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Cross-cultural communication in nursing. A comparative study of nursing students from Poland, Turkey and Hungary

SUMMARY

Aim. The goal of this study was to show the opinions of nursing students concerning the most frequent difficulties in establishing effective communication with patients from other cultures.

Material and Methods. This cross-sectional study involved 354 first-year nursing students from five schools in Turkey, Poland and Hungary. It was based on a questionnaire developed by one of the authors.

Results. The respondents considered the familiarity with the language, overcoming the fear of cultural otherness and speaking slowly and clearly without the knowledge of medical jargon as the most crucial elements of effective communication with patients.

Conclusion. Although the students are open to establishing relationships based on communication with patients representing different cultures and faiths and understand the importance of the process, they need to be adequately prepared for cross-cultural interactions.

Key words: nursing students, nurse education, cross-cultural communication, multiculturalism, cultural competence.

Introduction

Together with the development of various forms of communication, as well as a result of globalisation and migration processes and a professional mobility policy, cultural diversity has become a frequent phenomenon in many countries[1]. The modern world is characterised by cultural multiplicity and diversity, both in terms of values as well as practices[2]. This diversity does not come only from the collision of different languages, dialects and communications, but also from the variety of attitudes, behaviours, reactions and all the elements that have a direct relation with the culture which people come from and take on its specific characteristics as a result of socialisation. Culture shapes the way of perceiving the world; it is a collection of values, social practices and forms of expression which are respected by a group and which give them meaning and validity. Despite the fact that culture is most often defined through ancestry, language and traditions, it can also be defined through geographic regions, religion and socio-economic status. It is always relativised to the society that shapes and executes it, and though people live in various ways, within each community there is a way of life specific to its members; a prevailing pattern of acting and thinking[3].

This diversity is a particular challenge for nursing personnel while caring for patients who come from different cultures. Moreover, if we assume that cultures are dynamic and undergo constant changes[4], this implies the necessity to adjust nursing care to the cultural needs of patients[5] along with flexibility and openness of the staff to cultural diversity[6].

Research shows that migrants often experience lower quality of care when compared to the majority of the local population[7]. Nurses, along with other health care workers, often lack the knowledge and skill to deal with the needs of patients who come from different cultures[8]. Difficulties in communication, as well as verbal and nonverbal processes of coding

[1] A. Majda, J. Zalewska-Puchała, *Intercultural sensitivity in nursing care*, „Problemy Pielęgniarstwa" 2011, 19, 2, s. 253–258, (Original Work Published in Polish).

[2] G. Hofstede, G. J. Hofstede, *Cultures and organizations. Programming the mind*, PWE, Warszawa 2007, (Original Work Published in Polish).

[3] P. Sztompka, *Sociology. Analysis of Society*, (Original Work Published in Polish) Znak, Kraków 2002.

[4] K. Szymańska, *Organisational culture as a part in the development of open innovation – the perspective of small and medium-sized enterprises*, „Management" 2016, 20, 1, s. 142–154.

[5] S. Dyson, C. Smaje, *The health status of minority ethnic groups* [in:] *Ethnicity and Nursing Practice*, L. Culley, S. Dyson (Eds.), Palgrave, Basingstoke 2001, s. 39–65; M. Leininger, M. R. McFarland, *Transcultural Nursing: Concepts, Theories, Research and Practice*, 3rd edn. McGraw-Hill Medical Pub, Division, New York 2002.

[6] S. Dyson, C. Smaje, op. cit.

[7] E. Wiking, S. E. Johansson, J. Sundquist, *Ethnicity, acculturation, and self-reported health. A population based study among immigrants from Poland, Turkey, and Iran in Sweden*, „Journal of Epidemiology Community Health" 2004, 58, s. 574–82; W. E. Parmet, L. Sainsbury-Wong, M. Prabhu, *Immigration and Health: Law, Policy, and Ethics*, „The Journal of Law, Med*icine* and Ethics" 2017, 45, 1, s. 55–59.

[8] A. Berlin, S. E. Johansson, L. Tornkvist, *Working conditions and cultural competence when interacting with children and parents of foreign origin – Primary Child Health Nurses' opinions*, „Scandinavian Journal of Caring Sciences" 2006, 20, s. 160–8. 4; T. Crawford, S. Candlin, P. Roger, *New perspectives on understanding cultural diversity in nurse–patient communication*, „Collegian" 2017, 24, s. 63–69.

and decoding[9], constitute the main obstacle in intercultural encounters, i.e. those between a nurse and a patient who are each representatives of separate cultural environments.

