EDUCATION FOR HEALTH

ORIGINAL RESEARCH PAPER

# Validation of a Turkish Translation of the Communication Skills Attitude Scale with Turkish Medical Students

**H Harlak, Ç Dereboy, A Gemalmaz**

*Adnan Menderes University, Aydýn, Turkey*

***Published:*** *21 April 2008*

**Harlak H, Dereboy Ç, Gemalmaz A**

**Validation of a Turkish Translation of the Communication Skills Attitude Scale with Turkish Medical Students**
***Education for Health*, Volume 21, Issue 1, 2008**

**Available from: http://www.educationforhealth.net/**

## ABSTRACT

**Objective:** In recent years, many medical schools have added communication skills training to their curricula, and some studies have measured medical students' attitudes toward learning communication skills. The Communication Skills Attitude Scale (CSAS) was developed in England; however, there is no scale to measure these attitudes in Turkey. This study aims to adapt and examine the psychometric properties of a Turkish translation of the Communication Skills Attitude Scale in a group of Turkish medical students.

**Methods:** One hundred and seventy nine students from years 1 to 5 in Adnan Menderes University Medical School in Turkey voluntarily participated in the study. Mean age was 19.7 years (±3.8). Factor analysis was conducted to assess construct validity, and Cronbach alphas were calculated to evaluate internal consistency.

**Results:** Exploratory factor analysis confirmed the original structure of the scale as positive and negative subscales, with some modifications. After putting items 8 and 13 into the positive subscale and item 22 into the negative subscale, alphas were calculated as 0.92 and 0.71, respectively. For divergent validity, comparisons showed that groups from training years 1 to 5 differed ($p<0$ .001) in their positive and negative subscale scores.

EDUCATION FOR HEALTH
Change in Learning & Practice. Open Access e-Journal indexed on Medline

**Conclusions:** This study substantiates the validity and internal consistency of the Turkish version of the CSAS and demonstrates that it can be used in future studies and educational evaluations to measure medical students' attitudes towards learning communication skills.

**Keywords:** Communication skills training, medical education, the Turkish Version of the Communication Skills Attitude Scale (CSAS), undergraduate, factor analysis, positive attitude scale (PAS) and the negative attitude scale (NAS).

# Introduction

Communication skills are essential for clinical practice (Lloyd & Bor, 1996). Physicians are expected to interview the patient efficiently and be persuasive toward their health issues (Westberg & Jason, 1996). The doctor's communicative behaviour influences patient outcomes such as their satisfaction, compliance with recommended treatment, and understanding and recall of information (Ong et al. 1995). In a review of communication skills training (Aspergen, 1999), it was found that training is effective with medical students as well as senior doctors. In the recommendations of the British Medical Council (2003) communication skills training was noted to be important in medical education to promote positive patient-physician relationships. Also, communication skills education and empathy are learning objectives proposed by the U.S. Association of American Medical Colleges (1999).

Communication skills are needed for medical practice and can be taught and learned. In recent years many medical schools worldwide have developed curricula in communication skills (Makoul, 2003). In the curriculum of Turkey's Adnan Menderes University Medical School, communication skills training begins with basic communication skills (totalling 30 hours) in training year 1 and continues with clinical communication skills (totalling 26 hours) in year 2. In years 3, 4 and 5 it consists of essential communication skills training for specific situations (totalling 24 hours). Family physicians and social and clinical psychologists teach in the training programme, using interactive techniques, role-playing and small group interactions.

As is required for all aspects of the curriculum in medical schools, it is important for faculty of our school to assess the effects of our curriculum on students' communication skills. In the last 5 years, other researchers have investigated medical students' attitudes toward communication skills learning. Rees and colleagues developed a scale to measure students' attitudes toward communication skills learning, called the Communication Skills Attitude Scale (CSAS) (Rees, Sheard & Davies, 2002). The CSAS has been used in subsequent studies by Rees and other researchers (Rees & Sheard, 2002; Rees & Sheard, 2003; Cleland, Foster & Moffat, 2005; Shankar et al., 2006).

