

Examination of the Relationship Between Perceived Manager Support and Medical Error Attitudes Among Healthcare Employees

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ARTICLE INFO	ABSTRACT
<p>Keywords: Healthcare Employees Manager Support Medical Error, Patient Safety Error Reporting</p> <p>Received 1 December 2025 Revised 14 May 2026 Accepted 30 May 2026</p> <p>Article Classification: Research Article</p>	<p>Purpose – Managerial support is not limited to tasks such as controlling and supervising employees or planning and maintaining work processes. It also assigns managers the role of guiding and educating employees. Healthcare employees who perceive high levels of managerial support are expected to demonstrate higher job performance. Medical errors in healthcare institutions represent critical adverse events in healthcare delivery. These errors, often irreparable, are among the most significant issues affecting human health. Such errors are critical due to their potential to result in severe adverse outcomes. This study aimed to examine the relationship between perceived manager support and attitudes toward medical errors among healthcare employees. A positive attitude reflects a high level of awareness regarding the importance of error reporting and medical errors. A negative attitude indicates that participants have a low awareness of the importance of error reporting and medical errors.</p> <p>Design/methodology/approach – This quantitative study was conducted by analyzing data obtained via a survey from 274 healthcare employees working at a university medical school hospital. The perceived manager support scale and the medical error attitudes scales were used in data collection.</p> <p>Results – Perceived manager support is higher in the middle-income group. Employees in internal medicine clinics perceive higher manager support compared to those in surgical clinics. Intensive care staff are more sensitive to medical errors than emergency department staff. The level of medical error attitudes among physicians and nurses is higher than that of technicians. A weak but statistically significant correlation exists between perceived manager support and attitudes toward medical errors.</p> <p>Discussion – Training programs and anonymous error reporting can contribute to the prevention of medical errors. It is suggested that a learning-oriented approach to errors by managers would be beneficial.</p>

1. Introduction

Healthcare is one of the most complex services offered today. As institutions providing 24/7 services through multidisciplinary collaboration, the management of healthcare organizations remains inherently complex. Any disruptions or errors in service delivery can have irreparable negative consequences. Patient health and safety are unequivocally the primary focus of healthcare delivery. The provision of safe patient care is contingent upon effective service delivery and robust management. Manager support may be needed both for the adaptation of new employees to the sector and for learning newly implemented methods or processes. This study aimed to examine the relationship between perceived manager support and attitudes towards medical errors among healthcare employees. It is known that how manager support is perceived is important in shaping employees' attitudes (Kuvaas and Dysvik 2010). This study stemmed from the idea that employees, when supported by their managers, will be more dedicated to their work and exhibit positive attitudes towards medical errors. A positive attitude towards medical errors indicates that healthcare employees have a high level of awareness regarding patient safety and understand the importance of medical errors and error reporting. A negative attitude, on the other hand, indicates a lack of sufficient awareness of the importance of medical errors and error reporting (Güleç and İntepeler, 2013). Additionally, it should be noted that the term manager was used instead of supervisor in this study. As the role examined involves broader Managerial

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responsibilities that extend beyond the scope of supervision, the term manager is considered more appropriate.

A review of the literature on manager support reveals: Studies by Başlar and Göktepe (2021), Durmuş (2024), Eisenberger et al. (2002), Erer and Tekin (2021), Kottke and Sharafinski (1988), Maertz Jr et al. (2007), Ozbozkurt et al. (2021), Özdemir (2020), Paille et al. (2013), Tymon Jr et al. (2011), Yorgancioglu Tarcan et al. (2021) are available. Regarding medical error attitude, in the literature; Er and Özkan (2024), Ghalandarpoorattar et al. (2012), Ghobadi et al. (2023), Gouda Metwally and Abdeldayem Ata Hussein (2022), Gülnar et al. (2020), Kircav et al. (2020), Kiyamaz and Koç (2018), Korhan (2017), Öncü et al. (2021), Tarhan and Elibol (2023), and Unal and Seren (2016) are among the studies conducted. The use of technology in healthcare, the introduction of new practices, the emergence of new diseases, and the diversification of specialties are leading to increased complexity in healthcare services. This, in turn, leads to a diversification and complexity of work processes and errors. To improve the quality of healthcare services and prevent errors, it is primarily necessary to scientifically research and investigate medical errors. This study explores the relationship between managerial support and attitudes toward medical errors within the context of contemporary healthcare practices. It distinguishes itself from previous research by testing a unique hypothesis and addressing current developments in the field. By examining this relationship, the study aims to emphasize the critical role of managerial support in initiatives aimed at preventing medical errors, a persistent and significant challenge in healthcare.

