The interaction between a patient and a physician begins as early as infancy and usually continues with visits to an array of various health care providers throughout one’s lifetime. While physicians play a crucial role in most people’s lives, the significant relationship between provider and patient is not always effective. For this reason, it is essential to explore the physician-patient relationship and, more specifically, the communication that occurs during a medical encounter.

Effective physician-patient communication is imperative to health care procedures and such important outcomes as increased medical knowledge, patient satisfaction, and adherence to regimens (Northouse & Northouse, 1992). However, problems often occur. Inadequacies in communication during medical visits can lead to low levels of patient compliance and cooperation, miscommunication and misinformation, and dissatisfaction with health care (Kreps & Thornton, 1992).

Because patients are often exposed to a physician’s office at a very early age, the relevance of exploring pediatric medical visits is apparent. Just as we tend to start young in encouraging healthy eating habits and proper language skills, so, too, can we originate our efforts to create a productive and conducive physician-patient relationship with children. Further research must be conducted to precipitate this.

For a child, a visit to the doctor is a significant one. Not only is he or she put in the spotlight but also exposed to happenings and procedures that, for most children, occur
quite rarely. In addition, a new authority is involved—the physician. Consequently, for the pediatric patient (i.e., those as young as a newborn and as old as age 20), going to the doctor can be a momentous occasion that can result in learning and growth or, on the other hand, can create apprehension and a feeling of isolation. Because medical encounters can be a seemingly out-of-the-ordinary event, it may be particularly worthwhile to investigate the process of the medical visit according to those who experience it—the children. Especially important is investigating perceptions that children have of their medical visits in relation to their health care provider.

Children’s beliefs regarding their medical experiences can be a source of vital information. Their perceptions of medical visits might undermine their cooperation and affect their adjustment and reactions to future encounters with physicians. Yet knowledge of these perceptions could assist parents and health care providers in reducing such anxiety early on and possibly eliminating problems that could otherwise occur later. Still, their perceptions may reinforce the positive occurrences already taking place in the examining room. Physicians can take note and continue treating children and communicating with them in ways that increase effectiveness. Once children’s beliefs are known, adults involved with the medical visit are better able to employ the techniques, language, and approaches that address the children’s concerns. Effective communication with children during medical visits can affect their responses to procedures, compliance with therapy, and knowledge about health and illness (Dorn, 1984).

To uncover these issues, Chapter 2 reviews previous literature related to pediatric patients’ perceptions and the limitations that have evolved with this research, as well as outlines the research questions of the current project. In Chapter 3, the methods of the
present research are explained. Chapter 4 describes the results of both the quantitative instrument and the qualitative analysis. Chapter 5 discusses the results of the present research. Finally, Chapter 6 summarizes the present study and addresses its limitations. Implications for further research and for physicians are also discussed.
Chapter 2

Previous Relevant Literature

Literature addressing the importance of health communication began to take shape only a few decades ago and has slowly gained momentum in aiding efforts to learn about and improve health care visits for all those involved (for example, see Morris & Chenail, 1995). Research on medical interviews today is not limited to adult consultations; pediatric visits are beginning to be investigated as well (Bachanas & Roberts, 1995; Bernzweig, Takayama, Phibbs, Lewis, & Pantell, 1997; Ginsburg, Slap, Cnaan, Forke, Balseley, & Rouselle, 1995; Ginsburg, Menapace, & Slap, 1997; Inman, 1991; Rifkin, Wolf, Lewis, & Pantell, 1988). And, just as valuable information about medical visits has been obtained by gaining adult patients' insight, so, too, can children's perceptions be a useful tool in the continued quest for better communication. The following will discuss the relevancy and findings of studies that investigated children's or adolescents' perceptions about medical visits and outline the limitations of current research.

Findings in Previous Research Regarding Pediatric Patients' Perceptions

Although few studies have been done in this area, some pertinent findings shed light on the current research project. The following studies lay the foundation for the investigation of pediatric patients' perceptions of their physicians and/or their medical visits. Some studies that involve adolescents' opinions regarding medical experiences note the effects of physicians' language and communication, type of visit, age, and gender on relationships with youth.
Better communication is most notable in these studies as an important need for adolescents. In Ginsburg et al.'s (1997) study, subjects said they wanted to be spoken to in plain English, and viewed medical language as a way that physicians avoided communication and the truth. In addition, the youths criticized physicians’ use of juvenile language. Pediatric patients frequently misinterpret physicians’ metaphors and language (Pantell & Lewis, 1987). It seems that physicians must communicate to their young patients in a way that is neither too advanced nor too childish, and for this reason, physicians may have difficulty judging what can or cannot be understood by children of different ages (Perrin & Perrin, 1983).

Age and medical fears were found to be significantly related in a study by Aho and Erickson (1985). These researchers found that having to go to the doctor seemed to be a fear expressed more frequently by seventh graders than by any other grade level. In addition, age was related to the number of fears identified, as the first graders in the sample expressed the smallest number of fears. While this finding was not expected, Aho and Erickson proposed that one reason for the youngest children having the fewest fears was that the older children had more opportunities to learn to be afraid through more exposure to medical procedures. Similarly, Bachanas and Roberts (1995) found that younger children rated health care personnel, procedures, and settings as more approachable and reported liking them more than older children.

The type of visit (i.e., well-child, illness, follow-up, etc.), as well as whether the visit was an initial visit or later visit, and the effects on the communication process during pediatric medical encounters was discussed by Pantell and Lewis (1986). These researchers stated that if past studies by Korsch, Gozzi, and Francis (1968), Foye,
Chamberlin, and Charney (1977), and Arnston (1982) are compared, differences in communication patterns are evident between patients being seen for health care maintenance and patients being seen for acute illness. However, a study by Pantell (1980) using uniform methodology at a single site did not reveal any differences in interaction patterns among children being seen for different reasons. Pantell and Lewis (1986) also identified studies by Korsch et al. (1976) and Arnston (1982) as having compared initial visits to later visits and documented different patterns of interaction.

A correlation between the gender of the physician and communication with children during medical visits surfaced in Bernzweig et al.’s (1997) research. While satisfaction was greatest when both physician and patient were female, scores on the questionnaire used were generally higher when both the physician and the child were of the same gender and lower when they were of different genders. Ginsburg et al.’s (1997) studies support this, as their findings report that nearly all females seemed to feel that they would prefer female providers. However, in contrast, while males initially said that physician gender did not matter, many stated they would be more comfortable being examined by a female and being counseled by a male.

Just as it seems children and adolescents have varying reactions to their medical visits depending on differing physician factors, so, too, does it appear that physicians vary their treatment depending on differing patient factors. Past studies have found that physicians treated boys differently by providing them with more information; also, physicians interacted and talked more extensively with older children (Pantell & Lewis, 1986). These differing communication patterns based on gender and age may reflect differences in children’s perceptions of and satisfaction with their medical visits.
Limitations of Previous Research

While it is important to gain a better understanding of children’s perceptions regarding health care to facilitate a more comfortable and productive medical encounter for the pediatric patient, several limitations are evident. As seen above, few studies have been published that specifically examine such issues (Bush & Holmbeck, 1987). A pediatric medical visit involves more people than the normal physician-patient relationship in an adult visit; in addition to the child and the physician, one or two parents and, often, siblings are involved. Because of this, little has been written about the separate role of the child in a medical visit. In most cases, the parent represents and replaces the child; the child is only the subject of the medical examination (Inman, 1991).

The majority of literature that has considered the child regards children’s thoughts about illness only. For example, studies have discovered that children’s concepts of health, illness, and bodily functions change with age and that one source of communication difficulty in pediatric medical visits arises from limitations in children’s abilities to understand information (Bibace & Walsh, 1980; Dorn, 1984; Perrin & Gerrity, 1981). Although such information is meaningful, it does not directly address the child’s experience and perceptions of the medical visit—children’s beliefs about the physician, the nurse, the medical procedures, or the encounter’s interactional features.

An additional drawback to much of the current literature is that the studies often take place in nonmedical settings (Bachanas & Roberts, 1995). Aho and Erickson’s (1985) study analyzed the effects of grade, gender, and hospitalization on children’s medical fears, but their instrument, a medical fears questionnaire, was administered to the children in their classrooms. Furthermore, informative studies can be found regarding
children or adolescents and medical care, but instead of occurring in the medical setting, most took place at the subjects' schools. Studies by previous researchers have employed this method (Broome & Hellier, 1987; Bush & Holmbeck, 1987; Ginsburg, et al., 1995; Ginsburg, et al., 1997; Kowpak, 1991; Redpath & Rogers, 1984; Resnick, Blum, & Hedin, 1980; Rosenfeld, Fox, Keenan, Melchiono, Samples, & Woods, 1996). This may limit the strength of any findings because the children were asked questions out of the context of their encounter with medical professionals.

Moreover, the issue of time may also be a factor as many children cannot accurately relate to or remember situations that they have not recently experienced. Because all of the above studies occurred outside of the medical environment, the subjects were asked to recall situations that may have transpired much earlier. Measurements of children's responses to medical visits may not be fully valid if the children do not have the experience of a medical visit fresh in their minds. Validity may be extended if the participants are assessed while actually in a medical setting and recently exposed to an interaction with a physician (Bachanas & Roberts, 1995).

