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ABSTRACT

FACULTY OF ARTS, LAW & SOCIAL SCIENCES

MASTER OF ARTS

AN EVALUATION OF THE IMPACT OF CULTURAL DIFFERENCES ON THE QUALITY OF HEALHCARE PROVIDED BY GERMAN CLINICIANS TO TURKISH MUSLIM PATIENTS

By SUZANNE BURLAGE

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In today's globalized world, people are faced with challenges that may occur due to the lack of understanding of another's values and beliefs. In Germany, the largest immigrant population comes from Turkey, and the majority practice Islam. Although many of them have lived in Germany for over 30 years, most of them have not fully integrated into the German society.

Because of the differences in the values and beliefs of German and Turkish people, the quality of care provided by physicians to immigrant patients can potentially be affected. This study discusses Islamic beliefs and how they can alter the patient's perception of care provided. Cultural differences, such as *individualism* versus *collectivism*, *uncertainty avoidance*, *linear-active* versus *reactive* and *high-context* versus *low-context* communication, between German and Turkish people will be further examined.

To explore this topic in greater depth, qualitative research was conducted in Germany. Interviews with German and Turkish physicians and medical students along with Turkish patients were completed to further investigate the cultural differences that could possibly affect the quality of care given.

The results revealed that the following cultural differences could have an effect on the care provided to Turkish immigrant patients: perception of illness, language barriers, the role of the family, the need for security and trust and *high-context* versus *low-context* communication. It was also found that doctors could show more empathy and respect for their patients' religious beliefs and the modesty of Muslim women along with understanding better the importance of fasting during Ramadan. Because they feel that many doctors do not fully understand the meaning of Ramadan to them, Turkish patients do not consult them about how to alter their medical treatments during this time. Suggestions are given for intercultural training for both healthcare professionals and patients that should be implemented to overcome the lack of understanding and increase the quality of care given to immigrant patients.

Table of Contents

List of tables

Tables

List of Appendices

Abbreviations

IC	Intercultural Communication
UK	United Kingdom
USA	United States of America

Enclosed materials

Items placed on CD:

Doctor Transcript Folder:

1. Doctor 1 Transcript
2. Doctor 2 Transcript
3. Doctor 3.4 Transcript
4. Doctor 5 Transcript
5. Doctor 6 Transcript
6. Doctor 7 Transcript
7. Turkish Doctor 1 Transcript

Medical Student Transcript Folder:

1. Medical Student 1 Transcript
2. Medical Student 2 Transcript
3. Medical Student 3.Turkish Doctor 2 Transcript

Patient Interview Folder:

1. Patient 1 Translated Interview
2. Patient 2 Translated Interview
3. Patient 3 Translated Interview
4. Patient 4 Translated Interview
5. Patient 5 Translated Interview
6. Patient 6 Translated Interview
7. Patient 7 Translated Interview
8. Patient 8 Translated Interview
9. Patient 9 Translated Interview
10. Patient 10 Translated Interview
11. Patient 11 Translated Interview
12. Patient 12 Translated Interview
13. Patient 13 Translated Interview

1 Introduction

Being a patient in the healthcare system is never easy, no matter if you are in your own country or abroad. The level of stress can become very high depending on the type of situation you are in and how serious your condition may be. Effective communication builds a strong relationship between the medical professional and the patient during the process of making the medical diagnosis and providing treatment. Without adequate communication, it can be much more difficult to gain an understanding of what symptoms or problems the patient is facing. When miscommunication arises, it could potentially lead to a misdiagnosis with the worse case scenario being a life-threatening situation (Sadiq, 2008).

In today's globalizing world, it becomes more and more imperative for healthcare professionals to understand the similarities and differences between various cultures that they are treating. Medical school programs in the United Kingdom and United States are focusing heavily on the importance of interpersonal communication skills training and have incorporated it heavily into their curriculum to improve patient care and satisfaction, reduce risks and costs for medical treatment and to develop a strong, long-term, patient-centered relationship. In Germany, they have started to implement medical communication skills training, but not quite to the same extent. Although some of the schools have begun to incorporate intercultural communication (IC) training into their interpersonal skills practice in the western world, many medical programs, including several in Germany, have not implemented an in-depth training program of this sort of skill set into their curriculum. As doctors and staff are faced with patients from all over the world, it is extremely important to increase cultural awareness and sensitivity to improve the quality of patient care.

The largest immigrant population in Germany is people from Turkey, with the majority of them practicing Islam. Although many of them have been living here for over 30 years, they have still not fully integrated into the German society (Zielke-

Nadkarni, 2003). German and Turkish people have quite different values and beliefs, which if not understood, can potentially lead to various misunderstandings.

In this dissertation, an evaluation will take place to look at the impact that cultural differences have on the quality of healthcare provided by German clinicians to Turkish Muslim patients. A brief summary of the history of Islam and their beliefs will be given, along with a discussion on how these can influence the perception of the care given. Next, the cultural differences between Germans and Turkish people and how these cultural differences can potentially affect the quality of care provided will be discussed. Various intercultural theories will be explored such as *individualism* versus *collectivism*, *uncertainty avoidance*, *linear-active* versus *reactive* and *high-context* versus *low-context* communication (Hall, 1976; Gudykunst and Kim, 2003; Lewis, 2006; Hofstede, Hofstede and Minkov, 2010). These topics have been researched in a thorough literature review and then were further investigated by interviewing German and Turkish physicians, medical students and Turkish Muslim patients in Germany. The participants in this study were either interviewed face-to-face or through written questionnaires.

The hypothesis explored here is that doctors and nurses in the western world are not provided with adequate training about how to effectively communicate with patients whose culture and belief system is entirely different from their own. Doctors and medical staff in Germany are faced with large Muslim immigrant populations from Turkey. However, because of the lack of understanding of the differences between native German clinicians and Turkish patients, a high level of stress and discomfort are thought to be felt between both the healthcare professionals and the patients, resulting in a decreased level of patient care and satisfaction while increasing the level of risks involved and the cost to care for the patient.

This topic was chosen because of the researcher's background in the medical field and her strong desire to learn how different cultural backgrounds affect the communication between doctors and patients, which can impact the level of care and patient satisfaction. Lack of communication can increase risks and cost to treat pa-

tients while also jeopardizing the long-term relationship between the clinician and patient. She is interested in exploring the need for further training for doctors and staff to learn how to communicate more effectively with patients of various cultures to improve the quality of healthcare provided while helping to reduce these medical risks that can occur. The researcher chose to take a closer look at the Turkish Muslim population, which is the largest immigrant population in Germany, because their culture and belief system is so different from that of the western world. Because of the vast differences between the Eastern and Western world, it is important to learn as much as possible about their values and beliefs and how they communicate. Of course one cannot learn everything about every culture, but it is good to have a general understanding about how to communicate more effectively and then learn from experience.

The objective of chapter 2 is to lay the foundation for the theoretical framework. The following will be discussed: 1) the history of Islam and their beliefs, 2) health and disease: an Islamic framework, 3) the role of the Muslim family, 4) a brief summary of German and Turkish cultural traits, 5) and the theories behind the cultural differences between German and Turkish people. Chapter 3 will focus on the methodology used to conduct the qualitative research for 3 months in Germany. Chapter 4 will present the findings, analyze and discuss what the main differences are between German and Turkish people that could potentially affect the quality of care provided.

The aim of this study was to discover how these differences could potentially affect the quality of care provided. The research also focused on what can be done to overcome the lack of understanding and what kind of further training can be offered to medical professionals to increase cultural awareness. Understanding these factors and creating programs to overcome them will potentially increase overall patient care and satisfaction, which in the end will reduce the amount of medical risk associated with them and lower the cost of care. Not many studies have been done on this particular topic, so this will be seen as an introduction to uncover some of the basic challenges which can be built upon from there.

2 Theoretical framework

2.1 Background on Muslims

2.1.1 History

In the ever-changing globalized world, there are approximately 1.57 billion Muslims in which about one-fifth of them live as a religious minority community. The Asia-Pacific region has the largest population of Muslims residing in this area, which accounts for 62% of the overall population. The largest Muslim community lives in Indonesia, which consists of about 202 million (12.9%) Muslims. In the West, the number of Muslims is vastly increasing, and it is estimated that approximately 38 million (2.4%) live in Europe with the rest, approximately 4.5 million (.3%), residing mainly in the United States (US) and Canada (Pew Forum on Religion and Public Life, 2009 cited in Grim and Hsu, 2011, p. 15-16).

Although Muslims have been present in the West since almost the inception of Islam, which dates back to the 7th century, two large migration waves have been seen in the 20th century. The first occurred when Muslims migrated from Syria, Lebanon and other Arab countries to the US after World War I, which was towards the end of the Ottoman Empire (Queen, 1996 cited in Anwar, 2008, p. 8). The second large Muslim migration took place after World War II to many areas in the West. For instance, "Algerians went to France, Pakistanis to Britain, Indonesians to the Netherlands, or were specifically recruited to meet the economic and labor needs of the West as in the case of Germany, the US, Canada and Australia" (Anwar, 2008, p. 8).

"In 1965, a contract between Turkey and Germany initiated the flow of a work force of 2.1 million people from east to west, the largest ethnic minority with a total of 7.2 million immigrants" (Herbert, 1986 cited in Zielke-Nadkarni, 2003, p. 169). While in the recession in the late 1960s, the German government decided to reduce the amount of Turkish migrants and finally halted advertising abroad by 1973. People who immigrated before 1973 "have been termed the first generation, their children and grandchildren the second and third generations" (Schilder, 1998, cited in

Zielke-Nadkarni, 2003, p. 169). In Germany, they represent a culture with very distinct customs, which are extremely different from those natives of Christian descent. Although Turkish people have now lived in Germany for more than 30 years, they have not fully integrated into the German society and their specific care needs have not been completely addressed (Schilder, 1998, cited in Zielke-Nadkarni, 2003, p. 169).

It has been discovered that Muslim migrants in Western Europe, such as the Turkish in Germany, have some short-term problems that relate to their legal and social status along with their religion, languages, values and customs - some of which they share with other ethnic minorities and migrants. Many of them feel that Western culture may be a threat to their religion, values and customs. Because of this, they turn to their migrant networks for support and are often very conservative and safeguarding. Much of the time, they are blamed for the conditions that they are faced with, such as a high unemployment rate. However, because they are usually the ones that take the low-paid and less popular jobs that the natives are unwilling to do, Europe's economy is able to benefit from them (Anwar, 2008).

Many immigrants are often discriminated against because of their race and religion (Spallek, Zeeb and Razum, 2010). Most first generation Muslims and their children continue to face high unemployment compared to native white people living in the same area, due to poor performance in school and the difficulty in finding employment in the manual labor market (Spallek, Zeeb and Razum, 2010). They also face problems with learning the local language, which defers their progression in both the industrial and social sectors. Because they seem to rarely come into contact with natives as they are usually working nightshifts, this also limits them from integrating further into the host country in which they live (Anwar, 2008).

2.1.2 Islamic Beliefs

Although many would believe that the Islamic religion is vastly different, there are some similarities to Christianity and Judaism, which have been known to shape the culture of the West. The Islamic history is described below:

> *"It shares with them a Middle Eastern Origin, and a medieval experience of processes of theological articulation that took place within the context of a shared Greek patrimony. Muslim theology, no less than the religious thought of medieval Christian and Jewish intellectuals such as Aquinas and Maimonides, is a complex and brilliant fusion of the Semitic and the Hellenic spirit: Plato and Moses are the property of Muslims no less than of Christians and Jews. Moreover, Islam is the only non-Christian religion to accord specific recognition to Jesus, the central figure in traditional Western European religion, whom Muslims revere as a healer, a perfect messenger of God (Allah) and as a miracle-working Messiah, although, like Unitarians, Muslims do not accept the doctrine of divinity" (Winter, 2008, p. 25).*

In Islam, there are "Five Pillars of Faith" in which Muslims abide by:

- *Shahadah* "The testimony of faith".
- *Salah* "The five daily ritual prayers".
- *Zakat* "Annual obligatory alms tax for the poor".
- *Sawm* "Fasting during the month of Ramadan".
- *Hajj* "The annual pilgrimage to Mecca" (Winter, 2008, p. 26).

Along with the five pillars, the concept of "cleanliness" pervades the religion (Woll, Hinshaw and Pawlik, 2008, p. 3051). It is important to take note of this when analyzing general health practices in Islam. In order to cleanse their soul, Muslims believe that "dietary restrictions, fasting, meditation, and prayers for psychological tranquility" are all practices that aid in this manner (Sachedina, 2005, cited in Woll, Hinshaw and Pawlik, 2008, p. 3051).

In one of Islam's *Five Pillars, Salah* (in the Arab world and Africa) or *Namaz* (in Turkey, Iran and the Indian subcontinent), it is very evident that there is a lack of hierarchy (Winter, 2008). The five daily ritual prayers are required to be performed by every man and woman, as long as they are an adult and are sane (al-Shahri and al-Khenaizan, 2005). Just as the ill or physically frail are excused from attending *Hajj*, those who are sick are only required to perform what they can physically do without worsening their condition. For those who are able to do so, they must perform *wudu* or *abtest* (Turkish), which is the cleansing of the mouth, nostrils, face, hands

and forearms, the wiping of the head and the washing of the feet. If they are unable to perform *wudu* because of severe illness, they must cleanse themselves by carrying out *tayammum* instead which entails touching a stone or clean dust with both hands, and moving the hands over the face, hands and forearms (Keller, 1995 cited in Winter, 2008, p. 27; al-Shahri and al-Khenaizan, 2005). Cleansing of one's private body parts, such as genitalia, must also take place after urination or evacuation, sexual intercourse and ejaculation otherwise the *Salah* or *daily prayers* are not valid (Sarhill et al., 2001; Winter, 2008).

As the Islamic calendar contains 12 lunar months, it causes Islamic dates to fall around 10 days earlier each year in the Western calendar; causing all of the festivals to move forward in this same way. *Eid ul-Adha*, which marks the end of the Hajj, is one of the most prominent. Another festival, for which dates fluctuate, is *Eid ul-Fitr*, which corresponds to the end of fasting for Ramadan (Sarhill et. al., 2001; Ahsan, 1985, cited in Winter, 2008, p. 28).

Ramadan is considered to be one of the Five Pillars of Islam. It requires healthy and sane Muslim adults to abstain from food, drink, tobacco products and sexual activity between sunrise to sunset (Winter, 2008). If one does not remain abstinent during this time, they will break or nullify the fast. They can eat and drink between sunset and dawn, but it is looked down upon if one overeats during this time, as they are not practicing self-control. As the Islamic calendar is lunar, it is not unheard of to have had Ramadan in all four seasons throughout one's lifetime (Sabiq, 1991, cited in Sadiq, 2008, p. 83).

Ramadan is further described as:

> *"Religiously it is understood as a means of detaching oneself from worldly, material cravings, thus allowing the spiritual seeker to focus on Allah without distraction. On the moral plane, it is believed to help the rich to empathize with the sufferings of the hungry" (Winter, 2008, p. 29).*

Because human intellect is considered to be the most valuable creation from Allah, therefore, they prohibit the use of alcohol and other narcotic drugs (al-Munajjid, 1987, cited in Winter, 2008, p. 30). While celibacy is looked down upon, the Muslim

scriptures confirm that sexual intercourse with one's partner is a fruitful reward from Allah. However, Islam restricts sexual acts with any person to whom they are not married. "The seclusion of a man and woman together is regarded as a sign of low standards, as is the unnecessary exposure of the body. Hence men and woman are encouraged to dress in a dignified way that often seems at odds with Western norms (Naficy, 1999, cited in Winter, 2008, p. 30). Women normally cover their entire body excluding their face, hands and feet when outside of the family compound. Bouhdhiba and Musallam (1983 and 1985 cited in Winter, 2008, p. 30) stated the following:

> *"Such traditions, indifference to which can cause considerable embarrassment and discomfort, reflect not only the religion's understanding of public morality and decency but also its theological valorizing of the human body, seen as a manifestation of the sacred which must be unveiled only in the most reverent and private context".*

2.1.3 Health and Disease: an Islamic framework

2.1.3.1Illness

The Qur'an does not discuss much about physical illness; it primarily focuses on attending to the state or condition of one's heart (Laird et al., 2007; Ahmed, 2008). As proclaimed by *Sacred Law*, there are certain laws that pertain to the body. One must respect their body whether living or dying. They are acting as the temporary caretaker of their body and soul (Ahmed, 2008).

"In Arabic, one who is sound and healthy is said to be *salim.* The *salim* will therefore not see illness as a punishment, but rather as a 'test' from Allah; these tests that we experience at many junctures throughout life afford the opportunity to deal with many of the ills of heart" (Ahmed, 2008, p. 37). Table 1 further explains the states of the heart.

Table 1. The States of the Heart

THE HEALTHY HEART	THE DISEASED HEART
Belief in Allah	Disbelief in Allah
Sincerity of purpose	Hypocrisy
Humility	Arrogance
Hope in Allah's good Providence	Despairing of Allah's mercy
Contentment	Dissatisfaction
Regard for Sacred Law	Disdain for Sacred Law
Divine Love	Material and temporal love

The Table 1 was adapted from (Ahmed, 2008, p. 37).

Concurrently, Islamic medicine evaluates another area of medicine, which is often not overlooked by those practicing Western medicine. Muslims diagnose and treat spiritual diseases such as: "envy, avarice, anxiety and obsessive/compulsive disorders" (Hanson, 2008, p. 46). They see these ailments as psychopathological and feel that they should be treated and diagnosed just as one would any other medical condition (Hanson, 2008).

Different beliefs about health, sickness and medical care are often unfamiliar to local healthcare providers (Dogan et al., 2009). For instance, Germans and other western cultures tend to believe that cancer and other diseases have bodily causes more so than spiritual (Kuhn, 2000 cited in Dogan et al., 2009, p. 684). Kuhn further discusses that "Turkish people living in Germany often complain about headaches, gastrointestinal discomfort and some psychosomatic disorders. In these situations, communication problems may play an important role and the exaggerated expression of pain, which is subjective and culturally-specific issue may lead to a wrong diagnosis" (Kuhn, 2000 cited in Dogan et al., 2009, p. 684). Others concur with the different perception of pain that is associated among immigrants and said the following, "Some immigrants have a more pain-orientated depiction of symptoms

which can mislead doctors to a false perception of the underlying disease, and thus to an incorrect diagnosis and a wrong decision concerning what treatment should be given" (Spallek, Zeeb and Razum, 2010, p. 94). While patients in the Western world typically perceive various aspects of disease as "purely" medical, migrants from some other parts of the world see disease as "an established part of spirituality, morality or religion" (Spallek, Zeeb and Razum, 2010, p. 94).

When one is ill and deciding on what medical treatment that they should follow, the individual is fully in control of the final decision. While the Qur'an suggests that one speaks with people that are more knowledgeable than they are, it is up to the individual to decide whether or not the treatment is ethical according to their Islamic beliefs as many of the scholars have varying opinions (Hanson, 2008). However, although it is up to the individual to make the decision on their treatment, most of the time, the family is involved in the decision making process (al-Shahri and al-Khenaizan, 2005).

Space precludes much information to be provided in this study, but Muslims have particular classifications for the various stages of their disease and how they should go about treating it and when they can decide to forgo treatment or not. Each of the four authoritative Sunni schools (Shafi'i, Hanafi, Hanabali and Maliki) have varying opinions around medical treatment; so therefore, it comes down to the individual's final decision on what is ethically sound according to their beliefs (Dhami and Sheikh, 2008; Baba, 2013).

As with most patients, one of the most important aspects of obtaining help from a professional is trust. "In Islamic law, all information necessary for diagnoses and treatment provided by a physician to the patient is considered a sacred trust" (Hanson, 2008, p. 50). For Muslims, removing their clothes for a physical examination can be quite a challenging situation. Because of the dress code that is to be followed by Muslim men and woman, it is extremely uncomfortable for one to expose their intimate body parts, as this is normally reserved for their spouse. However, if doctors need to examine these areas to make a diagnosis, it is permitted, but special

care must be taken. According to the Muslim faith, a doctor must have permission from the patient or their guardian before they are allowed to perform any type of medical procedure (al-Shahri and al-Khenaizan, 2005; Hanson, 2008).

2.1.3.2 Same-Sex Physicians

In Islam, segregation has been practiced to reduce the chances of extramarital relationships developing. They strongly advise individuals of the opposite sex to refrain from physical contact; however, these rules are more relaxed when seeking treatment from a physician (McDermott and Ahsan, 1993, cited in Dhami and Sheikh, 2008, p. 60). When seeking medical treatment, it explains why many prefer to see a same-sex clinician, especially when an examination of the genitalia is needed (Sarhill et al., 2001; al-Shahri and al-Khenaizan, 2005). If an interpreter is needed for the consultation, the use of same-sex interpreters is highly desirable (Dhami and Sheikh, 2008).

2.1.3.3 Managing the fasting patient

Ramadan, which is the ninth month of the Islamic calendar, is regarded highly above all of the others because it was the time when the revelation of the Qur'an began over fourteen centuries ago. Allah had chosen Muhammad as his prophet to spread the Divine Word across the world. Therefore, Ramadan is a very distinct chapter in religious history (Sadiq, 2008).

Fasting during Ramadan is a spiritual exercise, in which the main aim is "to reflect on one's relationships – both with Allah and with one's fellow man" (Sadiq, 2008, p. 82). Table 2 further explains the various reasons why Muslims fast.