Perceived manager support includes issues such as providing individual attention to each member, guiding them, coaching them, helping subordinates fulfill their job responsibilities, and evaluating job satisfaction (Guchait et al. 2014). Researchers, who define manager support as a sub-dimension of organizational support, state that positive organizational behaviors in employees are related to their support from their managers (Fakunmoju et al. 2010). Negative organizational behaviors can be observed in employees who are not supported by their managers (Goh et al. 2015; Zincirkiran et al. 2016). A manager who supports employees leads by example and provides the support they need to perform their jobs effectively (Tymon Jr. et al. 2011). Healthcare is a unique service sector that demands effective management due to its inherent characteristics, such as lack of substitutability, time-sensitivity, minimal margin for error, pervasive uncertainty, and high technology intensity (Tengilimoğlu et al. 2012). In this highly sensitive and important sector, healthcare employees must be experts in their fields and adapt to rapidly changing and evolving processes to be successful. In this sector, where errors are irreparable, medical errors are extremely important. A medical error is the failure to carry out a planned treatment as intended (an error in implementation) or the incorrect planning and implementation of treatment (an error in planning) (Akalin 2004). Medical errors can be categorized into four main groups (Tapan 2019):

Diagnostic Errors: Misdiagnosis or delay in diagnosis, failure to perform appropriate and necessary assessments, use of diagnostic and treatment methods that are inappropriate for current conditions, failure to act appropriately on test results.

Treatment Errors: Determining an inappropriate treatment method, improper application of a surgical procedure, intervention, or test, making a dosage or method error in medication administration, interfering with an abnormal test result or delaying treatment.

Preventive Treatment Errors: Not administering prophylactic treatment or making an error in its administration, inadequate monitoring during treatment.

Other Errors: Errors due to lack of communication, inadequate equipment and related errors, system-related errors, blood transfusion errors, confusion of laboratory samples or results.

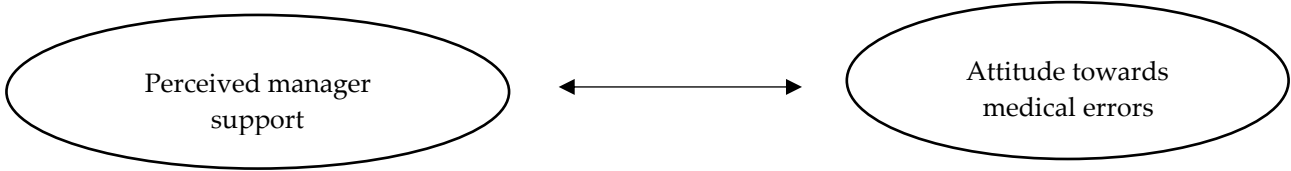
As can be seen, errors are likely to occur at many stages of healthcare delivery. To reduce and prevent medical errors, healthcare employees are expected to be aware of and vigilant about the possibility of errors. Developing preventive attitudes among healthcare employees is known to reduce medical errors and increase patient safety (Güven et al. 2019). Therefore, the objectives of this research are:

1. To measure perceived manager support among healthcare employees
2. To measure healthcare employees' attitudes toward medical errors

3. To examine the relationship between perceived manager support and attitudes toward medical errors among healthcare employees.

Research Hypothesis: H1: There is a positive relationship between perceived manager support and attitudes toward medical errors among healthcare employees.

Research Model:



This research design, focusing on the relationship between perceived manager support and medical errors, can be explained by the patient safety culture approach. Indeed, today's healthcare institutions require the use of high technology and the application of complex medical procedures. In this case, a patient safety approach is necessary to prevent medical errors. Patient safety culture is concerned with the extent to which the beliefs, attitudes, and values that influence the behavior of healthcare employees affect patient safety (Yılmaz, 2020). Positive patient safety is characterized by communication based on mutual trust, continuous organizational learning, evidence-based and patient-centered care, management and leadership support, and a non-punitive approach to incident and error reporting. Negative patient safety culture, on the other hand, is characterized by inadequate management and, consequently, insufficient support in reporting incidents that threaten patient safety. Manager support plays a significant role in the sub-dimensions of patient safety culture. Teamwork, the ability to report errors without fear of punishment, and the implementation of measures to prevent errors from recurring based on these reports are all related to management (National Patient Safety Foundation, 2015). The relationship between perceived manager support and attitudes towards medical errors has been examined within this theoretical framework.

2. Method

This section provides information about the research method. This research was conducted using quantitative methods. It is descriptive and correlational in nature. The purpose of the study was to examine the relationship between perceived manager support and attitudes toward medical errors among healthcare employees.

2.1. Sample

The participants in this study were physicians, nurses, administrative staff, technicians, working at a university medical school hospital. These occupational groups were considered important because they interact with patients regarding medical errors. The research population consisted of approximately 2,200 employees. The sample size table developed by Yazıcıoğlu and Erdoğan (2004) was used to determine the study's sample size. According to this table, the sample for the relevant population consisted of 224 individuals. The 95% confidence interval was calculated as 224 ($\alpha=0.05$, $p=0.80$, $d=0.05$). A convenience sampling method was adopted, and data were collected via face-to-face surveys. 274 individuals were contacted for the study. Participation in the study was voluntary.

2.2. Data Collection Tools

Research data were collected via face-to-face surveys between May 2, 2024, and June 30, 2024. A demographic information form, the perceived manager support scale (Aydın Göktepe, 2017), and the attitude towards medical errors scale (Güleç and İntepeler, 2013) were used to collect the research data.

Demographic information form: This form included questions to obtain descriptive information about the participants, such as their age, gender, marital status, education level, occupation, and clinic they work in.

Perceived manager support scale: The Cronbach's alpha coefficient for the scale was calculated as 0.91. The scale consists of 7 items and consists of two subscales: Instrumental support (first 4 items) and emotional support (last 3 items). The scale items were converted into a 5-point Likert-type questionnaire (Aydın Göktepe, 2017).

Attitude towards Medical Errors Scale: The scale was developed by Güleç and İntepeler (2013). In this study, the Cronbach's alpha coefficient for this scale was calculated as 0.76. The scale has 3 subdimensions: Perception of medical error, approach to medical error, and causes of medical errors. The perception of medical error dimension consists of 2 statements, while the approach to medical error and causes of medical errors dimensions consist of 7 statements each. The scale has a total of 16 statements. It is a 5-point Likert type. Scale statements are "strongly disagree" (1), "disagree" (2), "undecided" (3), "agree" (4) and "strongly agree" (5). Statements 10 and 13 of the scale are reverse scored. Participants whose scale mean is below 3 are evaluated as having negative attitudes towards medical errors, while participants who score 3 and above are evaluated as having positive attitudes towards medical errors. Negative attitude indicates that the participants' awareness of the importance of error reporting and medical errors is low, while positive attitude indicates that; It indicates that participants have high awareness of the importance of error reporting and medical errors (Güleç and İntepeler, 2013).

2.3. Data Analysis

The research data were analyzed using the SPSS 26 Package Program. First, descriptive statistics were calculated. Then, the data were assessed for conformity to a normal distribution. After confirming that the data met the normality assumptions, parametric statistical analyses were conducted. Frequency distribution was used for descriptive information, t and ANOVA tests were used to identify differences between variables, and correlation tests were used for relationship analysis.

