NOTE: The original questionnaire was in Chinese and that the study was conducted in Chinese. The English translation is not a validated translation of the original questionnaire. It is provided for indicative purposes only.

Dear Participants：

We are the researchers of * Hospital and we invite you to participate in our study.

To provide the basis for developing scientific intervention strategies, which may help more people and upgrading medical standards in the future, this study needs to investigated the knowledge, attitude, and practice toward ischemic stroke among the healthcare workers. Your participation in this study is voluntary and this study has been ethically approved by the Medical Ethics Committee. If you agree to participate in this study, please refer to the following instructions.

1. Please complete the questionnaire,there is no absolute right or wrong answer, you just need to fill in according to your actual situation. You can ask us any questions during the answering process, and when you are finished, please submit it in time.

2. This study is a simple questionnaire, it will not cause harm to your physical and psychological condition, but it may involve some privacy question, such as your gender, age, etc. We will keep it strictly confidential and will not disclose your information, please feel free to fill it out.

3. As a participant, You can stay informed about information and progress related to this study. If you decide to withdraw from it, please inform us than your data will not be included in the results.

Finally, we sincerely thank you for taking the time out of your busy schedule to support our scientific study!

□ I have knowledge of and consent to the use of the collected data for scientific study.

Informed Consent Signature:

Date of participation: Year Month Day

Part I Basic Information

1.Your gender：	a.Male b.Female
2.Your age：	_____Years
3.Your education：	a.Junior college/Below b.Bachelor's degree c.Master's degree/Above
4.Your professional title：	a.None b.Primary title c.Middle title d.Vice-senior Title e.Senior Title
5.Your years of work：	a.≤5 years b.5-10 years c.11-15 years d.≥16 years
6.Your occupation：	a.Physicians b.Other healthcare workers (including nurse and medical technicians)
7.Type of hospital you work in：	a. Public Primary Hospitals b. Public Secondary Hospitals c. Public Tertiary hospitals d. Public Specialist Hospitals e. Private medical institutions

Part II Knowledge

1. Identification of Ischemic stroke can be divided into simple identification, specialty identification and image identification	**a.Correct**	**b.Wrong**	**c. Unclear**
2.Simple identification of ischemic stroke includes BEFAST test, FAST (Face-Arm-Speech Test) and the "Stroke 1-2-0".	**a.Correct**	**b.Wrong**	**c. Unclear**
3.Patients diagnosed with stroke at the primary diagnosis should be promptly referred to a higher level hospital and clarify whether it is an ischemic stroke or not	**a.Correct**	**b.Wrong**	**c. Unclear**
4.Overexertion, diarrhea, cold, and staying up late are common precipitating factor of ischemic stroke; inarticulateness and numbness and weakness of limbs are common precursors of ischemic stroke.	**a.Correct**	**b.Wrong**	**c. Unclear**
5.According to the category of neurological deficits, symptoms of ischemic stroke include higher cortical, motor, and sensory d ysfunction; according to the dysfunction caused by the damage to brain tissue innervated by different vascular regions, the sym ptoms of ischemic stroke can be subdivided into ischemic stroke within internal carotid artery system and vertebrobasilar ische mic stroke	**a.Correct**	**b.Wrong**	**c. Unclear**
6.Final identification and confirmed diagnosis of ischemic stroke requires the support of brain imaging examination	**a.Correct**	**b.Wrong**	**c. Unclear**
7.Patients with symptoms consistent with acute ischemic stroke should be evaluated with cranial imaging immediately upon arrival at the hospital to shorten the time from admission to completion of imaging evaluation	**a.Correct**	**b.Wrong**	**c. Unclear**