Table 2. Why Muslims Fast

Fasting
• Teaches the principle sincerity as a Muslim fasts to please Allah alone.
• Cultivates a consciousness of the Divine because a fasting person keeps his fast without any human authority checking his actions.
• Develops empathy with the less fortunate through sharing temporarily in their pain and hunger.
• Teaches moderation, willpower, self-reassurance, self-control and self-discipline.
• Inculcates a spirit of social belonging, unity, brotherhood and equality as it joins together a whole Muslim society in observing the same sacred ritual, in the same manner, at the same time, for the same reasons, throughout the world.

Table 2 was adapted from (Sadiq, 2008, p. 82).

Every healthy Muslim male and female is required to fast (Sarhill et al., 2001). Those who are exempt from participating in fasting are listed in Table 3 below.

Table 3 Those Exempt from Fasting

• Children under the age of puberty.∗
• Those with learning difficulties or retardation such that they are unable to comprehend the nature and purpose of the fast.∗
• The old and frail that are not capable of fasting.+
• The acutely unwell for whom fasting will exacerbate their condition.++
• Those with chronic illnesses, in whom fasting may be detrimental to health.++
• Travelers (who are journeying greater than approximately 50 miles) as if they fell they may be harmed by the fast.++
• Menstruating woman.++
• Pregnant and nursing women if they fear for their own health, or that of their children.++

Table 3 was adapted from (Sadiq, 2008, p. 83).

Notes: ∗atonement not required; +should feed a destitute person for every missed day; ++the missed fasts are required to be made up one day for each day missed when the reason for exemption has expired.

2.1.3.4Complications with fasting and medical condition

While one is sick, they may be exempted from fasting temporarily or permanently. If they have an acute onset that may be exacerbated or delay their recovery, they may be excused from fasting (al-Shahri and al-Khenaizan, 2005). They can then make up these days of fasting that they missed at a later date. Those who have certain intractable conditions, such as cancer, are able to be permanently exempt from fasting. They may substitute their fasting with providing food for the poor (Sadiq, 2008).

If patients are unsure whether or not they should participate in fasting due to their current condition, they should contact their physician for a medical consultation. It is up to the doctor whether or not they should adhere from fasting or taking their medication during daylight hours depending on their medical condition (Darsh, 1995, cited in Sadiq, 2008, p. 84). However, research shows that many do not consult their physician during these critical times (al-Shahri and al-Khenaizan, 2005; Sadiq and Sheikh, 1999, cited in Sadiq, 2008, p. 84). Many of them feel that if their caregiver is not Muslim, that they will prohibit fasting, even if there is no medical risk, because they do not fully understand the meaning and importance of fasting. Many decide to alter their medication schedule and omit it during the day while fasting (Sadiq, 2008).

Because one cannot eat during fasting, any medication that is taken orally during dawn and sunset, can nullify the fast. A study done by Aslam and Healy (1986 cited in Sadiq, 2008, p. 84) found that out of the 81 drug regimens evaluated of patients during Ramadan that 46% changed their dosage schedule during the time that they were fasting. The patients missed doses, altered the times at which they took their medication and many would take all of the medication once daily. Much of the time it did not have a serious consequence, but there are several circumstances in which it can be very detrimental. In some cases, short-acting agents may lose their effect after some time into fasting, so it is beneficial for them to consult with their doctor. In other cases, a larger dose that is taken all at once can be dangerous and have toxic side effects, especially for that of older patients (Sadiq, 2008).

2.1.4 The Family

One of the most important characteristics of the Muslim community is the importance of the family bond (Laird et al., 2007). "The family unit is regarded as the cornerstone of a healthy and balanced society" (Doi, 1984, cited in Dhami and Sheikh, 2008, p. 57). The traditional Muslim family is often a conglomeration of three or more generations, which provides the families with many advantages such as: security, a strong family bond, and physical and psychological support, especially in dif-

ficult times. In the Muslim family, the older one is the more respect and esteem that they hold. The elderly are seen as the leader of the hierarchy, and their family must learn from their vast life experiences. It is seen as an opportunity to care for one of their elders and is seen as a gift from Allah (Laird et al., 2007; Dhami and Sheikh, 2008).

2.2 Cultural Differences between Germans and Turkish

As one evaluates the cultural similarities and differences between Germans and Turkish Muslim immigrants, one can see that they typically communicate and function quite differently, but this is only a generalization and one should take each individual person into consideration as people within their own culture can vary greatly.

2.2.1 German cultural traits

As many would agree, in general, the German culture is very focused around the monochronic use of time, which means they like to consider completing one task before starting another. When studying the way a German company is constructed, one will notice that they are very traditional, have created many manuals with a long line of rules and tend to have a very hierarchical system. Germans tend to communicate with a very direct and open approach, and they are often very loud. They are more concerned about telling the truth then delivering the message in a diplomatic way. Germans tend to listen well, are quite disciplined and always on the cusp of learning more. They prefer to have a lot of background information and are equipped with a long attention span (Lewis, 2006).

2.2.2 Turkish Cultural Traits

Turkey consists of six former Russian-dominated Central Asian republics and much of the nation is not in Europe (Lewis, 2006). When one visits Turkey, they can see that it is quite different from any other Muslim states. The nation is very modern and this is due in part to the influence of the founder, Kemal Ataturk. In April of 1920, Mustafa Kemal was elected as their first president. He transformed the coun-

try and created a new political and legal system, which made both the government and education secular. He superseded the Islamic calendar with the Western calendar and allowed Western hats to be worn instead of the fez and woman no longer wore the veil. Through making Turkey more westernized while also focusing on going back to their Turkish roots, Kemal felt as though Islam should be regarded as a religion, but banned as a lifestyle (Lewis, 2006). However, the Turkish that live in Germany are very diverse and vary greatly on whether they practice Islam traditionally or in a more modern way.

Turkish people typically value the following:

- "Belief in one's own honesty"
- "Western-orientation"
- "Modified Islamic tenets"
- "Fierceness and tenacity"
- "Warmth and likeability"
- "Male dominance" (Lewis, 2006 , p. 390)

In general, Turkish people respect their space and tend to have about a meter between each other when speaking. Many things tend to take a lot of time in Turkey, so people tend to show up late for appointments. The Turkish culture tends to be very accommodating and to appreciate when others show warmth and build trust as soon as possible (Lewis, 2006).

The communication style of Turkish people derives from three different sources, which are: Islamic, Mediterranean and Eastern (Ottoman, Seljuk). The first two incorporate their liveliness and show us that they are multi-active and dialogue-oriented. However, the third piece attributes the fact that they are very reactive; probably more than any other Europeans, but this also correlates with them being a listening society. Their Islamic beliefs tend to be a bit more relaxed than other Arab countries, but definitely have an influence on their culture (Lewis, 2006).

2.3 Theory behind the cultural differences between Germans and Turkish

To assess some of the cultural differences between German and Turkish people, several different intercultural theories will be discussed, such as the following: *individualism* versus *collectivism (the role of the family), uncertainty avoidance* and *linear-active* versus *reactive (need for security and trust),* and *high-context* versus *low-context communication* (Hall, 1976; Lewis, 2006; Hofstede, Hofstede and Minkov, 2010). It must be kept in mind that generalizations are made in this study about Germans and Turkish people, and that each person must be treated as an individual as their communication styles, values and beliefs may vary immensely.

2.3.1 Individualism versus collectivism

The vast majority of the people in the world live in a community in which the interest of the group supersedes the interest of the individual. Interculturalists identify this cultural trait as *collectivism*. They are always centered on the power of the group. The *collectivist-style* family in which the child grows up in is quite large and usually includes the parents, siblings, grandparents, aunts, uncles, cousins, servants and other housemates. In cultural anthropology, this is known as *extended family* (Hofstede, Hofstede and Minkov, 2010).

People in a collectivist culture belong to very few in-groups. Such groups would entail their family, work and university. These groups have a large influence on the way they behave in the social setting and how one behaves many different ways in their personal life. They tend to communicate with high-context messages, which means that they are often very "indirect, ambiguous, implicit and probabilistic" (Gudykunst and Kim, 2003, p. 62).

According to Hofstede's (2013) study on individualism versus collectivism, Turkey scored low on *individualism* with a 37. Many are very focused on belonging to the *in-group* and think collectively as a group with their *extended family*. Loyalty is gained by looking after their group members. They communicate indirectly and try to avoid open conflict. The needs of the group always come before task fulfillment.

One must invest lots of time and effort to build trust with both the individual and their family (Hofstede, 2013).

The rest of the world lives as *individualists*, where the interest of one's self is regarded over the interest of the group (Hofstede, Hofstede and Minkov, 2010). In this type of culture, the goals of the individual are the focus (Gudykunst and Kim, 2003). In most of these families, children are born into a unit consisting of two parents and possibly a few other siblings. Relatives of their family live somewhere else and are seldom seen that often. In cultural anthropology, this is known as a *nuclear family*. Children in this type of family learn to think for themselves and are expected to live on their own once they reach adulthood (Hofstede, Hofstede and Minkov, 2010).

Individualists belong to many in-groups, such as: family, social groups, professional organizations and religious affiliation. Because they are a member of so many different in-groups, their individual in-groups have very little influence on their behavior; however, because they belong to many groups, this may influence their behavior in any social setting. They tend to communicate with low-context messages, which means they are "direct, precise, clear and absolute" (Gudykunst and Kim, 2003, p. 62)

In Hofstede's study, Germany scored very high in individualism with a 67. Many of them have small families and the focus tends to be on the parent-child relationship. They are encouraged to believe in themselves and their own full potential. They base loyalty on their own personal preferences for people along with their sense of duty and responsibility (Hofstede, 2013).

From this research, one would predict that German doctors would tend to be more focused on the individual, which could potentially cause some misunderstandings when treating patients, such as Turkish people. They may face challenges with communicating effectively with the large number of family members that come for the consultation or to visit them in the hospital. The hospital may not be equipped

to handle that many people in a room, while the nurses may be overwhelmed (Hofstede, Hofstede and Minkov, 2010).

Because of their collectivist nature, the Turkish patients may have some challenges when interacting with German doctors. They tend to speak indirectly and do not normally speak their own opinion. They consult the *in-group* and value their opinion. They may be startled when the German physician uses a direct form of communication and only addresses the patient rather than the group (Hofstede, Hofstede and Minkov, 2010).

2.3.2 Uncertainty Avoidance

Uncertainty avoidance is characterized by "the extent to which members of a culture feel threatened about ambiguous or unfamiliar situations" (Hofstede, Hofstede and Minkov, 2010, p. 191). The way in which one interprets the world, their meaning in life and the power, which one has to control their daily outcome, creates these uncertainties (Marris, 1996, cited in Gudykunst and Kim, 2003, p. 30).

According to Berger and Calabrese (1975) as cited in Gudykunst and Kim (2003, p. 30), uncertainty is created when one is confronted with "strangers' attitudes, feelings, beliefs, values and behavior". With experience, one must learn how to predict what behavioral patterns will be used when interacting with strangers. The German physician must sit back, listen and observe how the Turkish patient is interacting during the consultation. He must connect with the patient and build trust, which will allow for the patient to open up. If a strong enough level of trust is not built, the Turkish patient will not share all of the information needed which could affect the quality of care provided (Gudykunst and Kim, 2003)

Of course the level of uncertainty is high when one interacts with strangers, but it also creates a high level of anxiety in certain instances. "Anxiety refers to the feelings of being uneasy, tense, worried, and apprehensive about what might happen" (Stephen and Stephan, 1985, cited in Gudykunst and Kim, 2003, p. 34). It

tends to be an emotional response to strangers rather than a cognitive response like that of uncertainty (Gudykunst and Kim, 2003).

If one looks at a medical consultation, for instance, the level of anxiety can be rather high for both the patient and the doctor depending on the circumstances. This high level of anxiety may cause them to be unable to effectively communicate with each other, which in the end could make it harder for the doctor to diagnose the patient's problem (Gudykunst and Kim, 2003).

When examining Hofstede's (2013) data findings, Germany is fairly strong on avoiding uncertainty with a score of 65 while Turkey comes in even higher with a score of 85. Germans tend to have a very systematic approach by making plans and researching the situation more in-depth to reduce the amount of uncertainty. They are a culture that makes many laws and rules and explains every detail of the process so that everyone is informed. If they have all of the details, then they know that a lot was done to fully understand the situation and make a more educated decision. They rely on their expertise to reduce the amount of uncertainty (Hofstede, 2013).

In general, Turkish people have a very strong need for rules and laws. They reduce their amount of anxiety by following many cultural rituals. Although they may seem very religious and refer to *Allah* quite often, they are often just displaying social habits that relieve the tension that is present (Hofstede, 2013).

When seeking medical attention, a Turkish individual will expect that the German clinician is very thorough and follows the rules. They will have their family and friends there to support them while their problem is being diagnosed and a treatment plan is being created. They may incorporate their religious beliefs into their medical treatment, but the doctor must understand that this is very important to them and part of the ritual. It will help them reduce the level of anxiety or tension that they may be feeling when visiting their doctor (Gudykunst and Kim, 2003).

2.3.3 Linear-active versus reactive

Richard Lewis (2006) created the LMR (linear-active/multi-active/reactive) method of testing so that individuals could have a way to determine their own cultural profiles. Linear-active individuals do one thing at a time and have everything scheduled within a particular time period. The German culture is very linear-active and is well known for their conception of time (Lewis, 2006).

On the other hand, multi-active people do not follow a set, precise schedule and are not that concerned with time or being on time, for that matter. They value reality and what is going on in the moment versus a man-made, fixed appointment. Although Turkey falls into the reactive category, they tend to be multi-active in some instances. Because personal relationships are very important to them, they feel that statements that are made are promises (Lewis, 2006).

As Lewis (2006) discusses, high-trust societies, such as Germany, are normally linear-active and have trust for their colleagues or acquaintances until he or she proves untrustworthy. They assume that the individuals will follow the rules and they can trust them because of this. They feel that if one says what they are going to do and continually do it, it builds strong trust between the individuals (Lewis, 2006).

Lewis (2006) further discusses that in low-trust societies, such as Turkey, they are often multi-active or reactive cultures. They initially feel suspicious about the people with whom they are interacting with and are more flexible with rules and laws. They trust only those who know them best such as their family and one or two close, lifelong friends. "They trust people who show them compassion, accept closeness, protect their vulnerabilities and disobey regulations in keeping that trust if it is necessary" (Lewis, 2006, p. 148).

Because Germans tend to be a high-trust society, they must take extra time to build a strong relationship with their Turkish patients because of their lack of trust. They must have the understanding that building trust with them will take time and pa-

tience, but once they have created a strong partnership, they will continue to seek medical advice from them over years to come (Lewis, 2006).

2.3.4 High-context communication versus low-context communication

Edward Hall's (1976, 2000) well-known cultural framework compares how all cultures communicate. *Low-context* cultures tend to communicate through very detailed statements both in text and speech, which also correlates to being an individualistic country. Germans tend to communicate in this form and are known for delivering very precise, detailed messages with many rules in place. On the other hand, *collectivist* cultures, including Turkish and Muslims, more than likely, communicate in a more *high-context* manner, which means that a message is implied without clearly being spoken. Nonverbal messages must be observed in order to decipher the message along with being a member of the close-knit in-group. For instance, the family of the Turkish patient is going to have a clear understanding of what is being communicated even if they are not fully stating it; meanwhile, the German doctor is going to need to ask a lot of open-ended questions that then cipher down to very direct questions to diagnose the case (Hall, 1976).

German clinicians have to take extra precaution and time to try and gain a better understanding of what the Turkish patient is trying to share with them. It takes a lot of time, patience and experience to begin to understand how to interpret the message and piece together the circular or reactive message into a more linear fashion in which they are used to communicating (Hall, 1976; Lewis, 2006).

3 The Research Study - Methodology

3.1 Research objectives and strategy

In today's globalizing world, it becomes more and more important to understand the similarities and differences between various cultures to reduce the amount of miscommunication that may occur between medical professionals and patients. Because of these circumstances, the researcher decided to undertake a project to uncover what knowledge would be helpful to acquire while treating patients of different cultures, specifically Turkish Muslim patients in Germany. An in-depth literature review was completed, which examined the similarities and differences between German and Turkish people combined with a look at the Islamic religion, their beliefs and how they affect medical care. Qualitative research was performed which involved conducting semi-structured interviews with German clinicians, current medical students and Turkish patients and doctors. Ideally this would help gain some valuable information from both the doctor and patient perspective. It would potentially help reveal how the participants may be thinking about a particular situation or how they derive their own understanding of some past behaviors that had been demonstrated (Yin, 2011).

The goal of the research was to uncover the following information:

- What are the main cultural differences between native German clinicians and Turkish Muslim immigrant patients that impact the quality of healthcare?
- How can we overcome the lack of understanding of the differences between native German medical professionals and Turkish immigrant patients and give the patient the most beneficial medical treatment?
- What kind of further training can be offered to healthcare professionals to increase overall patient care and satisfaction to reduce the amount of risk and the cost of care while enhancing the long-term relationship between the clinician and the patient?

The following key terms will be defined: *culture*, *cultural differences*, *quality of healthcare*, *lack of understanding* and *clinician/patient relationship*.

For this study, *culture* will be defined as: "the ideas, customs, and social behavior of a particular people or society" (Oxford University Press, 2013). *Cultural differences* are the differences perceived between Germans and Turkish Muslims. The *quality of health care* will be defined as:

- Open and effective communication with patient and doctor
- Able to uncover patient's needs and address them effectively
- Able to treat case effectively
- Patient feels comfortable when visiting the doctor
- Increased patient compliance
- Reduce patient risk and further complications
- Long-term relationship formed with patient and clinician

Lack of understanding is one not having enough knowledge of a particular culture's beliefs and values. *Clinician/patient relationship* is the partnership created between the doctor and the patient, which enables the data to be obtained, a diagnosis to be made and a treatment plan to be created as a team, while increasing compliance and providing support (Dorr Goold and Lipkin, 1999).

3.2 Choice of research technique

Qualitative research methods were used with techniques from Matthew Miles and Michael Huberman (1994) and Robert Yin (2011). Qualitative research was used because it provides "a source of well-grounded, rich descriptions and explanations of processes in identifiable local contexts. With qualitative data, one can preserve chronological flow, see precisely which events led to which consequences, and derive fruitful explanations" (Miles and Huberman, 1994, p. 1). Good qualitative data can lead to new findings and allows the researcher to move beyond initial conceptions and to create or revise conceptual frameworks. Because one is given words versus numbers and statistics, a colorful story is created that explains one's

thoughts and opinions that one "places on the events, processes and structure of their lives" (Miles and Huberman, 1994, p. 10). This allows for us to gain a better understanding and know more details, therefore, making it possible to make some potential changes based on the occurrences described (Miles and Huberman, 1994).

In this study, qualitative research was important because statistical evidence would only give numbers that explained how often misunderstandings occurred between the doctor and patient, but it would not give specific instances of what was actually taking place and why. The researcher wanted to uncover what was truly happening so that they could create a training program to address these challenges and increase the effectiveness of communication between the physician and patient, which would in the end increase the quality of care that they received. However, there are some limitations incurred when doing qualitative data. Some of the issues that exist with qualitative research are:

> *"Labor-intensiveness (and extensiveness over months or years) of data collection, frequent data overload, the distinct possibility of researcher bias, the time demands of processing and coding the data, the adequacy of sampling when only a few cases can be managed, the generalizability of findings, the credibility and quality of conclusions, and their utility in the world of policy and action" (Miles and Huberman, 1994, p. 2).*

Because the size of the study is quite small, one may question how accurate the data is. What if the findings are in fact, wrong? How does one know if they are or not? These are the risks one takes when participating in qualitative research and must keep these factors in mind when making final conclusions on the data found. It is important to be aware of bias, to back up findings with theory, relating to and building on other research that has been conducted. One must also bear in mind that this sample may not represent what is taking place in the general population (Miles and Huberman, 1994).

3.3 Methodology

3.3.1 Preliminary Research

In spring, 2012, a preliminary literature review about treating patients of different cultures in healthcare was performed. Many studies and books were found that identified challenges that doctors face when treating patients from another culture (al-Shahri and al-Khenaizan, 2005; Laird et al., 2007; Sheikh and Gatrad, 2008). Many also gave insight from the patient perspective, and it explained how further misunderstandings occur because of lack of understanding of someone else's culture. A lot of data was also found that discussed how different cultures view medicine, such as Western Medicine versus Eastern Medicine. Preliminary interviews were completed with doctors in the United Kingdom who taught communication skills courses at various medical schools. Many of the programs did not offer much along the lines of intercultural communication, but they did recognize that they needed to start addressing these challenges faced and increase the cultural awareness of their medical students. From this initial research, it allowed the researcher to formulate many areas of interest that could be investigated on a deeper level.

Semi-structured interviews were conducted and prior to beginning the interviews, vast research on the Islamic religion was performed to gain a better understanding of their values and beliefs while also looking at Turkish people in Germany and studies that discussed challenges that were face by doctors and nurses when treating Muslim patients. By understanding more about Muslims and Turkish people, questions were formulated for the interview guide, which was based around particular scenarios that they face on a regular basis (Miles and Huberman, 1994; Yin, 2011).

