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Medical Center Staff Attitudes about Spanking

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Abstract

Several medical professional organizations, including the American Academy of Pediatrics, recommend that parents avoid hitting children for disciplinary purposes (e.g., spanking) and that medical professionals advise parents to use alternative methods. The extent to which medical professionals continue to endorse spanking is unknown. This study is the first to examine attitudes about spanking among staff throughout medical settings, including non-direct care staff. A total of 2,580 staff at a large general medical center and 733 staff at a children's hospital completed an online survey; respondents were roughly divided between staff who provide direct care to patients (e.g., physicians, nurses) and staff who do not (e.g., receptionists, lab technicians). Less than half (44% and 46%) of staff at each medical center agreed that spanking is harmful to children, although almost all (85% and 88%) acknowledged that spanking can lead to injury. Men, staff who report being religious, and staff who held non-direct care positions at the medical center reported stronger endorsement of spanking and perceived their co-workers to be more strongly in favor of spanking. Non-direct care staff were more supportive of spanking compared with direct care staff on every item assessed. All staff underestimated the extent to which their co-workers held negative views of spanking. If medical centers and other medical settings are to lead the charge in

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informing the community about the harms of spanking, comprehensive staff education about spanking is indicated.

Keywords

spanking; attitudes; medical staff; medical center

Introduction

Disciplinary hitting of children, typically called “spanking,” remains a common practice among American parents, with 80% of children spanked by the time they reach school age (Gershoff, Lansford, Sexton, Davis-Kean, & Sameroff, 2012). The majority of Americans still approve of spanking, with 65% of women and 76% of men in a 2014 national survey agreeing that children sometimes need a “good hard spanking” (Child Trends Databank, 2015). Thus, the majority of American parents continue to approve of and to use hitting as a form of discipline (i.e., spanking) with their children.

Despite approval of spanking in the majority of American homes, there are reasons for concern about its continued use. Currently, children are the only people in U.S. society whom it is legal to hit (Gershoff & Bitensky, 2007), and yet they are the most vulnerable to the harm it can cause (Shonkoff et al., 2012). Indeed, spanking and other forms of physical punishment have been linked with a range of negative outcomes for children, including decreased long-term compliance, increased aggression, increased mental health problems, and impaired cognitive ability (Gershoff, 2002; Gershoff & Grogan-Kaylor, 2016). Especially concerning are findings that children who are spanked are at higher risk for physical abuse. One large study in North Carolina found that parents who spanked were almost three times as likely to engage in abusive behaviors, such as kicking, beating, and hitting with objects, than were parents who did not spank (Zolotor, Theodore, Chang, Berkoff, & Runyan, 2008). In another study, parents who spanked their 1 year olds were 36% more likely to have involvement with child protective services before their children turned 5 than were parents who did not spank (Lee, Grogan-Kaylor, & Berger, 2014). Reviews of maltreatment records in Canada have revealed that 75% of substantiated cases of physical abuse start out as spanking (Durrant, Trocmé, Fallon, Milne, Black, & Knoke, 2006). Spanking is consistently linked with harm to children and is not effective at promoting positive child behavior (Gershoff & Grogan-Kaylor, 2016).

The medical community has attended to these research findings and three medical professional organizations have issued policy statements arguing that parents should avoid spanking and that medical professionals advise parents to use alternative methods: the American Academy of Pediatrics (AAP; 1998, 2014), the American Academy of Child and Adolescent Psychiatry (AACAP; 2012), and the National Association of Pediatric Nurse Practitioners (NAPNAP; 2011). In addition, in its statement calling for the abolition of corporal punishment in schools, the American Medical Association (AMA; 1985/1995/2005/2015) stated that it “encourages physicians to work toward the abolition of corporal punishment in their communities,” which would seem to include in homes as well.

However, whether individual medical professionals' own attitudes are in line with these guidelines is unknown, as there have been no recent studies of their attitudes, and most studies have been solely of physicians. A 1992 survey of 1,200 Ohio physicians found that 70% of family physicians and 59% of pediatricians supported spanking as an appropriate response to a child's misbehavior (McCormick, 1992). In a survey of child abuse pediatricians in 1996, support was much lower, with only 39% agreeing that spanking was appropriate in certain contexts (Fargason, Chernoff & Socolar, 1996). The most recent study of physician attitudes was conducted in 1998 by the AAP Division of Child Health Research; among the 603 pediatric fellows surveyed, 67% supported the use of spanking by parents generally or in certain circumstances (AAP, 1998). Thus, as of 18 years ago, the majority of pediatricians were accepting of spanking, at least in some circumstances. The only recent study of physician attitudes about spanking asked if they considered it to be "harsh discipline" at particular child ages based on community standards, and although nearly all thought spanking a child on the buttocks with a hand was harsh for children under 1 year, only around 45% of physicians thought spanking was harsh when used with 3 to 10 year olds (Block et al., 2016).

