

## ARTICLE

# Use of the emergency medical services by patients with suspected acute primary healthcare problems: developing a questionnaire to measure patient trust in healthcare

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## Abstract

**Rationale, aims and objectives:** The objective of this study was to develop a questionnaire measuring the level of trust and its constituents in patients calling the Emergency Medical Services (EMS) for suspected acute primary healthcare problems. The questionnaire is called the Patient Trust Questionnaire (PTQ). The following frontline service providers were involved: (1) The Dispatch Centre, (2) the Emergency Medical Services, and (3) the receiving unit (Emergency Department/Healthcare Centre).

**Method:** Cross-sectional data were collected repeatedly and redundant items were discarded using a step-by-step approach. Based on a literature review, the PTQ was developed in line with the following 4-step procedure: (1) Item construction, (2) a face-to-face evaluation of separate items, (3) an empirical pre-evaluation targeting each separate frontline service provider and (4) an empirical full-scale evaluation. The inclusion criteria for participating were that the patient must be 18 years of age or older and suspected having an acute primary healthcare problem when calling the EMS. In the final full-scale evaluation of the questionnaire, 427 patients were included.

**Results:** A set of 8 items with good psychometric properties remained through the developing procedure. Two constituents of trust emerged (labelled credibility and accessibility), which were robust across all frontline service providers.

**Conclusion:** A new measuring instrument has been developed for this particular healthcare chain, for patients with suspected acute primary healthcare problems calling the EMS. Although not yet validated, the PTQ is a potentially useful tool in future healthcare research with reference to the concept of patient trust.

## Keywords

Acute primary healthcare, Emergency Department, Emergency Medical Services, Healthcare Centre, patient dependence, patient vulnerability, patient mistrust, patient trust, person-centered healthcare, questionnaire

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## Introduction

This study describes the development of a Patient Trust Questionnaire (PTQ) that measures 2 constituents of trust that patients experience in the proximate healthcare system

after having called the emergency medical services for suspected acute primary healthcare problems. More specifically, the PTQ captures the patient's sense of receiving optimal treatment throughout the healthcare chain. In this study, the entire chain of healthcare involves the following frontline service providers: the Dispatch

Centre (DC), the Emergency Medical Services (EMS) and the receiving unit (i.e., the Emergency Department [ED] and the Healthcare Centre [HCC]). Trust in HCCs is rated lower by the patients than trust in EDs [1], which emphasizes the importance of evaluating the entire chain of care from a patient perspective.

The DC is responsible for the European emergency number (in Sweden 112 [2]) and the EMS for the transportation of these patients to an optimal medical facility based on their medical and healthcare needs [3,4]. All ambulances are staffed by at least one registered nurse or pre-hospital emergency nurse [5], which makes it possible to assess and triage patients to the most appropriate level of care [6]. When a patient is transported by the EMS, the receiving unit is usually the ED, but may also be the HCC [7]. The HCC takes care of the most common diseases, which are chronic diseases in a large proportion of children and the elderly, as well as mental illness and substance abuse [8]. Hospital care is primarily focused on patients with serious illnesses and life-threatening conditions [9]. Urgent care is delivered by ambulatory care outside the traditional emergency room [5]. Those mainly treated have injuries or illnesses requiring immediate care, but which are not serious enough to require an ED visit. From a patient perspective, such situations are urgent because they are perceived as a crisis that cannot be handled alone [10,11]. To evaluate the chain of healthcare when the need for care is perceived as urgent by the patient, a questionnaire focusing on patients' experiences and based on caring science concepts is needed.

However, although a high proportion of patients initially meet this particular chain of care, there is no questionnaire available that can be used to measure trust at different points of the healthcare chain, involving the DC, EMS, ED and HCC. Most available questionnaires concerning trust in a healthcare context target specific functions, such as the patient's trust in particular groups of professionals [12-14], in healthcare insurance [14-16], in hospitals, or in particular medical systems [17]. One questionnaire that is not limited to a particular function and that is designed to measure a similar concept of trust is the Consumer Emergency Care Satisfaction Scale (CECSS) [18]. It is a widely used tool to evaluate healthcare and it has been used in a multitude of studies [18-27]. Unfortunately, as pointed out by Hall *et al.* [14], patient satisfaction is a sprawling and broad concept that cannot be reliably measured. As used by the Swedish EMS, the CECSS showed a validity problem with a tendency to overestimate consumer satisfaction [27].

