

Cerrahi Hemşirelerinin Baskın Dili Konuşamayan Hastalarda Bakım Deneyimleri ve Algıları: Nitel Bir Çalışma

The Experiences and Perceptions of Surgical Nurses in Providing Care to Patients Who Do Not Speak the Dominant Language: A Qualitative Study

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ÖZ

Amaç: Baskın konuşulan dili anlama ve konuşma konusunda yetersiz olan hastaların perioperatif süreçte daha fazla olumsuz deneyim yaşayabildiği bilinmektedir. Bu çalışma, baskın dili konuşamayan hastalara perioperatif bakım sağlama konusunda cerrahi hemşirelerin deneyimlerini ve algılarını araştırmayı amaçlamıştır.

Yöntem: Bu çalışma, 13 cerrahi hemşirenin katılımıyla yürütülen kalitatif bir araştırmadır. Veriler, yarı yapılandırılmış bir form kullanılarak derinlemesine görüşmeler yoluyla toplanmıştır. Verilerin analizinde tematik analiz kullanılmıştır. Çalışmada ayrıca verilerin güvenilirliğini ve metodolojik titizliğini artırmak için Lincoln ve Guba kriterleri kullanılmıştır.

Bulgular: Araştırma verileri üç ana temanın belirlendiğini göstermiştir: (1) bakım gereksinimlerini belirlemede kullanılan alternatif yöntemler, (2) iletişimi kolaylaştırmada kullanılan stratejiler ve (3) mesleki öz-yetersizlik algısı.

Sonuç: Bu çalışma; hemşirelere, sağlık yöneticilerine ve politika yapıcılarına bu hastalar için bakım kalitesini iyileştirme, hasta güvenliğini artırma ve yenilikçi çözümler geliştirme konularında rehberlik edebilir.

Anahtar Kelimeler: Baskın dili konuşamayan bireyler, Perioperatif dönem, Hemşirelik bakımı.

ABSTRACT

Objective: It is known that patients with impaired understanding and speech of the dominant language may experience more negative experiences during the perioperative process. This study aimed to investigate the experiences and perceptions of surgical nurses regarding providing perioperative care to patients who do not speak the dominant language.

Method: This study is qualitative research conducted with the participation of 13 surgical nurses. Data were collected through in-depth interviews using a semi-structured form. Thematic analysis was used to analyze the data. The current study also employed Lincoln and Guba criteria to increase the data trustworthiness and rigor.

Results: The data of study revealed three main themes: (1) alternative methods for determining care needs, (2) strategies used to facilitate communication, and (3) perception of occupational self-inadequacy.

Conclusion: This study can guide nurses, health administrators, and policymakers in improving the quality of care, increasing patient safety, and developing innovative solutions for these patients.

Key words: Non-dominant language speakers, Perioperative period, Nursing care.

1. INTRODUCTION

The effectiveness of perioperative care is contingent on the establishment of a clear and unimpeded mutual understanding between the surgical nurse and the patient with regard to ideas, feelings and experiences (1). In instances where the patient lacks comprehension of the nurse's language, measures must be taken to ensure effective communication. These measures may include the utilisation of translation services or the employment of an interpreter.

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Yazar Katkıları: A) Fikir/Kavram, B) Tasarım, C) Veri Toplama ve/veya İşleme, D) Analiz ve/veya Yorum, E) Literatür Taraması, F) Makale Yazımı, G) Eleştirel İnceleme

Nevertheless, the implementation of these strategies has the potential to engender stress for both the patient and the nurse, primarily due to concerns regarding the accuracy of translation and the difficulty of expressing oneself with clarity. Inability to speak the dominant language has been demonstrated to directly impact a wide range of factors, including disease and treatment processes, patients' perspectives on illness and symptoms, acceptance of treatment, family relationships, marital patterns, sexuality, personal hygiene, daily living habits relating to nutrition, communication with nurses and recovery processes (2, 3). Research has indicated that surgical patients with non-dominant language experience prolonged hospitalisation, an elevated risk of infection, delayed surgical recovery and increased readmission rates (4). This predicament can engender a sense of helplessness and hopelessness in both the patient and the nurse, thereby exerting a detrimental influence on nurses' job satisfaction and professional self-efficacy.