Studies of spanking attitudes among medical professionals other than doctors are rare. One study of 882 nurses and nurse practitioners found that 40% perceived spanking as "sometimes necessary," although 77% agreed that spanking can become abuse (Hornor et al., 2015). A second study was a survey of all members of the American Professional Society on the Abuse of Children, the majority of which were physicians, nurses, counselors, and social workers. Among the 565 participants in this survey, 74% agreed or strongly agreed that spanking is harmful to children while 82% agreed that spanking is a maladaptive disciplinary technique (Taylor & Lee, 2015). We are aware of no other studies of spanking attitudes among direct care staff.

Medical professionals' attitudes about spanking are important to understand because parents trust medical professionals as sources of parenting advice (Taylor, Moeller, Hamvas, & Rice, 2013) and report stronger support for spanking if they believe the professionals they consult, including physicians, have positive attitudes about spanking (Taylor, Hamvas, Rice, Newman & DeJong, 2011). Attitudes about spanking are also important because they affect the likelihood that staff will recognize and report physical abuse. A study with students training to be nurses or teachers, and thus future mandated reporters of maltreatment, found that the more positive their attitudes were toward spanking, the less likely they were to recognize certain behaviors, such as pinching or burning a child with a hot object, as being abusive (Bluestone, 2005).

Beyond physicians and nurses, it is also important to understand the spanking attitudes among other staff in medical settings, including those who do not provide direct care to children and families. Non-direct care staff may directly or indirectly communicate support for spanking to parents: for example, by endorsing a parent's passing comments in favor of spanking or by failing to intervene when a parent hits a child in a medical setting waiting room. Previous research has found that staff who do not provide direct care to patients (e.g., custodians, receptionists, lab technicians) are half as likely to intervene if they witness parents hitting children in a medical center than are staff who provide direct care to patients

(e.g., physicians, nurses, therapists, social workers) (Font et al., 2016). This failure to intervene may reflect more favorable attitudes about spanking but there are no existing data on this issue. The current study is the first to examine the spanking attitudes of staff in medical settings who do not provide direct care to patients.

In an effort to understand the current spanking attitudes of staff in medical settings, the present study surveyed staff throughout two medical centers, one general hospital and one children's hospital. The goal was to address the following research questions: What are current medical staff attitudes about spanking? What are their perceptions of their coworkers' attitudes? Are these attitudes predicted by any demographic characteristics or by whether staff members have a direct care or non-direct care role at the hospital?

METHOD

Procedure

All staff members at a large general medical center in Wisconsin and at a children's hospital in Missouri were invited to participate in a voluntary online survey. Survey participation was anonymous, and responses were not linked to staff identities in any way. Participants were instructed that by clicking forward from the introductory page, they were indicating their consent. Study procedures were approved by the institutional review boards of each hospital and of the University of Texas at Austin.

Participants

Characteristics of each sample are presented in Table 1. A total of 2,580 staff at the general medical center completed the survey, as did 733 staff at the children's hospital, which represents 39% of the general hospital staff and 10% of the children's hospital staff. However, due to missing data on key variables (e.g., job type), we excluded 400 participants from the general medical center and 24 from the children's hospital, resulting in a final sample of 2,889. Majorities of the participants at both sites were female (85% at both), White (96% and 80%), and college graduates or higher (63% and 74%). At the general medical center, 30% of the sample were nurses (n = 645), 2% were doctors (n = 42), 23% were other staff who provided direct care to patients (e.g., physical therapists, care assistants; n = 502), and slightly less than half (n = 991; 45%) were staff who did not provide direct care (e.g., custodians, receptionists, medical records staff, lab technicians). At the children's hospital, slightly more than a third (34%) of the sample were nurses (n = 243), 11% were doctors (n = 75), 18% were other staff who provided direct care to patients (e.g., physical therapists, care assistants; n = 126), and 38% (n = 265) were staff who did not provide direct care (e.g., custodians, receptionists, medical records staff, lab technicians). In the general medical center sample, 41% worked in outpatient care, 24% in inpatient care, 3% in the emergency department, and 33% in other settings; in the children's hospital sample, 23% worked in outpatient care, 36% in inpatient care, 8% in the emergency department, and 33% in other settings. Majorities of the staff at each site reported that they were parents and that they were religious.