The patient's sense of receiving optimal healthcare includes multiple aspects, where the sheer quality of the medical treatment is only one of them. In addition, patients typically have expectations that involve at least (a) their personal integrity, (b) a belief that the decisions concerning their treatment are based upon accurate and relevant information, (c) a sense of being treated with dignity and respect and (d) a feeling that the healthcare professionals have the capacity and the ambition to help in the best possible way [13]. If any of these expectations is

challenged or violated, the patient is likely to mistrust the healthcare system [28].

Hupcey, Penrod, Morse and Mitcham [28] as well as Pearson and Raeke [13] argue that it is important to distinguish between social trust and interpersonal trust in a healthcare context. Social trust is the trust in a particular institution and interpersonal trust is built up over time. Johns [29] notes that trust is used as both a process in the establishment of a relationship and an outcome of the relationship. Berg and Danielsson [30] showed that patients and nurses were aware of their striving for trust by attempting to build a caring relationship, but this did not automatically result in trust. Hupcey *et al.* [28] found that trust will be achieved if there is congruence between the initial expectation of the truster and the behavior of the trusted. Trust has significance for both intrinsic and instrumental grounds and is one of the aims of medical ethics [31]. It is important for conceptual and empirical reasons to distinguish between measures of trust and predictors of trust [14]. Hupcey *et al.* [28] consider that there are other concepts that are closely related to trust, but these concepts do not have all the attributes of trust, for example, confidence, faith and risk-taking. Confidence is an allied concept to trust, but does not involve testing or placing oneself in a dependent situation. Faith does not involve testing. Risk-taking is similar to trust, except that the benefits of risk-taking do not always outweigh the risk. Trust exists when someone decides to place herself/himself in a dependent or vulnerable position. It is not based on any assessment of risk, according to Hupcey *et al.* [28]. Furthermore, trust is a concept used in everyday language as well as in scientific nursing and in medicine, psychology and sociology. Trust is an important component in any interpersonal relationship [12,32].

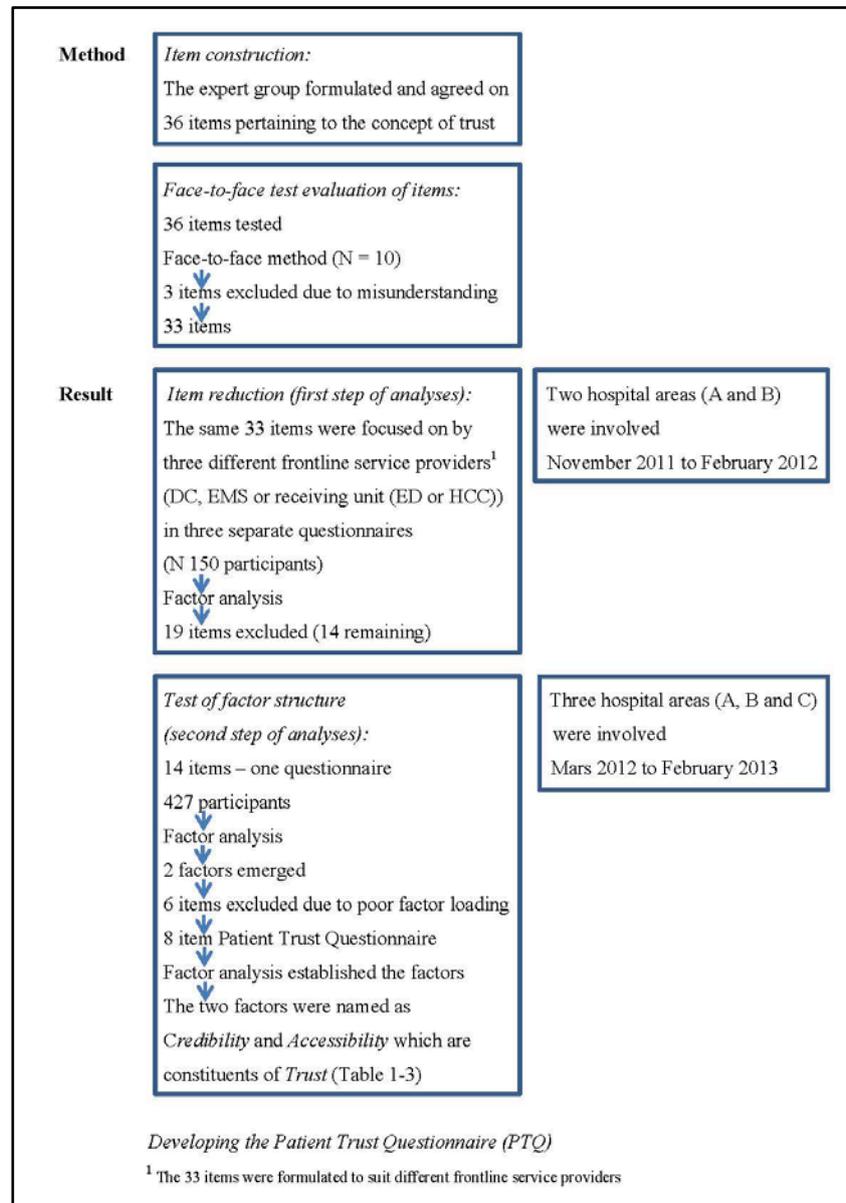
In light of the above literature review and the argument that there is a need for a context-independent questionnaire to capture the patient's degree of trust in the frontline healthcare system, we took measures to develop a number of straightforward and easy-to-understand items with unambiguous face validity. The aim was to attain a quantitative instrument that meets acceptable psychometric standards.

