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Trust in family physician: a scale adaptation study

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A – Study Design, **B** – Data Collection, **C** – Statistical Analysis, **D** – Data Interpretation, **E** – Manuscript Preparation, **F** – Literature Search, **G** – Funds Collection

Summary **Background.** As is the case in all sectors, trust between physicians and patients in the health sector is essential. However, a lack of trust in the healthcare sector may contain some costs, as in other sectors. A patient who does not trust the doctor or whose sense of trust is damaged will go to different doctors, causing unnecessary use of health services and different costs due to the demand for health services.
Objectives. Primary care is the first step where low-cost preventive and therapeutic health services are provided. Family medicine is the first step in health service where communication between family members, patients, and physicians is realized and maintained. In this regard, the need for a scale to measure physician–patient trust in family medicine is the starting point of this study.
Material and methods. Exploratory and confirmatory factor analyses were used in this study, conducted with a cross-sectional research design. Data was obtained from two different samples, and analyses were performed.
Results. As a result of the analysis, it was determined that the "Trust in Family Physician Scale" is a valid and reliable measurement tool.
Conclusions. It is recommended that the developed Scale be used in different cultures, that health authorities and physicians strengthen the doctor–patient relationship, and that the element of trust be prioritized.
Key words: trust, general practice, family physician.

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Background

Trust is defined as "meaningful consistency" in existing relationships between individuals or between individuals and organizations, including fulfillment of promises, sincerity, honesty, and virtue. Trust in physicians, on the other hand, encompasses patients' confidence and beliefs about their physicians' competence, motivation and honesty, and attention to privacy. A patient who trusts his/her physician manifests this in many areas, from accepting the treatment to showing commitment and complying with the recommendations offered. Factors that influence trust in the doctor include factors such as time given to the patient, listening sufficiently, giving the patient the opportunity to ask and answer questions, providing information about the current condition or illness, kindness, courtesy, empathy and honesty in accordance with the rules of communication [1, 2].

The impact of physicians' communication skills on patients' feelings of trust helps improve the quality of preventive and therapeutic care. Physician–patient relationships have significant effects on trust. Trust in physicians can affect patients' health outcomes, attitudes, satisfaction, and service quality. Studies have shown that trust significantly affects the quality of service and patient satisfaction [3, 4].

In some other studies, it has been stated that in sectors with high levels of trust, establishing trust in service users increases the importance of perceived service quality [5]. The concept of trust is also known to be of vital importance in physicians' relationships with their patients and other healthcare providers. In addition, trust impacts clinical outcomes [6]. Patients with high perceptions of the quality of service provided visit their physicians more often, which reveals that trust only affects the quality of health care provided and the quality of communication available [7].

In some studies, it is seen that a *sense of trust* in family medicine has started to develop for physicians, healthcare professionals, and patients. For example, **from the physician's point of view:** *Family physicians have learned what a holistic approach means, and patients have become like a family. The biopsychosocial aspects of the work started to be questioned, and family members started to be addressed by name. This situation increased professional satisfaction in physicians and improved their sense of trust. Continuous care mentality developed, and patient ownership came to the fore.* **In terms of Family Health Center Staff:** *since the patient profiles served are clear, patient satisfaction will be easily achieved, and the sense of mutual trust will increase, as the employees' approaches to patients will be closer and more sincere. From the Patient's Perspective: as the level of education increases, the idea of confirming the treatment given by the doctor, which exists in the community, decreases, and the sense of trust in the physician increases. The waste of resources and workload caused by the thought of confirming the treatment and decisions made by the doctor will naturally disappear* [8].

The most crucial aspect that makes the family medicine system essential and valuable is that the family is addressed continuously and comprehensively within the framework of holistic approaches, such as the health needs of individuals, the health needs of their families, acute-chronic health problems, and living conditions and environmental conditions, where first contact with the physician and patient is occurs [9].