8.Non-contrast CT (NCCT) and Cranial MRI can effectively exclude intracranial hemorrhage and occupying lesions before endovascular treatment	**a.Correct**	**b.Wrong**	**c. Unclear**
9.The stroke patients, caused by acute anterior circulation large vessel occlusion, received the treatment of stent-based thrombectomy device in combination with intravenous thrombolysis has higher reperfusion rate and better prognosis than those received the treatment of Intravenous thrombolysis only, without significant increase in safety endpoint events.	**a.Correct**	**b.Wrong**	**c. Unclear**
10.Combination of aspiration and stent-based thrombectomy is not only used for remedial treatment after failed mechanical thrombectomy or failed aspiration, but is increasingly being used as a first reperfusion protocol In clinical.	**a.Correct**	**b.Wrong**	**c. Unclear**
11.When stent-based thrombectomy fails to achieve good reperfusion and the patient is still within the 6-h time window for arterial thrombolysis, the practice of remedial treatment with arterial administration of rt-PA is currently limited to clinical experience and has no clear evidence-based medical basis.	**a.Correct**	**b.Wrong**	**c. Unclear**
12.Local anaesthesia, conscious sedation or general anaesthesia are all reasonable options for the treatment of anterior circulation large vessel occlusion	**a.Correct**	**b.Wrong**	**c. Unclear**
13.The best way for perioperative anaesthetic management of Interventional treatment of posterior circulation large vessel occlusion is still unclear, the choice of anaesthesia can be individualised to take into account the patient's situation and the	**a.Correct**	**b.Wrong**	**c. Unclear**

conditions of the interventional catheterisation unit			
14.Direct aspiration may be more effective for larger and more rigid thromboembolisms	**a.Correct**	**b.Wrong**	**c. Unclear**
15.Angioplasty and stenting are commonly used for the remedial treatment of failed thrombectomy in large vessel occlusive stroke	**a.Correct**	**b.Wrong**	**c. Unclear**
16.Contraindications of early endovascular intervention include Severe active bleeding, Significant bleeding tendency, Severe cardiac, hepatic, and renal organ insufficiency, and the Expected survival of less than 90d	**a.Correct**	**b.Wrong**	**c. Unclear**
17.The prehospital transport of acute ischemic stroke can be divided into drip and ship mode and mothership mode	**a.Correct**	**b.Wrong**	**c. Unclear**
18.For thrombectomy after the 6-hour window, a multimodal imaging examination is mandatory	**a.Correct**	**b.Wrong**	**c. Unclear**
19.For large vessel occlusion strokes within 4.5 to 24 h of onset, direct endovascular treatment can be performed after adequate evaluation	**a.Correct**	**b.Wrong**	**c. Unclear**
20.Atherosclerotic large vessel occlusion requires routine application of tirofiban after mechanical embolization	**a.Correct**	**b.Wrong**	**c. Unclear**
21.After reperfusion, intensive antihypertensive therapy is required	**a.Correct**	**b.Wrong**	**c. Unclear**
22.Primary prevention of ischemic stroke includes lifestyle improvement, control of risk factors/causes	**a.Correct**	**b.Wrong**	**c. Unclear**
23.Secondary prevention of ischemic stroke requires additional Specialty specific treatment in addition to primary prevention	**a.Correct**	**b.Wrong**	**c. Unclear**

Part III Attitude

1.More knowledge about ischemic stroke needs to be disseminated to the public	a.Strongly Agree	b.Agree	c.Neutral	d.Disagree	e.Strongly Disagree
2.Primary doctors need more training on ischemic stroke	a.Strongly Agree	b.Agree	c.Neutral	d.Disagree	e.Strongly Disagree
3.On-site handling of ischemic stroke is more important than in-hospital treatment	a.Strongly Agree	b.Agree	c.Neutral	d.Disagree	e.Strongly Disagree
4.Primary doctors need more accurate early identification of stroke caused by large vessel occlusion	a.Strongly Agree	b.Agree	c.Neutral	d.Disagree	e.Strongly Disagree
5.Primary doctors should pay more attention to early assessment of vascular for ischemic stroke	a.Strongly Agree	b.Agree	c.Neutral	d.Disagree	e.Strongly Disagree
6.Emergency doctors are more critical than neurologists in the diagnosis and treatment of ischemic stroke	a.Strongly Agree	b.Agree	c.Neutral	d.Disagree	e.Strongly Disagree
7.I am confident enough in recognizing ischemic stroke	a.Strongly Agree	b.Agree	c.Neutral	d.Disagree	e.Strongly Disagree
8.I am confident enough in deal with the ischemic stroke patients	a.Strongly Agree	b.Agree	c.Neutral	d.Disagree	e.Strongly Disagree

