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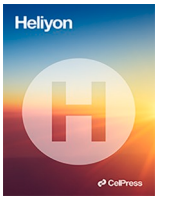

Research article

On clinical nurses' views about diversities- A qualitative study

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ABSTRACT

It is a must for nurses to provide healthcare to people from diverse cultures, ethnicities, religions, and genders. This descriptive qualitative study aimed to explore nurses' approaches to various people. The study collected data via semi-structured interviews and contacted 40 nurses through snowball sampling. Most nurses were between the ages of 25–40 and female, 22 of them had postgraduate degrees, and 18 had undergraduate degrees in nursing. Only 10 of them had received special training related to diversity. MaxQda software program was used for content analyses, and four basic themes were determined respectively, "Nurses' perceptions of diversity," "Nurses' perceptions of diversity towards patients," "Nurses' perceptions of diversity towards healthcare professionals," and "Nurses' perceptions of diverse towards the institution." Participant nurses mainly revealed that although legal and organizational procedures aimed to prevent discriminative attitudes in clinical environments, discriminatory attitudes of nurses and healthcare professionals toward diverse people still occurred.

1. Introduction

Until the beginning of the 20. century, nearly all civilized societies were controlled by upper-class white men. As a result, diverse people from the leading culture were marginalized based on ethnicity, race, religion, language, sex, or sexual orientation. The "Diversity management" concept first emerged in the United States of America (USA) to manage personal and cultural differences among employees. Later, globalization became a worldwide concept parallel with the internationalization of businesses, employees, and clients [1].

Nursing is a profession that cares for all human beings except for their diverse characteristics. Diversity and equality are essential values that form the basis of nursing practices. These two values are also at the core of the Nursing and Midwives Council's (NMC) Code of Professional Practice and Behaviour Standards for Nurses, Midwives, and Nursing Assistants. NMC (2018) has stated that nurses have duties such as treating people, protecting their human dignity, recognizing individual preferences and diversities, and defending and respecting human rights [2]. International Council of Nurses also (2021) has underlined that respecting human rights is like the nursing profession [3].

Nursing should ensure that all fundamental human rights are considered while providing care. The care process cannot differ by age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, political opinion, race, or social status [3]. Therefore, promoting diversity in nursing has become an important topic [4].

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Diversity issues are expected to be a growing healthcare challenge soon. Because of regional conflicts, wars, terrorism, and economic reasons, millions still move between diverse geographies. As a result of those political and social issues, today, people need more professional nurses who are aware of those changes. Promoting and improving of respecting diversity in healthcare settings has become critical in today's hospital organizational climates, not only for patients and their relatives but also for the nursing workforce. Understanding other patients' and colleagues' cultures, traditional and regional attitudes, or religious aspects may help nurses to develop their professional competencies for providing better and qualified nursing care [4].

Turkiye's interregional multicultural social structure and migration wave from Syria and other Middle Eastern countries require nurses to be more competent in the concept of "diversities" and "diversity management." Although it is essential to investigate how nurses perceive diversity, more studies are needed on this subject [5]. Therefore, using a qualitative research design, the study aimed to explore clinical nurses' views, opinions and testimonies related to diversity.

2. Materials and methods

2.1. Aim

To explore clinical nurses' views and opinions about diversities.

2.2. Design

It was a descriptive qualitative study based on content analysis.

2.3. Sample and setting

Snowball sampling was applied. Inclusion criteria were working in a hospital in Istanbul for at least one year [1], three years or more of professional experience [2], bachelor's or upper degrees in nursing education [3] and working as a staff or a manager nurse [4]. The study reached out to 40 nurses. Table 1 exhibits the participants' main characteristics.

2.4. Data collection

The study collected data via semi-structured individual in-depth interviews that varied between 30 and 60 min. Saturation was reached with 40 nurses. One researcher conducted all interviews between December 2020 and January 2021. Interviews were conducted outside of working hours and at appropriate times for each participant. First, she introduced herself and explained the purpose of the research. Secondly, she asked questions about the participant's personal and professional characteristics based on an information form. That form consisted of inquiries related to gender, age, marital status, education level, occupational status, professional experience, unit of work, income level, type of institution, place of birth, university education, place of birth, and region of the hospital.

During the interview, the researcher also directed further questions one by one and noted the nonverbal messages of the participants. Finally, the researcher thanked the participant and asked if the participant had anything to add.

Table 1
The main characteristics of the participant nurses.

Variables	Groups	n	%
Age groups	≤25	2	5
	25–40	**34**	**85**
	≥40	4	10
Gender	**Female**	**34**	**85**
	Male	5	12,5
	Other	1	2,5
Marital status	Married	16	40
	Single	**24**	**60**
Educational level	Undergraduate	18	45
	Postgraduate	**22**	**55**
Institution	Private hospital	3	7,5
	Public hospital	**36**	**90**
	University hospital	1	2,5
Professional experience	≤5 years	11	27,5
	5–15 years	24	60
	≥15 years	5	12,5
Received training on diversities	Yes	9	22,5
	No	**31**	**77,5**

2.5. Interview form

The interview form had three questions about the participant's personal and professional characteristics (school/professional experience/professional status), one question about what the participant got from the concept of diversity, one question about her experience with diversities, whether she had problems with a colleague/teammate/management/family about diversities and open-ended questions aimed to explore participants views and perceptions about diversities.