Perioperative nursing care involves making a general health assessment of patients, preparing them physically, psychologically and socially for the operation, and providing them with the necessary knowledge and skills through education. It is a dynamic and systematic process in which privacy and patient rights must be protected at every stage, communication is prioritised, and the patient and their family are evaluated holistically (5). For all these reasons, surgical nurses must consider the impact of language barriers on the perioperative nursing care process, be sensitive to the patient's cultural differences through having the knowledge of support systems which can be accessed during the care process, and for facilitating the redesign of care services for the patient groups (6).

Turkey has experienced substantial migration due to its geographical proximity to the Middle East, a region affected by ongoing economic, political, and social challenges, leading to frequent language barriers between surgical patients and nurses (7). A substantial body of literature exists on the subject of working with non-dominant language patients. These studies report that the main problem experienced by nurses is language barriers (8-12). Communication barriers can negatively affect patient safety and the quality of care in perioperative nursing. Turkey, including the province of Aydın in Western Turkey, is home to a culturally and linguistically diverse population that is reflected in surgical settings throughout the country (7,9,10,13). Although previous studies have identified language barriers as a major challenge in healthcare settings, most have focused on general communication difficulties, patient outcomes, or the experiences of healthcare professionals across different clinical environments (7-11). Limited research has specifically explored how surgical nurses experience and manage language barriers throughout the perioperative process, where timely communication, patient education, informed consent, and patient safety are critical components of care. Furthermore, qualitative evidence describing nurses' perceptions, coping strategies, and professional challenges in this context remains scarce. Therefore, this study was conducted to provide an in-depth understanding of surgical nurses' experiences in caring for patients who do not speak the dominant language.

Aim of the study

This study aimed to examine the perioperative care experiences of surgical nurses in patients who cannot speak the dominant language.

2. METHOD

Design

The present qualitative study was conducted in accordance with the phenomenological research design, with a view to revealing and understanding the perioperative nursing care experiences of surgical nurses in patients who do not speak dominant language (14). The study was reported in accordance with the Standards for Reporting Qualitative Research (SRQR) guidelines (15, 16).

Participants and Setting

Purposive sampling was utilised to recruit surgical nurses from various surgical clinics of a culturally diverse university hospital located in western Turkey. The inclusion criteria were: (1) having worked in a surgical clinic for at least six months, (2) having experienced a language barrier at least once during the perioperative care process and (3) being willing to participate in an individual interview. The exclusion criteria were as follows: (1) having no direct patient care, and (2) not being able to speak Turkish well enough to conduct the interview. The hospital where the study was conducted is the largest one in the province and among the hospitals in the west of the country and the language barrier is widespread. Patients with different dialects and religions apply to these hospitals. The nurses included in the study have a different culture from the patients whom they care for.

Thirteen surgical nurses participated in the study. All of the nurses were female, with a mean age of 30.6 years (range 25 to 38). 70.9% of the participants had an undergraduate degree. Their experience in the nursing profession ranged from 2 to 16 years. The participants represented a range of surgical specialties, including general surgery, cardiovascular surgery, and other surgical units. The descriptive characteristics of the nurses participating in the study are shown in Table 1.

Table 1. The Descriptive Characteristics of the Participants (n=13).

Variables	Number of participants (n)
Gender	
Male	-
Female	13
Age	
Less than 28 years	4
28- 38 Years	9
Level of education	
Bachelor	11
Master	2
Years of clinical practice	
0- 2 Years	2
3- 5 Years	2
5- 10 Years	5
11 years and more	4
Working unit	
General surgery	3
Cardiovascular surgery	3
Gynaecology	2
Orthopaedics and traumatology	2
Urology	2
Plastic and cosmetic surgery	2

Data Collection Tools

This study was conducted at a university hospital in western Turkey between May 2025 and June 2025. Data were collected from 13 nurses through in-depth interviews. Since this study focused on the care experiences of nurses providing perioperative care to surgical patients with language barriers, a semi-structured interview form (Table 2) was developed based on previous studies examining the communication challenges experienced by Turkish nurses caring for patients who do not speak the dominant language during the physical and psychosocial care processes of the perioperative period (8, 9, 11, 12). The interview form also addressed the difficulties and solutions encountered by the patients during providing information and education processes. In addition to the questions in the interview form, the nurses were asked to freely share their working experiences in their institution. Additionally, the participants were invited to provide any additional comments they wished to contribute.

Table 2. The Questions of Interview Form.

