

# Questionnaire on the Quality of Physician-Patient Interaction (QQPPI)

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The following are a series of statements and assertions concerning today's consultation, including decisions and results. Please indicate to what extent you agree or disagree with these statements.

There are 5 possible responses to the following questions:

1 = "I DO NOT AGREE"

2 = "I PARTLY AGREE"

3 = "I AGREE "

4 = "I STRONGLY AGREE"

5 = "I FULLY AGREE"

Beside each question, please indicate the answer that best reflects the experiences you had in the course of **today's** consultation.

- |   |                            |                            |                            |                            |                            |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 The physician seemed to be genuinely interested in my problems.                                 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 2 The physician gave me detailed information about the available treatment options.               | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 3 I felt I could have trusted the physician with my private problems.                             | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 4 The physician and I decided together on all treatment decisions.                                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 5 The physician's explanations were easy to understand.   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 6 The physician spent sufficient time on my consultation.   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 7 The physician spoke to me in detail about the risks and side effects of the proposed treatment. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 8 The physician understood my needs and problems and took them seriously.                         | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 9 The physician did all he/she could to put me at ease.   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 10 The doctor asked about how my illness affects my everyday life.                                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 11 The doctor gave me enough time to talk about all my problems.                                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 12 The physician respects the fact that I may have a different opinion regarding treatment        | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 13 The physician gave me a thorough examination.  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 14 The physician gave me detailed information about my illness.                                   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |