

Validation of the Polish version of the Anderson and Dedrick Trust in Physician scale

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ABSTRACT

Purpose: The aim of this study was to validate the Trust in Physician Scale (TPS) for Polish patients.

Materials and Methods: The validation of a Polish-language version of Anderson and Dedrick's TPS was performed with a group of 849 patients. Validation consisted of the translation and evaluation of the psychometric properties of the Polish TPS and its application among Polish-speaking patients. We also explored the TPS with the patient's sex, age, education, income, marital status, and number of physician visits. **Results:**

The internal consistency of the Polish TPS was high (Cronbach's alpha = .891). In our study, the TPS is positively associated with age, education, income, marital status, and number of physician visits. Also, we have found that the TPS is negatively associated with sex and place of residence.

Conclusions: The Polish-language scale fulfills all the criteria of psychometric and functional validation with the original version of the Trust in Physician Scale.

Keywords: Trust in Physician Scale; validation; Polish version

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INTRODUCTION

Integration processes with the European Union, influencing the modern health care system, give the patient – as the recipient of medical services – the opportunity to participate in assessing the quality and reliability of a medical facility. The literature [1-4] emphasizes that there is still need for measuring and improving the quality of care.

The *New England Journal of Medicine* (NEJM) published the results of a survey on the level of public trust that doctors hold as a professional group [5].

Between 2011 and 2013, the survey was conducted by national research institutes within the International Social Survey Program (ISSP) in 29 countries. Two parameters were evaluated: trust in the physician as a professional and individual satisfaction with treatment during the last visit to the doctor. It turned out that citizens trusted doctors the most in countries such as Switzerland, the Netherlands, Denmark, the United Kingdom, Finland, France, and Turkey (confidence levels from 75% to 83%). The ratings were closed by Croatia, the United States, Chile, Bulgaria, Russia, and Poland with 43-58% confidence. Less than half of the respondents trusted doctors in Bulgaria, Russia, and Poland, which closed the ranking with trust in doctors at 43%.

The first type of trust is interpersonal, that is, the trust of one person in another, and cannot be transferred to other people [6,7]. Institutional trust refers to trust in rules, roles and norms, independent of those who hold these roles [6-8]. This is a general attitude that results from personal experiences, previous experiences and contacts with representatives of a particular institution created by the media, and, on the other hand, the effect of applicable social norms [6,7,8]. Trust on the macro scale (trust system) is trust in social institutions or systems, expecting the person to be properly treated by the system, for example, by health care if needed [7,9]. There is also a high level of knowledge-based trust, stemming from a firm belief in the future direction of a partner's behavior based on past experience. Institutional trust grows with the degree of professionalism of an organization, which in the context of health care is important [7,10,11].

All of the aforementioned types of trust exist in relationships with healthcare providers. Two of them – knowledge-based trust and identification-based trust – relate to interpersonal relationships (for example, between the physician and the patient), while the other two operate on the organizational level to a greater degree [7]. Trust is an important factor in relationships between patients and physicians. Patients with greater trust in physicians show better follow-up and continuity of care [9]. Cook et al. showed that trust in a

provider and patient satisfaction with healthcare services are related [12].

We have examined the Trust in Physician Scale for patients who speak Polish in relation to the patient's gender, age, education, profession, income, marital status, and number of physician visits. In response, in our study we aimed to explore the patient-physician relationship with the above-mentioned variables.

MATERIALS AND METHODS

Materials

The study used the Anderson and Dedrick Trust in Physician Scale (TIPS), including 11 statements [13]:

1. I doubt that my doctor really cares about me as a person.
2. My doctor is usually considerate of my needs and puts them first.
3. I trust my doctor so much that I always try to follow his/her advice.
4. If my doctor tells me something is so, then it must be true.
5. I sometimes distrust my doctor's opinion and would like a second one.
6. I trust my doctor's judgment about my medical care.
7. I feel my doctor does not do everything he/she should for my medical care.
8. I trust my doctor to put my medical needs above all other considerations when treating my medical problems.
9. My doctor is a real expert in taking care of medical problems like mine.
10. I trust my doctor to tell me if a mistake was made about my treatment.
11. I sometimes worry that my doctor may not keep the information we discuss totally private.