1.	Can you describe your experiences in managing the nursing care of patients who do not speak dominantly language during the perioperative process?
2.	How did you manage nursing care for patients who do not speak the dominant language?
3.	What ethical issues have you encountered in the perioperative process for patients who do not speak the dominant language?
4.	Can you describe your experiences in communicating with patients who do not speak the dominant language during the perioperative process?
5.	Is there anything else you would like to add on this topic?

Of the surgical nurses who met the inclusion criteria of the study ($n = 36$), half declined to participate, mainly due to workload. Five nurses did not provide a reason for refusal. Before the interviews, the purpose of the study was explained, and verbal informed consent was obtained from those who agreed to participate. The data were collected through face-to-face interviews conducted in a quiet seminar room within the surgical wards using a semi-structured interview form. The semi-structured interview form was pilot tested with three nurses prior to data collection. The interviews were conducted by the first author, who had completed a doctorate in Surgical Diseases Nursing and had experience in qualitative studies. The second author had also completed a doctorate in the same field and had experience in qualitative studies. It is noteworthy that no nurse withdrew from the interviews or expressed a desire to exit the study. During the analysis process, it was observed that no new codes, categories, or themes emerged from the interviews and that the data began to repeat. Data saturation was reached after the thirteenth interview; therefore, no additional participants were recruited (17). The nurses were interviewed once and each interview was recorded using a voice recorder lasting an average of 30 minutes (range 25–35 minutes).

Data Analysis

The data were analysed using Braun and Clarke's thematic analysis approach (18). First, the audio-recorded interviews were transcribed verbatim and the transcripts were read repeatedly to gain familiarity with the data. During the interviews, participant verification was achieved through real-time clarification and confirmation. The interviewer periodically summarized participants' statements. Credibility was enhanced through participant verification during the interviews, expert review of the interview form, and the independent analysis of data by both researchers. The coded data were examined and grouped into potential themes based

on similarities in meaning. The researchers reviewed and refined the themes by evaluating their consistency with both the coded extracts and the entire dataset. Following this process, the themes were clearly defined and named. Finally, a descriptive approach was adopted when reporting the findings.

Trustworthiness and Rigor

To ensure the trustworthiness of the study, the criteria proposed by Lincoln and Guba—credibility, transferability, dependability, and confirmability—were applied throughout the research process (19, 20). Credibility was enhanced through expert review of the semi-structured interview form, participant verification during interviews, and independent coding of the data by both researchers. Transferability was supported by providing detailed descriptions of the study setting, participants, and data collection procedures. Dependability was ensured by maintaining a clear audit trail throughout the research process, including documentation of coding decisions and theme development. Confirmability was strengthened through independent analysis by both researchers and discussion until consensus was reached. In addition, direct quotations from participants were included to increase the transparency and authenticity of the findings.

Ethical Considerations

Approval was obtained from the Aydın Adnan Menderes University Faculty of Nursing Non-Interventional Ethics Committee (dated 11/02/2025 and numbered E-76261397-050-04-684375) before collection of the data, and the institutional permission was obtained from the Chief Physician of Aydın Adnan Menderes University Application and Research Hospital (dated 13/02/2025 and numbered E-97594401-804.01-686243). The purpose of the study was explained to the participants by the researcher. Verbal consent was obtained from all participants to take part and their voice to be recorded in the study. The interviews were audio-recorded and the personal descriptive data of all participants was removed. During the data collection process, the nurses were assigned codes (N1, N2, N3, ..., N13). The transcription of all text and the audio recordings were saved on an encrypted desktop computer. It was an obligation to ensure that these records are stored on the designated computer for the stipulated period of five years as mandated by the prevailing legislation.

3. RESULTS

The analysis yielded three overarching themes: (1) alternative methods for determining care needs, (2) strategies used to facilitate communication, and (3) perception of occupational self-inadequacy. The themes and sub-themes developed in the thematic analysis guided by Braun and Clarke are shown in Table 3.

Theme: Alternative Methods for Determining Care Needs

It was determined that the experiences of the nurses participating in the study in determining the care needs of patients who did not speak the dominant language were grouped under two sub-themes: ‘observation and intuition based on clinical experience’ (Table 3).

Table 3. The Themes and Sub-Themes.