*Communication Skills Attitude Scale*

The CSAS was developed after an earlier qualitative pilot study (Rees & Garrud, 2001) that explored medical students' attitudes toward communication skills learning. The scale consists of 26 items within two subscales, each with 13 items. In subscale I, called the positive PAS scale, the items (item no. 4, 5, 7, 9, 10, 12, 14, 16, 18, 21, 22, 23 and 25) relate to positive attitudes toward communication skills learning, such as statements like "learning communication skills has improved my ability to communicate with patients" (item 10). Subscale II, the negative PAS scale (items 1, 2, 3, 6, 8, 11, 13, 15, 17, 19, 20, 24 and 26), consists of items expressing negative attitudes toward communication skills learning, such as "I don't need good communication skills to be a doctor". All 26 items have response options along a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). In

EDUCATION FOR HEALTH
Change in Learning & Practice. Open Access e-Journal indexed on Medline

Rees' research, it was found that items in the CSAS loaded onto two factors (Rees, Sheard & Davies, 2002). After reversing the response values of items 1 and 22, both the PAS and NAS scores are calculated by summing response values for the 13 items of each subscale. Possible ranges for each score varied from 13 to 65, with higher scores indicating stronger attitudes.

For the internal consistency of the CSAS, Rees et al. (2002) calculated Cronbach alphas of 0.873 for the PAS and 0.805 for the NAS. In a study carried out with students in different years of their medical training, Cleland et al. (2005) calculated alphas between 0.805 and 0.826 for the PAS, and between 0.749 and 0.78 for the NAS.

This study aimed to adapt and examine the psychometric properties of a Turkish version of the CSAS (Rees, Sheard & Davies, 2002) in a group of Turkish medical students.

# Methods

***Participants***

The total number of students in Adnan Menderes University Medical School was 278, with numbers in year 1 to year 5 of 70, 76, 61, 43, and 16, respectively. All were asked to participate in this study. There were 179 respondents (64% response rate), including for years 1 to 5 respectively 59, 35, 42, 27, and 16 respondents. Ninety-seven respondents (54%) were female, 82 (46%) male and their mean age was 19.7 (±3.8) years.

*Procedures*

The study was presented to the Medical School administrators, the Lecturer's Committee for Communication Skills, and it was approved. Before the students completed questionnaires, researchers instructed them, in the class setting, on the purpose of the study. Participation was voluntary and informed oral consent was taken. Students were told that there was no need to write their names on the questionnaire; questionnaires were filled out immediately and returned.

*Instruments*

The CSAS was translated from English into Turkish independently by a social psychologist, a family physician and an English teacher. Together they agreed on a Turkish version of the scale. For the back translation, a similar group (with a sociologist instead of social psychologist) applied the same procedure. After back translation, authors compared the Turkish version and back-translated items, then created a final Turkish version of the scale. Items were left in the same order as in the original, and we used the same 5-point Likert response structure.

The questionnaire also queried students' demographics, including age, sex and year of training.

*Data analysis*

Data were analyzed using Statistical Package for the Social Sciences (SPSS 13.0). We used factor analysis to assess construct validity. Alphas were calculated for the Positive and Negative Attitudes Subscales and Cronbach alphas were determined to assess internal consistency.

EDUCATION FOR HEALTH
Change in Learning & Practice.
Open Access e-Journal indexed on Medline

# Results

The distributions of responses to the CSAS obtained from respondents are shown in Table 1.

