ORIGINAL RESEARCH ORİJİNAL ARAŞTIRMA

DOI: 10.5336/nurses.2024-104031

Defining the Intercultural Communication Apprehensions and Patient Safety Attitudes of Healthcare Professionals: A Descriptive and Correlational Study

Sağlık Profesyonellerinin Kültürlerarası İletişim Kaygıları ve Hasta Güvenliği Tutumlarının Belirlenmesi: Tanımlayıcı ve Korelasyonel Bir Araştırma

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This study was presented as an oral presentation at 2nd International Congress of Health Research, October 12-15, 2022, Online.

ABSTRACT Objective: To determine healthcare professionals' intercultural communication apprehension and patient safety attitudes and to examine the correlation between them **Material and Methods:** The study, which was cross-sectional, correlational and descriptive, was conducted with 390 nurses, physicians and midwives across Türkiye. The data of the study were collected with the "Participant Information Form", "Intercultural Communication Apprehension Scale", and "Patient Safety Attitude Questionnare". The collected data were analysed using descriptive statistics, comparisons, reliability and normality tests, correlation and regression analysis. **Results:** The "Intercultural Communication Apprehension Scale" total score of the participants was 47.28±4.33, and the "Patient Safety Attitude Questionnaire" score was 151.84±31.79. While there was a negative (r=-0.173; p<0.01) relationship between the Intercultural Communication Apprehension Scale score and the "Job satisfaction" sub-dimension of the Patient Safety Attitude Scale; Intercultural Communication Apprehension Scale score "Stress recognition" (r=0.220; p<0.01), "Work conditions" (r=0.104; p<0.05). A positive relationship was found between the sub-dimensions. **Conclusion:** As a result of the study, the participants were found to have a moderate level of communication apprehension and show low patient safety attitudes in general. It was concluded that intercultural communication concerns of participants, job satisfaction, which are subscales of patient safety attitudes, stress recognitions, and evaluations of working conditions are related.

Keywords: Communication; cultural competency; health occupations; patient safety

ÖZET Amaç: Bu çalışmanın amacı, sağlık profesyonellerinin kültürlerarası iletişim kaygıları ile hasta güvenliği tutumlarını belirlemek ve aralarındaki ilişkiyi incelemektir. **Gereç ve Yöntemler:** Kesitsel, ilişki arayıcı ve tanımlayıcı olarak gerçekleştirilen bu çalışma, Türkiye genelinde görev yapan 390 sağlık hemşire, doktor ve ebe ile yürütülmüştür. Araştırmanın verileri; "Katılımcı Bilgi Formu", "Kültürlerarası İletişim Kaygısı Ölçeği" ve "Hasta Güvenliği Tutum Ölçeği" ile toplanmıştır. Verilerin istatistiksel analizinde; tanımlayıcı istatistikler, karşılaştırmalar, güvenilirlik ve normallik testleri, korelasyon ve çoklu doğrusal regresyon analizi kullanılmıştır. **Bulgular:** Katılımcıların "Kültürlerarası İletişim Kaygısı Ölçeği" toplam puan ortalaması 47,28±4,33, "Hasta Güvenliği Tutum Ölçeği" toplam puan ortalaması ise 151,84±31,79 olarak belirlenmiştir. Kültürlerarası İletişim Kaygısı Ölçeği puanı ile Hasta Güvenliği Tutum Ölçeği alt boyutlarından "İş doyumu" alt boyutu arasında negatif bir ilişki bulunurken (r=-0,173; p<0,01); Kültürlerarası İletişim Kaygısı Ölçeği puanı "Stresi tanılama" (r=0,220; p<0,01), ve "Çalışma koşulları" (r=0,104; p<0,05) alt boyutları arasında pozitif bir ilişki bulunmuştur. **Sonuç:** Çalışmanın sonucunda, katılımcıların genel olarak orta düzeyde iletişim kaygısına sahip oldukları ve düşük hasta güvenliği tutumu gösterdikleri görülmüştür. Katılımcıların kültürlerarası iletişim kaygıları, hasta güvenliği tutumlarının alt boyutları olan iş doyumu, stresi tanılama ve çalışma koşulları ile ilişkili olduğu sonucuna varılmıştır.

Anahtar Kelimeler: İletişim; kültürel yetkinlik; sağlık profesyonelleri; hasta güvenliği

TO CITE THIS ARTICLE:
Tunçer Ünver G, Kahraman M. Defining the intercultural communication apprehensions and patient safety attitudes of healthcare professionals: A descriptive and correlational study. Turkiye Klinikleri J Nurs Sci. 2025;17(1):195-204.

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Peer review under responsibility of Turkiye Klinikleri Journal of Nursing Sciences.