Themes	Sub-Themes	Startup codes	N
Alternative methods for determining care needs	Observation	I try to observe the patient's reactions (N=7)	7
	Experience-based intuition	My experience is guiding in the care process of the patient (N=3), I can predict the risks in the surgical process according to the clinical characteristics of the patient (N=3)	6
Strategies used to facilitate communication	Non-verbal clues	The patient is trying to express themselves using body language (N=3), The patient's facial expressions and gestures provide clues (N=3)	6
	Companion support	If there are companions who know the patient's language, I include them in the process (N=4)	4
	Interpreter	I use interpreters frequently (N=6), I have colleagues who speak languages, they help (N=1)	7
	Technology	I use voice translation applications in patients who speak different languages (N=12), I frequently use artificial intelligence (N=2)	14
Perception of occupational self-inadequacy	Inability to ensure informational privacy	I think I cannot ensure informational privacy (N=9)	9
	Uncertainties in the process of obtaining informed consent	As a patient rights advocate, I cannot be sure how well the patient understands the risks during the consent process (N=5)	5
	Poor quality of care	The quality of care given to patients who do not speak the language is low (N=3)	3
	Management of value and belief differences	I don't know how to approach patients with different cultures and beliefs (N=3), I can't question what the concepts of disease/health mean to patients (N=1)	4

Subtheme I: Observation

Some statements of the nurses on this theme are as follows: "*When there is no common language, the only way to determine the needs of patients is often through observation.*" (N12) "*Observing is my most crucial skill in situations that may present behavioural findings such as pain.*" (N3) "*The facial expression of patient, agitated behaviour, or posture give me clues about their needs.*" (N5) The nurses participating in the study stated that they frequently relied on observation to determine the care needs of patients who did not speak the dominant language. The findings suggest that observation was not merely a supplementary assessment method but often became the primary means of understanding patients' needs when verbal communication was limited. Nurses described paying close attention to facial expressions, body posture, and behavioural changes to identify symptoms such as pain, discomfort, or anxiety.

Subtheme II: Clinical Experiences and Intuition

It was determined that the nurses participating in the study used their professional experience-based intuition to anticipate risks in the care process and take measures against risks in patients who did not speak the dominant language. The nurses reported that in the care process of patients who do not speak the dominant language, they view intuitive assessments as a complementary component to observation in determining care needs. "*...my clinical decision-making skills, strengthened by my experiences in the clinic, are very important. I have to know what is expected from the surgery that patients have undergone, and I observe them.*" (N6). "*What kind of symptoms or complications do I expect in which disease? This is a result of my clinical experience. For example, the ECG of the patient who has undergone bypass surgery is important. I check it, and if the ECG has a normal output, I do not expect any pain.*"

(N8) These accounts demonstrate that nurses referred to their clinical experiences and intuitive judgments as additional resources when assessing patients whose care needs could not be fully explored through verbal communication.

Theme: Strategies Used to Facilitate Communication

The subthemes of the theme strategies used by the nurses participating in the study to facilitate communication with patients who do not speak the dominant language were determined as “nonverbal clues, companion support, interpreter, and technology” (Table 3).

Subtheme I: Non-verbal Clues

The nurses mentioned that they frequently use non-verbal clues such as gestures, facial expressions, and body language in communication with patients who cannot speak the dominant language. They emphasized that this method is one of the most powerful alternative communication methods and facilitates communication universally. *"For example, our patient rooms are for 2 people. If the patients sometimes do not express themselves or indicate with their facial expressions that they do not want to talk, I remove the other people in the room."* (N7) *"My most effective method is to use facial expressions and gestures. By looking at their facial expressions and gestures, I can guess what the patient wants to say. And I realize that people can communicate with facial expressions/gestures or body language."* (N10) These findings suggest that on-verbal cues were frequently used by nurses as a practical strategy to both convey information and understand patients' needs when verbal communication was limited.

Subtheme II: Companion Support

The nurses emphasized that having a companion who speaks the dominant language facilitates the process for patients who do not speak the dominant language, and they use the companion as a source of information during the process. *"Companions are mostly familiar with the medical history of patients. I can obtain data from them, or they can translate the questions that I want to ask to the patients."* (N11) *"The companion is someone who can convey what I want to tell the patient and who is also familiar with the illness-related processes of patient. If the patient has a companion, it is easier to maintain communication."* (N2) The findings suggest that companions became an integral part of the communication process when language barriers were present. While this facilitated the exchange of information, it also highlighted nurses' dependence on third parties to assess patients' needs and deliver care-related information.