## Methods

### Setting and data collection

Data for this study were collected between November 2011 through February 2013 from 3 out of 5 hospital areas (A, B and C) in the Region Västra Götaland, situated in southwest Sweden. The Region Västra Götaland serves more than 1.6 million inhabitants and consists of 49 municipalities [33]. The EMS are located at 46 stations in the area and in total there are about 100 ambulances or lying-down patient transports. Approximately 181,000 assignments per year were carried out on average [34].

Figure 1 Method and result in the development procedure of the Patient Trust Questionnaire (PTQ)



Two different sets of data were collected, which both used the following 3 inclusion criteria: participants must (1) be at least 18 years of age; (2) have a suspected acute primary healthcare need as indicated by them and assessed as priority green or yellow [35] (i.e., low priority) according to the rapid emergency triage and treatment system (RETTs previously METTS), as based on vital signs and symptoms [35] and (3) be able to speak and understand the Swedish language. In addition, patients who were subjectively assessed by the EMS staff as being unable to fill in the questionnaire were excluded from the study. Patients were allowed to have a relative or friend as assistance. Participants were asked to return the questionnaires by ordinary mail to the first author within 3 days. The choice to let the patients fill in the questionnaires within 3 days was based upon an intention to reduce the number of recall errors. It is well known from research in

memory and cognition that the risk of recall errors increases with the time that has passed between an event and the inquiry [36,37].

### Design and questionnaire developing procedure

The full developing procedure of the Patient Trust Questionnaire (PTQ) is described in Figure 1. Initially, a questionnaire was constructed that included a 5-point likert-like response scale, ranging from 1 (disagree) to 5 (strongly agree). Negatively worded items were reverse-coded. The research group formulated and agreed upon 36 items that were derived from a literature review of the concept of trust [38]. As a requirement, items had to be applicable to the caring contexts of the DC, EMS and the

ED/HCC. The research group involved in this study included a professor in pre-hospital care, a professor in caring science, 2 associate professors in caring science, a researcher in psychology and the first author (registered nurse, pre-hospital emergency nurse and doctoral student).

To test the items for clarity and understandability, a face-to-face evaluation was conducted with 10 current or former patients with personal experience from relevant caring instances, who also varied in terms of age, gender and ethnicity. Participants were asked to speak aloud as they reasoned about their responses while completing the questionnaire, which revealed their understanding of the items [38]. As a result, 3 items were discarded due to ambiguous formulations so that 33 items remained.