Reliability and repeatability of the scale were confirmed by independent studies in which Cronbach alpha coefficient ranged from 0.85 to 0.90.

A five-point Likert scale is used for assessment of patient trust [3], with 1 – Strongly Disagree, 2 – Disagree, 3 – Neutral (neither disagree or agree), 4 – Agree and 5 – Strongly Agree.

According to this method, the highest score for each question is five points. Exceptions are questions 1, 5, 7, and 11, as they have a maximum rating of one point. As a result, these questions are reversed in turn and then added to the answers of the remaining questions [3].

The procedure of adapting the scale to a Polish version was carried out with permission of the author of the scale, Dr. Robert F. Dedrick of the University of South Florida, USA.

The study group included 849 patients, 485 men (57.1%) and 409 women (42.9%). The study was conducted between March and December 2015. Patients were from Białystok hospitals, departments of internal medicine.

Stages of the adaptation process

The validation process consisted of two parts: translation and evaluation of the psychometric properties of the newly translated instrument. Its purpose was to compare the obtained results at the intercultural (international) level and apply the test in Polish [14]. An important factor of validation is adaptation for intercultural comparison (the ability to compare the results of the questionnaire on an intercultural level) and practical use of the questionnaire in Polish [15].

Equivalence of the adopted tools with the original version is measured in five categories of equivalence [14]: facade (e.g., test graphic, instruction), psychometric (correlation between versions), functional (relevance to the same purpose), translations (degree of difficulty of wording) and reconstruction (methods for checking reliability and relevancy, types of norms).

The validation process consisted of the following steps: obtaining permission to use the scale (contact with the authors of the questionnaire), preparing the Polish -language version of the scale, applying the Polish-language version of the scale and assessing the psychometric properties of the scale.

During cultural adaptation, all the principles of equivalence of scale to the original version were tried.

In the first stage of validation (forward translations), efforts were made to preserve, through transcription and translation, the fidelity of the translation of the questionnaire in Polish [16]. The original version of the research tool was translated by two independent translators whose mother tongue was Polish; they were English philology graduates, involved in translation and English-language teaching of English at the higher education level daily.

In the next stage, a preliminary version of the Polish language questionnaire was created based on the two translations. The scale was back translated; that is, the newly acquired scale was re-translated into the original language by a translator whose native language is English, but who has lived in Poland for many years and is fluent in that language [15,17]. In the next stage of the scale validation process, according to the literature recommendation [5], the principle of facade equivalence of the questionnaire was in graphical compliance, quantity and method of question formulation, as well as the form of answers to the questions asked, instructions on how to conduct the research, and selection of the research group.

Thanks to such precise rules, it was possible to achieve a high degree of facade equivalence with the original scale version. During the preparation of the polish version, an identical graphical form of the scale was used, as prepared by the authors of the original version.

The next step of validation, according to literature recommendations [14,15], was to preserve the faithfulness of the reconstruction, which relates to the different stages of scale construction, methods of assessing its relevance and reliability, the similarity of groups, and the types of standards used. Because the Polish version was created by the already existing scale, some elements of this principle were omitted, and the focus was on the execution of studies similar to those used by the authors of the original version.

The last element of validation was evaluation of the psychometric equivalence of both questionnaires. According to the literature requirements [17], the research process analyzed elements similar to those in the original version. Internal cohesion was assessed using the Cronbach alpha coefficient tests and the discriminatory power of the items.

Statistics

Statistical software Statistica version 10 (Statsoft, Kraków, Poland) was used for statistical analysis. Means and standard deviations were used to describe TPS. Internal consistency reliability was assessed by determining the coefficient Cronbach's alpha and inter-item correlation coefficients. Spearman correlation analysis was used to calculate correlations between the TPS and age, gender, education, income, marital status, and frequency of doctor visits. A level of statistical significance of $p < 0.05$ was used.

Ethics

Consent of the Bioethics Committee of the Medical University of Białystok R-I-002/52/2011 was obtained.