Subtheme III: Interpreter

The nurses emphasized that the use of interpreters can be particularly effective for patients who do not speak the dominant language. The nurses also noted that the interpreters facilitate communication, but they are not sure whether they mastered health-related concepts and terms. *"The entire communication process is dependent on the interpreter."* (N5) *"Among the nurses working in the institution, those who speak the language are defined as interpreters. I can reach to these people and get support."* (N8) *"I often worry whether the words the interpreter uses reflect what I want to say. Is the word correct? Is the content correct? How*

can I check it when I do not understand what they are saying? I always have to verify the interpreter. I can not be sure." (N10). Although interpreters facilitated communication, the findings revealed an underlying tension between accessibility and trust. While nurses relied on interpreters to convey information, they also expressed concerns regarding the accuracy and completeness of medical translations, particularly when complex clinical concepts were involved.

Subtheme IV: Technology

The nurses emphasized that they use AI-powered translation applications and also voice translation applications for illiterate patients. It is noteworthy to mention that this method is quite widely used among nurses. *"I use AI-powered translation applications that work with voice recording."* (N1) *"My foreign language is not enough. In this process, we benefited the most from technological developments in nursing care. Especially, translation and AI-powered translation applications have made this process much easier."* (N7) The findings indicate that technology has become an increasingly important communication resource in perioperative nursing practice. Participants described translation applications as practical and accessible tools that helped overcome immediate communication barriers, particularly when interpreters or companions were unavailable.

Theme: Perception of Occupational Self-inadequacy

The experiences of nurses who participated in the study regarding their perceptions of professional self-inadequacy when providing care to patients who do not speak the dominant language consisted of the sub-themes "inadequacy in ensuring informational privacy, uncertainties in the informed consent process, low quality of care, and management of differences in values and beliefs" (Table 3).

Subtheme I: Inability to Ensure Informational Privacy

The nurses who participated in the study stated that they experienced ethical concerns, particularly regarding ensuring informational confidentiality, when providing care to patients who do not speak the dominant language. They felt that they were unable to manage this process well. *"...it is difficult to maintain confidentiality due to the nature of my service (gynaecology)."* *We talk about sexuality, we talk about birth. I ask everything through an interpreter. Therefore, the interpreter also has access to the information about the patient."* (N6) *"Sometimes we use a companion to translate; the issues that are wanted to be privately talked about are included in the patient-nurse-companion triangle. I can not ensure informational privacy."* (N9) These results indicate that the use of interpreters and companions, while facilitating communication, also created ethical concerns regarding confidentiality and privacy. Nurses perceived the involvement of third parties in sensitive conversations as a challenge to maintaining professional standards of patient-centred and confidential care.

Subtheme II: Uncertainties in the Process of Obtaining Informed Consent

The nurses who emphasize their role as patient advocates, particularly in the consent process for patients who experience language barriers, highlighted that the uncertainty surrounding the understanding of patients and approval of consent leads them to perceive

themselves as professionally inadequate. *"For example, in getting consent, all the consent forms are in Turkish. How can they understand? It is the physician who gets the consent, but as a patient advocate, it is the job of nurses to make sure that the patients understand and consent."* (N2) *"Every patient has the right to receive care in accordance with ethical principles. Informed consent should be in the own language of patients and at a level that they can understand. Of course, this is often difficult to be sure of it due to language and communication barriers."* (N13) The findings indicate that language barriers extended beyond communication difficulties and raised concerns about patients' ability to provide truly informed consent, contributing to nurses' feelings of professional inadequacy.

Subtheme III: Poor Quality of Care

The nurses emphasized that the perioperative process affects patients physically, psychologically, and socially. Therefore, they aim to provide a holistic patient care due to these effects. However, they noted that the language barrier prevents them from providing a holistic patient care to many patients, leading to a perception of inadequacy regarding the quality of nursing care they provide during this process. *"There is a female cancer patient who does not speak Turkish in our ward. It is very difficult to evaluate the patient psychologically. I am insufficient to support the self-understanding of patient and the process of acceptance in the postoperative period."* (N1) *"Of course, the quality of care is low. Because I can not explain myself to the patient, and the patient can not explain herself to me."* (N13) The findings indicate that language barriers limited nurses' ability to provide holistic care, particularly in addressing patients' psychosocial needs, leading to concerns about the quality and comprehensiveness of care.