2.4. Research Ethics

Approval for this research was received from the Selçuk University Faculty of Health Sciences Non-Interventional Research Ethics Committee dated 27.03.2024 and with decision number 339. The research was carried out in accordance with the ethical principles expressed in the Declaration of Helsinki (World Medical Association, 2024).

3. Findings

In this section, the research data are presented and explained in tables

Table 1. Descriptive Information

Features (n=274)	Number (n)	Percentage (%)	
Gender	Female	153	55.8
	Male	121	44.2
Age	18-25 years	87	31.8
	26-33 years	90	32.8
	34 years and older	97	35.4
Marital status	Married	167	60.9
	Single	107	39.1
Income status	Low	54	19.7
	Medium	200	73.0
	High	20	7.3
Education Level	High school	40	14.6
	Associate's degree	88	32.1
	Bachelor's degree	102	37.2
	Postgraduate degree	44	16.1
Unit of Work	Internal Medicine Clinics	43	15.7
	Surgical Clinics	121	44.2
	Intensive care	50	18.2
	Emergency service	60	21.9
Job	Physician and Nurse	131	47.8
	Administrative Staff	64	23.4
	Technician*	79	28.8
Total	274	100	

*Medical laboratory and pathology technician, medical imaging technician, medical prosthesis and orthosis technician, physiotherapy technician, radiotherapy technician, health care technician, anesthesia technician, emergency medical technician.

As seen in Table 1, a total of 274 people participated in the study. The majority of participants were female (55.8%) and male (44.2%). 31.8% of participants were between the ages of 18-25, 32.8% between the ages of 26-33, and 35.4% between the ages of 34 and over. 60.9% of participants were married and 39.1% were single. 19.7% of participants reported low income, 73.0% middle income, and 7.3% high income. 14.6% of participants had a high school degree, 32.1% an associate's degree, 37.2% a bachelor's degree, and 16.1% a postgraduate degree. Of the participants, 15.7% reported working in internal medicine clinics, 44.2% in surgical clinics, 18.2% in intensive care units, and 21.9% in emergency rooms. 47.8% of the participants were physicians and nurses, 23.4% were administrative staff, and 28.8% were technicians.

The skewness and kurtosis values of the research data were examined. The perceived manager support scale was found to have a skewness of -0.335 and a kurtosis of -0.184, while the attitude towards medical errors scale had a skewness of -0.889 and a kurtosis of 1.173. When skewness and kurtosis values range from -1.5 to +1.5, the data are considered to be normally distributed (Tabachnick and Fidell 2013). Parametric tests were applied to analyze the data based on the normal distribution of the data.

Means on five-point Likert scales were as follows: It is interpreted as low when it is in the range of 1.00-2.33, medium when it is in the range of 2.34-3.66, and high when it is in the range of 3.67-5.00 (Büyüköztürk 2021).

Table 2. Mean Scores of Participants on the Perceived Manager Support and Attitudes Towards Medical Errors Scale and Its Sub-dimensions

Scale and Sub-Dimensions	$\bar{x} \pm SS$	Min	Max
Perceived Manager Support Scale	3.34 \pm .94	1	5
Instrumental Support Sub-dimension	3.38 \pm .96	1	5
Emotional Support Sub-dimension	3.29 \pm 1.04	1	5
Attitude Scale on Medical Errors	3.40 \pm .43	1.25	4.38
Medical Error Perception Sub-Dimension	2.82 \pm .88	1	5
Medical Error Approach Sub-Dimension	3.40 \pm .59	1	4.71
Medical Error Causes Sub-Dimension	3.57 \pm .55	1.57	5

Table 2 shows the participants' mean scores on the perceived manager support scale and the attitude toward medical errors scale and their subscales. The participants' mean score on the perceived manager support scale was 3.34 out of 5. The participants' mean score on the attitude toward medical errors scale was 3.40 out of 5.