The main paradigm of the nurse-patient relation is the philosophical argument, which states that every human has an ontological inclination to other humans. According to this argument, humanity, as well as the health recovery process, depends on the level of a dialogic interaction with another human. Thus, the nursing process, deprived of interpersonal relations, becomes disintegrated, and there is a danger of the patient becoming dehumanised.

Communication is an essential part of nursing[10]. It is a complex process involving far more than linguistic elements – it requires the interpretation of speech, sounds, facial expressions, body language and gestures[11]. Effective communication with patients poses a challenge to nurses. The challenge is even greater if the patient comes from a different culture and speaks a different language[12].

The language barrier may make access to health care difficult, impede the patient's ability to communicate their needs, as well as hinder the health care worker's ability to understand the patient's needs and provide optimal medical and nursing care. As a result, intercultural health care faces a series of difficulties, which often lead to insufficient exchange of information and low quality of nursing care[13]. The situation may be compounded when patients feel unsafe and experience anxiety as a result of their illness[14].

In preparing for the nursing profession, the development of communication techniques intensifies, which makes the interaction more efficient. However, the efficiency itself, even if technically perfect, cannot replace a proper bond with the patient. Although theoretical knowledge is a necessary condition of being an educated and technically proficient nurse, it does not fulfil the condition of being good and, especially, wise and thoughtful in dialogic interaction with the patient[15].

In order to establish dialogue and effectively communicate with a patient from another culture, nursing staff should have a set of skills that allow them to perceive and acknowledge patients from different cultures. It simultaneously helps to better understand their own community and their place in it. A set of the skills allows them to react respectfully and empath-

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[9] O. L. Lekhanovaa, O. A. Glukhovaa, *Nonverbal encoding and decoding of nonverbal communication means as a condition of reflection development in communication in children with speech underdevelopment*, „Procedia – Social and Behavioral Sciences" 2016, 233, s. 504–507; D. Matsumoto, L. Juang, *Intercultural Psychology*, GDP, Gdańsk 2007. (Original Work Published in Polish).

[10] M. Ali, *Communication skills 1: benefits of effective communication for patients*, „Nursing Times" 2017, 113, 12, s. 18–19.

[11] H. Bradby, *Communication, interpretation and translation* [in:] *Ethnicity and Nursing Practice*, L. Culley, S. Dyson (Eds.), Palgrave, Basingstoke 2001, s. 129–148.

[12] V. L. Van de Berg, *Still lost in translation: language barriers in South African health care remain*, „Journal South African Family Practice" 2016, 58, 6, s. 659–666; T. Crawford, S. Candlin, P. Roger, op. cit.

[13] K. J. Watts, B. Meiser, E. Zilliacus, R. Kaur, M. Taouk, A. Girgis, P. Butow, D. Goldstein, S. Hale, A. Perry, S. K. Aranda, D. W. Kissane, *Communicating with patients from minority backgrounds: Individual challenges experienced by oncology health professionals*, „European Journal of Oncology Nursing" 2017, 26, s. 83–90.

[14] R. Eckhardt, S. Mott, S. Andrew, *Culture and communication: identifying and overcoming the barriers in caring for non-English-speaking German patients*, „Diver Health Soc Care" 2006, 3, s. 19–25.

[15] M. Jantos, Z. Pucko, *Meeting-communication-dialogue. Preconditions* [in:] *Interpersonal communication in nursing*, A. Kwiatkowska, E. Krajewska-Kułak, W. Panka (Eds.), Czelej, Lublin 2003, s. 11–29. (Original Work Published in Polish).

ically to people of all nationalities, races, classes, religions, ethnicities and other groups in a way that it recognises, affirms and appreciates as a value. It is very important because most people tend to look at things from their own cultural perspective, as well as interpret and judge events, along with other people and their behaviours, in respect to the standards known to them. Generally, people tend to look at things from their own cultural perspective, as well as interpret and judge events, along with other people and their behaviours, in respect to the standards known to them[16]. Bennett does not consider this to be a natural state, because there is a tendency in human behaviour, when in contact with persons from different cultures, to perceive the situation through a prism of one's own norms[17].

Purpose

The goal of this cross-sectional study was to present the differences and similarities in the opinions of nursing students concerning the most frequent difficulties in establishing effective communication, as well as to show the attitudes, skills and knowledge necessary for interactions with patients from other cultures.