2.6. Data analysis

The researchers used an Excel program to analyze the participants' demographic data. Then, they used Colazzi's (1978) seven-step analysis technique to analyze the qualitative data [6]. This procedure was based on content analysis. First, one author described the audio recordings, and then two authors read transcriptions three times. Two researchers also identified essential statements in the transcribed texts and highlighted the important and repeated ones to explore the themes and sub-themes. In this process, the study used MaxQda Analytics Pro 2020 program for data analysis.

2.7. Ethical consideration

The researchers got an ethical approval before performing the study from the University of Health Sciences Hamidiye Scientific Research Ethics Committee (19.10.2020-20/382). Since it is an obligation to get a signed informed consent from each participant for all human studies in Turkiye, the reaserchers got a written informed consent. Moreover, the interviewer researcher requested verbal consent from each participant before recording the interview and after getting and recording verbal consent, she started to ask further questions and record the interview.

2.8. Methodological rigor

Rigor was evaluated regarding credibility, dependability, transferability, and confirmability. Participants were selected from various units, genders, origins, institutions, and ages. The interviews obtained from the participants were audio-recorded and transcribed. One researcher conducted all interviews. The coding and categorizing were determined independently, but these codes and categories were checked together by researchers, who made a decision together. Also, determined codes were sent to two participants to check them [6]. These two participants confirmed the determined codes. In reporting the results, the study followed unified criteria to report the qualitative research checklist. Combined criteria (COREQ) were used to write the qualitative research. The article was translated into English and edited.

3. Results

The themes are as follows: *Nurses' perceptions of diversities, Nurses' perceptions of diversities toward patients,* and *Nurses' perceptions of organizational approaches to diversities.*

3.1. Theme 1: nurses' perceptions of diversities

When the participants were asked who they perceived as diverse, many nurses stated that they perceived a person as diverse in terms of race, ethnicity, nationality, religion, language, culture, lifestyle, sexual orientation, disability, and character traits. Here are some of the relevant statements:

> "The diversity may be religious, cultural, sexual orientation, ethnicity, or someone from a diverse country" (P3, Female).
>
> "Maybe I say this. For a diverse person to be diverse, a person with a physical disability or a mental disability may come to mind at first. But, other than that, I think the characters of people show that they are diverse."
>
> "There might be a diversity in the way of speaking, colour and skin tone. Even speaking can make a diversity so that I can make such a classification" (P28, Male)

3.2. Theme 2: nurses' perceptions of diversities toward patients

It has been determined that nurses mostly exhibit negative attitudes towards patients under 12 subthemes. These were orphans, disabled, having a contagious disease, being a psychiatric patient, substance/alcohol use, obese, convict, religion, ethnicity, socio-economic level, sexual orientation, and language.

3.2.1. Homeless patients

Participants stated that diverse attitudes were displayed toward the orphan patient. For example, here is a quote that says that orphan patients have not cared enough and that the nurses do not want to care for these patients:

"*They don't want too much. I saw they didn't want him because you have to take care of everything. Such patients are mostly placed in institutions with social work tools. You accompany and care for that patient until he is placed in those institutions, etc. So nurses don't want to work too hard with these patients."* (P29, Female).

On the other hand, one participant emphasized that in some cases, the approach to the orphaned patient becomes even more difficult. For example, the orphan pregnant patient was strange and morally questioned according to the following sentences: *"That is to say, some are shown without showing compassion and mercy, and others are shown the opposite because they are lonely, but as I said more, our patients who give birth are mentioned a lot, especially because they are obstetricians. Then why did she get pregnant if she was an orphan? Why didn't he think? In addition to being inside ourselves, such a judgmental person like this happens to the patient by turning into an attitude."* (P2, Female).

3.2.2. Disable patient

Nurses said they felt sorry for disabled patients and approached them more empathetically. A nurse stated, "*I think I cared once. I did not see a negative approach in anyone. Everyone is trying to be more helpful. They feel a little sad; they are hurt and have such feelings. They have never had a negative approach*" (P21, Female).

3.2.3. Patient with an infectious disease

Participants said they nervously approached a patient with an infectious disease and took more precautions. A nurse noted, "*Of course. Especially about gloves. We use double-layer gloves. For example, let's consider the time when there was no pandemic. We do not approach a patient who comes in this type without a pandemic, without a gown, gloves, or glasses, or without wearing a box apron at work. We pay attention to this. For example, after getting out of that patient, the equipment is changed again during the whole job while passing it to the other patient. Apron, glasses, etc. We pay more attention to these patients*" (P16, Female). Another one shared her anxiety about caring for a patient with AIDS, "*By the way, I have never worked with a patient with AIDS. But I'd probably be scared, too, if I worked. I would be nervous about having an IV attempt. So, it can be read from my face. Let me point it out*" (P9, Female).

3.2.4. Psychiatric patient

Participants stated that they feared being physically attacked while caring for psychiatric patients. A nurse said they warned each other about the psychiatric patient: "*Here's that he has this ailment or something. Here he can attack. That's the case*" (P18, Female). Another participant said that psychiatric patients are treated with prejudice: *"… So I say yes, there is aggression, one of their fears or because their approach is so distorted. But certainly, the first problem is not that they fear aggression but that they approach it entirely with prejudice. Oddballs"* (P12, Female).

3.2.5. Patient with substance/alcohol addiction

Participants said they were treated with distance while providing care to a substance-addicted patient. One participant's statement was as follows: *"… when a drug addict comes, I immediately learn his name. I will call you by name. Sit down like this; I'm going to do it this way. I act distant. I touch from afar. I do what I have to do and get out. I see the same thing in my friends" (*P22, Female).

