CULTURAL ISSUES FOR ETHNIC MINORITY MUSLIM PATIENTS IN MEDICAL INTERPRETATION

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Dedication

I dedicate this thesis to my mother.

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ABSTRACT

This thesis addresses the issue of cultural gaps in medical interpretation for ethnic minority patients in the UK. The study considers the various roles of the interpreter in health care (HC) settings. It aims to explore the advocate role of the interpreter. It also looks at the significant role of the interpreter's visibility to highlight and interpret some cultural concerns which may impact the patient's health and HC quality. Interpreters are the bridge of language communication. The research engages with Muslim patients and discusses their concerns when receiving treatment from HCPs. The research also involves HCPs who do not share the same cultural backgrounds as their patients.

The thesis addresses issues related to Muslim patients' experiences in HC. It highlights differences in religious and cultural backgrounds and how they may impact LEPs' adherence to medical treatment and appointments. The thesis discusses specific experiences of both HCPs and HCUs, using these to shed light on some issues related to cultural difference and the interpreter's role in resolving miscommunication between the HCP and the HCU. This thesis finishes by discussing possible future research directions.

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List of Abbreviations

ASTM	American Society of Testing Materials
BBC	British Broadcasting Corporation
CCHP	Cross Cultural Health Programme
CHIA	California Healthcare Interpreting Association
CI (s)	Community Interpreter(s)
F2F	Face to face interpreting
HC	Health care
HCP(s)	Health care provider(s)
HCS	Health care service
HCU(s)	Health care user(s)
ITIA	The Irish Translator and Interpreter Association
LEP	Limited English proficiency
NCEIHC	National Code of Ethics for Interpreters in Health Care
NCIHC	National Standard of Practice for Interpreting in Health Care
NHLP	National Health Law Programme
NHS(s)	National Health Service(s)
NRPSI(s)	National Register of Public Service Interpreter(s)
NSPIHC	National Standards of Practice for Interpreters in Health Care
PSI	Public service Interpreting
RI	Remote Interpreting
SU(s)	Service User(s)
TAIM	Traditional Arabic Islamic Medicine
TRI	Telephone Remote Interpreting

CHAPTER ONE

INTRODUCTION, BACKGROUND TO THE STUDY

1.1 Introduction to the Study

The large number of immigrants to the UK has increased the demand for interpretation services in the country for ethnic minority patients receiving treatment in hospitals and general practices (Bischoff, 2003). In the United Kingdom, as per the 2011 census, the Muslim population was 2,516,0004, 4% of the total population. Arabs accounted for 240,000 usual residents (0.4 per cent of the population). The census does not give any information about what proportion of Arabs usually resident in Britain are Muslims, and what proportion other religions. Given that the vast majority of Arabs in the Arab world are Muslims, it also seems clear, however, that the majority of Arabs in Britain are Muslims. This thesis focuses only on first-generation Arab Muslims who speak little or no English. Despite the easy access to interpretation services and the awareness of the crucial role of the interpreter, miscommunication can still occur. Managing a mistake may require acknowledging the underlying cause of the error. In order to overcome an error within an organisation, we have to be aware of the safety procedures, 'detect the triggers', and have the urge to change (Reason and Hobbs, 2003).

It has been argued that the existence of language and cultural barriers between HCPs and ethnic minority patients could result in ineffective communication, which may lead to adverse clinical outcome (Flores, 2005; Ralph et al., 2017) such as patients' declining the treatment,

which could consequently lead to death (Coroners Court Alice Springs, 2010), accepting an operation without knowing what it involves (Mitchell et al., 2016), misperception and disappointment (Anderson et al., 2008; Cass et al., 2002), extending the period of hospitalisation, and making hasty decisions such as seeking to leave the hospital despite the doctor's advice (Henry et al., 2007; Einsiedel et al., 2013).

While immigrants encounter challenges in adapting to the new 'host' culture with their own culture (Berry, 1990). HCPs face challenges in dealing with patients having various languages, religious beliefs, and cultural backgrounds. This can result in HC disparities. One of the keys to reducing these differences is to increase cultural competence (Padela and Punekar, 2008, p.69).

'Cultural competence' is defined as a "set of congruent behaviours, attitudes, and policies that comes together in a system, agency, or amongst professionals and enables them to work effectively in cross-cultural situations" (Cross et al., 1989, p.13). Betancourt and Green highlight the importance of cultural competence training to reduce patients' disparities and improve HCS:

> cultural competence training should be evaluated in a stepwise fashion by using the tools of health services research and the principles of quality improvement, and it should be held to the same standards as other educational interventions and activities. Just as medicine strives to meet other challenges in U.S. health care, so should it focus on developing the skills needed to care for the country's diverse population (Betancourt and Green, 2010, p.583).

According to some researchers, training in this aspect can positively impact "knowledge, attitudes, and skills" of HC professionals working with ethnic minority patients (Beach et al., 2005). Therefore, providing culturally competent HC by accommodating health care users'

(HCUs) cultural and religious beliefs can help to minimise ethnic disparities in HC (Brach, 2000). Thus, highly qualified "intercultural communication" between HCPs and patients with limited English proficiency (LEP) could promote HCS, resulting in the correct diagnosis and the patient's adherence to the treatment (Wheeler and Bryant, 2017, pp.1-11).

The HCP utilises the interpreting service to facilitate complicated medical communication (Howe et al., 1998; Cass et al., 2002). The effective use of a professional interpreter can facilitate efficient communication which can positively influence understanding, "uptake" of HC, which consequently leads to satisfactory clinical results (Flores, 2006; Karliner et al., 2007; Flores, 2005). It is postulated that: if you wish to help a community improve its health, you must learn to think like the people of that community (Paul, 1955). Before asking a group of people to assume new health habits, it is wise to ascertain the existing habits, how these habits are linked to one another? what functions they perform? and what they mean to those who practise them? (ibid)

This thesis will discuss the challenges confronted by HCUs while receiving HC in the UK. It will address the most commonly issues faced by Arab Muslim patients in medical consultations. It will explore the causes of miscommunication. Attum and Shamoon (2018) point out in order to provide quality HCS to Muslim patients, it is required to have "an understanding of the differences in cultural and spiritual values. Important differences include diet, ideas of modesty, privacy, touch restriction, and alcohol intake restriction" (ibid, p.1).

Religious values are associated with cultural practices and limitations that shape patients' beliefs towards health and illness, impact expectations from the HCPs influence compliance to the HCP's advice, guide medical decision-making, and affect clinical results (Johnson et al., 1999; Geertz, 1983). Practising religion and adhering to its rules can have an impact on our

health; both spiritually and physically. It also influences the patient's health behaviours, coping strategies, and attitude towards health and illness (Koenig, 2009).

This thesis will provide an insight into how the cultural gaps between HCUs and HCPs, along with the interpreter's use of literal interpretation, could reduce trust between the patient and the HC worker, which could negatively impact on clinical results. Although, most HCPs encourage interpreters to use the linguistic model in interpretation (Gadon et al., 2007; Hsieh, 2008). The linguistic model in interpretation is also called the 'translation machine' model, in that interpreters are viewed as invisible participants – mere converters of the spoken message from one language into another without distorting that message (Bot, 2007, p.82). Various models of interpretation which are of relevance to this thesis will be discussed in chapter 4.

The interpreter's role can trigger miscommunication due to cultural clashes between HCPs and their ethnically and religiously diverse patients. This research will explore the importance of adopting the advocate model of interpretation in certain situations. The advocate model involves staying emotionally neutral while interpreting and offering to interpret any cultural concerns which may impact the patient's safety (Butow et al., 2012; Prentice et al., 2014). This role will be discussed in detail in chapter (4). This thesis will illustrate some cases where the interpreter's use of the advocate model could provide better quality HCS.

1.2 Aim of the Study

This research addresses how cultural difference between HCPs and patients may lead to ineffective communication. It focuses specifically on Arabic-speaking Muslim patients.

This research is inductive. Trochim (2006) differentiates between inductive and deductive approaches as follows: while the former means starting from 'the specific' and moving to the

'general', the latter starts from the general and ending up with 'specific' results. Inductive research is recommended when the research is based on 'experience' or 'observation'. Deductive research is advised when the argument relies on 'laws' and 'rules'. Creswell and Plano-Clark (2007) argue that in deductive research the researcher "works from the 'top down', from a theory to hypotheses to data to add to or contradict the theory" (ibid, p. 23). The inductive method is where the researcher works from the "bottom-up, using the participants' views to build boarder themes and generate a theory interconnecting the themes" (Creswell and Plano-Clark, 2007, p. 23). Despite disagreements among researchers as to the best method to use when conducting research these methods may in some cases be equally useful in addressing the same question, the only difference being the starting points.

In considering how cultural difference between HCPs and patients may lead to ineffective communication, we may note that both patients with limited English and English-speaking HCPs struggle to overcome gaps in communication. Nowadays, HCPs book a professional interpreter to facilitate effective communication with patients. However, most HCPs request the interpreter to act as a language modifier. By using the linguistic model in interpretation, the interpreter only interprets words from the source language into the target one. Communication without explaining cultural values to each of the HCP and the patient can result in some problems such as extending the recommended consultation time, frustration, patient's non-adherence to treatment plans, poor clinical outcomes, and consequently lower quality HCS. It has been argued that:

> quality healthcare outcomes depend upon patients' adherence to recommended treatment regimens. Patient nonadherence can be a pervasive threat to health and wellbeing and carry an appreciable economic burden as well. In some disease conditions, more than 40% of patients sustain significant risks by

> misunderstanding, forgetting, or ignoring healthcare advice. While no single intervention strategy can improve the adherence of all patients, decades of research studies agree that successful attempts to improve patient adherence depend upon a set of key factors (Martin et al., 2005, p.189).