3.3.2 Participants and data collection

Because the researcher had several personal contacts with doctors in Germany, which also has a large population of Muslims, equating to approximately two million people (Anwar, 2008), interviews with German native physicians and medical students along with Turkish (Muslim) patients in Germany were conducted for the

study. In addition, a couple of Turkish doctors were interviewed to gain perspective from their point of view about practicing medicine and treating Turkish people in Germany, which also provided more background on Turkish people.

The doctors consisted of several different specialties such as: Ear, Nose and Throat Specialists, Orthopedic[1] Surgeons, General Practitioners, an Ophthalmologist, Internal Medicine Specialists, a Psychiatrist and a Cardiologist. Most of them treated approximately 20 percent Turkish people in their practice; so, they had experience in frequently interacting with this particular culture. The Turkish psychiatrist treated 80-90 percent Turkish people.

Nine *semi-structured* in-depth interviews were conducted in English with physicians, seven German and two Turkish, in Berlin and Cologne from February through April 2013. These face-to-face interviews were conversational, and although many questions were prepared in the interview guide, it varied as to where the conversation led to what questions were asked to the participant. As qualitative interviews require the interviewer to listen intensely, they allow them to formulate new questions based on the information given in the interview (Yin, 2011).

The medical students were either German or Turkish natives and were interviewed face-to-face in English. Two German female students were questioned, one of which studied in Berlin and the other in Poland, but had previously worked as a nurse in Berlin. One Turkish male student was interviewed who lived and studied in Berlin for the last five years. Three medical students were interviewed to gain a better understanding of the exposure that they had to treating patients of various cultures and to discuss the training they had received on intercultural communication.

In total, thirteen patients were interviewed and were given a written questionnaire in German, which was then translated to English. Twelve participants were of Turkish descent with an Islamic background, however, one Lebanese patient was in-

[1] As an American conducting this research, American spellings have been used throughout this study.

cluded in the data as her background was unknown when given the written interview, but her data was relevant. Females were predominantly interviewed, with nine in total; however, four males were interviewed for the study. The average age was 36 with a range from 17 to 52. Ten participants defined Turkish as their mother tongue, with one speaking German, one Kurdish and one Arabic as their native language. Two of the participants were 1st generation migrants living in Germany, while eight were 2nd generation and three were 3rd generation. Nine of the subjects immigrated to Germany, while on average, living there 25.5 years with a range of 8 to 42 years, while four of them were born in Germany. Nine of the patients went to German doctors while three of the subjects went to both German and Turkish doctors combined and one went to a Turkish doctor only.

3.3.3 Interview format

The *semi-structured,* face-to-face interviews with the doctors consisted of *closed*- and *open-ended* questions that were based around gaining answers to the research questions. The researcher wanted to learn about their experiences treating Muslim patients, what percentage of their patient population was Turkish, what challenges they have faced and what they have done to make themselves more culturally aware of patients with different backgrounds. It was also important to find out if they had done any further training to improve their clinical communication skills when it comes to interacting with patients from a different culture. An example of a question that was asked is: "From your experience, describe the challenges that doctors face when treating Muslim patients." The full set of questions that were asked is located in the "Interview Guides" in Appendix A-C.

The *semi-structured*, face-to-face interviews with the medical students consisted of *closed*- and *open-ended* questions that were designed to gain answers to the research questions. The researcher wanted to learn what percentage of the patient population was Turkish at the medical school they attended, about their experiences treating Muslim patients and the challenges they have faced when treating them. For instance, medical students were asked the following: "Tell me about a recent

story of an incident with a Muslim patient where you felt that the patient was uncomfortable".

Each face-to-face interview lasted approximately 42 minutes, with a range from 13 to 100 minutes, in order to respect their time and other commitments that they had. Please refer to Appendix A-F for more information on the structure of the questions used in both the face-to-face and written format along with the transcribed interviews.

One *semi-structured* in-depth pilot interview was done with a Middle Eastern woman, who gave insight to how others from the East were treated in Germany and allowed one to test the questions and create a more concrete interview guide. The majority of the patient interviews consisted of more *structured* written interviews, which included open-ended questions, which were translated into German (Yin, 2011). For example, the patients were asked the following question: "Describe a situation when you visited your doctor and you felt uncomfortable and had a negative experience." Patients were interviewed this way because of the difficulties faced with the language barrier and being able to find patients that were willing to speak face-to-face about their experiences with medical doctors in Germany. The questionnaire was either provided in a printed Word document or in an online survey format through Google Documents. They completed the surveys in German, and then they were translated back into English.

Informal conversations were also held with various members of Turkish nonprofit organizations who provided first hand knowledge of the Turkish culture in Germany along with personal experiences of how they have integrated into the German society and what they are doing to help other immigrants do so. This information assisted in gaining a better understanding of their culture and helped with formulating new ideas for further research. It also provided information that one could build off when interviewing others.

3.3.4 Modifications to Interviews

Although qualitative research is a great tool to uncover more information through personal interviews and open discussions, one must truly understand their target audience and make sure they are clear in the data that they are trying to uncover for their research. In doing so, they may realize when they are not receiving the data they want and may need to restructure what information they are asking for. "Because qualitative research permits and in some ways encourages multiple midstream adjustments throughout the study process, investigators have an opportunity, unlike doing most other kinds of research, to influence the findings. Such influence may be purposeful or inadvertent" (Yin, 2011, p. 77). With that being said, one can get into the middle of their research and uncover new ways of obtaining different data (Yin, 2011).

The study's direction was designed ahead of time, and the first set of interview questions that was created consisted of open-ended questions such as: "What challenges do you face when treating Muslim patients?" and "How do you think patient care has been affected due to misunderstandings and lack of cultural awareness?" As the participants began to be interviewed, the researcher realized that the approach needed to be altered and the questions needed to be restructured. Although these seem to be relevant questions one should ask to obtain information that would result in data that was relevant to answer the research questions, the in-depth information that was needed was not being collected and the questions seemed to be too direct. From there, a few experts in the field were contacted, and a second set of questions was created.

Robert Strauss, of Global Perspectives Consulting, advised to create an *operational definition* for "the quality of healthcare" along with other key terms used in the research questions.

An *operational definition* is:

> *"A process by which the characteristics of a concept can be defined, including identification and classification. It consists of the methods or tests that are used in analyzing a given variable or concept, which can be used to confirm the validity of the information obtained" (Answers Corporation, 2013)*.

By creating these definitions, questions were formulated that centered on these points and potentially collect information that answered the research questions. He also advised to create questions using the *Behavior Event Interview (BEI)* approach, which allows the participants to describe an event in a story format using past events that have occurred that relate to the two variables that need to be extracted from the data obtained (Strauss, 2013). The two variables defined are cultural differences, which is the independent variable, and the quality of health care, which is the dependent variable. *BEI* tends to elicit good or bad behaviors from the past rather than circumvent future best intentions (Strauss, 2013). Further questions were created such as: "Tell me about a time when you felt that you did not effectively communicate with a Muslim patient".

The questions were well worded and directed towards obtaining the information that was needed; however, again the questions were too direct and abrupt, focusing too much on miscommunications and misunderstandings. Because these occurrences were being asked about directly, the researcher felt that the participants were still not able to open-up as freely and discuss specific instances about interacting with and treating Muslim patients. A set of questions needed to be developed where one could encourage them to discuss stories about occurrences that would provide more viable data.

This brings up an interesting point: how should one phrase questions to cater towards a culture that is known to be very "direct", particularly Germans? Because the interviews with the doctors are done in a very professional context about a highly sensitive situation, and a strong level of trust had not been developed due to the

the lack of time allowed to build a strong relationship, they are less apt to divulge as much detailed information. Therefore, the questions were restructured in a more indirect way and focused on gaining recommendations from them. A third round of questions was constructed to ask the remaining participants. They consisted of situational questions that included a less invasive approach involving questions that painted a picture of instances that could potentially occur when treating Muslim patients. Questions were formulated such as:

- "Tell me about a time when you felt that you had a positive experience with a Muslim patient".
- Case Study (Read an example of a case):
    - "How would you react in this situation"?
    - "How would you recommend to handle this case scenario"?
    - "Have you had anything similar to this happen"?
    - "How did you handle it"?
- "How do you accommodate a female Muslim patient when she comes in for a medical consult or surgical procedure"?
    - "How do you approach physical contact?"

This particular format of questions allowed for the topic to be approached more broadly at first and then hone in on particular occurrences. Trust was built by asking about positive experiences, next case scenarios were given and discussed, followed by questions on how they would recommend to handle the situation, if they had faced something similar and how they handled it. Questions were then asked regarding any negative experiences or other challenges they had faced when treating Muslim patients. At the end, they were asked, "if they felt doctors needed to do further training to become more culturally aware and if so, what should they do?" After shifting to this approach, more rich examples of situations that they faced were gathered.

When interviewing patients, a whole new set of challenges was faced. Of course, it is much more difficult to find people to speak with you as it can potentially be a sensitive topic for them because it involves discussing their interactions with doctors and unveiling their medical condition. It was also difficult to connect with Turkish people as many of them are not that well integrated into the German society and therefore have very little contact with people from outside their own culture. The re-

searcher faced this challenge by networking and connecting with various people who worked for non-profit organizations that assist Turkish migrants and also by asking several of the doctors if they would hand out the surveys to their patients to fill out while sitting in the waiting room. Another challenge that was faced was the language barrier. As many Turkish people in Germany do not speak English, if an interview was to be conducted in person, a translator would have been needed to be there to converse back and forth in German and then translate to English. Many of the Elder Turkish do not speak German that well, so it would be even more beneficial to conduct the interviews in Turkish, but the resources were limited.

3.4 Data Management

All face-to-face interviews were audio recorded, and notes were taken during the interviews, which were kept confidential in a notebook. Each interview was transcribed using the EXMARaLDA transcription software. Written interviews were translated from German to English in electronic documents. All documents were stored on the researcher's personal computer under various codes to ensure confidentiality.

3.5 Data Analysis

The face-to-face interviews were transcribed verbatim from the audio recordings. The transcription of the face-to-face interviews was 338 pages long with 62,763 words. The written interviews were translated back into English from German and were 39 pages with 7,209 words. After completing the interviews, the data was analyzed and categorized into common themes, which then were backed-up with other studies that had been previously completed (Miles and Huberman, 1994; Yin, 2011).

Yin's (2011) five-phased cycle of compiling, disassembling, reassembling, interpreting and concluding was used to work through the data and analyze it. From the interview transcriptions, categories were created that were relevant and enabled one to sift through the data and find common themes. Various quotes from the participants were used that were relevant and pertained to the following topics: *percep-*

tion of illness, language barriers, the role of the family, security and trust, high-context versus low-context communication, empathy and respect, modesty and *Ramadan*. The five-phased cycle allowed one to narrow down the information as much as possible and use information that was important for this study.

3.6 Research validity and reliability

The physicians were selected using snowball sampling, which involves selecting new participants as an offshoot of existing ones (Yin, 2011). Each time a doctor was interviewed, he was asked if he could recommend some other doctors to interview that treated a fair amount of Muslim patients. In doing so, the sample was created through the networks of others and knew that they would have some relevant information to share. This approach also allowed one to build a relationship quicker with the participant because of the referral was made by one of their colleagues, which enabled them to feel more comfortable in talking to the researcher. It also allowed for various specialties of doctors to be interviewed instead of just interviewing only general practitioners or gynecologists. It also permitted an interview with a doctor within a hospital setting versus those only in a clinic setting. It made it possible to also seek information from doctors who treated chronic cases versus acute cases.

The medical students that were interviewed were referred by contacts that the researcher had in Berlin, which enabled stronger rapport to be established with them much quicker (Yin, 2011). Patients were selected in several different ways. Snowball sampling was again used in some instances as people that were interviewed referred participants that they knew that qualified for the study and gave them the questionnaire to complete (Yin, 2011). This allowed one to find participants that were willing to partake in the study much easier instead of having to randomly approach people without any previous relationship. Convenience sampling, which is selecting subjects because they are readily available, was also used to find several of the participants as they were approached in the Turkish Neighborhood of Neukoln,

in Berlin, in cafes and stores (Yin, 2011). By using several different methods to select patients, it created a diverse group of participants.

The data received from physicians has adequate representation for the purposes of this research because it focused on various areas of medicine practiced, but this study was used as only an introduction to exploring the impact that cultural differences have on the healthcare provided. Although the sample size was small, the researcher felt as though they could potentially gain a broad sense of what was taking place. As the sample size consisted of only three medical students, a general overview of what students are being exposed to in medical school and whether or not they had much experience working with patients of other cultures was obtained. The data collected from the patients gives only a general representation of what they are being faced with while being treated by German clinicians on a very superficial level because of language barriers and the sample size. By using various methods of selecting participants and data collection, it reduced the amount of bias that could have been created if the sources all confirmed preconceptions of the researcher (Yin, 2011). Although some generalizations can be extracted from the data collected, one must still take into consideration that the results cannot be perceived as full representation of what is taking place at all times in the general population and further studies must be completed to find more in-depth data. Face-to-face interviews were audio-recorded so that they could be referenced during the write-up and ensure better accuracy of the data collected (Yin, 2011).

3.7 Ethical considerations

Upon solidifying the topic of the research project, the supervisor and the researcher discussed interviewing doctors and patients. She explained in great detail what would be needed to present to the ethics committee in order to get the project approved. They worked side-by-side to ensure the committee would accept the project as it was considered to be a bit more of a sensitive topic since it involved interviewing doctors and medical patients. The forms that were included in the application process were as follows:

- Ethics application form
- Participant information sheets for doctors, medical students and patients
- Participant consent form
- Ethics committee application checklist
- Proposed interview questions
- Dissertation proposal

Many of these forms are provided in Appendix A-C and G-L. Both the ethics committee and the supervisor of the project perused all of the forms and information, and there were no areas of concern for the research project.

Once the research project had been approved, participants were interviewed shortly there after. Before each interview, the scope of my project, how their personal information would be kept confidential and that they could refrain from the study at any time was discussed. In order to keep things confidential, names of the interviewees were not stored and were give labels such as Doctor 1-7, Turkish Doctor 1-2, Medical Student 1-3 and Patient 1-13.

To decrease the amount of time and resources spent on conducting interviews, a topic was chosen, which was felt to be both beneficial to the doctor and the patient along with the healthcare field in general. This work can be shared among practitioners to gain a better understanding about the challenges that they may face when treating Muslim patients. Patients can also learn more about how they should handle these situations when they visit their doctor, which will enable them to communicate more effectively and feel comfortable enough to raise concerns that they may not have normally done in the past. This information is also valuable for medical communication skills instructors to know about so that they may implement more theory and scenarios into the medical school curriculum pertaining to intercultural communication. Consultants and trainers can use this information to uncover client needs in hospital and clinical settings. The researcher was also extremely flexible when it came to interviewing the doctors or patients and met with them when it was

most convenient for them, and used Skype to connect if they were outside of Berlin. This enabled resources to be minimally effected.

Participant confidentiality was taken very seriously, and subjects were not probed too deep for particular case information, which would breach doctor/patient confidentiality. Previous interviews were not discussed with them, nor were discussions prolonged, as their time was very valuable and they have many other commitments. It was mentioned that the conversation would be audio-recorded for personal review so that one could enable more accurate recording of the data obtained. They were informed that the recordings would be kept confidential and stored on the researcher's personal laptop computer. An information sheet was provided to each participant, which described what the study was about and some of the information that would be asked of them. They were then asked to sign a participant consent form, and they were told they could withdraw from the study at any time if they had any concerns.

4 Findings and Discussion

In this chapter, the information gathered from the interviews with German and Turkish clinicians, medical students and Turkish Muslim patients will be analyzed and discussed. As Dogan et al. (2009, p. 690) points out, "Communication is influenced by individuals' worldview, which includes their perception of illness, their cultural background, sensitivity and good will". With the evidence provided, one can concur that several different aspects have an affect on the communication between doctors and patients, which can potentially have an impact on the quality of healthcare provided by German physicians to Turkish Muslim patients.

Many have further discussed that:

> *"Effective communication between patients and healthcare providers is an important element in quality healthcare. In challenging healthcare environments, healthcare providers need the skills to explore the meaning of illness, determine patients' social and family contexts, and provide patient-centered and culturally competent care as an aspect of ethical responsibility" (Markova, 2007 cited in Dogan et al., 2009, p. 690).*

The results of this study agree with several other studies that have been conducted regarding different key points that can influence the quality of healthcare, which have been previously discussed. Direct quotes from the doctors and medical students will be used in their original form in this section. Direct quotes from patients are translated from German to English and can be referenced in the footnotes. However, in all of the quotes used in the findings, if words are missing in the sentence or the sentence structure is not properly formed, corrections are placed in parentheses to make the sentence read appropriately.

4.1 Perception of illness

The *perception of illness* and *pain* came up in multiple conversations throughout this study. The results concurred with other studies that Turkish immigrants in Germany may have a different perception of pain (Spallek, Zeeb and Razum, 2010). While patients in the Western world typically perceive various aspects of disease as "purely" medical, migrants from some other parts of the world see disease as "an

established part of spirituality, morality or religion" (Spallek, Zeeb and Razum, 2010, p. 94).

"According to one German hospital nurse, a great proportion of nurses' problems when working with foreign patients is due to the lack of knowledge regarding culturally determined ideas of health and illness, and insufficient adaptation of these patients to German culture and hospitals" (Kuckert, 2001 as cited in Dogan et al., 2009, p. 685). As previously mentioned in Kuhn (2000 cited in Dogan et al., 2009, p. 684) and several other studies, many of the doctors repeatedly mentioned that the Turkish patients often talk about having "pain all over" in this study which relates to their perception of illness. Doctor 1 (ll. 39-43) stated the following:

> "*…It is very difficult when there is one foreign patient (that) is coming alone and they are saying, 'here is pain, and here is pain, and here is pain', in very different places. And you don't see anything, and it is impossible to talk with them about the problem. Sometimes that is difficult. We call that the 'whole-body-syndrome'. It is very difficult*".

It has been found that in some Southern countries, however, illness is frequently believed as something that comes from the outside world, invades the body, and takes control of the entire being as a whole (Schouler-Ocak et al., 2008). Doctor 5 (ll. 129-135) expanded on this occurrence in Turkish Muslim patients,

> "*I try to see what is the first sign and to differentiate (it), to see if it is a regional or a complete (body) problem. When a greater problem (exists), at this point, I think (it) is kind of a depression (disorder) mainly in Turkish or Arab women that expresses itself with headache or sore throat and dizziness. (This) is a big problem, and I (can)not resolve it. (It) is not an organic problem. (This) is a big difficulty…German practitioners need to open their mind for thinking about depression or (other) psychological problems".*

Although many of the doctors discussed that their Turkish and Arabic patients often mention that they have "pain all over", the doctors, of course, wanted to diagnose their problem. However, the patient's "perception of illness" probably was not always taken into consideration while discussing their medical case.

4.2 Language barriers

One of the main challenges that German physicians and Turkish Muslim migrant patients are faced with is the language barrier. Because many of their families came here as "guest workers" over 40 years ago, most of them have never truly integrated into the German society. It was believed that they would only come and work for a few years; however, their families have continued to stay and live and work in Germany (Anwar, 2008). Turkish Doctor 1 (ll. 48-58) agreed with much of the data and described the following situation taking place in Germany:

> *"Unfortunately migrants, migrants are migrants, and they are not earning that much, so they all tend to live in a certain part of the city, next to each other and to live with the people coming from the same countries and speaking the same language, which is especially (the case) in Berlin, a very easily observed phenomena. There are Turkish districts here where you can (live in), as the Germans call it, 'parallel Welt', which is a parallel world…They are living in the same country and in the same city, but in a parallel world, doing (all of their) shopping every day (with) almost everything in Turkish and not at all getting in contact with Germans, so to say. And this goes on and on and on, and when they at all have to go to a German authority or state office, they take their children for translation".*

As the researcher toured through several of the areas in Berlin where Turkish immigrants live, it was very apparent that they live in this "parallel world" that Turkish Doctor 1 explains. During the day, mass amounts of Turkish people are walking up and down the streets and stopping in on their favorite local bakery or restaurant. Many of them are speaking in Turkish rather than German, and the grocery stores are definitely catered towards Turkish cuisine. It feels as though you are in Istanbul rather than Berlin.

Because of the lack of integration by the Turkish people into Germany, Doctor 2 (ll. 63-77) discussed the problems he faces with the language barrier with his Turkish patients:

> *"…(Communicating in German and being able to speak) the German language, (this) is most (of the) problem, and I say it's a similar problem. It is more difficult (to uncover the symptoms of) a systemic disease like rheumatoid arthritis…I feel (that) there is more than only a bit of pain in the shoulder. I would ask them to come again with a translator, a member of the family or some(one) (close to*

them). I feel that causes no problem, I say, 'Please come again with your husband or your girlfriend or (whomever else)'. It is mostly the Turkish women who cannot speak the language. They can understand, but they cannot speak. Yes, I would say that most times when there is a problem, it is a communication problem (that exists because of the lack of knowledge of) German words…You have to imagine that Turkish people came 30-40 years ago (to) Berlin with the special Berlin program. They came from Anatolia…They came as similar people, (working class). And the women were not able to write (or) read, (neither in German or) in the Turkish language. These wives are now living (for) 30 years in Berlin, and they can only speak Turkish".

