Research Article

The validity and reliability of a new scale to measure patient-determined communication barriers in hospitals

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Abstract

Objective: Creating an environment that boosts effective communication between patients and healthcare personnel, and identifying factors that impair good communication, have favorable results on the quality of healthcare services. The primary goal of this study was to develop a new valid and reliable scale that could be used to identify communication barriers at the patient level. **Method:** The study was conducted with 421 patients receiving healthcare services at Gaziantep University Şahinbey Research and Practice Hospital. The respondents varied in age, gender, education level and by the department to which they were admitted. Descriptive statistics, exploratory factor analysis, confirmatory factor analysis and Cronbach's alpha test were utilized. **Results:** Based on the analysis of the data collected, a new valid and reliable scale (Cronbach's alpha= 0.81) was constructed, consisting of 28 items and 7 sub-dimensions. **Conclusion:** The proposed scale showed that the main factors leading to the creation of communication barriers were waiting times, fear and anxiety experienced by the patients, security staff, patients' need for attention, lack of trust towards healthcare personnel, concern and need for being informed and prejudice.

Key words: Health communication, communication barriers, patients, healthcare personnel, hospitals

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Hastanelerde hastalar tarafından belirlenen iletişim engellerini ölçen yeni bir ölçeğin geçerlik ve güvenilirliği

Özet

Amaç: Hasta ve sağlık çalışanları arasındaki iletişimi engelleyen faktörleri belirlemenin ve etkili bir iletişim ortamı oluşturmanın sağlık hizmetleri üzerinde olumlu sonuçları bulunmaktadır. Bu çalışmanın temel amacı hastalar tarafından belirlenen iletişim engellerini ortaya koymada kullanılabilecek geçerli ve güvenilir yeni bir ölçek geliştirmektir. **Yöntem:** Çalışma hastanede sağlık hizmeti alan cinsiyet, yaş, eğitim durumu ve başvurduğu sağlık birimine göre farklılık taşıyan 421 hasta ile gerçekleştirilmiştir. Tanımlayıcı istatistikler, açımlayıcı faktör analizi, doğrulayıcı faktör analizi ve Cronbach's alpha testi uygulanmıştır. **Bulgular:** Yapılan çalışmada toplanan verilerin analizi neticesinde 28 madde ve 7 alt boyuttan oluşan geçerli ve güvenilir (Cronbach's alpha= .81) yeni bir ölçek ortaya konulmuştur. **Sonuç:** Çalışma neticesinde ortaya konan ölçekte hasta düzeyinde iletişimi engelleyen faktörler; bekleme süresi, hastadaki kaygı ve endişe, güvenlik personeli, hastanın ilgi ihtiyacı, sağlık personeline duyulan güvensizlik, merak/bilgi ihtiyacı ve ön yargı olarak belirlenmiştir.

Anahtar kelimeler: Sağlık iletişimi, iletişim engelleri, hasta, sağlık çalışanları, hastane

Introduction

Communication plays a vital role in each and every step of the healthcare process[1]. Recently, there has been a surge in the studies conducted to establish communication barriers between healthcare personnel and patients during the provision of health services. Published literature indicates that maintaining a physician-centered communication during medical encounters between patients and healthcare personnel was regarded as a barrier to communication and some patients avoid asking questions to healthcare personnel or seeking information from them about their condition and treatment process[2-4]. This creates further anxiety and fear among patients while discussing their health status[5]. As a solution to this problem, there are studies that recommended active participation of patients in healthcare decision making[6-15]. Studies focusing on involvement of patients in the diagnosis and therapeutic process have demonstrated that allowing participation of patients in the overall disease management process has salutary effects particularly for cancer patients[6,16].

Other studies have shown that communication barriers between patients and healthcare personnel mainly stem from cultural factors[17,18]. Differences in age, gender, education level and beliefs among patients and healthcare personnel lie at the heart of communication problems[2,19-22]. Other barriers to effective communication include patients' unfamiliarity with medical jargon used by healthcare personnel, lack of a clear message conveyed to patients and touching on one subject after another with sudden transitions[23-25], and voice inflection, tone, body language, accent and phrases used during interpersonal communication for information sharing are crucial for good communication[11,26-28]. Additional barriers to doctor-patient communication have been cited as lack of empathy/understanding and insensitivity to patients' feelings, expectations and viewpoints by healthcare personnel [22,24,29,30].