The "gradual referral system", stated to be addressed within the scope of the current health transformation program in

Türkiye, has not yet been officially implemented in our family medicine system. Many health authorities have criticized this as "leading to backlogs of patients in higher level hospitals"; for example, while the referral rate was 0.4% in 2010, this rate dropped to 0.3% in 2022. While there are 27,762 family medicine units in Türkiye, the population per family physician is 3,072; this ratio is 3,187 in Istanbul and 2,828 in Northeast Anatolia. While the total number of applications to family physicians was 258,436,607 in 2018, this number reached a high figure of 332,907,540 in 2022. While the rate of application to family physicians was 4.0 in 2022, this rate was 1.0 in 2002 when the primary health center system was in place [10].

Objectives

This study aimed to adapt a scale to measure the level of trust of patients applying for primary care services to their family physicians.

Material and methods

The study was designed to determine a valid and reliable measurement tool to measure the trust of patients receiving health care services and the family physician they receive service from. Trust in Family Physician Scale was developed by Anderson and Dedrick [11]. The questions applied for this Scale were translated into Turkish by Deniz and Çimen. Generally, Trust in Family Physician Scale covers all people receiving medical services. Patients sometimes receive very short-term treatments from one physician, and sometimes, they may be examined by other physicians in the same branch for the same disease. There are short-term interactions with specialty physicians, but long-term interaction and communication with family physicians. Therefore, in family medicine, on the other hand, patients have more prolonged interactions with their physicians, and many patients receive medical services from the same family physician for many years.

For this reason, creating a different scale for measuring trust in family physicians constituted the motivation point for this study. Since cancer patients' treatment processes are long and similar to family medicine in terms of the duration of receiving medical services, the patient's trust in physicians scale [12], which was applied by Lord et al. in cancer patients, was adapted to Turkish culture for this study as the Trust in Family Physician Scale. Information that these questions would be used in the Trust in Family Physician Scale study was shared with Lord et al. The study was initiated with their approval. The original scale questions consist of 11 items and show a single-factor structure. First, a Turkish language adaptation was made. The Scale, translated into Turkish by three linguists who are experts in their field, was evaluated by two public health experts and one expert in communication and trust. With the expert opinions, two items that were not meaningful in the Turkish adaptation were removed from the study, and the Scale was completed with nine items.

The judgment statements in the Scale were evaluated with 5-point Likert-type scale options (1 = Strongly Disagree to 5 = Strongly Agree). When the Scale's total score approached 45, or the average score was close to 5, this indicated a high level of trust in the family physician. There were no reverse-coded items in the Scale. Item analysis is required to determine the measuring power of the items in the scale. This situation, expressed as item analysis, can be done using correlation-based item analysis and internal consistency-based analysis [13, 14]. This study analyzed item-total correlation scores, and items with total correlation scores above 0.30 were included in the Scale. In addition, item discrimination was confirmed with *t*-Test results for the lower and upper 27% of the groups.

Two separate datasets were used for exploratory and confirmatory factor analysis during development of the Scale. Before the data was collected, an ethical compliance document dated 04.16.2024 and numbered 689077 was obtained from the Dicle University Social and Human Sciences Ethics Board for the ethical compliance of the study. Data collection in both data sets was carried out with the help of online forms. Participants were reached using the snowball sampling method. Data was collected from people over 18 years of age who received service from family medicine. For the first data set, 360 participants were reached, and three surveys with missing data were excluded from the study. Explanatory factor analysis was performed on this data set. For the confirmatory factor analysis, 400 participants were reached, different from the first data set, and 15 forms with missing data were excluded from the study. Confirmatory factor analysis was applied to the second data set of 385 participants.

In the study, the existence of the sub-dimensions of the Scale was tested by factor analysis. The accuracy of the obtained factor structure was then tested using confirmatory factor analysis. Exploratory and confirmatory factor analyses were conducted on two separate data sets. The data sets were compiled online. The first data set consisted of 357 participants with all the data. Item analysis and exploratory factor analysis were applied to this data set. The second data set was collected to verify the factor structure obtained from the exploratory factor analysis. This data set consists of 385 participants. The Kaiser-Meyer-Olkin (KMO) and Bartlett's Sphericity tests were used to assess the suitability of exploratory factor analysis, the Principal Axis method for factorization, and the varimax method for factor rotations. A cut-off point of 0.30 was assumed. The model's goodness of fit obtained from confirmatory factor analysis was tested with CMIN/DF, CFI, RFI, GFI, and RMSEA. When the sample size was evaluated regarding factor analysis, it was accepted that 5, 10, 15 times the number of items was sufficient. However, it was also stated that a number of observations over 300 would be sufficient [15]. The Scale has nine items. The fact that the number of observations in both data sets was over 300 shows that the sample size is sufficient. Analyses were carried out with the SPSS 22 package program and the Amos 23 package program.