RESULTS

A total of 900 patients returned questionnaires; 849 (94.3%) patients' questionnaires were complete and used in the analysis. The average age of the patients was 45 ± 16 years (19-65). Fifty-five percent of the respondents lived in the city, and 45% lived in the village. Fifty-one percent of the respondents were married. In terms of education, 26% of respondents had vocational education, and 34% had secondary; 22% had incomplete higher, and 38% had higher education. In terms of education, 41% of respondents had vocational education, and 33% had secondary; 26% had incomplete higher. Thirty-five percent of the respondents described their financial situation as poor; 42% as average, and 23% as

good. In the last year, 23% of the respondents visited their doctor one time; 25% 2-3 times, 39.3% four or more times, and 12% did not visited.

The highest mean scores were for items: "I trust my doctor so much that I always try to follow his/her advice" 3.86 ± 0.83 , and "I trust my doctor's judgment about my medical care" 3.8 ± 0.89 ; and the lowest mean score was for item "I sometimes worry that my doctor may not keep the information we discuss totally private" 2.36 ± 1.26 .

Most patients trusted their physicians on medical advice (53.4%) and medical needs (52.9%). With regard to items worded in a negative direction, most of patients disagreed or strongly disagreed about: worrying that physicians may not keep information private (65.4%), distrusting physician's opinion and wanting a second opinion (53.9%). Details are shown in Table 1.

Table 1. Respondents' responses to the Patient-Physician Trust scale issues

Issue number / issue		Scale point response n=849					Average ± SD
		point					
		1	2	3	4	5	
1.	I doubt that my doctor really cares about me as a person	169	267	265	106	42	2.51±1.09
		19.9%	31.4%	31.2%	12.5%	5%	
2.	My doctor is usually considerate of my needs and puts them first	30	61	337	301	120	3.49±0.94
		3.5%	7.2%	39.7%	35.5%	14.1%	
3.	I trust my doctor so much I always try to follow his/her advice	10	40	176	453	170	3.86±0.83
		1.2%	4.7%	20.7%	53.4%	20%	
4.	If my doctor tells me something is so, then it must be true	19	73	219	413	125	3.65±0.91
		2.2%	8.6%	25.8%	48.6%	14.8%	
5.	I sometimes distrust my doctor's opinion and would like a second one	102	356	225	126	40	2.58±1.03
		12%	41.9%	26.5%	14.9%	4.7%	
6.	I trust my doctor's judgments about my medical care	22	89	182	403	153	3.67±0.97
		2.6%	10.5%	21.4%	47.5%	18%	
7.	I feel my doctor does not do everything he/she should for my medical care	106	311	213	171	48	2.698±1.1
		12.5%	36.6%	25.1%	20.1%	5.7%	
8.	I trust my doctor to put my medical needs above all other considerations when treating my medical problems	15	61	162	449	162	3.8±0.89
		1.8%	7.2%	19.1%	52.9%	19%	
9.	My doctor is a real expert in taking care of medical problems like mine	13	64	203	406	163	3.76±0.9
		1.5%	7.5%	23.9%	47.8%	19.3%	
10.	I trust my doctor to tell me if a mistake was made about my treatment	38	83	266	372	90	3.46±0.96
		4.5%	9.8%	31.3%	43.8%	10.6%	
11.	I sometimes worry that my doctor may not keep the information we discuss totally private	290	265	178	68	48	2.36±1.26
		34.2%	31.2%	21%	8%	5.6%	
Total		814	1670	2426	3268	1161	3.26±1.14
		8.7%	17.9%	26%	35%	12.4%	

Calculations were made for all subjects. The reliability of the Cronbach coefficient of this scale was 0.981. In this sample, patient-physician had a mean score of 36.5 with a standard deviation of 7.8.

Item 4 (If my doctor tells me something is so, then it must be true), item 9 (My doctor is a real expert in taking care of medical problems like mine) showed highest inter-item correlation coefficients, ranging from 0.945 to 0.950. Details are shown in Table 2.