Methods

A cross-sectional, comparison study was conducted among the first year students. Nursing students were from five schools in three countries: Turkey, Poland and Hungary. The research was conducted from October 2014 to January 2015. This design allowed us to gain a preliminary understanding of the student's views and perceptions of cultural-specific content in their nursing courses[18].

Setting

The research subjects were 354 first-year nursing students from five schools in three countries: Turkey (Mehmet Akif Ersoy University in Burdur, Kilis 7 Aralik University), Poland (Pomeranian University in Słupsk, University of Applied Sciences in Piła) and Hungary (University of Debrecen Faculty of Health).

Data Collection

The study proper was preceded by a pilot study outside the area of research. Links to the survey were sent out electronically. After pre-testing of the questionnaire was completed, the researcher modified some questions (clarity and wording of items) based on feedback from the pre-test.

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[16] D. Cieślikowska, *Psychological and social consequences of going to another country* [in:] *From migration to integration. Vademecum. HFPC*, A. Chmielecka (Eds.), Warszawa 2012, s. 37–66. (Original Work Published in Polish).

[17] M. J. Bennett, *Toward Ethnorelativism: A Developmental Model of Intercultural Sensitivity* [in:] *Education for Intercultural Experience*, R.M. Paige (Eds.), Intercultural Press, Yarmouth 1993, ME, s. 21–77.

[18] M. Sandelowski, *Whatever happened to qualitative description?*, „Research in Nursing and Health" 2000, 23, s. 334–340.

The invitation to participate in the research was sent out to the members and associates of European Transcultural Nursing Association (ETNA). Five of them responded to the invitation, and eventually three recipients from Poland, Turkey and Hungary decided to participate in the research.

Recruitment was consecutive, and snowball sampling was used. Each researcher distributed the survey questionnaire to their network of nursing students. Participants were emailed a link and completed the survey at home or in their place of work. The electronic survey was presented in the host country's language. For participants who could not access the online survey, paper questionnaires were used.

A questionnaire was sent to the students via the Internet. The level of acceptance of the students' views was measure with a four-element Likert scale without a neutral choice. Validation of the questionnaire fulfilled the guidelines approach to translation and validation questionnaire[19]. The questionnaire was adapted for comparative research by of cultural adaptation. Each questionnaire was translated by two independent, professional translators.

The questionnaire contained questions regarding understanding and definitions of a culturally different patient, assessments of the usefulness of knowledge of other cultures in the professional work of a nurse, selection of the most important elements influencing contact of nursing staff with a representative of a different culture, an indication of the difficulties and barriers in caring for a culturally different patient most often encountered by nursing staff in their professional work, as well as specifying the necessary knowledge, skills and behaviours and attitudes in professional relations with a representative of a different culture.

The invitation letter informed potential participants of the aim of the survey, stated the name of the ethics committee/s which provided ethical approval for the study and emphasised that participation was anonymous, confidential and voluntary. Web-based electronic survey software was used to collect data in each country. The respondents were informed that their participation in the study was voluntary and that they would not be obligated to provide answers to any question(s) with which they were uncomfortable. The respondents were also informed that they could opt out from the study at any time without any consequences.

Data Analysis

In the study, the statistical analysis was based on the quantitative presentation of social and psychosocial phenomena – here measuring the opinions of the student. The study results were also supplemented with the qualitative analysis of the participants' statements.

After the respondents' answers were received, they were entered anonymously into the data collection worksheet. After data collection, each questionnaire was checked visually for completeness. Data was entered, cleaned and coded using Statistica 10 PL software. The results were presented as a frequency table and descriptive statistics. The significance of relationships between categorical variables was analysed by correlations between variables, Pearson's χ^2*test*, as well as descriptive statistics. The most common answer (dominant) was defined, along with the frequency distribution for each variable, with an assumed level of confidence of $p \leq 0{,}05$ in normal distribution.

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[19] Eurostat, *Guidelines for the Development and Criteria: for the Adoption of Health Survey Instruments, European Commission*, Belgium 2011, retrieved from http://ec.europa.eu/health/ph_information/dissemination/reporting/healthsurveys_en.pdf.

Ethical consideration

The study protocol and procedures were approved by the Committee of Bioethics in the country of the main researcher, No. 5/02/2013. The participating co-researchers ensured that local country regulations were followed.

Results

A convenience sample of $N=354$ nurses responded to the survey from the following 3 countries: Hungary – 83, Poland – 123, Turkey – 148.

Respondents demonstrated openness to meeting a culturally different patient, and 84.13% of them declared that they would like to establish contact with someone under their care without seeking support and help from other people or medical personnel.