3.2.6. Obese patient

Some participants said that it is difficult to care for an obese patient; it also strains their physical strength, and it is demoralizing and stressful the; following statements: "*In other words, since the obese patient is a type of patient that makes it very difficult, something happens, but still, if the patient is at least himself and open, we don't do that thing. Why did you ever gain so much weight? Why didn't you pay attention? Of course, we do not do it to the patient's face, but yes, a patient who breaks us as moral motivation, that is, an obese patient.*" (P3, Female).

"*When the obese arrives in the intensive care unit, we sometimes say "Oh, shit!" How will we position him? How will we move?*" (P1, Male).

3.2.7. Convicted patient

They approach those convicted of crimes such as rape, abuse, child sexual abuse, and terrorism more negatively. One participant stated that he did not evaluate a patient who committed sexual abuse and a person who steals in the same way: "*So it sounds like a thief and sexual abuse don't go together.*" (P6, Female). Another participant expressed his view on terrorism with the words, " … *it can be difficult to care for a person who has committed a terrorist crime*" (P24, Female). Another participant said, "*For example, murder and rape, these are probably very disgraceful crimes, I can't think of other crimes right now, but these two things are probably a little creepy. It affects my emotional approach and yes*" (P2, Female).

3.2.8. Religion

Participants stated that they exhibited positive and negative attitudes toward patients with different religious beliefs. One participant said they helped patients with various spiritual practices: "*Here in these Shafi patients, we have had patients who wanted bricks to make ablution in any case or job. So, we tried to meet them as much as we could. As I said, I don't know what denomination it has, but they put such a stone or something under their pillows. I can't remember which sect it is. We were trying to meet such small things*" (P16, Female). On the other hand, some participants stated that patients with different religions and atheists were discriminated. One participant said that patients with different religious beliefs were excluded, "*For example, this is what we experience. It is against Alevis. In other words, he is*

making various statements. In other words, his belief is different from yours. You don't believe in God; what are you doing here? You know, different things can happen. Alternatively, we had Christian patients. For example, they got permission for this, and they got permission from the hospital's management. Someone had come here for their religion. There was only one thing missing, something like that. This style is more religious" (P7, Female).

3.2.9. Ethnicity

Participants stated that patients with different ethnic origins were exposed to negative attitudes. They said that being Kurdish, Romanian, Arab, and Refugee caused patients to be excluded and exposed to discriminatory attitudes. One participant stated, "*Kurdish patients are perceived as prone to violence and do not want to be cared for. For example, I do not want to generalize about a patient or relative of Kurdish origin, but we often encounter this. When he has a problem, instead of saying I have a problem in this area, he may fight and show violence. Verbal or physical. That's why people don't want one more to click to care for that group of patients*" (P29, Female). Another participant said that since the patient was Kurdish, not enough attention was paid to them: "*I think he was a Kurdish friend. He was a Kurdish patient. There is no more effective listening or adequate explanation*." (P17, Female).

A participant indicated, "*If a participant is Syrian, although the care is given completely, the necessary warm communication is not established. Care is served, but there is a behavioural difference*" (P2, Female). The same participant stated that Asian patients were treated more sympathetically. Still, when it comes to Syrian patients, she said, "*Don't approach an ordinary, normal, Turkish citizen patient, for example, diligently giving information or communicating at work. For example, if all of these are Syrians at once, or if they are Syrians in general, but only one or two South Asians or something from the African continent, I can't remember their country. Still, when patients with those IDs are not approached this way and are even more sympathetic towards them, the situation is the opposite for Syrians. Hostile language is used. Maybe patients think this is everyone; they may not perceive it, but I can feel the difference because I see it in themselves*" (P2, Female).

3.2.10. Socioeconomic level

Many participants stated that the attitudes of health professionals changed according to the socioeconomic level of the patients. One participant noted that the patient with a low socioeconomic status needed to be given more attention and that communication problems were experienced due to the low level of education. A participant expressed his experiences while the attorney general looked at a patient with the following sentences: "*I mean, I looked at the Chief Public Prosecutor. I was the nurse of the Istanbul Chief Public Prosecutor. I was there looking for it. My feet were shaking there. His current position, which reflects this to me, is the fear that if I make a mistake in the current thing, he will fire me or fire me, so taking care of him was a difficult situation for me in terms of emotional and professional. A good nurse you are more than yourself at that moment. But I always said something. Why can't I do this to a person whose financial situation is low socioeconomically and culturally? In other words, since the two of them are human, we will look at them as human beings. Why couldn't I get close to that person? This is a human being. This is a human. He needs treatment. He also needs care. In this. Why do we have that thing inside of us? I am in favour of overcoming this. Unfortunately, it doesn't work in Turkey*." (P28, Male).

3.2.11. Patients with diverse sex orientation

Many participants stated that patients with different sexual orientations were exposed to judgmental and cynical attitudes, were not respected as human beings, and were perceived as prone to violence. At the same time, the participants also stated that they do not want to provide care services to patients with different sexual orientations and that these patients are a matter of curiosity. The statements of the participants about these patients are given below:

> "*In other words, he says that I do not like such people and can exclude them this way. I'm so annoying. I mean, I don't like people with different sexual orientations. What kind of man is he saying?"* (P23, Female).

A male participant clearly stated that those people were potentially overboard. He said, "*In other words, as I said attitudes, we approach without patient discrimination. So we do not have an attitude from the health personnel. But as I said, they are also ready to go a little overboard. So that's why it's a little controlled by the security team.*" (P26, Male).

> Another nurse reported, "*Maybe I had a few incidents in the Emergency Department. It could be because of that. Especially with trans people. There are a lot of transvestites. They attack the security guards a lot. Refuses treatment but does not leave the hospital*" (P37, Female).