In this research, we argue that interpreting in a health context does not only imply the exchange of words from one language into another. Rather interpretation is to build a constructive bridge of communication between the HCP and the patient it is crucial to interpreting culture and as well as language. There are a few occasions where interpreting culture is unnecessary, and in some situations, cultural misinterpretation could result in serious outcomes.

The main aim of this research is to provide an analysis of current issues in relation to interpreting which impact LEPs. It is hoped that these will provide information which can be used to improve the interpretation service for LEPs. This can be achieved by encouraging HCPs to use the advocate role of the interpreter when required.

1.3 Background and Significance of the Study

During the last few decades, the UK has faced a rapid increase in immigration. It rose from 329,000 per year in 1991 to 630,000 in 2017 (Sturge, 2018, p.7). According to official UK migration statistics, net immigration was estimated at 282,000 immigrants for the year by the end of December 2017 (Sturge 2018, p.11). Hence, the UK has became increasingly multicultural, multi-religious, and multilingual.

Muslims are subject to religious restrictions, which could impact their medication intake and their general welfare. Some members of these communities follow religion, culture, or

tradition blindly without recognising the difference between the three categories. This research will focus on Arab Muslim patients, and will address their religious and cultural concerns.

Due to a lack of education, awareness and knowledge and the use of some unqualified and untrained medical interpreters, some ethnic minority patients may not receive an optimal treatment or an accurate diagnosis. Proper communication plays a significant role in overcoming diversity disparities hence the importance of conducting this research.

Cultural and religious issues put extra pressure upon the patients as well as national health services (NHS). Therefore, this aspect needs to be researched in depth to lessen the pressure upon HCPs such as GPs and hospitals. Cultural gaps between patients, interpreters and HCPs could create communication barriers. The interpreter can play a crucial role in improving HCS.

1.4 Background of the Researcher

The researcher has practised as a public service interpreter (PSI) in the UK since 2009. She has been registered with many interpretation agencies such as the Bigword, Language Empire, and ITL in Newcastle-Upon-Tyne, United Kingdom. In her work, she has been confronted with several challenging situations and has realised the complexity of HC interpreting and the issues faced by Arab Muslim patients in the United Kingdom. This motivated her to conduct an in-depth study to identify the gaps between Muslim patients, HCPs and interpreter's role with a view to helping overcome both linguistic and cultural barriers.

1.5 Research Questions

This thesis seeks to answer the following general research questions:

- To what extent is cultural awareness crucial in caring for LEPs?
- What are the steps the UK took to improve the interpretation service, and have they been successful?
- How can the advocate model help the interpreter to build effective communication in HC?
- What are the possible consequences of lack of cultural awareness of Muslim HCUs, and who is responsible for this lack of awareness?

1.6 Theoretical and Conceptual Issues

Theoretical frameworks are designed to enable researchers to apply methods of obtaining and analysing data more clearly, precisely, and coherently. Theoretical frameworks are also lenses through which researchers can interpret the meaning of their data and explain the findings to others. In this thesis, the researcher considers the interpreter and the interpretation process in the light of four possible interpreter orientations: conduit, cultural broker, cultural clarifier, and cultural advocate. The conduit role requires the interpreter to use his/her language skills only in transferring the message. The cultural broker (cultural facilitator), cultural clarifier and cultural advocate roles require the interpreter's interference and his/her use of cultural knowledge to resolve any cross-cultural issues in HC settings (Kaufert and Koolage, 1984). These roles will be discussed further in chapter (4).

This study explores the interpreter's role in making communication more effective. Historically, interpreters have been considered as language "experts", or "linguistic conduits". In HC, this provides an operating conceptual framework within which the interpreter adheres to the National Code of Ethics for Interpreters in Health Care (NCEIHC) to the National Register

of Public Service (NRPSI). Interpreters have to adhere to 'neutrality'. The HC interpreter in the UK accordingly has to be 'impartial', 'neutral', 'invisible' and a 'conduit' (NRPSI, 2011). Neutrality in interpretation is defined as being 'unbiased' with 'non-involvement' (Janzen and Korpiniski, 2005, p. 188). A neutral party in a dialogue is defined as "one who does not take sides, offer opinions, or show bias" (Roy 2000, p. 105).

The community interpreter's (CI) role has often been debated. The issues of 'invisibility' and 'multiple roles' have been controversial, because of "the complexity of human interactions CIs face in their daily work, whether in the legal, medical or public service encounters" (Arocha, 2005, p. 2). This research highlights the significance of the medical interpreter's advocacy role on behalf of the patient and the HCP, in order to improve the quality of HC in general. The researcher draws on from Claudia Angelelli's *Revisiting the Interpreter's Role: a study of conference, court, and medical interpreters* (2004). In this book, Angelelli succeeds in showing that the interpreter plays a "powerful" role in interpreting (ibid, p. 98). The interpreter can contribute to improving the HCS. Angelelli explores the interpreter's role as a communication facilitator through acting as a bilingual and bicultural agent in overcoming the language and cultural barriers to communication (ibid, p. 19). Brach et al. (2005) state that effective communication can play a pivotal role in facilitating communication and building an undisputable relationship between the HCP and the HCU. It has been stated that the enhanced "quality of communication between patients and clinicians can have a major impact on health outcomes" (Brach et al., 2005, p.424).

This study is also guided by Marjory A. Bancroft's "A profession rooted in social justice" (2015) wherein Bancroft defines the interpreter's role in resolving cultural miscommunication to protect the patient (ibid, pp. 217-231). This study is also enlightened by Uldis Ozolins' "Ethics and the role of the interpreter" (2015) in Holly Mikkelson and Renee Jourdenais'

Routledge Handbook of Interpreting (2015), where Ozolins discusses the interpreter's active roles in the HC setting. The writer states that CIs can step out of their role and use their language and cultural skills to protect the patient's safety (ibid, pp. 319-336).

The CIs' roles are divided into four main types: the conduit or linguistic role, the communication-facilitator or clarifier, the bilingual-bicultural mediator or cultural broker, and the advocate or helper role (Roy, 2002). These roles are categorised by the degree of the interpreter's involvement and visibility (Leticia, 2017, p.2).

"The conduit model (which will be discussed in chapter 4) has had the highest impact on practitioners' understanding of the profession" (Calle-Alberdi, 2015, p.17), and its application has been examined by a few scholars such as Roy. According to Roy, the conduit role requires the interpreter to convey the message while keeping reminding speakers that he/she remains "uninvolved on any other level" (2002, p.347). Kotzé states that the interpreter should act as "invisible" and "uninvolved" (2014, p.127). He believes that this as the most acceptable role for interpreters (ibid, p.127). However, it has been postulated that some situations require the interpreter to adopt other roles such as clarifier, cultural broker, or advocate, depending on the situation (Niska, 2002, pp.137-138).

As noted, the model of interpreting that the researcher supports in this thesis is the advocate role. This has encouraged the researcher to look behind word-for-word – and even sense-for-sense – interpretation to see ways in which apparent meanings have been assembled by dominant groups to serve their own interests. This is not to say that the researcher's intention is to totally discredit theories which encouraged the so-called conduit role of the interpreter.

The researcher does not aim to entirely negate the role of word-for-word interpretation, but rather to understand how the CI can adapt his or her role to go beyond this. The

researcher's purpose is one of friendly critic not aggressive assassin. Indeed, it can be useful to adopt different roles on different occasions – whether that of conduit, cultural broker, cultural clarifier, or cultural advocate.

This research is not limited to exploring the interpreter's role in the UK only. It is also based on other studies conducted in other parts of the Anglophone world such as Australia, Canada, the UK, and the USA. This is primarily due to the lack of relevant studies about the interpreter's role in the UK. Thus, it also gave the opportunity to look at the interpreter's role in more depth. More specifically, this research aims to look at the effect of the cultural advocate role on the quality of communication between Arabic-speaking Muslim patients and English HCPs in the UK. On a practical level, this study hopes to provide insights which can ultimately help to improve the interpretation service for LEPs in the UK and may also benefit other researchers in other parts of the world.

1.7 Methodological Approach of the Study

This study examines the problems arising from the cultural gaps between UK-based HCPs and Arab Muslim patients in the UK. This research is based upon survey questionnaires given to HCPs and Muslim patients, and structured interviews given to HCPs. The researcher has used two general research methods: quantitative and qualitative. The former approach is used in the survey questionnaires (via closed questions: sections 7.2.1 and 7.2.2) to test respondents' understanding (UK-based HCPs and Arab Muslim patients) of the issues resulting from the cultural differences between the two groups. The qualitative approach is also used via open questions in the questionnaire and questions in the structured interviews to gain a broader understanding of problems faced by Arab Muslim patients and by HCPs dealing with Muslim patients in the UK.

1.8 Structure of the Thesis

This thesis consists of eight chapters organised as follows:

Chapter One is an introduction of the thesis. It introduces the reader to the focus of this work, its scope, motives, and rationale behind doing it. It discusses the impact of HC on the followers of the religions found in Britain. It also outlines the structure of the thesis and the main research questions.

Chapter Two presents various definitions of culture, religion, and tradition, identifying the differences between them. It discusses the meaning of culture in HC, and the impact of culture on patient's views of health and illness. It highlights the importance of cultural competence in HC.

Chapter Three provides an overview of interpreters, along with the provision of interpretation in the UK. It discusses new trends, such as skype interviews. It then discusses how interpreters are vetted. It provides information on the booking policy for HC interpreters in the UK. Finally, it presents interpreter's training issues in the UK.

Chapter Four outlines the interpreter's various roles in HC settings. It addresses the interpreter's conduit, non-conduit, codiagnostic, cultural clarifier, cultural broker, and advocate roles. It illustrates the differences between these roles.