Table 3. T-test Analysis of the Perceived Manager Support Scale and its Sub-Dimensions

Variables		Perceived Manager Support Scale	Sub-Dimensions	
			Instrumental Support	Emotional Support
Gender	Female	3.38 \pm .93	3.42 \pm .95	3.33 \pm .29
	Male	3.29 \pm .95	3.33 \pm .98	3.23 \pm .59
t		t=.80	t=-.75	t=-.76
p		p=.424	p=.450	p=.448
Marital status	Married	3.32 \pm .92	3.37 \pm .95	3.26 \pm .29
	Single	3.37 \pm .97	3.40 \pm .99	3.33 \pm .65
t		t=-.41	t=-.24	t=-.58
p		p=.678	p=.808	p=.562

Table 3 presents the results of the analysis examining the difference in participants' average perceived manager support scores based on gender and marital status. It should be noted that the t-tests and ANOVA tests used for the difference analysis are exploratory in nature. Accordingly, no statistically significant difference was found in participants' average perceived manager support scores based on marital status and gender.

Table 4. T-Test Analysis of the Attitude Scale and its Sub-Dimensions on Medical Errors

Variables		Attitude Scale on Medical Errors	Sub-Dimensions			
			Medical Perception	Error	Medical Approach	Error Causes
Gender	Female	3.37 ± .40	2.76 ± .82		3.35 ± .54	3.56 ± .54
	Male	3.44 ± .47	2.90 ± .95		3.46 ± .64	3.58 ± .54
t		t=1.41	t=1.29		t=1.45	t=.38
p		p=.158	p=.196		p=.148	p=.699
Marital status	Married	3.40 ± .43	2.84 ± .85		3.40 ± .57	3.57 ± .55
	Single	3.39 ± .44	2.78 ± .93		3.40 ± .61	3.56 ± .55
t		t=.22	t=.49		t=0.00	t=.178
p		p=.825	p=.619		p=.999	p=.859

Table 4 shows the results of the analysis examining the differences in participants' mean scores on attitudes toward medical errors based on gender and marital status. Accordingly, no statistically significant differences were found in participants' mean scores on attitudes toward medical errors based on gender and marital status.

Table 5. ANOVA Test for the Perceived Manager Support Scale and its Sub-Dimensions

Variables		Perceived Manager Support Scale	Sub-Dimensions	
			Instrumental Support	Emotional Support
Age	18-25 ¹	3.44 ± .98	3.50 ± 1.02	3.37 ± 1.05
	26-33 ²	3.36 ± .96	3.35 ± 1.00	3.37 ± 1.07
	34 years and older ³	3.24 ± .88	3.31 ± .87	3.13 ± .99
Test and p value		F=1.131 p=.324	F=0.911 p=.403	F=1.707 p=.183
Income status	Low ¹	2.95 ± .99	3.01 ± 1.09	2.87 ± 1.05
	Medium ²	3.48 ± .89	3.53 ± .88	3.41 ± 1.00
	High ³	3.03 ± .96	2.96 ± 1.03	3.13 ± 1.12
Test and p value		F=8.10	F=8.47	F=6.221
Post-Hoc (Scheffe)		p=.000 2>1	p=.000 2>1	p=.002 2>1
Education Level	High school ¹	3.28 ± .94	3.38 ± 1.08	3.16 ± 1.20
	Associate's degree ²	3.44 ± .88	3.51 ± .90	3.34 ± 1.01
	Bachelor's degree ³	3.29 ± 1.00	3.33 ± 1.03	3.23 ± 1.05
	Postgraduate degree ⁴	3.32 ± .78	3.26 ± .82	3.40 ± 0.91
Test and p value		F=.474 p=.701	F=.868 p=.458	F=.551 p=.648
Unit of Work	Internal Medicine Clinics ¹	3.61 ± .82	3.66 ± .87	3.54 ± .85
	Surgical Clinics ²	3.14 ± .97	3.20 ± .99	3.07 ± 1.08
	Intensive care ³	3.45 ± .91	3.47 ± .93	3.42 ± 1.05
	Emergency service ⁴	3.47 ± .93	3.49 ± .96	3.44 ± .99
Test and p value		F=3.58	F=3.079	F=3.39
Post-Hoc (Scheffe)		p=.014 2<1	p=.028 2<1	p=.018 2<1
Job	Physician and Nurse ¹	3.45 ± .89	3.48 ± .90	3.43 ± .99
	Administrative Staff ²	3.17 ± .96	3.20 ± 1.01	3.14 ± 1.04
	Technician ³	3.29 ± 1.00	3.38 ± 1.02	3.18 ± 1.10
Test and p value		F=2.07 p=.127	F=1.775 p=.171	F=2.290 p=.103