Part IV Practice

1.I will pay more attention to patients at risk of stroke in my daily work	a.Always	b.Often	c.Sometimes	d.Seldom	e.Never
2.I will recommend patients to receive thrombolysis or thrombectomy therapy	a.Always	b.Often	c.Sometimes	d.Seldom	e.Never
3.I will remind patients with ischaemic stroke to have regular reviews	a.Always	b.Often	c.Sometimes	d.Seldom	e.Never
4.For patients in primary/secondary prevention, I would remind their families to take specific preventive measures	a.Always	b.Often	c.Sometimes	d.Occasionally	e.Never
5.I am happy to receive training in ischaemic stroke management	a.Always	b.Often	c.Sometimes	d.Occasionally	e.Never

6. I am happy to disseminate the knowledge about ischemic stroke to patients and others around me.	a.Always	b.Often	c.Sometimes	d.Occasionally	e.Never

The original questionnaire (in Chinese)

亲爱的参与者：

我们是*医院的科研人员，诚挚邀请您参与我们的课题研究。本研究旨在了解您对于缺血性卒中的知识，态度以及行为意愿，为制定科学的策略提供依据，这可能在未来帮助到更多的人，提升医疗水平。您参与这项研究是自愿的，本研究已通过伦理审查委员会的审查，如果您同意参与本研究，请参阅以下说明。

1.请您完成问卷，答案无关对错，您只需要根据实际情况填写。回答过程中的任何问题您都可以向我们提出，完成后，请您及时提交。

2.本研究是简单的问卷调查，不会对您的身体和心理状况造成伤害，但会涉及一些隐私问题，如您的性别、年龄等，我们会严格保密，不会泄露您的信息，请您放心填写。

3.作为参与者，您可以随时了解与本研究相关的信息和研究进展，如果您决定退出研究，请告知我们，您的数据将不包含在研究结果中。

最后，衷心感谢您能百忙之中抽出时间支持我们的科学研究！

□我已知晓并同意将所收集的数据用于科学研究。

知情同意签字：

参与时间：　　年　　月　　日

第一部分 基本信息

1.您的性别：	a.男	b.女
2.您的年龄：	____岁	
3.您的教育程度：	a.大专及以下 b.本科 c.硕士及以上	
4.您的职称：	a.无职称 b.初级 c.中级 d.副高级 e.高级	
5.您的工作年限：	a.≤5 年 b.5-10 年	

	c.11-15 年
	d.≥16 年
6.您工作的类型：	a.医生
	b.其它医务工作者（如护士、医技工作者等）
7.您所工作的医院类型：	a.公立一级医院
	b.公立二级医院
	c.公立三级医院
	d.公立专科医院
	e.私立医疗机构

第二部分 知识

1.缺血性卒中识别可以分为简易识别法、专科识别法和影像识别法	**a.对**	**b.错**	**c. 不清楚**
2.缺血性卒中的简易识别包括 BEFAST 试验，FAST 试验（面-	**a.对**	**b.错**	**c. 不清楚**