As far as environmental factors are concerned, lack of technical capabilities as well as failure to provide sufficient privacy at healthcare facilities where encounters between healthcare personnel and patients occur [24,28,29,31], crowded and noisy environment[28,32], time spent to diagnose and treat patients' problems and behaviors of security staff working at a hospital other than healthcare staff are major influential factors [16,24,29,33,34]. On the other hand, in addition to the prolonged waiting time for patients both before and after treatment, insufficient security level, crowded hospital settings and long working hours, use of medical terminology with patients, prejudice and misunderstanding, and low educational level of patients and their relatives and individual factors such as psychological problems have been reported as the causes of workplace violence observed in healthcare settings in Turkey [35-39].

An overall review of relevant studies shows that in order to achieve effective communication, there is a need to encourage active participation of patients into the treatment process, to identify individual differences and to develop a tool that would take into account the impact of communication skills of healthcare personnel and environmental factors and establish patient-determined communication barriers. The present study aimed to develop a scale which could be used to identify patient-determined barriers to communication with the hope to fill a gap in this field.

Method

Study sample

The study was conducted at Gaziantep University Şahinbey Research and Practice Hospital. The study enrolled a total of 421 inpatients receiving medical or surgical treatment (n=112) and outpatients (n=309). Our hospital is located in the county of Gaziantep in the southeastern part of Turkey. As per the study inclusion criteria, patients aged 18 years and older were enrolled. Approval for the conduct of the study was obtained from the Ethics Committee for Clinical Trials of Gaziantep University and all participants gave consent before enrollment.

Data collection

The data for the study was collected from 1 to 20 April 2016 between 10:00-15:30 hours to evaluate the validity and reliability of the proposed scale. To collect the data, dedicated questionnaire forms containing questions to identify personal information and communication barriers were used. It took approximately 15 to 20 minutes to complete the forms used for the study.

The personal information form consisted of 5 questions to identify demographic characteristics, including age, gender, income status, education level and the hospital department to which individual patients were admitted.

Aydın and Şahin (2016) proposed a model to solve communication problems in hospital settings, and aimed to identify the causes of communication problems between patients and their relatives and healthcare personnel based on the results of their model application. For the present study, a pool of items to identify barriers to communication was developed by referring to the items reported by Aydın and Şahin (2016). Relevant literature and it consisted of a total of 33 items conveying both positive (n=29) and negative (n=4) expressions. The initial version of the scale included the domains of fear and anxiety (4 items), concern and need for being informed (8 items), need for attention (6 items), lack of trust towards healthcare personnel (3 items) and prejudice (4 negative items) which represented inner feelings/thoughts of the patients as well as the security staff (4 items) and waiting time (4 items). Patients were asked to choose the most appropriate answer from 5 categories including "Strongly disagree", "Disagree", "Not sure", "Agree", "Strongly agree" on a 5-point Likert-type scale. For the scoring of the scale items, positive statements were scored from 1 to 5 starting from "Strongly disagree" category and negative statements were scored from 5 to 1 starting from "Strongly disagree" category.

Analysis of the data

Data were analyzed using SPSS 22.0 statistical software package. Descriptive statistics, exploratory factor analysis, confirmatory factor analysis and Cronbach's alpha test were used for the assessment of the study data. Type 1 error level was determined 0,05.

Results

Sample Characteristics

The age of the participants ranged between 18 to 86 years with a mean age of 40.91±6.69 years. 56.3% of the patients were female (n= 237) and 43.7% were male (n= 184). The income of the sample ranged from 250 to 4000 Turkish Lira (TL) with a mean income of 1612.74±817.34 TL. The education level of the patients included university (25.7%, n= 108), high-school (18.3%, n= 77), secondary school (9.7%, n= 41) and primary school (18.3%, n= 77) graduates. 9.7% of the patients were illiterate (n= 41). Of the participants, 61% (n= 257) were found to have been admitted to medical departments and 49% to surgical departments (n= 164) (Table 1).

Validity

As a starting point, questions forming the basis of the communication barriers scale were evaluated for content validity by a panel of 5 experts including a medical doctor, a nurse, a psychologist and two communication specialist. Evaluation of expert opinions was performed by the technique proposed by Davis[40]. Since content validity indexes (CVIs) computed using ratings of item relevance by content experts did not reveal an item index less than 0.80, none of the questions were excluded from the measuring tool.