**Table 1. Distribution of the students' responses in the Turkish Communication Skills Attitude Scale**

| Item No. | Mean | Std. Dev. | Skewness | Kurtosis | Kolmogorov-Smirnov* |
|---|---|---|---|---|---|
| 1 | 4.29 | 1.00 | -1.71 | 2.69 | .298 |
| 2 | 1.97 | 1.17 | 1.24 | 0.69 | .295 |
| 3 | 2.96 | 1.31 | -0.22 | -0.86 | .206 |
| 4 | 3.51 | 1.24 | -0.57 | -0.82 | .284 |
| 5 | 3.86 | 1.13 | -1.16 | 0.89 | .303 |
| 6 | 2.44 | 1.24 | 0.68 | -0.59 | .282 |
| 7 | 3.16 | 1.18 | -0.47 | -0.65 | .242 |
| 8 | 2.80 | 1.26 | 0.11 | -1.01 | .196 |
| 9 | 3.73 | 1.19 | -0.94 | -0.04 | .312 |
| 10 | 3.48 | 1.18 | -0.68 | -0.13 | .236 |
| 11 | 2.63 | 1.09 | -0.33 | 0.03 | .261 |
| 12 | 3.14 | 1.20 | -0.49 | -0.65 | .233 |
| 13 | 2.97 | 1.05 | -0.53 | 0.33 | .203 |
| 14 | 3.60 | 1.07 | -0.86 | 0.15 | .315 |
| 15 | 2.70 | 1.15 | 0.40 | -0.74 | .244 |
| 16 | 3.70 | 1.04 | -1.05 | 0.97 | .318 |
| 17 | 2.89 | 1.15 | 0.17 | -0.84 | .194 |
| 18 | 3.37 | 1.22 | -0.54 | -0.61 | .260 |
| 19 | 1.97 | 1.05 | 1.23 | 1.09 | .316 |
| 20 | 2.37 | 0.99 | 0.34 | -0.63 | .267 |
| 21 | 3.82 | 1.07 | -0.99 | 0.38 | .315 |
| 22 | 3.27 | 1.32 | -0.24 | -1.21 | .222 |
| 23 | 3.73 | 1.10 | -1.15 | 0.98 | .322 |
| 24 | 2.61 | 1.04 | 0.27 | -0.37 | .285 |
| 25 | 4.04 | 1.10 | -1.35 | 1.37 | .296 |
| 26 | 2.09 | 1.04 | 1.00 | 0.55 | .283 |

- $p<0.01$, Lilliefors Significance Correction

Item means range between 1.97 and 4.29. Standard deviations are similar across items (min. 0.99 and max. 1.32). Skewness values of items 2, 6, 8, 15, 17, 19, 20, 24 and 26 are positive, but negative for other items. The extent of kurtosis found suggests a pattern of non-normality for the scale. We used Kolmogorov-Smirnov to test for normality of the distribution. This confirmed that the distribution of the data differed from normal.

*Exploratory factor analysis*

We conducted factor analysis to examine the scale characteristics of the data. Exploratory factor analysis can be used for confirmatory purposes if factors that emerge are to be the same as those found in previous studies (Gorsuch, 1997). Factor analysis findings of a previous study can be used to anticipate how many dimensions (underlying constructs) will account for most of the variance within data obtained from an instrument when applied in a subsequent study (Stevens, 2002). If our factor analysis of the CSAS yields the same dimensions as the original scale, it would support the construct validity of the scale. Principal components

EDUCATION FOR HEALTH
Change in Learning & Practice.
Open Access e-Journal indexed on Medline

analysis with direct oblimin rotation extracted six factors with eigenvalues over 1 and explained 62.18% of total variance. The more factors extracted the greater the percent of variance in the data "explained" by the factor solution (Tabachnick and Fidel, 1996). However, our purpose in employing exploratory factor analysis was for confirmation, that is, to examine whether the CSAS has two dimensions as suggested by Rees et.al (2002). Therefore, we conducted exploratory factor analysis for principal components extracting two factors using direct oblimin rotation.

Factor analysis showed that the Kaiser-Meyer-Olkin measure of sampling adequacy was 0.91 and Bartlett's test of Sphericity was significant ($p< 0.001$). As these tests were significant, we interpreted the factor analysis results. Two factors explained 43.55% of the total variance. Eigenvalues were 9.44 for factor I and 1.88 for factor 2. The factor loadings of the individual items are shown in Table 2.

**Table 2. Factor loadings of the Turkish CSAS scale items**

| Item no. | Factor I | Factor 2 |
|---|---|---|
| 1 | .762 | .071 |
| 2 | -.692 | .148 |
| 3 | -.421 | .295 |
| 4 | .762 | -.052 |
| 5 | .629 | .063 |
| 6 | -.653 | .424 |
| 7 | .614 | .062 |
| 8 | .292 | .247 |
| 9 | .851 | .105 |
| 10 | .765 | .140 |
| 11 | -.284 | .400 |
| 12 | .759 | .081 |
| 13 | .242 | .139 |
| 14 | .710 | .076 |
| 15 | -.125 | .580 |
| 16 | .654 | .340 |
| 17 | -.033 | .463 |
| 18 | .680 | .085 |
| 19 | -.595 | .254 |
| 20 | .196 | .454 |
| 21 | .819 | .084 |
| 22 | -.248 | .269 |
| 23 | .772 | .196 |
| 24 | -.423 | .365 |
| 25 | .824 | .162 |
| 26 | -.571 | .272 |