Although the language barrier came up quite frequently in this study, the doctors felt that it may cause some misunderstandings and for some things to be lost in translation, but they did not feel that it affected the quality of care of the patient because they usually brought a family member to translate or were asked to make another appointment and bring a translator (Doctor 1-2, 5, 7). In Dogan et al.'s (2009) study, it was also found that problems with communication were faced due to language barriers. Research carried out by Schilder (1998 cited in Dogan et al., 2009, p. 690) found that "there are communication problems between Turkish patients and nurses in Germany as a result of the language barrier; but that communication also depends on cultural harmony, and disharmony plays a major role and may be more critical that the language problem". While the language barrier may be a problem, it is also important to understand the cultural differences, which will be looked at further in this study.

Becker (1998 cited in Dogan et al., 2009, p. 690) also found that some Turkish patients were given incorrect treatments or interventions because of the language barrier and cultural misunderstandings. Although, "not all cultural misunderstandings result from language barriers, but there is a close relationship between culture, health and communication" (Nussbaum, 1992 cited in Dogan et al., 2009, p. 690). Incorrect treatments or interventions due to miscommunications caused by language barriers were not reported in this study; however, it is important to keep this in mind and try to make sure that both the doctor and the patient understand each other clearly so that the quality of care is not affected.

Doctor 6 also mentioned that some of the Turkish patients, in general, speak very little in Turkish or in German, and that they do not have a very elaborate vocabulary in either, so it makes it difficult to get a detailed explanation of what they are experiencing. Many of the patients also agreed that the language barrier caused some challenges when it came to expressing themselves and explaining to the doctor what they were facing. As Patient 1 (Q6) explained,

> *"For me, it's basically the language barrier that didn't exist in my native country. It is an indescribably dreadful feeling if you put a lot of effort into describing something (to) your (doctor), (and he) simply doesn't understand (you) or doesn't show enough patience (when speaking with you)[2]".*

Many patients expressed this same feeling and explained that they felt much more comfortable with their doctor when they could speak in their mother tongue (Patients 1, 3-5, 7, 9, 12 - Q5, Q6).

As with patients of any background, the language must be simplified by the doctor in order for them to understand. As Patient 9 (Q4) further describes, "Doctors don't inform us enough about our sickness. They talk to us in (the) medical language, using too many Latin words[3]".

Many of the patients also commented on the fact that they feel that their doctors are not taking enough time for them to listen to more details about their case, but they feel because they are not able to speak German well, that this bothers the physician. A few stated that they have felt like second-class citizens and were spoken to like a child because of their lack of knowledge of the German language (Patient 1, 3, 9, 11- Q4, Q6, Q5.2).

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[2] Patient 1, Question 6: "Bei mir ist einfach die sprachliche Barriere die id in meine Heinatland nicht hatte Es is ein unbeschreiblir screnecliches gefuhle, wern mein sicralle reihe gibs etwas zu besschreiber, dach des gegenube es einfach nicht vesters bzw nicht die geduld hot".

[3] Patient 9, Question 4: "Artze informieren ans nicht genung von unserer krankheit. Sie sprechen mit uns in der Arzlichen sprache b.s.p. Lateiniche worter werden zu oft benuzt".

4.3 Cultural Differences between Germans clinicians and Turkish Muslim immigrant patients

As discussed in Chapter 2, although there are some similarities, there are several cultural differences between German physicians and Turkish Muslim patients. Although these are generalizations, the three main differences that were found were the role of the family (*Individualism* versus *Collectivism),* the need for security and trust *(Uncertainty Avoidance and Linear-Active* versus *Reactive) and High-Context* versus *Low-Context Communication*.

4.3.1 The role of the family

As seen in Hofstede's study, Germany scores very high in individualism, with a 67, and Turkey scores very low, with a 37, which means they are a more collectivist society (Hofstede, 2013). When asked about the cultural differences between Germans and Turkish people, Medical Student 3 (ll. 50-58), who is also Turkish, stated,

> *"Oh, the whole culture is different. Family, family life, money, the role of money in life, and then personal interaction and then discipline, of course. German people try to do the best in their jobs and try to be disciplined, and Turkish people don't…then (they are) waiting for the last day, and they try to do (it) all on the last day. And you know, the people in Germany are much more alone…they live alone. The Turkish people are like a community, (they have) big families. They don't like to be alone, but German people like to be alone. It (also) depends (on) where (the German people come from), in Munich they are different than the people in Berlin, like West and East".*

The data obtained in this research study complements the previously done research that Turkish Muslim people are very centered around their family and live in big communities (Dhami and Sheikh, 2008; Hofstede, Hofstede and Minkov, 2010). "The notion of honor plays an important role in Turkish culture and is strongly related to family life; indeed it is more closely associated with the family than it is with individual persons" (Schouler-Ocak et al., 2008, p. 655). Because honor is so important to the family, "all of the family members are obliged to bear themselves with dignity and avoid compromising their family's reputation" (Schouler-Ocak et al., 2008, p. 656).

Many of the doctors mentioned that when a Turkish patient comes to see them for treatment, most all of the time they bring not only their husband or wife, but also several members of the family (Doctor 1-7). The family is involved in not only translating, but also in taking care of the ill and making decisions together on the treatment…honor for one's family plays a big role when one is ill along with the whole community supporting them. Doctor 2 (ll.164-171) agrees and states,

> *"As a family, they (Turkish) are very busy with good family structures. If something happens to them in an accident or if they have problems or a disease or something, all the family takes care (of them), (including) their children, their mother and father. (Their father) is like a 'God'. (They have a) good family structure, better than (that of) the Germans. When mama has a disease, they come (with) 5-6 people into that room, and I say, 'Who is the ill person'? And (then) they say, 'only mama'. I (then) say, 'only one person (may) sit here (that) speaks German, and the others, please wait outside'. In the hospitals, we (also) see (that) when (they have an ill) person, then they come (to visit them with) 10 people (or) more".*

The family dimension was mentioned numerous times throughout the interviews and is typical of both Turkish and Muslim patients; however, this did not seem to bother the doctors. Many of them agreed that they had to know how to handle the consultation when several family members were present. They noted that typical German families did not tend to bring the whole family with them, and their unit usually consisted of a single-family household, unlike the extended family that are present in many Turkish establishments (Hofstede, Hofstede and Minkov, 2010). Doctor 3 (ll. 144-150) commented on the following:

> *"…It may not count for everyone, but a lot of them (Turkish) have bigger families, and they stick together more…Turkish people usually have a sister or brother or (someone) else (in their family who lives with them). I think (a) household with just one person is the future in Germany, I think".*

As mentioned by Hofstede, Hofstede and Minkov (2010), the collectivists are always centered on the power of the group. The extended family is always present in a time of need. Medical Student 1 (ll. 99-102) further mentioned that,

> *"If there is a three-person room, with three patients, and a Turkish (patient) among them, then there is (a) lot of family (present in the room). I think that is*

also strange for (the) other patients in this room. They would stay sometimes all day and bring food into the hospital because there is only German food (provided)".

A hospital manager mentioned that this could become a challenge if the Turkish were rooming with more individualistic cultures, as they would want some privacy and not have as many visitors around for the entire day. Another challenging factor that the nurses are faced with is how to manage the large families if the others in the room would like to not have so many visitors present. What must they do to keep both patients comfortable and happy? In the perfect world, if possible, they try to room Turkish people with others of a similar collectivist background to reduce the amount of stress that this may cause for the other patients and staff (Manager, 2013).

Medical Student 2 (ll. 74-88) concurred with the power of the family bond and shared the following story about Turkish families visiting a member after surgery:

"…We had this one Muslim, young guy, he was like 18 years old, and he had some kind of surgery. After the surgery, for one day, he was not supposed to eat, and he should not drink (for several) hours (after the procedure). (They also recommended that) his family should not visit him immediately. He should take (care and have some) rest. If you eat something, your stomach, because of (the) narcotics, could feel bad, and (it may cause you to) throw up. And that is what I was telling you about the families staying together. So the Islamic family could not handle the situation of not visiting him right away because they are sticking together (so much). And so, I think, like 20 people, his family, his mother, I think (approximately) 10 brothers or (so), they were visiting right after the surgery even though the doctor said not to do (so). They brought him a lot of food and other things. He was drinking and eating right after the surgery and hanging out with his family. In the evening, he was throwing up like (crazy). So because, you know, he just did not want to listen to what the doctors told him, I think, it was also some kind of cultural thing in some way…".

Instead of telling the patient, "I told you so", the doctors gave the patient medication to treat the nausea (Medical Student 2). They could have very well handled this situation differently and made the family leave, but they knew this was important for the patient, so they allowed him to be surrounded by visitors, eat after surgery, and treated it medically versus emotionally.

As one can see, the in-group is very important to Turkish patients, and they consult with each other about their medical conditions, while valuing their family's opinion (Gudykunst and Kim, 2003). Patient 9 (Q3) mentioned that, "When I told my girl friends about my sickness and (the) medications, which I got from my doctor, they told me that this doctor gives everyone the same medication[4]". This evidence shows that they consult with their in-group about their consultations and treatments, which in the end could affect the treatment of their illness. Turkish Doctor 2 (translated by Medical Student 3, ll. 95-102) made the following comment about this cultural norm:

> *"The neighbor's thoughts are always important for Turkish patients. For example, the doctor recommended (a particular medication), and the patient (goes) home, (translation by Med Student 3)…and they talk with the neighbors and family members, saying, 'I have read (the information about this medication), what are your experiences with it'? Then when the neighbor or family member would say, ' I don't know about this medicine, I would rather take the other one', she will take the other (medication instead). They will not listen to the doctor".*

4.3.2 Security and trust

The next difference that was noticed across the two cultures was the need for security and a strong relationship built on trust, which tends to describe the need to avoid *uncertainty* and ties in with *linear-active* versus *reactive* cultures. Trust is important not only for Turkish people, but is also an important element in the Islamic religion (Hanson, 2008). Although both Germany and Turkey like to avoid uncertainty, Turkey actually ranked higher than Germany with scores of 85 and 65 respectively (Hofstede, 2013). Because the Turkish Muslims, especially women would truly like to avoid uncertainty as much as possible, much anxiety is created when they are in unknown situations and communicating with strangers. "Muslim women, particularly those from immigrant backgrounds, find clinical encounters that involve examination of intimate body parts to be sources of anxiety and, therefore,

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[4] Patient 9, Question 3: "Als ich mit meiner Freundinnen von meiner Krankheit und den Medikamenten erzahlte, die ich von meinem Arzt bekommen hatte, sagten sie mir das dieser Arzt jedem die gleichen Medikamenten gebe".

fore, major barriers to seeking and using care" (Hasnain et al., 2011, p. 80). Because of this, it truly takes them much longer to build up their level of trust with people whom they do not know well (Gudykunst and Kim, 2003). The fear and lack of trust stems from them being a *reactive* culture along with being immigrants and never fully integrating into the German Society (Lewis, 2006; Spallek, Zeeb and Razum, 2010).

As stated earlier in Chapter Two, according to Berger and Calabrese (1975) as cited in Gudykunst and Kim (2003, p. 30), when meeting a person, one has uncertainty "about the strangers' attitudes, feelings, beliefs, values and behaviors". It is apparent that Turkish patients do not trust German doctors because they have uncertainty about their "attitudes, feelings, beliefs, values and behaviors". Because of their reactive nature, strong relationships are needed in order to trust their doctor (Lewis, 2006). Turkish Doctor 1 (ll. 249-264) underlines this statement as follows:

> *"May be I should mention one more thing, that is, from the sides of the Turkish patients, interestingly, they don't feel, or they never trust their German doctors. (It) is very typical that in the 6 week summer school holidays, not all, but let's says the ones that can afford it. That's also a very typical thing you know, they go with cars all the way from Germany to Turkey. I also worked for a short time in Istanbul, for example, and that why it's typical in Turkey, in the summer (during) these 6 weeks time that the people go and see a Turkish doctor in Turkey. They say, 'Well the German doctor does not really understand me'. I mean, how can that be, they are going to the best university clinic (in) Germany, and it is also (occurs) that we get patients in (the) spring and winter, and they come and say, 'I went to a doctor in Turkey, and he gave me instead of this (treatment), (he gave me a different) medication'. I mean ok, that is also fine, but they don't really feel, or they never really have this feeling of trust here, they are always (having various) questions (about their doctor) in their heads. 'Are we really being taken good care of? Are we taken serious? And are they doing the best they can do'? Yes, this is what we see very often. That people also seek medical treatment when they are in Turkey, although they really don't need to".*

A study in Sweden also concurs with Turkish Doctor 1 and discusses that "Doctors in Turkey were often consulted during vacations and when professionals in Sweden were considered to be failing" (Bäärnhielm and Ekblad, 2000, p. 442). Many of those participants spent a great deal of money in Turkey being treated. "The Turk-

ish doctors were often described as having access to less equipment and resources but understanding better, giving clear diagnoses, comprehensive treatment and clearer instructions then their Swedish colleagues" (Bäärnhielm and Ekblad, 2000, p. 442). However, on the other hand, the healthcare in Turkey was criticized for being quite expensive, and they could incur the risk of being financially cheated (Bäärnhielm and Ekblad, 2000).

Lack of trust for the physician was confirmed in other studies. In order for patients to recover, they needed a certain level of belief and trust (Bäärnhielm and Ekblad, 2000). The study in Sweden illustrated that "some of the participants found it more difficult to judge if they could trust a doctor in Sweden than in Turkey. Some participants thought that their migrant background made it more difficult for them to be trusted by Swedish health professionals and felt a lack of social and family support" (Bäärnhielm and Ekblad, 2000, p. 444). Medical Student 3 and Turkish Doctor 2 (ll. 37-39) also confirmed the lack of trust that Turkish patients have for their German Physicians and stated the following, "Then it is also common that Turkish patients go to Turkish doctors, they are not going to German doctors. First of all, (it's) because they cannot speak German…and they feel, I don't know, more comfortable with a Turkish doctor, I guess".

After polling the patients about what concerns them when going to their doctor, they brought up the idea of trust or lack of comfort when being seen by their German physician. As Patient 4 (Q5) concurs, "When a doctor from my home country takes over the treatment, I feel warm-heartedness[5]". As Lewis (2006) states, most Turkish people would like a healthcare professional who is compassionate and accepts closeness. As Patient 5 (Q5) goes on to say, "I prefer to be treated by a doctor

[5] Patient 4, Question 5: "Wenn ein Arzt aus meinem Kuttor-Kreis die Behandlung ubernimmt, fuhle ich warmheszlichkeit".

from my country of origin[6]". It is quite evident that Turkish patients feel much more comfortable and build a higher level of trust with a doctor from Turkey much more quickly than with one from Germany. This is not only due to language barriers, but they feel that they can connect much easier and that the doctors can relate to them because of similar cultural beliefs. Because of their need to avoid uncertainty, Patient 12 (Q6) mentioned that it was important to show a certain respect and give them a sense of security[7]. Because they are unfamiliar with the German culture and beliefs, their level of anxiety rises and they do not feel as secure. They long for a sense of security and want to be able to predict the direction in which they are going and want to have people whom they know well and feel comfortable with guide them down the correct path for their medical treatment (Hofstede, Hofstede and Minkov, 2010).

Patient 3 (Q6) also mentioned a very important factor to build trust when speaking with the patient and a translator,

> *"The physician should always address the patient directly, even if a family member is present as a translator, for this alone creates trust for the (female) Muslim patient. Just because someone does not speak a language perfectly or even has somebody to translate with them, one cannot treat the patient as a third class citizen, by not speaking directly to the patient[8]".*

Several of the doctors also noticed that the level of trust varies between German and Turkish patients. Doctor 6 (ll. 29-40) discussed the following:

> *"This is also a very open question, it is to whom you compare them (with and) to*

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[6] Patient 5, Question 5: "Es ist mir lieber mit einem Arzt behandelt zuwerden aus meiner Ursprungsland".

[7] Patient 12, Question 6: "Beim Frauenarzt (als Mann) eine gewisse Seriositat und Sicherheit gewahrleisten".

[8] Patient 3, Question 6: "Der Arzt sollte immer die Patientin direct ansprechen, auch wenn ein Familienmitglied als Ubersetzer anwesend ist. Denn allein das schafft schon Vretrauen bei der Muslimischen Patientin. Nur, weil jemand die Sprache nicht perfekt beherrscht oder gar jemanden zur Uebersetzung dabei hat, darf man den Patientin nicht als Mensch dritter Klasse behandeln, in dem man nicht das direkte Worst an die Patientin richtet".

which social classes. The difference is (seen in how one) accept(s) the doctor. It is much bigger and narrower than the Germans. If they accept you as a person or as a doctor, then they really do and (they) think with you and do what you think that they need to (do). They are more critical in the first phase (on whether) they accept you or not. If they (do not) accept you, then your work is very difficult. German patients might accept you the first minute and would ask, 'Is this going the right way? Is that the healthy and natural medicine? Is this not too much chemistry and school medicine'? This is a (somewhat) more difficult relation(ship) (that one must form with the Turkish patient). The relationship with (them) might be difficult in the first minute, accepting you, then accepting your authority, this might be the biggest difference. (This is) generally speaking because there are a lot of differences (that exist)".

4.3.3 High-context versus low-context communication

As previously discussed, Turkish and Muslim communities are seen as collectivist societies, which in-turn, tend to communicate in a very *high-context* fashion (Gudykunst and Kim, 2003). As Doctor 3 (ll. 15-16) mentions, "And sometimes, may be, well they would not directly come to the point. That's also sometimes a problem". At times the doctors have problems fully understanding the point the patient is trying to make as much of the message is implied and patients explain their situation differently from Germans (Hall, 1976). If a doctor cannot fully decipher the reason the patient came to see him, it could potentially alter the diagnosis and affect the quality of care that is given. It also ties back into the patient's perception of illness.

Doctor 4 (ll.141-144) goes on to explain,

"*Sometimes there is a difference, the German patients say 'here is my problem', and Turkish or Muslim patients say 'it hurts here and here and here and here and here', and in fact, may be they are not happy with their situation, and we call it 'Turkish total body pain'".*

As found in previous research, Turkish people, along with most Muslim cultures, tend to communicate in a more indirect fashion while the Germans tend to be very direct and come straight to the point. They tend to give many details about what is concerning them about their health (Lewis, 2006).

Doctor 6 (ll. 199-205) agrees that there is a big difference in communication patterns and that the Turkish Muslims tend to communicate more indirectly:

> *"Ok, this is absolutely true, this is very difficult, and I had very unpleasant situation(s) at the beginning of my work because they really sometimes don't give the information that I need. They also keep back information because they think they happened to be operated (on) or put in the hospital or something and then they tell you (?). But after a long experience with them, I cannot tell you why, that happens now very seldom. This is a very good question, it is an important thing, and I have the impression that this comes with experience".*

Doctor 6 (ll. 209-217) gives a great example of why it is so important to build a strong relationship with the patient from the initial visit and how this helps to uncover the underlying message that the patient is portraying:

> *"That is why you have to work out an excellent contact from the beginning, polite, warm atmosphere, which makes them forget their fears as foreigners, as migrants, as Muslims, as Turks…prejudices, so that they can come to the point. And even so, you must always be aware that the situation can exist that they won't tell you something. And they won't tell you about that (?) problem, which is, very often, the real cause of them coming to the doctor. Not about the head or the nose, they have problems in the family, big problems. But after knowing, and I am not a good example, because my father worked there for 20 years, and I am working there for 20 years, I get this information (from them), so for you, I am a special person…it's not representative".*

Doctor 6 (ll. 219-231) gave another great example of how he had to ask a lot of questions to get the patient to finally come to the point and really explain why they are depressed versus the patient first coming in and telling the doctor that she has a stomachache, which in the end was caused by an uneasy feeling:

> *"But these discussions are really important and there are a lot of cultural difficulties. They would not tell you their stories, you know, a woman is coming and saying, 'I am depressed, I am depressed'. I ask, 'what is going on'? (She says) 'Well my son marries". And I ask her, 'Well is she not Turkish'? 'Yes, she is Turkish'. 'Then, what is the problem'? 'She is not from the same village'. You know that (what) you must get out (of it), if not, she (will) tell you, 'Ok, I have a stomachache'. 'Ok, we do a colonoscopy or ultrasound or CAT scan and she would do (it) because, yes, great, let's do these procedures'. You will never know that she has a problem with the marriage. So this information, especially in this part of medicine, the anamnesis is a question of (a lot of) experience, and a doctor of 30 (years old) would ask something (different from) someone of 50 (years old). This kind of experience you can-*

not only learn (from a book). It is important to be aware that the secondary indications in migrants would be more difficult to get than in Germans…".

Medical Student 3 (ll.81-88) stated what one has to do to communicate more effectively with Turkish patients to find out more detailed information,

"If you have a Turkish patient, you just have to ask many questions…and they will answer with a few words. If you ask a question to a German patient, they will describe all (of) the disease story from last year (until) now. And you have to be more specific with a Turkish patient. If you say, 'Yeah, do you have other diseases'? She would say 'no', but if you would say, 'do you have diabetes'? Then she would say, 'yes'. You have to say 'do you have this, do you have that…'? But with a German person you say, 'Do you have other diseases'? They will say, 'Yeah, I have diabetes or hypertension or something (like that)'. This is not a disease for a Turkish person".

As one can conclude from this research, if the doctors are not a part of the in-group, they will need to be able to build a strong level of trust and ask many questions about the patient's life to decipher what is actually the cause of their problem.