Measures

Independent Variables—Several self-reported demographic characteristics were used as predictors of staff attitudes about spanking: if female; if White; age; education level; if a parent; and if very or somewhat religious. An additional predictor was whether the staff member's position involved direct care or not; nurses, physicians, and others who provided direct care to patients were grouped into "direct care" while other medical center staff were grouped into "non-direct care." Subgroup sizes for each medical center sample are included in Table 1.

Dependent Variables

Personal attitudes toward spanking: Staff responded to nine items about their own beliefs about spanking. Five items were taken from the *Attitudes toward Spanking* scale (Holden, Coleman, & Schmidt, 1995). Four additional items were created for this survey. All items were rated on a scale from 1 ("strongly disagree") to 5 ("strongly agree"). The nine items together had good internal consistency, $\alpha = .90$. In the regression analyses, a scale combining these nine items was used as the outcome measure. Subsequent analyses examined dichotomous versions of individual items where "agreed" and "strongly agreed" were combined into a single group and compared with those who "neither agreed nor disagreed", "disagreed", or "strongly disagreed."

Perceived co-worker attitudes toward spanking: Four items from the *Attitudes Toward Spanking* (Holden et al., 1995) scale were rewritten so that each began with the phrase, "My coworkers think that…" in order to tap perceptions about co-workers' attitudes about spanking ($\alpha = 89$).

Analyses

For the analyses described below, we first used linear regression models to examine the associations between our composite outcomes (attitudes toward spanking and perceived coworker attitudes toward spanking) and the demographic and employment characteristics of the respondents. We then examined differences between direct care and non-direct care staff in their responses to the individual items contained in the two composite scales. For the individual item comparisons, we used dichotomized versions of the items (agree or strongly agree vs. all other responses). To identify the statistical significance of differences by direct care status, we used chi-squared tests.

RESULTS

Medical center staff on average reported ambivalent attitudes about spanking. Few staff reported strong favorable attitudes. For example, only 16% at the general medical center and 15% at the children's hospital agreed that "Sometimes, the only way to get a child to behave is with a spank," and only 9% and 6% of staff at the two centers agreed that spanking has "no negative effects" on children. Yet, while 85% and 88% of staff at the two medical centers acknowledged that spanking can lead to injury, less than half (44% and 46%) agreed that "spanking is harmful to children." A third (32% and 35%) of each sample agreed that it

was “parents’ right to spank their children,” and slightly more than half of staff (57% and 58%) acknowledged that “spanking is a form of hitting children.”

Table 2 presents results from regression models predicting staff members’ own positive attitudes about spanking (see columns 2 and 4). In both samples, women were less supportive of spanking than men (βs = −.18, $p < .001$, and −.11, $p < .01$). Older staff (age 46 and above) were less supportive of spanking than were staff in the 18 to 24 year range at the general medical center, but there were no age differences at the children’s hospital. Staff with some college, but without a college degree, at the general medical center were more likely to endorse spanking than were staff with a high school degree or less (β = .10, $p < .05$). Among staff at the children’s hospital, staff with a professional degree were less likely to endorse spanking (β = −.21, $p < .01$). Staff at both medical centers who reported being religious endorsed spanking more than did staff who were not religious (β = .08, $p < .001$, and β = .09, $p < .05$), while staff at the general medical center who are parents were less supportive than were staff who were not parents (β = −.08, $p < .001$). Direct care staff were significantly less likely to endorse spanking than were non-direct care staff at both medical centers (β = −.11, $p < .001$, and β = −.09, $p < .05$).