臂-语言试验）以及“中风 1-2-0”			
3.基层诊断的卒中患者应及时转至上级医院，并明确是否为缺血性卒中	**a.对**	**b.错**	**c. 不清楚**
4.劳累、腹泻、寒冷、熬夜是缺血性卒中的常见诱因；头晕、头痛等是缺血性卒中的常见先兆。	**a.对**	**b.错**	**c. 不清楚**
5.根据神经功能缺损的类别划分，缺血性卒中的症状包括高级皮层、运动、感觉功能障碍症状；根据不同血管支配区所支配的脑组织受损后的功能障碍划分，又包括颈内动脉系统及椎-基底动脉系统缺血性卒中症状	**a.对**	**b.错**	**c. 不清楚**
6.缺血性卒中最终的鉴别和确诊需要头部影像学检查的支持	**a.对**	**b.错**	**c. 不清楚**
7.符合急性缺血性卒中症状的患者，应在到达医院后立即予以颅脑影像学评估，缩短从入院到完成影像学评估的时间。	**a.对**	**b.错**	**c. 不清楚**
8.头颅非增强 CT 平扫（non-contrast CT，NCCT）、头颅	**a.对**	**b.错**	**c. 不清楚**

MRI 均可以在血管内治疗前有效排除颅内出血及占位性病变			
9.采用支架样取栓器治疗急性前循环血管闭塞所致的卒中患者较静脉溶栓能明确增加患者的血管再通率、改善预后且安全终点事件无明显增加。	**a.对**	**b.错**	**c. 不清楚**
10.血栓抽吸联合支架取栓不仅可用于单纯机械取栓或血栓抽吸失败后的补救治疗，更越来越多地被临床作为首次再通方案使用	**a.对**	**b.错**	**c. 不清楚**
11.支架取栓手术未能达到良好再通，而患者仍处于发病 6h 动脉溶栓时间窗内，动脉予 rt-PA 行补救治疗的做法目前仅限于临床经验，尚无明确循证医学依据	**a.对**	**b.错**	**c. 不清楚**
12.前循环大血管闭塞治疗选择局部麻醉、清醒镇静或者全身麻醉都是合理的	**a.对**	**b.错**	**c. 不清楚**
13.后循环大血管闭塞介入治疗围手术期麻醉管理的最佳方式	**a.对**	**b.错**	**c. 不清楚**

尚不明确，可结合患者病情特点及介入导管室条件个体化选择麻醉方式			
14.对负荷较大、质地较硬的血栓栓塞，直接抽吸的取栓效果可能更具优势	**a.对**	**b.错**	**c. 不清楚**
15.血管成形及支架植入术常用于大血管闭塞卒中取栓失败的补救治疗	**a.对**	**b.错**	**c. 不清楚**
16.严重活动性出血或已知有明显出血倾向者，严重心、肝、肾等脏器功能不全，预期生存期小于 90d 为早期血管内接入治疗的禁忌症	**a.对**	**b.错**	**c. 不清楚**
17.急性缺血性卒中院前转运分为逐级转运（drip and ship）模式和直接转运（mothership）模式	**a.对**	**b.错**	**c. 不清楚**
18.对于 6 小时后取栓，必须经过多模式影像检查	**a.对**	**b.错**	**c. 不清楚**
19.对于发病 4.5~24h 内的大血管闭塞卒中，经过充分评估后，	**a.对**	**b.错**	**c. 不清楚**

可直接进行血管内治疗					
20.动脉粥样硬化性大血管闭塞，机械取栓后需要常规应用替罗非班	**a.对**	**b.错**	**c. 不清楚**		
21.血管再通后，需要强化降压治疗	**a.对**	**b.错**	**c. 不清楚**		
22.缺血性卒中的一级预防包括改良生活方式、控制危险因素/病因	**a.对**	**b.错**	**c. 不清楚**		
23.缺血性卒中的二级预防在一级预防外，还需要额外的专科特异性治疗	**a.对**	**b.错**	**c. 不清楚**		
第三部分 态度					
1.需要向公众普及更多的缺血性卒中知识	a.非常同意	b.同意	c. 一般	d.不同意	e.非常不同意
2.基层医生需要更多关于缺血性卒中的培训	a.非常同意	b.同意	c. 一般	d.不同意	e.非常不同意
3.缺血性卒中的现场处置比院内治疗更重要	a.非常同意	b.同意	c. 一般	d.不同意	e.非常不同意
4.基层医生需要更精准早期识别大血管闭塞引起的卒中	a.非常同意	b.同意	c. 一般	d.不同意	e.非常不同意