Finally, a major instrument used to measure pediatric patients' satisfaction is limited. Rifkin et al. (1988) developed a Child Satisfaction Questionnaire that measured pediatric patients' satisfaction with their medical visit. The full 19-item measure contained both positively and negatively worded items. Specifically, this measure assigned all positively worded items to a physician-child rapport subscale and all negatively worded items to a physician communication skills subscale. Positively worded items represented items for which high satisfaction was signified by agreement; negatively worded items represented items for which disagreement was associated with
high satisfaction. However, most negatively worded items did not contain negative words such as “no” or “not.” Rifkin et al. (1988) found a “strong relationship between age (young) and the tendency to endorse negatively worded items, $r(73) = .57, p < .001$, but no correlation between age and response to positively worded items $r(73) = .00$” (p. 250). They hypothesized that the tendency of younger children to endorse negatively worded items suggested that they had difficulty understanding these items and simply affirmed them. To reduce younger children’s confusion with negatively worded items, Rifkin et al. (1988) eliminated them, a move that resulted in a 12-item scale containing all positively worded items. While this may make it easier for young children to understand, it also stimulates further questions, as there is a possibility that the younger children simply could not understand their physician and were not satisfied with physician communication skills. As mentioned above, physician communication skills were represented only with the negatively worded questions. More research needs to be done to clarify these questions.

Research Question

As can be seen from above, (a) few studies have specifically examined pediatric patients’ perceptions of medical visits; (b) most studies that have considered pediatric patients are regarding their thoughts about illness; (c) studies involving children frequently take place in nonmedical settings; (d) studies occurring long after a pediatric patient has experienced a medical visit may limit what children can accurately remember or relate to; and (e) the Child Satisfaction Questionnaire is limited in that it separates physician-child rapport and physician communication skills into positively and negatively worded questions, respectively. The current study seeks to remedy the limitations
discussed above and further the crucial knowledge and insight that can be gained from pediatric patients.

RQ1: What are 5- to 18-year-old patients’ perceptions of their pediatric visits?

RQ2: How is patient race, patient sex, patient age, physician sex, parent sex, visit type, patient’s number of visits to the physician in the last year, whether or not the physician seen was the patient’s usual provider, and whether or not the patient received a shot related to his or her satisfaction of physician-patient interaction during medical visits?

RQ3: How do pediatric patients’ responses to quantitative and qualitative measures compare?
Chapter 3

Method

Both quantitative and qualitative methods were used to collect data for triangulation purposes. According to Frey, Botan, Friedman, and Kreps (1991), "In the context of communication research, triangulation means that different research techniques producing consistent results provide a more effective base for describing, explaining, understanding, interpreting, predicting, controlling, and critiquing a communication process or event than a single research technique producing a single result" (p. 14). Measurement validity and reliability, as well as the credibility of the conclusions drawn, can be increased by combining quantitative measurements with more open-ended, qualitative measurements of the same concept (Frey et al., 1991). Hence, this project involves a quantitative measurement scale and interviews using open-ended questions.

Subjects and Setting

Fifty-five children and adolescents between the ages of 5 and 18 (M = 10.6 years) who were patients in the pediatric department of a large clinic in the northwestern part of the United States served as subjects. The clinic functions as a major health care facility for an urban community of approximately 60,000 people in addition to serving an extended radius of surrounding smaller farm communities in the area. Twenty-nine participants were female and 26 were male. The subjects were recruited and assessed in the pediatric department. Of the visits, 23 (42%) were for well-child visits, 16 (29%) were for the management of illness, 11 (20%) were follow-up appointments, and 5 (9%) were for treatment of injuries. Forty-eight (87%) of the 55 subjects were European
American, 3 (5%) were Hispanic American, 2 (4%) were Native American, and 2 (4%) were African American. Approximately two-thirds of the subjects were seen by their usual physician. In the past year prior to the visit, 53 (96%) of the children and adolescents had seen a physician and 13 (24%) had 5 or more visits.

Four physicians served as medical providers for the subjects in this study. All of these practitioners were board certified pediatricians. Three physicians were female and one was male. All were European American. Their ages ranged from 35 to 47 years. Forty-one (75%) of the medical visits were with female physicians and 14 (25%) of the visits were with a male physician.

Quantitative Instrument

Children and adolescents completed the Child Satisfaction Questionnaire, developed by Rifkin et al. (1988), which measured their satisfaction with the medical visit. Specifically, the questionnaire measured physician rapport and physician-child communication during the medical visit (see Appendix A). Sample items from the questionnaire include “I could talk to the doctor like a friend” and “The doctor asked me questions about the things I like to do.” Reliability in past studies has been .75, .62, and .89 (Bernzweig et al., 1997; Lewis, Pantell & Sharp, 1991; Rifkin et al., 1988), using a shorter version of the questionnaire. The questionnaire used in this study was the longer of two versions, consisting of 19 items measuring child satisfaction with physician-child communication within the medical visit. Seven of the items on the questionnaire are negatively worded and relate to physician communication skills, while the other 12 items are positively worded and relate to physician-child rapport. The shorter version of the Child Satisfaction Questionnaire involves the use of only the 12 positively worded items.
The questionnaire was read aloud to children unable to read the items easily. Graphic symbols were included to aid the child in conceptualizing each possible response. Children and adolescents able to read were allowed to complete the questionnaire without the aid of the researcher.

For scoring, a 5-point Likert format was used: “1” was assigned to “not at all,” “2” to “very little,” “3” to “some,” “4” to “a lot,” and “5” to “really a lot.”

**Qualitative Analysis**

Subjects answered six open-ended questions in addition to two others, depending on their answers to Questions 1 and 2. These questions were developed by the researcher in order to enable the subjects to further expand their perceptions of their medical encounter beyond the quantitative measure. Sample questions include “What was the best thing about talking with your doctor today?” and “What would help to make talking to your doctor better or easier?” (see Appendix B).

The open-ended questions were asked aloud by the researcher and were audiotaped to allow for transcription and analysis.

**Procedure**

Receptionists in the pediatric department waiting area approached parents of the subjects after they checked their children in for their scheduled appointments. The purpose and requirements of the study were explained, and children and adolescents’ participation was requested both verbally by the receptionists and in written form on a handout given to the parents. One hundred sixteen potential subjects declined participation in the study. While this is twice the number of actual participants, those who declined most likely could not allow the additional time for the study after the
appointment. Following their medical visit, participants were then taken into a large room in the pediatric department to complete the assessment and to be interviewed. If parents were accompanying their child, they were requested to sign a consent form prior to the participation of the child or adolescent. While the child participated in the study, parents also filled out a demographic sheet asking information regarding child’s race, child’s sex, child’s age, doctor’s sex, accompanying parent’s sex, type of medical visit the child had just experienced, approximate number of medical visits the child had been to in the last year, if the child saw his or her usual doctor, and if the child received a shot during the visit (see Appendix C). Four subjects were not accompanied by one or both parents. Two of them, aged 16 and 17, filled out the demographic sheet themselves. The other two subjects were accompanied by a legal guardian who signed the consent form and filled out the demographic information.

After obtaining consent, the participants were told that there were no right or wrong answers to the questions; they were assured of confidentiality, and a brief explanation of the procedure was given to each subject (and parent, if accompanied by one). The questionnaire was then administered to the children and adolescents. Each item was read by the researcher to children having difficulty reading the items themselves. Older children read and completed the questionnaires independently after receiving instructions.

Following completion of the questionnaires, the researcher asked each participant a series of six open-ended questions. This part of the study was audio-taped with permission of the participants and their parents to enable accurate transcription. Three participants’ responses were not audio-taped because of technical difficulties. The
assessment took approximately 15 minutes to complete. Both the questionnaires and the additional questions were administered typically in the presence of parents, but efforts were made to ensure that each subject's responses were made privately. Names were not recorded, and none of the children or adolescents appeared to be upset by the procedure. Upon completion, subjects were offered their choice of a small toy, a piece of candy, or a free coupon for McDonald’s in appreciation of their participation.
Chapter 4

Results

Quantitative and qualitative findings are now discussed. Quantitative results are explicated first, with qualitative results described subsequently.

Quantitative Findings

Quantitative results suggest that pediatric patients were generally satisfied with their medical visits. Mean scores for each individual indicated that subjects are at least somewhat satisfied. Patient age was found to be significantly related to satisfaction using the 19-item scale. Generally, the younger the patient, the less he or she was satisfied. However, using the 12-item scale and eliminating the negatively worded questions, patient age did not appear to be related to patient satisfaction. The following is a discussion of the results generated by the Child Satisfaction Questionnaire. An examination of various demographic information in relation to satisfaction is also explored.

Because the positively worded items and the negatively worded items used in the original 19-item scale represented two different factors in children's satisfaction—physician-child rapport and physician communication respectively—it is difficult to distinguish whether the younger children endorsed negatively worded items because they had difficulty understanding these items or because they were not satisfied with physician communication (i.e., they had trouble understanding the physician). In order to gather as much information as possible regarding child satisfaction relating to physician-child rapport and physician communication skills and to replicate the original measure and its
results, this research project included all 19 items—both positively and negatively worded. However, analysis of the data involved two trials, one using data from all 19 items and one using data from only the positively worded 12-item scale.