### Plan of analyses and data collections

The data was analyzed using a 2-step procedure, conducted with 2 separate cross-sectional sets of data. Through both steps, one requisite was to end up with the same set of items across all frontline service providers (i.e., for each version of the questionnaire). Guided by the results from analyses with statistical methods that are commonly used to evaluate multi-item questionnaires, items were discarded that did not contribute to a solid factor structure across all frontline service providers.

The purpose of the first step was to eliminate empirically irrelevant items and to lay the foundation for sound psychometric properties. The aim was to reduce the number of items in preparation for a full-scale evaluation of the questionnaire. For this step of the analyses, 3 versions of the questionnaire were used, covering the same set of items - one version for each frontline service provider. Context-specific words that, for example, referred to the personnel were matched to fit the terminology of each separate frontline service provider. Hence, a pre-evaluation was conducted with 50 participants for each 33-item version of the questionnaire, with each version focusing on either the DC, the EMS and the ED/HCC respectively. Altogether, there were 150 participants (61% females) and their age ranged from 18 to 92 years old ( $M = 61.3$ ). Participants were recruited during November 2011 through February 2012 and they were patients who fulfilled the inclusion criteria and none of the exclusion criteria from hospital areas A and B.

The purpose of the second step was to confirm the factor structure that emerged in step one and to evaluate further the psychometric properties in a full-scale sample meeting the criterion of 10 participants per item [38]. For this step, all 3 versions of the questionnaire were combined into one single questionnaire, so that all participants responded to items focusing on all 3 of the frontline service providers. Of the 953 questionnaires that were administered by the EMS to the patients, 427 were completed and returned to the first author, resulting in a response rate of 44.8%. The mean age was 62 years and 53.6% of the sample were women. The data collection was carried out from March 2012 through February 2013 and participants who fulfilled the inclusion criteria and none of the exclusion criteria were recruited from hospital areas A, B and C.

### Statistical methods

Participants' responses were transformed into numerical values and analyzed using statistical software SPSS (SPSS Inc., Chicago IL, version 21.0). Items were evaluated in terms of factor structure and psychometric properties using statistical methods such as factor analyses, Cronbach's alpha reliability analyses, inter-item correlations, means and standard deviations for single items [38].

Factor analyses are typically used to evaluate multi-item instruments that are intended to capture abstract self-rating concepts. A factor analysis results in a series of factor loadings, each representing the contribution of each item to the underlying concept it captures. To contribute significantly to the variance of the latent concept, a factor loading should preferably achieve a value of 0.4 or higher [38]. By studying the pattern of the factor loadings, a certain factor structure emerged, revealing which items that were likely to capture the same latent concept. A solid factor structure is a necessary, although not a sufficient, prerequisite for construct validity [38,39]. To achieve reliable results in terms of factor structure, the ratio between the number of items analyzed and the sample size should be 10 or higher [38]. In this study, a series of separate explorative factor analyses were performed for each frontline service provider (i.e., the DC, EMS and the receiving unit (ED or HCC)), using principal axis factoring with varimax rotation and Kaiser normalization. Analyses were also set for orthogonal factors with eigenvalues  $> 1$  emerging for each factor, which should preferably achieve an explanatory proportion of the total variance larger than 60% [39].

Cronbach's alpha is an indication of reliability based upon a compilation of the inter-item correlations of all items that are intended to measure the same latent concept. As a rule of thumb, Cronbach's alpha values should be 0.7 or higher [38].

Inter-item correlations for separate pairs of items were studied to help decide which of any 2 items should be discarded. As one among other criteria when deciding which of 2 items should be eliminated, higher correlation with other items was preferred. However, inter-item correlations that are too high are not desirable. As a rule of thumb, inter-item correlations between 0.3 and 0.7 are commonly recommended, with correlations lower than 0.3 suggesting little congruence with the underlying construct and correlations higher than 0.7 suggesting over-redundancy [38]. In addition, we also studied item-to-total correlations to evaluate separate items [38].

Mean values of separate items were another evaluation criterion when deciding which of 2 items should be eliminated. An item that displays a mean value close to the maximum value within a certain sample leaves little room for yet higher values (cf. ceiling effects). Therefore, items with mean values closer to the mid-range of the scale were more desirable than items with extreme mean values [38].