In the second step, an exploratory factor analysis was conducted to ascertain the structural validity of the scale. Kaiser-Meyer-Olkin (KMO) and Bartlett's Test of Sphericity tests were used to determine the suitability of the data structure for the factor analysis. KMO test and Bartlett's Sphericity test yielded values of 0.84 for and 5537,478 respectively (p< 0.005). The common variance values (communalities) of the items ranged from 0.352 to 0.808. These results showed that the matrix consisting of the sample and relationships between the variables was suitable for the factor analysis. In the factor analysis, first the unrotated principal components analysis (PCA) was used followed by rotated PCA for the principal axes. In order to assign items to factors taking into account the results of the analysis, items with a factor load less than 0.5 (11,33), items loading onto two factors with a load difference less than 0.1 (9,10) and items which did not load on any factors (12) were removed and the analysis was repeated.

The results of repeated analysis showed that the scale consisted of seven sub-dimensions with an eigenvalue greater than 1 and the first sub-dimension accounted for 19.85%, the second sub-dimension accounted for 14.34%, the third sub-dimension accounted for 7.23%, the fourth sub-dimension accounted for 7.08%, the fifth sub-dimension accounted for 5.54%, the sixth sub-dimension accounted for 5% and the seventh sub-dimension accounted for 4.08% of the total variance. Seven sub-dimensions explain 63.16% of the total variance of the scale.

Factor weights of the scale ranged between 0.55 and 0.87. The scale consists of seven sub-dimensions including "need for attention", "security staff", "concern and need for being informed", "waiting time", "prejudice", "fear and anxiety" and "lack of trust towards healthcare personnel". The "need for attention" sub-dimension contains six items: the sub-dimensions of "security staff", "fear and anxiety", "concern and need for being informed" and "prejudice" factors contain four items and the sub-dimensions of "waiting time" and "lack of trust towards healthcare personnel" factors contain three items each. Based on the data shown in Table 2, confirmatory factor analyses were done on the final version of the scale which included 28 items having content and structure validity.

Table 1. The socio-demographic characteristics of patients

Variables	Patients (n= 421)
Age, years, mean ± SD (range)	40.91 ± 17.23 (18–86)
Sex, n (%)	
Male	237 (56.3%)
Female	184 (43.7%)
Education, n (%)	
Illiterate	41 (9.7%)
Primary school	77 (18.3%)
Secondary school	41 (9.7%)
High school	77 (18.3%)
University	108 (25.7%)
Master's degree	3 (0.7%)
Department Admitted, n (%)	
Medical	257 (61%)
Surgical	164 (39%)

SD: Standard deviation.

Finally, in confirmatory factor analysis, user model versus baseline model p value must be smaller than 0.05 for an acceptable model. Our model was statistically significant (p=0.000) according to the results of the confirmatory factor analysis. A number of different criteria were considered to evaluate the results of the confirmatory factor analysis. The thresholds reported by Hu and Bentler were used.[41] CMIN/DF was 1.922 which is smaller than 3; Comparative Fit Index was 0.929 (higher than the desired level which is 0.90); Tucker-Lewis Index was 0.919 and GFI was 0.904 also higher than desired level which is 0.90.

The Root Mean Square Error of Approximation (RMSEA) value was 0.047 (desired value is less than 0.05). Furthermore, Standardized Root Mean Square Residual was found to be 0.058 which is significantly lower than 0.08. Thus, based on all evaluated criteria, the validity of the scale was very high (Figure 1).

Reliability

The reliability of the scale for communication barriers was determined by computing Cronbach's alpha correlation coefficient for internal consistency. Cronbach's alpha value was 0.81. Since this value is greater than 0.70, we may assume that the scale is reliable. Tables 3 and 4 show Cronbach's alpha reliability values.