To account for the negatively worded items, subjects' scores for these eight items were transformed so that a high overall score indicated satisfaction. For example, if a subject answered "really a lot" to a negatively worded item, which would normally indicate a score of "5," the score was transformed to a "1."

A T-test revealed means and standard deviations (see Table 1 below) for each individual question as very similar to results from Rifkin et al. (1988). Using the 5-point Likert scale as a comparison to the means, results indicated that for each question, subjects were at least somewhat satisfied. A mean of "3" would indicate "somewhat" satisfied, "4" indicates "a lot" satisfied, and "5" indicates "really a lot" satisfied. Mean scores for each individual subject using both the 19-item and the 12-item scale indicated at least some degree of satisfaction as well. The average score for each subject using the 19-item scale was 3.82. The average score for each subject using the 12-item scale was 3.88.

In comparing subjects' mean scores for the positively worded items and subjects' mean scores for items that were negatively worded, it was found that the means were fairly similar—3.88 and 3.72, respectively. An independent samples test was performed and revealed that there is no statistical difference between the average responses to positively worded items and the average responses to negatively worded items. A larger standard deviation for the negatively worded items indicates a much more varied response overall as compared to the positively worded items. Thus, because the means
Table 1. Statistics for 19-item Child Satisfaction Questionnaire

<table>
<thead>
<tr>
<th>Item Content</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Standard Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>I got along well with this doctor.</td>
<td>4.58</td>
<td>.63</td>
<td>8.48E-02</td>
</tr>
<tr>
<td>The doctor explained things s/he did to me during the checkup.</td>
<td>3.67</td>
<td>1.06</td>
<td>.14</td>
</tr>
<tr>
<td>I could talk to the doctor like a friend.</td>
<td>3.91</td>
<td>.91</td>
<td>.12</td>
</tr>
<tr>
<td>This doctor helped me learn how to take care of myself.</td>
<td>3.91</td>
<td>1.14</td>
<td>.15</td>
</tr>
<tr>
<td>The doctor let me say how I felt about the things s/he did to me.</td>
<td>3.35</td>
<td>1.21</td>
<td>.16</td>
</tr>
<tr>
<td>The doctor knows what it's like to be my age.</td>
<td>3.84</td>
<td>.92</td>
<td>.12</td>
</tr>
<tr>
<td>The doctor asked me questions about the things I like to do.</td>
<td>3.27</td>
<td>1.55</td>
<td>.21</td>
</tr>
<tr>
<td>The doctor explained things so I could remember them.</td>
<td>3.61</td>
<td>1.22</td>
<td>.17</td>
</tr>
<tr>
<td>The doctor I just saw cared about how I felt.</td>
<td>4.25</td>
<td>.87</td>
<td>.12</td>
</tr>
<tr>
<td>The doctor I saw today helped me feel calm.</td>
<td>4.20</td>
<td>.87</td>
<td>.12</td>
</tr>
<tr>
<td>When I was done seeing the doctor, I felt better about my health.</td>
<td>3.98</td>
<td>.97</td>
<td>.13</td>
</tr>
<tr>
<td>This doctor understood what I was trying to say.</td>
<td>3.95</td>
<td>.95</td>
<td>.13</td>
</tr>
<tr>
<td>When I was with the doctor the grown-ups talked so much it was hard to say anything.</td>
<td>3.00</td>
<td>1.58</td>
<td>.21</td>
</tr>
<tr>
<td>When the doctor explained things I got all mixed up.</td>
<td>4.07</td>
<td>1.18</td>
<td>.16</td>
</tr>
<tr>
<td>The doctor I saw today talked too much.</td>
<td>3.82</td>
<td>1.40</td>
<td>.19</td>
</tr>
<tr>
<td>This doctor used words I did not understand.</td>
<td>3.75</td>
<td>1.22</td>
<td>.16</td>
</tr>
<tr>
<td>This doctor talked about a lot of stuff I did not understand.</td>
<td>3.76</td>
<td>1.32</td>
<td>.18</td>
</tr>
<tr>
<td>It was hard to talk to the doctor I just saw.</td>
<td>3.87</td>
<td>1.44</td>
<td>.19</td>
</tr>
<tr>
<td>It was hard to talk to the doctor about my worries.</td>
<td>3.78</td>
<td>1.41</td>
<td>.19</td>
</tr>
</tbody>
</table>
are so similar, this information seems to support the use of both positively and negatively worded questions.

Mean scores using data from the 19-item scale did not vary as a function of patient race, patient sex, physician sex, parent sex, visit type, patient’s number of visits to the physician in the past year, whether or not the physician seen was the patient’s usual provider, or whether or not the patient received a shot. However, results similar to Rifkin et al.’s (1988) study were found relating mean scores and patient age (see Figure D1, Appendix D). An independent samples T-test revealed a highly significant relationship between age and satisfaction, $p < .01$, with younger subjects much more likely to be dissatisfied. This significance was also supported when using mean scores from only the negatively worded items (see Figure D2, Appendix D). Again, a strong relationship existed between young age and the tendency to be dissatisfied, $p < .01$. Hence, it appears that younger patients may indeed be confused by the negatively worded questions and therefore select an inaccurate response to these items.

Mean scores using data from the 12-item, positively worded scale did not vary as a function of patient race, patient sex, patient age, physician sex, parent sex, visit type, whether or not the physician seen was the patient’s usual provider, or whether or not the patient received a shot. In comparison to the above relationship between subject age and satisfaction, using the positively worded 12-item scale revealed no significance, $p = .523$ (see Figure D3, Appendix D). However, the 12-item scale did show that the mean scores vary as a function of the patient’s number of medical visits in the past year (see Figure D4, Appendix D). Analysis revealed a relationship between patients’ number of visits to the physician in the past year and satisfaction, $p = .027$. Surprisingly, it was found that
patients who had more visits to the physician in the past year were more dissatisfied than those who visited the physician less.

Qualitative Findings

Qualitative results suggest that two prominent themes exist that significantly impact children’s and adolescents’ perceptions regarding their medical visits and their physicians. First, pediatric patients were interested in developing and maintaining interpersonal relationships and effective communication with their physicians. Second, children and adolescents appeared to be concerned with the practical features involved with a medical visit; they cared about the happenings (i.e., being asked personal questions, parental presence, physical examinations, etc.) that occurred while they were with the physician, as well as whether or not they were healthy. The following is a discussion of themes found in subjects’ answers in relation to the oral interview questions that were asked of them. The categories are discussed in order of frequency.

Question 1 What do you like about talking with the doctor? What do you like when your doctor talks with you?

Five main categories were found in response to this question. The majority of responses (42%) given to this question refered to interpersonal communication issues. The next most frequent response (27%) was in relation to the practical reasons for seeing a physician. Fifteen percent (15%) of subjects gave a response that revealed they were unsure about their answer. A miscellaneous category of responses accounted for 9% of the subjects. Finally, a category of general communication issues made up 4% of the responses.
These categories show that pediatric patients care very much about the communication that occurs between the physicians and themselves, as almost half of the responses given to this question were related to interpersonal communication or general communication. Additionally, almost a third of the patients were concerned with practicality issues. Very few individuals were unsure about their answer or gave miscellaneous answers.

Interpersonal communication. Three subcategories emerged relating to interpersonal communication between the physician and patient: (a) physician listening, (b) creation of a positive climate by the physician, and (c) patient disclosure about non-health topics. First, many stated that they liked that the doctor listened to them. Because subjects mentioned that they felt comfortable talking to the doctor, it is likely that the physicians developed a supportive communication climate with their patients to facilitate therapeutic listening. One subject said the following: “She makes me feel like I can ask her questions about anything, and she doesn’t make me feel dumb.” It is evident that in this case the patient felt attended to and supported.

Second, the importance of the physician creating a positive climate and showing care for the pediatric patient can be seen with the responses to the above question. Many pediatric patients stated that they liked that their doctor was friendly and/or nice. One subject’s comments included the following: “It’s fun. She makes things interesting.” Another said, “She’s nice and pretty funny.” Thus, physician friendliness seems to be an important element in establishing a satisfying visit to the doctor for patients. In addition, a friendly environment more easily enables patients to feel at ease and disclose their concerns.
Third, participants stated that they liked telling the doctor about other things going on in their lives, such as what they are doing for summer vacation or that they are getting a new sister or brother. This sort of communication not only demonstrates a sense of security on the part of the patient but also enables the patient to become recognized as more of an individual and develop a unique relationship with his or her physician. For patients, self-disclosure about non-health topics is important because it furthers the developing relationship between physician and patient and helps improve future interactions.

Practical issues. Two subcategories were discovered regarding the practical reasons that children and adolescents like talking with a physician: (a) learning about health issues and (b) receiving a medical information. First, subjects liked that their doctors were very knowledgeable, allowing patients to learn more about themselves and their health. For instance, one subject said, “She can answer a lot of questions that I have, I guess, about things.” Another said, “You understand more about why you either feel the way you do or why things help.” These statements represent a strong showing of patients’ desire to get answers and to understand more.