Chapter Five postulates Muslim patients' issues in HC such as dietary restrictions. It demonstrates the impact of Muslim patient's beliefs on health and illness. It discusses factors affecting Muslim patient's access to HC. It examines the effect of fasting on patients.

Chapter Six defines the methodology used in the study. It considers the strengths and weaknesses of quantitative and qualitative research methods. It presents a pilot study, a pilot

study being defined as the pre-testing or 'trying out' of a particular research method (Baker 1994, pp. 182-3). This pilot study is used to assess the feasibility of the survey questionnaires. Chapter (6) discusses the results. It describes the methodology the researcher used in this study and the challenges she faced.

Chapter Seven presents the main study. It discusses its findings and limitations and provides the results of the study which compares HCPs' responses with those of patients.

Chapter Eight concludes the study, considers the limitations, and provides recommendations for further research.

CHAPTER TWO

CULTURE, RELIGION, TRADITION AND HC

2.1 Introduction

This chapter considers the importance of culture, religion, and tradition in HC. Section (2.2) illuminates the significance of culture in HC. Sections (2.2.1- 2.2.2- 2.2.3- and 2.2.4) consider various definitions of culture, religion, tradition, the relationship between them and the definition of culture in HC. The chapter then provides an overall definition of culture (Section 2.2.5). Then it examines the importance of culture in HC (Section 2.3), culture and patient's safety (Section 2.3.1), cultural awareness can improve patient's satisfaction in (Section 2.3.2), how culture can impact patients' views towards health and illness (Section 2.3.3), the issue of HC disparities among ethnic minority patients in the UK is addressed (Section 2.4), the importance of cultural competence in HC (Section 2.5), and conclusion (Section 2.6).

2.2 The Importance of Culture, Religion, and Tradition in Providing Quality HCS

Understanding the meaning of religion, culture and tradition in HC can help the HCP to respond when the patient's religious preference contradicts with the prescribed medication or treatment. The Department of Health (2009) highlights the importance of religion and beliefs in the patient's recovery. It has been recommended that the HCP has to understand the spiritual, social and cultural beliefs of the patient. Patients should be treated equally

regardless of their beliefs (General Medical Council, 2013). Joshua Hordern (2016), an Associate Professor of Christian Ethics at Oxford University UK, stresses the importance of religion and culture as essential 'sources' for personal power in HC. He argues that HCP should be sensitive to their patients' religious needs and be aware of the significance of cultural beliefs. Understanding the significance of the patient's religious beliefs and culture is a key factor in providing safe HCS, and therefore can ensure providing quality care. It has been postulated that it is pivotal for HCPs to understand the patient's culture and beliefs and their influence on their medication intake (Weissman et al., 2005; Klein and Albani, 2007; Narayanasamy, 2003). According to the General Medical Council (2013) and Department of Health (2009) in the UK, it is the doctor's civic obligation to navigate between the patient's religious beliefs and cultures, particularly given that the religious values of the patient can help the HCP to meet their ethnic minority patients' needs (Rumun, 2014, p. 37).

Dealing with ethnic minority patients may involve dealing with patients with different languages and cultures. Language is the mirror through which we reflect our beliefs, habits, thoughts, and ideas about people or attitudes towards certain aspects of life. Language and culture are tightly inter-connected. Malinowski is one of leading anthropologists who pointed out the significance of culture in understanding language (Katan, 1999). It has been postulated that language depicts culture; "language mirrors other parts of culture, supports them, spreads them and helps to develop others" (Hongwei, 1999, p. 121). Hongwei notes that "language is the life-blood of culture (ibid, p. 121). In interpretation, language and culture are interconnected. Cultural understanding plays a substantial part in enhancing effective communication between speakers. Understanding words along with the 'underlying' culture can help the interpreter to establish a better understanding of the spoken message (National Code of Ethics for Interpreters in HC (NCEIHC, 2004, p. 9).

Thus, it is crucial to consider both language and culture in the process of interpretation. To deliver a quality interpretation service for patients with LEPs, it is essential for the interpreter to be fully aware of the linguistic components of the spoken message and the speaker's beliefs, culture, religion, including tradition. Using the linguistic model only in interpretation (which we will discuss later in detail in chapter 4) is not adequate because disregarding these beliefs may result in a poor interpretation service, and consequently negative clinical results. To deliver a high quality HCS it is important to understand the meaning of culture, religion, and tradition, as discussed below.

2.2.1 What is culture?

Due to the broad scope of culture, it has been proven that it was challenging for "sociologists, anthropologists, economists and policy-makers" (Karami, 2014, p.495), to limit its meaning to one definition. Some believe that culture is inherited from one generation to another. Others suggest that culture is a set of knowledge that involves "beliefs, art, morals, laws, customs, human capabilities and habits" (ibid., p.495).

Thus, the term culture has been defined in various ways; some are more useful than others. One of the most prominent definitions of culture was defined by the father of British social anthropology; Edward Burnett Tyler who defines culture as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities including habits acquired by man as a member of society" (Tylor, 1871, p.1).

For Peoples and Bailey (1991), culture is a set of "knowledge and behaviour" that are passed on across generations (ibid, pp.21-23). In a way that slightly agrees with Peoples and Bailey, Keesing believes that culture refers to certain 'patterns' of behaviors that belong to a group of people and are socially inherited (Keesing, 1981, p. 68). Geert Hofstede (1984)

defines culture as “the collective programming of the mind which distinguishes the members of one human group from another. Culture in this sense includes systems of values; and values are among the building blocks of culture” (Hofstede, 1984, p.21).

Hofstede (1994) categorized culture into four elementary components: ‘symbols’ ‘rituals’, ‘values’ and ‘heroes. These elements refer to the following:

- ‘Symbols’ refer to verbal and non-verbal language.
- ‘Rituals’ are the socially essential collective activities within a culture.
- ‘Values’ are the feelings do not open for discussion within a culture about what is good or bad, beautiful or ugly, normal or abnormal, which are present in most of the members of a culture or at least in those who occupy pivotal positions (ibid, 1994, p.79)

‘Heroes’ are the real or imaginary people who serve as behaviour models within a culture. A culture’s heroes are expressed in the culture’s myths which can be the subject of novels and other forms of literature (Rushing and Frentz, 1978, pp.63-72).

The United Nations Educational, Scientific and Cultural Organization (UNESCO) (2002) defines culture as a set of unique religious, “material, intellectual, and emotional” characteristics shared by a community. Along with “art and literature”, culture also includes styles of living, ‘traditions and values (ibid, p.229).

For Matsumoto and Juang, human culture is defined as a distinctive system of information that ties a group of people together and inherited from one generation into another, which lets the group to fulfil their everyday needs for living, maintain their ‘well-being’ and happiness (Matsumoto and Juang, 2012, p.15).

As reported by Hofstede culture is a combined ‘programming’ of ‘spirits’ that divides a group of people from others (Hofstede, 1994, p. 4). Schein (1985) believes that culture is a way shared by a community to find solutions to issues and resolve problematic situations.

Nonetheless, the term ‘organizational culture’ has received great interest over the last few decades particularly in HC organizations (Harrison et al., 1992; Gerowitz, 1998). Through ‘organizational culture’ a group of people share the same distinctive views towards situations and events (Langfield-Smith, 1995; Morgan, 1986; Williams et al., 1996). Weiss describes ‘organizational culture’ as a set of beliefs, limitations and assumptions that ties a group of people together, and which therefore creates a sense of identity that motivates them to be committed to it and consequently leads to a sense of social stability (Weiss, 1996).

Based on the above definitions, we notice that the focus of most scholars is on the way a group of people adapts socially within an organization. It is noticeable that a social group shares the same culture and the more an individual is culturally adherent the more he/she will be part of the group and will therefore be socially accepted within the community he/she belongs to.

One of the most important features of the persistence of culture is that it should be inherited from one generation to another through socialization with others (Fieldhouse, 1995; Matsumoto and Juang, 2012). Even though respecting tradition is a crucial part in the cultural inheritance, culture is not a fixed system. Rather it is constantly changing over time (Fieldhouse, 1995). Culture is a set of shared, changeable, and debatable beliefs, values, and rules transmitted from one generation to another. Another prominent distinctive characteristic of culture shared by many authors but expressed differently is its distinctiveness. This is expressed using words such as: “distinctive spiritual” (UNESCO, 2002, p.229), “distinguishes the member” (Hofstede, 1984, p.21), “certain patterns” (Keesing, 1981,

p.68) and ‘unique’ (Matsumoto and Juang, 2012, p.15). All these definitions share one meaning in common which is uniqueness.

Since cultural adherence unities a human being to a community, which shares the same geographic background, culture unites a social group belonging to the same ethnic origin together. Nevertheless, it is not necessary for a group having the same culture to share one religion. Some characteristics of culture are common while others are ‘unique’. For instance, what is taboo and unacceptable in one culture could be common and acceptable in another culture. Therefore, culture is a distinctive feature of a human being or a social group, which can impact on the way we see or practise things in life. Characteristics of culture can be either noticeable, e.g., the way we dress, the food we eat or the language we speak, or hidden such as our beliefs and values. The features of culture may impact our attitudes towards health and illness, who is responsible to look after and decide of the patient, how to disclose bad news such as death, how to treat a terminally ill patient and what is expected to be done after death (Harrison, 2009).

For the purposes of this research, culture can be defined in a broad way, as the ways of living of a community which includes beliefs, values, customs, ways of dressing, social relationships and religious codes which are passed from one generation to another and are in constant change.

2.2.2 Definition of religion

Religion derives from ‘religio’, “to bind back or to tie” (Testerman, 1997, p.287). Like spirituality, the term religion has suffered from a multiplicity of definitions. The term religion is increasingly used by scholars in the narrow sense of institutionally based dogma, rituals, and traditions (ibid).