Table 5 presents the results of the analysis examining the differences in participants' perceived manager support and sub-dimension mean scores based on age, income, education level, work unit, and occupation. According to this result, there were no statistically significant differences in participants' perceived manager support and sub-dimension mean scores based on age, education level, and occupation. Participants' perceived manager support and sub-dimension mean scores were found to differ statistically significantly based on income and work unit. A post-hoc test examining the differences revealed that participants with a moderate income had higher perceived manager support and sub-dimension mean scores than participants with a low income. Similarly, a post-hoc test revealed that participants working in internal medicine clinics had higher perceived manager support and sub-dimension mean scores than participants working in surgical clinics.

Table 6. ANOVA Test for the Attitudes to Medical Errors Scale and its Sub-Dimensions

Variables		Attitude Scale		Sub-Dimensions	
		on Medical Errors	Medical Error Perception	Medical Error Approach	Medical Error Causes
Age	18-25 ¹	3.38 ± .41	2.77 ± .89	3.37 ± .61	3.57 ± .54
	26-33 ²	3.49 ± .40	2.95 ± .85	3.49 ± .51	3.64 ± .54
	34 years and older ³	3.33 ± .46	2.74 ± .89	3.34 ± .63	3.50 ± .55
Test and p value		F=3.11 p=.046	F=1.52 p=.219	F=1.66 p=.191	F=1.55 p=.214
Income status	Low ¹	3.14 ± .52	2.64 ± .07	3.28 ± .69	3.51 ± .65
	Medium ²	3.42 ± .40	2.88 ± .81	3.43 ± .56	3.58 ± .52
	High ³	3.44 ± .41	2.70 ± .92	3.46 ± .55	3.63 ± .51
Test and p value		F=1.65 p=.192	F=1.70 p=.183	F=1.33 p=.26	F=0.40 p=.667
Education Level	High school ¹	3.31 ± .57	2.93 ± .98	3.27 ± .74	3.45 ± .60
	Associate's degree ²	3.41 ± .40	2.78 ± .95	3.47 ± .64	3.52 ± .54
	Bachelor's degree ³	3.39 ± .40	2.77 ± .82	3.36 ± .48	3.60 ± .56
	Postgraduate degree ⁴	3.49 ± .40	2.88 ± .79	3.47 ± .54	3.68 ± .48
Test and p value		F=1.185 p=.316	F=0.420 p=.739	F=1.376 p=.250	F=1.473 p=.222
Unit of Work	Internal Medicine Clinics ¹	3.37 ± .36	2.88 ± .91	3.41 ± .53	3.47 ± .45
	Surgical Clinics ²	3.45 ± .43	2.82 ± .89	3.46 ± .56	3.62 ± .58
	Intensive care ³	3.47 ± .36	2.84 ± .80	3.37 ± .58	3.74 ± .47
	Emergency service ⁴	3.26 ± .51	2.75 ± .92	3.29 ± .68	3.38 ± .55
Test and p value		F=3.171 p=.025	F=.180 p=.910	F=1.27 p=.282	F=4.955 p=.002
Post-Hoc (Scheffe)		3 > 4	-	-	3 > 4
Job	Physician and Nurse ¹	3.49 ± .40	2.87 ± .82	3.45 ± .53	3.70 ± .51
	Administrative Staff ²	3.22 ± .48	2.75 ± .80	3.26 ± .62	3.32 ± .57
	Technician ³	3.40 ± .40	2.79 ± .03	3.43 ± .63	3.55 ± .52
Test and p value		F=8.261 p=.000	F=.519 p=.596	F=2.416 p=.091	F=10.711 p=.000
Post-Hoc(Scheffe)		1>3	-	-	1>3