Table 2. Results of exploratory factor analysis and factor loadings of the scale

				Components			
				4			7
				Concern and	5		Lack of trust
	1	2	3	need	Waiting	6	towards
Item	Need for	Security	Fear and	for being	Time	Prejudice	healthcare
Numbers	attention	staff	anxiety	informed			personnel
m1	**,803**	,095	,007	,123	,045	,089	,088
m2	**,802**	,092	-,045	,119	,093	,102	,067
m3	**,747**	-,007	,038	,086	,082	-,016	,190
m4	**,663**	,065	-,036	,178	-,016	,021	,027
m5	**,577**	,341	,051	-,117	-,039	,089	-,059
m6	**,558**	,131	,031	,126	,034	-,025	,311
m7	,120	**,848**	,052	,080	-,054	,080	,065
m8	,076	**,835**	,105	,047	,001	,072	,079
m9	,128	**,724**	,007	,141	,056	-,082	,137
m10	,148	**,654**	-,016	,042	,157	-,016	,193
m11	-,029	,044	**,849**	,116	,040	-,087	-,106
m12	,005	,083	**,805**	,273	,145	-,006	-,051
m13	,107	,015	**,706**	,067	,277	-,115	,005
m14	-,077	,020	**,670**	,327	,075	-,076	,049
m15	,175	,086	,119	**,763**	,081	,038	,073
m16	,053	,066	,200	**,714**	,070	-,037	-,058
m17	,151	,084	,174	**,706**	,239	,000	,061
m18	,211	,078	,253	**,647**	,155	-,002	,215
m19	,074	,013	,172	,140	**,877**	-,089	,011
m20	,067	,018	,211	,069	**,815**	-,083	-,041
m21	,021	,111	,077	,277	**,802**	-,023	-,021
m22	,059	-,028	-,082	,012	-,059	**,778**	,052
m23	,030	-,047	,051	,055	-,062	**,760**	,086
m24	,088	,130	-,089	-,046	-,064	**,691**	,065
m25	,015	,007	-,114	-,032	,009	**,658**	,183
m26	,142	,156	,002	,025	,003	,149	**,801**
m27	,190	,088	-,099	,055	-,077	,155	**,794**
m28	,105	,193	-,013	,098	,012	,141	**,746**
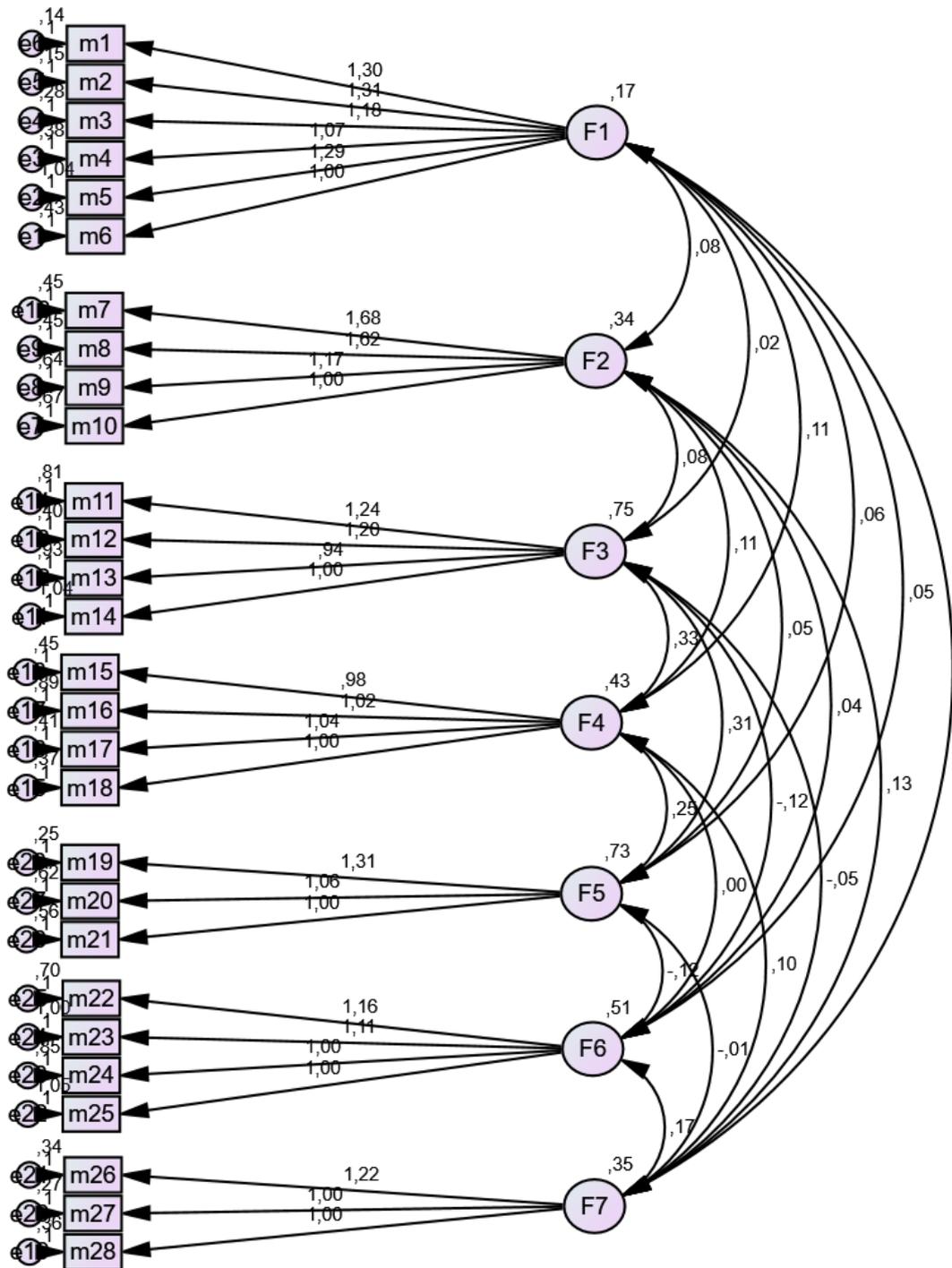
Chi-Square=632.247, df=329, P-value=0.000, RMSEA=0.047