It has been argued that the idea of religion is similar to that of culture in that it is easy to utilise in normal conversation but difficult to be precisely defined (Dow, 2007, p.4).

Clifford Geertz suggests religion is a: a system of 'symbols' that works to build a strong and permanent moods and inspirations in individuals through articulating "conceptions of general order of existence and clothing these conceptions such as aura of factuality that the moods and motivations seem uniquely realistic" (Geertz, 1993, p.90).

Emilie Durkheim in *The Elementary Forms of Religious Life* (1965) rejected the view that religion is a kind of "proto-science or philosophy". Durkheim stipulates that religion is rather seen as a kind shared knowledge among all humans which all individuals feel the need to have regardless of their educational level or technological or scientific progress (ibid, p.8). Berger (1929-2017) is one of the most prominent sociologists of the modern era, defined religion in the Sacred Canopy (1967): "[religion is] the establishment, through human activity, of an all-embracing sacred order, that is, of a sacred cosmos that will be capable of maintaining itself in the ever-present face of chaos" (Berger, 1967, p. 51).

We clearly notice that the focus of the above definitions is on how religion interacts with human behaviour. Thus, while Durkheim addresses the definition of religions by highlighting the importance of practising religious beliefs by uniting an individual within the community, Geertz focuses on how religion can impact on human behaviours, beliefs and understanding of the universe (Fox, 2013, p.6).

Thinkers have adopted quite different assessments of religion, ranging from that of the believer in a particular religion to scepticism or even outright hostility. Perhaps the most famous of the hostile sceptics is Karl Marx (1818-1883), who views religion as expressive and 'evaluative'. Marx believes that social and economic situations may impact on how we form and regard religion including our understanding on religion. For instance, people turn to

religion when they face some economic difficulties or performing the same dominant religion could be varied from one community to another (Marx and Engels, 1975).

Most modern scholars, however, see religion in a more positive way, considering practising religion is to fulfil a useful, or even essential social role, regardless of truth or otherwise of religions. According to John Bowker: “religious organizations may become an end in themselves; but the creative health of religions lies in the recognition that the system is not the end, but a means to ends which transcend the organization” (Bowker, 1997, p. 16).

According to Christiana Smith (1996), religion refers to values and practices that are built not only in ‘ordinary’ universe but also in the spiritual, scared, eternal and religious world. What distinguishes religion is that “religious-meaning-systems” function with an alignment to “supernatural beings”, and “timeless truths” (Smith, 1996b, p.7).

Harrison argues that religion is a collection of beliefs and practices that tightens our relationship with the blessed. Religion is described as understanding the ‘relation’ to God or gods (Harrison, 2009). It involves shared specific beliefs, its most prominent characteristic being its limitations. Religion takes the limitless and unites it into the boundaries of language and culture, even as it may also transform culture.

For the purposes of this thesis, religion is defined as holy and sacred practices. People’s relationship with God or a spiritual power is strengthened through our obedience to the Almighty, adherence to limitations and acceptance of reality. Our strong relationship with God can be enhanced through praying and worshipping. Hence, religion is practising a set of spiritual beliefs and believing in values which strengthen our relationship to God. It is the bond that creates peace between God and us. For instance, a patient believing in God believes that turning to God is the first step towards recovery. One of the benefits of practising religion is to empower the person through strengthening his/her relationship with the community, and

enhancing his/her relationship with God, that may lead to “psychological stability” (Basu-Zharku, 2011).

Since the focus of the HCP is to optimise the patient’s health, it is crucial for the clinician to be culturally aware of any religious constraints that may aggravate the patient’s health and may result in negative clinical outcomes (Koenig, 2007). This should involve both physical and spiritual health. On some occasions, physicians might not share the religious beliefs of their patients. However, sensitivity to the patient’s cultural needs and values and obtaining the patient’s consents is therefore essential before making any assumptions, particularly when looking after patients from different cultures and who are new residents in the country, they are receiving the treatment in.

2.2.3 Definition of tradition

Tradition was defined by the cultural anthropologist; Alice Horner as the process of passing customs, beliefs, and thoughts from one generation to another (Horner, 1990). However, this heritage transmission is selective; it only includes valued customs and beliefs chosen by individuals and passed over from the older to the younger generation (Smolicz, 1976).

Tradition does not refer to something static or unchangeable but rather is related to something localised (Graburn, 2001). It is a set of cultural characteristics that in constant change and transmitted across generations. Tradition is “value laden” and has various applications (Finnegan, 1991, p.105). However, one of the most used definitions of tradition is the process of transferring customs and beliefs orally. The concrete definition of culture is what is handed down from one generation to another. The concept of tradition could imply customs or any old beliefs inherited from one generation to another. Tradition should not be necessarily significant. It could be both valued and unvalued (ibid).

Tradition is defined as: transmitted customs or beliefs from generation to generation (Oxford University Press, 2018). This definition is sufficiently broad to cover everything, which is standardly meant by tradition in everyday English, and adequately distinguishes tradition from culture and religion.

2.2.4 Relationship between culture, religion, and tradition

While religion affects culture (Beckford and Demerath, 2007), it is also affected by culture, as religion is an essential layer of culture. Culture and religion are both associated with various communication traits and behaviours (Croucher and Harris, 2012). Some Islamic scholars relate culture to Islam and define religion as a set of ideas, principles and 'patterns' that are practised by a group who share the same religion. In Islam, these are the principles along with the acts of the Prophet Muhammad's Islamic law (*Shari'a*) in devotion to God.

The fact that tradition does not refer to something static or unchangeable but rather is related to something 'localised' means that culture could be related to location and religion. Thus, the difference between culture and religion does not only lie in the habits, beliefs and values involved. Rather, it relies on the reason behind practising them whether this stems from our fear of society or our fear of God. If the answer is our fear of God, then it is pure religion, while if the reason is to be socially accepted among a community, then it is culture.

In Islam, women frequently wear a 'veil'. This can be of different types, with different names such as *hijab*, *burqa* and *niqab* (El Guindi,1999). A *hijab* covers the head and body of a Muslim woman apart from hands and face (Al-Jabari, 2008, p.255). A *burqa* is a covering that covers the whole body from head-to-toe (Shirazi and Mishra ,2010, p.44). *Niqab* refers to a full-face veil worn by Muslim women and covers the face excluding the eyes (Bayat, 2013). A *khimaar*

is a loose scarf worn by Muslim women covering their heads, 'bosoms' and necks (Al-Jabari, 2008, p.256). In the *Quran* it is the word خمار *khimaar* which is used for a 'veil' (*Quran*, Surah *An-Nur* verse 31):

وَقُل لِّلْمُؤْمِنَاتِ يَغْضُضْنَ مِنْ أَبْصَارِهِنَّ وَيَحْفَظْنَ فُرُوجَهُنَّ وَلا يُبْدِينَ زِينَتَهُنَّ إِلاَّ مَا ظَهَرَ مِنْهَا وَلْيَضْرِبْنَ بِخُمُرِهِنَّ عَلَى جُيُوبِهِنَّ وَلا يُبْدِينَ زِينَتَهُنَّ إِلاَّ لِبُعُولَتِهِنَّ أَوْ آبَائِهِنَّ أَوْ آبَاء بُعُولَتِهِنَّ أَوْ أَبْنَائِهِنَّ أَوْ أَبْنَاء بُعُولَتِهِنَّ أَوْ إِخْوَانِهِنَّ أَوْ بَنِي إِخْوَانِهِنَّ أَوْ بَنِي أَخَوَاتِهِنَّ أَوْ نِسَائِهِنَّ أَوْ مَا مَلَكَتْ أَيْمَانُهُنَّ أَوِ التَّابِعِينَ غَيْرِ أُولِي الإِرْبَةِ مِنَ الرِّجَالِ أَوِ الطِّفْلِ الَّذِينَ لَمْ يَظْهَرُوا عَلَى عَوْرَاتِ النِّسَاء وَلا يَضْرِبْنَ بِأَرْجُلِهِنَّ لِيُعْلَمَ مَا يُخْفِينَ مِن زِينَتِهِنَّ وَتُوبُوا إِلَى اللَّهِ جَمِيعًا أَيُّهَا الْمُؤْمِنُونَ لَعَلَّكُمْ تُفْلِحُونَ (*Quran*, Surah An-Nur *verse* 31).

> And say to the believing women that they restrain their eyes, and guard their private parts, and that they disclose not their *natural and artificial* beauty except that which is apparent thereof, and that they to draw their head-coverings over their bosoms, and that they disclose not their beauty save to their husbands, or to fathers, the fathers of their husbands, or their sons, or the sons of their husbands, or their brothers, or the sons of their brother's, or the sons of their sisters, or their women, or what their right hands possess, or such of male attendants as have a sexual appetite, or young children who have no knowledge of the hidden parts of women. And they strike not their feet so that they hide of their ornaments may become known. And turn ye to Allah all together, O believers, that you may succeed (Ali, 2015, p.405).

This verse defines the meaning of *khimaar* in Islam. Muslim women are told to wear a long scarf to cover their face and chest areas.

Although women's modesty is encouraged in Islam and the *Quran*, there are still some debates on the appropriateness of wearing the *burqa*. Modesty in women's dress has been interpreted differently in various cultures. While most women in Afghanistan wear the *burqa*,

few do in Pakistan, which results in confusing tradition embedded in local culture with religious requirements. Therefore, in this example 'traditional dress' is a more appropriate term than 'Islamic dress' simply because other devout Muslims all over the world do not feel obliged to wear the *burqa* but are still classed as devout Muslims.