Ethical approval

Our study titled "Trust in family physician: a scale adaptation study" has been evaluated by the Presidency of the Social and Human Sciences Ethics Committee of our University in accordance with the Scientific Study and Publication Ethics Directive of Higher Education Institutions and was approved by the Rectorate of our University on 04.16.2024 under no. 689077.

Findings

This section includes demographic information about the data collected for Study 1, item analysis, and factor analysis results.

59.9% of the participants are male, 40.1% are female, 73.9% are married, and 26.1% are single. 72% of the participants have a bachelor's degree or higher. The occupational distribution of the participants is 11.5% students, 57.1% civil servants, 12.6% workers, 6.4% homemakers, and 6.2% self-employed. 14.3% of the participants are between the ages of 18–24, 23.2% are between the ages of 25–24, 35% are between the ages of 35–44, 21.8% are between the ages of 45–54, and 5.6% are 55 years of age and over.

Inter-item correlations were examined by item correlation, and it was determined that inter-item correlation values ranged between 0.416 and 0.734. For item discrimination, 96 participants, which corresponds to 27% of the total number of participants, were ranked from the lowest score to the highest score, and the difference between the groups formed was examined with an independent sample *t*-Test. The sig-

Table 1. Descriptive findings about the participants							
		n	Percent			*n*	Percent
Gender	male	214	59.9	marital status	married	264	73.9
	female	143	40.1		single	93	26.1
Occupation	student	41	11.5	education status	primary	18	5.0
	civil servant	204	57.1		high school	51	14.3
	laborer	45	12.6		associate's degree	31	8.7
	pensioner	22	6.2		bachelor's degree	169	47.3
	housewife	23	6.4		master's degree	46	12.9
	self-employment	22	6.2		PhD	42	11.8
Age range	18–24	51	14.3				
	25–34	83	23.2				
	35–44	125	35.0				
	45–54	78	21.8				
	55–64	20	5.6				

Table 2. KMO results for evaluating the suitability of the data for factor analysis		
KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy		0.921
Bartlett's Test of Sphericity	Approx. Chi-square	1,954.553
	Degree of freedom	36
	Significance	0.000

Table 3. Item factor loadings of the Trust in Family Physician Scale	
Factor Matrix	
	Factor
	1
I trust my family physician completely	0.816
My family physician does his best to help me	0.799
My family physician always listens to my concerns	0.796
My family physician always gives me the best treatment	0.786
My family physician is open with me	0.766
Overall, I am satisfied with the medical care I receive	0.757
My family physician does not share my medical record with others without my consent	0.723
My family physician always explains everything to me carefully	0.702
My family physician is very competent and thorough	0.583
Extraction Method: Principal Axis Factoring	

a. 1 factor extracted; 4 iterations required.

nificance of the differences between item score averages and the groups can be expressed as an indicator of internal consistency [16]. The *p*-values were significant for all items between group averages. Therefore, no item was removed from the scale. Normality research for the data was conducted with normality tests. As a result of the Kolmogorov-Smirnov normality test, the test statistic value was found to be 0.151, and the *p*-significance value < 0.001. Although it is stated at the end of the test that the data is not normal, it can be expressed with skewness and kurtosis values that the data does not deviate much from normality. The skewness value was determined for the data set as -0.796, and the kurtosis value as -0.190. Skewness and kurtosis with values between -1 and +1 can be considered as an indication that there is not much deviation from normality [17]. The Kaiser-Meyer-Olkin (KMO) test and Barlet's test of sphericity were applied for factor analysis.