Second, patients also liked that the physician helped them in some way. For one subject, the doctor gave her ideas. For others, the physician figured out what was wrong and what the patient could do to feel better. This represents the fundamental reason for going to the doctor—to get some sort of help, and it was recognized and appreciated by many subjects.

Unsure. Eight subjects replied that they didn’t know what they liked about talking with the ‘doctor.’
Miscellaneous. Five miscellaneous responses occurred.

General communication issues. Two subcategories were found in connection with general communication issues and what pediatric patients liked about talking with their doctor: (a) understanding the physician and (b) patient acknowledgment. First, subjects reported that they appreciated understanding what the doctor said and that the doctors explained what they were saying quite well. One subject said, “I could understand every word he said.” The physicians talked at the patients’ level, using terms, words, and concepts that could be easily comprehended. These patients liked it when their physicians gave thorough explanations that they could understand. This enables them to participate actively in the communication exchange.

Second, another subject liked that the physician acknowledged that he was the one getting treated. This patient expressed the importance of the physician “actually talking to [him] instead of just telling [his] parents.” Although only mentioned by one subject, this comment represents an issue that must be continually dealt with in pediatric medical encounters. As most patients in a pediatric settings are accompanied by their parent(s), it has become apparent that the physician must especially address the patient, rather than just the parents.

Question 1.5 How important is this to you?

Because this question is closely related to question 1, the researcher only asked question 1.5 if it would be helpful and relevant to the answer given for question 1. Therefore, 22 subjects did not answer this question. Of the 33 who did respond to this question, only one said that what he or she said was not important. The remaining subjects all stated that it was important to some degree. Most also expanded upon their
answer to question 1, saying statements such as “Pretty important; it makes me feel very comfortable” and “It’s very important because I think that if I don’t understand what she’s saying that it’s kinda pointless.”

**Question 2** What don’t you like about talking with the doctor? What don’t you like when your doctor talks with you?

Six main categories were found in response to this question. The main response (31%) given to this question was a simple “nothing.” The next most frequent response (25%) revealed that the subjects were unsure. Twenty percent (20%) of the responses were in relation to the negative aspects of the practical reasons for seeing a physician. A miscellaneous category of responses accounted for 9% of the subjects. Another 9% of subjects’ answers make up a category of problems with general communication issues. Finally, 5% of subjects referred to difficulties relating to interpersonal communication issues.

Because about one-third of the responses to the above question were “nothing,” it can be deduced that these patients were somewhat satisfied with talking with their physician. One-fourth of the patients answered that they were unsure, which neither supports nor opposes such satisfaction. However, concerns with practical issues, as well as communication issues (general and interpersonal), also appear to be significant.

**No dislikes.** Seventeen of the 55 subjects answered “nothing” in reply to the above question. Some left it at that, while others expanded their answers with comments like “I don’t dislike anything about it at all.”

**Unsure.** Fourteen of the subjects answered “I don’t know” in reply to the question. Two subjects did add comments that indicated that they were not happy about
going to the doctor but did not divulge their reasons for their unhappiness. Examples of this are the following: “I don’t want to come. I just wanted to stay home” and “I’m mad. It makes me mad.”

**Practical issues.** Five subcategories were discovered regarding the practical reasons that children and adolescents dislike talking with a physician: (a) fear of something wrong, (b) discussing personal issues, (c) physical exams, (d) shots, and (e) physician disclosure to parents. First, subjects indicated a fear of finding out something was wrong with them. Their comments included the following: “Sometimes it’s a little scary, but probably because you just don’t want anything wrong with you. . .you just want to make sure that you’re healthy. . .it’s scary to think that you might be sick” and “I don’t like to hear stuff like I don’t have very good health.” These pediatric patients appear very concerned with and aware of their health status. They were very aware that, practically speaking, they were seeing the doctor for an issue that was medically related. With these medical issues sometimes comes a diagnosis that these patients did not want to hear.

Second, others said that discussing personal issues was what they did not like about talking with the doctor. Subjects indicated that they felt uncomfortable with answering personal questions and talking about personal issues such as puberty. Although personal questions and issues seem to be essential elements of discussion for a physician to obtain a full patient history and to treat the patient in a thorough manner, these topics seemed to make the subjects uncomfortable. Others indicated that they felt uncomfortable with asking the doctor certain questions, as one subject said the following: “I just feel, I kind of feel weird just cause some of the questions that you want to ask.” This concern could be based on a number of different factors. For instance, patients may
feel that asking questions may pose some sort of risk to them. Also, there may not be a supportive environment present that would enable the patients to feel comfortable disclosing or asking questions. This concern with personal issues appears to be closely related to the following subcategory.

Third, participants also indicated feeling uncomfortable with the physical examination. One subject said, "Sometimes I get nervous about tiny things like if I've got something weird that I don't want to show them." Just as patients feel that they are being invaded by the physician asking personal questions or initiating the discussion of personal issues, so too does the physical examination during a medial encounter play a role in such feelings of vulnerability.

Fourth, one subject who received a shot during his visit thought that getting shots was his major dislike about going to the 'doctor.' While not heard very often, this comment does not come as a surprise, as the receiving of shots for pediatric patients can be painful and traumatic.

Miscellaneous. Five miscellaneous responses occurred.

General communication issues. Two subcategories were associated with problems regarding general communication issues during the medical encounter: (a) misunderstandings and (b) amount of parent communication with the physician. First, subjects talked about their difficulty in understanding what the doctor said when he or she talked. Comments included the following: "Sometimes they say words I don't understand. . .really long, scientific words" and "Sometimes she says stuff I don’t understand, so it’s easier to talk to, like, not doctors and stuff." This problem not only commonly occurs during medical visits but also during everyday conversations between
adults and children. However, misunderstandings seem to be especially prevalent in the pediatric examining room, since children and adolescents often cannot decode medical jargon used by health care providers. The occurrence of such problems causes a breakdown in the flow of communication between physician and patient and can lead to the conversation becoming one-sided.

Second, problems erupted with the presence of a third party caregiver (usually one or more parents) and the amount of communication. One subject reported disliking that his “mom and dad talk to [the physician] so much.” In this situation, the patient most likely felt left out of the discussion that was probably about him. As a patient, it is important to be an active participant in the medical encounter, rather than a passive bystander. Talk between physician and parents that excludes the pediatric patient can dehumanize and isolate him or her.

**Interpersonal communication.** Subjects reported difficulties with interpersonal communication in relation to non-continuous care. These patients indicated that they felt uneasy with the doctor when they did not know him or her very well. Their comments were the following: “Well, because I only see them once a year, it’s kinda like a stranger thing” and “If I don’t feel comfortable around the doctor it’s hard to say things.” These patients are recognizing the need for a more regular relationship with their physician to better facilitate communication during their medical visit. The development of a stable relationship between a patient and his or her physician enables both parties to feel more at ease with each other and the subject matter that they are discussing.
**Question 2.5 How important is this to you?**

Because this question is closely related to question 2, the researcher only asked question 2.5 if it would be helpful and relevant to the answer given for question 2. Therefore, 52 subjects did not answer this question. Of the three who did respond to this question, all indicated that their answers for question 2 were not important.

**Question 3 What was the best thing about talking with your doctor today?**

Six main categories were found in response to this question. The majority of responses (38%) given to this question were in relation to the practical reasons for seeing a physician. The next most frequent response (27%) referred to interpersonal communication issues. Fifteen percent (15%) of subjects gave a response that revealed they were unsure. A category consisting of general communication issues makes up 5% of the subjects' responses. Another 5% said various fun activities were the best things about talking with their doctor. Finally, a miscellaneous category of responses accounted for 5% of the subjects.

These results show that both practical issues and communication (interpersonal and general) are looked upon very highly by pediatric patients, accounting for over two-thirds of the responses. Although a more minor answer, next in frequency was the response that subjects were unsure. Answers regarding fun activities and miscellaneous responses were not as numerous.

**Practical issues.** Three subcategories emerged regarding the practical issues that children and adolescents like talking about with their doctor: (a) learning about their health, (b) finding out how to get well, and (c) learning about themselves. First, subjects said they liked hearing about their health and finding out that they were healthy or that
they were getting better. One subject answered, “Just knowing that I’m healthy and what
I’m doing is working.” This answer is very similar to subjects’ responses relating to
practical issues for Question 1. These patients show an interest in their health and well-
being. It is apparent that they want to be healthy or at least on the road to recovery.

Second, others said that the best thing about talking with their doctor was getting
advice and finding out how to get better. Some of their comments included “He told me
what was wrong with me and how to fix it” and “The best thing was talking about how to
do my medicine to get better.” Similar to the first subcategory, these patients place great
importance on health and, more specifically, improving their health. They are most
interested in getting well and appreciate the role their physician plays in this process.

Third, subjects also liked learning about themselves when they talked with their
doctor. This is seen in the following example: “I guess I learned what’s normal and how
everything is supposed to go and stuff.” These patients see their visit to the doctor as a
learning experience as well.