EDUCATION FOR HEALTH
Change in Learning & Practice. Open Access e-Journal indexed on Medline

*Internal consistency*

After obtaining PAS and NAS scores, Cronbach alphas and item-total correlations were calculated. Cronbach alphas were 0.65 for the NAS and 0.90 for the PAS. An alpha of 0.70 or greater suggests at least modest reliability (Nunnally & Bernstein, 1994), therefore, the alpha for the NAS subscale was lower than desirable. On the other hand, item-total correlation is accepted as a primary criterion and must be equal to or greater than 0.20 (Nunnally & Bernstein, 1994). For the NAS, all item-total correlations were greater than 0.20 except for items 8 (r=0.08) and 13 (r=0.05). However, we found that these two items correlated better with the PAS scores (r=0.38 and r=0.32, respectively, p<0.01). In the opposite direction, the correlation (r) of item 22 with the PAS was only -0.07, but was 0.24 with the NAS (p< 0.01). Therefore, we added items 8 and 13 to the PAS and item 22 to the NAS. Item 1 was significantly correlated with both the NAS (r=0.52, p<0.01) and the PAS (r=0.75, p<0.01). Because its correlation with PAS was stronger than the one with NAS, we added it to the PAS. After making these changes, there were 11 items in the NAS (2, 3, 6, 11, 15, 17, 19, 20, 22, 24, and 26) and 15 items in the PAS (1, 4, 5, 7, 8, 9, 10, 12, 13, 14, 16, 18, 21, 23, and 25). Alphas were recalculated as 0.71 for new NAS and 0.92 for new PAS. Item-total correlations for both scales are shown in Table 3.

**Table 3. Item-total correlations of the items in PAS and NAS (p<0.01)**

| NAS items | *r* | PAS items | *r* |
|---|---|---|---|
| 2 | 0.639 | 1 | 0.746 |
| 3 | 0.566 | 4 | 0.742 |
| 6 | 0.743 | 5 | 0.629 |
| 11 | 0.494 | 7 | 0.608 |
| 15 | 0.453 | 8 | 0.382 |
| 17 | 0.339 | 9 | 0.841 |
| 19 | 0.602 | 10 | 0.768 |
| 20 | 0.173* | 12 | 0.770 |
| 22 | 0.404 | 14 | 0.715 |
| 24 | 0.537 | 13 | 0.319 |
| 26 | 0.604 | 16 | 0.718 |
| | | 18 | 0.684 |
| | | 21 | 0.801 |
| | | 23 | 0.781 |
| | | 25 | 0.814 |
| | | 13 | 0.319 |

* Correlation is significant at the 0.05 level (2-tailed).

*Comparisons according to year of study*

In order to examine the divergent validity of the CSAS, response values from students of different training years were compared. Divergent validity describes the ability of a measure to yield different mean values between relevant groups (Nunnally and Bernstein 1994). Means obtained in our study are presented in Figure 1. As we had changed the number of items in each subscale, subscale scores were calculated dividing the total score by the number of items in the new scale so that they could be compared with the scores obtained in other studies.

EDUCATION FOR HEALTH
Change in Learning & Practice. Open Access e-Journal indexed on Medline