The KMO value was 0.921, and the Chi-square value for Barlett's test of sphericity was 1,954.553, with a *p*-significance value < 0.001. The results indicated that the data set was suitable for factor analysis. The principal Axis method was used for factorization, and the Varimax method was used for factor rotation.

Factor loadings ranged between 0.583–0.816. It formed a single-factor structure, explaining 61.00% of the total variance. As a result of the exploratory factor analysis, it was determined that the data was collected in a single factor, and a second data set was collected to test the accuracy of this factor structure. The one-factor structure created for this data set was tested with confirmatory factor analysis.

Results of the analysis performed with the second data set

Confirmatory factor analysis was conducted to test the accuracy of the single-factor structure. A new data set was collected for the second part of the study. The second data set consisted of 385 respondents. The demographic information of this data set is given below.

Table 4. Demographic findings for the second data set							
		n	Percent			*n*	Percent
Gender	male	241	62.6	marital status	married	270	70.1
	female	144	37.4		single	115	29.9
Occupation	student	55	14.3	education status	primary education	19	4.9
	civil servant	214	55.6		high school	55	14.3
	laborer	46	11.9		associate's degree	38	9.9
	pensioner	24	6.2		bachelor's degree	181	47.0
	housewife	22	5.7		master's degree	64	16.6
	self-employment	24	6.2		PhD	28	7.3
Age range	18–24	63	16.4	total		385	100
	25–34	100	26.0				
	35–44	123	31.9				
	45–54	77	20.0				
	55–64	20	5.2				
	65 +	2	0.5				

Table 5. Multiple normality scores						
Variable	Min	Max	Skew	c.r.	Kurtosis	c.r.
M9	1.000	5.000	-0.554	-4.435	-0.839	-3.362
M8	1.000	5.000	-0.598	-4.789	-0.879	-3.520
M7	1.000	5.000	-0.512	-4.100	-1.084	-4.341
M6	1.000	5.000	-0.662	-5.306	-0.835	-3.342
M5	1.000	5.000	-0.572	-4.579	-0.984	-3.940
M4	1.000	5.000	-0.560	-4.484	-0.804	-3.220
M3	1.000	5.000	-0.592	-4.738	-0.888	-3.557
M2	1.000	5.000	-0.564	-4.518	-1.020	-4.086
M1	1.000	5.000	-0.607	-4.865	-0.767	-3.074
Multivariate					63.318	44.146

Table 6. Standardized regression coefficients	
	Estimation
I trust my family physician completely	0.786
My family physician does his best to help me	0.752
My family physician always listens to my concerns	0.793
My family physician always gives me the best treatment	0.859
My family physician is open with me	0.831
Overall, I am satisfied with the medical care I receive	0.876
My family physician does not share my medical record with others without my consent	0.643
My family physician always explains everything to me carefully	0.771
My family physician is very competent and careful	0.785

According to the findings obtained from the second data set, 62.6% of the participants are male, 55.6% are civil servants, 14.3% are students, and the rest are from different professions. 70.1% of the participants are married, and 29.9% are single. 31.9% of the participants are between the ages of 35–44, 26% between 25–34, and 20% between 45–54. Most participants have a bachelor's degree (47%).

The Mardia coefficient and critical ratio value can be suggested as an evaluation method for multivariate normality. For the multiple normality value, a c.r. value less than 5 indicates multiple normality [18]. This is presented in Table 5.

According to Table 5, each item's skewness and kurtosis values are in the range of -1.5 to +1.5. However, the c.r. value of 44.146 is considerably higher than the value required for multiple normality. Since the data set does not meet the multiple normality condition, the "asymptotically distribution-free" method, which does not seek normality, was used for CFA. The CFA path graph created for the data set is given in Figure 1.

The data set formed a single-factor structure. Standardized regression coefficients are summarized in Table 6.

Standard regression coefficients are between 0.643 and 0.876. The general fit indices for model fit and the fit values obtained from the model are summarized in Table 7. Critical values for model fit are compiled from Ergül and Yılmaz [19].