3.2.12. Language

Most participants stated they could not communicate with the patient because of language differences. One participant noted that using a translator all the time was very tiring: *"… here, you constantly give someone on the phone, talk on the phone, tell him, let him explain the situation, this is very troublesome, units that are already very busy urgently in the process. And dealing with them makes us more tired.*" (P8, Female). Another participant emphasized that complicated processes are experienced when not understood due to language diversities. *"We cannot communicate with their families because of the language difference. A translator is not always available now. That is, both because it is few and because it was called from many places. So there is a lot of communication problem.*" (P15, Female).

3.3. Theme 3: nurses' perceptions of diversities in the organization

Difference perceptions of the participants towards the institution were examined in two themes: "perception of diversity management" and "organizational approaches toward diverse patients."

3.3.1. Management of diversities

Some of the participants stated that diversity management was a management practice. Some said it was an educational practice. Some expressed it as eliminating the diversities. Some of the participants described it as the acceptance of diversity. Others have depicted it as living freely. Finally, some of them told the management of diversity as an approach.

The participants' views on their perceptions of diversity management are as follows: "*Diversity management is how people with different characteristics or different characteristics come together, how they can be coped with, how they can learn to live with them*" (P4, Female).

> "*The first thing that comes to my mind when I say management of diversities is, at least, I perceive these people as my approach to them, be it their culture or sexual orientation*" (P6, Female).

> *"Management of diversities, so some people sometimes see diversities as the enemy. They may not accept diversities. The management of diversities can also be to make these people accept the difference*" (P19, Other).

3.3.2. Organizational approaches toward diverse patients

Some of the participants stated that their institutions treat all patients equally, fairly, and objectively:

> *"Yes. I'm thinking. So, for example, there is no discrimination against a Syrian patient or our normal citizen. We provide the same treatment opportunities to those patients"* (F27, Male).

> *"I don't think there is a patient discrimination. All patients are treated equally. There is no discrimination based on language and religion*" (P40, Female).

However, others stated that only some patients were treated equally and fairly. They said that patients with whom they know health professionals are treated more attentively:

> *"Not only in terms of socioeconomic level but also in terms of what he knows, hospital staff, team, physicians can be known. If you have acquaintances at work, the patient's relative can be admitted outside the visiting hours. Nevertheless, if no one he knows, he can see the patient during normal visiting hours. So, these are priorities. I wouldn't say it is being watched, but it is done*" (P16, Female).

> *"For example, if you know him. Our doctors are too many. What if he is his acquaintance and takes everything from his dialysis? For example, there is no need for dialysis, but let's do it in dialysis. Let's try this one too. Or let's stand by it for hours and look at this or that. For example, while he takes care of his patient for half an hour, he takes care of the other for ten minutes. So, it does. These are the situations we encounter. There are no lies*" (P16, Female).

Some participants also stated that the relatives of people in managerial positions are treated more closely:

> "*So, if you are close to the senior manager, you will be much more comfortable in this hospital, but if you are a normal citizen, you must follow the visiting rules and obey every rule. Of course, they don't bother you to ask why they don't apply the rule, but still, it will be a problem"* (P33, Female).

Many participants stated that translation services are provided in their institutions for patients who speak different languages: "*We have an interpreter. We especially invite him when giving information to families. That's how we communicate*" (P15, Female). Another participant stated that the ministry has a translation policy: "*So there is something, you know, there are translators in all institutions, with the Ministry's policy of everything*" (P25, Female).

Some participants stated that there are environments in their institutions where patients can pray and perform their religious practices. A participant noted that there are mosques in Muslim patients' institutions: "*What I can say is when you look at it as beliefs, for example, there are areas where they can pray next to the mosque in the hospital. They can use them. Alternatively, we can provide something for referrals to use at work"* (P29, Female). The same participant stated that patients with different religious beliefs could also reach religious officials: "*Or if he has a different religion and wants to pray at work, he was a priest at work, or if he wants to see someone as a clergyman, or if he is a Muslim, if he wants to talk to an imam and relax at the hospital, here are these. You can call the relevant assigned persons*" (P29, Female).

Participants stated that institutions have unique practices for elderly patients. For example, one participant said that elderly patients aged 65 and over in their institution were given priority for examination in the outpatient clinic: "*Policy for elderly individuals has priority only in the outpatient clinic area over 65 years of age*" (P26, Male). Another participant stated that social service units arrange accommodation for orphaned elderly patients: "*We have social services, for example, they take care of our elderly people. If they do not have a place to stay, they look after them*" (P22, Female).

> Participants also stated that there was a practice for patients with infectious diseases to ensure their privacy: "*We don't even write it in the patient's file. There is an infectious disease section. We do not write the patient as visible labels on the extra*" (F37, Female). Another participant emphasized privacy: "*Honestly, I have never encountered HIV. We encountered hepatitis. C, B. It is forbidden to even write to the patient's file with it. Currently, you know, in terms of patient privacy*" (F13, Female).

Some participants stated that a private room was reserved for convicted patients in their institutions. "*We have a separate service in the prisoner's service, dealing with such patients. They are obviously held there. They are looked after there*" (P13, Female).

Most of the participants stated that there are particular practices in their institutions for disabled patients. One participant noted

that the Ministry of Health has a policy for disabled patients and that institutions are organized according to disabled individuals: "*This Ministry of Health has policies for people with disabilities. For example, shower cabins for people with disabilities were built in one room of each clinic. The toilet was built. The current structures ensure that people make every area with disabilities. Apart from that, the practices of the ministry. They are trying to comply directly with the legislation of that ministry.*" (P25, Female).