Received: 21 May 2024 ***Received in revised form:*** 07 Sep 2024 ***Accepted:*** 19 Sep 2024 ***Available online:*** 26 Sep 2024

United Nations Economic and Social Council Population Department reported that "4 out of every 100 individuals around the world live in a society whose language and culture they do not know".[1] This intense migration has caused the population of those accessing the right to health to change. Similarly, cultural and linguistic differences have come to the fore. Therefore, cultural sensitivity is considered a human right, not a privilege, in the process of receiving healthcare, which is one of the fundamental rights. At this point, "World Health Organization (WHO)" focuses on the concept of acceptability, which is one of the most important components of the right to access health.[2] This component is related to medical ethics values and cultural sensitivity. Intercultural communication is essential in creating this sensitivity and providing safe/quality healthcare services. Intercultural communication is usually full of uncertainties that trigger intercultural communication apprehension. This concept is defined as the anxiety experienced while communicating with individuals from different ethnic or cultural origins.[3] Individuals with high intercultural communication apprehension may avoid communication with individuals from different cultures.[4] Intercultural communication affects the quality of healthcare services provided and patient safety, as well.[5]

Joint Commission International (JCI) reports that adverse events resulting from failure to ensure patient safety are globally among causes of death and disability and the root cause of more than half of these events is errors in communication".[6] The harm caused is personal and includes a high cost and loss of trust in health systems.[2,7] A study showed that poor communication in hospitals in the USA costed the country 12 billion dollars a year and unnecessary hospital stays of patients.[7] At this point, it is impossible to ignore the economic damage associated with communication problems while providing healthcare services, as well as the harm they cause to individuals.[8]

In the literature, numerous studies have investigated the correlation of patient safety with certain variables in different cultures.[9-11] However, no studies have been found examining the communication apprehension experienced by healthcare professionals while providing care to patients from different cultures as well as their patient safety attitudes. Therefore, this study aims to determine healthcare professionals' intercultural communication apprehension and patient safety attitudes and to examine the correlation between them. It is thought that the results of the present study will be guiding for edu-cators and managers in determining the current situ-ation in healthcare professionals' education and practices and planning reactive/proactive interventions on the issue. It will also contribute to the literature.

The study seeks to answer the following questions:

- What are the participants' intercultural communication apprehension levels?
- What are the independent variables that cause a difference in participants' intercultural communication apprehension levels?
- What are the participants' patient safety attitudes?
- What are the independent variables that cause a difference in participants' patient safety attitudes?
- Is there any significant correlation between intercultural communication apprehension levels and patient safety attitudes of the participants?

MATERIAL AND METHODS

DESIGN

This study has descriptive, correlational, and cross-sectional design. It was reported based on the Statement-Checklist of items that should be included in reports of cross-sectional studies (STROBE) checklist.

PARTICIPANTS

Sample size of the study was calculated by G*power Software 3.1 (Heinrich-Heine Universität Düsseldorf, Germany). In line with this analysis, the minimum number of participants was determined to be 272 at a significance value of 0.05, power of 95%, and effect size of 0.20. Considering the possibility of data loss, it was aimed to reach more than 272 participants.[10,11] Sample of the study consisted of 390 physicians, nurses, and midwives working in public, private, and university hospitals in 47 cities in Türkiye.

The criterion sampling method was used in the present study.

Inclusion criteria for the study were determined as follows:

a. Working as a physician, nurse, and midwife in inpatient wards of public, private, and university hospitals.

b. Providing healthcare to patients from different cultures

c. Having at least one year of professional experience.

DATA COLLECTION

Ethical approval was obtained from the Social Sciences Research Ethics Committee of Ondokuz Mayıs University (date: December 3, 2019; no: 2019/123). First, an online link specific to this study was created to collect data. This link was then shared by the researchers in nursing-related groups on social media platforms [Facebook (Meta Platforms, Inc., ABD), Instagram (Meta Platforms, Inc., ABD), Twitter (Twitter, Inc., ABD)] between March 2020 and January 2021. The first page included information about the study's aim, scope, and ethical aspects for participants. This page had a checkbox to check for those who agreed to participate in the study. To improve the quality and reliability of the data, the system did not allow sending data collection forms with incomplete answers. Data collection form consisted of a "Personal Information Form", the "Patient Safety Attitude Questionnaire", and the "Personal Report of Intercultural Communication Apprehension Scale". This study was conducted in accordance with the principles of the Declaration of Helsinki 2008.

A Personal Information Form was prepared upon the literature review and includes 13 questions about the demographic and professional characteristics.

The Patient Safety Attitude Questionnaire (PSAQ) was developed by Sexton et al., and adapted into Turkish by Baykal et al.[12,13] It consists of 46 items and 6 subscales (job satisfaction, teamwork climate, safety climate, perception of management, stress recognition, and work conditions). The items are rated with a 5 Likert type scoring. Total score ranges between 46-230 points. High scores signify that the patient safety attitude increases positively. Baykal et al. found that the Cronbach's alpha coefficient of the scale was 0.93.[13] In this study, it was found to be 0.95.