Statistical analysis showed statistical compatibility between a desire to engage in interaction during contact with a culturally different patient and the respondents' nationality ($\chi^2=24{,}27353$ $p=0{,}00206$). All students from Poland expressed a desire for independent contact with a culturally different patient, while students from Turkey and Hungary (28,38%, 28,92%) would ask another person for help.

Statistical analysis showed no relationship between nationality and the need for knowledge of different cultures by working nursing staff. Respondents unequivocally stated that knowledge of other cultures was very much needed (35,71%) or needed (55,24%) in the professional work of nurse ($r=0{,}091$ $p=0{,}188$).

Statistical analysis in a few cases showed no relationship between nationality and the assessment of elements necessary to establish effective communication with a culturally different patient. Among the exceptions were knowledge of the language and the ability to overcome the fear of cultural otherness, respect and appreciation of cultural difference and the ability to recognise problems arising from cultural differences, as well as knowledge of the impact of culture on health and illness (Tab. 1).

Table 1. Characteristics affect the nursing staff to make contact with the person presenting different culture

Characteristic	Turkish students (n=148)	Polish students (n=123)	Hungarian students (n=83)
Which of the following characteristics affect the nursing staff to make contact with the person presenting different culture?			
1. Overcoming ethnocentric attitude and stereotypes r=0,189 p=0,006			
Facilitate to a large degree	32,42%	62,26%	15,66%
Facilitate	56,76%	35,85%	51,81%
Facilitate to a smaller degree	2,7%	–	30,12%
Do not facilitate	8,11%	1,89%	2,41%
2. The knowledge of language r=0,422 p<0,001			
Facilitate to a large degree	66,22%	77,36%	30,12%
Facilitate	33,78%	22,64%	38,55%
Facilitate to a smaller degree	–	–	27,71%
Do not facilitate	–	–	3,62%

3. Speaking slowly and clearly, without medical jargon r=0,066 p=0,340			
Facilitate to a large degree	44,59%	61,11%	43,37%
Facilitate	47,30%	35,85%	40,96%
Facilitate to a smaller degree	6,76%	3,04%	13,25%
Do not facilitate	1,35%	–	2,42%
4. Knowledge of the differences between nurse's culture and the culture of the patient r=0,148 p=0,032			
Facilitate to a large degree	22,97%	33,96%	15,66%
Facilitate	70,27%	54,72%	50,60%
Facilitate to a smaller degree	2,70%	11,32%	25,0%
Do not facilitate	4,06%	–	8,74%
5. Knowledge of the impact of culture on health and illness r=0,161 p=0,019			
Facilitate to a large degree	29,73%	45,28%	25,30%
Facilitate	60,81%	47,17%	48,19%
Facilitate to a smaller degree	8,11%	7,55%	22,89%
Do not facilitate	1,35%	–	3,62%
6. The ability to overcome the fear of cultural otherness r=0,329 p<0,001			
Facilitate to a large degree	50,0%	60,38%	21,68%
Facilitate	41,89%	33,96%	45,78%
Facilitate to a smaller degree	8,11%	5,66%	27,71%
Do not facilitate	–	–	4,83%
7. Respect and appreciation of cultural differences r=0,225 p=0,001			
Facilitate to a large degree	63,51%	58,49%	39,76%
Facilitate	31,43%	33,96%	48,19%
Facilitate to a smaller degree	5,06%	7,54%	8,43%
Do not facilitate	–	–	3,62%
8. Ability to recognize problems arising from cultural differences r= 0,232 p=0,001			
Facilitate to a large degree	44,59%	54.72%	25,0%
Facilitate	48,65%	39.62%	55,42%
Facilitate to a smaller degree	6,76%	5.66%	19,28%
Do not facilitate	–	–	0,3%
9. Knowledge of social policy for example: the issue of the treatment of ethnic minorities r=0,003 p=0,965			
Facilitate to a large degree	27,03%	37,74%	25,30%
Facilitate	50,0%	49,06%	50,60%
Facilitate to a smaller degree	17,57%	13,2%	21,69%
Do not facilitate	5,4%	–	2,41%

Source: own study.

The respondents considered familiarity with language (54.76%), overcoming the fear of cultural otherness (52,86%) and speaking slowly and clearly without medical jargon (48,57%) as the most crucial elements of effectively establishing contact with a patient.