Figure 1. Results of confirmatory factor analysis

Table 3. Descriptive statistics, item total correlations and Cronbach's alpha values if item deleted

Subscale	Item numbers	Min-max	Mean	Std.dev	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
	m1	1-5	4,4252	,65264	,667	,733
Need for attention	m2	1-5	4,4371	,66473	,660	,734
	m3	1-5	4,3943	,71804	,603	,743
	m4	1-5	4,2850	,76188	,511	,762
	m5	1-5	3,8789	1,14935	,448	,806
	m6	1-5	4,3729	,77529	,505	,763
	m7	1-5	3,5796	1,19182	,697	,727
Security staff	m8	1-5	3,6366	1,16025	,688	,732
	m9	1-5	3,9952	1,05333	,600	,775
	m10	1-5	4,0238	1,00684	,535	,803
	m11	1-5	3,1805	1,40601	,701	,733
Fear and anxiety	m12	1-5	3,5867	1,21898	,734	,722
	m13	1-5	3,5416	1,26728	,555	,801
	m14	1-5	3,1425	1,34115	,558	,802
Concern and need for being informed	m15	1-5	4,0499	,93089	,614	,694
	m16	1-5	3,7815	1,15871	,510	,761
	m17	1-5	4,1116	,93319	,595	,703
	m18	1-5	4,2185	,89695	,594	,706
Waiting time	m19	1-5	3,9525	1,22964	,788	,703
	m20	1-5	3,8931	1,20336	,677	,815
	m21	1-5	4,0428	1,13937	,671	,820
	m22	1-5	3,4964	1,17842	,564	,623
Prejudice	m23	1-5	3,1829	1,27887	,521	,648
	m24	1-5	3,5226	1,16602	,473	,676
	m25	1-5	3,2304	1,25038	,471	,678
Lack of trust towards healthcare personnel	m26	1-5	3,8456	,93218	,657	,677
	m27	1-5	3,9121	,79545	,626	,711
	m28	1-5	3,8551	,84538	,600	,735

Table 4. Descriptive statistics and Cronbach's alpha values for subscales and total scores

Sub-dimensions of the scale	Min-Max	Mean±Std.dev	Cronbach's Alpha
1. Sub-dimension: Need for attention	8-30	25.79±3.36	0.78

2. Sub-dimension: Security staff	4-20	15.23±3.53	0.81
3. Sub-dimension: Fear and anxiety	4-20	13.45±4.19	0.81
4. Sub-dimension: Concern and need for being informed	4-20	16.16±3.03	0.77
5. Sub-dimension: Waiting time	3-15	11.88±3.12	0.84
6. Sub-dimension: Prejudice	4-20	13.43±3.59	0.71
7. Sub-dimension: Lack of trust towards healthcare personnel	3-15	11.61±2.15	0.78
Total	58-136	107.57±12.17	0.81