The three patient education issues above all support the idea that pediatric patients
are inquisitive and care about their health status. They seem to want to take an active role
regarding how to improve or get healthy. In addition, they seek to find out more about
themselves.

Interpersonal communication. Five subcategories were discovered relating to
interpersonal communication between the physician and patient: (a) creation of a positive
climate by the physician, (b) physician listening, (c) patient disclosure about non-health
topics, (d) physician comforting strategies, and (e) attention by the physician. First,
subjects approved of the physicians’ efforts to create a positive climate. They attributed
numerous positive characteristics to their physicians. Some examples include the following: "She was nice to me" and "She was happy." These physician characteristics create a warm environment in which the patient is more likely to feel comfortable and relaxed. Additionally, in regards to the actual interaction between physician and patient, it is much easier to disclose to an individual who is "nice" and "happy" rather than mean or unhappy.

Second, others felt they were listened to and that their doctor understood them. As one subject explained, "I could feel that she didn’t care that I was, like, right or wrong on the things she asked me and stuff." It is important for every patient to be attended to and to receive acknowledgment without judgment. The physician, being a therapeutic listener, must verbally and nonverbally express such behaviors. This allows the patient to feel important and supported.

Third, another two subjects said they liked talking with the doctor about topics other than their health, such as "Talking about my favorite stuff" or "Telling her that we just got home from Nebraska." Such self-disclosure on non-health related topics enables the patients to share a more human side of themselves than is usually encouraged during a medical encounter. Much of the medical visit involves the dehumanizing physical exam and/or discussion of personal subjects. By talking about objects or happenings outside of the medical visit, the patients can make a relationship-building connection with their physician.

Fourth, others said the best thing about talking with the doctor was their doctor’s comforting words. One subject explained this by saying, "Him telling me it wouldn’t hurt that much." Another said, "He made me a lot calmer because I had to get a shot."
During the course of medical encounters, physicians occasionally initiate or participate in necessary medical procedures that the pediatric patient may deem painful. Because pediatric patients often look up to the physician, a physician’s words or actions—especially those that comfort or calm—can speak volumes.

Fifth, when reflecting on talking with their doctor, subjects expressed that the best part was when the physician asked them questions. In the patients’ words, they answered with the following: “When she asks stuff” and “When she was asking me questions.” These examples reflect the patients’ need for attention from their physician. They seek to make a connection, to solidify a comfortable relationship with their physician. Often, pediatric patients’ voices can get lost in the shuffle during the exchange that usually occurs between physician and parent. However, when the patients are addressed and questioned, they feel as though they are a more essential part of the interaction.

Unsure. Eight subjects answered that they did not know what was the best thing about talking with their doctor.

General communication issues. Subjects reported understanding the physician as being the best thing about talking with their doctor. One patient said, “She explained things so that I could understand them.” These subjects expressed appreciation that their physicians explained things in a manner that enabled them to better grasp the medical concepts involved. Moreover, pediatric patients can be more involved in communicating and clarifying important details when they understand what is being said. Finally, with understanding comes a better chance of alleviating patient fears.

Fun activities. Subjects related a type of fun activity during some part of the visit as being the best part. Examples of this are the following: “I got to play a lot,” “She lets
us play in her chair,” and “The heart checking.” These are all examples of activities that pediatric patients may have a chance to experience during their medical visit. For each individual patient, various activities throughout their medical encounter will likely be considered especially fun.

Miscellaneous. Three miscellaneous responses occurred.

**Question 4 What was the worst thing about talking with your doctor today?**

Five main categories were found in response to this question. The major response (33%) given to this question was “nothing.” The next most frequent response (29%) revealed that the subjects were unsure. Another 29% of subjects’ answers were in relation to the practical reasons for seeing a physician. Five percent (5%) referred to general communication issues. Finally, a miscellaneous category of responses accounted for 4% of the subjects.

The responses for this question were almost evenly split into three major categories—those who answered “nothing,” those who were unsure, and those who felt that practical issues were the worst thing about talking with the doctor. A small number of subjects reported disliking general communication and miscellaneous issues.

**No dislikes.** Eighteen subjects answered this question with a “nothing.” Some added that “there wasn’t anything bad.” These comments imply that they were satisfied or happy about talking with their doctor at this particular visit.

**Unsure.** Fourteen subjects stated that they didn’t know what the worst thing was about talking with their doctor.

**Practical Issues.** Six subcategories emerged regarding the practical issues that children and adolescents dislike talking about with their physician: (a) dislike of
diagnosis, (b) discussion of sensitive topics, (c) worries about illness, (d) shots, (e) change in regimen, and (f) taking blood pressure. First, some subjects indicated that they did not like their doctors’ diagnoses, such as having strep throat or being overweight. For patients, their diagnoses may be perceived as initiating other negative consequences brought on by themselves or others. This may encompass many different things such as the following: having to stay home from school, missing out on extracurricular activities, taking medicine, changing normal habits, or being made fun of by others.

Second, others explained that sensitive topics of discussion were the worst thing; subjects mentioned some of these “taboo” topics, saying the following: “Talking about my friends,” “Personal questions,” and “Puberty... I don’t like talking about it.” Topics such as these are sometimes delicate, evoking extreme discomfort or embarrassment for patients. Not only is the topic related to or about themselves, which can promote uneasiness, but it is also with a physician who is often more like a stranger than a close confidant. While most subjects admitted that these discussions are necessary when talking with the ‘doctor,’ they still expressed feeling uncomfortable.

Third, subjects also stated their worries about the results of their illness. Examples of this were “About how it might not go away” and “She said I had to go to the hospital if I don’t get better.” This closely relates to the first subcategory, in that sickness provokes fear of what may happen to the patient. Results of illness can range from taking medication and staying home from school to being put in the hospital and having surgery. Regardless of the seriousness of the illness, however, almost any infirmity causes some change in lifestyle, and pediatric patients have a right to be concerned about the outcome.
Fourth, two subjects were unhappy about getting shots. This is not a surprise, as numerous people, young and old, dislike receiving an injection. For pediatric patients, receiving a painful shot can overpower the rest of the medical visit and prompt dissatisfaction with the entire encounter.

Fifth, another two subjects talked about changes in their medicine regimen as being what they disliked most. For the patient, a change in medication or dosage may imply many things. It could cause patients to feel they did something wrong. Or they may feel frustrated that the medicine is not working as well as they would like it to. Any type of change, including that of a medicine regimen, is a disruption that can upset the normal, more regular pace of things.

Sixth, one participant stated that the worst thing about talking with the doctor was “Taking the blood pressure...it hurt kind of.” This is a more obvious practical issue in relation to dislikes when pediatric patients see their ‘doctor.’ There are numerous tests and procedures that often occur during a medical encounter that are uncomfortable or even painful.

General communication issues. Two subcategories were discovered relating to dislike of the communication between the physician and patient: (a) amount of parent communication with the physician and (b) misunderstandings. First, subjects mentioned that because of their parents, they did not get to talk with their physician as much as they would have liked to. Often, a third party’s presence (usually one or more parents in pediatric medical visits) and extensive communication with the doctor, takes the attention away from pediatric patients during their medical visit. One patient explained, [The doctor] “talked too much with my mom and dad and my sister.” Another subject felt that
he did not get to talk to the doctor that much. This situation can be frustrating for a pediatric patient who is trying to gain some independence regarding his or her health care. Young patients often seek their own chance to explain the situation or particular ailment.

Second, the other dislike relating to communication was the subjects' problems with understanding things that the physician said. A lack of understanding can be extremely problematic during medical encounters because it can cause the normal communication exchange to collapse. Pediatric patients' misunderstandings often accompany incorrect assumptions about or perceptions of the actual situation, which, in turn, causes further breakdown of the original message the physician means to communicate.

Miscellaneous. Two miscellaneous responses occurred.

**Question 5 What would help to make talking to your doctor better or easier?**

Six main categories were found in response to this question. The majority of responses (31%) revealed that the subjects were unsure. The next most frequent response (25%) given to this question suggested improvements related to general communication issues. Eighteen percent (18%) referred to enhancing interpersonal communication issues. Fifteen percent (15%) of subjects gave a response of “nothing.” A miscellaneous category of responses accounted for 5% of the subjects. Four percent (4%) also spoke of improvements to the medical environment. Finally, 2% mentioned improvements in relation to the practical reasons for seeing a physician.

Almost half of the answers to this question concerned interpersonal and general communication issues. Following in frequency was approximately one-third of respondents who were unsure what would help to make talking to their doctor easier. A
smaller percentage did not have any suggestions. Minor concerns were miscellaneous issues, improvements to the medical environment, and improvements related to practical issues.

Unsure. Seventeen subjects answered “I don’t know” to this question.

General communication issues. Two subcategories were discovered relating to improvements in general communication between physician and patient: (a) physicians’ use of less technical language and (b) less parent communication with the physician. First, subjects spoke of improvements related to how the doctor spoke to them. The majority wished they could understand their physician—that doctors would speak more slowly and use simpler words. Their comments included the following: “If it wasn’t so technical. Like everything, well most of the stuff is, like, words that I don’t know what it means” and “not using such big words, I mean kind of explaining them just a little because they’re so complicated sometimes.” Patients cannot fully participate in their own medical care if they do not understand what is being said. Not only does this lead to a more passive, frustrated patient, but also a situation that sets the stage for incorrect assumptions, misunderstandings, and general confusion.