Statistical analysis showed a relation between nationality and the students' assessment of the difficulties and obstacles in establishing effective communication with a culturally different patient: language barrier, prejudices and stereotypes prevailing among nursing staff, the impossibility of effective non-verbal communication, the inability to establish contact with a representative of the religion of the patient (Tab. 2). Respondents cited language barrier (32.38%), prejudices and stereotypes among nursing staff (23,33%) and the inability to understand non-verbal communication (21,43%) as the most frequent difficulties in effective dialogue.

Table 2. The most nursing staff of their work meets difficulties, barriers to patient's different culturally care by respondents opinion

Characteristic	Turkish students (n=148)	Polish students (n=123)	Hungarian students (n=83)
What kind of difficulties, barriers to patient's different culturally care, meets the most nursing staff of their work?			
1. The language barier r=0,286 p<0,001			
Very frequently	43,24%	37,74%	19,28%
Frequently	41,89%	58,49%	44,58%
Rarely	14,86%	3,77%	36,14%
Never	–	–	–
2. Prejudices and stereotypes prevailing among nursing staff r=0,161 p=0,019			
Very frequently	27,02%	28,30%	16,87%
Frequently	54,05%	54,72%	50,60%
Rarely	18,93%	16,98%	32,53%
Never	–	–	–
3. Bad interpretation of behaves arising from culture r=0,097 p=0,160			
Very frequently	21,62%	26,42%	15,66%
Frequently	52,70%	66,04%	51,81%
Rarely	25,68%	7,54%	32,53%
Never	–	–	–
4. The impossibility of effective non-verbal communication r=0,165 p=0,016			
Very frequently	24,32%	30,19%	13,25%
Frequently	50,00%	49,06%	46,99%
Rarely	25,68%	20,75%	39,76%
Never	–	–	–
5. Staff difficulty in accepting diversity of the patient r=–0,129 p=0,061			
Very frequently	13,51%	33,96%	21,69%

Frequently	47,30%	50,94%	53,01%
Rarely	39,19%	15,10%	26,30%
Never	–	–	–
6. Ignorance of the customs, rituals specific to the patient's culture r=0,009 p=0,897			
Very frequently	9,46%	26,42%	20,48%
Frequently	59,46%	52,83%	40,96%
Rarely	31,08%	20,75%	38,56%
Never	–	–	–
7. The inability to establish contact with the representative of the religion of the patient r=–0,155 p=0,024			
Very frequently	8,11%	20,75%	24,10%
Frequently	55,41%	50,94%	49,40%
Rarely	36,48%	28,31%	26,50%
Never	–	–	–

Source: own study.

Students participating in the research also called attention to the crucial elements of knowledge, skills and the attitudes necessary for effective communication with a culturally different patient. Statistical analysis showed no relation between nationality and cultural competences; however, it is worth noting that among Turkish students, theoretical preparation is listed more often, while Poles placed greater emphasis on developing the appropriate skills and attitudes, and Hungarians placed greater emphasis on developing the appropriate skills and theoretical preparation (Tab. 3).

Table 3. The most important elements of cultural competence in the students' statements

Turkish students	**Polish students**	**Hungarian students**
What competencies (knowledge, skills and behaviors/attitudes) are necessary in the work of nursing staff in relation to a person presenting a different culture? The knowledge		
• Knowledge about different cultures, cultural differences, diversity, stereotypes, prejudice and discrimination – 50.0% • The influence of different culture son health, disease prevention, diagnosis, treatment of disease – 47.30%	—	• Knowledge about different cultures, cultural differences, diversity, stereotypes, prejudice and discrimination – 42.17% • The influence of different cultures on health, disease prevention, diagnosis, treatment of disease – 44.58%

Skills		
• Openness in relation to other cultures – 55.41%	• Overcoming barriers and cultural differences – 58.49% • Openness in relation to other cultures – 58.49%	• Communication skills, verbal and non-verbal cross-cultural situation – 53.01%
Attitudes/behaviour		
• Overcoming ethnocentric attitudes, prejudices, stereotypes – 52.7% • The attitude of respect for yourself and the other person – 72.97%	• Overcoming ethnocentric attitudes, prejudices, stereotypes – 54.72% • Sensitivity to cultural differences, respect and recognition of cultural differences – 56.6% • The attitude of respect for yourself and the other person – 79.24%	• The attitude of respect for yourself and the other person – 49.40%

Source: own study.

Among important theoretical information, the students listed knowledge about different cultures, cultural differences, diversity, stereotypes, prejudice and discrimination – 45,24%, among skills – openness in relation to other cultures – 50,0%, attitudes – respect for yourself and the other person – 65,24%.