Two separate regression models predicted staff perceptions of their co-workers’ attitudes about spanking (see columns three and five in Table 2). Women perceived their co-workers to be less supportive of spanking than did men (β = −.18, $p < .001$, and β = −.11, $p < .01$). At the general medical center, staff aged 56 and older perceived their co-workers to be less supportive than did staff aged 18 to 24 (β = −.12, $p < .01$), and staff with some college or with a college degree reported their co-workers as more supportive than did staff with a high school degree or less (βs = .11, $p < .01$). Parent status and religiosity did not predict coworker attitudes at either medical center, but type of position did: direct care staff perceived their co-workers as being less supportive of spanking than did non-direct care staff (β = −.11, $p < .001$; β = −.14, $p < .01$).

Given that whether a staff member’s position involved direct care or not was a significant predictor of personal and perceived coworker attitudes across both sites, we proceeded to explore potential differences between these groups at the item level. As seen in Table 3, direct care and non-direct care significantly differed on every item tapping their own attitudes about spanking among staff at the general medical center and on 7 of the 9 items among staff at the children’s hospital. In each case, direct care staff had less favorable attitudes toward spanking than did non-direct care staff. Similarly, direct care staff members were more likely to perceive that their co-workers had unfavorable attitudes about spanking than were non-direct care staff; this was true across all four items and across both sites.

DISCUSSION

Parents’ use of disciplinary hitting, such as spanking, has increasingly come under criticism. It has been condemned as a form of violence by the United Nations (U. N. Committee on the Rights of the Child, 2006) and has been actively discouraged by three major medical professional organizations, namely the AAP (1998, 2014), the AACAP (2012), and NAPNAP (2011), and has been indirectly discouraged by the AMA (1985/1995/2005/2015).

Given that one of parents' most trusted sources for parenting advice is medical professionals (Taylor et al., 2013), professionals in medical settings are poised to communicate the risks of spanking to parents and to encourage them to use alternative disciplinary techniques. However, this will likely only be possible if the professionals themselves hold unfavorable attitudes about spanking.

The goal of the present study was to understand the extent to which medical staff members endorse spanking and whether these attitudes are systematically related to any staff demographic or job characteristics. Results revealed substantial ambivalence in spanking attitudes. Although only small proportions of both direct care and non-direct care staff at each medical center felt spanking was sometimes necessary to discipline children (13% – 20%), a majority of the staff at both medical centers agreed that spanking is a form of hitting children (51% – 61%) and did not agree that spanking is harmful to children (51% – 62%), with non-direct care staff significantly less likely than direct care staff to endorse either of these attitudes. Direct care staff were equally split in whether they thought spanking is harmful (50% at each hospital); it is clear that many direct care staff do not view spanking as a problematic behavior. In general, staff agreed that spanking is not necessary but appeared reluctant to pass judgment that it is wrong for parents to spank. These results suggest that the evidence on the harmful effects of spanking children has not been widely disseminated to or accepted by the medical community.

An unexpected finding was that direct-care medical staff displayed a "pluralistic ignorance" (Miller, Monin, & Prentice, 2000) about their coworkers' spanking norms, such that they underestimated the actual percentage who held negative attitudes about spanking. At both medical centers, direct care staff were much less likely to say that their colleagues thought spanking was a bad disciplinary technique than the actual percentage who held that belief (39% vs 58%, and 42% vs 56%). Similarly, 50% at each center believed spanking is harmful for children, and yet substantially fewer direct care staff members (37% & 41%) thought their co-workers feel the same way. Non direct care staff also underestimated the extent to which their colleagues thought spanking was bad (28% vs 47%, and 32% vs 41%) or harmful (27% vs. 28%, and 30% vs 39%). The fact that staff consistently underestimate negative spanking attitudes among their co-workers may discourage them from voicing their own attitudes. It may also lead to a bystander effect, whereby staff members fail to act when parents spank their children in a medical settings because they worry their choice will not be supported by others around them.

There are several potential avenues for interventions to reduce support for spanking among medical setting staff. The findings suggest that a substantial proportion of medical staff do not view spanking as harmful to children and are either unaware of or discount research findings regarding the potential harms to children that have been linked with spanking (Gershoff & Grogan-Kaylo, 2016; Lee et al., 2014; MacKenzie, Nicklas, Waldfogel, & Brooks-Gunn, 2012; Zolotor et al., 2008). Thus, a first strategy would be to educate staff by summarizing and disseminating the large body of research findings that link spanking to increased risks of physical and emotional harm to children (e.g., Gershoff & Grogan-Kaylor, 2016). An example of such a research summary is one commissioned by Phoenix Children's Hospital that is posted on their website for staff and patients to access (Gershoff, 2008).