Discussion

Looking at the studies that aimed to investigate communication barriers between patients and healthcare personnel during the provision of healthcare services, it is understood that the fundamental problems resulted from cultural factors. This fact was demonstrated by Taylor et al. in 2013 in a study that involved interviews with 34 health care personnel and by Ferguson et al. in a literature review for the studies conducted between 1966 and 2000.[18,19] Also, differences in gender, education, beliefs and a generation gap may be the source of communication barriers.[2,19-22] In contrast with the factors cited above, the need for attention was determined as a major factor in this study when the causes of communication barriers between patients and healthcare personnel were examined. This finding is consistent with the results of studies performed in 2011 by Ferahani et al. in Tehran, Iran involving 35 individuals in two hospitals where they showed that lack of empathy and poor understanding of patient expectations and perspectives on the part of health care personnel were the primary communication barriers.[24]

When the relevant literature on communication barriers between patients and healthcare personnel, particularly factors aimed at the use of verbal and non-verbal communication tools are revealed.

Overall, factors including patients' unfamiliarity with medical jargon, a lack of a clear message conveyed to patients and touching on one subject after another with sudden transfer[11,23,24], have a negative effect on the transfer of information during the communication process, and also tone of voice, body language, accent and phrases used during information sharing are essential for communication.[26-28] Incomplete exchange of information between healthcare personnel and patients results the need for information. Concern and need for being informed were identified as a sub-dimension of the scale related to communication barriers between patients and healthcare personnel in this study. Patients are curious to know about their treatment process and what type of procedures they will undergo over the course of their treatment. On the other hand, an information gap causes increased fear and anxiety about patients' health conditions.[5] Also, fear and anxiety were sub-dimensions in this study. Fear and anxiety originating from both lack of information on their health status and the severity of their illness were identified as a communication barrier.

Waiting time and security staff factors were identified as additional sub-dimensions. With respect to waiting time and security staff, our findings are consistent with those of previous studies on communication barriers between patients and health care personnel. In Turkey, prolonged waiting times for patients both before and after treatment and insufficient security levels are being investigated as potential causes of violence observed in healthcare services.[35-39] However, in this

study, the security staff was identified to be a part of and necessary for the running of the institution.

The new scale constructed with the aim of determining communication barriers between patients and healthcare personnel included prejudice as a sub-dimension. Basically, prejudice was reported to stem from a lack of confidence in the expertise of health care personnel and in the management policy of healthcare institutions in Turkey. In those studies, prejudice towards healthcare personnel was identified as a variable when explaining the violent acts of patients against healthcare personnel.[36-38] Prejudice causes a breakdown of communication between the patients and healthcare personnel, and can lead to violence by the patient and their relatives towards healthcare personnel. Confidence in health care personnel, which is not applicable for each institutions in Turkey, represents another sub-dimension in our scale. And finally, the sub-dimension of lack of trust is related to the confidence in the expertise of healthcare personnel in their fields and the decisions taken by them. The trust of patients and their relatives in the professional experience of healthcare personnel has an impact on their involvement in their own treatment process.

Conclusion and recommendations

Since developing effective communication during the provision of healthcare services yields several positive outputs, it would be highly beneficial to overcome obstacles to good communication. As such, there is a need for instruments that could evaluate factors hampering communication at the level of both patients and healthcare personnel. With the present study, a new valid and reliable scale was constructed to identify communication barriers at the patient level. The sub-dimensions of the proposed scale can quantify personal attitudes of patients including the need for attention, prejudice, fear and anxiety, lack of trust towards healthcare personnel and concern/the need for being informed and attitudes towards security staff and waiting time. Individual healthcare facilities and their personnel may take action to devise strategies to eliminate communication barriers, taking into account the results obtained from each sub-dimension of the scale.

The limitation of the study is the application of the scale to a relatively small sample of 421 patients who were admitted to Gaziantep University Şahinbey Research and Practice Hospital to receive healthcare services.

Although patients were not divided into different categories, such as those undergoing a medical procedure and those who were not, differences and similarities in such study groups, and possibly their relatives, should be determined on the basis of region, hospital or the healthcare setting (clinic, outpatient clinic, emergency department etc.) using the proposed scale (Appendix 1-2). Additionally, there is a need to design similar tools at the healthcare personnel level in order to achieve effective healthcare communication.