In our study, the TPS is positively associated with age ($R = 0.860, p < 0.001$), education ($R = 0.842, p < 0.001$), income ($R = 0.831, p < 0.001$), marital status ($R = 0.752, p < 0.001$), and visit a doctor ($R = 0.190, p < 0.001$).

Also, we have found that the TPS is negatively associated with sex ($-0.706, p < 0.001$) and place of residence ($-0.742, p < 0.001$). Details are shown in Table 2.

Table 2. Statistics summary of the Patient-Physician Trust scale and its reliability

Issue number / issue		Average	SD	Item-scale correlation	Cronbach's alpha coefficient
1.	I doubt that my doctor really cares about me as a person	2.51	1.09	-0.891	-0.981
2.	My doctor is usually considerate of my needs and puts them first	3.49	0.94	0.909	0.980
3.	I trust my doctor so much I always try to follow his/her advice	3.86	0.83	0.899	0.981
4.	If my doctor tells me something is so. then it must be true	3.65	0.91	0.950	0.979
5.	I sometimes distrust my doctor's opinion and would like a second one	2.58	1.03	-0.904	-0.980
6.	I trust my doctor's judgments about my medical care	3.67	0.97	0.944	0.979
7.	I feel my doctor does not do everything he/she should for my medical care	2.698	1.1	-0.884	-0.981
8.	I trust my doctor to put my medical needs above all other considerations when treating my medical problems	3.8	0.89	0.930	0.980
9.	My doctor is a real expert in taking care of medical problems like mine	3.76	0.9	0.945	0.979
10.	I trust my doctor to tell me if a mistake was made about my treatment	3.46	0.96	0.915	0.980
11.	I sometimes worry that my doctor may not keep the information we discuss totally private	2.36	1.26	-0.875	-0.982
Total		35.83	7.8	0.891	0.986

In our study, the TPS is positively associated with age ($R = 0.860, p < 0.001$), education ($R = 0.842, p < 0.001$), income ($R = 0.831, p < 0.001$), marital status ($R = 0.752, p < 0.001$), and visit a doctor ($R = 0.190, p < 0.001$).

Also, we have found that the TPS is negatively associated with sex ($-0.706, p < 0.001$) and place of residence ($-0.742, p < 0.001$). Details are shown in Table 3.

Table 3. Correlations between the Patient-Physician trust scale and the variables of interest

Dependent Variable	R Coefficient	t Statistic	P value
Age	0.860	49.75	<0.001
Gender	-0.706	-29.70	<0.001
Place of residence	-0.742	-33.27	<0.001
Education	0.842	45.97	<0.001
Income	0.831	44.24	<0.001
Marital status	0.752	35.67	<0.001
Number of physician visits	0.190	5.65	<0.001

DISCUSSION

Based on our results, presented here the TPS is a validated tool for use with Polish patients.

Our findings provide support for its construct validity and test-retest reliability. The internal consistency of the scale was high, 0.981, and is in accordance with previous reports [13,18]. For example, in a study from India [18] Cronbach's alpha was 0.87, and in one [19] with older Chinese adults in the US, Cronbach's alpha was 0.84. Most patients trusted their physicians

regarding medical advice and medical needs. Our findings indicate that patient trust correlates highly with satisfaction with the physician in the validated model. Patient-physician trust was correlated with age, gender, place of residence, education, and income. Our results are also in accordance with a Polish study [20], including 120 patients. The TPS properties in relation to the age, gender, and health status were assessed. The TPS had good reliability in primary care patients (Cronbach's alpha coefficient was 0.90).

A negative correlation was found between age and the trust scale; the younger

the respondent, the higher trust in the physician, and conversely, a positive correlation between self-assessment of health and the trust scale.

In a Polish study [21], the majority of Polish people over 65 years of age reported a high level of satisfaction with the medical care they received. It was suggested that this might be related to their low expectations. Similarly, in our study, older patients reported greater trust in their physicians.