Personal Report of Intercultural Communication Apprehension Scale (PRICA) was developed by Neuliep and McCroskey and was adapted into Turkish by Ay, et al.[3,14] The scale consists of 14 items that are rated with a 5 Likert type scoring. Total score ranges between 14-70 points. Higher scores indicate higher intercultural communication apprehension. Ay, et al. found that the Cronbach's alpha coefficient of the scale was 0.88. In this study, it was found as 0.82.

DATA ANALYSIS

The data were analyzed in SPSS Statistics 21 (IBM, USA) software. In psychometrical analysis, the correlation between the scale scores was evaluated using Pearson's correla-tion coefficient. Descriptive statistics, parametrical statistics, and advanced analysis method (Bonferroni post hoc test) were used. The confidence interval and significance levels were 95% and $p<0.05$, respectively.

RESULTS

CHARACTERISTICS OF THE PARTICIPANTS

When characteristics of the participants were examined, it was found that their average age was 32.16±7.53 years. 64.4% were female and 62.8% were single. When examining the occupational characteristics of the participants, it was determined that 17.7% of them were midwives, 55.4% were nurses and 26.9% were physicians, and 61.1% worked at public hospitals. 54.1% worked in internal medicine units. The majority of them had worked for more than 7 years (78%), and they hadn't received training on communication with patients from different cultures (93.3%), and 65.6% evaluated themselves as incompetent in communicating with those from different cultures. A great majority had received education on patient safety (80.5%) and mostly (81.3%) thought the patient safety education they received was ade-

quate. 41.3% of the participants evaluated themselves as professionally competent for people from different cultures..

INTERCULTURAL COMMUNICATION APPREHENSION LEVELS OF THE PARTICIPANTS

Participants' PRICA mean scores were 47.28±4.33 on the overall scale (Table 1). The participants who were younger, female, undergraduate and high school graduates, thought that the patient safety education they had received was not adequate, and saw themselves as incompetent in communicating with people from different cultures and providing care had higher PRICA scores (Table 2).

PATIENT SAFETY ATTITUDES OF THE PARTICIPANTS

Participants' mean scores were 151.84±31.79 on the overall PSAQ, 30.97±10.72 in the job satisfaction subscale, 43.83±8.73 in the team-work climate subscale, 18.48±4.44 in the safety cli-mate subscale, 24.25±6.59 in the perception of management subscale, 14.45±4.50 in the stress recognition subscale, and 19.84±4.93 in the work conditions subscale (Table 1). The participants who were aged 31 years and over, received education on patient safety, thought that patient safety education they received was adequate, received training on communication with people from different cultures, and evaluated themselves as competent in communicating with people from different cultures, and professionally competent for had higher PSAQ scores compared to the others (Table 2). Moreover, the participants who worked in private hospitals had higher PSAQ scores than those worked at public hospitals.

CORRELATION BETWEEN THE PRICA AND PSAQ SCORES

Table 3 shows the correlation between the participants' PRICA and PSAQ scores. The correlation coefficient between the measurements was determined to be r=-0.173 (Job satisfaction subscale) with the correlation between the measurements being negative and advanced significant, r=0.220 (Stress recognition subscale) with the correlation between the measurements being positive and advanced significant, r=0.104 (Work condition subscale) with the correlation between the measurements being positive and significant.

According to Table 4, regression analysis was performed using the Enter method to determine the factors predicting the patient safety attitudes of the participants. The presence of autocorrelation and multicollinearity was assessed by "Durbin Watson" and the "Variance inflation factor", and it was confirmed that the basic requirements of the regression analysis were met. A total of two models were established. In the first model, it was found that except for being older than 30 years ($p<0.05$) and working in a private hospital ($p<0.001$), the other variables did not have a statistically significant effect on the patient safety attitude score of the participants ($p>0.05$). It was determined that the variables in the model together accounted for 9% of the PSAQ (F=3.828; p=0.000; Adjusted R^2=0.062). In the second model, it was determined that the other variables did not have

TABLE 1: PRICA and PSAQ scores of participants.

Subscale	Minimum	Maximum	Mean (SD)	Cronbach alpha value
PRICA total	22	51	47.28 (4.33)	0.822
Job satisfaction	11	55	30.97 (10.72)	0.931
Team work climate	18	60	43.83 (8.73)	0.885
Safety climate	6	25	18.48 (4.44)	0.902
Perception of management	7	35	24.25 (6.59)	0.909
Stress recognition	5	25	14.45 (4.50)	0.769
Work conditions	7	30	19.84 (4.93)	0.768
PSAQ total	66	227	151.84 (31.79)	0.958

PSAQ: Patient safety attitudes questionnaire; PRICA: Personal Report of Intercultural Communication Apprehension Scale; SD: Standart deviation.

TABLE 2: Comparison of the participants' PRICA and PSAQ mean scores based on their characteristics (n=390).