Subtheme IV: Management of Value and Belief Differences

The nurses have emphasized that they are aware of the cultural and religious differences of patients who do not speak the dominant language in the perioperative process, and these differences negatively affect nursing management. *"What can I do about the cultural characteristics of the patients? What can be done in the perioperative process for the patients with a different culture, and how should they be approached? Unfortunately, I do not have any answers to these questions."* (N4) *"They also have a different culture from me. Their ways of expressing themselves, their outlook on life, and their values are different. Quality care can not be provided without internalizing these."* (N6) The findings indicate that language barriers were often accompanied by cultural and religious differences, creating additional challenges for nurses in delivering culturally responsive and individualized care

4. DISCUSSION

The present study has determined that the nurses rely on their intuitions gained from the clinical experiences, facial expressions and behaviours of the patients to identify the care needs of patients who do not speak the dominant language in the perioperative process. In some limited situations, facial expressions and behavioural signs can be used to monitor subjective symptoms such as pain and fatigue (21, 22). However, determining the care needs should not only be based on observations but also on patient self-report and the results of clinical examination (22). It is expressed by the nurses that the patients can not be holistically evaluated

at the desired level due to the difficulties in communication caused by the language barrier. Previous studies also reported that the psychological, social, emotional, or spiritual needs of the patients who do not speak the dominant language are not adequately evaluated (9, 23). The perioperative process, in particular, should be provided with a holistic approach that focuses on the patients and their families (24). This result indicates a significant deficiency. The nurses who participated in the study stated that they rely on their intuition based on the experiences when identifying the needs of patients who do not speak the dominant language. Intuition is not merely an "instinctive feeling"; it is a process based on knowledge and caregiving experiences, and it has its place alongside research-based evidence. Previous literature suggests that intuition may play a role in nursing decision-making alongside knowledge, experience, and objective clinical data (25, 26). In the present study, nurses described drawing on their clinical experience and intuitive judgments when verbal communication was limited. These findings suggest that intuition was perceived by participants as one of the resources used to support patient assessment and care planning in the context of language barriers.

The present study determined that the nurses used various alternative techniques to facilitate communication with patients who do not speak the dominant language. Communication disorder is defined as the biggest obstacle for providing appropriate, timely, and safe care to the patients who do not speak the dominant language (13). One of the strategies commonly used by nurses to overcome this obstacle is non-verbal communication techniques (9, 13). A recent study reported that non-verbal communication reassures patients and their families about their medication process and provides them with some degree of relief (27). However, it is emphasized that although non-verbal communication practices are widely used, body movements can be interpreted differently and misunderstood depending on the culture and beliefs of patients (28, 29). In addition, it was determined that the support of companion and interpreters was frequently used to facilitate communication. In this study, the term companion referred to a family member who stayed with the patient and could speak the dominant language, while the term interpreter referred to a nurse working at the hospital who could speak the language, rather than a trained interpreter. In some studies, it is reported that the use of interpreters is common to communicate with patients who do not speak the dominant language (30, 31). Although the use of professional interpreters is useful in managing complex situations such as perioperative process and in improving patient care satisfaction, the availability and accessibility of interpreters, convenience, confidentiality, privacy issues, and the negative effects that may arise in comfort of the patients constitute limitations (32). It is crucial for patient safety that the individuals providing support as interpreters are trained and the translation is accurately performed. In the United States, it is reported that interpreters assigned to patients with language barriers must be qualified (1). The findings of this study suggest that, in countries with culturally and linguistically diverse populations such as Turkey, strengthening interpreter services and exploring the integration of official translation technologies into patient care may help facilitate communication during the perioperative process. Some studies have reported that nurses frequently use translation applications in communication with patients who do not speak the dominant language (26, 33). Similarly, nurses participating in this study reported using AI-powered translation applications to facilitate communication. While translation applications have the advantage of always being accessible,

they also have limitations, particularly when AI is used, due to the possibility of technical glitches, less personal interaction, and data processing by a third-party server (13, 34). Although participants perceived these technologies as practical and accessible tools, several ethical and technical concerns should also be considered. AI-based translation systems may inaccurately translate medical terminology, symptoms, or treatment-related information, potentially affecting patient safety and clinical decision-making (35, 36). Furthermore, the use of voice-recording and online translation applications may raise concerns regarding confidentiality, data security, and the protection of patient privacy. These concerns may be particularly relevant in perioperative settings, where accurate communication is essential for patient education, informed consent, and shared decision-making (37). Therefore, while translation technologies may support communication in situations where interpreters are unavailable, they should be used cautiously and preferably within institutionally approved frameworks that ensure both linguistic accuracy and data security. It is emphasized that strategies to facilitate communication with patients who do not speak the dominant language should be evaluated with their advantages and disadvantages, and the most appropriate strategy for the patient and the process should be used. Nurses should be extremely aware of this issue.