4. Discussion

4.1. Theme 1: nurses' perceptions of diversities

Participants identified individuals according to gender, ethnicity, sexual orientation, sect, working style, habits, culture, region, religion, language, education level, success, clothing style, speaking accent, character, thought, nationality, living environment, and growing environment.

Nursing students stated that language differences are vital in patient communication [7]. In addition, nursing students in Jordan and Turkey said that although they wanted to provide similar health services, they could not do so because of the language barrier [7]. In another study conducted with Polish nurses, it was reported that as the education level of nurses increases, they show more closeness to their patients of different nationalities and reduce social distance [8]. In another study conducted with Polish nurses, it was reported that nurses with a low level of education had more negative attitudes toward Muslim and homosexual individuals [9]. Sahile et al. (2019) stated in their study that attitudes toward psychiatric patients vary depending on the education level of nurses [10]. Therefore, it is understandable that as the education level of nurses increases, their attitudes are more favourable because they have more information about the differences.

4.2. Theme 2: nurses' perceptions of diversities toward patients

Although nurses highlighted 12 issues such as being an orphan, to be disabled, having an infectious disease, being a psychiatric patient, substance/alcohol use, obesity, being convict, religion, ethnicity, socioeconomic level, sexual orientation, and language, four of them (having a contagious disease, religion, race, sexual orientation, and language) were highly cited by many participants.

In our study, it was noteworthy that some of the nurses' colleagues said they did not want to care for patients with infectious diseases, especially those with HIV/AIDS. In a study investigating the discrimination experiences of patients, patients stated that patients with HIV/AIDS were judged by healthcare professionals and stigmatized as indecent [11]. In a study conducted in Egypt, nurses also said they avoid physical contact with patients with HIV/AIDS, use double gloves during their care and take extra precautions to prevent contamination [12]. It is seen these findings coincide with the statements of some colleagues of the nurses in our study that they approach more cautiously when providing healthcare services to patients with HIV/AIDS.

Respecting beliefs and practices that do not harm health is a very effective way of gaining patients' trust. Thus, respondents mostly declared that they assist their patients in worship. In another study, it was reported that nurses regulate the nutrition of their Muslim patients following their religious beliefs [13]. Nurses respect patients' religious differences and assist them in providing conditions suitable for their thoughts. On the other hand, some participants stated negative attitudes toward Alevi patients. It is thought that the opposing approaches of healthcare professionals toward Alevi patients stem from stereotypes about Alevis and some healthcare professionals' religiosity levels.

Nurses stated that there are stigmatizing, punitive and accusatory attitudes towards patients with alcohol/substance addiction, psychiatric diagnoses, and obese patients and that they often do not want to care for them. A study conducted with nurses working in emergency units and the field of mental health found that nurses were not satisfied with providing care to patients with alcohol dependence or a psychiatric diagnosis and were uncomfortable with this situation when they had to provide care [14]. Nurses do not trust alcohol/substance-addicted patients; they also think such patients may be liars, deceitful and irresponsible individuals. They have limited communication with these patients; for this reason, they do not want to provide such patients with the same quality of care as other patients. These patients and those with psychiatric diagnoses are also prone to violence [15]. Nurses act in nontherapeutic and unethical behaviours towards their patients due to prejudice.

Participants stated that it is difficult to care for obese patients, and they have physical difficulties while caring for obese individuals in intensive care units. In addition, some nurses openly stated that they did not want to take care of obese patients. In the study, intensive care nurses noted that the maintenance of obese patients was complex. They stated that they had difficulty turning and positioning the obese patient due to their weight, and they were exhausted and naturally did not want to get tired. In addition, nurses stated that they thought obese patients ate too much because they could not control themselves and preferred to be obese [16]. Although nurses have indicated that every patient deserves the best health care, these findings are critical in revealing that the situation can differ in practice [17].

Participants stated that negative attitudes could be related to their ethnic origins (Kurdish, Arab, and Romanian). For example, a study reported that Syrian women were excluded because of the perception that they gave birth too often. Furthermore, it has been stated that nurses used to discriminate against Kurdish women in this regard, and now they display the same approach toward Syrian women [18]. In light of these findings, it is possible to say that healthcare professionals exhibit negative attitudes towards patients from specific ethnic backgrounds influenced by politics, media, or stereotypes.

Some participants stated that the refugees were more privileged than the Turkish people and benefited from the healthcare services they could not. Jordanian nurses' views on refugees were similar to a previous study. They stated that many citizens in need in their country offer all support to refugees and have mixed feelings towards refugees [19]. The research findings are consistent with the

literature, and it is observed that health professionals remain between their countries' economic, political, and social conditions and professional and ethical principles. In addition, participant nurses also stated that refugees exhibit violent behaviour.

Nurses participating in the study stated that some health professionals refused to provide health services to refugee patients. In a survey conducted by the Center for Migration Studies, refugees also noted that the negative attitudes of some health professionals towards them prevent their access to health services [18].

Nurses stated that health workers also exhibited negative attitudes towards lesbian, gay, bisexual and transgender/transsexual (LGBT) individuals. A previous study also reported that health professionals discriminated against transgender people [20]. In addition, our study encountered nurses who had prejudices that LGBT individuals could transmit contagious diseases. Another study reported that LGBT individuals were at risk of HIV and sexually transmitted infections, which were perceived as higher, especially among gays [21]. In studies conducted with Turkish nurses, it has been reported that nurses have negative attitudes toward LGBT individuals [22,23]. A study also said that nurses stated that LGBT individuals should not be allowed to live freely in Turkey and believed they would disrupt the social order [22].