Table 6 presents the results of the analysis examining the differences in participants' attitudes and sub-dimension mean scores on medical errors based on age, income, education level, unit of employment, and occupation. According to this result, it was determined that there were no statistically significant differences in participants' attitudes and sub-dimension mean scores on medical errors based on age, income, and education level. Participants' attitudes and sub-dimension mean scores on medical errors based on unit of employment and occupation were found to differ statistically significantly. A post-hoc test examining the differences revealed that participants working in intensive care units had higher mean scores on medical errors than participants working in emergency departments. Similarly, the post-hoc test revealed that participants

working as physicians and nurses had higher mean scores on medical errors than participants working as technicians.

Table 7. Correlation Analysis of the Perceived Manager Support Scale and its Subdimensions and the Attitudes Towards Medical Errors Scale and its Subdimensions

		Attitude on Errors	Scale Medical Errors	Medical Perception Dimension	Error Sub- Dimension	Medical Approach Dimension	Error Sub- Dimension	Medical Causes Dimension	Error Sub- Dimension
Perceived Manager Support Scale	r	0.159**		0.171**		0.166**		0.032	
	p	0.008		0.005		0.006		0.598	
Instrumental Support Sub-Dimensions	r	0.178**		0.151*		0.167**		0.072	
	p	0.003		0.012		0.005		0.235	
Emotional Support Sub-dimension	r	0.118		0.175**		0.144*		-0.021	
	p	0.052		0.004		0.017		0.724	

* Correlation is significant at the 0.05 level. **Correlation is significant at the 0.01 level..

Table 7 presents the correlation analysis results for perceived manager support and its sub-dimensions, as well as the attitude scale toward medical errors and its sub-dimensions. According to this table, a weakly positive and significant correlation was found between perceived manager support and attitude toward medical errors (r: 0.159; p<0.01).

4. Discussion and Conclusion

In this study, it was found that healthcare employees had a moderate level of perceived manager support (3.34±0.94). When recent studies on this subject are examined, it is seen that the results are similar. In addition, in this study, it was found that middle-income participants had a higher perception of manager support compared to low-income participants. In the reviewed studies, it was generally found that the level of perceived manager support did not differ according to socio-demographic characteristics. In the study conducted on healthcare employees in Erzincan province by Polat and Köse (2024), it was found that healthcare employees' perceived manager support was at a moderate level. It was also found that perceived manager support did not differ according to demographic variables (Polat and Köse 2024). As a result of the study conducted by Korkut and Çetin Gürkan (2019) on 300 healthcare employees in the Thrace region, it was found that the average perceived manager support score of public hospital employees was 2.57, while the average perceived manager support score of private hospital employees was 3.39 (Korkut and Çetin Gürkan 2019). A study conducted by Zincirkıran et al. (2016) on 367 healthcare employees in the Diyarbakır province found that younger healthcare employees' perception of manager support was lower than that of older participants (Zincirkıran et al. 2016). A study conducted by Aksoy (2024) on 300 healthcare employees in the Malatya province found that participants' perceived manager support levels were moderate. Women were found to have higher levels of perceived manager support than men. A significant difference was found in the perception of manager support based on education level and hospital position (Aksoy 2024). A study conducted by Karaca et al. (2022) on 291 healthcare employees in Sakarya found that the participants' mean perceived manager support scores were moderate (Karaca et al. 2022). This study found that healthcare employees had a moderate attitude toward medical errors (3.40±0.43). In addition, this study found that participants working in the intensive care unit had a more positive/sensitive attitude towards medical errors than participants working in the emergency room. This difference may be due to the stricter implementation of patient safety protocols in intensive care units compared to emergency departments. In addition, the more visible negative consequences of errors in the intensive care unit may have led employees to develop a more sensitive attitude toward errors. When recent studies on this subject are examined, it is seen that the results differ. It is thought that the differences may have arisen due to the different professional groups included in the study and the units they work in. As a result of the study conducted by Güven et al. (2019) on nurses, it was found that the nurses' medical error attitudes were at a moderate level. As a result of the study conducted by Çınar et al. (2020) on 223 health sciences faculty students, it was found that the students' medical error attitudes were at a moderate level. In addition, a study by Çınar et al. (2019) found a statistically significant