Variable	Groups	n	PRICA mean (SD)	PSAQ mean (SD)
Age (31.02±7.49)	≤30	197	47.67 (4.30)	146.77 (32.00)
	31≤	193	46.87 (4.32)	157.02 (30.81)
	Test and p values		U=21.379 ***p=0.033**	U=15.188 ****p=0.001**
Gender	Female	258	46.67 (4.30)	151.68 (32.35)
	Male	132	46.52 (4.31)	152.15 (32.77)
	Test and p values		t=2.497 ***p=0.013**	t=-0.131 p=0.892
Profession	Physician[a]	105	46.67 (3.70)	153.72 (31.28)
	Nurse[b]	216	47.63 (4.69)	149.02 (32.16)
	Midwife[c]	69	4711 (4.00)	157.81 (30.80)
	Test and p values		F=1.793 p=0.168	F=2.260 p=0.106
Institution	Public hospital[a]	268	47.23 (4.33)	147.44 (29.82)
	University hospital[b]	53	47.73(4.74)	155.30 (35.65)
	Private hospital[c]	69	47.14(4.05)	166.30 (31.95)
	Test and p values		F=0.341 p=0.890	F=10.507 ****p=0.000**; c>a
Education background	Undergraduate and high school graduates	217	47.76 (4.45)	36.23 (4.45)
	Master's and higher degrees	173	46.68 (4.11)	37.31 (4.11)
	Test and p values		t=1.840 ***p=0.014**	t=0.191 p=0.282
Unit	Medical unit	211	47.43 (4.46)	151.02 (31.37)
	Surgical unit	179	47.10 (4.19)	152.81(32.35)
	Test and p values		t=0.748 p=0.341	t=0.723 p=0.582
Professional experience	≤5 years[a]	143	47.61 (4.33)	35.48 (6.81)
	6-9 years[b]	106	47.62 (3.69)	34.86 (6.90)
	≥10 years[c]	141	47.69 (4.73)	39.66 (7.09)
	Test and p values		F=2.49 p=0.130	F=2.604 p=0.075
Receiving education in patient safety	Received	314	47.12 (4.18)	154.96 (31.85)
	Did not receive	76	47.93(4.91)	138.96 (28.31)
	Test and p values		t=-1.456 p=0.146	t=4.013 ****p=0.000**
Patient safety education they received was adequate	Yes	317	47.05 (4.27)	155.50 (31.76)
	No	73	48.28 (4.50)	135.95 (26.83)
	Test and p values		t=-2.201 ***p=0.028**	t=4.871 ****p=0.000**
Receiving education in communication with different cultures	Received	26	46.46(4.18)	167.76 (29.50)
	Did not receive	364	47.34 (4.34)	150.70 (31.68)
	Test and p values		U=4161.500 p=0.303	U=3241.500 ****p=0.007**
Sufficient in communicating with people from different cultures	Yes	134	46.30(3.85)	159.83 (34.89)
	No	256	47.79(4.49)	147.66 (29.26)
	Test and p values		t=-3.262 ****p=0.001**	t=3.452 ****p=0.001**
Professionally competent for people from different cultures	Yes	208	46.79 (3.93)	159.82 (31.34)
	No	182	47.84 (4.70)	29.88 (66.00)
	Test and p values		t=-2.381 ***p=0.018**	t=5.494 ****p=0.000**

*p<0.05; **p<0.01; ***p<0.001; PRICA: Personal Report of Intercultural Communication Apprehension Scale; PSAQ: Patient safety attitudes questionnaire;
F: One-way analysis of variance; t: Independent samples t test.
The variables profession, institution, and professional Eexperiences were categorized into three groups: a (Category 1), b (Category 2), and c (Category 3).

a statistically significant effect on the patient safety attitude score of the participants, except for seeing the patient safety education as adequate ($p<0.05$) and thinking that they were professionally competent in providing health services to different cultures ($p<0.01$) ($p>0.05$). The variables in the model together accounted for 12% of the variance in the PSAQ score ($F=11.087$; $p=0.000$; Adjusted $R^2=0.115$).

TABLE 3: Correlation between the participants' PRICA and PSAQ scores.

		PSAQ						
Scales	Test	Job satisfaction	Team work climate	Safety climate	Perception of management	Stress recognition	Work conditions	PSAQ total
PRICA	r value	**-0.173****	-0.062	-0.054	0.025	**0.220****	**0.104***	-0.041

*p<0.05; **p<0.01; PRICA: Personal Report of Intercultural Communication Apprehension Scale; PSAQ: Patient safety attitudes questionnaire.

TABLE 4: Predictors of participants patient safety attitudes.