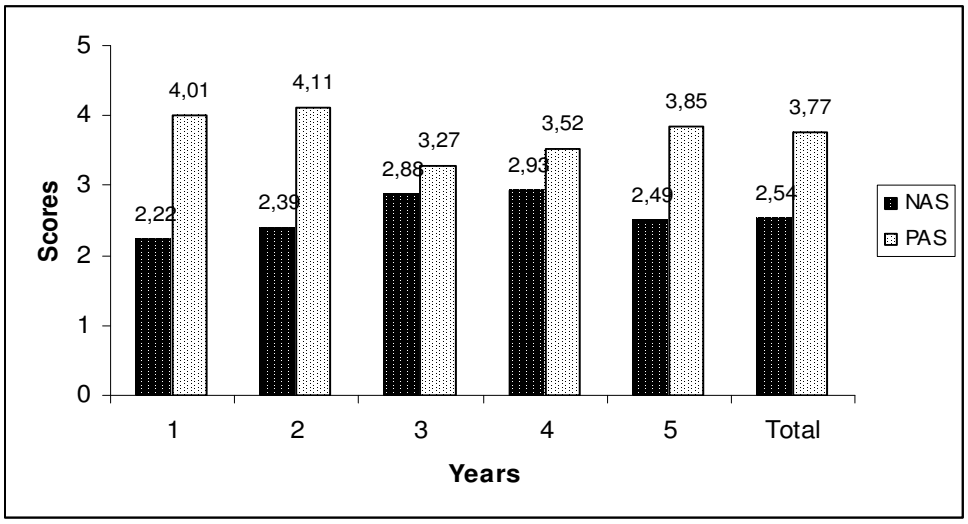


**Figure 1. Mean scores of CSAS Turkish version, by training years 1 to 5.**

The one-way ANOVA comparing the five groups showed that students from different years differed in their PAS scores (F=9.91, df=4,174) and NAS scores (F=15.79, df=4,174) (p<.001). Post-hoc tests (Scheffe) were not significant; however, there were some significant differences among groups (p< 0.01). There is no significant difference in PAS scores between students in years 1 and 2. Year 1 students' PAS scores were significantly higher than year 3 students' scores. Students in year 2 have higher PAS scores than in year 3 and year 4 (p<.05). Thus, students tend to have attitudes that are more positive in years 1 and 2 than in years 3 and 4. In years 4 and 5, positive attitudes toward communication skills learning increase somewhat, but not significantly. With respect to their NAS scores, students in years 1 and 2 did not differ; however, they had significantly lower NAS scores than students in years 3 and 4. Therefore, there is an increasing trend in negative attitudes from years 2 to 4.

# Discussion

This study confirmed that the CSAS is a valid and internally consistent instrument in its Turkish translation. Factor analysis results supported the distinction of the positive and negative attitude subscales made by Rees et al. (2002) and thus validated the CSAS. However, in our study we needed to make modest modifications in the item composition of the subscales. Initially, Rees et al. had put item 1 into the PAS but then, because of their factor analysis results, they moved it to the NAS. This item, in fact, is a positive statement, and therefore, it would be expected to correlate best with other positive attitude items. The reason items 8 and 13 correlated more strongly in our study with the PAS scale and item 22 with the NAS scale might relate to the translation. The English statement of item 13 was that, "communication skills learning is so easy that I do not deign to learn it". However, the Turkish statement did not fully include the same meaning. In reverse translation it was the neutral or slightly positive statement, "communication skills learning is easy".

Internal consistency analysis showed that the reliability of two subscales was adequate. In a different study, Shankar et.al (2006) found relatively lower alpha values (0.774 for PAS and 0.546 for NAS). In that study, however, a group of students whose native language was not English completed the original, English form of the CSAS. Although the alpha calculated in our study for the NAS is somewhat lower than the one for PAS, it is still acceptable.

EDUCATION FOR HEALTH
Change in Learning & Practice. Open Access e-Journal indexed on Medline

For divergent validity, we compared PAS and NAS scores for students at each year of training and against the findings of previous studies. In one previous study (Cleland, Foster & Moffat, 2005), students' attitudes toward communication skills learning were found to be positive. In year 1, mean PAS scores obtained in that study indicated a downward trend from year 1 to year 3, similar to that seen in our study. Its authors calculated mean PAS scores as 4.14 for year 1, 3.78 for year 2 and, 3.72 for year 3. In our study, these same scores were 4.01, 4.11 and 3.27 respectively. We can envision one explanation for students' downward attitudes. The first two years of training are a pre-clinic training period covering basic science subjects such as physiology and histology. In years 3 and 4, students begin working with patients. It is possible that students in years 1 and 2 do not yet have a physicians' bio-medical perspective on patients, whereas by years 3 and 4 students have begun to develop a biomedical understanding of illness. It is well known that the bio-medical approach does not place as much emphasis on communication skills as the bio-psychosocial model of care; it has been criticized for this (Engel, 1977; Larivaa et al., 2001). Students in years 3 and 4, with their new biomedical perspective, might be expected to have less positive attitudes toward learning communication skills than they previously had as first and second year students.

We conclude that the Turkish version of the CSAS can be used to explore medical school students' attitudes toward learning communication skills. It can be used in future studies of various research designs and to evaluate and improve communication skills training programmes in medical schools in Turkey. This study also suggests that the CSAS might be appropriate for use in other countries after additional translations and adaptation studies.