difference between the medical error attitudes of students who received patient safety training and who did not. It was observed that the medical error attitudes of students who received patient safety training were higher than others (Çınar et al. 2020). As a result of the study conducted by Özlük (2020) on nurses, it was found that the medical error attitudes of nurses were low (Özlük 2020). A study conducted by Güney et al. (2021) on midwives found that midwives had low attitudes towards medical errors. Additionally, it was found that those who worked voluntarily in the ward, those with fewer shifts, those who were older and had longer tenure, and those who were satisfied with their profession had higher attitudes towards medical errors than others, meaning they had a lower tendency to make medical errors (Güney 2021). A study conducted by Ulusoy and Tosun (2020) on 203 physicians and nurses found that physicians and nurses' attitudes towards medical errors were moderate (Ulusoy and Tosun 2020). A study conducted by Kandemir and Yüksel (2020) on nurses found that nurses' attitudes towards medical errors were high (Kandemir and Yüksel 2020).

The study found that participants' perceived manager support and attitudes toward medical errors were moderate. Analysis testing for differences based on demographic differences revealed that participants' average scores for perceived manager support and attitudes toward medical errors did not differ statistically significantly based on gender and marital status.

Furthermore, participants' average scores for perceived manager support did not differ statistically significantly based on age, education level, or occupation, but did differ significantly based on income status and unit of employment. Participants with moderate income levels were found to have higher perceived manager support than those with low income levels. Furthermore, participants working in internal medicine clinics were found to have higher perceived manager support than participants working in surgical clinics.

Participants' mean scores did not differ significantly according to age, income level, or education level; however, significant differences were observed based on unit of employment and occupation. Accordingly, participants working in intensive care units were found to have higher attitudes toward medical errors than participants working in emergency departments. Additionally, participants working as physicians and nurses were found to have higher levels of attitudes toward medical errors than participants working as technicians.

A weak, positive, and significant relationship was found between perceived manager support and attitudes toward medical errors. Therefore, the research hypothesis, "H1: There is a positive relationship between perceived manager support and attitudes toward medical errors among healthcare employees," is accepted.

Medical errors are a significant problem that is almost impossible to repair and negatively impacts patient safety. It would be beneficial to take measures to reduce medical errors in healthcare institutions. These measures could be related to both the functioning and order of the healthcare system and to healthcare employees. Training could be planned for employees to raise awareness, improve attitudes, and behaviors to prevent medical errors. It should also be emphasized that reporting medical errors anonymously and without concealment is crucial. Managers should shift away from a blaming and punitive approach toward healthcare employees who commit medical errors and prioritize efforts to learn from errors and take preventative measures. Furthermore, as the research demonstrates, there is a positive relationship between perceived manager support and medical error attitudes. The findings suggest that strengthening managerial support may contribute to more positive attitudes toward medical errors. The following suggestions can be offered to managers to ensure manager support (Eisenberger et al. 2016):

- Don't just do what you have to do. What should already be present in a business won't be perceived as manager support. Conduct workforce activities at the discretion of employees.
- Be fair and honest in implementing, monitoring, and performing manager activities.
- Set achievable goals and reward them proportionally.
- Provide individualized benefits to employees instead of generalized benefits.
- Support your subordinate managers, ensuring they, in turn, support your employees.
- Build a strong social network.
- Initiate organizational support before hiring begins.

The data was obtained from survey results based on subjective evaluations. Therefore, it may contain biases, which can be considered a limitation. The fact that the data for this study were obtained through convenience sampling can be considered a limitation. It is thought that conducting similar studies using probability-based sampling models would provide significant support to the literature. Furthermore, a qualitative research design could be proposed as a research proposal to further explore the relationship between manager support and medical error attitudes.

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