Furthermore, in a study from China [22], patient trust in physicians was significantly correlated with age, education level, annual income, and health insurance coverage of the patients. In a US study [24], a relationship was found between level of trust in physicians and the participants' age, race, and gender. Being younger, being male, a higher educational level, fewer years of residence in the US and in the community, poorer self-reported health status, and poorer quality of life were all associated with a lower level of trust in physicians among older Chinese adults in the US [19]. Consistent with a previous report [23], our study indicates that males had a lower level of TPS (negative correlation) and that patients from the villages reported a higher level of trust. Also,

Freburger et al. [24], assessing patients' trust in their rheumatologist, found that decreased trust was associated with older age, minority status, higher education, a diagnosis of fibromyalgia or osteoarthritis, and poorer health. In spite of the cultural differences, our findings are in accordance with these studies. In contrast to the study from India [18], trust in physicians was not related to age, gender, education, health status, time spent with the physician, and the physician's gender, age, and medical specialty. However, the number of patients in this study was rather small (n=112), which could affect the results.

Our findings indicate that a higher level of TPS was present among patients who were married. Our results are in contrast to those of a study by Simon et al. [19] that found a higher level of TPS in present among unmarried participants. They suggest that living with fewer persons and being unmarried may indicate a weaker social network and social support system, which, in turn, may result in people developing trust in their physicians, who could be their major source of professional health care advice and support.

Consistent with previous reports [22,23], we noted that income was significantly correlated with trust. In contrast to our findings, Simon et al. [19] found that income was not correlated with trust.

Many authors [1,22-25] have attempted to create the most accurate definition of the relationship between physicians and patients. For example, Hollander and Szasz [26] created a model of three basic types of relationships between a

physician and patient that takes into regard their clinical applications: activity-passivity (e.g., in coma); targeting-cooperation (in regard to infectious diseases); and participation (in the case of most chronic diseases). Patients from our study could be classified in the participation relationship.

Emanuel and Emanuel [21] proposed the following model: paternalistic, where the doctor makes decisions about the patient's health; informative, where the doctor is a professional who provides the patient with relevant information, which he/she uses to make a decision; interpretive, where the doctor provides the necessary information, including the risks and benefits of treatment, and the patient makes a competent decision; and joint dialogue.

The present study has several limitations. First, although this study was representative of Polish patients in the Bialystok area, our results may not be generalizable to other Polish populations in Poland. Second, our report evaluated data from patients hospitalized at the internal medicine department. Third, we did not examine the relationship between the length of contact with physicians and patients' health status. Fourth, this study used a cross-sectional design, and longitudinal designs are needed to better understand TPS among Polish patients.

CONCLUSIONS

The Polish-language scale fulfills all the criteria of psychometric, and functional validation with the original version of The Trust in Physician Scale. The TPS is positively associated with age, education, income, marital status, and number of physician visits, and is negatively associated with gender and place of residence. The Polish TPS will allow us to use the scale as a research tool.

Conflicts of interest

The authors declare no conflicts of interest.

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REFERENCES

1. Nair M, Baltag V, Bose K, Boschi-Pinto C, Lambrechts T, Mathai M. Improving the Quality of Health Care Services for Adolescents, Globally: A Standards-Driven Approach. *J Adolesc Health*. 2015 Sep; 57(3):288-98.
2. Prybil LD, Bardach DR, Fardo DW. Board oversight of patient care quality in large