This study has limitations. The response rate is not as high as desirable, likely due to students' voluntary participation. In addition, further studies with larger student samples from other medical schools in Turkey are needed to confirm that findings about the CSAS are the same for medical students nationwide.

# Acknowledgements

The authors would like to thank the students who participated in this study. The authors also thank F. Serdar Gürel, Gülhan Demiriz, Taylan Ürkmez, Günay Güreş for their help in translating the scale and Kamil Ertekin for collecting and entering data.

# References

ASPEGEREN, K. (1999). BEME Guide No. 2: Teaching and learning communication skills in medicine. *Medical Teacher,* 21, 563-70.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC) (1999). Contemporary issues in Medicine: Communication in Medicine. Report III. Medical School Objectives Project. Retrieved July 3, 2006, from http://www.aamc.org/meded/msop/msop3.pdf

CLELAND, J., FOSTER, K. & MOFFAT, M. (2005). Undergraduate students' attitudes to communication skills learning differ depending on year of study and gender. *Medical Teacher*, 27, 246-51.

ENGEL, G.L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*,196,129-36.

GORSUCH, R.L. (1997). Exploratory factor analysis: its role in item analysis. *Journal of Personality Assessment,* 68, 532-60.

LARIVAA, P., KIUTTU, J. & TAANILA, A. (2001). The patient centered interview: the key to biopsychosocial diagnosis and treatment, *Scandinavian Journal of Primary Health Care*, 19, 8-13.

LLOYD, M. & BOR, R. *Communication Skills for Medicine*. New York: Churchill Livingstone.

MAKOUL, G. (2003). Communication skills education in medical school and beyond. *JAMA,* 289, 93.

NUNNALLY, J.C. & BERNSTEIN, I.P. (1994). *Psychometric Theory*, 3rd edn. New York: Mc Graw Hill.

ONG, L.M., DEHAES, J.C., HOOS, A.M. & LAMMES, F.B. (1995). Doctor-patient communication: a review of the literature. *Social Science and Medicine*, 40, 903-18.

REES, C.E. & GARRUD, P. (2001). Identifying undergraduate medical students' attitudes towards communication skills learning: a pilot study. *Medical Teacher,* 23, 400-6.

REES, C.E. & SHEARD, C. (2002). The relationship between medical students' attitudes towards communication skills learning and their demographic and education related characteristics. *Medical Education,* 36, 1017-27.

REES, C.E., SHEARD, C. & DAVIES, S. (2002). The development of a scale to measure medical students' attitudes towards communication skills learning: the Communication Skills Attitude Scale (CSAS). *Medical Education,* 36, 141-7.

REES, C. & SHEARD, C. (2003). Evaluating first year medical students' attitudes to learning communication skills before and after a communication skills course. *Medical Teacher,* 25, 302-7.

SHANKAR, R.P., DUBEY, A.K., MISHRA, P., DESPHANDE, V.Y., CHANDRASEKHAR, T.S. & SHIVANANDA, P.G. (2006). Student Attitudes twards communication skills training in a medical college in Western Nepal. *Education for Health,* 19, 71-84.

STEVENS, J. (2002). *Applied Multivariate Statistics for the Social Sciences,* 4th edn. London: Lawrence Erlbaum Associates, Publishers.

TABACHNICK, B.G. & FIDEL, L.S. (1996). *Using Multivariate Statistics,* 3rd ed. New York: Harper Collins College Publishers.

GENERAL MEDICAL COUNCIL (2003). *Tomorrow's Doctors: Recommendations on undergraduate medical education*. London: General Medical Council. Retrieved June 25, 2004, from http://www.gmc-uk.org/Education/Undergraduate

WESTBERG, J. & JASON, H. (1996). Influencing Health Behavior. In S.H. Woolfe, S. Jonas & R. Lawrence (Eds.), *Health Promotion and Disease Prevention in Clinical Practice* Baltimore, MD: Williams and Wilkins.