4.4 Understanding Muslim beliefs

Prior to this, the cultural differences have been discussed that may have an impact on the quality of health care provided by German clinicians to Turkish Muslim patients. Next some cultural beliefs will be discussed that are specific to the Islamic religion that healthcare providers must be aware of when caring for their patients. For Muslim patients, it is extremely important to respect their beliefs and show empathy, respect the modesty needs of female patients and understand the importance of fasting during Ramadan (Hasnain et al., 2011).

4.4.1 Empathy and respect

One major thing that was mentioned by several of the patients was that they felt that the doctors needed to express more empathy towards them and respect their religious beliefs while being patient with them (Patient 1-4, 6, 8-13 – Q2, Q3/4,Q6, Q5.2). It was found in other studies that "Turkish patients primarily expect compassion and consideration from healthcare personnel" (Dogan et al., 2009, p. 690). One

patient explained that there has been several instances where she felt that one of her doctors had implied that she was asking a stupid question when her doctor rolled her eyes or made other facial expressions (Patient 3). She went on to say,

> *"This means, that doctors, no matter how strange the life or culture of a Muslim patient may appear to them, (need) to respect them as a patient. The doctor can already achieve this through small gestures, for example, by first extending their hand in greeting to the Muslim patient, instead of the young child and/or teenager who has just come along to translate[9]" (Patient 3, Q6).*

4.4.2 Modesty

Many of the female patients felt that they would be more comfortable if treated by a female doctor (Patient 1, 4-5, 10-12 – Q6, Q5.2). This backed up the evidence that because of the dress code that Muslim men and women follow, it is quite challenging to undress and expose their intimate body parts to others (Hanson, 2008). Patient 10 (Q2) told a story about a time when she was in the hospital for a fracture, and one of the doctors took the blanket away abruptly that covered her private body parts. She explained how unhappy she was, and that the doctors should be more considerate of Muslim women in these circumstances.

Several of the patients explained that doctors should be more understanding of their religious beliefs and respect the fact that they may not feel comfortable about talking about their sexuality. They also mentioned that they should respect and understand why they wear a headscarf (Patient 4-6, 8, 10, 11, 13 – Q6, Q5.2). These findings are consistent with what is found in other studies. As stated in a study by Hasnain et al. (2011, p. 80), "From a health policy standpoint, the most illustrative example of insensitivity by providers or the healthcare system is the failure to provide for Muslim women a female doctor when performing intimate physical examinations, such as breast and pelvic exams". Although Westerners see this as standard of

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[9] Patient 3, Question 6 3rd bullet: "Das heisst, dass Arzte, egal wie fremd ihnen die Lebensweise oder der Kulturkreis einer muslimischen Patientin erscheinen mag, diese zu respektieren als Patientin. Das erreicht der Arzt schon durch kleine Gesten, der muslimischen Patientin zum Beispiel als erstes die Hand zur Begrussung zu reichen, anstatt dem kleinen Kind und / oder dem Teenager, der lediglich zur Ubersetzung mitgekommen ist".

care, it is a violation of the Muslim female patient and her family, "that inflicts personal humiliation and generates anger and resentment between Muslim patients and their healthcare providers" (Hasnain et al., 2011, p. 80). Many Muslim women who have immigrated find clinical examinations of their private body parts to cause their level of anxiety towards healthcare professionals to increase and therefore, many will not seek care because of this (Hasnain et al., 2011). If they feel that they are not being respected, they are less apt to continue to seek healthcare, which in the end, may cause them to not seek treatment until the disease is very serious.

4.4.3 Ramadan

As Ramadan is an important spiritual exercise in the Islamic religion for most people, it is important for the doctors and patients to have open discussions about fasting and how it can affect their quality of health if they have a specific medical condition (Sadiq, 2008). The doctors interviewed in this study all had knowledge about Ramadan and what is involved with it. Some of them would take precautions and have discussions with their patients before Ramadan about their diseases and medications that they were taking. Others only discussed it if they had a serious disease that could be affected by it or if the patient brought it up to them. Many of the doctors realize that their patients do not always take their medications during Ramadan (Doctor 1-6). As Doctor 3 (ll. 14-15) stated, "Well some, when they have Ramadan, of course, they don't take the tablets. Of course, that's a problem. And during the day time anyway". Doctor 4 (ll. 21-24) agreed and went on to say:

> *"I have (the) same problems. Many women, older woman, have very dry eyes. They have to take liquid eye drops, and they don't take it during (the) daytime during Ramadan. I tried to explain (that) it is necessary, and it is not forbidden by the religion, but they don't do it".*

Patients in this study tended to concur with Sadiq (2008) in that they did not ask their doctor about Ramadan because they felt that since the doctor was not Muslim, he or she did not know much about it and would probably recommend them to not fast as it would affect their health (Patient 1, 11-12 – Q3.2/4.2). For instance, Patient 1 (Q5) said, " We're told over and over again that fasting is unhealthy, but no

alternatives are presented to us and no support in the form of suggestions is offered[10]". Patient 11 (Q3) commented and said the following, " (I do not ask) always, the answers are always the same: 'Don't fast and drink a lot' (of water)[11]".

Although many did not seek medical advice during Ramadan, several were aware of the implications of fasting if they had a more serious condition as diabetes, and decided to not fast because of this. Several of the participants also did not observe Ramadan and did not fast due to their own beliefs or for personal reasons. For many, it is very important for the doctor to at least acknowledge the importance of Ramadan and discuss a plan of action for the patient's treatment versus telling them that it is not healthy and that they should not participate in fasting no matter what their case may be (Patient 1-13 – Q3.2/4.2).

4.5 Cultural awareness and training

Many of the doctors felt that having awareness of other's cultural beliefs and values was significant; however, they all agreed that understanding the person as an individual was the most important (Doctor 1-3, 5-7). As Doctor 5 mentions, he feels because of globalization, more cultural awareness is needed. He goes on to say that it is necessary to learn some of the fundamentals of intercultural theories and culture specific information (Doctor 5, ll. 204-209).

Doctor 7 (ll. 88-91) agrees that more cultural training is needed, as it would allow them to handle their medical cases with more ease and patience. He also felt that it was valuable to understand how others perceived illness in different parts of the world as this would allow them to potentially understand their patients better (Doctor 7, ll. 108-118). The medical students concurred and felt that it would be helpful to learn about treating other cultures during their training in school (Medical Student 1-3). The patients agreed that their quality of healthcare provided would be

[10] Patient 1, Question 5: "Zum Beispiel wird, nimes new gesages, class Fasten ungesund ist, abe es weder keine Alternativen gezeligt ocles nein wird nicht dase meit 2 B tricks und tipps unteistraitst".

[11] Patient 11, Question 3: "Nicht immer, die Antworten sind immer gleich. Nicht fasten viel trinken".

improved if healthcare professionals had a better understanding of their culture and beliefs (Patient 4-6, 8, 10, 11, 13 – Q6, Q5.2).

From the results of this study, one can see how important it is for healthcare professionals to understand the various cultural beliefs and values of their patients to increase the overall quality of care provided.

5 Conclusion and recommendations

5.1 Main findings

As the world becomes more and more globalized, no matter where one lives, they will be interacting with various cultures from all over the world. In this study, some important cultural differences were found between native German clinicians and Turkish Muslim immigrants that can potentially have an impact on the quality of healthcare provided to the patients. Although it is difficult to measure the level to which the quality of healthcare is affected specifically, it really comes down to the perception of both the doctor and the patient. The doctors in this study did not feel that these findings affected the quality of care given, but the patients felt that they were not always given the best quality of care because of these limitations in understanding their cultural and religious beliefs and values.

One's perception of illness can truly affect the quality of healthcare they are given. As this study found, Turkish immigrants frequently mentioned to their doctor that they had "pain all over". If the healthcare professional is not cognizant of the difference in perception of illness between Germans and Turkish people, they could potentially not find the true cause of their problem (Spallek, Zeeb and Razum, 2010). As mentioned in the study, Turkish people felt more comfortable with a doctor from their own country as they understood them better.

Language barriers caused both doctors and patients challenges when communicating with one another as the majority of the patients spoke Turkish and did not speak German well. If a translator is not used in conjunction with the patient consultation, important information about symptoms and other problems that he or she may be having could potentially be missed, resulting in a misdiagnosis. However, although language barriers may cause challenges in communication, it is much more than just simply language, the patient's cultural beliefs must also be taken into consideration.

Turkish people along with other collectivistic societies often have extended families that are involved with support and the decision making process when one is ill. If

medical professionals bear this in mind, they will not be overwhelmed when they see multiple family members coming with the patient for the consultation or when they have numerous visitors while they are in the hospital. Hospitals, especially, must be prepared for the large families and the large amount of visitors and make contingency arrangements.

As found in this study and many others, Turkish Muslim immigrants long for a sense of security and a strong relationship built on trust. They truly want to avoid uncertainty at all costs and want to feel as though they can trust their doctor and other healthcare professionals.

Communication styles vary no matter what culture you are interacting with, and in this study, German doctors definitely noticed how Turkish Muslims typically communicate in a more indirect fashion often referred to as high-context communication. They speak with many implied messages, sometimes talking around the point. As previously discussed, this could potentially affect the quality of care given if doctors cannot decipher the messages and extract more details about the patient's medical condition, which in the end could lead to a misunderstanding or misdiagnosis.

The patients in this study felt the doctors could have showed more empathy and respect towards their religious beliefs and values. Their perception of the quality of care provided by their doctors would be more positive if more of the doctors showed that they had a general understanding of Islamic beliefs and were able to incorporate this into the consultation. Their level of trust goes up if they feel as though they are more connected with their doctor.

Muslim woman also are quite modest and due to religious beliefs feel very anxious when having to undress or show their intimate body parts to medical professionals. Obviously if they are feeling uneasy, this affects their perception of the quality of care given. They are also very reluctant to talk about sexuality and would prefer to have a female care provider when possible, especially in gynecological cases.

Fasting during Ramadan can also be a challenge for Muslim patients. It was found in this study and several others that many of the patients do not consult their doctors about their medical treatment during Ramadan due to feeling that their physician has a lack of knowledge and understanding, and the patients are often being told that it is unhealthy. In some instances, the patient's health can be severely affected if they alter their medication times or doses such as those who are diabetic or epileptic.

5.2 Limitations and further research

This research has provided some valuable insights into a sensitive and important area of work, however some of the limitations to the study must be acknowledged. Firstly, there was not a lot of previous research done on this particular field of study, so it could not be reviewed in-depth. Secondly, because the sample size was so small, it was only an introductory study and is not a representation of the whole population. Thirdly, the study only involved one doctor who practiced medicine in a hospital setting, which is not sufficient to uncover what is going on at the hospital level. Fourthly, it only looked at the perspective from the doctor and the patient, but did not involve other healthcare staff. And lastly, when interviewing Turkish patients, the interviews were conducted in German, which is not their mother tongue, and they were not able to express themselves properly. Because of this, I feel my data received from the patients was not as rich as it could have been. Even so, the findings frequently support the findings of other research as reported in the review chapter.

In regards to future studies, I would suggest that more in-depth research needs to be done about caring for Turkish Muslim immigrant patients to uncover what their specific needs are to increase their quality of healthcare. Larger numbers of doctors and patients should be interviewed to identify if these occurrences and feelings are consistently happening or if it only occurs in the minority of the immigrant population. More physicians practicing medicine in a hospital setting should be interviewed to gain a better understanding of what is taking place in a large hospital set-

ting where so many more variables are present. Healthcare staff, such as nurses and medical assistants, should be interviewed because they often spend much more time with the patient and their families than the doctor actually does, so they may be faced with more challenges. The interviews with the patients should be conducted in Turkish and a Turkish translator should be present. This allows patients to understand what is being asked of them better and express themselves in much more detail then they were able to in German. It would also be beneficial to interview the interpreters and gather information about where they see cultural misunderstandings are occurring.

5.3 Recommendations

Bearing in mind the above-stated reservations, in answer to the other research questions: "How can we overcome the lack of understanding of the differences between native German medical professionals and Turkish migrant patients and give the patient the most beneficial medical treatment?" and "What kind of further training can be offered to healthcare professionals to increase overall patient care and satisfaction to reduce the amount of risk and the cost of care while enhancing the long-term relationship between the clinician and the patient?", the following initial recommendations were made.

Intercultural communication training should be implemented at several different levels in the healthcare field in not only Germany but internationally; however, it is only in the infancy stages of being introduced to medical professionals. Training will encourage doctors and staff to understand other cultures better, which will enhance the patient's quality of care provided. Many of the doctors that were interviewed agreed that further training would be beneficial, not only to learn more about Turkish people or Muslims, but how to generally approach people of different cultures (Doctor 1, 3, 5, 6-7). In order for it to be effective, it must be applied at several different levels.

First, intercultural communication should be offered in medical school during their clinical communication skills training frequently. The medical students interviewed

in this study, concurred and thought it would help them communicate more effectively in the future with their patients. They said that they were not currently receiving any type of training (Medical Student 1-3).

Secondly, this type of training should be offered to practicing doctors and their staff and must be supported by the management team. However, this is type of training should be ongoing versus just one session. In a hospital setting, much more in-depth, ongoing training should be offered as the complexity of the situations that hospital staff is faced with is much greater. Some hospitals have implemented intercultural training programs and positions that cater to the needs of patients from various cultures; however, this is not the majority. Charite, the medical school and hospital in Berlin, currently offers a two-day continuing education course for physicians twice a year on intercultural competence (Charite, 2013). This is a great start, but much more needs to be done to recognize the need and importance of intercultural communication training in the healthcare field.

The staff should also receive ongoing training as they are often in more contact with the patient then the doctor is. This opens the door for intercultural communication specialists to partner with medical professionals and train them on the basic theory behind IC communication, discuss challenges they have faced, and apply the knowledge they have learned to overcome these problems and increase the quality of healthcare provided to not only Turkish people, but other immigrant patients. As Germany has a large Turkish Muslim population, culture-specific training should also be incorporated. It would also be beneficial to have some Turkish individuals share information about their culture and some of their experiences living in Germany.

Just as medical professionals need training, so do the patients. An IC training program should be offered to the Turkish, as they need to have a better understanding of how the healthcare system is set-up in Germany along with understanding how Germans communicate and perceive illness. Hospitals and other local organizations could create programs to cover these needs of the patients and offer them as often

as needed to meet the demands. This will also create a stronger bond of trust between the medical professionals and their patients as they will now be more informed. Turkish patients who have integrated well into Germany could share their experiences of how they have successfully lived there and how they have learned to communicate more effectively with their doctor. Ethno Medizinisches Zentrum has set-up a program similar to this in Germany and is successfully helping migrants receive better healthcare (EMZ, 2013). However, more of these organizations could be formed to cover a larger amount of the population, which is why it would be beneficial to have more hospitals and larger clinics create these types of training programs.

To increase the overall compliance of taking medical prescriptions while fasting, doctors should receive some further training on the beliefs surrounding Ramadan and how to manage the fasting patient. Medical professionals should encourage their patients to come in for a medical consultation well before they start Ramadan and discuss any chronic medical problems and the medications that they are currently taking to see if anything needs to be adjusted. They could also come in at the end of fasting to either change their medication regimen back or keep their current plan if it proven to be efficacious (Car and Sheikh, 2004, cited in Sadiq, 2008, p. 89). If doctors proactively address this with their patients, the compliance rate will increase, their disease will be managed effectively and Turkish patients will see the overall perception of healthcare professionals more positively.

Another facet that could be implemented more frequently is offering patient education brochures in Turkish to further describe the disease that they may have. More of the doctors could also use anatomical models and pictures to help describe the patient's condition as the visualization can assist with the language barrier (Patient 1-13, Q1.2/2.2)

All of these suggestions will obviously take some time to fully implement, but the first step is to recognize the need for cultural awareness. From there, ongoing training programs created for various healthcare professionals along with hiring care

providers with diverse experience will improve the quality of care for immigrant patients in the long term.

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Appendices

Appendix A: Interview Guide for Doctors

Background information

1. What other cultures do you treat as patients?
2. What percentage of your patients is Turkish? Muslim?
3. What differences do you recognize when interacting with people from another culture?
4. What other culture's values and beliefs are you familiar with?
5. On a scale of 1-10, how much do you know about the Muslim culture?
    a. What do you know about it?
6. Have you read any additional information on the Muslim religion?
    a. If so, what do you know about their values and beliefs?

Situational Questions

7. Tell me about a time when you felt that you had a positive experience with a Muslim patient.
    a. What happened?
    b. What was it that made it such a positive experience?
8. Tell me about a recent story of an incident with a female Muslim patient where you felt that she was absolutely comfortable with you and was able to explain her symptoms in depth.
    a. What made the situation so positive?
9. Case Study:
   "Zara, a 27-year-old housewife from Sudan, attended a follow-up appointment at her local hospital. Her physician was on leave, so she was seen by a locum replacement. On entering the patient's room, the physician extended his hand. Zara politely declined, but failed to give her reasons for doing so. The resulting consultation was tense and dysfunctional."
    a. How would you react in this situation?
    b. How would you recommend handling this case scenario?
    c. Have you had anything similar to this happen?
    d. How did you handle it?
10. Case Study:

"A 54-year-old South Asian man with chronic rheumatoid arthritis, well controlled on daily non-steroidal anti-inflammatory medication, consulted his general practitioner to discuss alternative treatment options for the forthcoming Ramadan period. His GP thought it best to switch to suppositories." The patient failed to use the suppositories as inserting medication rectally would nullify his fast. This resulted in an increase in pain and stiffness." (…should have switched to long-acting oral preparation taken once daily with his largest meal).

    a. How would you recommend treating this case scenario?

b. Have you had anything similar to this happen?
c. How did you handle it?

11. Case Study:

"A patient was admitted to hospital having had a seizure while driving. Prior to this episode his epilepsy had been well controlled on phenytoin 100mg three times daily. Observing the fast of Ramadan, which had commenced only 3 days earlier, he omitted his morning and afternoon doses, on each of the three days." (Recommend single daily dose)

a. What recommendations would you make for a similar patient that was about to participate in Ramadan?

12. How do you prepare patients for Ramadan with diseases such as diabetes, epilepsy, heart condition, etc.?
13. From your experience, describe the challenges doctors face when treating Muslim patients.
    a. What do you recommend to deal with these challenges that are faced when treating Muslim patients?
    b. What would you recommend to improve treatment (or the quality of patient care) for Muslim patients?

Situations specific to Muslims

14. What adaptations do your nurses make to accommodate the shame/honor orientation of your Muslim patients?
15. How do you accommodate a female Muslim patient when she comes in for a medical consultation or surgical procedure?
    a. How do you approach physical contact?
16. How has the high-context or indirect communication style of Muslims impacted your office procedures and protocols?
17. How do you handle delivering the patient's diagnosis when you have the entire family in the room?
18. How do you handle it if you have to translate back and forth with a family member versus speaking directly to the patient?
    a. How do you handle it when it is sensitive information?
19. How do Muslim patients perceive pain?
20. Are precautionary measures taken to make sure that medication with an alcohol base, pig-based insulin or any other medications that have unclean constituents are substituted for other medications?
    a. If so, what is done?

Hospital Setting

21. In a hospital setting, how do you and your staff handle the large number of visitors that come to see the patient?
22. What precautions are taken to cater to the dietary needs of a Muslim patient?
23. What precautionary measures are taken when the patient has to remove their clothes for a medical examination?
24. Is the attempt made to offer same-sex physicians?

25. While they are hospitalized, how is it made possible so that the patient can participate in daily prayers sessions (5x a day)?
26. If a Muslim patient dies in the hospital, are you aware of the procedures/rituals they must perform on the body? If so, what do they normally do?
27. What programs has the hospital created to ensure that patients of different cultures standards of care are met so that they feel comfortable and that they are receiving the quality of care that they expect?

Cultural Sensitivity and Awareness

28. What changes in standards, procedures, and protocols has the European Medical Association (EMS) recommended in the past five years for delivering healthcare across cultures?
29. Do you think doctors need to do anything to increase cultural awareness?
30. What do you recommend one to do to increase their cultural awareness?
    a. Have you done any further training to increase your cultural sensitivity?
    b. If so, what have you done?
31. What sort of steps do you take to inform patients of different cultures about their medical condition? (i.e. provide forms and brochures in their native language)
    a. What sort of information do you provide to them? (Any provided in their native language?)
    b. What type of patient education is offered to them? (If they have acute or chronic problem)
32. Describe to me what you think would help physicians improve the effectiveness of communication between patients of a different culture and themselves, which would benefit the quality of care provided and increase overall patient satisfaction.

Appendix B: Interview Guide for Medical Students

Background

1. How do you feel when interacting with people from another culture?
2. What other culture's values and belief are you familiar with?
3. What other nationalities does your university hospital treat?
4. What percentage of the patients treated at your university hospital are Muslims? Turkish?
5. What differences have you noticed that you need to be aware of when treating Muslim patients?

Situational

1. Tell me about a situation when you witnessed a consultation between a doctor and a Muslim patient where the doctor and patient were not openly communicating.
    a. How did the doctor handle it?
    b. What did he/she do to increase the flow of communication?
2. Tell me about a time when you or the doctor mentoring you did not effectively communicate with a Muslim patient.
    a. What happened?
    b. How did you/doctor improve the situation?
3. Describe a situation in which you/practicing doctor were unable to uncover the exact needs of the patient and could not care for them properly.
    a. What happened?
    b. How was the patient's health affected by it?
4. Tell me about a recent story of an incident with a Muslim patient where you felt that the patient was uncomfortable.
    a. How did you handle the situation?
    b. How did you make them feel more comfortable?
    c. How did you handle it the next time that they came to see you?
5. Tell me about a situation in which the level of risk for the patient was increased due to lack of understanding between you and the patient.
6. Describe to me what you think medical schools could do to better prepare physicians to communicate more effectively with patients of different cultures, which would benefit the quality of care provided and increase overall patient satisfaction.