When Table 7 is examined, it is seen that the model shows good fit with a χ^2/sd index value of 0.882, Root Mean Square Error of Approximation (RMSEA) value of 0.000, Standardized Root Mean Square Residual (SRMR) value of 0.0315, Comparative Fit Index (CFI) value of 1.000, Normed Fit Index (NFI) value of 0.934, ND A Goodness-of-Fit Index (GFI) value of 0.977.

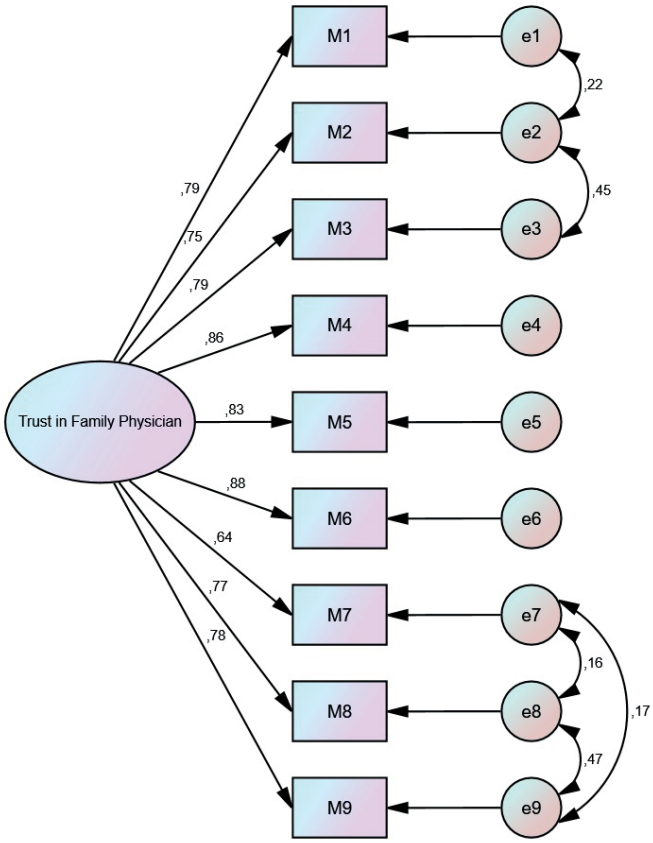

Figure 1. CFA path graph

Table 7. Model Fit Indices

Index	Good fit	Acceptable compliance	Proposed model
NFI	0.95 ≤ NFI ≤ 1.00	0.90 ≤ NFI ≤ 0.95	0.934
CFI	0.97 ≤ CCFI ≤ 1.00	0.95 ≤ CCFI ≤ 0.97	1.000
GFI	0.90 ≤ NFI ≤ 0.95	0.95 ≤ NFI ≤ 1.00	0.977
SRMR	0.00 ≤ SRMR ≤ 0.05	0.05 ≤ SRMR ≤ 0.10	0.0315
RMSEA	0.00 ≤ RMSEA ≤ 0.05	0.05 ≤ RMSEA ≤ 0.10	0.000
χ^2/sd	0 < χ^2/sd ≤ 2	2 ≤ χ^2/sd ≤ 3	0.882

Discussion

Patient trust is an essential component of the patient–physician relationship. However, research on trust in the physician–patient relationship is limited, and even less so in family medicine. In the business organization theory, Thom et al. [20] argue that low levels of trust increase 'transaction costs' such as monitoring and verification. Applying this logic to the doctor–patient service demand relationship, they argue that relationships with low levels of patient trust can be expected to be characterized by more demand for diagnostic tests, referrals, or additional medical information. If the patient doubts whether the doctor will prescribe medication or examine them unless they request it, other services, such as medication or examinations, may be requested more frequently by patients with low levels of trust. Conversely, the patient may also be more likely to be refused by the doctor, given that requests prompted by lower levels of trust are more likely to be due to a lack of trust rather than a "legitimate" medical concern. Trust can reduce healthcare service costs and improve communication between physicians and patients.