Communication skills are vital for healthcare professionals to understand patients' emotional and psychological needs and evaluate disease symptoms. It is an issue emphasized in the international literature that nurses have communication problems with patients from different cultures, primarily due to language differences [24]. In this study, the nurses emphasized that the issues experienced in communication negatively affect the care and treatment processes. It is an issue noted in the literature that the communication between healthcare professionals and patients affects patient outcomes. Likewise, giving the most effective and correct health care to the patient and performing the practices safely depend on the ethics of communication between the health professional and the patient [25]. A study in the USA reported that the language barrier in accessing healthcare services affects the satisfaction of patients who speak different languages with the healthcare system and their perceptions of healthcare providers. It has been stated that this obstacle is also effective in deciding whether to continue or stop receiving health services. Due to the language barrier, patients perceive healthcare workers as "rude" and "unwilling to help" [26].

4.3. Theme 3: nurses' perceptions of organizational approach related to diversity management

In our research, the participants stated that the level of competence of the manager, the institution's policy and culture, the institution's location, the unit of work, and the employees' getting used to the diversity of the patients they serve to affect the attitudes towards differences. The participants also stated that the ability of managers to manage differences is essential. A study with head nurses investigated the barriers and support of patients to manage their cultural and religious differences. The head nurses said they did not address the differences due to the low awareness of the guidelines prepared for disagreements, insufficient training for cultural competence, and resource limitations. Head nurses stated that mutual understanding with patients, greater diversity in the workplace, and support from social assistance institutions outside the hospital are facilitating factors in managing differences [27]. When we evaluate the research findings, the manager nurses are expected to be competent in managing the differences. However, nurse managers' competency level varies depending on the awareness of differences and institutional and external factors.

In our research, the participants stated that the policy and culture of the institution affected the approaches toward diversity. He noted that the management should organize training on how these processes should be managed, and the workforce should be developed. In our research, the participants stated that the region of the institution also affects attitudes toward diversity. For example, in a previous study, head nurses noted that the workforce is more diverse in big cities. At the same time, recruiting various professionals in hospitals in more rural areas is complex, and they hire people who reflect their communities [27].

Furthermore, a study reported that nurses see work environments with cultural differences as supportive environments for nurses from different cultures [28]. In addition, a survey study reported a significant relationship between an inclusive work environment and an increase in the quality of care [29]. Therefore, it is possible to say that inclusiveness and representation of differences in the workplace create a positive environment in the workplace.

In our research, participants stated that top managers were more concerned about their acquaintances or colleagues. In a study conducted in Turkey, health professionals said that they give privileges to individuals with high social status and the relatives of their colleagues [30].

Participants stated that the institution has certain practices for different patient groups. For example, in this title, having an interpreter for patients with language differences, pricing for health care services for refugee patients, practices for religious belief differences, practices for elderly patients, procedures for patients with contagious diseases, policies for patients with substance abuse, practices for convicted patients, practices for disabled patients, unique applications for psychiatric patients were examined under the sub-titles [31].

Participants stated that prayer rugs in their rooms, arrows pointing to the qibla, and religious officials are called for the terminal period so patients can perform their spiritual prayers in their institutions. In addition, patients can invite a religious official of their own religious beliefs [32]. As a requirement of quality standards in health, it is obligatory to have a place of worship in the palliative care service [33]. Joint Commission International also points out the importance of spiritual care. Indeed, most patients need to pray to feel more comfortable and not lose hope [34].

The participants stated that their institutions have certain practices for elderly and disabled patients. For example, many arrangements were made in a city hospital in Istanbul for disabled and elderly patients. The World Health Organization also offers recommendations for inclusive health systems that enable people with disabilities to benefit more from health services [35]. Mobile devices also provide opportunities for many mentally disabled individuals to access and receive better health services [36]. When we look at the practices in Turkey and around the world, there are studies for disabled individuals to access and benefit from health

services more efficiently.

Participants stated that their privacy is taken care of within the institution, and confidentiality is ensured. They also said that there are some special applications for convicted patients. The treatment of convicted patients in private services and security/security guards next to convicted patients can be examples of these practices. In a study, nurses stated that security guards were next to the convicted patient [37]. It is seen that the aim is for convicts to benefit from health services equally, and there are also protective practices for the health professionals who will assist. They also stated that there are procedures related to the approach to the patient with substance addiction. The Nursing Regulation published by the Ministry of Health in 2011 determined the duties, authorities, and responsibilities of the "Alcohol and Substance Addiction Center Nurse" [38]. Alcohol and substance addiction treatment is a particular category, and it is possible to say that the health care to be provided to these patients and the characteristics of the health professionals who will provide the service are determined by the regulations.

In our study, the participants talked about the procedures related to the approach to psychiatric patients. The duties, authorities, and responsibilities of Mental Health and Diseases Nursing are defined in the Nursing Regulation of the Ministry of Health [38]. Therefore, it can be said that health professionals also know about existing procedures and training programs.

5. Limitations

This study has limitations since it was performed in one city in Turkey. Furthermore, since the society is mainly Sunni Muslim, the results should be limited to this population.