Another case in which culture, religion and tradition interact is female circumcision *khitan* or female genital mutilation (FGM) is another example where culture, religion and tradition interact. This rite is believed to be more culturally than religiously based. However, it is practised in African Christianity (Ethiopia and Kenya). FGM is practised in some east African and Arabic countries. In 1995 and 2001, demographic studies in Egypt concluded that about 97% of women had been circumcised (Tag-Eldin et al., 2008). It is worth noting here that FGM is not obligatory under the Islamic law but still this is practised in some parts of the Muslim world. Thus, while for some Muslims FGM can be interpreted as a religious procedure, it is a traditional belief for others. Regardless, in the UK performing FGM is illegal, and therefore HCPs are obliged to report it to the police (Hordern, 2016).

2.2.5 Overall definition of culture

From all the above definitions we conclude that culture is something internal and material at the same time. It is internal in that it is a set of beliefs, ideas, religious views, habits, customs, assumptions, knowledge, ideologies, customs, tastes and ideologies. These factors are internal and have an influence on the way we think, the way we dress, and the way we behave and act. These latter aspects are, by contrast, external and are influenced and controlled by our internal beliefs. We as human beings like to submit ourselves to these cultural rules out of fear of society or love for these cultural aspects. This provides us with a feeling of satisfaction (if we love this culture) and the satisfaction of others, which emerges from our submission to these cultural behaviours.

Hence, culture is a set of values, beliefs, and customs shared by a group of people sharing the same geographic location, religion, or language. It may restrict our ways of living in that it defines what we should/should not do. Cultural adherence may impact our social relationship with people belonging to the same culture.

2.3 Culture in HC

In HC, culture has been defined as a set of "beliefs, values and assumptions" (Scott et al, 2003, p., 2). A study shows that despite the acknowledgement of the importance of culture in HCP's-patient relationship, its values are not equally addressed by general practitioners (GPs) (Wachtler et al., 2006). There is a lack of studies exploring the impact of cultural difference in HCP's-patient relationship (Schouten and Meeuwesen, 2006). The growing interest in culture change stems from the desire to improve the quality of HC and wellbeing along with organisational and practical changes (Mannion et al., 2009). A report identifies significant

cultural defects within NHS trusts and suggests a structural cultural shift within the NHS (Francis, 2013). It has been suggested that failing to acknowledge culture may result in a lack of understanding of its potential negative effects and a failure to realise its positive potentials for offering new models of thinking. Cultural negligence can deprive an individual of the feeling of dwelling in a local moral universe (Napier et al., 2014, p. 5).

2.3.1 Culture and patient safety

Although providing a high standard service is one of the shared objectives among HCS globally, patients are still confronted with preventable disparities (Dixon-Woods et al. 2013; de Vires et al., 2008). Thus, the HCS does not meet the requirements for patients' safety (Department of Health, 2001). It has been noted that patients' safety has been threatened within European hospitals including the UK (Vincent et al., 2001), and the USA (Andrews et al., 1997; Brennan et al., 1991; Leape et al., 1991) and other countries (Institute of Medicine, 1999; Department of Health, 2000, 2001). Poor quality medical care has started to attract media attention and by the early 21st century the case of 'safety in hospitals' became a worry for patients (Institute of Medicine, 1999; Department of Health, 2000, 2001). Therefore, HCPs must tackle this issue (Department of Health, 2001). However, in confronted situations that threaten patients' safety, it is advised not to focus on "who is responsible for this" 'but rather on 'how' and 'why' this happened (Vincent, 2002).

Investigating the 'how' and 'why' can help HCPs to find out the causes of problems and therefore reach solutions to improve HC quality by avoiding similar future situations. Take for instance, the Bristol heart scandal where 30 to 35 babies under the age of one year who had heart operations died between 1991 and 1995. Patients' lives would have been saved if negligence had not occurred in the first place (Dyer, 2001). One of the main factors that contributed to this tragedy at a British hospital is culture (Kennedy, 2001). The NHS lawyer

Robert Francis reported in *The Guardian* that the "culture of the NHS" was responsible for this; it was the culture that disregarded "the priority that should have been given to the protection of patients". It was the culture that "too often did not consider properly the impact on patients of actions being taken" (Francis, quoted in Taylor, 2013, p. 1). It is significant to illuminate here that the 'culture' in this context does not merely denote a group of people who share the same language and race, but rather it embraces a set of beliefs and values shared by the NHS workforce. The Institute of Medicine called for developing 'a culture safety' to avoid similar errors in the future (Institute of Medicine, 1990, p. 166). According to some reports, such unpleasant incidents which have massively cost both patients and the HCS could have been deterred or avoided. Normally, these were only simple cases such as 'wrong site', 'drug error' or 'infection', but there are more severe cases where some HCUs lost their lives due to mistakes made by other HCPs (e.g., the Vincristine deaths) or by the clinicians who committed repeated mistakes (e.g., the Manitoba and Bristol paediatric surgery fatalities).

2.3.2 Cultural awareness can improve patient's satisfaction

Medicine is considered as the central success of the biological sciences. 'Biomedical' methods to enhance patient safety have minimised disease and death globally. Nevertheless, the need to adapt these methods to the impact of culture on health actions still remains (WHO Regional Office for Europe, 2013). It has been argued that some guidelines for HCU safety have removed the cultural factor by considering it 'difficult to quantify' (Holden, 2012). A study entitled "Workforce diversity, diversity training and ethnic minorities: The case of the UK NHS" examined cross-cultural issues in the UK. One of the participants argues that learning about different cultures can be difficult because "there are so many", while another participant says, "I think it [learning about different cultures] is a hard thing. It is impossible

to know all the different nuances, different issues, and dos and don'ts of each cultural background" (Hussain et al., 2020, p. 212).

Dogra et al. (2007) believe that HCPs need to treat patients equally regardless of their ethnic, racial, or religious backgrounds and their impact on patient diagnosis. Nonetheless, being culturally neutral can result in some ethical issues. For instance, asking a female Muslim patient to take her head covering off during examination or not allowing a Hasidic Jewish patient to bring food to the hospital may reflect cultural negligence of the significance of religious bonds. In contrast to Dogra's opinion, a recent study encourages cultural awareness. It reveals that adopting a 'multiculturalist' philosophy by being culturally aware of the diversity of groups and their social differences produces better results and is more effective than an ideology that ignores such differences among ethnic minorities (Gündemir et al., 2019). Therefore, cultural understanding of how various cultures of care can play a substantial role in improving HC quality and therefore enhance patient's safety is important.

2.3.3 Culture can impact on patients' views of health and illness

The influence of culture on health was first examined by the social anthropologist and doctor William Rivers. Rivers was the first individual who used the "double-blind trials" in scientific tests. However, the "double-trial" experiments which were initially developed by Rivers (2001) led to eradicating the social factors from clinical tests which led to the emergence of modern biomedicine. Making the trials purely biomedical with no social factor involvement and the creation of 'modern biomedicine' were not in fact Rivers' goals. Rivers valued cultural factors influence in medicine. He believed that culture and medicine are inseparable (Rivers, 2001).

While ‘medical humanities’ involves the interrelationship between health and culture and how culture can be beneficial in defining health, ‘medical anthropology’ involves how the system of medical knowledge can be influenced by cultural factors such as the intake of some herbal treatments, people’s understandings, and what defines ‘moral’ and ethical’ types of behaviours (Needham, 1972; Good, 1994). Nowadays, ‘medical anthropologists’ concentrate on how human values and habits whether common or uncommon can impact their illness. Thus, the influence of cultural concepts on HC-related behaviours has been recently enhanced in the latter years of the 20th century (Frenk et al., 2010). Being from a different culture can impact accepting or declining treatment. HCUs’ beliefs and ideas about the cause and cure of an illness which may clash with biomedicine and science can influence ‘health-related behaviour’ (Taïeb et al., 2010; Rubincam, 2017; Weinman, 2012).

In HC, culture can impact the way we understand specific symptoms, accepting or declining the treatment, the way we interact with the HCP, and the patient’s decision making (Simolka and Schnepp, 2017; Ali et al., 2006). Hence, culture can involve the way people understand their health issues, and their attitudes towards health, illness, or treatment, which may impact on clinical outcomes. Thus, culture can influence HC beliefs in many ways, starting from preventing a disease, diagnosing an illness, to beliefs about an illness such as the cause of a disease, birth rites, and ending in treatment plans which may include some religious dietary restrictions that may affect the patient’s adherence to the treatment. Therefore, understanding patients’ ‘spiritual or religious needs’ will enable HCPs to identify the value of their patients’ beliefs and practices which play a vital role in patients’ health. This may impact the patient’s decision-making about an illness or a care plan (Rumun, 2014).

A research study in Switzerland conducted on migrants’ experience reported that “there is a high potential for misunderstandings, and obviously a large gap between the respective

concepts of illness and appropriate treatment" (Maier and Straub, 2011, p. 233). Patients' expectations of treatments can be varied depending on their beliefs towards an illness. This affects their willingness to accept or decline a treatment (Al-Qazaz et al., 2011). It has been indicated that failing to take cultural factors into a consideration may result in poor quality HCS (Parveen et al., 2016).

Irregular antenatal visits or missing screening tests are common problems which may negatively affect the mother and infant's health. A study conducted in the UK on South Asian women concluded that missing appointments result from pessimistic views of antenatal care (Dormandy et al., 2005). Another study in Nigeria revealed that women booked their appointments too late due to their beliefs that such tests are unnecessary for a healthy mother (Ebeigbe and Igberase, 2010).

Likewise, some thoughts may seem normal in some societies but abnormal in others. For instance, the concept of obesity is viewed differently in different societies (Popenoe, 2003). Obesity can, in origin, be considered a western disease that goes back to the 17th century (Coombs, 1936). It causes some health issues and even sudden death among its patients (Hippocrates, quoted in Burns, 1993). Unlike in developed countries, where the concept of obesity is classed as a disease, in developing poor countries like sub-Saharan Africa obesity is viewed as a sign of health, victory, joy and prosperity (Crawford et al., 2001).