EDUCATION FOR HEALTH
Change in Learning & Practice. Open Access e-Journal indexed on Medline

## Appendix I: Communication Skills Attitude Scale (CSAS) items*

1. In order to be a good doctor I must have good communication skills
2. I can't see the point in learning communication skills
3. Nobody is going to fail their medical degree for having poor communication skills
4. Developing my communication skills is just as important as developing my knowledge of medicine
5. Learning communication skills has helped or will help me respect patients
6. I haven't got time to learn communication skills
7. Learning communication skills is interesting
8. I can't be bothered to turn up to sessions on communication skills
9. Learning communication skills has helped or will help facilitate my team-working skills
10. Learning communication skills has improved my ability to communicate with patients
11. Communication skills teaching states the obvious and then complicates it
12. Learning communication skills is fun
13. Learning communication skills is too easy
14. Learning communication skills has helped or will help me respect my colleagues
15. I find it difficult to trust information about communication skills given to me by non-clinical lecturers
16. Learning communication skills has helped or will help me recognise patients' rights regarding confidentiality and informed consent
17. Communication skills teaching would have a better image if it sounded more like a science subject
18. When applying for medicine, I thought it was a really good idea to learn communication skills
19. I don't need good communication skills to be a doctor
20. I find it hard to admit to having some problems with my communication skills
21. I think it's really useful learning communication skills on the medical degree
22. My ability to pass exams will get me through medical school rather than my ability to communicate
23. Learning communication skills is applicable to learning medicine
24. I find it difficult to take communication skills learning seriously
25. Learning communication skills is important because my ability to communicate is a lifelong skill
26. Communication skills learning should be left to psychology students, not medical students

Rees Charlotte, Sheard Charlotte & Davies Susie (2002). The development of a scale to measure medical students' attitudes towards communication skills learning: the Communication Skills Attitude Scale (CSAS). *Medical Education,* 36, 141-7.
Blackwell Publishing. Permission Contract No. Ikopicai/94263

---

## Appendix II: Turkish translation of the CSAS

1. İyi bir doktor olmak için iyi iletişim becerilerine sahip olmak zorundayım.
2. İletişim becerilerini öğrenmem için bir neden göremiyorum.
3. Hiçkimse iletişim becerileri zayıf olduğu için tıp eğitiminde başarısız olmayacaktır.
4. İletişim becerilerini geliştirmem tıp bilgimi geliştirmem kadar önemlidir.
5. İletişim becerilerini öğrenmem hastalara saygı duymama yardımcı olacaktır.
6. İletişim becerileri öğrenmeye vaktim yok.
7. İletişim becerileri öğrenmek ilginç.
8. İletişim becerileri derslerine katılmaktan sıkılmıyorum.
9. İletişim becerilerini öğrenmem ekiple daha kolay çalışabilmeme yardımcı olacaktır.
10. İletişim becerilerini öğrenmek hastalarla iletişim kurma yeteneğimi geliştirdi.
11. İletişim becerileri öğretimi zaten açık olanı ortaya koyar ve sonra onları karmaşık hale getirir.
12. İletişim becerilerini öğrenmek eğlenceli.
13. İletişim becerilerini öğrenmek çok basit.
14. İletişim becerilerini öğrenmek meslektaşlarıma saygı duymama yardımcı olacaktır.
15. Tıp doktoru olmayan öğretim üyelerinin iletişim becerileri hakkında verdiği bilgilere güvenmenin zor olduğunu düşünüyorum.
16. İletişim becerilerini öğrenmek hastanın onayını alma ve gizlilik ile ilgili hasta haklarının farkına varmama yardımcı olacaktır.
17. İletişim becerileri öğretimi daha bilimsel bir konu gibi olsaydı imajı daha iyi olurdu.
18. Tıp fakültesine başladığımda iletişim becerileri öğrenmenin gerçekten iyi bir fikir olduğunu düşünmüştüm.
19. Doktor olmak için iyi iletişim becerilerine ihtiyacım yok.
20. İletişim becerilerimde bazı sorunlarım olduğunu itiraf etmek bana zor geliyor.
21. İletişim becerileri öğrenmenin tıp eğitiminde gerçekten yararlı olduğunu düşünüyorum.
22. iletişim kurma yeteneğimden çok, sınavları geçme yeteneğim tıp fakültesini bitirmemi sağlayacaktır.

23. İletişim becerileri öğrenimi tıp eğitimi içinde yer alabilir.
24. İletişim becerileri öğrenmeyi ciddiye almanın zor olduğunu düşünüyorum.
25. İletişim becerilerini öğrenmek önemli çünkü, iletişim kurabilmem yaşam boyu sürecek bir beceridir.
26. İletişim becerilerini öğrenmek tıp öğrencilerine değil, psikoloji öğrencilerine bırakılmalıdır.

---