6. Conclusion

In our study was showed deeply and detailed Turkish nurses'perceptions, views and opinions towards diverse people. Throught nursing education even thought nursing students are teached how they treat equally, objectively to all of their patients with different cultural background, age, sexual orientation, race, ethnic, religious etc, Nurses have experienced in complex feelings towards their patients. Some nurses try yo struggle to manage negative opinions to their patients but some reflect their negative opinions, views which result from different age, cultural background, religious etc to their patients. This is so important point in terms of nursing ethic, roles, image and patients' right. We analyzed nurses' word deeply and determined that nurses have less negative opinions towards diverse people especially as nurses increase educational level and acquaintedness with different people. We recommend both of university and workplace can ve inclusive diverse climate. Whenever possible nursing students should learn with different people and nurses work with different team member, provide nursing care to different patients.

Even nurses were aware of their professional responsibilities in serving nursing care to all individuals. However, whatever their diverse characteristics, they stated their colleagues or other health professionals negatively approached patients according to their various features such as ethnicity, religion, infectious illness, etc. Especially Syrian refugees, LGBTIs, Alevi Turkish people, Kurdish, originated Turkish citizens, obese patients, and psychiatric and convicted patients were the diverse groups.

Increasing awareness that the institution's adoption of effective diversity management practice will improve the quality of health services, using existing legal procedures to prevent discrimination by the institution's managers, and increasing qualitative and quantitative research in this field is recommended.

CRediT authorship contribution statement

Hanife Cakir: Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Arzu Kader Harmanci Seren:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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There is no conflict of interest between the authors.

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Appendix A. Supplementary data