5.基层医生应更加注重缺血性卒中早期血管评估	a.非常同意	b.同意	c. 一般	d.不同意	e.非常不同意
6.急诊科医生在缺血性卒中的诊疗中比神经科医生更关键	a.非常同意	b.同意	c. 一般	d.不同意	e.非常不同意
7.我有足够的信心识别缺血性卒中	a.非常同意	b.同意	c. 一般	d.不同意	e.非常不同意
8.我有足够的信心处理缺血性卒中患者	a.非常同意	b.同意	c. 一般	d.不同意	e.非常不同意
第四部分 行为实践					
1.我在日常工作中会更关注有卒中风险的患者	a.总是	b.经常	c.有时	d.很少	e.从不
2.我会推荐患者接受溶栓或取栓治疗	a.总是	b.经常	c.有时	d.很少	e.从不
3.我会提醒缺血性卒中患者定期复查	a.总是	b.经常	c.有时	d.很少	e.从不
4.对处于一级/二级预防的患者，我会提醒他们的家人具体的预防措施	a.总是	b.经常	c.有时	d.偶尔	e.从不
5.我乐于接受缺血性卒中管理的培训	a.总是	b.经常	c.有时	d.偶尔	e.从不
6.我乐于向患者与身边的人普及缺血性卒中的知识	a.总是	b.经常	c.有时	d.偶尔	e.从不

Supplementary Table 1. Knowledge toward ischemic stroke

Knowledge	Correct N (%)	Mean ± SD	*P**
1. Identification of ischemic stroke can be divided into simple identification, special identification, and imaging identification.	244 (94.2)	0.92±0.28	0.939
2. Simple identification of ischemic stroke includes the balance, eyes, face, arm, speech, time (BEFAST) test, face, arm, speech, time (FAST) test, and the "Stroke 1-2-0".	239 (92.3)	0.87±0.33	0.454
3. Patients diagnosed with stroke at the primary diagnosis should be promptly referred to a higher-level hospital and clarify whether it is an ischemic stroke or not.	200 (77.2)	0.86±0.35	0.557
4. Overexertion, diarrhea, cold, and delayed sleep are common influential factors of ischemic stroke; inarticulateness and numbness and weakness of limbs are frequent precursors of ischemic stroke.	241 (93.1)	0.94±0.23	0.261

5. Based on the category of neurological deficits, symptoms of ischemic stroke include higher cortical, motor, and sensory dysfunction; based on the dysfunction caused by the damage to brain tissue innervated by different vascular regions, the symptoms of ischemic stroke can be subdivided into ischemic stroke within internal carotid artery system and vertebrobasilar ischemic stroke.	245 (94.6)	0.92±0.28	0.394
6. Final identification and confirmed diagnosis of ischemic stroke requires the support of brain imaging examination.	252 (97.3)	0.96±0.21	0.158
7. Patients with symptoms consistent with acute ischemic stroke should be evaluated with cranial imaging immediately upon admission to the hospital to shorten the time from admission to completion of imaging evaluation.	248 (95.8)	0.94±0.23	0.110
8. Non-contrast CT (NCCT) and cranial MRI can effectively exclude intracranial hemorrhage and occupying lesions before endovascular treatment.	231 (89.2)	0.85±0.35	0.414
9. Stroke patients, caused by acute anterior circulation large-vessel occlusion, who received	217 (83.8)	0.79±0.41	0.022