Model		B	SD	β	t	p	Durbin Watson	VIF
1	(Constant)							
	Patient Safety Attitudes	185.641	10.944		16.963	0.000		
	Age (31≤)	-13.211	6.232	-0.201	-2.120	***0.035**		3.742
	Gender (Female)	-0.333	3.488	-0.005	-0.096	0.924		1.127
	Occupation (Nurse)	0.324	4.765	0.005	0.068	0.946	1.773	2.322
	Institution (Private Hospital)	-18.60	4.234	-0.224	-4.394	****0.000**		1.080
	Education Background (Master's and higher degrees)	5.436	3.950	0.850	1.376	0.170		1.593
	Unit (Medical Units)	3.221	3.349	0.510	0.962	0.337		1.152
	Professional experience (≥10 years)	1.042	6.524	0.016	0.160	0.873		4.064
	R^2=0.092; Adjusted R^2=0.062; F=3.828; p=0.000***							
2	(Constant)	175.001	6.093		28.721	0.000		
	Patient Safety Attitudes							
	Receiving education in patient safety	-7.304	4.903	-0.091	-1.490	0.137		1.643
	Patient safety education they received was adequate	-10.665	4.989	-0.131	-2.138	***0.033**		1.650
	Receiving education in communication with different cultures	-12.064	6.158	-0.095	-1.959	0.051	1.773	1.028
	Sufficient in communicating with people from different cultures	-3.987	3.866	-0.060	-1.031	0.303		1.469
	Professionally competent for people from different cultures	-1.553	3.694	-0.197	-3.398	****0.001**		1.480
	R^2=0.126; Adjusted R^2=0.115; F=11.087; p=0.000***							

*p<0.05; **p<0.01; ***p<0.001

DISCUSSION

Increasingly multicultural structures in the world have significantly influenced the need for intercultural communication. Intercultural communication has become an obligation especially in the delivery of healthcare services. The present study aimed to determine whether there is any correlation between intercultural communication apprehension and patient safety attitudes of healthcare professionals revealed that while there was no significant correlation between the PRICA and PSAQ scores of the participants, the PRICA was significantly correlated with the subscales of the PSAQ (stress recognition, job satisfaction, work conditions) and both factors were associated with a large number of factors.

As a result of the study, the participants were found to have a moderate level of communication apprehension. Hospitals have stressful working environments.Working in shifts and providing care to

patients from different cultures are important stressors.[15]

Female participants and those younger than 30 were found to have higher intercultural communication apprehension levels. Gender has been regarded among barriers to intercultural communication. For individuals migrating from different cultures, such as Muslim immigrants, the gender of the healthcare professional can be essential and can be seen as a barrier to communication.[16] The present study was conducted in Türkiye having a predominantly muslim society.

It has been reported in the literature that intercultural awareness increases as the ages of healthcare professionals increase.[17] Likewise, in the present study, intercultural sensitivity and intercultural communication of older healthcare professionals may have been positively influenced and this may have caused lower levels of intercultural communication apprehension.

It was found that the participants with an undergraduate or lower level of education experienced a higher level of intercultural communication apprehension. Another study indicated that a high level of education affected intercultural awareness and empathy positively.[17] This may be one of the factors affecting the results. Intercultural communication is one of the pillars of healthcare services and requires a continuous learning education.[18] While the history of this education process goes back many years, studies have been continuing to make it a compulsory component of programs such as international business, medicine, and nursing. In Türkiye, the state of intercultural communication courses being compulsory in nursing undergraduate and graduate programs differs from institution to institution, and there is no standardization.[19] There is a similar situation in the world. For example, it was found in a study conducted in Korea that the course of intercultural nursing was compulsory in 31.6%.[20] Another study reported that in Europe, the curricula of medical faculties were insufficient in terms of intercultural competence and communication, medical education programs and physicians were largely unprepared for the social and cultural diversity.[21] In a qualitative study investigating the experiences of healthcare professionals providing women's health services to refugees in Türkiye that the doctors and nurses experienced anxiety while providing transcultural health care and evaluated themselves as insecure and incompetent.[22] Before preparing educational programs on the topic, a road map can be determined for all healthcare professionals through a needs analysis by considering the characteristics of the country and the culture, especially in the areas of practice.

It was found that the participants who evaluated the patient safety education they received inadequate, who evaluated themselves as incompetent in communicating with people from different cultures, and who evaluated themselves as professionally incompetent for people from different cultures had higher intercultural communication apprehension levels. One of the dimensions of intercultural communication is understanding a person's cultural background. Healthcare without cultural data is not complete. A lack thereof causes people to display more negative attitudes toward intercultural care and communication. It also affects the competence perceived by healthcare professionals to provide care to individuals from different cultures. In addition, in terms of communication problems, how healthcare professionals evaluate their competence is as important as awareness of sociocultural components of the disease of patients they provide care for. In this case, healthcare professionals may evaluate themselves as incompetent both in communication and also in the profession. Measurements including self-evaluation of healthcare professionals should be conducted, they should develop themselves in areas needed, and managers should take responsibility.