Standard deviations of separate items were yet another evaluation criterion when deciding which of 2 items should be eliminated. For an item to co-vary with other items, it needs to have some variance in the first place. If it does not, it will be a constant and thus contribute nothing to the

total variance. Therefore, items with higher standard deviations were preferred before items with lower standard deviations [38].

### Ethical considerations

This study was approved by the Regional Ethics Review Board in Gothenburg (Dnr 372-12).

## Results

### First step of analyses: an empirical pre-evaluation

Data in the empirical pre-evaluation were evaluated to reveal and eliminate redundant items and to analyze the factor structure of the remaining items. One prerequisite was to end up with the same set of items across each frontline service provider (i.e., for each version of the questionnaire). Guided by factor loadings, Cronbach's alpha values and other statistics, items were discarded that did not contribute to a solid factor structure across the 3 versions of the questionnaire. This procedure resulted in 14 remaining items distributed across 2 factors, with 7 items for each factor. After a study of the items that covered each of the 2 subscales and a thorough discussion, the research group understood and interpreted the subscales, labelling them *credibility* and *accessibility* respectively.

Table 1 Factor loadings<sup>1</sup> of participants' responses to items in the context of the Dispatch Centre

Items	Credibility	Accessibility
1. I was sure to have received the help I needed (N=362)	<b>0.933</b>	0.224
2. I was convinced that I got the right care (N=357)	<b>0.858</b>	0.134
3. I felt that I was taken seriously (N=366)	<b>0.776</b>	0.257
4. I trusted the Dispatch Centre staff (N=370)	<b>0.419</b>	0.13
5. It was difficult to get answers to my questions (N=356)	0.209	<b>0.71</b>
6. I felt that it was difficult to hand over my problems (N=359)	0.319	<b>0.628</b>
7. I think I should have been given more attention (N=360)	0.237	<b>0.562</b>
8. The response I got was unworthy of a person in my situation (N=356)	0.1	<b>0.531</b>

<sup>1</sup>Principal axis factoring with varimax rotation and Kaiser normalization. Bold factor loadings within a column indicate items belonging to the same subscale

### Second step of analyses: a full-scale evaluation

As the 14-item version of the questionnaire was evaluated using a full-scale sample, it was revealed that 6 of the items did not have acceptable factor loadings or did not provide for a clean factor structure across all 3 frontline service providers. When these items were removed, a 2-factor solution emerged that again provided support for the concepts of credibility and accessibility as constituents of trust.

Thus, at this point in the developing procedure, the questionnaire included 8 identical items for each of the 3 frontline service providers in the healthcare chain (the DC, the EMS and the ED/HCC), along with requests for certain demographic and background information. The factor analyses of this version of the questionnaire resulted in a total variance of 63-77% and a robust factor structure across all 3 frontline service providers with high internal consistency and few cross-loadings (Tables 1-3).

Table 2 Factor loadings<sup>1</sup> of participants' responses to items in the context of the Emergency Medical Services

Items	Credibility	Accessibility
1. I was sure to have received the help I needed (N=409)	<b>0.825</b>	0.143
2. I was convinced that I got the right care (N=409)	<b>0.783</b>	0.094
3. I felt that I was taken seriously (N=417)	<b>0.75</b>	0.201
4. I trusted the EMS staff (N=415)	<b>0.645</b>	0.134
5. I felt that it was difficult to hand over my problems (N=404)	0.232	<b>0.768</b>
6. It difficult to get answers to my questions (N=404)	0.131	<b>0.747</b>
7. I think I should have been given more attention (N=403)	0.207	<b>0.665</b>
8. The response I got was unworthy of a person in my situation (N=404)	0.015	<b>0.502</b>

<sup>1</sup>Principal axis factoring with varimax rotation and Kaiser normalization. Bold factor loadings within a column indicate items belonging to the same subscale

Moreover, Cronbach's alphas for credibility and accessibility respectively, across all three frontline service providers (0.87 and 0.73 for the DC, 0.84 and 0.77 for the EMS, 0.95 and 0.83 for the ED/HCC) indicate acceptable reliability. In addition, bivariate inter-item correlations (Tables 4-5) ranged between 0.29 and 0.88, with the majority of correlations being between 0.3 and 0.7, indicating good correlation between the items within each factor. Item-to-total correlations for the full scale (8 items) across the three frontline service providers ranged between 0.409 and 0.806 for the DC, 0.422 and 0.728 for the EMS,

and finally 0.406 and 0.908 for the ED/HCC. On the basis of these indications of psychometric quality, we conducted no further analyses.