- nonprofit health systems. *Am J Med Qual.* 2014 Jan-Feb;29(1):39-43.
3. Shi L, Lebrun-Harris LA, Parasuraman SR, Zhu J, Ngo-Metzger Q. The quality of primary care experienced by health center patients. *J Am Board Fam Med.* 2013 No-Dec;26(6):768-77.
 4. Donabedian A. The quality of care. How can it be assessed? *JAMA.* 1988 Sep;260(12):1743-48.
 5. Blendon RJ, Benson JM, Hero JO. Public trust in physicians--U.S. medicine in international perspective. *N Engl J Med.* 2014 Oct;371(17): 1570-2.
 6. Skytt ChB, Winther L. Trust and local knowledge production: Interorganisational collaborations in the Sønderborg region. Denmark. *Geografisk Tidsskrift-Danish. J Geography* 2011;111(1):27-41.
 7. Lount RB Jr. The impact of positive mood on trust in interpersonal and intergroup interactions. *J Pers Soc Psychol* 2010 Mar;98 (3):420-3.
 8. Smith ML. Building institutional trust through e-government trustworthiness cues. *Inform Technol People* 2010;23(3):222-46.
 9. van der Schee E, Groenewegen PP, Friele RD. Public trust in health care: a performance indicator? *J Health Organ Manag* 2006;20(5): 468-76.
 10. Meijboom B, de Haan J, Verheyen P. Networks for integrated care provision: an economic approach based on opportunism and trust. *Health Policy* 2004 Jul;69(1):33-43.
 11. Zucker G. Production of trust: institutional sources of economic structure. *Res Org Behav* 1986;8:53-111.
 12. Cook C, Kokoso-Lasaki O., O'Brien, R. Satisfaction with and perceived cultural competency of health care providers: the minority experience. *J Natl Med Assoc* 2005 Aug;97(8):1078-87.
 13. Anderson LA, Dedrick RF. Development of the trust in physician scale: A measure to assess interpersonal trust in patient-physician relationships. *Psychol Rep* 1990 Dec;67(3 Pt 2): 1091-100.
 14. Brzyski P. Aspekty metodologiczne użycia skal jako instrumentów pomiarowych w badaniach epidemiologicznych. *Przew Lek* 2012;69(12): 1287-92. (Polish)
 15. Drwal R. Adaptation of personality questionnaires. Wydaw. Naukowe PWN. Warszawa 1995 (Polish)
 16. Drwal R. Problemy kulturowej adaptacji kwestionariuszy osobowości [w:] *Kulturowa adaptacja testów.* Ciechanowicz A. Ed. Polskie Towarzystwo Psychologiczne - Wydział Psychologii Uniwersytetu Warszawskiego - Laboratorium Technik Diagnostycznych im. Bohdana Zawadzkiego. Warszawa. 1990.115-38. (Polish)
 17. Weitzner MA, Meyers CA, Steinbruecker S, Saleeba AK, Sandifer SD. Developing a care giver quality-of-life instrument: preliminary steps. *Cancer Pract* 1997 Jan-Feb;5(1):25-31.
 18. Baidya M, Gopichandran V, Kosalram K. Patient-physician trust among adults of rural Tamil Nadu: a community-based survey. *J Postgrad Med* 2014 Jan-Mar;60(1):21-6.
 19. Simon MA, Zhang M, Dong X. Trust in physicians among U.S. Chinese older adults. *J Gerontol A Biol Sci Med Sci* 2014 Nov;69 Suppl 2:S46-53.
 20. Marcinowicz L, Jamiołkowski J, Gugnowski Z, Strandberg EL, Fagerström C, Pawlikowska T. Evaluation of the Trust in Physician Scale (TIPS) of primary health care patients in north-east Poland: a preliminary study *Fam Med Primary Care Rev* 2017;19(1):39-43.
 21. Tobiasz-Adamczyk B, Brzyski P , Gałaś A, Błędowski P, Grodzicki T. Satisfaction from the Use of Health Care Services by Older Adults. *Polityka Społeczna* 2011;4:23-31. (Polish)
 22. Emanuel E, Emanuel I. Four models of the physician – patient relationship. *JAMA* 1992 Apr;267(16):2221-6.
 23. Zhao DH, Rao KQ, Zhang ZR. Patient Trust in Physicians: Empirical Evidence from Shanghai, China. *Chin Med J (Engl).* 2016 Apr 5;129(7): 814-8.
 24. Freburger, JK, Callahan LF, Currey, SS, Anderson LA. Use of the Trust in Physician Scale in Patients With Rheumatic Disease: Psychometric Properties and Correlates of Trust in the Rheumatologist. *Arthritis Rheum* 2003 Feb15;49(1):51-8.
 25. Danquah R, Martin M, Martin D, Hale J. An evaluation of the relationship between patients' adult attachment styles of veterans and their level of trust in their physicians at a veteran health care system. *Eur J Business Soc Sci.* 2016;5(5):65-82.
 26. Davidhizar R. The "responsible" client-facilitator relationship. *Hosp Top* 1987 Mar-Apr;65(2):35-9.