This study indicated that the nurses feel professionally inadequate in ensuring informational privacy for patients who do not speak the dominant language, in the uncertainties of the informed consent process, in low-quality care, and in managing differences in values and beliefs. In addition, the nurses stated that the interpreters they used to overcome the language barrier in communication with the patients negatively affected their self-efficacy in ensuring informational privacy. Several studies report that the language barrier between the nurse and patient is the biggest obstacle in providing timely and accurate care (13, 32, 38). In addition, the nurses expressed that they felt inadequate to ensure whether the informed consent was understood by the patients or not. In the literature, it is reported that ethical dilemmas occur when the informed consent can not be obtained, empathy can not be established, the diagnosis and treatment process can not be carried out as desired, and care can not be adapted to the cultural characteristics of the patients (9, 39, 40). The results of this study are consistent with the literature (8, 9, 12, 41). In the present study, nurses described several specific difficulties in managing perioperative care for patients who did not speak the dominant language. These difficulties included uncertainty regarding whether patients fully understood preoperative information and informed consent procedures, concerns about maintaining informational privacy when communication depended on companions or interpreters, challenges in assessing psychological, emotional, and spiritual needs, and difficulties in adapting care to patients' cultural and religious beliefs. These findings suggest that language barriers affect not only the transmission of information but also nurses' ability to provide holistic and ethically sound perioperative care. Previous studies have reported that the majority of nurses provide care to patients with different cultural backgrounds and face challenges in the care process (9, 10). Differences in language, culture, and religion are important factors that can directly affect communication experiences, lifestyle habits, and perceptions of disease and health processes (6, 11, 13, 42). Due to increased immigration in some countries such as the United States, Australia, and Turkey, cultural and linguistic differences between nurses and patients can negatively affect the quality of healthcare services (43). Cultural and traditional practices such

as the use of herbal medicine, breastfeeding preferences, and placenta burial may be present in the lifestyle habits of patients from different cultures (13). In addition, religious beliefs and practices, such as fasting and prayer, are perceived as relevant factors in patient recovery (44). These challenges may be particularly relevant in the Turkish healthcare context, where increasing migration and cultural diversity have led nurses to care for patients from a wide range of linguistic, cultural, and religious backgrounds. In surgical settings, where patient education, informed consent, privacy, and timely decision-making are essential components of care, communication barriers may create ethical and professional uncertainties for nurses. The participants' accounts indicate that these uncertainties can contribute to feelings of professional inadequacy, particularly when nurses are unable to verify patients' understanding or ensure culturally responsive care. To improve perceptions of professional self-efficacy, it is considered important to identify situations related to these dilemmas to increase awareness among nurses and to develop institutional strategies for resolving them.

Limitations

This study has some limitations. Firstly, the study was conducted with the nurses working in the surgical clinics at a university hospital in western Turkey. Secondly, the study focused on experiences of encountering language barriers, and the findings revealed that nurses frequently referred to cultural differences in addition to language-related challenges. However, the study did not examine the cultural competence of the participating nurses. The participants may have differed in their levels of cultural awareness and competence, which should be considered when interpreting the findings. Thirdly, a considerable proportion of eligible nurses declined participation, primarily due to workload. As nurses with heavier workloads may have had more frequent experiences caring for patients who did not speak the dominant language, their non-participation may have introduced selection bias and limited the range of experiences represented in the study. Future research should consider nurses' cultural competence and include broader and more diverse samples to further explore these issues.

5. CONCLUSION

This qualitative analysis of the experiences of surgical nurses caring for the patients who do not dominantly speak the language revealed three key themes in the data: (1) alternative methods for determining care needs, (2) strategies used to facilitate communication, and (3) perception of occupational self-inadequacy. The surgical nurses reported difficulties in holistically assessing patients who did not speak the dominant language, overcoming communication barriers, and managing ethical dilemmas during the perioperative process. The findings suggest a need for educational initiatives focusing on culturally sensitive care, communication skills, informed consent, and patient privacy. In addition, healthcare institutions should strengthen interpreter services and provide accessible translation technologies and multilingual educational materials to support safe and effective perioperative care for linguistically diverse patient populations.

Conflict of Interest Statement

The authors declare that they have no conflict of interest.

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