The participants were found to display low levels of patient safety attitudes, which is compatible with literature. There are studies reporting different patient safety attitudes of healthcare professionals.[22,23] Problems related to language and culture are usually considered a threat to patient safety and the concept of cultural competence is essential in providing safe and qualified healthcare services to patient groups with different cultures. This situation shows that although Türkiye is home to people from many cultures, the attitudes toward patient safety in healthcare services offered to individuals with different lan-

guages and cultures are not at desired levels. It was concluded that the age had a positive effect on patient safety attitude, which is compatible with the study by Kakemam et al.[23]

The present study revealed that while healthcare professionals working in private hospitals showed the highest patient safety attitude, those working in public hospitals had the lowest level of patient safety attitude. likewise, studies conducted in Türkiye and Slovakia reported that patient safety culture levels were higher in private hospitals.[24,25] On the contrary, a study conducted in Iran indicated that patient safety culture levels were higher in public hospitals.[26] This result can be associated with health policies adapted by countries. In addition, the concept of patient safety is influenced by the structure of the institution's culture and the quality approach adopted. One of the ways health institutions to keep the quality of health service delivery at the optimum level is gaining international accreditation. The oldest accreditation that attaches importance to international patient safety and quality of service is "JCI accreditation".[27] When JCI hospital standards are examined, it can be seen that they include practices that have the concept of quality improvement and patient safety at their core. When health institutions with JCI accreditation in Türkiye are examined, they are mostly private hospitals and private university hospitals.[28] This situation may have influenced the results of the study.

In the study, it was found that the participants who received patient safety education and evaluated this education adequate had a high level of patient safety attitude. In a recent study, participants who received patient safety education had higher levels of patient safety attitude.[23] This result is compatible with the results of previous studies.[29,30] Healthcare professionals need to participate in continuous education in terms of awareness. In this regard, the Patient Safety Curriculum Guide prepared by WHO and documents prepared by many international organizations can be used in the development and standardization of existing practices in health organizations.[31] Intercultural communication should be an important focus of patient safety education to promote delivery of safe and quality healthcare.

The results of the study showed that the participants who received training on communication with different cultures and evaluated themselves competent in communicating with people from different cultures had higher patient safety attitudes. In another study, participants stated that the language barrier caused misdiagnosis, delayed treatment, and decreased trust in the services received.[32] Accreditation Canada, which has existed for more than 60 years in Canada to develop quality and safety, highlighted the importance of addressing language barriers by a recent review of the international evidence on language in healthcare services based on dimensions of care.[33] In a study evaluating language and culture barriers from the perspective of healthcare service receivers, individuals reported that they experienced stress about failure to receive appropriate care.[32] Overcoming these barriers requires big steps and obligations about national health pol-icy rather than individual efforts.

In this study, it was found that the participants who evaluated themselves as professionally competent for people from different cultures had more positive patient safety attitudes. Healthcare provided to different cultures is full of uncertainties. A healthcare professional who can not communicate with others may experience stress. The result indicating that there is a positive correlation between intercultural communication apprehension and "Stress recognition" and "Work conditions" sub-dimensions of the patient safety attitude scale supports this result. According to this result, the participants who had higher intercultural communication apprehension levels evaluated their stress levels as high and their working conditions as more negative.[34] Brasaitė et al., concluded that heavy workload, not feeling professionally competent, communication interruptions, and insufficient knowledge affected patient safety negatively.[35] Intercultural communication enhances the quality of care, patient safety, provides an effective communication, alleviates healthcare professionals' stress, and increases satisfaction perceived by healthcare receivers. Thus, the results of steps taken for intercultural communication competence will have positive effects on the variables that threaten patient safety.

No correlation was found between intercultural communication apprehension and patient safety attitudes. But there was a negative correlation between the PRICA and the "Job satisfaction" subscale of the PSAQ. This result showed that the apprehension experienced due to communication problems affected the job satisfaction of healthcare professionals negatively. Communication, which forms the basis of healthcare service delivery, has an undeniable with job satisfaction.

CONCLUSION

It was concluded that the healthcare professionals had a moderate level of communication apprehension while showing low levels of patient safety attitudes. The participants who were aged 31 years and over, received patient safety education, thought that patient safety education they received was adequate, received training on communication with different cultures, evaluated themselves as competent in communicating with people from different cultures, and evaluated themselves as professionally competent for people from different cultures were higher levels of patient safety attitudes. Furthermore, the participants who worked in private hospitals had higher PSAQ scores than those who worked at public hospitals, and participants having an experience of 10 years or more showed higher levels of patient safety attitudes.

The healthcare professionals who were younger, were female, had bachelor and the high school graduate degrees, thought that patient safety education they received was not adequate, those evaluated themselves as incompetent in communicating with people from different cultures, and evaluated themselves as professionally incompetent for people from different cultures had high levels of communication apprehension.

Seniority, working in a private hospital, receiving comprehensive and adequate patient safety education and professional competency for different cultures were revealed as significantly correlated with the Patient Safety Attitude.