Another example, the right to be beautiful, extends to the poor in some cultures. In Brazil it is culturally believed that everyone has the right to be beautiful regardless of his/her financial status. The concept of beauty extends to involving plastic surgery for the poor (Edmonds, 2007). Thus, ways of thinking about health and illness are varied across cultures. which can impact patient's safety.

2.4 HC Disparities Among Ethnic Minority Patients in the UK

The increasing number of different ethnic minorities from various languages and cultures results in barriers to HCPs ensuring fair access to HCS. This has led to poor quality HCS for patients from diverse backgrounds (Szczepura et al., 2004), and consequently increased the frequency of rates of mortality of several illnesses in the UK among ethnic minority patients (Nazroo, 2003). A study revealed that patients with communication difficulties were at three times higher risk of suffering avoidable harmful events than patients with no communication problems. Around half of the events were related to disability or multiple hospital admissions (Bartlett et al., 2008).

Building effective communication is based on understating the crucial link between culture and language and the impact on minority patients' safety. According to some researchers, 50% of these risks could be avoided if cultural and language issues were recognised and addressed. Building on this, the government, HCP and HCS need to work hard to implement specific rules to protect LEPs and consequently improve HCS (Reason, 2000; Vincent, 2001).

The need to improve HCS for ethnic minority patients has been acknowledged by the Department of Health and professional organizations (Szczepura et al., 2004). Hence, one of the United Kingdom Government policy schemes is to ensure provision of fair HCS for everyone (Sallah,2010). One of the solutions to resolve HC disparities for ethnic minority patients is to provide a culturally sensitive (Bhopal, 2009), and culturally competent HCS.

HCPs can try to provide the most appropriate cultural adjustments for ethnic minority patients. Being in a foreign country does not necessarily mean that minority patients have abandoned their own culture and adapted to the new culture. Their own culture is still there

and respecting it is important for their emotional stability. Schott and Henley say, “culture is not like a coat. You cannot take off your own coat when you leave your country and put on someone else’s. Culture is woven into each of us as into a piece of cloth. If we pull out and discard the vital threads of culture, the whole cloth falls apart” (Schott and Henley, 1996, p. 23).

2.5 The importance of Cultural Competence in HC

Cultural competence in HC is defined as having the skills to provide HCS that meets the patient’s needs (Betancourt et al., 2002). Cultural competence is a set of knowledge and skills to provide HC to patients from different languages and cultures (Seeleman et al., 2009). Grant and Luxford (2011) suggest that there is a demand for “frameworks of intercultural communication” to assist HCPs working with patients from different cultural backgrounds (pp.16-27) . To be a qualified professional health worker one needs to be medically qualified. However, assessing and prescribing the treatment for a patient from a different ethnic background could be impacted when the lack of cultural awareness occurs.

Cultural awareness means knowledge of cultural values and trying to adjust the style of the practice to satisfy the patient's requirements and values. Cultural values might include gender roles and some limitations and dynamics in a specific culture. Culture is invisible, yet it is crucial. Padela notes: “culture is like the air we breathe, invisible but essential for life, often perceived only when quickly moving in the opposite direction” (Padela et al., 2011, p.4).

Thus, cultural awareness and sensitivity to the patient’s needs are required when providing treatment to patients from a different culture than their HCPs. Overcoming cultural problems requires achieving cultural competence. For instance, it is not sufficient for the pharmacist to understand only the drug action, the patient’s metabolism, and economics. Instead, he/she

has to be aware of the cultural background of the patient in order to deliver culturally satisfied HC in the pharmacy. Professional pharmaceutical care is achieved by acknowledging the cultural influence on the patient's life. Strand and Hepler argue that cultural knowledge results in satisfactory results which can be accomplished by involving the patient, the physician, and the pharmacist in making a decision on drug therapy (Hepler and Strand, 1990). The pharmacist must grasp as much information as possible about the patient's cultural background to achieve an effective treatment. By overcoming the communication barrier, we develop HC. The language used with the patient is the first step to overcoming the communication problem and to making communication more effective. Learning communication skills improves communication between the health worker and the client (Zweber, 2002).

Maguire and Pitceathly (2002) argue that using effective communication skills can benefit both HCPs and patients. This helps clinicians to identify their patient's medical issues more precisely, while patients receive satisfactory HCS, and gain a better understanding of the problem and the available options for treatments. This will, therefore, lead to medical adherence. Moreover, patients will be less vulnerable to some mental illnesses such as depression or anxiety.

Accordingly, HCPs should have cultural knowledge about their ethnic minority patients. Bruijnzeels, Voorham, and De Hoop stressed the importance of cultural knowledge of the patient and the level of the patient's 'acculturation' to build an effective doctor-patient relationship (Bruijnzeels et al., 1999, pp.307-310).

Schouten and Meeuwesen echo this view: "using a culturally sensitive approach by paying attention to the cultural variables as outlined in our theoretical model is recommended" (Schouten and Meeuwesen, 2006, p.32). The HCP needs to be careful of their attitudes

towards the patients' culture, as our attitude towards culture plays an essential role in gaining the patient's satisfaction and making effective communication and interaction with the HCU. Hence, it is recommended to understand and appreciate the patient's cultural beliefs (Purnell and Paulanka, 1998).

Studying culture is significant in HC because cultural clashes may lead to 'pathological development'. Cultural conflict may result when communicating with people from different cultures and belong to the same geographical area. This may be problematic in some cases. Most cultures, particularly religious ones, contain moral limitations and 'ethical justifications.' Culture goes beyond knowledge to encompass worldviews and concepts of health, illness, and recovery, and even death.

It has been argued that linguistic and cultural differences may create misunderstanding which may lead to unsatisfactory clinical results (Hamilton and Woodward-Kron, 2010). Any insufficient understanding between the HCP and the patient can cause misunderstandings (Roberts et al., 2005, p.468). According to Xu et al. (2010), "deficiencies in communication" may impact the patient's safety negatively. Pressman and Dickinson (2016) argue that failure in building effective communication: "costs in unnecessary pain, in avoidable deaths, in poor health outcomes, in the prolongation of illnesses" (ibid, p.1).

2.6 Conclusion

This chapter has provided various definitions of culture, religion, and tradition. It has highlighted the importance of culture, religion, and tradition for many ethnic minority patients and how the awareness of these aspects may enhance the quality of HC. While religion is related to spiritual power, and therefore practising it enhances our relationship with God, culture can be related or unrelated to religion. In HC, the HCP may deal with patients

from various cultural backgrounds. It is important for the HCP to be culturally sensitive to the HCU's beliefs unless practising them produces conflict, is illegal or affects the patient's safety.

Lack of cultural knowledge may increase the rates of mortality among patients from diverse backgrounds. It can also lead to miscommunication and therefore lack of trust between the HCP and the HCU. Hence, building effective communication can both help the HCP to diagnose the patient and help the HCU in adhering to the treatment that goes along with his/her cultural beliefs.

However, achieving cultural competence is a difficult task for the HCP, due to time restrictions and cultural pressure. This pressure might distract the HCP from recognising the patient's cultural background during the consultation process. For example, while patients might be ill, fearful, uncomfortable, in pain or preoccupied with an illness, the HCPs may be too much focused on the health problem or neglect to interact caringly or personally (Kai, 2006). Providing an efficient interpretation service can play a significant role in overcoming cultural barriers. Thus, providing well-trained and qualified interpreters can help the HCP to reconcile cultural conflict to understand the HCU's cultural backgrounds needs, and accommodate HC according to his/her needs. In the following chapter, we will discuss the provision of interpreting in the UK and NHS policy for vetting qualified professional interpreters.

CHAPTER THREE

HC INTERPRETERS IN THE UK

3.1 Introduction

This chapter will discuss the background of interpreters working in HC. This involves the skills, experience and qualifications required to work as an interpreter in the UK. It will provide information on the provision of interpreting in the UK and the limitations of using the language service. It explains the NHS booking policy for interpreters, and issues of training interpreters in the UK. Finally, it discusses modes of interpreting: face-to-face interpreting, (F2F) telephonic interpreting (TI) and remote interpreting (RI).

3.2 Who are the Interpreters?

The interpreters' task is to orally convey the meaning of a 'spoken' or 'sign communication' from the source language into the target language (National Health Law Programme (NHLP), 2010). According to Esposito, (2001; cf), and Regmi et al. (2010) an interpreter is someone who translates from a source language into a target one, transmitting meaning relying on vocabulary, syntax, context, and culture.

The interpreter is viewed as an "active constructor of data" impacted by its 'intersubjectivities' (Berger, 2015; Temple, 2002). Hence, interpretation is 'reconstruction' rather than meaning discovery (Temple and Young, 2004). It is a process of re-presenting words rather than recreating. The main role of the interpreter is to translate between two

languages by maintaining his/her 'disengaged' existence (Kammarkollegiet: National Judicial Board for Public Lands and Funds, 2010). Interpreting involves the oral rendition of spoken or signed communication from one language into another (National Health Law Programme (NHLP), 2010).

Interpreting is the process of understanding and clarifying a spoken or sign language and conveying the message sincerely, objectively, and precisely into the target language by considering the cultural and social perspectives (American Society of Testing Materials (ASTM), 2007) The interpreter's job is to facilitate communication between people who do not share the same language (NHLP, 2010).