Distributing brief and digestible research summaries such as this one to staff may help change attitudes about spanking.

Second, medical center administrations could directly educate their staff about the spanking policy statements by AAP, AACAP, AMA, and NAPNAP. It is likely many staff, and especially non-direct care staff, are unaware that prominent medical professional organizations have issued policy statements on spanking and child discipline. Brief educational interventions that increase awareness of these policies may help reduce attitudinal support for spanking among medical staff.

Third, medical centers could engage in universal, center-wide interventions by instituting policies that take clear stands against spanking. An example of such a policy intervention is a No Hit Zone which prohibits any hitting within a medical center, including parents spanking children (Frazier, Liu, & Dauk, 2014). Upon implementation of a No Hit Zone, staff members are trained in the potential harms to children of spanking and in responsibilities to and ways of intervening if staff witness parents hitting their children in the medical center. One in four staff have observed parents hitting children within a medical center setting (Font et al., 2016), and thus an institutional policy and staff training could equip staff with information and skills to intervene. A No Hit Zone policy would provide all staff a consistent message against spanking, which would counteract the problem of staff overestimating how much their colleagues support spanking. No Hit Zones have yet to be evaluated but are a promising means of educating both staff and patients about the potential harm of spanking.

Fourth, embedding a “social norms approach” within any one of these intervention strategies might also be helpful in educating direct-care medical staff that they are in fact in the majority in believing that spanking is harmful for children. This kind of approach has been helpful in changing community norms regarding other public health problems such as sexual violence, violence against women, and binge drinking (Berkowitz, 2007; Fabiano, Perkins, Berkowitz, Linkenbach, & Stark, 2003; DeJong et al., 2006). By providing staff members accurate information about their co-workers’ attitudes about spanking, an intervention focused on social norms could be a first step in increasing staff members’ willingness to discuss spanking with parents and to intervene when parents hit children.

This study has several strengths which are balanced by a few weaknesses. This is the first effort of which we are aware that assessed spanking attitudes among all types of staff at a single institution, and as such is the first survey of attitudes among non-direct care staff in a medical setting. A key weakness of the study is that there was a low response rate among physicians at each medical center, and thus our results may not be an accurate representation of their attitudes. The relatively few physicians in the sample is a limitation because physician attitudes about spanking are strongly predictive of parents’ own attitudes about spanking (Taylor et al., 2011, 2013). That said, the 117 physicians in our study is larger than that in a recent published survey of physician attitudes (n = 73; Block et al., 2016). The children’s hospital also had a low response rate; and yet the results from that sample were very similar to those from the general hospital. An additional weakness is that both medical centers were located in the Midwest, which limits their generalizability to medical staff

across the country. However, national survey data indicate that attitudes about spanking in the Midwest are at the average for the country (Enten, 2014) and thus may in fact be fairly representative of staff nationally. Finally, staff members were not asked if they were aware of the policy statements by AAP, AACAP, AMA, and NAPNAP. This information would have been helpful for recommending future interventions, but it awaits future research.

Results from this study indicated that support for spanking remains fairly widespread among the medical staff community and especially so among non-direct care staff. If health care professionals are to lead the charge in informing the public about the harms of spanking, staff education about the risks associated with spanking and about how to talk with families in medical settings about age-appropriate discipline could be important avenues for reducing spanking among the families and communities that they serve.

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Table 1

Demographic characteristics of both samples.

	General medical center, full sample *n* = 2,180	**Children's hospital, full sample *n* = 709**
Female	1835	590
Male	327	105
White	2090	566
Non-White	90	143
18 to 24 years	130	59
25 to 35 years	558	251
36 to 45 years	469	173
46 to 55 years	583	108
56 years and above	431	111
High school or less	158	55
Some college	627	129
College degree	1051	289
Professional degree(e.g., MA, MD, JD, PhD)	329	228
A parent	1420	497
Not a parent	748	203
Religious	1822	589
Not religious	330	113
Direct care staff position	1189	444
Non-direct care staff position	991	265

Note. Not all subgroups add to the full sample *n*s because of missing data.

Table 2

Composites of staff members' own positive attitudes about spanking and perceptions of coworker attitudes regressed on demographic characteristics and whether staff position involves direct care.