Second, subjects felt that it would be better to see the doctor without their parents being present. In explanation, most of them said that their parent(s) interrupted or took over the conversation. This implies the need for a decrease in the amount of communication between parents and physicians and an increase in the amount between patients and physicians, as one subject stated, “Maybe if I was in there alone, like just me and him.” This need is also illustrated with another subject’s comment: “I find that it’s easier when my mom’s not there just because she seems to usually take over the
conversation and then it’s not about me anymore.” As therapeutic listeners, it is important for physicians to demonstrate attending behaviors toward the pediatric patient to improve the communication exchange. Because patients want to make a connection with their doctor and feel that they are important and listened to, adults involved in the pediatric consultation should try to regulate the amount and frequency of communication exchanges involving physicians with both parents and patients.

Interpersonal communication. Four subcategories emerged relating to improvements in interpersonal communication between physician and patient: (a) continual care, (b) patients’ friendliness, (c) more patient disclosure about non-health topics, and (d) more time for the medical visit. First, patients valued continual care by their physicians and could identify the relationship between their own infrequent visits and its effect on communication. Subjects thought knowing their doctor better would help make talking to their doctor easier. Some of their comments are as follows: “If you saw her more often you’d be able to communicate more. I only see her like usually once a year unless if I get sick” and “Maybe like knowing them like better than just seeing them every once in awhile.” Patients’ requests for a more stable relationship with their physicians parallel their desire for better communication during the medical visit. They recognized the difficulties involved in trying to talk with their physician about personal issues when they see him or her infrequently.

Second, two subjects also thought that if they, as patients, were more friendly, talking to the doctor would be better. Comments such as “being nice” came from younger children who most likely felt that it was their responsibility to make things better. While initially these comments may seem inappropriate, it is relevant to mention
that the responsibility for bettering the interactions between physician and patient does not rest solely with the physician. Patients, too, should participate in improving the communication during medical visits.

Third, subjects appreciate it when physicians inquire about other things going on in their lives aside from health issues. This, too, improves the physician-patient relationship. One subject’s comment was, “I think if a doctor doesn’t do that, you know, it’s kind of like she comes in and does her thing and then leaves. But my doctor, she comes in and she asks you what you’re doing.” This ratifies the need for a more intimate, developed relationship between physician and patient. Patients seek to become individuals in their physicians’ eyes.

Fourth, another said that having more time would help make talking to the doctor better or easier. This patient most likely felt that his time with the physician was rushed. Although this concern was only mentioned by one subject, adequate time for a medical encounter is essential to facilitating the much needed communication that occurs between physician and patient. If a patient feels rushed, he or she may be less likely to disclose sometimes vital medical information or concerns to the physician, possibly leading to frustration, dissatisfaction, noncompliance, and possible health risks.

No improvements. Eight subjects said “nothing” or that they could not think of anything that would make talking to their doctor better or easier. This implies that they are currently satisfied with talking to their doctor.

Environment. Subjects said making the surroundings more comfortable would help when talking to the doctor. One subject thought it would be better if “There were more stuff for people my age, like if there were posters of like sports people on the wall
instead of like the sink and all of that other stuff.” Creating an atmosphere in which patients feel welcome, cared for, and respected is one of many ways to help patients avoid feeling shame and humiliation (Lazare, 1987). For pediatric patients, this sort of ambience includes items on the walls and in the examining rooms that promote a feeling of comfort.

Miscellaneous. Three miscellaneous responses occurred.

Practical issues. Another subject said it would help if his physician “didn’t talk about so much about punishments [with his parents] as much.” This subject is relating one of the practical downsides, in his eyes, of talking with the ‘doctor.’ Occasionally, it is necessary for physicians to discuss with parents subjects that the pediatric patient most likely does not want to hear, especially punishments.

**Question 6 What do you wish the doctor would do differently when s/he is talking to you?**

Four main categories were found in response to this question. The majority of subjects (36%) gave a response of “nothing.” The next most frequent responses (33%) given to this question refer to general communication issues. Twenty-four percent (24%) revealed that the subjects were unsure. Finally, a miscellaneous category of responses accounted for 5% of the subjects.

The two most frequent responses accounted for a little over two-thirds of the answers to this question and were “nothing” and general communication issues, respectively. On a more minor level, subjects also reported being unsure and miscellaneous issues.
No improvements. Twenty subjects replied “nothing” to this question. Some offered additional positive comments such as the following: “She’s a good doctor. She knows what she’s doing and stuff” and “I think she’s doing a fine job.”

General communication issues. Four subcategories were discovered suggesting improvements regarding general communication between physician and patient: (a) physicians’ use of less technical language, (b) physicians’ expansion of explanations, (c) less parent communication with the physician, and (d) physicians’ use of more eye contact. First, subjects wished that their doctor would talk differently so that they could understand more of what he or she said. Some of their comments included the following: “Bring things to my level and talk to me like a normal person—not like a colleague or something” and “Not talk like a genius, you know, put it into words I can understand.” These patients would like to understand what their physicians are saying, but feel as though the communication is not at their level. Because pediatric patients feel incompetent to understand what their physician says, others wished that the doctor would talk to their parents more. One of the subjects explained, “Cause my mom understands better than I do about what she’s talking about. I just don’t understand.” These comments are interesting, as most would expect that pediatric patients would want the physician to talk with them rather than their parents. However, in frustration, these patients may transfer their communication responsibilities over to their parents, knowing that they are more likely to understand the physician.

Second, subjects also mentioned that the doctor should expand upon what he or she tells the patient. Examples of the subjects’ comments are the following: “Be more specific,” “Tell me like how to take the stuff you know and what he wants me to do;
maybe tell me more about what's wrong,” and “Make sure and explain why things are the way they are.” Physicians may underestimate the interest pediatric patients take in knowing about and understanding their health status. Patients solicit answers and explanations regarding their medical condition, as well as their proposed treatment.

Third, others wished that the doctor would talk to them more. In both cases, the subjects implied that the doctors talked to the parents more than to them. One subject said, “It's okay to have my mom in there, but I guess the doctor needs to realize it's my appointment.” Here, the patients are requesting more communication time with their physicians. They want to be in the middle of the interaction rather than be a silent observer.

Fourth, subjects expressed concern about eye contact, as they said that doctors should look at them when they talk. Eye contact is another important nonverbal listening behavior that portrays the listeners’ involvement and interest. However, the use of eye contact can and should be used on the part of the speaker, as well. When physicians speak to their patients but do not look at them, patients feel excluded and unimportant. In addition, their misuse of eye contact can imply a higher status compared to the patient (Wolvin & Coakley, 1996).

**Unsure.** Thirteen said that they didn’t know what their doctor could do differently.

**Miscellaneous.** Three miscellaneous responses occurred.

In summary, as seen above, two major themes evolved from the qualitative findings: communication issues—both interpersonal and general—as well as practical issues. Results from the qualitative data (see Table 2 below) demonstrate the importance
Table 2. Summary of Answers to Qualitative Questions 1-6

<table>
<thead>
<tr>
<th>Question 1 Likes</th>
<th>Question 2 Dislikes</th>
<th>Question 3 Best</th>
<th>Question 4 Worst</th>
<th>Question 5 Make Better</th>
<th>Question 6 Do differently</th>
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<td>Practical Issues 38%</td>
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<td>General Communicatio n Issues 5%</td>
<td>General Communicatio n Issues 5%</td>
<td>Nothing 15%</td>
<td>Miscellaneous Issues 5%</td>
</tr>
<tr>
<td>General Communicatio n Issues 4%</td>
<td>General Communicatio n Issues 9%</td>
<td>Fun Activities 5%</td>
<td>Miscellaneous Issues 4%</td>
<td>Miscellaneous Issues 5%</td>
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<tr>
<td>Interpersonal Communicatio n Issues 5%</td>
<td>Miscellaneous Issues 5%</td>
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<td>Environment 4%</td>
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<td>Practical Issues 2%</td>
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</tr>
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of the affective dimension of communication to the physician-patient relationship. It is apparent that pediatric patients are keenly aware of the interpersonal skills of their physicians and are able to articulate this awareness. The numerous responses regarding the interpersonal dimension add evidence that indicates the need for physicians to cultivate interpersonal skills. Appropriate therapeutic listening on the physician’s part demonstrates attending behavior and creates a supportive environment in which the patient feels cared for and respected. Also directly related to interpersonal communication, patients noted the importance of a more stable relationship with their physician and disliked the communication interaction that resulted when seeing their
physician only once a year. Patients' need for more continual care reflects their desire for a sense of commitment and certainty, a measure of consistency, a feeling of reliability, and an awareness that the relationship shared with their physician is unique.