Training Programs at your Medical School

1. What type of further training courses have you attended to increase your cultural sensitivity?
2. What courses are being offered in your studies to increase your cultural awareness?
3. What kind of intercultural communication training is incorporated into your clinical communication skills training?

Appendix C: Interview Guide for Patients

Background Information
Age:_____
Gender:_____
How long have you lived in Germany?:_____
Nationality (Where did you move here from/where do your parents originate from) _____
What generation are you (1st. 2nd or 3rd) living in Germany?
_____
Which language do you define as your mother tongue?
_____
Religion:_____

Interview Questions:
Please answer the following question in as much detail as you can:

1. Is your doctor you are referring to in the following questions, German or foreign? If not from Germany, where is he/she from?_____
2. How often do you visit your doctor?_____

Situational Questions (Please provide as much detail as you can)

1. Tell me a recent story of an incident with your physician where you had a positive experience. (Please do your best to make it clear what made it positive)
2. Describe a situation when you visited your doctor and you felt uncomfortable and had a negative experience. (Please do your best to make it clear what made it a negative experience)
3. Tell me about a time when you felt the quality of your healthcare was not satisfactory.
4. What challenges do you face to obtain quality healthcare if you visit your doctor in Germany?
5. Describe to me the differences that you see when being treated by your doctor in Germany versus your doctor in your home country. (Please only answer this question if you have moved to Germany from your home country)
6. What are 3 ways that one can ensure that quality healthcare is given to Muslim woman?

Other Questions:

1. What types of services are offered to help you communicate more effectively with your doctor? (Please circle all that apply)
    a. Translators
    b. Staff who speaks your native language
    c. Patient forms in your native language
    d. Patient education brochures in your native language
    e. Patient education tools (pictures, books, anatomic models)
    f. Any other services you would like to mention?

2. What type of patient education does your doctor offer to you?
3. Do you ask your doctor's advice about what to do if you have a medical treatment that might be affected by the requirements of Ramadan?
4. Is he/she able to give you useful advice on your medical treatment during Ramadan? If so, what do they advise you to do during this period of time?
5. In your opinion, what could doctors do to improve treatment for Muslim patients?

Appendix D: Doctor 5 Interview Transcript

Referenced file: C:\\Documents\transcription Suzanne Burlage dissertation\A_Doctor 5.3.26.13.mp3

Speakertable

P

Sex: m

[1]

	0 [00:00.0]	1 [00:02.0]
I [v]	So, first question, what other cultures do you treat as patients?	
P [v]		Mainly Muslim cultures,

[2]

	..
P [v]	Turkish, Arab people but also Chinese is getting more in the last year. South American

[3]

	..
P [v]	People, some African people it is an international mixture but mainly Turkish and Arab.

[4]

	2 [00:04.0]	3 [00:06.3]
I [v]	Uhuh, ok, what percentage would you say is Turkish out of your whole population	
P [v]		

[5]

	..	4 [00:06.8]	5 [00:07.5]
I [v]		And how about Ger-man?	
P [v]	Turkish, hmm, I think more 20, 20 to 25 are Turkish.		German,

[6]

	..	6 [00:07.8]	7 [00:08.1]
I [v]		Ok, stil	
P [v]	more than 50 are Germar		Other cultures and in the last years Spanish people

[7]

	..
P [v]	and when you see Europe as a whole, it is not a different culture. Polish, Berlin has

[8]

	..
P [v]	many Polish, because of that we have many Polish people. Russians are a big part of the

[9]

	..	8 [00:10.5]	9 [00:11.7]	10 [00:11.8]
I [v]		And what percentage would you say is Arab		So 30 percent is
P [v]	people also.		10 I think	

[10]

	..
I [v]	Muslim. Uhm, what differences do you recognize when interacting with people from

[11]

	..	11 [00:15.2]
I [v]	another culture?	
P [v]		The problem is with language and also when they live for a long time

[12]

	..
P [v]	in Berlin. The elder Turkish people, Turkish wives, many of them don’t understand

[13]

	..
P [v]	German and cannot express themselves in German. And therefore, it is often necessary

[14]

	..
P [v]	to get some translator for to make sure. When other problem is the poor education, I

[15]

	..
P [v]	think many of the elder Turkish and Arab people don’t have a good school education so

[16]

	..
P [v]	it is difficult to talk about medical things and to talk about the function of physiology or

[17]

	..	12 [00:20.4]	13 [00:21.2]
I [v]		So how do you handle that?	
P [v]	anatomy		I try to explain it, I try. It’s difficult for people if

[18]

	..
P [v]	the feeling that they have a good education, it is difficult to tell alternatives and say

[19]

	..
P [v]	we can do so or we can do so. And it is difficult to have the participation of the people

[20]

	..
P [v]	in the decision of treatment mostly. It is the expectation that I say how to make the

[21]

	..
P [v]	treatment, people with little education cannot be involved in that, just in small extent.

[22]

	14 [00:25.3]	15 [00:27.4]
I [v]	So then they rely more on their family to help with those decision	
P [v]		Yes, I have the

[23]

	..
P [v]	feeling that these people want simple messages "you have this illness and we have to do

[24]

	..	
I [v]		And
P [v]	so and so." I try not to talk about alternatives. I make sure it’s the one main alte	

	native that I discuss.	

[25]

	..
I [v]	then would you say with more highly educated you would give them more alternatives

[26]

	..	17 [00:32.4]
I [v]	and describe more.	
P [v]		Yes, people that went to school in Germany with education, it's nearly

[27]

	..
P [v]	the same to talk about alternatives and therapy as with German people. I think it's not

[28]

	..	18 [00:34.8]
P [v]	mainly the problem with religion or with cultural sources but with educatior	I think that

[29]

	..
P [v]	sometimes religious problem or cultural problem with the, how to say, the effect about

[30]

	..
P [v]	disease or illness, but it's a problem of education and understanding of the body,

[31]

	..	19 [00:37.1]
I [v]		And on a scale of 1 to 10 how much
P [v]	medical knowledge from school or from parents.	

[32]

	..	20 [00:39.6]
I [v]	would you say you know about the Muslim culture	
P [v]		It's not much, we don't know

[33]

	..
P [v]	Anything. I did not learn anything in school about Muslim culture. It is what I read in

[34]

	..
P [v]	combination with some medical practices, what I read in papers or journals. The

[35]

	..
P [v]	information is not specific medical information but information in the media, I look, I

[36]

	..	21 [00:42.6]
I [v]		So would you say on a 1 to 10 how much you know, 3 4 somewhere
P [v]	Read, I hear to.	

[37]

	..	22 [00:44.7]
I [v]	there	
P [v]		I don’t know, the fundamental things, but about Ramadan, but with its 4 weeks

[38]

	..
P [v]	every year, that they have to take care of Ramadan, and then the other, it’s not all Muslim

[39]

	..
P [v]	Woman, about 50 percent, cover their hair. So you must be careful to avoid the scarf, not

[40]

	..	23 [00:47.9]
I [v]		So you have to take
P [v]	to make some painful, with touch, they would not blame the women	

[41]

	..
I [v]	specific care and make sure to be careful with contact and that you have permission.

[42]

	24 [00:49.	25 [00:49.6]
I [v]		How do you handle in your practice, I mean are a lot of them on chronic
P [v]	uhuh	

[43]

	..
I [v]	therapy where you have to worry about treatment during Ramadan, do you have many

[44]

	..	26 [00:54.8]
I [v]	of those patients to worry about?	
P [v]		I don't I treat many chronic diseases, but its with

[45]

	..
P [v]	diabetes, epilepsy, heart conditions that are with Ramadan. But I don't have that problem.

[46]

	..
P [v]	I have very few chronic diseases and if you need the medication, I can handle it

[47]

	..
P [v]	saying "take it in the evening or in the morning". And with acute illnesses that they have

[48]

	..
P [v]	to take antibiotics, I try to find an antibiotic some anti-allergy medication that is also

[49]

	..
P [v]	necessary when Ramadan is in summer or spring. I try to find therapy that is only

[50]

	..

P [v]	necessary once or twice a day, and people are not in conflict with Ramadan. If not, I try to

[51]

	..
P [v]	explain that every Muslim does not harm himself because of Ramadan if it is necessary

[52]

	..
P [v]	to have medical treatment. It is allowed by religion to interrupt Ramadan and to continue

[53]

		27 [01:02.9]
	..	
I [v]		OK good. And these are some more
P [v]	Later, and I try to help with such an explanatio	

[54]

	..
I [v]	situational. Tell me about a time when you had a positive experience with a Muslim

[55]

		28 [01:07.9]
	..	
I [v]	patient, what happened and what made it a positive experienc	
P [v]		Umm, a positive

[56]

	..
P [v]	experience, umm sometimes its not concrete, one person, but sometimes the people if they

[57]

	..
P [v]	are show how they express and how they present the problems, sometimes I have the feeling

[58]

	..
P [v]	that it is the little education that it is not possible to explain much and sometimes it is a

[59]

	..
P [v]	situation that it is not this image and people of whom I thought they had very little

[60]

	..
P [v]	education can better understand what I want to explain and therefore it is also better co-

[61]

	..
P [v]	operation in therapy. Those are the positive moments, when I think someone has little

[62]

	..
P [v]	education and I see he has more education than I supposed and I can better explain what

[63]

	..	29 [01:14.7]
I [v]		And so you found with lets say less educated and
P [v]	to do and I have better co-operation.	

[64]

	..
I [v]	Turkish who fall into that categorization, that if you lets say simplify things you get

[65]

	..	30 [01:19.1]
I [v]	better understanding	
P [v]		I think, if its less education I have to give simple answers and

[66]

	..
P [v]	simple explanation, and if it is better education I can give more different explanations.

[67]

	31 [01:20.7]
I [v]	And how do you go about determining if they are less educated in the very beginning,

[68]

	..	32 [01:24.1]
I [v]	I mean are you asking what they.	
P [v]		I mean I am not, I don't ask this. I think it would blame

[69]

	..
P [v]	the people if I ask these questions like can you write, can you read. I don't ask. But I see

[70]

	..
P [v]	the reaction if I explain, I see the reaction and I see if they understand or don't

[71]

	..
P [v]	understand my explanation, therefore I give more simple explanations more simple

[72]

	..
P [v]	devices until I have the feeling that my simple messages are understood. But I don't use

[73]

	..	33 [01:28.5]
I [v]		OK, sure. And can you tell me about a recent story of an
P [v]	any questions about education,	

[74]

	..
I [v]	incident with a female Muslim patient where she felt that she was absolutely

[75]

	..	34 [01:33.8]
I [v]	comfortable with you and was able to explain her symptom?	
P [v]		There was this Turkish

[76]

	..
P [v]	woman with carcinoma (?) in the Larynx (?) and it was difficult to find out, it took a

[77]

	..
P [v]	long time to find out and she needed two operations. But she got a recurrent

[78]

	..
P [v]	carcinoma (?) and the second operation it was necessary to operate the larynx, to

[79]

	..
P [v]	remove the larynx completely and it was difficult for her to get used to this situation,

[80]

	..
P [v]	and there was a long time that she needed help by nurses at home to deal with the

[81]

	..
P [v]	situation, but with some time, some months she learned how to handle the situation. Now

[82]

	..
P [v]	she is by herself and can manage everything she does not need any help, so that is a

[83]

	..	35 [01:40.9]
I [v]		And what were
P [v]	positive result in regard of this severe decease that she had to overcome	

[84]

	..	36 [01:43.1]
I [v]	some of the problems she had to deal with, obviously like speech	
P [v]		She had the fear after

[85]

	..

P [v]	the removal of the larynx, you have an external opening of the trachea (?) and it is

[86]

	..
P [v]	necessary to get the cannula to keep it open and to protect against dirt to get in and to

[87]

	..
P [v]	prevent dryness of the trachea and she, the first time se was afraid to take out the cannula

[88]

	..
P [v]	and she needed someone to support but now she can do it herself, she has overcome

[89]

	..	37 [01:47.4]	38 [01:48.2]
I [v]		And that took about how long	
P [v]	her fear and now she does not need external help		It was

[90]

	..
P [v]	bout 8 months 9 months. I don’t remember exactly it took nearly a year to get this far.

[91]

	39 [01:49.1]	40 [01:50.9]
I [v]	And the nurses that were helping her were they German, Turkish	
P [v]		I don’t know, she got

[92]

	..
P [v]	it from the hospital the nurses. Mostly in the main service are German nurses, but I see

[93]

	..	41 [01:52.3]
P [v]	more Turkish nurses in homecare	I think this is a good case study, this woman who

[94]

	..
P [v]	learned to deal with her severe decease and now she if fine and she is here for control

[95]

	..	42 [01:54.2]
I [v]		How did you guys go about making her feel
P [v]	and she is well now despite of her disease	

[96]

	..
I [v]	comfortable with everything, the process how did you make her feel comfortable, was

[97]

	..	43 [01:58.7]
I [v]	it mainly up to the nurses or.	
P [v]		Umm, I talked with her and sometimes her son. Her son

[98]

	..
P [v]	accompanied her to the examination. I tried to explain and also some of my employees

[99]

	..	44 [02:00.7]
I [v]		Alright, here is just another
P [v]	the nurses to help the patients to get her more self-reliant	

[100]

	..
I [v]	kind of case study, just a short one, so there is Zara she is housewife from Sudan, she

[101]

	..
I [v]	attended to follow up an appointment at the local hospital, her physician was on leave so

[102]

	..
I [v]	she had to be seen by another doctor, on entering the patients room the physician

[103]

	..
I [v]	extended his hand and Zara politely declined but failed to give her reasons for doing so.

[104]

	..
I [v]	The resulting consultation was tense and dysfunctional. So how would you react to this

[105]

	..	45 [02:14.4]
I [v]	particular situation	
P [v]		I think if there is hesitation to shake hands, I don't have to shake

[106]

	..
P [v]	hands, it is not a problem. Its also one of the points like the covering of the hair and not

[107]

	..
P [v]	to give hands by some women. But it is not, the further treatment does not depend on

[108]

	..
P [v]	this. I see to it actually if I offer my hand and she does not take it, I will take it back and

[109]

	..	46 [02:18.2]
I [v]		Would you say when you started out in medicine and
P [v]	make greeting by words and signs.	

[110]

	..
I [v]	you started seeing these different kind of cases did it catch of guard of by surprise at

[111]

	..	47 [02:22.3]
I [v]	all	

P [v]		In the hospital, I have been with many Muslim and Turkish patients, and it was

[112]

	..
P [v]	nothing to think about much. I think it is the right of everybody to give hands or not to

[113]

	..
P [v]	give hands, but it does not influence anything in treatment or in how to meet a patient or

[114]

	..	48 [02:25.1]
I [v]		Yes it is funny this was a case in a 'how to treat Muslim patients
P [v]	how to deal with them.	

[115]

	..
I [v]	' or something, so it has happened several times. The other ones I have are more GP kind

[116]

	..
I [v]	of stuff so... From your experience describe challenges doctors face in treating Muslim

[117]

	..	49 [02:32.2]
I [v]	patients	
P [v]		One problem is there are not related to Muslim patients at all, I see many difference I

[118]

	..
P [v]	see Turkish, Arab or Lebanese patients and some, its parallels to Christian patients. Its

[119]

	..
P [v]	not a homogenous group. Sometimes cultural, some main point is with European thinking

[120]

	..
P [v]	you have some partial view on disease and function. I think in Muslim thinking,

[121]

	..
P [v]	they see themselves as a whole and if there is a certain disease or illness, it inflicts the

[122]

	..
P [v]	whole person; therefore, I think there is more fear of some disease. I think it is more

[123]

	..
P [v]	resignation of what they can do by themselves so that is more difficult with Muslim

[124]

	..
P [v]	patients. And with European patients or American, it is better to say you have a disease,

[125]

	..
P [v]	but it is one problem and it does not affect you as a whole. You do things by your

[126]

	..	50 [02:40.7]
I [v]		So how do you go
P [v]	self, that is easier. But I think it is also a problem of education.	

[127]

	..
I [v]	about, when you are trying to understand and diagnose a problem, and they tell you they

[128]

	..
I [v]	hurt all over, how do you go about trying to pinpoint and finding out what is going on.

[129]

	51 [02:46.1]
P [v]	I try to see what is the first sign and to differentiate, to see if it is a regional or a

[130]

	..
P [v]	complete problem. When a greater problem, at this point, I think it is kind of a

[131]

	..
P [v]	depression mainly in Turkish or Arab women that expresses itself with headache or

[132]

	..
P [v]	sore throat and dizziness. That is a big problem and I could not resolve. That is not an

[133]

	..
P [v]	organic problem. That is a big difficulty, and I think it is also a problem with

[134]

	..
P [v]	Gynecology, German practitioners, to open their mind for thinking about depression or

[135]

	..	52 [02:51.5]
I [v]		Then when you start feeling that they are maybe depressed, is
P [v]	psychological problems.	

[136]

	..	53 [02:55.5]
I [v]	there a way that you are able to steer them towards seeking that kind of help	
P [v]		I try to

[137]

	..	54 [02:55.9]	55 [02:56.6]
I [v]		Yes because it is tricky	
P [v]	talk about, to think about (?)		Neurological problems and to have

[138]

	..
P [v]	a way. It’s not something that I can handle, but I try to open the mind to think for other

[139]

	..
P [v]	reasons, not only organic reasons and to see if it is possible to make a treatment by a

[140]

	..
P [v]	neurologist or psychiatrist. I try to open the things to recognize this. Sometimes I have

[141]

	..
P [v]	the impression that it is possible to do so, mostly it is Turkish women who have these

[142]

	..
P [v]	Problems. Sometimes in the next consultation, they get treatment against depression

[143]

	..
P [v]	and they could open themselves for this kind of problem and for therapy of this

[144]

	..	56 [02:59.5]
I [v]		Would you say that this is mainly Turkish women who came her 30-40 years
P [v]	problem.	

[145]

	..	57 [03:02.7]
I [v]	ago or is it generation after generation?	
P [v]		I think it is not a problem of generation, no

[146]

	..

P [v]	children or teenagers but a problem of grownup Turkish women, younger or elder

[147]

	..	58 [03:04.2]
I [v]		Ok alright and anything else you would recommend just
P [v]	women there are no difference.	

[148]

	..	59 [03:07.7]
I [v]	to improve the treatment and quality care for these Muslim patients	
P [v]		That what I told in

[149]

	..
P [v]	the beginning, it is a support for doctors and medical staff, what are the main themes of

[150]

	..
P [v]	religion and what art the taboos not to talk about and to be careful, and that we are

[151]

	..
P [v]	working in a medical department and need some fundamental information about religion

[152]

	..
P [v]	and about some imaginations to avoid such problem with giving the hand. Conflicts

[153]

	..
P [v]	with not giving the hand, not shaking the hand. What is also, to have an impression

[154]

	..
P [v]	about the imagination, what is the reason of a disease or sickness is it some punishment

[155]

	..
P [v]	for wrong living or is it a functional problem in the body. Sometimes it is useful to have

[156]

	..	60 [03:14.4]
I [v]		Ok, and what
P [v]	this information to see how people deal with diseases and illnesses	

[157]

	..
I [v]	would you say what adaptation do your nurses do to accommodate to the shame and

[158]

	..
I [v]	honor orientation of Muslim patients, so when they come in with the headscarf, how

[159]

	..	61 [03:20.1]
I [v]	does everyone accommodate?	
P [v]		We except this in my practice, we except this, and we try

[160]

	..
P [v]	to work without touching their hair and without shaking hands, and in most cases this is pos ble. I

[161]

	..
P [v]	remember one, I think not Turkish but Arab woman, and she had a sore throat. I

[162]

	..
P [v]	had to look in the mouth, and she had to take off the scarf. It was a problem for her, and

[163]

	..
P [v]	she asked for the address of a female colleague in the neighborhood, and we gave her

[164]

	..
P [v]	the address of a female colleague. I remember only one woman who had these problems.

[165]

	62 [03:24.	63 [03:24.9]
I [v]	OK,	
P [v]		But it was not the problem with the official religion of this person with covering

[166]

	..
P [v]	the face and not showing to me as a doctor, it’s not, I think it’s not Islam itself who makes

[167]

	..	64 [03:27.3]
I [v]		And have
P [v]	these rules, but it’s what makes the woman itself of her religious imaginations	

[168]

	..
I [v]	you had many challenges when women are coming to you I mean cause you are always

[169]

	..	65 [03:31.5]
I [v]	Commented on touch and all that, but just in communicating with	
P [v]		Mostly they don’t talk

[170]

	..
P [v]	about this, but I can see the action if they take the hand to the body and not... if they I

[171]

	..
P [v]	say "hallo" and they say "hallo" like this with a cross here on the breasts, than I see it’s ok

[172]

	..