In this sense, Anderson and Derdrick [11] pioneered the development of a scale for physician–patient trust. This 11-item scale was a criterion for assessing trust between individuals in the patient–doctor relationship. Thom et al. developed a new measurement tool to measure trust between patients and doctors in their study [21]. It is anticipated that this new measurement tool will aid in investigating clinician trust and the consequences of mutual trust. It will also allow for investigating the relationships between mutual trust (physician–patient) and the care process. The study was designed to be limited to HIV-infected adults with chronic pain and primary care clinicians. Unlike clinicians, the patient–physician relationships and trust dimensions of the focal physician group (family physicians) were investigated using the Trust in Family Physician Scale. Patients in the family doctor system usually deal with the same family doctor for a long time unless their place of residence changesd. Unlike clinicians, family doctors are the first unit to be consulted for general routine examinations and all kinds of diseases, not only for a single type of disease. In addition, family doctors follow up on their patients regarding preventive health services. Since they have closer and longer-lasting communication with patients, they likely have more human relationships, such as friendship and trust with patients, compared to other doctors.

In this respect, it would be appropriate to examine the physician–trust relationship with a separate measurement tool, which constitutes the focus of this study. Similarly, Moseley et al. evaluated the physician–trust scale specifically for pediatricians [22]. With these developed scales, it has become possible to address the physician–trust relationship from different perspectives. Kıraç examined the relationship between trust in physicians and outpatient satisfaction [23]. Temel and Şantaş evaluated the issues of supply creating demand and trust in physicians based on patient perception [24]. It is possible to increase the examples in literature. Family medicine has become widely used in our country as preventive medicine. Considering the prevalence of the field and the services it provides day by day, it is thought that the Trust in Family Physician Scale will be used as a reference in the field.

Conclusions

Trust is an essential issue in the health services sector. The starting point of this study was the lack of research on trust in family physicians, especially in primary care centers such as family medicine, where there is a long-term communication relationship between the patient and his/her family and the physician. Accordingly, the Scale developed by Lord et al. [12] was adapted to Turkish culture and the family medicine system and named the "Trust in Family Physician Scale". Exploratory and confirmatory factor analyses of the Scale were performed on two samples. It was determined that the Scale formed a single factor structure, and it is seen that the model shows good fit with an χ^2/sd index value of 0.882, RMSEA value of 0.000, SRMR value of 0.0315, CFI value of 1.000, NFI value of 0.934, and a Goodness-of-Fit Index (GFI) value of 0.977. The Scale consists of 9 questions and measures patients' level of trust in family physicians.

A sense of trust in family medicine by citizens receiving health services facilitates access to health services. The patient's feeling of comfort towards the physician is significant for the patient to trust the physician. Establishing good communication with the family physician (regular communication, being able to ask questions and receive information and answers, knowing the physician's medical competence-education, the physician being open and transparent) can lead to more open discussion of issues related to the patient's health and the patient receiving the necessary health services with the right guidance. Family physicians provide a wide range of support, from preventive health services to chronic disease management. This is very important in terms of

preventing health problems in the long term or intervening early. Despite all possible health risks, the main operating element of the family medicine system is undoubtedly the patient's trust in the family physician. As a result, it was determined that the Scale is a valid and reliable measurement tool that can be used to measure the level of trust between the family physician and the patient in family medicine. It is recommended that this Scale be used in future studies of different populations and cultures.