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APPENDIX-1

Scale to measure patient-determined communication barriers

Scale items	1 Strongly Disagree	2 Disagree	3 Not sure	4 Agree	5 Strongly Agree

Need for attention

1. I need understanding from the healthcare personnel.
2. I need the healthcare personnel to care for me.
3. I need the healthcare personnel to have a positive attitude towards me.
4. I'd like to be able to communicate with the healthcare personnel when I need it.
5. I need the healthcare personnel to communicate with me in a friendly manner.
6. I'd like to trust the healthcare personnel.

Security staff

7. Security staff helps me receive healthcare service.
8. Security staff helps me in meeting with healthcare personnel.
9. I think the security staff is a part of the hospital system.
10. I consider that the security staff is necessary.

Fear and anxiety

11. I am afraid of losing my life.
12. I am anxious about what's going to happen to me.
13. I am anxious about whether my health will improve or not.
14. Medical practices scare me.

Concern and need for being informed

15. I'd like to be informed about the treatment steps that would be administered to me.
16. I am curious to know about the scope of healthcare practices.
17. I am curious about what's going to happen to my health in the future.
18. I am curious to know about my current health state.

Waiting time

19. It disturbs me when there is a delay in the provision of results of the investigations required for making a diagnosis.
20. It disturbs me when my treatment is prolonged.
21. It disturbs me when I have to wait to receive healthcare service.

*Prejudice**

22. I think the healthcare personnel do not work adequately.
23. I believe some patients are given priority.
24. I believe I am neglected by healthcare personnel.
25. I think there is a delay in the provision of my treatment.

Lack of trust towards healthcare providers

26. I feel confident that treatment is provided by expert healthcare personnel.
27. I trust the information provided by the healthcare personnel.
28. I believe appropriate treatment is administered.

*Reversed scored items

APPENDIX

Hasta merkezli iletişim engelleri ölçeği

Ölçek Maddeleri	1 Kesinlikle Katılmıyorum	2 Katılmıyorum	3 Kararsızım	4 Katılıyorum	5 Kesinlikle Katılıyorum
İlgi İhtiyacı					
1. Sağlık personelinin beni anlamasını isterim.					
2. Sağlık personelinin benimle ilgilenmesini isterim.					
3. Sağlık personelinin olumlu bir yaklaşım içerisinde olmasını isterim.					
4. İhtiyacım olduğunda sağlık personeliyle iletişim kurmak isterim.					
5. Sağlık personelinin arkadaş gibi davranmasını isterim.					
6. Sağlık personeline güvenmek isterim.					
Güvenlik Personeli					
7. Güvenlik personeli sağlık hizmeti almama yardımcı olur.					
8. Güvenlik personeli sağlık personeli ile bir araya gelmeme yardımcı olur.					
9. Güvenlik personelinin hastane sisteminin bir parçası olduğunu düşünürüm.					
10. Güvenlik personelinin gerekli olduğunu düşünürüm.					
Korku ve Endişe					
11.Hayatımı kaybetme korkusu yaşarım.					
12. Ne olacak kaygısıyla endişelenirim.					
13. Sağlığımın düzelip düzelmemesi konusunda endişelenirim.					
14. Tıbbi uygulamalar beni korkutur.					
Merak ve Bilgi İhtiyacı					
15. Uygulanacak tedavinin aşamalarını merak ederim.					
16. Sağlık personelinin uygulamalarının içeriğini merak ederim.					
17. Sağlığımın ileride nasıl olacağını merak ederim.					
18. Sağlık durumumu merak ederim.					
Bekleme Süresi					
19. Teşhis için istenilen tetkiklerin sonuçlarının çıkmasının zaman alması beni rahatsız eder.					
20. Tedavimin uzun sürmesi beni rahatsız eder.					
21. Sağlık hizmeti alırken bekletilmem beni rahatsız eder.					
Ön Yargı*					
22. Sağlık personelinin yeterince çalışmadığını düşünürüm.					
23. Bazı hastalara öncelik tanındığını düşünürüm.					
24.Sağlık personeli tarafından ihmal edildiğimi düşünürüm.					
25.Tedavimin geciktiğini düşünürüm.					
Güvensizlik					
26. Tedavinin, konusunda uzman sağlık personelince yapıldığını bilirim.					
27. Sağlık personelinin verdikleri bilgilere güvenirim.					
28. Uygun tedavinin uygulandığını düşünürüm.					

*Ters kodlanması gereken maddeler.