English version of the scale

Instructions:

Each item below is a statement with which you may agree or disagree. Beside each statement is a scale that ranges from strongly agree to strongly disagree. For each item please circle the number that represents the extent to which you agree or disagree with the statement. Please make sure that you answer every item and that you circle only one number per item. It is important that you answer according to what you actually believe and not according to how you feel you should believe or how you think we may want you to respond.

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Neutral (neither disagree or agree)
- 4 = Agree
- 5 = Strongly Agree

1. I doubt that my doctor really cares about me as a person. *	1	2	3	4	5
2. My doctor is usually considerate of my needs and puts them first.	1	2	3	4	5
3. I trust my doctor so much I always try to follow his/her advice.	1	2	3	4	5
4. If my doctor tells me something is so, then it must be true.	1	2	3	4	5
5. I sometimes distrust my doctor's opinion and would like a second one.*	1	2	3	4	5
6. I trust my doctor's judgments about my medical care.	1	2	3	4	5
7. I feel my doctor does <u>not</u> do everything he/she should for my medical care.*	1	2	3	4	5
8. I trust my doctor to put my medical needs above all other considerations when treating my medical problems.	1	2	3	4	5
9. My doctor is a real expert in taking care of medical problems like mine.	1	2	3	4	5
10. I trust my doctor to tell me if a mistake was made about my treatment.	1	2	3	4	5
11. I sometimes worry that my doctor may not keep the information we discuss totally private.*	1	2	3	4	5

* NOTE. The TPS is scored by reverse scoring items 1, 5, 7, and 11 and summing all items for the total score.

Higher scores reflect more of the construct (trust).

Polish version of the scale

Polska wersja skali

Instrukcja:

Poniżej znajdują się stwierdzenia, z którymi możesz się zgodzić lub nie zgodzić. Obok każdej wypowiedzi jest skala, która waha się od zdecydowanie zgadzam się do zdecydowanie nie zgadzam się. Dla każdego elementu skali proszę zaznaczyć liczbę reprezentującą stopień, w jakim się zgadzasz lub nie zgadzasz z danym stwierdzeniem. Upewnij się, że odpowiadasz na każdy element i zaznaczasz tylko jeden numer przy danym problemie skali. Ważne jest, aby odpowiadać tak, jak w rzeczywistości uważasz, a nie w zależności od tego, jak sądzisz, że powinieneś uważać lub jak myśleć, że można zareagować.

- 1 = Zdecydowanie nie zgadzam się
- 2 = Nie zgadzam się
- 3 = Ani tak ani nie
- 4 = Zgadzam się
- 5 = Zdecydowanie zgadzam się

1. Wątpię, że mój lekarz naprawdę troszczy się o moją osobę.*	1	2	3	4	5
2. Mój lekarz zwykle rozpatruje moje potrzeby i stawia je na pierwszym miejscu.	1	2	3	4	5
3. Ufam bardzo mojemu lekarzowi, dlatego zawsze stosuję się do jego rad.	1	2	3	4	5
4. Jeżeli mój lekarz coś mówi, zawsze musi być to prawda.	1	2	3	4	5
5. Czasami nie ufam mojemu lekarzowi.*	1	2	3	4	5
6. Ufam orzeczeniom i opiniom mojego lekarza.	1	2	3	4	5
7. Czuję, że mój lekarz nie robi wszystkiego co powinien dla mojej opieki medycznej.*	1	2	3	4	5
8. Ufam mojemu lekarzowi co do sposobu leczenia moich schorzeń.	1	2	3	4	5
9. Mój lekarz jest prawdziwym ekspertem w leczeniu chorób.	1	2	3	4	5
10. Mogę powiedzieć mojemu lekarzowi jeżeli popełni błąd.	1	2	3	4	5
11. Czasami obawiam się, że mój lekarz nie dochowa tajemnicy.*	1	2	3	4	5

*NOTE. W skali pozycje 1, 5, 7 i 11 są rejestrowane odwrotnie, a łączny wynik jest sumą wszystkich punktów.

Wyższe punkty odzwierciedlają większą konstruktywność (zaufanie).