P [v]	not to give the hand. And then for me it’s not a big problem because women don’t have

[173]

	..
P [v]	to take off the clothes for the examination. (??) if the care is (?) its mostly we can, that I

[174]

	..
P [v]	can manage or she can manage, that she can take off one ear and I can make the

[175]

	..	66 [03:36.8]
I [v]		And how
P [v]	treatment in the ear. It’s a little more complicated, but no fundamental problems.	

[176]

	..
I [v]	has the high context or indirect communication style of say Turkish, Arab people

[177]

	..
I [v]	impacted your procedures in the office, so in protocols and when you are speaking back

[178]

	..	67 [03:42.4]
I [v]	and forward with them.	
P [v]		I think its not fundamentally different. I try to watch the reaction,

[179]

	..
P [v]	but it’s not a problem of Turkish or Muslim patients also if there are other people who

[180]

	..
P [v]	are not speaking German or with a few German. I have to explain these little words and

[181]

	..
P [v]	simple thoughts. Sometimes perhaps Asian people it is possible to talk in English, with

[182]

	..
P [v]	Spanish people and South American people it is often possible to talk in English or with

[183]

	..
P [v]	people from North Africa it is also often possible to talk in English in French. But

[184]

	..	68 [03:48.1]
I [v]		How do
P [v]	French is bigger problems, French is my problem not a problem of my patients	

[185]

	..
I [v]	you handle delivering a patient's diagnosis when you have the entire family in the room

[186]

	..	69 [03:52.4]
I [v]	like most of them have, multiple family members that come	
P [v]		If it’s some systemic

[187]

	..
P [v]	Problem, it’s no problem to talk about with the family. If it’s more psychological

[188]

	..
P [v]	Problems, I don’t want to talk about this with the whole family. I try to make another

[189]

	..
P [v]	appointment and to see if perhaps with husband or perhaps one son or daughter to talk

[190]

	..
P [v]	about, that nobody is blamed by talking about this with a greater audience in the

[191]

	..	70 [03:56.0]
P [v]	background.	And if its some systemic problem its no problem to talk about before the

[192]

	..	71 [03:56.8]
I [v]		How do you handle it when you have to translate back and forward with a family
P [v]	family.	

[193]

	..	72 [04:00.5]
I [v]	member, versus just speaking to the patient directly	
P [v]		umm, it’s a problem. I sometimes

[194]

	..
P [v]	say one sentence, and they talk many sentences. I have sometimes the impression

[195]

	..
P [v]	that they talk about other things, not the things I said. If I get a short answer after a long

[196]

	..
P [v]	Talk, I try to watch the reaction in the face of the patient and to have some message that I

[197]

	..
P [v]	can find in the words, but it’s a problem. I had one Turkish employee and sometimes

[198]

	..
P [v]	patients wanted to sit down with them, and it was a problem. I had my questions it was

[199]

	..
P [v]	a long talk and I got a short answer and I did not know what they talked about. In many

[200]

	..
P [v]	situations it was not helpful to have a Turkish nurse because I did not understand their

[201]

	..	73 [04:06.9]
I [v]		So you feel like maybe something is being left out, lost in translation,
P [v]	communication.	

[202]

	..	74 [04:09.8]	75 [04:	76 [04:10.9]
I [v]	not getting the full story	You don’t do operations at all, do you?		ok. lets skip that
P [v]			no.	

[203]

	..
I [v]	part. And I know we discussed this a little bit but do you think doctors need to do

[204]

	..	77 [04:15.0]
I [v]	anything to increase cultural awareness?	
P [v]		I think yes. It's, I think, it's because of

[205]

	..
P [v]	Globalization. It’s really increased with international operating concerns, and it’s necessary

[206]

	..
P [v]	at least in Berlin and bigger cities to have some fundamental explanations of cultures.

[207]

	..

P [v]	Not only Muslim and Arab, also Chinese, people of India or Indonesia. Sometimes

[208]

	..
P [v]	there are some differences in culture between Germans and Austrians and German and

[209]

	..	78 [04:19.4]
I [v]		And what do you
P [v]	Spanish people, there can be misunderstanding also with all Euro ans.	

[210]

	..	79 [04:21.2]
I [v]	recommend for one to increase their awareness?	
P [v]		I think it's some education, by the

[211]

	..
P [v]	Doctor's organization for all physicians. An organization for all doctors in all Berlin

[212]

	..
P [v]	or some region. I think it would be the best if they come with some information, also

[213]

	..
P [v]	some information by external teachers to give some fundamental information about

[214]

	..
P [v]	other cultures. That would make it easier for everyone for themselves to increase their

[215]

	..
P [v]	knowledge and to go in terms of culture, (?) especially information. Medical board, the med cal

[216]

	..	80 [04:26.0]	81 [04:27.4]
I [v]		Have they done anything like that, that you know of?	
P [v]	for Berlin.		I don’t, not

[217]

	..
P [v]	fundamental, there are some in the paper of Erste kamer (??) there are some articles about

[218]

	..
P [v]	cultural differences. I can’t remember I had an offer for some conference or seminar or

[219]

	..
P [v]	information in the greater (?) for this, it’s hidden. Some articles or some special groups,

[220]

	..	82 [04:30.4]
I [v]		Besides some of the reading and stuff that you mentioned
P [v]	smaller groups of physicians.	

[221]

	..
I [v]	that you have done, have you done anything else, or anything else that you do try to

[222]

	..	83 [04:35.2]
I [v]	increase your sensitivity	
P [v]		At university, I did not learn anything about cultural

[223]

	..
P [v]	differences. I think nowadays it is necessary to give also some information at the

[224]

	..

P [v]	university for students. If you are younger, you can remember it better, you can learn

[225]

	..
P [v]	Easily. If you have been working for some years, it is more difficult to remember new

[226]

	..	84 [04:38.8]
I [v]		And this part is
P [v]	information. That’s a demand at the universities to give informatio	

[227]

	..
I [v]	about when you are informing patients about their medical condition, are you like for

[228]

	..	85 [04:43.7]
I [v]	forms or brochures or any of that provided in their native language	
P [v]		Almost nothing, I

[229]

	..
P [v]	try to explain. Mostly it’s... it’s a must to give an explanation on how to take the

[230]

	..
P [v]	Medication, and how to take care for special time, what to do, what not to do. But some

[231]

	..
P [v]	chronic illnesses I try to give information with pictures and with few text. And the best

[232]

	..	86 [04:47.2]
I [v]		Have
P [v]	is to have self-explaining pictures, they are independent from text and language.	

[233]

	..
I [v]	you had any incidents where you had a really negative experience with say Muslim

[234]

	..
I [v]	patient where something you just felt went bad because of miscommunication and

[235]

	..	87 [04:52.3]	88 [04:52.4]
I [v]	misunderstandings		Have there been any incidents where you had a negative
P [v]		What?	

[236]

	..	89 [04:55.1]
I [v]	experience treating a Muslim patient	
P [v]		Umm, sometimes it’s a problem if it’s by younger

[237]

	..
P [v]	Muslims, higher aggressiveness. If they have any demands and I cannot fulfill their wishes

[238]

	..
P [v]	and demands, they get more aggressive. That can be a conflict situation. But it is more in

[239]

	..
P [v]	young Muslims. Or if there are many patients and a younger man has to wait and is

[240]

	..
P [v]	angry about waiting. It isn’t often, but sometimes we have conflict about such situations.

[241]

	90 [04:58.9]	91 [05:00.4]
I [v]	And how do you go about dealing with such situations	
P [v]		I try explain that it’s not a

[242]

	..
P [v]	confrontation from myself that they have to wait, but it's caused by the situation that

[243]

	..	92 [05:02.1]
I [v]		anything else that you can
P [v]	there are many people and many patients who need treatment.	

[244]

	..	93 [05	94 [05:03.2]
I [v]	thing of		Ok good I think that's pretty much it, unless there are other instances or
P [v]		no	

[245]

	..	95 [05:06.3]
I [v]	stories that you would like to share.	
P [v]		What I said at the beginning that I try to give some

[246]

	..
P [v]	information at times to develop some information based on religion and culture. Its

[247]

	..
P [v]	a good thing, what we get as information, some written or painted information we get

[248]

	..
P [v]	from pharmacy and they make this in their own interest but its difficult to get this

[249]

	..
P [v]	information in Turkish language. Its even difficult to get the information in English and

[250]

	..
P [v]	there are some independent organizations that develop this information. Its a good idea

[251]

	..	96 [05:11.2]
I [v]		Do you think doctors would support the idea of bringing people in to do like
P [v]	to do so.	

[252]

	..	97 [05:13.8]	98 [05:13.9]
I [v]	staff training		Cause I think, like my idea is to deal with the whole practices
P [v]		I think so.	

[253]

	..
I [v]	because I think everyone deals. And its not just Muslims or anything like that, its just

[254]

	..	99 [05:20.3]
I [v]	the cultural whole and if you can just learn the interpersonal part of it.	
P [v]		Yes, it’s necessary

[255]

	..
P [v]	to sometimes if there are problems with patients, when they have to wait, if the

[256]

	..
P [v]	communication outside at the desk is not good and there is a conflict. The conflict does

[257]

	..
P [v]	also influence me and my treatment, so like you said, it is good that everybody knows

[258]

	..	100 [05:23.1]
P [v]	about this.	Its also, there is also a problem with the assistance in practice mostly are

[259]

	..
P [v]	women and it’s sometimes difficult get some respect from young Muslim men, because

[260]

	..
P [v]	they think they are women and they are the servants and not some, don’t have the equal

[261]

	..	101 [05:26.0]
I [v]		Anything else that you know that
P [v]	are not respected by the men and that is sometime problem.	

[262]

	..	102 [05:28.4]
I [v]	your staff faces when it just comes to other cultures	
P [v]		This problem with the respect that

[263]

	..
P [v]	mostly it’s the men that they don’t. If it’s rather sure, the women outside tell, and I tell the

[264]

	..
P [v]	same it is more accepted if it is the doctor and the man, they accept its easier, they don’t

[265]

	..	103 [05:30.9]
I [v]		So if you could help them overcome that part of it.
P [v]	accept it when my assistance tells it.	

[266]

	104 [05:32.4]	105 [05:32.5]	106 [05:33.6]
I [v]		No but just sometimes. Ok sounds good.	
P [v]	It’s not always.		

Appendix E: Medical Student 2 Interview Transcript

Referenced file: C:\\Documents\transcription Suzanne Burlage dissertation\A_Med Student 2.3.9.13.mp3

Speakertable

P

Sex: m

[1]

	0 [00:00.0]	1 [00:02.0]
I [v]	How do you feel when interacting with people from another culture?	
P [v]		How I feel about

[2]

	.. 2 [00:04.0]	
I [v]	Yes, just how do you feel when interacting with people from different cultures?	
P [v]	it	

[3]

	3 [00:06.4]
P [v]	Umm, In general it is really interesting. And also in my semester there are a lot of

[4]

	..
P [v]	people from different countries so a lot of different cultures and also Islamic people. It

[5]

	..
P [v]	is really interesting what they are telling me about their culture, and also the attitudes

[6]

	..	4 [00:41.0]
I [v]		What are
P [v]	they have about life. You can see the differences also it is really interesting	

[7]

	..

I [v]	some of the stories that they have told you, or what you have seen that is different.

[8]

	5 [00:43.8]
P [v]	Well basically, the most different between us. I cannot really say one certain thing that

[9]

	..
P [v]	is really like the most different between us. Ummm, like in medical school I just notice the

[10]

	..
P [v]	Norwegian people they do not (?) at all…?

[11]

	..
P [v]	Yes, so, the Norwegian

[12]

	..
P [v]	people seem to be more honest in some way. Some of the Islamic people we have, they

[13]

	..
P [v]	really like to argue to be honest. If they have an attitude to something, they will stick to

[14]

	..
P [v]	that attitude. They are starting a lot of discussions that are also interesting in class.

[15]

	..
P [v]	Because sometimes they disagree with something that the teachers says for example,

[16]

	..
P [v]	then some people will just sit there and just think like “whatever, I have my own opinion

[17]

	..	6 [02:08.5]
P [v]	about that", but they would start a discussion for sure,	And, well, so that is not really

[18]

	..	7 [02:15.2]
I [v]		No but that is just about different cultures, that it is
P [v]	based on patient contact you know.	

[19]

	..	8 [02:16.9]
I [v]	ok.	
P [v]		Yes, but it is funny that some of the Islamic people here, because probably in their

[20]

	..
P [v]	country the rules are so different, and they are really interested in how it works dating

[21]

	..
P [v]	girls for example. So, if for example German or a Norwegian guy knows the line, know

[22]

	..
P [v]	where you should stop, where it is kind of getting rude for example, they sometimes don

[23]

	..
P [v]	't really know, For example, one guy has asked me every single day if I want to go to

[24]

	..
P [v]	Switzerland for vacation, or if I want to go to this or that city for vacation. And I said,

[25]

	..

P [v]	when will you stop that? And he said I am a man, I will never stop. So you can see

[26]

	.. 9 [03:19.6]	
I [v]		Yes interesting, so he is asking you on vacation even though you
P [v]	differences there too.	

[27]

	.. 10 [03:22.4]	
I [v]	have not dated or anything.	
P [v]		no, nothing at all. But he won't stop, I know that he won't

[28]

	..
P [v]	stop. It's probably like, it hurts him that I as a girl not dating him even though he is

[29]

	.. 11 [03:41.3]	
I [v]		alright, what would you say, what other
P [v]	asking me. His honor and pride is broken.	

[30]

	..
I [v]	cultures, their values and beliefs, which ones are you familiar with? You know, say the

[31]

	..
I [v]	Norwegians or the Islamic. You know, another culture that you know about and that you

[32]

	.. 12 [03:44.6]	
I [v]	feel comfortable with.	
P [v]		I have actually met so many different cultures now that I cannot

[33]

	..
P [v]	really, I mean every culture is a little bit different, some are closer to your own cultures

[34]

	..
P [v]	and some are a little bit more far away. And probably since the Western cultures are

[35]

	..
P [v]	very similar it is more normal that you feel more comfortable with cultures from the

[36]

	..
P [v]	Western part and from the Eastern part it is more in some way more exotic to you. But I

[37]

	..
P [v]	mean, still I don't feel uncomfortable you know, it is just that you learn more and you

[38]

	..
P [v]	find more differences in some way. When I went for example, I want for an, I had a

[39]

	..
P [v]	Jewish boyfriend for just a couple of months and I visited him in Tel Aviv and I really

[40]

	..
P [v]	felt comfortable with his family, but the differences between cultures are huge. But

[41]

	..
P [v]	on the other hand, when you hang out with young people at a party then you don't really

[42]

	..	13 [05:16.1]
I [v]		What were some of
P [v]	notice the differences. It is more about the family stuff you know	

[43]

	..	14 [05:17.6]
I [v]	the differences within the family in Israel.	
P [v]		The differences in Israel, well there are some

[44]

	..
P [v]	that are really, really, really religious. And they were actually living in parts where they

[45]

	..
P [v]	were trying to occupy new ground, you know. Because of the Torah and stuff. But

[46]

	..
P [v]	the parents they love their sons really a lot so they were celebrating the Shabbat every

[47]

	..
P [v]	weekend with them, and really trying to do everything in the traditional way of the

[48]

	..
P [v]	Torah, to let them also stay over at their house for Shabbat, because you have to

[49]

	..
P [v]	follow certain rules to do that. And so you could just see that the family was living so

[50]

	..
P [v]	much together. I think in Western cultures, some but not all, for example German, but I

[51]

	..
P [v]	also think US, and I don’t know about Spanish cultures or something like that, but I feel

[52]

	..
P [v]	that the family connection is not that close anymore as it maybe was a 199 years ago or

[53]

	..
P [v]	something like that. And I think that in some other cultures, for example like Islamic

[54]

	..
P [v]	cultures and stuff like that, the value of the family staying together is higher. So I think

[55]

	..	15 [07:00.4]
I [v]		I know that you have not spend much time yet in the hospital setting
P [v]	I noticed that there.	

[56]

	..
I [v]	in your school, but do you know what other nationalities are they typically treating

[57]

	..	16 [07:04.4]
I [v]	there, in Poland	
P [v]		Well, in Poland the nationality is Polish, for sure. Because here

[58]

	..
P [v]	actually in Szczecin it is not really multicultural. Except for the exchange students.

[59]

	..
P [v]	But for example we have two black people in our semester and they are still, they don't

[60]

	..
P [v]	like black people. Except for the exchange students for example. And in Berlin that was

[61]

	..
P [v]	totally different, our hospital was a Christian hospital, and because it was south of Berlin,

[62]

	..
P [v]	there were not a lot of other cultures around that hospital, so we did not really treat so

[63]

	..
P [v]	many people from other cultures, but we had two patient with an Islamic background.

[64]

	17 [08:04.3]
P [v]	One little short story was actually that this Muslim patient, he was maybe like 54 years

[65]

	..
P [v]	old. He was really strict about not eating pork. One day I remember we did not have any

[66]

	..
P [v]	other sausages for breakfast anymore than pork, and since the doctors, and to be honest

[67]

	..
P [v]	there was a lot of stress that they…and they were like just tell hem that it isn't pork and

[68]

	..
P [v]	he won't notice. So actually, I think that that was not really good treating of other

[69]

	..
P [v]	cultures. Because, I think, if that guy does not want to eat pork, then you should not give

[70]

	..
P [v]	him pork and tell him that it is not. But I think, sometimes, doctors are, since they learned

[71]

	..
P [v]	the whole anatomy of the body and stuff like that, they probably have more the

[72]

	..
P [v]	impression like it does not matter to your stomach if you eat pork or something else. So,

[73]

	..
P [v]	I don't get it, and I don't really accept it in some way you know. But sometimes doctors

[74]

	..	18 [09:40.3]
P [v]	are not very sensitive, for example with rules like that. That is my impression.	And the

[75]

	..
P [v]	other story was that we had this one Muslim, young guy, he was like 18 years old, and

[76]

	..
P [v]	he had some kind of surgery. After the surgery for one day, he was not supposed to

[77]

	..
P [v]	eat and he should not drink for some hours, and his family should not visit him

[78]

	..
P [v]	Immediately as he should take his rest. If you eat something, your stomach, because of

[79]

	..
P [v]	Narcotics, your stomach could feel bad and you can throw up and stuff. And that is

[80]

	..
P [v]	what I was telling you about the families staying together. So the Islamic family could

[81]

	..
P [v]	not handle the situation of not visiting him right away because they are sticking so much

[82]

	..
P [v]	together. And so I think like 20 people, his family, his mother, I think like 10 brothers or

[83]

	..
P [v]	something, they were visiting right after the surgery even though the doctor said not to

[84]

	..
P [v]	do that. And they brought him a lot of food and stuff. He was drinking and eating right

[85]

	..
P [v]	after the surgery and hanging out with his family, and in the evening he was throwing

[86]

	..
P [v]	up like hell. So because, you know he just did not want to listen to what the doctors told

[87]

	..
P [v]	him, I think it was also some kind of cultural thing in some way, but it was kind of

[88]

	..	19 [11:35.9]	20 [11:36.8]
I [v]		And how did the doctors handle that?	
P [v]	funny though I think,		Actually everybody, the

[89]

	..
P [v]	doctors and the nurses, we were laughing private because we were like “we told him” so

[90]

	..	21 [11:51.0]
P [v]	we were just laughing actually	But we did not tell him because that would have been

[91]

	..
P [v]	rude to tell him like “we told you”. We just gave him something against being sick in the

[92]

	..	22 [12:06.1]
I [v]		Have there been any other differences that you noticed when you are treating
P [v]	stomach.	

[93]

	..	23 [12:09.7]
I [v]	Muslim patients than when you are treating let’s say “Western” patients?	
P [v]		Hmm, I got the

[94]

	..
P [v]	impression that they are concerned also about their physical privacy. Because if you

[95]

	..
P [v]	are caring for an old German person, probably first you would not feel comfortable by

[96]

	..
P [v]	his body being cleaned by another person, for example, but he would get used to that

[97]

	..
P [v]	really soon I think. With the German patients I did not notice that they had problems

[98]

	..
P [v]	with physical contact, and body contact at all. And sometimes I was thinking like, don't

[99]

	..
P [v]	you feel a little bit ashamed you know. And for example this guy, he was like 50 years

[100]

	..
P [v]	old or something. That guy, he didn't want to have really physical contact in some way,

[101]

	..
P [v]	especially with the women working there. I think that was also part of the religion in

[102]

	..
P [v]	some way. So maybe you should not approach them like maybe other patients because

[103]

	..
P [v]	you think like that is my normal job, I am doing that every day. You should also have in

[104]

	..	24 [13:43.2]
P [v]	mind that maybe the religion, the culture is different.	On the other hand it was kind of

[105]

	..	25 [13:53.7]
I [v]		And anything
P [v]	funny, because in the speech they sometimes were really flirty. So. yes.	

[106]

	..
I [v]	that you, you know just felt uncomfortable with when treating them. Were you allowed

[107]

	..	26 [13:57.8]
I [v]	to wash them, or how did they handle that part of it? The Muslim patients	
P [v]		No they try

[108]

	..
P [v]	to do it themselves, or they asked family members to help them. The only thing I think I

[109]

	..
P [v]	was a little uncomfortable with, also now with that guy in my class, I feel

[110]

	..
P [v]	uncomfortable with people being too flirty. I have the impression that in their culture

[111]

	..
P [v]	they just handle that different, you know. And I would say that in my culture, the guys

[112]

	..
P [v]	or the men they have other rules about flirting. Sometimes they would not just say

[113]

	..
P [v]	things that go too far in some way. You know like that guy asking me for vacation every

[114]

	..
P [v]	single day. And also in the hospital I got the impression that they were more a little bit

[115]

	..	27 [14:59.8]
I [v]		And to the point that you really felt uncomfortable, that they were really trying to
P [v]	flirty.	