	General medical center sample		Children's hospital sample	
	Personal spanking attitudes	**Perceived coworker attitudes about spanking**	**Personal spanking attitudes**	**Perceived coworker attitudes about spanking**
Female (reference group: male)	**−0.18***** (0.05)	**−0.12***** (0.05)	**−0.11**** (0.08)	**−0.08*** (0.08)
White (reference group: non-White race or ethnicity)	−0.02 (0.09)	−0.03 (0.09)	−0.08 (0.08)	−0.02 (0.08)
Age (reference group: 18–24 years)				
25–35 years	0.04 (0.07)	0.01 (0.08)	0.10 (0.11)	0.10 (0.120)
36–45 years	0.01 (0.08)	0.01 (0.08)	0.11 (0.13)	0.07 (0.13)
46–55 years	**−0.09*** (0.07)	−0.07 (0.08)	0.03 (0.13)	0.02 (0.14)
56+ years	**−0.14***** (0.08)	**−0.12**** (0.08)	−0.08 (0.13)	−0.04 (0.14)
Education level (reference group: high school or less)				
Some college	**0.10*** (0.07)	**0.11**** (0.07)	0.02 (0.12)	−0.04 (0.12)
College degree	0.06 (0.07)	0.**12**** (0.07)	0.02 (0.12)	0.05 (0.13)
Professional degree (e.g., MA, MD, JD, PhD)	0.00 (0.08)	0.05 (0.08)	−0.**21**** (0.12)	−0.13 (0.13)
Parent (reference group: never a parent)	**−0.08***** (0.04)	−0.01 (0.04)	−0.01 (0.07)	−0.01 (0.07)
Religious (reference group: not at all religious)	**0.08***** (0.04)	0.01 (0.05)	**0.09*** (0.07)	0.01 (0.08)
Direct care staff position (reference group: not direct care)	**−0.11***** (0.03)	**−0.11***** (0.04)	**−0.09*** (0.06)	**−0.14**** (0.07)

Note: Standard errors are in parentheses. Sample *n* varies across item due to missing values: general medical center *n* ranges from 2090 to 2114; children's hospital *n* ranges from 655 to 664.

* $p < .05$;

** $p < .01$;

*** $p < .001$.

Table 3

Percent of staff who agreed with each statement about spanking by whether their positions involve direct care.

	General medical center			Children's hospital		
	Direct care staff	**Non-direct care staff**	**χ^2 test**	**Direct care staff**	**Non-direct care staff**	**χ^2 test**
Own attitudes about spanking						
It is sometimes possible that spanking a child can lead to an injury.	89.2	80.0	**38.1*****	90.3	82.5	**9.0****
There are better ways to discipline a child than to spank them.	79.2	68.4	**34.1*****	81.6	67.1	**14.4*****
Spanking is a form of hitting children.	61.4	51.4	**22.9*****	60.8	54.6	2.7
Overall, I believe spanking is a bad disciplinary technique.	57.6	46.6	**27.9*****	55.7	41.1	2.3
When all is said and done, spanking is harmful for children.	49.5	37.6	**33.4*****	50.1	39.2	**7.2****
I believe it is the parents' right to spank their children if they think it is necessary.	27.9	36.5	**19.4*****	33.3	38.9	**8.1****
Spanking is a normal part of parenting.	15.4	24.6	**30.3*****	18.6	27.3	**7.5****
Sometimes, the only way to get a child to behave is with a spank.	12.9	19.4	**17.6*****	13.0	20.4	**19.7*****
There are no negative effects of spanking or physical punishment.	7.2	11.0	**10.2****	4.3	9.1	**6.5***
Co-worker attitudes about spanking						
Most of my co-workers think that spanking is a bad disciplinary technique.	39.3	28.4	**30.1*****	42.0	32.3	**6.5***
Most of my co-workers think that spanking is harmful for children	36.5	26.7	**25.3*****	40.5	29.8	**8.1****
Most of my co-workers think that spanking is a normal part of parenting.	18.6	24.8	**13.2*****	17.9	24.2	**4.1***
Most of my co-workers think that sometimes the only way to get a child to behave is with a spank.	14.3	18.9	**8.9****	11.4	20.6	**11.0****

Note: Sample *n* varies across item due to missing values: general medical center *n* ranges from 2138 to 2170; children's hospital *n* ranges from 685 to 703.

* $p < .05$;

** $p < .01$;

*** $p < .001$.