General communication issues also emerged as a concern, as noted from the qualitative data. Most notable was patients' problems in understanding what their physicians said. This is similar to the results of Ginsburg et al.'s (1997) study that found subjects expressing the need to be spoken to in plain English. However, dissimilarly, no subjects in the present study expressed rejection of juvenile language. While the complexity of health care problems, diagnoses, and treatments makes it difficult to create and interpret messages without ambiguities and lost information, it is still important to work to alleviate the common occurrence of miscommunication and misunderstandings. Perrin and Perrin (1983) found that physicians have difficulty judging what their pediatric patients of different ages can or cannot understand. However, underuse rather than overuse of medical jargon is the safer route for physicians to follow. When health care providers use medical jargon patients can become confused, leading to misinterpretation and frustration (Kreps & Thornton, 1992). Patients also frequently mentioned problems with having their parents in the examining room with them. Most often, parents took the focus away from the pediatric patient. It seemed that these patients wanted more individual attention, including one-on-one talk time with their physicians.

Aside from issues relating to communication, comments dealing with practical issues were significant as well. Patient education appeared to be very important to the subjects in this study. They desired and expected thorough explanations regarding their diagnoses, prognoses, and treatment. This need for complete information was not only to
learn more about themselves and their health status but also to lessen their fears that something was seriously wrong with them. Patients looked up to their physicians and perceived them as very knowledgeable educators.

Although communication issues, both interpersonal and general, as well as practical issues were the major themes seen throughout the subjects’ responses to the open-ended questions, it should be noted that subjects also frequently answered “nothing” or indicated that they were unsure of their answer. Most often, these answers were given in response to questions asking about what patients disliked about talking with their doctor and regarding the worst thing about talking with their doctor. While “nothing” or unsure answers reflect positively on the patients' communication interactions with their physicians, these subjects were also able to talk very easily and knowingly about what they liked and disliked in addition to many constructive comments about what could be done better or differently. In other words, those who did contribute a response other than “nothing” or unsure answers were aware of the positive and negative aspects of their medical visit and spoke very passionately.
Chapter 5
Discussion

This study combines both qualitative and quantitative data to analyze pediatric patients’ perceptions of and satisfaction with physician-patient interaction during medical visits. According to Frey et al. (1991), “directive questioning employs closed questions that limit the kinds of answers respondents can provide. Nondirective questioning uses open questions that allow respondents to frame their own answers” (p.193). While information from quantitative data, which uses directive questioning, is extremely useful, using questionnaires alone limits subjects’ abilities to fully express their viewpoints. Yet, if used along with qualitative data, such as answers to open-ended questions, a much broader and clearer picture of the issues at hand can be obtained.

Quantitative Instrument

Overall, results from the quantitative data indicate that the pediatric patients in this study were satisfied to some degree (mean of 3.82 using the 19-item scale and mean of 3.88 using the 12-item scale out of 5) with their medical visit. While this is valuable information, its application can be limited in some ways. Still, the child satisfaction questionnaire used for this study was easy to administer and provided a reference point for the pediatric patient’s perspective from which medical visits can still be evaluated and improved.

Although a correlation was found between age (young) and dissatisfaction when including negatively worded items in the measurement used for this study, these results do not support the findings of Bachanas and Roberts (1995), which revealed that younger
children rated health care personnel, procedures, and settings as more approachable and reported liking them more than older children. Using only the 12-item scale, the current research project found no relationship between age and satisfaction. Even when using the full 19-item scale, it is the younger children who appear to be less satisfied with their visit to the doctor, and as mentioned above, it is suggested that this is due to their inability to understand the negatively worded items on the 19-item scale.

As Pantell and Lewis (1986) stated, past studies by Korsch et al. (1968), Foye et al. (1977), and Arnston (1982) show differences in communication patterns depending on the type of pediatric medical visit. Results from the current research project do not support these findings. Satisfaction did not vary as a function of the reason for the visit. However, this result is supported by a study by Pantell (1980) in which a uniform methodology was used at a single site; no differences in interaction patterns were found between children being seen for different reasons. Studies by Korsch et al. (1976) and Arnston (1982) were also identified by Pantell and Lewis (1986) as having compared initial visits to later visits and documented different patterns of interaction. This may relate to the current project, as it was found using data from the 12-item scale that subjects who had been to the doctor more often in the past year reported being less satisfied with their visit as compared to those who had visited the physician less frequently. This suggests that patients who encounter the doctor more frequently may have higher expectations of the physician-patient interaction.

Quantitative results did not indicate any relationships between patient sex, parent sex, or physician sex and satisfaction. Bernzweig et al.’s (1997) findings revealed a connection between the gender of the physician and the communication with the children
during the medical visits, and Ginsburg et al. (1997) supported this as well. These results could not be duplicated in the current project because only one of four physicians used in this study was male.

Qualitative Analysis

To summarize the qualitative results (see Table 2 above), when one considers pediatric patients' positive perceptions of communicating with their physicians, the patterns found from Question 1 and Question 3 suggest that these subjects were concerned with both interpersonal communication issues and practical issues. Combining these categories accounted for 69% and 65% of responses to Questions 1 and 3, respectively. Subjects gave unsure responses in a large number (15%) of their answers to these questions. Hence, relating to interpersonal communication issues, the subcategories of physician listening, creation of a positive climate, patient disclosure about non-health topics, physician comforting strategies, and attention by the physician were all very important. Relating to practical issues, the subcategories of learning about health issues, receiving medical information, learning about themselves, and finding out how to get well were also significant.

Pediatric patients' more negative perceptions of communicating with their physicians can be summarized by looking at patterns found in their responses to Question 2 and Question 4. These patterns suggest that the majority of subjects did not have or were unsure about any negative aspects. Combining these two categories for each question accounts for 56% and 62% of responses, respectively. However, concern about practical issues seem to be strong, as this category accumulated 20% and 29% of responses for Questions 2 and 4. Thus, regarding practical issues, the substantial
subcategories were the following: fear of something wrong, discussing personal issues, physical exams, shots, physician disclosure to parents, dislike of diagnosis, discussion of sensitive topics, worries about illness, change in regimen, and taking blood pressure.

Question 5 and Question 6 involve pediatric patients' suggestions for improving the communication between themselves and their physician. For these two questions, patterns indicate that these patients are fairly content, as 46% of answers to Question 5 and 60% of answers to Question 6 were unsure or suggested no improvements. Still, general communication issues seem to be important, as this category accounted for 25% and 33% of responses for Questions 5 and 6, respectively. Interpersonal communication issues were also identified in a significant number of responses (18%) to Question 5. Therefore, the subcategories relating to general communication issues—physicians' use of less technical language, less parent communication with the physician, physicians' expansion of explanations, and physicians' use of more eye contact—were viewed as important to subjects. Regarding interpersonal communication issues, the subcategories of continual care, patients' friendliness, more patient disclosure about non-health topics, and more time for the medical visit were significant.

Comparison of Quantitative and Qualitative Results

By combining information gained from both quantitative and qualitative results, similarities and differences can be seen. Just as the Child Satisfaction Questionnaire (Rifkin et al., 1988) revealed that subjects were generally satisfied with physician-patient interaction during their medical visits, so too did responses to the open-ended questions reveal similar levels of satisfaction. Fifty-six percent (56%) of the subjects that answered Question 2, which asked about their dislikes, said either “nothing” or that they were
unsure. In addition, the most frequent responses to Questions 4 and 5, which asked about suggestions for improvements, revealed that subjects were unsure (31% for Question 4) or that they had no suggestions for improvements (36% for Question 5). Still, unlike those of the Child Satisfaction Questionnaire, answers to the open-ended questions were nondirected and therefore enabled subjects to say as much as they wished concerning the issues about which they felt strongly. Hence, even though it appears from the quantitative data that these pediatric patients were generally satisfied, support for this satisfaction, as well as additional information regarding pediatric medical encounters and physician-patient interaction, can be extracted if qualitative data is used.

Additionally, much can be learned from looking at the individual items on the Child Satisfaction Questionnaire and comparing them to results of the open-ended questions. Most of the items of the CSQ match the comments from various subjects offered in response to the open-ended questions. Yet, with the open-ended questions, subjects were able to expand upon and more completely describe how and why they felt the way that they did. For example, one item on the 19-item CSQ reads, “This doctor used words I did not understand.” This item matches subjects’ responses to Question 2 and Question 5 of the open-ended questions that explain their thoughts regarding physicians’ use of less technical language in more detail: “Sometimes they say words I don’t understand. . .really long, scientific words;” “If it wasn’t so technical. Like everything, well most of the stuff is, like, words that I don’t know what it means;” and “Not using such big words, I mean kind of explaining them just a little because they’re so complicated sometimes.” A second item from the questionnaire reads, “When I was done seeing the doctor, I felt better about my health.” Subjects’ answers to Question 3 that
related to this item regarding interest in learning about health were the following: “Just knowing that I’m healthy and what I’m doing is working” and “He told me what was wrong with me and how to fix it.” This last comment, regarding patients’ concerns about finding out how to get well, in addition to “The best thing was talking about how to do my medicine better” also relate to the item on the Child Satisfaction Questionnaire that reads, “This doctor helped me learn how to take care of myself.”