Discussion

Interpersonal communication and relationships with the culturally different patient

Recognition and naming of intercultural encounters entails the need to establish proper interactions which will lead to mutual understanding of both parties in order to achieve a therapeutic effect. The results of the study show that for the participants, communication is a key factor in contact with culturally different patient – they point out familiarity with foreign languages, speaking slowly and without medical jargon and understanding non-verbal communication. Thus, the participants paid the most attention to actions which are part of behavioural strategy in order to establish successful communication. Overcoming ethnocentric attitudes and stereotypes can also be classified as a part of this strategy. Andrews and Herberg[20] suggest that in order to establish effective intercultural communication, cognitive and affective strategies should also be used. Following this approach, the respondents' answers may be classified as follows: affective strategy – respect for and acknowledgment

[20] M. M. Andrews, P. Herberg, *Transcultural Nursing Care*, [in:] *Transcultural Concepts in Nursing Care*, M. M. Andrews, ,& J. S. Boyle, (Eds.), Lippincott, Philadelphia 1999, s. 539–544.

of cultural differences, ability to recognise problems resulting from cultural differences, ability to overcome fear of cultural otherness; cognitive strategy – knowledge of cultural differences between the nurse and the patient, knowledge about the influence of culture on health and illness, knowledge about social policies regarding treatment of ethnic minorities. It is worth noting that the respondents chose practical and instrumental factors from among all the elements important in the communication process.

As part of their studies, students in Poland as well as in Turkey develop their skills of establishing dialogue with a patient. Unfortunately, both these countries' nursing programmes do not include separate courses that deal with issues of multiculturalism and prepare students to care for culturally different patients. Research conducted in other countries shows that implementation of such courses improves the effectiveness of the care provided by nursing staff[21].

The authors of this study believe that emphasis should be placed on practical preparation of students for handling difficult situations – including those involving care for culturally different patients – as early as during the bachelor degree programme. This is because intercultural communication is, above all, interpersonal communication, and every person is an individual and not just a representative of a culture. Communication occurs between people, not between cultures[22].

The competence of cultural communication

The results of Sarafis and Malliarou's[23] research show that providing students with cultural competences as early as during the bachelor programme provides them greater certainty as to the validity of their actions, eliminates stress and fear of culturally different patients, makes nursing interventions culturally sensitive, as well as fosters the creation of a multicultural society. These results may explain the attitudes of the Turkish students who participated in this study and exhibited uncertainty when faced with interactions with representatives of other cultures. The lack of courses oriented towards multiculturalism has the effect of lowering the independence of students and creating a dislike of interaction with people who are different[24]. It may be that this awareness of gaps in their education and a lack of ordered knowledge were factors that contributed to the responses of Turkish students who participated in this research, more often than their Polish counterparts, indicating the significance of the affective domain of multicultural competence over that of the cognitive and behavioural domains. Griffin[25] believes that cultural knowledge, understood as an awareness of differences, thoughtfulness or looking at the same event from different perspectives, and skilful interaction, or the ability to adapt communication

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[21] S.T. Murphy, M. Censullo, D.D. Cameron, J.A. Baigis, *Improving cross-cultural communication in health professions education*, „Journal of Nursing Education" 2007, 46, s. 367–72.

[22] K. Van Damme-Ostapowicz, *Multicultural dialogue* [in:] *Problems of multiculturalism in medicine*, E. Krajewska-Kułak, I. Wrońska, K. Kędziora-Kornatowska (Eds.), (Original Work Published in Polish), PZWL, Warszawa 2010, s. 103–113.

[23] P.A. Sarafis, M.M. Malliarou, *Cultural self-efficacy of baccalaureate nursing students in a Greek University*, „Iranian Journal of Nursing and Midwifery Research" 2013, 18, s. 446–50.

[24] L. Chin-Nu , B. Mastel-Smith, A. Danita, L. Yu-Hua , *Cultural Competence and Related Factors Among Taiwanese Nurses*, „Journal of Nursing Research" 2015, 23, 4, s. 252–261.

[25] E. Griffin, *Basics of social communication*, GWP, Gdańsk 2002. (Original Work Published in Polish)

to a given situation, are a condition of effective communication between representatives of different cultures.

Among the elements the respondents noted in terms of cultural competence, the most often listed as important were attitude (37,59%), skills (36,59%) and knowledge (25,68%). Greek nursing students, in survey by Sarafis and Malliarou, indicated that the most important element of caring for a culturally different patient was having a proper attitude towards that group of patients[26]. An opposite opinion on the preparation for culturally sensitive care was expressed by members of actively working nursing staff in Poland[27] – they indicated that skills were the most important (38%).