[116]

	..	28 [15:02.9]
I [v]	make advance or just like a friendly flirty.	
P [v]		Umm, probably for them it wasn't that serious,

[117]

	..
P [v]	for them it was like come on I am just flirting but I really felt uncomfortable then.

[118]

	..
P [v]	Because I did not really learn in my life how to respond to that you know. I learned not

[119]

	..
P [v]	to hurt another person and being too rude, but on the other hand here I was in a situation

[120]

	..
P [v]	where I felt like I had to be rude to make clear that I don’t want that. And so it is kind

[121]

	..
P [v]	of like tearing you apart you know, in how you have to respond. That makes me

[122]

	..	29 [15:56.0]
I [v]		Ok, Tell me about a situation
P [v]	uncomfortable and that made me uncomfortable yes.	

[123]

	..
I [v]	where you witnessed a consult between a doctor and a patient in which the doctor and

[124]

	..
I [v]	the patient were not openly communicating. I don't know if you have had any of those

[125]

	..	30 [16:02.3]	31 [16:03.6]
I [v]	incidents where you saw that as well between doctors and patients.		ok, And
P [v]		No not really	

[126]

	..
I [v]	this is more if you actually had a doctor mentoring you, You have not had that yet, so.

[127]

	32 [16:05.9]
I [v]	Describe a situation in which you and the practicing doctor were unable to uncover the

[128]

	..
I [v]	exact needs of the patient and could not care for them properly. Did you ever come

[129]

	..	33 [16:10.6]
I [v]	across something like that?	
P [v]		No I think the only situation I already told you is with the

[130]

	..	34 [16:20.1]
I [v]		Tell me about a situation in which the level of risk for
P [v]	guy that did not want to eat pork.	

[131]

	..
I [v]	the patient was increased due to lack of understanding between you and the patient.

[132]

	..	35 [16:24.4]	36 [16:26.5]
I [v]	Again, I don't know if you have had....		Describe to me what you
P [v]		Hmm, no actually not.	

[133]

	..
I [v]	think medical schools could do better to prepare you guys to communicate more

[134]

	..	37 [16:30.1]
I [v]	effectively with patients of different cultures.	
P [v]		In my school, I am having a psychology

[135]

	..
P [v]	class right now, where we learn to interact with patients. But it is more about like, for

[136]

	..
P [v]	Example, telling them, breaking bad news, for example. This really helps, because we

[137]

	..
P [v]	learn about theories and about certain steps you would have to do to do that. But we

[138]

	..
P [v]	Don’t really learn about the different cultures, and maybe that could be included as well

[139]

	..
P [v]	in some way. Because also the Muslim guy, who is always discussing, he is also always

[140]

	..
P [v]	discussing about that, and maybe in his culture you would tell that in a different way.

[141]

	38 [17:25.5]	39 [17:33.5]
I [v]		what does
P [v]	Not all the situations, but some things, you would tell that different probably.	

[142]

	..
I [v]	he say, when you guys are doing the breaking bad news thing, does he bring examples

[143]

	..	40 [17:36.9]
I [v]	or so about how it would be handled differently.	
P [v]		I don't really have an example about

[144]

	..	41 [17:42.2]	42 [17:42.5]
I [v]		That's ok.	In your theory class where you do the breaking the bad news
P [v]	that right now.		

[145]

	..	43 [17:45.7]
I [v]	and that kind of stuff, so you do the theory and then do you do role-plays?	
P [v]		Yes, we do

[146]

	..
P [v]	Role-plays. So first we are going through the theories, and then everybody is holding a

[147]

	..
P [v]	presentation about a different topic, and after that, we do role-plays about that. So for

[148]

	..
P [v]	Example, we had a role-play where 10 pairs had to show how they would tell a patient

[149]

	..
P [v]	that they had diabetes, for example, a type that you have for the rest of your life. So first,

[150]

	..
P [v]	we learned the theories, and then the fake doctor tries to use that theory in the role-play

[151]

	..
P [v]	and afterwards we discuss with every pair if he did the theory good and what they could

[152]

	..
P [v]	do better. And the psychologist, she sits right next to that and sometimes she interrupts,

[153]

	..
P [v]	and she says like for example, “a word like that, I would not use because it has too much

[154]

	..	44 [18:58.9]	45 [19:00.1]
I [v]		And how long is that class? Is it just this semester?	
P [v]	negative value”.		Yes it is only one

[155]

	..	46 [19:02.9]
I [v]		Ok, and do you have any other communication classes in semesters to come?
P [v]	semester.	

[156]

	47 [19:03.0]
P [v]	We had also sociology, but only for four weeks. And basically, we were doing the same

[157]

	..
P [v]	thing with a different teacher. But it is interesting because even though the topics are

[158]

	..
P [v]	kind of similar, I mean they are focusing on different stuff sometimes, so it is also really

[159]

	..	48 [19:3	49 [19:30.8]
I [v]		ok.	
P [v]	interesting.		I think that will be basically the only topics about communication.

[160]

	..
P [v]	But that is why in Berlin they remodeled the medicine studies because then the students

[161]

	..
P [v]	will start from the first semester with working in the hospitals and I think they do that

[162]

	..
P [v]	because first because of learning by doing and second because they get the patient

[163]

	..
P [v]	contact from the beginning, that they learn to communicate not only by one psychology

[164]

	..	50 [20:14.7]	51 [20:15.7]
I [v]		Yes, and they just changed that recently?	
P [v]	class, but by doing it.		Yes, I think the modern

[165]

	..
P [v]	medicine studies, that's how they call it, they started that 3 year ago but parallel to that

[166]

	..
P [v]	the other medicine school was also offered, and it was only a small class of the modern

[167]

	..
P [v]	medicine studies. And this year they changed that, you can only do the modern

[168]

	..	52 [20:51.5]
I [v]		And so in
P [v]	medicine classes in Berlin. And I think in two other cities in Germany as well.	

[169]

	..	53 [20:53.3]	
I [v]	Poland, will do you more about the psychology or is this about it?		ok. So
P [v]		That's about it.	

[170]

	..	55 [20:56.9]
I [v]	they bring in actors at all? or is it just you guys role-playing with each other?	
P [v]		We are

[171]

	..	56 [21:02.1]
I [v]		So they don’t have actors coming in playing
P [v]	Role-playing. the psychologist is watching it.	

[172]

	..	57 [21:03.3]
I [v]	patients.	
P [v]		No but we were doing a good job I think. Because some pairs did not do a good

[173]

	..
P [v]	job and you could see some communication problems. And some pairs are really

[174]

	..	58 [21:23.5]
I [v]		Because I know that in England and also a
P [v]	really good so they are kind of the role model.	

[175]

	..
I [v]	lot in the US and maybe in the new program in Berlin, they do a lot with the actors,

[176]

	..
I [v]	and they have people that are actually paid in these situations to act the whole thing out.

[177]

	..
I [v]	So they are the patient and you have to figure out how to since you don't have all the

[178]

	..	59 [21:31.6]	60 [21:34.5]
I [v]	background so that is really interesting.		Yes and then
P [v]		Wow that sounds really cool.	

[179]

	..
I [v]	they do the dummies but they breath and bleed and die. Do you guys do any of that

[180]

	..	61 [21:37.0]	62 [21:37.6]
I [v]	kind of stuff?	Like simulated patients?	
P [v]			No, we don't. may be, I mean we do nursing right

[181]

	..
P [v]	now, first aid, we are learning how to do injections, and we are just using each other.

[182]

	63 [21:51.1]	64 [21:52.	65 [21:52.6]
I [v]	You don’t have a dummy, you have each other..		In all those discussions in
P [v]		yes.	

[183]

	..
I [v]	psychology and sociology they have not brought up anything on cultures or

[184]

	..	66 [21:55.3]	67 [21:57	68 [21:57.3]
I [v]	interpersonal?		ok.	
P [v]		Only interpersonal.		But as I told you, probably, even though it

[185]

	..
P [v]	sounds funny because there are so many people from different cultures at the university

[186]

	..
P [v]	here. But still in the team there are no people from other cultures, so in the hospital they

[187]

	..
P [v]	don't really see the need to do that I guess. So that's why we don't have any classes on

[188]

	..	69 [22:29.2]
P [v]	that.	

Appendix F: Patient 1 Interview Translated in English

Background Information

Age:____45_____
Gender:__Female_____
How long have you lived in Germany?__Since 1992_____
Nationality (Where did you move here from/where do your parents originate from) __Turkey_____
What generation are you (1st. 2nd or 3rd) living in Germany? _____1st generation_____
Religion:__Muslim_____

Interview Questions:
Please answer the following question in as much detail as you can:

1 Is your doctor of German descent? If not where is he/she from?_____Yes_____
2 How often do you visit your doctor?___1-2 times every 3 months _____

Situational Questions (Please provide as much detail as you can)

1 Tell me a recent story of an incident with your physician where you were not able to effectively communicate.

I went to see my gynaecologist because I have been involuntarily childless for several years. He wanted to prescribe potency (fertility?)-enhancing pills to me all the time. However, I had to explain to him somehow that this wasn't the problem. Only after a while I found out about the existence of fertility centers through friends and about the fact that there were problems with my ovaries.

2 Describe a situation when you visited your doctor and you felt uncomfortable and could not openly communicate.

I felt very uncomfortable describing my situation in the scenario mentioned above. Furthermore, the doctor was lacking in concentration and seemed as if he did not really want to take time for me.

3 Give me an example of an incident where your physician was unable to uncover your needs and treat your symptoms effectively.

No answer

4 Tell me about a time when you felt the quality of your healthcare was affected due to the lack of cultural understanding from your doctor.

No answer

5 Give me some examples of what you see as the cultural differences between you and your physician.

No answer

6 Describe to me the differences that you see when being treated by your doctor in Germany versus your doctor in your home country. (Please only answer this question if you have moved to Germany from your home country)

For me it's basically the language barrier that didn't exist in my native country. It is an indescribably dreadful feeling if you put a lot of effort into describing something and your vis-a-vis simply doesn't understand or doesn't show enough patience.

Other Questions

1 What types of services are offered to help you communicate more effectively with your doctor (Translators, staff who speaks your native language, patient education tools, any other services you would like to mention)?

Of course, there are translators in bigger hospitals, but as I live in a rather rural area, I have never had the good fortune of consulting a translator. Until now there were only brochures for information, but obviously I can't talk to those.

2 What type of patient education does your doctor offer to you?

None. If there is Turkish-speaking staff, they are usually annoyed, as everyone approaches them with their problems and as they already have quite a large workload.

3 Are patient handouts and information provided in your native language?

Yes, usually there are.

4 Do you ask your doctor's advice about what to do if you have a medical condition that might be affected by the requirements of Ramadan?

I have to admit that I have never really asked about it in detail, but when I went to see a doctor during Ramadan he only told me to drink plenty (of water).

5 Is he/she able to give you useful advice on your medical treatment during Ramadan? If so, what do they advise you to do during this period of time?

For instance, we're told over and over again that fasting in unhealthy, but no alternatives are presented to us and no support in the form of suggestions is offered.

6 In your opinion, what could doctors do to overcome some of the challenges they face when treating patients with different cultural backgrounds?

Doctors should really take some time and stop making me feel like a second-class-patient just because I don't speak German that well. They should also try to understand why some subjects, like sexuality, are touchy for us. Moreover, I have realized and have become aware of the fact that many people with a migration background have long been suffering from mental illness but can't find a Turkish-speaking psychiatrist.

Ethics Application Form

UREC REGISTER

UREC publishes a list of approved projects on the University intranet, which is searchable by all staff and students of the University. The entry for each project comprises the following data:

- project title
- funding body (if appropriate)
- duration of project
- date and expiry of ethics approval
- name of researcher

Inclusion on this list is a condition of ethics approval, unless the Committee is informed of compelling reasons for an exemption. If you wish to request that your information is withheld, please tick the box below and state the reasons for your request.

☐ **I do not wish my project details to be included on the UREC list for the following reasons:**

Please indicate that you are enclosing with this form the following completed documents:

XX☐ Participant consent form ☐ Participant Information Sheet

XX☐ Summary of the research

Signed *Suzanne M. Burlage* Date 15/01/13

Cum

I support this application:

Signed 22.01.13 Date

Title ~~Supervisor~~

***applications not countersigned by a supervisor/project director will not be accepted; please note that this applies equally to members of staff who are also students**

PU!

Appendix H: Ethics Checklist Form

5.5 ANGLIA RUSKIN UNIVERSITY

5.6 ETHICS REVIEW CHECKLIST FOR RESEARCH WITH HUMAN PARTICIPANTS

Date 08.12.10. V1.0

Name:	Suzanne M. Burlage	**SID:**	1128894

Title of Research Project:	An evaluation of the impact of cultural differences between Muslim patients and German clinicians on the quality of healthcare given.

Faculty:	Art, Law and Social Sciences	**Supervisor(s):**	Dr. Anne Ife

Type of research: *Tick all that apply*	☐ Undergraduate X☐ Taught postgraduate ☐ Research degree ☐ Member of staff ☐ Other

If you have answered **NO** to *all* the above questions, you do not need formal ethics approval. You do, however, need to submit this checklist signed and dated to the relevant Faculty Research Ethics Panel (FREP) Administrator prior to starting your research.

If you have answered **YES** to *either* or *both* Questions 1 and 2, you need to submit an application, including this checklist, to your FREP.

If you have answered **YES** to Question 3, you need either to submit your application to your FREP or an NHS Research Ethics Committee (REC), even if the study does not

involve the NHS. Please seek further advice if you are unsure about which committee it needs to be submitted to.

If you have answered **YES** to Question 4, you need to seek approval from an NHS REC, even if your study does not involve the NHS.

If you have answered **YES** to Question 5, you need to obtain approval from:

a. Both an NHS REC and the NHS Trust(s) where you are carrying the research

out (R&D Management Approval) *or*

b. The Local Research Governance Group (Social Services).

Please note that you must send a copy of the final approval letter(s) to:

Beverley Pascoe, RESC Secretary, Research, Development and Commercial Services.

Additional information:

Applicant's signature:	Suzanne M. Burlage	**Date:**	15/01/13

Supervisor's signature:		**Date:**	22.01.13

<u>All materials submitted to RESC/FREP will be treated confidentially</u>.

Appendix I: Information Sheet for Doctors

5.7 PARTICIPANT INFORMATION SHEET

An evaluation of the impact of cultural differences on the quality of healthcare provided by German clinicians to Turkish Muslim patients.

Purpose and value of study:

This study will explore the ways in which cultural differences between Muslim patients and German clinicians can potentially affect the quality of health care given. I would like to learn about your experiences when treating Muslim patients, what percentage of your patient population is Muslim, what challenges you have faced and what have you done to make yourself more culturally aware of patients of different cultures. I would also like to know if you have done any further training to improve your clinical communication skills when it comes to interacting with patients from a different culture. The results of this survey will be published in my Master Thesis.

Contact for further information:

Suzanne Burlage
Anglia Ruskin University
Faculty of Arts, Law and Social Sciences, Helmore 354
East Road
Cambridge CB1 1PT
Email: Suzanne.Burlage@anglia.ac.uk
+44 1223 363271 ext. 2089

You are invited to participate in an interview and discussion in a group of 5-7 people. During the interview, you will be asked several questions about your involvement in treating Muslim patients, what challenges you have faced and what have you done to make yourself more culturally aware of patients of different cultures. You will also be invited to give your opinion on how doctors could overcome some of the challenges faced when treating patients with various cultural backgrounds.

You can refuse to take part and you can withdraw at any time. If you agree, but you change your mind, fill in the bottom part of the "Participant Consent Form" and send/give it to the researcher. Your data will then be destroyed.

If you agree to take part, you need to read the Participant Information Form – the one you are reading right now – and fill in the Participant Consent Form. Then the researcher will contact you and will set up an appointment to interview you.

Your participation in the project will be kept confidential; no real names will be mentioned in the study, thus no one will be able to identify you. Any information/data that are collected from you will be stored on a computer that is password protected.

Appendix J: Information Sheet for Medical Students

Anglia Ruskin University
Cambridge & Chelmsford

5.8 PARTICIPANT INFORMATION SHEET

An evaluation of the impact of cultural differences on the quality of healthcare provided by German clinicians to Turkish Muslim patients.

Purpose and value of study:
This study will explore the ways in which cultural differences between Muslim patients and German clinicians can potentially affect the quality of health care given. I would like to learn about your experiences when treating Muslim patients, what percentage of patient population is Muslim at the medical school you attend, what challenges you have faced and what courses are offered at the university to make you more culturally aware of patients of different cultures. I would also like to know if the university is offering any further training to improve your clinical communication skills when it comes to interacting with patients from a different culture. The results of this survey will be published in my Master Thesis.

Contact for further information:

Suzanne Burlage
Anglia Ruskin University
Faculty of Arts, Law and Social Sciences, Helmore 354
East Road
Cambridge CB1 1PT
Email: Suzanne.Burlage@anglia.ac.uk
+44 1223 363271 ext. 2089

You are invited to participate in an interview and discussion in a group of 5-7 people. During the interview, you will be asked several questions about your involvement in treating Muslim patients, what challenges you have faced and what the university has done to make you more culturally aware of patients with different cultural backgrounds. You will also be invited to give your opinion on how doctors could overcome some of the challenges faced when treating patients of various cultures.

You can refuse to take part and you can withdraw at any time. If you agree, but you change your mind, fill in the bottom part of the "Participant Consent Form" and send/give it to the researcher. Your data will then be destroyed.

If you agree to take part, you need to read the Participant Information Form – the one you are reading right now – and fill in the Participant Consent Form. Then the researcher will contact you and will set up an appointment to interview you.

Your participation in the project will be kept confidential; no real names will be mentioned in the study, thus no one will be able to identify you. Any information/data that are collected from you will be stored on a computer that is password protected.

Appendix K: Information Sheet for Patients

5.9 PARTICIPANT INFORMATION SHEET

An evaluation of the impact of cultural differences on the quality of healthcare provided by German clinicians to Turkish Muslim patients.

Purpose and value of study:

This study will explore the ways in which cultural differences between Muslim patients and German clinicians can potentially affect the quality of health care given. I would like to learn about your experiences when being treated by a native German doctor, what challenges have you faced when communicating with the doctor about your medical case, what could the doctor have done differently and what have you learned about the differences between German clinicians and you. I would also like to learn about how doctors in your home country differ from native German doctors. The results of this survey will be published in my Master Thesis.

Contact for further information:

Suzanne Burlage
Anglia Ruskin University
Faculty of Arts, Law and Social Sciences, Helmore 354
East Road
Cambridge CB1 1PT
Email: Suzanne.Burlage@anglia.ac.uk
+44 1223 363271 ext. 2089

You are invited to participate in an interview and discussion in a group of 5-7 people. During the interview, you will be asked several questions about your interaction with native German doctors when attending a medical consultation, what challenges have you faced and how could the doctor have handled the consultation to make you feel more comfortable. You will also be invited to give your opinion on how doctors could overcome some of the challenges faced when treating patients with different cultural backgrounds.

You can refuse to take part and you can withdraw at any time. If you agree, but you change your mind, fill in the bottom part of the "Participant Consent Form" and send/give it to the researcher. Your data will then be destroyed.

If you agree to take part, you need to read the Participant Information Form – the one you are reading right now – and fill in the Participant Consent Form. Then the researcher will contact you and will set up an appointment to interview you.

Your participation in the project will be kept confidential; no real names will be mentioned in the study, thus no one will be able to identify you. Any information/data that are collected from you will be stored on a computer that is password protected.

Appendix L: Consent Form for Participants

5.10 PARTICIPANT CONSENT FORM

NAME OF PARTICIPANT:

Title of the project:

An evaluation of the impact of cultural differences on the quality of healthcare provided by German clinicians to Turkish Muslim patients.

Main investigator and contact details:

Suzanne Burlage
Anglia Ruskin University
Faculty of Arts, Law and Social Sciences, Helmore 354
East Road
Cambridge CB1 1PT
Email: Suzanne.Burlage@anglia.ac.uk
+44 1223 363271 ext. 2089

1. I agree to take part in the above research. I have read the Participant Information Sheet which is attached to this form. I understand what my role will be in this research, and all my questions have been answered to my satisfaction.

2. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice.

3. I have been informed that the confidentiality of the information I provide will be safeguarded.

4. I am free to ask any questions at any time before and during the study.

5. I have been provided with a copy of this form and the Participant Information Sheet.

Data Protection: I agree to the University[12] processing personal data, which I have supplied. I agree to the processing of such data for any purposes connected with the Research Project as outlined to me.

Name of participant
(print)……Signed……..…Date……

Name of witness
(print)……..Signed……..…Date……

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP

[12] "The University" includes Anglia Ruskin University and its partner colleges

---

If you wish to withdraw from the research, please complete the form below and return to the main investigator named above.

Title of Project:

An evaluation of the impact of cultural differences on the quality of healthcare provided by German clinicians to Turkish Muslim patients.

6 I WISH TO WITHDRAW FROM THIS STUDY

Signed: _____ Date: _____