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References

[1] J.L. Bronstein, D.I. Bolnick, "Her joyous enthusiasm for her life-work…": early women authors in the American naturalist, Am. Nat. 192 (6) (2018) 655–663.
[2] R. Stenhouse, Understanding equality and diversity in nursing practice, Nurs. Stand. 36 (2) (2021) 27–33, https://doi.org/10.7748/ns.2020.e11562.
[3] International Nurses of Council, The ICN code of for nurses. https://www.icn.ch/system/files/2021-10/ICN_Code-of-Ethics_EN_Web_0.pdf, 2021. (Accessed 13 May 2022).
[4] V. Morrison, R.R. Hauch, E. Perez, M. Bates, P. Sepe, M. Dans, Diversity, equity, and inclusion in nursing: the pathway to excellence framework alignment, Nurs. Adm. Q. 45 (4) (2021) 311–323, https://doi.org/10.1097/NAQ.0000000000000494.
[5] H. Çakır, A.K. Harmancı Seren, Diversity management in the context of healthcare professionals' attitudes towards diverse individuals, J. Health Nurs. Manag. 8 (1) (2021) 111–117, https://doi.org/10.5222/SHYD.2021.76598.
[6] G.A. Shosha, Employment of Colaizzi's strategy in descriptive phenomenology: a reflection of a researcher, Eur. Sci. J. 8 (27) (2012).
[7] A.K. Selçuk, E. Yanıkkerem, Nursing students' perspectives and caregiving experiences with refugees: a qualitative analysis, Nurse Educ. Today 109 (2022) 105240, https://doi.org/10.1016/j.nedt.2021.105240.
[8] J. Zalewska-Puchała, I. Bodys-Cupak, A. Majda, Attitudes of Polish nurses toward selected national groups, J. Transcult. Nurs. 32 (2) (2021) 137–144, https://doi.org/10.1177/1043659619900000.
[9] M. Lesińska-Sawicka, Nurses' attitudes towards selected social groups: cross-sectional survey among Polish nurses, Healthcare 10 (5) (2022) 795, https://doi.org/10.3390/healthcare10050795.
[10] Y. Sahile, S. Yitayih, B. Yeshanew, D. Ayelegne, A. Mihiretu, Primary health care nurses attitude towards people with severe mental disorders in Addis Ababa, Ethiopia: a cross-sectional study, Int. J. Ment. Health Syst. 13 (1) (2019) 1–8, https://doi.org/10.1186/s13033-019-0283-x.
[11] L.H. D'anna, M. Hansen, B. Mull, C. Canjura, E. Lee, S. Ssumstine, Social discrimination and health care: a Multidimensional framework of experiences among a low-income multiethnic sample, Soc. Work. Publ. Health 33 (3) (2018) 187–201, https://doi.org/10.1080/19371918.2018.1434584.
[12] I.A. Kabbash, E.A. Abo Ali, M.M. Elgendy, M.M. Abdrabo, H.M. Salem, M.R. Gouda, M. Hamed, Hiv/AIDS-related stigma and discrimination among health care workers at Tanta University Hospitals, Egypt, Environ. Sci. Pollut. Res. 25 (31) (2018) 30755–30762, https://doi.org/10.1007/S11356-016-7848-x.
[13] l.M. Alpers, Hospital food: when nurses' and ethnic minority patients' understanding of Islamic dietary needs differ, Nurs. Open 6 (4) (2019) 1455–1463, https://doi.org/10.1002/nop2.343.
[14] J. Molina-Mula, A. González-Trujillo, M. Simonet-Bennassar, Emergency and mental health nurses' perceptions and attitudes towards alcoholics, Int. J. Environ. Res. Publ. Health 15 (8) (2018) 1733, https://doi.org/10.3390/ijerph15081733.
[15] G. D'ettorre, M. Mazzotta, V. Pellicani, A. Vullo, Preventing and managing workplace violence against healthcare workers in emergency departments, Acta Bio-Med. Ateneo Parmense 89 (suppl 4) (2018) 28, https://doi.org/10.23750/abm.v89i4-S.7113.
[16] N. Robstad, F. Siebler, U. Söderhamn, T. Westergren, L. Fegran, Design and psychometric testing of instruments to measure qualified intensive care nurses' attitudes toward obese intensive care patients, Res. Nurs. Health 41 (6) (2018) 525–534, https://doi.org/10.1002/nur.21914.
[17] K. Bohm, R. Lund, J. Nordlander, V. Vicente, Ambulance nurse's experience to relieve pain in patients with addiction problems in Sweden, Int. Emerg. Nurs. 46 (2019) 100779, https://doi.org/10.1016/j.ienj.2019.06.002.
[18] The Association for Migration Research, Barriers to and facilitators of migrant communities' access to health care in Istanbul. https://gocarastirmalaridernegi.org/attachments/article/182/gar_msf_saglik.pdf, 2020. (Accessed 12 May 2022).
[19] M. Backlund, S. Olausson, Nurses' experiences as care providers for refugees in emergency and critical care in Jordan: a qualitative interview study, Glob. Qual. Nurs. Res 8 (2021) 1–14, https://doi.org/10.1177/23333936211056932.
[20] M. Mikulak, S. Ryan, R. Ma, S. Martin, J. Stewart, S. Davidson, M. Stepney, Health professionals' identified barriers to trans health care: a qualitative interview study, Br. J. Gen. Pract. 71 (713) (2021) e941–e947, https://doi.org/10.3399/BJGP.2021.0179.
[21] K.D. Brown, L. Sessanna, P. Paplham, Nurse practitioners and nurse practitioner students' LGBT health perceptions, J. Nurse Pract. 16 (4) (2020) 262–266, https://doi.org/10.1016/j.nurpra.2019.12.028.
[22] M. Aslan, E.P. Gürdoğan, The nursing community's discriminatory attitude towards LGBTQ individuals, Int J Hum Rights Healthc (2021), https://doi.org/10.1108/IJHRH-11-2019-0087.
[23] H. Çakır, A.K. Harmancı Seren, Are nurses homophobic? A survey study in public hospitals in Turkey, J. Nurs. Scholarsh. 52 (6) (2020) 613–622, https://doi.org/10.1111/jnu.12596.
[24] J.Y. Joo, M.F. Liu, Nurses' barriers to care of ethnic minorities: a qualitative systematic review, West. J. Nurs. Res. 42 (9) (2020) 760–771, https://doi.org/10.1177/0193945919883339.
[25] L.K. Sheldon, D.M. Hilaire, Development of communication skills in healthcare: perspectives of new graduates of undergraduate nursing education, J. Nurs. Educ. Pract. 5 (7) (2015) 30, https://doi.org/10.5430/jnep.v5n7p30.
[26] G.M. Tefera, M. Yu, Immigrant women's access to healthcare services in the United States: a qualitative meta-synthesis, J. Soc. Serv. Res. 48 (2) (2022) 285–299, https://doi.org/10.1080/01488376.2022.2035300.
[27] Ogbolu, Y., Scrandis, D. A., Fitzpatrick, G., 201. Barriers and facilitators of care for diverse patients: nurse leader perspectives and nurse manager implications. J. Nurs. Manag. 26 (1), 3-10. DOI: 10.1111/jonm.12498.
[28] C. O'callaghan, P. Loukas, M. Brady, A. Perry, Exploring the experiences of internationally and locally qualified nurses working in a culturally diverse environment, Aust. J. Adv. Nurs. 36 (2) (2018) 23–34.
[29] K.C. Brimhall, M.E. Mor Barak, The critical role of workplace inclusion in fostering innovation, job satisfaction, and quality of care in a diverse human service organization, Hum. Serv. Organ. Manag. Leadersh. Gov. 42 (5) (2018) 474–492, https://doi.org/10.1080/23303131.2018.1526151.
[30] R. Bilgin, M. Küçükhazar, General view of unethical behaviors and applications in public health institutions in Turkey, Journal of Munzur University Social Sciences 7 (13) (2018) 119–140.
[31] The Association of Turkish Travel Agencies, Announcement of the translation line for international patients, Access 21.05.2022, https://www.tursab.org.tr/haberler/uluslararasi-hastalar-icin-tercumanlik-hatti-duyurusu_7096, 2012.
[32] Official Gazette, Regulation on patient rights, Access 13.05.2022, https://www.mevzuat.gov.tr/mevzuat?mevzuatno=4847&mevzuattur=7&mevzuattertip=5, 1998.
[33] Ministry of Health, Quality standards in health, Access 18.05.2022, https://shgmkalitedb.saglik.gov.tr/eklenti/38654/0/skshastanesetiv62020revize29082020pdflinkpdf.pdf, 2020.
[34] C.A. Green, Complimentary care: when our patients request to pray, J. Relig. Health 57 (3) (2018) 1179–1182, https://doi.org/10.1007/s10943-018-0599-x.
[35] World Health Organization, Disability and health. https://www.who.int/news-room/fact-sheets/detail/disability-and-health, 2021. (Accessed 12 May 2022).
[36] K. Krysta, M. Romańczyk, A. Diefenbacher, M. Krzystanek, Telemedicine treatment and care for patients with intellectual disability, Int. J. Environ. Res. Publ. Health 18 (4) (2021) 1746, https://doi.org/10.3390/ijerph18041746.
[37] P.N. Muiruri, G. Brewer, R. Khan, "If it wasn't for ethics, I wouldn't go near him": an ınterpretative phenomenological analysis of caring for patient-prisoners in Kenya, Int. J. Offender Ther. Comp. Criminol. 63 (14) (2019) 2440–2452, https://doi.org/10.1177/0306624X19849556.
[38] Ministry of Health. Nursing Regulation, 2011 mevzuat.gov.tr/mevzuatmetin/yonetmelik/7.5.13830-ek-2%20ve%203.htm. (Accessed 17 May 2022).