Table 3 Factor loadings<sup>1</sup> of participants' responses to items in the context of the receiving unit (ED/HHC)

Items	Credibility	Accessibility
1. I felt that I was taken seriously (N=416)	<b>0.861</b>	0.338
2. I was convinced that I got the right care (N=411)	<b>0.85</b>	0.366
3. I was sure to have received the help I needed (N=411)	<b>0.837</b>	0.40
4. I trusted the staff at the receiving unit (ED/PC) (N=413)	<b>0.822</b>	0.344
5. It was difficult to get answers to my questions (N=404)	0.312	<b>0.825</b>
6. I felt that it was difficult to hand over my problems (N=404)	0.276	<b>0.8</b>
7. I think I should have been given more attention (N=408)	0.389	<b>0.723</b>
8. The response I got was unworthy of a person in my situation (N=400)	0.268	<b>0.35</b>

<sup>1</sup> Principal axis factoring with varimax rotation and Kaiser normalization. Bold factor loadings within a column indicate items belonging to the same subscale

Means and standard deviations for the two resulting subscales of the final questionnaire are presented in Table 6. Although these values are provided here mainly as a reference for future studies, it should also be noted that the mean values are quite high. However, the standard deviations suggest that there is still room for sufficient variance.

## Discussion

The aim of this study was to develop a questionnaire to measure patients' trust level and constituents of trust. The patients had to have an acute primary healthcare problem and must have called the EMS.

The results show that the PTQ has acceptable psychometric quality and that it consists of credibility and accessibility. The PTQ is useful as it applies to any of the frontline service providers separately, but can also be used to measure trust in the entire healthcare chain taken together. Credibility and accessibility influence trust in this healthcare chain. These constituents add scope and depth to trust, but trust is always present in the constituents [40]. Pearson and Reake [13] claim that trust is established by the healthcare providers' behavior and is based on reliability, compassion, integrity and open communication. Reliability is close to credibility. Accessibility on the contrary has not been identified as a constituent of trust in

previous studies. In emergency situations where the need for care seems urgent from a patient perspective, the constituents of trust might be different from those in other situations.

The final questionnaire has been tested with 2 different samples and in 3 different contexts (i.e. frontline service providers). This provides evidence for the robustness of the psychometric properties of the PTQ. Other similar studies only used one data collection.

The research group agreed to use the same items for all frontline service providers, even if there are differences in *praxis*. The main difference lies in the care situation for the DC. However, in our ambition to use the same set of items for all frontline service providers, we had to accept slightly lower factor loading for some items (0.35 at the lowest). According to Rattray and Jones [39], each factor should display items with factor loading > 0.4, while Tabachnick and Fidell [40] suggest that > 0.3 is sufficient, especially when developing a new questionnaire.

Several studies show that when developing scales that measure trust, it is difficult to compose confidential questions that do not produce all too positively slanted responses. The variation in responses to confidential questions does not correlate well with the variation in responses to other instruments measuring trust [42-44]. The same can be noted in this study where the mean values are quite high.

For items within the same subscale, inter-item correlations between 0.3 and 0.7 commonly recommended, with correlations lower than 0.3 suggesting little congruence with the underlying construct and correlations higher than 0.7 suggesting redundancy [38]. Tabachnick and Fidell [40], however, do not agree. They suggest that it depends on the questionnaire and whether or not the measuring instrument is new. The evaluation depends on the number of items in the scale [38]. To test the internal consistency further, item-to-total correlations were examined [38], with satisfactory results.

This study has a number of limitations. One such limitation is that the mean values of the two subscales were rather high. This is not optimal, but yet a common problem in this area of research [42-44]. One reason may be that patients responded with excessive positiveness, that is, more positively than they really meant. The risk of excessive positiveness increases with broader formulations of the items, which is typically the case in investigations of general satisfaction. Another reason might be that patients were in a vulnerable position of dependence, or that they simply expressed their genuine opinion. The problem with excessive positiveness is that ceiling effects occur much sooner when studying improvements.