Gerrish et al.[28] note that nursing staff may contribute to providing effective contact with a culturally different patient during culturally sensitive intercultural meetings. Based on Kim's work[29], they proposed that in developing general communication skills, it is possible to be flexible and adapt to the challenges of intercultural communication regardless of the specific interacting cultures. This approach was called "intercultural communication competence". The researchers also emphasised the need to create a "cultural communication competence" based on specific knowledge of the patient's culture influencing nursing care. Thanks to this, nurses will be able to avoid stereotyping the patients they care for.

Difficulties in communication

Analysis showed that in the respondents' point of view, the greatest obstacle in establishing effective communication with a culturally different patient was the lack of familiarity with language, as well as stereotypes and prejudices among nursing staff. Jabłecka's[30] study *Migranci i zdrowie – wyzwania wielokulturowości w praktyce medycznej w Polsce* (*Migrants and health – the challenges of multiculturalism in medical practice in Poland*) has shown that, among others, lack of familiarity with foreign languages in Polish personnel is very frequently an obstacle. Similar conclusions were reached by researchers from Turkey, who found that the inability to understand a patient speaking a foreign language presented difficulties for over 60% of the respondents[31]. This conclusion is supported by Dogan et al.[32] who found, in their study of Turkish migrants in Germany, as well as nursing staff and physiotherapists, that

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[26] P.A. Sarafis, M.M. Malliarou, op. cit.

[27] M. Lesińska-Sawicka, M. Nagórska, *Cultural competence in nursing* [in:] *Inovácie V Ošetrovateľstve „Rozvoj ošetrovateľstva od Florence Nightingale po súčasnosť"*, L. Kober (Eds.), Regionálna komora Slovenskej komory sestier a pôrodných asistentiek Nútpchahch Vyšné Hágy, Vysoké Tatry, s. 269–277. (Original Work Published in Polish).

[28] K. Gerrish, C. Husband, J. Mackenzie, *Nursing for A Multi-ethnic Society*, Open University Press, Buckingham 1996.

[29] Y.Y. Kim, *Intercultural communication competence: a systematic-theoretic view*, [in:] *Readings on Communication with Strangers*, W.B. Gundykunst, Y.Y. Kim (Eds.), McGraw Hill, New York 1992, s. 371–378.

[30] B. Jabłecka, *Migrants and health – the challenges of multiculturalism in medical practice in Poland*, retrieved from http://isp.org.pl/uploads/filemanager/pliki/Migranciizdrowie (Original Work Published in Polish).

[31] S.P. Kilic, D.K. Besen, Y. Tokem, C. Fadiloglu, G. Karadag, *An analysis of the cultural problems encountered during caregiving by the nurses working in two different regions of Turkey*, „International Journal of Nursing Practice" 2013, doi: 10.1111/ijn.12152.

[32] H. Dogan, V. Tschudin, I. Hot, I. Özkan, *Patients' Transcultural Needs and Carers' Ethical Responses*, „Nurses Ethics" 2009,16, s. 683–696.

the lack of mutual understanding of needs and expectations from both sides resulted from a lack of familiarity with the language and insufficient knowledge of Turkish culture.

Establishing communication with a patient who is a representative of another culture is the basis of cultural safety in healthcare. This means that nursing personnel should combine in their practice the ideals and moral values important for nursing, but also for humanity, for individuals and for society as a whole. Cultural safety in healthcare encompasses the issues of the human person, human rights, the origin and essence of social life, fundamental ethical and social principles, personalistic and humanistic social order, connections between the individual and the state, as well as the issues of the family, nation and human societies. Whether or not universal or national laws and social policies are respected, it is necessary for nursing personnel to look at their professional activities through the integration of social norms and ethical values[33]. The guiding principle of cultural safety in healthcare is that, above all, the patients decide what is safe for them and what is not[34], and it is up to them whether they will agree to the proposed form of care or not, taking into consideration their expectations and the cultural values represented by them. This raises the need for greater awareness of cultural differences in nursing staff in all professional activities undertaken by them. Thus, it is necessary to provide students with the ability to perceive others in a multifaceted way and to draw attention to the fact that frequently people act on the basis of an assumption that the experience of the world is the same for everyone. According to Schütz, each person has a certain idea concerning the rules of behaviour, social conventions and concepts of the procedures used, as well other information which enables them to act in a social world. Therefore, people act by adopting a number of assumptions that produce a sense of "mutual translatability of perspectives", which means that others with whom the actor needs to establish relations are treated as if they possessed the same knowledge, but because of different biographies, others may have specific components in their knowledge which may be ignored by the individual while establishing relations with others[35]. The awareness of nursing personnel of the phenomenon of intersubjectivity of the world facilitates cultural safety in healthcare and thus eliminates actions which may demean the cultural identity of a given person or social group. It is an essential element in the education of nursing students, aiming to protect both caretakers and the caregivers from the dangers presented by cultural differences[36], which in turn hinder establishing and maintaining interpersonal interactions.