The item that reads “The doctor I saw today helped me feel calm” is supported by answers to Question 3 regarding physician comforting strategies that said the following: “Him telling me that it wouldn’t hurt that much” and “He made me feel a lot calmer because I had to get a shot.” Relating to an item from the CSQ that reads, “The doctor asked me questions about the things I like to do,” one subject said, “I think that if a doctor doesn’t do that, you know, it’s kind of like she comes in and does her thing and then leaves. But my doctor, she comes in and asks you what you’re doing.” This was in response to Question 5 of the open-ended questions, regarding more patient disclosure about non-health topics. Another item from the questionnaire reads, “When I was with the doctor, the grown-ups talked so much it was hard to say anything.” Some subjects were able to expand upon this with their answers to the open-ended questions regarding the amount of parent communication with the physician. For instance, in answering Question 5 one subject said, “I find that it’s easier when my mom’s not there just because she seems to usually take over the conversation and then it’s not about me anymore.”

As these examples show, pediatric patients can contribute significant comments concerning what they like and dislike about their medical visits. Although these subjects are young, they are able to recognize important communication and practical issues that
also affect adults during their medical encounters. With such descriptive comments by pediatric patients, health care providers can take better aim at the improvements needed to make going to the doctor as comfortable and productive as possible.
This study demonstrates the value of adopting more than one method of data collection. Findings from both quantitative and qualitative data are extremely valuable. During routine office visits, pediatric patients are generally satisfied with their medical encounters but are able to offer numerous comments regarding their visits when given the opportunity to share. This study helps clarify those issues that are important to pediatric patients. The results indicate that these patients are concerned with interpersonal and general communication issues, along with the practical issues involved in a medical encounter. Using open-ended questions to gather qualitative data yielded information that reflects the voices, concerns and expectations of pediatric patients as health care consumers. Above all, this study illustrates that pediatric patients are not passive recipients of care. They actively interpret interactions and evaluate the communication exchange.

Limitations to the Present Study

Although the findings from the current study have important clinical implications, there are several limitations to this study. Many of these limitations represent opportunities for further study, which will be addressed in the following section.

First, although a sample size of 55 is significant, results can better be generalized using a larger sample. Second, the sample used was not a random sample, as subjects were recruited only on days that the researcher was available. In addition, patients were
recruited on a volunteer basis, so those subjects who chose to participate may bias the randomness of the sample.

Third, none of the participants in this study were seriously ill. Depending on the severity of a patient’s illness, the communication that occurs during a medical visit between physician and patient can be very different (Buller & Buller, 1987). Therefore, patients with serious illnesses may perceive their medical encounters quite a bit differently from patients seen for more minor problems.

Fourth, although patients involved in this study were fairly equal in relation to the number of male versus female participants, patients only encountered one male physician out of a total of four physicians that were available. This eliminated the opportunity to explore relationships between satisfaction and the sex of both patients and physicians.

Fifth, the physicians involved in this study also did not differ in regards to their ethnicity. All were European American, which eliminated the possibility of comparing satisfaction and the ethnicity of physicians and patients.

Sixth, because the open-ended questions were initially established and meant to be the same for all subjects, valuable information may have been lost due to the researcher’s inability to ask more probing questions relating to comments made by the participants.

Seventh, many of the youngest subjects had trouble understanding the questions they were being asked, both quantitatively and qualitatively. Their limited understanding did not allow for their thoughts to be fully expressed.

Implications for Further Research

Future studies should address all of the limitations discussed above. Studies of physician-patient relationships and communication should continue to focus on the
pediatric patient. In order to gain a clear understanding of the perspective of youth.

Further study into the insights and beliefs of pediatric patients regarding their medical care is necessary to define their expectations and attitudes.

Further research would also help to formulate and fine-tune questions to be used that would maximize pediatric patients' responses. Such questions would add to our knowledge base of their needs and preferences.

Because the 19-item child satisfaction questionnaire that was used to obtain quantitative data was set up so that all of the positively worded items belonged to the physician-patient rapport subscale and all of the negatively worded items belonged to the physician communication subscale, further study could mix these two subscales so that they are not strictly either positively or strictly negatively worded. This would eliminate the confusion as to whether endorsement is related to the issues of positively or negatively worded questions or to actual agreement with the content of each item.

Implications for Physicians

For practitioners who treat pediatric patients, numerous practical applications can be extracted from the current findings. First, physicians can listen therapeutically to their patients and create a positive climate in which patients feel safe and comfortable.

Second, physicians can ask their patients about non-health topics such as what they like to do or what they are doing for summer vacation. Third, physicians can talk at their patients' level, using terms, words, and concepts that are more easily understood. Fourth, because patients like to be acknowledged and attended to, physicians can make a special effort to address the pediatric patient and include him or her in the communication exchange. Fifth, because such situations are often delicate, physicians can be especially
sensitive with their patients when discussing personal issues and performing physical examinations. Sixth, during uncomfortable procedures or discussions, physicians can use comforting words to calm patients. Seventh, physicians can give thorough explanations regarding their patients' health to enable patients to learn more about themselves and their health status.
References


Appendix A

1. I got along with this doctor.
A. not at all  B. very little  C. some  D. a lot  E. really a lot

2. The doctor explained things s/he did to me during the checkup.
A. not at all  B. very little  C. some  D. a lot  E. really a lot

3. I could talk to the doctor like a friend.
A. not at all  B. very little  C. some  D. a lot  E. really a lot

4. This doctor helped me learn how to take care of myself.
A. not at all  B. very little  C. some  D. a lot  E. really a lot

5. The doctor let me say how I felt about the things s/he did to me.
A. not at all  B. very little  C. some  D. a lot  E. really a lot

6. This doctor knows what it’s like to be my age.
A. not at all  B. very little  C. some  D. a lot  E. really a lot
7. The doctor asked me questions about the things I like to do.
   A. not at all  B. very little  C. some  D. a lot  E. really a lot
   ○  ○  ○  ○  ○

8. The doctor explained things so I could remember them.
   A. not at all  B. very little  C. some  D. a lot  E. really a lot
   ○  ○  ○  ○  ○

9. The doctor I just saw cared about how I felt.
   A. not at all  B. very little  C. some  D. a lot  E. really a lot
   ○  ○  ○  ○  ○

10. The doctor I saw today helped me feel calm.
    A. not at all  B. very little  C. some  D. a lot  E. really a lot
    ○  ○  ○  ○  ○

11. When I was done seeing the doctor, I felt better about my health.
    A. not at all  B. very little  C. some  D. a lot  E. really a lot
    ○  ○  ○  ○  ○

12. This doctor understood what I was trying to say.
    A. not at all  B. very little  C. some  D. a lot  E. really a lot
    ○  ○  ○  ○  ○
13. When I was with the doctor the grown-ups talked so much it was hard to say anything.

A. not at all  B. very little  C. some  D. a lot  E. really a lot

14. When the doctor explained things I got all mixed up.

A. not at all  B. very little  C. some  D. a lot  E. really a lot

15. The doctor I saw today talked too much.

A. not at all  B. very little  C. some  D. a lot  E. really a lot

16. This doctor used words I did not understand.

A. not at all  B. very little  C. some  D. a lot  E. really a lot

17. This doctor talked about a lot of stuff I did not understand.

A. not at all  B. very little  C. some  D. a lot  E. really a lot

18. It was hard to talk to the doctor I just saw.

A. not at all  B. very little  C. some  D. a lot  E. really a lot

19. It was hard to talk to the doctor about my worries.

A. not at all  B. very little  C. some  D. a lot  E. really a lot
Appendix B

Open-ended Questions

1. What do you like about talking with the doctor? What do you like when your doctor talks with you?

1.5 How important is this to you?

2. What don’t you like about talking with the doctor? What don’t you like when your doctor talks with you?

2.5 How important is this to you?

3. What was the best thing about talking with your doctor today?

4. What was the worst thing about talking with your doctor today?

5. What would help to make talking to your doctor better or easier?

6. What do you wish the doctor would do differently when s/he is talking to you?
Appendix C

Demographic Information

Child’s race: European American/Caucasian  African American  Native American

                     Hispanic American  Asian American  Other

Child’s sex:  Female   Male

Child’s age: _____years_____months

Doctor’s sex: Female   Male

Accompanying parent’s sex: Female   Male   Both parents accompanying child

                     Not child’s parent

Today’s medical visit was a:  Illness visit   Illness follow-up/progress check visit

                                      Well-child visit   Injury visit

Approximate number of medical visits your child has been to in the last year: _____

Was this your child’s usual doctor that he or she saw today?  Yes   No

Did your child receive a shot today?  Yes   No
Appendix D

Figure D1

Mean Scores (19-item)

Patient Age (years)

Figure D2

Mean Scores (negative items)

Patient Age (years)
Mean Scores (12-item)

Number of Medical Visits

Patient Age (years)
Figure Captions

**Figure D1.** Patient age as a function of the mean scores from the 19-item Child Satisfaction Questionnaire.

**Figure D2.** Patient age as a function of the mean scores from the negatively worded items on the 19-item Child Satisfaction Questionnaire.

**Figure D3.** Patient age as a function of the mean scores from the 12-item Child Satisfaction Questionnaire.

**Figure D4.** Number of medical visits in the last year as a function of the mean scores from the 12-item Child Satisfaction Questionnaire.