The second limitation is that the questionnaire has not been validated. It has neither been tested for convergent nor discriminant validity. Although no empirical validation has yet been conducted with the PTQ, face validity was seriously taken into account during the development process.

Table 4 Bivariate inter-item correlations for the subscale of credibility

Frontline Service Provider and Item	Item 1	Item 2	Item 3	Item 4
<b>Dispatch Centre (DC)</b>				
1. I felt that I was taken seriously	—	0.727	0.832	0.484
2. I was convinced that I got the right care	0.727	—	0.824	0.412
3. I was sure to have received the help I needed	0.832	0.824	—	0.482
4. I trusted the staff at the dispatch centre	0.484	0.412	0.482	—
<b>Emergency Medical Services (EMS)</b>				
1. I felt that I was taken seriously	—	0.56	0.693	0.511
2. I was convinced that I got the right care	0.56	—	0.631	0.575
3. I was sure to have received the help I needed	0.693	0.631	—	0.496
4. I trusted the staff at the emergency medical services	0.511	0.575	0.496	—
<b>Receiving Unit (ED/HCC)</b>				
1. I felt that I was taken seriously	—	0.849	0.88	0.826
2. I was convinced that I got the right care	0.849	—	0.855	0.823
3. I was sure to have received the help I needed	0.88	0.855	—	0.83
4. I trusted the staff at the receiving unit	0.826	0.823	0.83	—

Table 5 Bivariate inter-item correlations for the subscale of accessibility

Frontline Service Provider and Item	Item 1	Item 2	Item 3	Item 4
<b>Dispatch Centre (DC)</b>				
5. It was difficult to get answers to my questions	—	0.415	0.454	0.329
6. I felt that it was difficult to hand over my problems	0.415	—	0.551	0.367
7. I think I should have been given more attention	0.454	0.551	—	0.29
8. The response I got was unworthy of a person in my situation	0.329	0.367	0.29	—
<b>Emergency Medical Services (EMS)</b>				
5. It was difficult to get answers to my questions	—	0.456	0.544	0.397
6. I felt that it was difficult to hand over my problems	0.456	—	0.67	0.372
7. I think I should have been given more attention	0.544	0.67	—	0.303
8. The response I got was unworthy of a person in my situation	0.397	0.372	0.303	—
<b>Receiving Unit (ED/HCC)</b>				
5. It was difficult to get answers to my questions	—	0.722	0.685	0.382
6. I felt that it was difficult to hand over my problems	0.722	—	0.755	0.359
7. I think I should have been given more attention	0.685	0.755	—	0.357
8. The response I got was unworthy of a person in my situation	0.382	0.359	0.357	—

Table 6 Mean values and standard deviations

Frontline Service Provider	Credibility		Accessibility	
	M	SD	M	SD
Dispatch Centre (DC)	4.74	0.517	4.57	0.768
Emergency Medical Services (EMS)	4.85	0.356	4.72	0.65
Receiving Unit (ED/HCC)	4.55	0.761	4.45	0.877

## Conclusion

The PTQ developed in this study can be used in different contexts to measure patients' trust. The final 8 items were the same regardless of frontline service provider, which means that the questionnaire does not need to be context-adapted. However, when the patient experiences an urgent

need for healthcare it is likely that her or his feeling is of the existential type, with little relevance to environmental factors [41].

There is certainly a need for this type of questionnaire in the healthcare sciences. The PTQ measures patients' degree of trust in terms of accessibility and credibility. The existence of credibility as a constituent of trust is in line with results from previous studies. Accessibility, however, has previously not been empirically identified as a constituent of trust. Accessibility might be specific for this particular healthcare chain where patients often experience vulnerable situations, commonly associated with strong existential feelings.

Compared to other professionals, nurses consistently rank high in terms of trust [45]. They may, however, not be able to verbalize what underlies this trust, or even why trust is relevant to their everyday practice [46]. One might speculate that the awareness of trust and both of its constituents may affect nurses' approach to patients in

this particular healthcare chain, making them more responsive to patients' existential needs. However, although not yet validated, then PTQ gives promise of a useful tool that can be utilized for investigating a variety of future research questions with reference to patients' trust.

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