It is recommended that:

- The experiences of healthcare professionals in providing health services to individuals from different cultures be investigated qualitatively and the current situation be analyzed,
- The feedback of the patient safety education provided be received effectively,
- Self-assessment be supported in receiving feedback,
- Courses and lectures which supporting communication with different cultures and patient safety be added as mandatory in the curricula of healthcare professionals at the undergraduate level.

Acknowledgements

The research was presented as an oral presentation at the 2nd International Congress of Health Research. We would like to thank English language expert Selçuk Yılmaz for translating, we would like to thank English language expert Emel Zindan De Camillis for proofreading for proper grammar, spelling, punctuation, and overall style for the manuscript and we would like to thank all of the healthcare professionals who participated in this study for their support.

Source of Finance

During this study, no financial or spiritual support was received neither from any pharmaceutical company that has a direct connection with the research subject, nor from a company that provides or produces medical instruments and materials which may negatively affect the evaluation process of this study.

Conflict of Interest

No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.

Authorship Contributions

Idea/Concept: *Gamze Tunçer Ünver, Mahmut Kahraman;* ***Design:*** *Gamze Tunçer Ünver, Mahmut Kahraman;* ***Control/Supervision:*** *Gamze Tunçer Ünver;* ***Data Collection and/or Processing:*** *Gamze Tunçer Ünver, Mahmut Kahraman;* ***Analysis and/or Interpretation:*** *Gamze Tunçer Ünver;* ***Literature Review:*** *Gamze Tunçer Ünver, Mahmut Kahraman;* ***Writing the Article:*** *Gamze Tunçer Ünver, Mahmut Kahraman;* ***Critical Review:*** *Gamze Tunçer Ünver.*