The elements cited are of such great importance that without them, making a proper nursing diagnosis is impossible, and the discovery of problems and the feelings of patients are difficult to understand, and nursing interventions are undertaken intuitively instead of being based on reliable and valid knowledge about the patient. The lack of knowledge of cultural diversity causes discomfort in both the medical personnel as well as the patient and is connected with hurt feelings, a low level of satisfaction with the care received, errors in diagnosis, fear, helplessness, etc.

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[33] M. Woods, *Cultural safety and the socioethical nurse*, „Nursing Ethics" 2010, 17, 6, s. 715–725.

[34] E. Papps, I. Ramsden, *Cultural safety in nursing: The New Zealand experience*, „International Journal of Qualitative Health Care" 1996, 8, 5, s. 491–497.

[35] J.H. Turner, *Structure of Sociological Theory*, (Original Work Published in Polish) PWN, Warszawa 2004.

[36] A.J. Browne, C. Varcoe, V. Smye, S. Reimer-Kirkham, M.J. Lynam, S. Wong, *Cultural safety and the challenges of translating critically oriented knowledge in practice*, „Nursing Philosophy" 2009, 10, 3, s. 167–179.

People encountering new cultures are exposed to an intensive process of confronting their way of thinking, as well as comparing the norms and values of their own culture. The awareness of the existence of various difficulties and barriers in establishing effective contact with a culturally different person does not have to be connected with ill will or dislike – these are often reactions resulting from a lack of experience and the inability to cope with different, possibly difficult situations. Many people treat cultural differences as an obstacle in communication. Every culture has its own style, values, customs, practices and rules concerning appropriate and inappropriate behaviour[37]. A person's origin determines the manner of behaving, thinking and feeling.

Conclusions

Based on the analysis conducted, it may be stated that students perceived difficulties in interactions with culturally different patients mainly on the level of communication, in spite of claiming sensitivity and openness in contact with representatives of different cultures. It is, therefore, important to systematise their knowledge and strengthen the correlation between knowledge with practice. This will provide them with greater confidence and self-reliance. Clarifying the concept of multiculturalism will also allow for the elimination of stereotypes and prejudices in the approach to culturally different patients.

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[37] K. Van Damme-Ostapowicz, op. cit.

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STRESZCZENIE

Małgorzata Lesińska-Sawicka, Agnieszka Grochulska, Joanna Żółtańska, Katalin Papp, Małgorzata Nagórska

Komunikacja międzykulturowa w wielokulturowym pielęgniarstwie. Studium porównawcze opinii studentów pielęgniarstwa z Polski, Turcji i Węgier

Cel. Celem badania było ukazanie opinii studentów pielęgniarstwa na temat najczęściej występujących trudności w nawiązaniu skutecznej komunikacji oraz wskazanie postaw, umiejętności i wiedzy niezbędnych w interakcjach z pacjentem odmiennym kulturowo.

Materiał i metoda. W badaniu wzięło udział 354 studentów pierwszego roku z pięciu szkół w Turcji, Polsce i na Węgrzech. Przekrojowe badanie zostało oparte na kwestionariuszu opracowanym przez jedną z autorek.

Wyniki. W nawiązaniu skutecznej komunikacji podkreślano znajomość języka i mówienie wolno, bez żargonu medycznego. Czynnikiem najważniejszym w podejściu do pacjenta odmiennego kulturowo są przezwyciężanie postawy etnocentrycznej, uprzedzeń, stereotypów oraz postawa poszanowania siebie i drugiego człowieka, wśród umiejętności ważne są otwartość w stosunku do innych kultur. Stwierdzono różnice pomiędzy poszczególnymi krajami.

Wnioski. Mimo iż studenci zwracają uwagę na wagę komunikacji w relacji z pacjentem odmiennym kulturowo i wykazują do niej gotowość, wymagają przygotowania do wejścia w interakcje międzykulturowe.

Słowa kluczowe: studenci pielęgniarstwa, edukacja pielęgniarska, komunikacja międzykulturowa, wielokulturowość, kompetencje kulturowe.

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