The HC interpreter's knowledge is not only based on his/her awareness of various cultures and how they are different from each other's in HC backgrounds. In some situations, the interpreter's role may extend to involving an additional 'intervention' model of interpreting which permits him/her to shift from the basic conduit model to act as a cultural broker, when necessary (Avery, 2001), which will be discussed further in chapter (4). In addition, interpreters need to be aware of the National Standards of Practice for Interpretation in HC along with National Council on Interpreting in Healthcare (NCIHC) and should be able to identify and avoid situations that may result in 'ethical dilemmas' (NCIHC and National Standard of Practice for Interpreting in Health Care and National Standards of Practice for Interpreters in Health Care (NSPIHC), 2005).

Hence, providing an effective interpretation service must involve additional roles to enhance the communication skills such as:

- Being an active listener
- Message delivery skills

- Appropriate and clear speech skills (NHLP, 2010)

CI uses the uninterrupted mode while interpreting. This requires the interpreter to keep pieces of information and interpret during normal pauses in the conversation. Hence, having a strong memory and listening skills are significant for providing an effective service (ibid, 2010).

In addition to the interpreter's role as language clarifier and cultural broker, interpreters must have the skills to interpret both verbal and non-verbal communication (Kelly, 2008). Thus, the interpreter must render body language, tone inflection, and volume into the target language. This creates an issue for telephone remote interpreters (TRIs) where no visual cues are shown (ibid).

3.3 The Provision of Interpretation in HC in the UK

The UK is a diverse society with 7.9% of the population from black and minority groups (Gill et al., 2007). At least three million people living in the UK were born in countries where English is not the national language (National Centre for Languages, 2006), and more than 300 languages are spoken in the UK which makes London as one of the most diverse cities in the world (Baker and Eversley, 2000). It is therefore important to ensure that HCPs have access to interpreters and employ staff who are trained in working effectively and productively in partnership with interpreters (National Centre for Languages, 2006).

Studies show the need to use interpreters to enhance the quality of HCS for ethnic minority patients (Phelan M, Parkman, 1995; Bischoff et al., 1995), and to make the service accessible for everyone (National Centre for Languages, 2006; Baron et al., 2010), regardless of their language and culture (The Race Equality Access, 2001). Interpretation service costs are

significant (Gan, 2012). “Birmingham Integrated Language and Communication Support Service provided interpreters for 30,000 consultations at a cost of over £1,000,000 in 2007/8” (Gill et al. 2011, p.1). The British Broadcasting Corporation (BBC) news reported the total cost on the language service in (2005) was £55 million (Easton, 2006; Drury, 2008).

The UK NHS has dedicated itself to offering an interpreter for LEPs when required (Department of Health, 2004; Department of Health, 2000). However, it has been reported that interpretation provision across the NHS still lacks efficiency (Free and McKee, 1998; Greenhalgh et al., 2007). In primary care, the use of unprofessional and untrained interpreters such as relatives or friends is one of the main issues in HC interpreting (Free at al., 2003, Lam and Green, 1994; Gerrish, 2001; Gerrish et al., 2004). Approximately 50% of general practices in the UK do not utilise the interpreting service (Greenhalgh et al., 2007). This could be the result of various factors; it could be due to the unavailability of interpreting services in the area or to a lack of funding for the practice. It could be also related to the patient’s preference to use a relative as an interpreter (Flores, 2005). LEPs’ preference for a family interpreter is not uncommon (Flores, 2005). This could be because they feel embarrassed to disclose confidential health issues to an interpreter who may belong to the same community as them. On the other hand, some HCPs may feel that a relative interpreter can be more helpful in explaining the ‘dynamic’ of the family relationship to establish an understanding with the entire family (Rosenberg et al., 2007, Edwards et al., 2005). This may explain why family interpreters are categorised as the ‘second best’ after professional interpreters (Greenhalgh et al., 2006). The inefficiency of the provision of interpretation services in the UK can be also linked to the GP’s views in treating ethnic minority patients (NHS England, 2018).

The issue of providing language support for LEPs has been debated by policy makers and scholars. It has been argued the interpretation service is limited and more services are needed

in order to provide a fair service for all patients to be able to access the service (Jones, 2007). However, others postulate that the NHS should limit their budget on interpreters and motivate LEPs to learn English (Adams, 2007). This may have a negative impact on vulnerable elderly patients with limited English, who may refrain from accessing HCS due to the language barrier. Another cost-effective measure used by the NHS is to consider the option of replacing F2F interpreting with cheaper alternative such as TI or 'app-based- support (NHS England, 2018) or RI, which we will discuss later in this chapter.

3.4 How are Interpreters Vetted?

Having excellent language skills is insufficient to ensure a high-quality interpretation service. Hence, interpreters must fulfil several criteria in interpreting along with their language proficiency in the source and the target languages. This includes qualifications, experience, and security vetting (NRPSIs, https://www.nrpsi.org.uk/for-interpreters/join-the-register.html, NHS England, 2018, p.12).

3.4.1 Minimum levels of interpreter qualification

Qualifications are one of the most trustworthy methods to measure the interpreter's quality. They are a precise tool for a high standard interpretation and translation service. The following are the top ten accredited qualifications identified by stakeholders for use with standard languages in the justice sector:

- IoLET Diploma in PSI (DPSI) – Law option
- IoLET Diploma in PSI (DPSI) – Health option
- IoLET Diploma in PSI (DPSI) – Local Government option
- Metropolitan Police Test / IoLET Diploma in Police Interpreting

- MA in Interpreting and Translation (as long as justice system-specific skills are examined)
- MA in Interpreting (as long as justice system-specific skills are examined)
- BA in Interpreting and Translation (as long as justice system-specific skills are examined)
- BA in Interpreting (as long as justice system-specific skills are examined)
- Post Graduate Diploma in Interpreting (as long as justice system-specific skills are examined)
- Post Graduate Diploma in Conference Interpreting (as long as justice system-specific skills are examined) (Ministry of Justice, 2014)

However, it is difficult to use qualifications to measure the quality of 'rare' language interpreters. Hence, stakeholders need to work hard to find a solution to provide a better-quality service for rare language interpreter users (Ministry of Justice, 2014).

According to NHS England (2018), it is recommended that language interpreters should be registered with the NRPSI and hold a Diploma in PSI (Health). However, where interpreters do not hold Diploma in Public Service Interpreting (DPSI), it is permitted to use interpreters who are native speaker of English and another language with a minimum level 3 of National Vocational qualification (NVQ) in interpreting. Alongside their own mother-tongue language, interpreters should also score 7.5 in International English Language Testing System (IELTS) plus a minimum level 3 in NVQ interpreting. Such interpreters should undergo training in medical terms to be able to communicate effectively.

3.4.2 Experience

It has been postulated that experience is vital but not sufficient for an interpreter working in the justice system. Experience must be married with relevant qualifications. Interpreters working in justice are required to have a minimum of 10 hours of experience, or 400 hours of experience for organisations which deal with the most serious cases (Ministry of Justice, 2014). Interpreters working for PSI are required to have 400 hours experience to be able to register with the NRSPI (Thacker, 2016, p.3). HC interpreters must have experience with HC terminology (NHS England, 2018, p.7).

3.4.3 Security clearance

In addition to language skills, qualifications, and experience, a professional interpreter needs to show evidence of minimum valid security clearance (NRPSI, 2007). Due to the nature of the interpretation profession, which may involve access to sensitive material, personnel security control is required to ensure an employee's character is trusted (Cabinet Office, 2013). This will provide assurance as to the integrity and reliability of persons seeking employment. According to the NRPSI (2007), it is important to consider the environment the interpreter works in such as police or courts. The registrant must provide different clearances depending on the nature of the public sector s/he works in. For instance, those working with vulnerable adults and children may require Enhanced Disclosure, while police may require their own vetting for non-police personnel. Some interpreters may have more than one clearance for this reason. Assigning assignments can rely on the type of security clearance which the client requires of the interpreter. In 2012, the Disclosure and Barring Service (DBS) replaced the activities of the Criminal Records Bureau (CRB), a DBS certificate being of the

same level as a CRB (Croad et al., 2014, p. 16). All interpreters must undertake Enhanced Criminal Records Bureau (ECRB) vetting before registering.

The security check should also include that the interpreter has the right to work legally in the UK (Bristol City Council, 2010). For instance, in CAPITA TI which is an interpretation agency providing interpretation services to public and private sectors, all interpreters are required to have the right to work in the UK and CAPITA TI must make sure they obtain evidence before assigning assignments to interpreters. The Security Watchdog can carry out an identity verification along with other security clearance checks required (CAPITA, 2013). All the interpretation agencies in the UK ensure that their freelance interpreters have identification verification and security checks through the Watchdog.

3.5 Booking Policy of Interpreters in the UK

The primary HC needs to book an interpreter for LEPs to facilitate communication between the HCP and LEPs (NHS England, 2018, p.7).UK booking policy follows a set of standards and recommendations. One of the booking policy recommendations is to book an interpreter who speaks the same dialect as the patient. Patients speaking the same language, but not the same dialect, as the interpreter may struggle to understand his/her dialect. The HCP should preferably also book an interpreter from the same country as the patient. The stereotypical view that if someone speaks the same language, they can understand all dialects of that language should be avoided (Marshall et al., 1998; Tribe with Sanders, 2003). Interpreters should be fluent in both languages and familiar with both cultures too (Tribe and Raval, 2003; Razban, 2003). Matching the religion and culture of the patient with that of the interpreter is important (Nijad, 2003).

Preferably, interpreters should have passed recognised language testing and have the right qualification for the task. A suitable and qualified interpreter can be accessed through organizations such as the NRPSI (www. nrpsi.co.uk) and the Institute of Linguists, (www.iol.org.uk). Interpreting requires specific skills; therefore, using family interpreters is not recommended (Vasquez and Javier, 1991; Pochhacker, 2000). In addition, using relatives as interpreters can create some issues which overlap with confidentiality (Juckett, 2005; Thompson and Woold, 2004) although some clients may insist upon it.