REFERENCES

1. United Nations. Department of Economic and Social Affairs. Population division. World population prospects: Highlights, 2019 Revision. United Nations 2019. [Cited: March 2021]. Available from: [Link]
2. World Health Organization, Seventy-Second World Health Assembly. Patient safety Global action on patient safety. 2019. Cited: July, 2022. Available from: [Link]
3. Neuliep JW, McCroskey JC. The development of intercultural and interethnic communication apprehension scales. Commun Res Rep. 1997;14(2):145-56. [Crossref]
4. Neuliep JW. Intercultural communication apprehension. The International Encyclopedia of Intercultural Communication. 2017:1-5. [Crossref]
5. van Dalen J. Communication skills in context: trends and perspectives. Patient Educ Couns. 2013;92(3):292-5. [Crossref] [PubMed]
6. Joint Commission on International Accreditation [Internet]. ©2024 The Joint Commission [Cited: May 10, 2023]. Standards for Hospitals 2021. Available from: [Link]
7. Auraaen A, Slawomirski L, Klazinga N. The economics of patient safety in primary and ambulatory care: Flying blind; 2018. In: OECD Health Working Papers, no:106. Paris: OECD Publishing; 2018. Aveilable from: [Link]
8. Gambashidze N, Hammer A, Wagner A, Rieger MA, Brösterhaus M, van Vegten A, et al. Influence of gender, profession, and managerial function on clinicians' perceptions of patient safety culture: a cross-national cross-sectional study. J Patient Saf. 2019;1(4). [Crossref] [PubMed] [PMC]
9. Hwang JI, Kim SW, Chin HJ. Patient participation in patient safety and ıts relationships with nurses' patient-centered care competency, teamwork, and safety climate. Asian Nurs Res (Korean Soc Nurs Sci). 2019;13(2):130-6. [Crossref] [PubMed]
10. Tunçer Ünver G, Harmanci Seren AK. Defining the patient safety attitudes and influencing factors of health professionals working at maternity hospitals. J Nurs Manag. 2018;26(5):579-86. [Crossref] [PubMed]
11. Cohen J, Cohen P, West S. Applied Multiple Regression/Correlationanaly Sisfor the Behavioral Sciences. 3rd ed. USA: Lawrence Earlbaum Publishers; 2003.
12. Sexton JB, Helmreich RL, Neilands TB, Rowan K, Vella K, Boyden J, et al. The safety attitudes questionnaire: psychometric properties, benchmarking data, and emerging research. BMC Health Serv Res. 2006;6:44. [Crossref] [PubMed] [PMC]
13. Baykal U, Sahin NH, Altunas S. Turkish adaptation of patient safety attitude questionnaire. Journal of Education and Research in Nursing. 2010;7(1):39-45. [Link]
14. Ay E, Kavuran E, Turkoglu N. Intercultural communication apprehension scale (PRICA): Validity and reliability study in Turkish. J Caring Sci. 2018;11(3):1638-46. [Link]
15. Plaza Del Pino FJ, Soriano E, Higginbottom GM. Sociocultural and linguistic boundaries influencing intercultural communication between nurses and Moroccan patients in southern Spain: a focused ethnography. BMC Nurs. 2013;12:14. [Crossref] [PubMed] [PMC]
16. Claeys A, Berdai-Chaouni S, Tricas-Sauras S, De Donder L. Culturally sensitive care: definitions, perceptions, and practices of health care professionals. J Transcult Nurs. 2021;32(5):484-92. [Crossref] [PubMed]
17. Gümüşsoy S, Dal NA, Beydağ KD, Toker E. Intercultural awareness, communication, and empathy skills in nurses and midwives working in provinces with mass migration. Perspect Psychiatr Care. 2021;57(2):426-32. [Crossref] [PubMed]
18. Degrie L, Gastmans C, Mahieu L, Dierckx de Casterlé B, Denier Y. "How do ethnic minority patients experience the intercultural care encounter in hospitals? a systematic review of qualitative research". BMC Med Ethics. 2017;18(1):2. [Crossref] [PubMed] [PMC]
19. Yorulmaz DS, Karadeniz H. Türkiye'de hemşirelik lisans programlarında verilen kültür derslerinin değerlendirilmesi. [Evaluation of the culture courses given in nursing undergraduate programs in Turkey]. Türkiye Klinikleri Journal of Nursing Sciences. 2021;13(3):598-604. [Crossref]
20. Jang MK, Kim HY. A convergence study on the effects of self-leadership and selesteem on nursing performance. Journal of the Korea Convergence Society. 2018;9(2):51-9. [Link]
21. Sorensen J, Norredam M, Suurmond J, Carter-Pokras O, Garcia-Ramirez M, Krasnik A. Need for ensuring cultural competence in medical programmes of European universities. BMC Med Educ. 2019;19(1):21. [Crossref] [PubMed] [PMC]
22. Unver GT, Baykal U. Experiences of healthcare professionals providing women's health services to asylum seeking women at the hospitals. Bezmialem Science. 2024;12(1):128-36. [Crossref]
23. Kakemam E, Albelbeisi AH, Davoodabadi S, Ghafari M, Dehghandar Z, Raeissi P. Patient safety culture in Iranian teaching hospitals: baseline assessment, opportunities for improvement and benchmarking. BMC Health Serv Res. 2022;22(1):403. [Crossref] [PubMed] [PMC]
24. Gurková E, Kalánková D, Kurucová R, Žiaková K. Assessment of patient safety climate by nurses in Slovak Public and private hospitals. J Nurs Manag. 2020;28(7):1644-52. [Crossref] [PubMed]
25. Tapan B, Gayef A, Kaptanoğlu AY. Comparison between a public and private hospital in terms of patient safety culture. Sanitas Magisterium. 2015;1(2):45-60. [Crossref]
26. Khoshakhlagh AH, Khatooni E, Akbarzadeh I, Yazdanirad S, Sheidaei A. Analysis of affecting factors on patient safety culture in public and private hospitals in Iran. BMC Health Serv Res. 2019;19(1):1009. [Crossref] [PubMed] [PMC]
27. Tarieh RRA, Zayyat R, Naoufal RN, Samaha HR. A case study exploring the impact of JCI standards implementation on staff productivity and motivation at the laboratory and blood bank. Health Sci Rep. 2022;5(1):e497. [Crossref] [PubMed] [PMC]
28. Avcil S, Özkan T. İstanbul'daki JCI akreditasyonuna sahip özel hastanelerin hizmet kalitesi. [Service quality of JCI accredited private hospitals in İstanbul]. Yönetim Bilimleri Dergisi. 2020;18(36):309-38. [Crossref]
29. Jin J, Yi YJ. Patient safety competency and the new nursing care delivery model. J Nurs Manag. 2019;27(6):1167-75. [Crossref] [PubMed]
30. Murray M, Sundin D, Cope V. New graduate registered nurses' knowledge of patient safety and practice: a literature review. J Clin Nurs. 2018;27(1-2):31-47. [Crossref] [PubMed]
31. World Health Organization. Patient safety curriculum guide: Multi-professional edition, 2011. Cited: October, 2023. Available from: [Link]
32. de Moissac D, Bowen S. Impact of language barriers on quality of care and patient safety for official language minority francophones in Canada. J Patient Exp. 2019;6(1):24-32. [Crossref] [PubMed] [PMC]
33. Bowen S. The impact of language barriers on patient safety and quality of care. Société Santé en Français. 2015;603-23. [Link]
34. Zanjani ME, Ziaian T, Ullrich S. Challenges and experiences of overseas qualified nurses adjusting to new roles and health care systems: A narrative review of the literature. Singapore Nursing Journal. 2018;45(2):7-16. [Link]
35. Brasaitė I, Kaunonen M, Martinkėnas A, Mockienė V, Suominen T. Health care professionals' skills regarding patient safety. Medicina (Kaunas). 2016;52(4):250-6. [Crossref] [PubMed]