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References

1. Deniz S, Çimen M. A Research on Determining the Level of Trust in Physicians. *Journal of Celal Bayar University Institute of Health Sciences* 2020; 8(1): 10–16, doi: 10.34087/cbusbed.656592.
2. Mazinani A, Motamedi M. Building Trust Between Patients and Physicians. *Multidisciplinary Cancer Investigation* 2017; 1(3): 25–26.
3. Lee, C. Patient loyalty to health services: the role of communication skills and cognitive trust. *IJHM* 2021; 14(4): 1254–1264.
4. Chang CS, Chen SY, Lan YT. Service quality, trust, and patient satisfaction in interpersonal-based medical service encounters. *BMC Health Serv Res* 2013; 13: 22, doi: 10.1186/1472-6963-13-22.
5. Alrubaiee L, Alkaa'ida F. The mediating effect of patient satisfaction in the patients' perceptions of healthcare quality-patient trust relationship. *International Journal of Marketing Studies* 2011; 3(1): 103.
6. Çakmak C, Uğurluoğlu Ö. Patient-Centered Communication and Service Quality Relationship: The Mediating Effect of Trust in Service Provider. *Journal of Dicle University Faculty of Economics and Administrative Sciences* 2022; 12(23): 93–108, doi: 10.53092/duiibfd.1031256.
7. Hong H, Oh HJ. The effects of patient-centered communication: exploring the mediating role of trust in healthcare providers. *Health Communication* 2020; 35(4): 502–511.
8. Solak F. *Evaluation of Family Medicine Practice: The Case of Eskisehir Province.* Kütahya: Dumlupınar University; 2010.
9. Kırılmaz H, Öztürk K. Research on patient satisfaction in family medicine. *Journal of Health Academicians* 2018; 5(1): 60–70.
10. Sağlık İstatistikleri Yıllığı 2022 [cited 01.07.2024]. Available from URL: https://www.saglik.gov.tr/TR-103184/saglik-istatistikleri-yilligi-2022-yayinlanmistir.html (in Turkish).
11. Anderson LA, Dedrick RF. Development of the Trust in Physician scale: a measure to assess interpersonal trust in patient–physician relationships. *Psychol Rep* 1990; 67(3 Pt 2): 1091–1100, doi: 10.2466/pr0.1990.67.3f.1091.
12. Lord K, Ibrahim K, Kumar S, et al. Measuring trust in healthcare professionals – a study of ethnically diverse UK cancer patients. *Clinical Oncology* 2012; 24(1): 13–21.
13. Tezbaşaran A. Likert Type Scale Preparation Guide 2008. Available from URL: http://www.academia.edu/1288035/Likert_Tipi_Ölçek_Hazırlama_Kılavuz.
14. McIver JP, Carmines EG. *Unidimensional Scaling (Quantitative Applications in the Social Sciences)*. Quantitative Applications in the Social Sciences series no. 07-024. Beverly Hills–London: Sage Publications; 1982.
15. Alpar R. *Applied Multivariate Statistical Methods.* Ankara: Detay Publishing; 2013.
16. Terzi Y. Questionnaire, reliability-validity analysis. Ondokuz Mayis Üniversitesi, Samsun [cited 02.07.2024]. Available from URL: https://personel.omu.edu.tr/docs/ders_dokumanlari/1030_32625_1500.Pdf.
17. Büyüköztürk Ş. *Sosyal Bilimler İçin Veri Analizi El Kitabı*. Ankara: Pegem Akademi; 2018 (in Turkish).
18. Karagöz Y. *SPSS and Amos 23 Applied Statistical Analyses.* Ankara: Nobel Publishing; 2016.
19. Ergül B, Yılmaz V. Investigation of intra-family relationships during the COVID-19 pandemic with confirmatory factor analysis. *IBAD Journal of Social Sciences* 2020; Special issue: 38–51.
20. Thom DH, Kravitz RL, Bell RA, et al. Patient trust in the physician: relationship to patient requests. *Fam Pract* 2002; 19(5): 476–483.
21. Thom DH, Wong ST, Guzman D, et al. Physician trust in the patient: development and validation of a new measure. *Ann Fam Med* 2011; 9(2): 148–154.
22. Moseley KL, Clark SJ, Gebremariam A, et al. Parents' trust in their child's physician: using an adapted Trust in Physician Scale. *Ambulatory Pediatrics* 2006; 6(1): 58–61.
23. Kıraç R. Hekime Güven ile Hasta Memnuniyeti Üzerine Kesitsel Bir Araştırma (Kahramanmaraş İli Örneği). *Elektronik Sosyal Bilimler Dergisi* 2024; 23(92): 1359–1374 (in Turkish).
24. Temel BB, Şantaş F. Sağlik Hizmetlerinde Arzin Talep Yaratmasi Ve Hekimlere Güven: Hastalarin Görüşleri Üzerine Bir Araştirma. *Hacettepe Sağlık İdaresi Dergisi* 2024; 27(1): 91–120 (in Turkish).

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