stent-based thrombectomy in combination with intravenous thrombolysis have higher reperfusion rates and better prognosis than those who received intravenous thrombolysis treatment only, without a significant increase in safety endpoint events.			
10. Combination of aspiration and stent-based thrombectomy is not only used for remedial treatment after failed mechanical thrombectomy or failed aspiration, but also is increasingly used as a first reperfusion protocol in clinical practice.	230 (88.8)	0.84±0.37	0.131
11. When stent-based thrombectomy fails to achieve satisfactory reperfusion and the patient is still within the 6-h time window for arterial thrombolysis, the practice of remedial treatment with arterial administration of rt-PA is currently limited to clinical experience and has no clear scientific evidence.	171 (66.0)	0.65±0.48	0.071
12. Local anesthesia, conscious sedation, or general anesthesia are all reasonable options for the treatment of anterior circulation large-vessel occlusion.	180 (69.5)	0.57±0.50	0.001
13. The best practice for perioperative anesthetic management of interventional treatment of	220 (84.9)	0.80±0.40	0.215

posterior circulation large-vessel occlusion is still unclear. The selection of anesthetics can be individualized by taking the patient's status and the conditions of the interventional catheterization unit into account the.			
14. Direct aspiration may be more effective for larger and more rigid thromboembolisms.	200 (77.2)	0.72±0.45	0.002
15. Angioplasty and stenting are commonly used for the remedial treatment of failed thrombectomy in large-vessel occlusive stroke.	218 (84.2)	0.82±0.38	0.015
16. Contraindications of early endovascular intervention include severe active bleeding, significant bleeding tendency, severe cardiac, hepatic, and renal organ insufficiency, and the expected survival of less than 90 days.	213 (82.2)	0.73±0.45	0.472
17. The prehospital transport of acute ischemic stroke can be divided into drip-and-ship mode and mothership mode.	224 (86.5)	0.82±0.38	0.072
18. For thrombectomy after the 6-h window, a multimodal imaging examination is mandatory.	222 (85.7)	0.82±0.39	0.130
19. For large-vessel occlusion strokes within 4.5-24 h of onset, direct endovascular treatment	226 (87.3)	0.83±0.37	0.035

can be performed after adequate evaluation.			
20. Atherosclerotic large-vessel occlusion requires routine application of tirofiban after mechanical embolization.	174 (67.2)	0.69±0.46	0.126
21. After reperfusion, intensive antihypertensive therapy is required.	182(70.3)	0.69±0.46	0.381
22. **Primary prevention of ischemic stroke includes lifestyle improvement and control of risk factors/causes.**	251 (96.9)	0.96±0.21	0.650
23. **Secondary prevention of ischemic stroke requires additional specific treatments in addition to primary prevention.**	237 (91.5)	0.89±0.31	0.682

***Comparison between males and females.**

Supplementary Table 2. Attitude toward ischemic stroke

Attitude, n (%)	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Mean ± SD
1. More knowledge about ischemic stroke needs to be disseminated to the public.	224 (86.5)	33 (12.7)	2 (0.8)	0	0	4.80±0.43
2. Primary doctors need more training on ischemic stroke.	220 (84.9)	37 (14.3)	2 (0.8)	0	0	4.79±0.42
3.On-site handling of ischemic stroke is more important than in-hospital treatments.	158 (61.0)	47 (18.1)	25 (9.7)	28 (10.8)	1 (0.4)	4.40±0.92
4. Primary doctors need more accurate early identification of stroke caused by large-vessel occlusion.	195 (75.3)	55 (21.2)	6 (2.3)	3 (1.2)	0	4.65±0.61
5. Primary doctors should pay further attention to early assessment of vascular factors for ischemic stroke.	191 (73.7)	52 (20.1)	12 (4.6)	3 (1.2)	1 (0.4)	4.61±0.64
6. Emergency doctors are more critical than neurologists in the diagnosis	166 (64.1)	71 (27.4)	14 (5.4)	8 (3.1)	0	4.53±0.71

and treatment of ischemic stroke.						
7. I am confident enough in recognizing ischemic stroke.	145 (56.0)	80 (30.9)	29 (11.2)	5 (1.9)	0	4.21±0.83
8. I am confident enough in dealing with ischemic stroke patients.	145 (56.0)	57 (22.0)	42 (16.2)	14 (5.4)	1 (0.4)	4.04±1.02

Supplementary Table 3. Practice toward ischemic stroke

Practice, n (%)	Always	Often	Sometimes	Seldom	Never	Mean ± SD
1. I pay further attention to patients who are at risk of stroke in my daily work.	162 (62.5)	77 (29.7)	12 (4.6)	8 (3.1)	0	4.32±0.82
2. I recommend patients to receive thrombolysis or thrombectomy.	150 (57.9)	69 (26.6)	29 (11.2)	11 (4.2)	0	4.13±0.94
3. I remind patients with ischemic stroke to have regular reviews.	190 (73.4)	63 (24.3)	5 (1.9)	1 (0.4)	0	4.59±0.59
4. For patients in primary/secondary prevention, I remind their families to take specific preventive measures.	170 (65.6)	79 (30.5)	9 (3.5)	1 (0.4)	0	4.48±0.61
5. I am happy to receive training on ischemic stroke management.	180 (69.5)	62 (23.9)	13 (5.0)	3 (1.2)	1 (0.4)	4.47±0.78
6. I am happy to disseminate the knowledge about ischemic stroke to patients and others.	175 (67.6)	72 (27.8)	9 (3.5)	3 (1.2)	0	4.51±0.68

Supplementary Table 4. Distribution of other healthcare workers' (nurses and medical technicians) baseline information and KAP scores

	N (%)	Knowledge		Attitude		Practice	
		Mean ± SD	P	Mean ± SD	P	Mean ± SD	P
Total	157	18.89±4.12		36.03±3.96		26.50±3.20	
Age (years)			0.805		0.002		0.167
<40	33 (21.02)	19.24±4.37		38.12±3.08		27.42±3.07	
40-50	77 (49.04)	18.69±4.15		35.64±3.48		26.18±3.11	
>50	47 (29.94)	18.96±3.96		35.19±4.74		26.38±3.36	
Gender			0.299		0.101		0.020
Male	97 (61.78)	19.15±4.28		35.39±4.06		26.97±3.17	
Female	60 (38.22)	18.45±3.84		38.08±2.77		25.75±3.11	
Education			0.142		<0.001		<0.001
College or below	120 (76.43)	18.62±4.19		35.39±4.06		26.01±3.24	
Bachelor's degree or above	37 (23.57)	19.76±3.81		38.08±2.77		28.11±2.45	
Professional title			0.010		0.012		0.020
None	63 (40.13)	19.22±4.17		35.62±4.04		25.87±3.22	

Junior title	58 (36.94)	19.00±3.52		35.33±4.18		26.40±3.29	
Intermediate title	23 (14.65)	16.52±5.28		37.52±3.01		27.30±2.87	
Senior titles	13 (8.28)	20.92±2.25		38.46±2.44		28.62±2.18	
Working experience			0.867		0.178		0.656
≤5 years	7 (4.46)	19.43±3.15		37.14±3.80		26.71±4.07	
5-10 years	16 (10.19)	18.25±5.20		37.38±3.22		27.00±2.83	
11-15 years	15 (9.55)	19.40±3.46		37.20±3.17		27.27±3.01	
≥16 years	119 (75.80)	18.87±4.12		35.63±4.10		26.33±3.23	
Hospital			0.387		0.074		0.541
Public hospitals	73 (46.50)	19.19±3.80		36.63±3.73		26.67±3.23	
Private hospitals	84 (53.50)	18.62±4.38		35.50±4.10		26.36±3.18	

Supplementary Table 5. Fit Indices for CFA Models

	Ref.	Measured results
CMIN/DF	1-3 excellent, 3-5 good	2.203
RMSEA	<0.08 good	0.068
IFI	>0.8 good	0.739
TLI	>0.8 good	0.718
CFI	>0.8 good	0.735
C.R.	>0.8 good	0.9306
AVE		0.265