Some HCPs may request the same interpreter throughout the process to encourage building of mutual trust between the HCP, the HCU and the patient. This can make the whole process flow better and involves all the participants, which may consequently lead to positive clinical outcomes (Raval, 1996, pp.29-42).

The NHS is aware of the various models of interpretation: the linguistic and community/cultural models, and the advocate model. The linguistic (conduit) model is to interpret what is being said without adding or taking away any piece of information (Hale, 2002). The conduit model is the main model for working in the legal sector (Hale, 2002). However, the advocacy model requires more involvement from the interpreter. This role is commonly found in HCS. For instance, the interpreter acts as an advocate by informing the HCP about any cultural issues (Mace and Scanlon, 1998). These models will be explained further in chapter 4.

3.6 Interpreter Training Issues in the UK

The need to use of trained interpreters has been well documented in the 'systematic literature' (Karliner et al., 2007; Flores, 2005). Inadequate training can cause some difficulties when working with language interpreters (Tribe, 1999). Training is considered a foundation for providing adequate interpreting services (Kelina, 2002, p.179). Nonetheless, it remains an issue in community interpretation (Ozolins, 2000). There are still several public service contexts where translating and interpreting tasks are still undertaken by inexperienced bilingual trainers (Valero-Garcés, 2016). Untrained interpreters can also impact "quality control". Bilingual translators or interpreters in less common languages are often unqualified trainers with no experience of the various tasks:

> This condition also affects quality control. Quite often the bilinguals who work as translators and interpreters in lesser-used languages are also untrained trainers who know little of the numerous tasks beyond language transfer that practitioners (Valero-Garcés, 2016 p.94,).

Hale (2007) lists the main issues related to training as: lack of the demand for training, absence of a compulsory pre-service training requirement for practising interpreters, unavailability of sufficient training programmes and efficiency of the training (Hale, 2007).

3.6.1 Lack of awareness of significance of using trained interpreters

It has been emphasised that training opportunities are 'scarce' and 'underdeveloped' for CIs along with other fields of interpreting such as conference interpreting (Pöchhacker 2004, p.30, Niska 2005). This may result from 'lack of awareness' of the significance of using trained interpreters (e.g., Pöchhacker, 2007, p. 136). Oledano and Aguilera (2017, p.51) suggest that this may be one of the reasons why the profession still lacks professional recognition and 'prestige'. Also, the current inefficiency in using interpreters and managing interpreting services (Ozolins, 2000) needs to be focused on to improve community Interpreting training. Hale (2007) remarks that there is a lack of awareness of the level of professionalism which is unbeneficial for interpreters to gain 'professional recognition' in their profession (Hale, 2007). The lack of understanding of the level of professionalism along with the increased demand for PSI leads to situations where 'semi-trained', 'semi-qualified', 'unqualified', or 'untrained' bilinguals are utilised to take part in interpretation (Watson, 2015).

3.6.2 Limited research training institutes/programmes in the UK

It is generally agreed that the UK has a clear demand for qualified and trained interpreters (Webb and Rabadán-Gómez, 2016, p.47). This is supported by various reports, articles and books (Corsellis, 2008; Graham, 2012; Giambruno, 2014 ; Hale, 2007). Due to limited budget, the UK interpreting service offers very little training for interpreters (Dagleish, 2016, p.91). It has been argued that one of the major challenges confronted by stakeholders in the UK is to provide appropriate training for their interpreters (Webb and Rabadán-Gómez, 2016, p.35). Thus, the call for investment to train community interpreters to work in specific sectors (such

as health or legal fields) has been flagged up as one of the major concerns in the interpreting service in the UK (Perez and Wilson, 2006).

It has been reported that although British training institutions offer programmes, the number of British Institutions providing PSI as part of their curriculum is still limited. Furthermore, this training is only provided at postgraduate level. According to the information on the Prospects Postgraduate Courses website: (https://www.prospects.ac.uk/postgraduate-courses?gclid=Cj0KCQjw-uH6BRDQARIsAI3I-UeFcG3Ir-mxYnctWjiELeW6R6NANi6z1Iz9JeCtfZjwRE3SiQKBq3AaAg6UEALw_wcB), only one university, Heriot Wat University (Edinburgh) in Scotland provides a one-year specialised degree programme.

However, there are some other further education institutions that provide PSI training as separate programme of study (Ricoy, 2010). This research training is new, and interpreters focus on studies of the process itself. Adam et al. (1995) Ostarhild, (1998), Sandrelli, (2001) and Corsellis, (2005, 2008) maintain that interpreting organisations must contribute towards interpreter development.

3.6.3 Costly training programmes

The high cost of training and sitting examinations along with the membership fees for professional associations can be an obstacle for potential interpreters. Corsellis (2008) points out that training and funding costs present a substantial obstacle for interpreters, in comparison with the low rate (salary) available to them. Also, in a report prepared for *Routes into Languages* by Anne Marie Graham of Arqueros Consulting, it is stated that there are no public funding sources to support such high funding, and few bursaries and training

programmes (Graham, 2012). D'Hayer (2012, p.240) mentions that because of poor funding there is no funding that covers the training of all languages in specific lectures.

Nonetheless, a small group of interpreters and translators receive limited funding for training to meet specific needs. Others are offered a training course by higher education institutions as part of their course curriculum (Hale, 2007). However, Ricoy (2010) remarks even that if the training is provided, the issue of investing time and money to become a qualified interpreter may remain an insuperable barrier. It must be borne in mind that a qualified interpreter does not have the same reputation as other similar professionals, with little chance of having a full-time employment and working for only slightly more money than the minimum wage (ibid).

D'Hayer identifies a number of problems encountered by future interpreters when deciding whether to take a training course: courses are not available in the desired language combination; students have dropped out and the course has had to close; – as a result of poor funding, there are insufficient funds to pay all language-specific lecturers; insufficient resources in interpreting, language and learning support; lack of available teaching and interpreting expertise; cross-fertilisation with expertise from conference interpreting scarcely exists; little or no theory is taught; little understanding of PSIT as a profession or the professionalisation process; low pass rate for the Diploma in Public Service Interpreting (DPSI) (D'Hayer, 2012, p. 240).

3.6.4 Lack of interpreter trainers for all languages

Another issue occurs in training lies in the inefficiency of training providers. It has been stated that practitioners taking part in training may lack the formal teaching skills, experience and academics have limited personal experience of interpreting or translation for the PSI.

Hence, it is crucial to train the trainers, and provide support to enhance their skills (Graham, 2012).

Thus, the shortage of training programmes for CI can be related to another issue the need for skilled trainers. Therefore, researchers call for "train-the-trainer" courses. Such courses should be delivered prior or along with the CI training programmes (Englund and Dimitrova 2002; Corsellis 2008). Kalina (2001, p.58) states that it is insufficient to utilise conference interpreter trainers to train CI as this may result in some problems.

When developing a course, as already mentioned, difficulties fall into three categories: (1) deciding on the most important course contents, (2) developing the most efficient teaching methodologies, with linguistic and cultural competence in both languages, (3) and recruiting qualified instructors (Hale, 2007, p.169). Recruiting instructors with the necessary work experience in a non-established discipline is a difficult task.

3.6.5 Shortage of training providers

Shortage of skilled workers occurs when the demand for workers for a skill is greater than the supply of qualified employees. Hence, this is the case with training providers; the teaching staff are limited and insufficient. This may hinder provision of the appropriate training. Graham (2012) reported in "Routes into Languages" one of the participants' views regarding training. This university tutor stated: "there are 365 languages used by the London [Metropolitan] Police. Don't tell me that every single institution can teach and train interpreters in all of these languages" (Graham, 2012, p.31).

Furthermore, some of the languages may be unknown or not even listed in any formal learning programmes. Even though a group of qualified teachers may be available,

“everchanging migration flows” cause an obstacle to finding instructors with the appropriate expertise in the newly required languages (Valero-Garcés, 2016).

3.7 Modes of Interpreting

In the following sections, I will consider various modes of interpreting: F2F interpretation (Section 3.7.1), telephonic interpreting (Section 3.7.2) and video-interpreting (sections 3.7.3-3.7.3.2.2).

3.7.1 F2F interpretation

F2F interpreting is one of the most frequently used methods of interpreting in HC. It is also called ‘consecutive’ interpreting (Srivastava, 2007). The interpreter interprets for the HCP and HCU using ‘pauses’ to allow him/her to process the message and transfer the information to the receiver (Putsch, 2002). This mode allows the interpreter to ‘observe’ the body language of speakers (Srivastava, 2007, p.131). Studies have found that interpreters and HCPs prefer F2F interpreting over other forms. Their second preference is videoconference interpreting, while TRI comes last (Locatis et al., 2010).

3.7.2 TI

This is type of RI can be used in an emergency. Interpreting is done via the telephone. SUs may use telephone speakerphones, headphones, and headsets (Srivastava, 2007). In this mode of interpreting, the interpreter can be either at the same location as one of the speakers or at a different location (Lee, 2007, p. 231). The interpreter can even work from another country. Working from another location is called TRI (Braun, 2007, p.21).

The Language Line is one of the most popular agencies that providers this service by allowing access to interpreters 24 hours a day, seven days a week (Srivastava, 2007). One of the main benefits of this mode of interpreting is that it provides access to interpreters in a short time regardless of the location and time. Another benefit is its cost effectiveness (Gracia-García, 2002; Mikkelson, 2003), as TRIs are only paid by the minutes they interpret. Furthermore, TI allows access to qualified interpreters at short notice. Interpreters are thus able to accept more assignments (Cheng, 2015; Gracia-García, 2002; Lee, 2007). However, TRIs also raises some concerns such as that it can be an ineffective method of communication. Speakerphones can interfere with patient's confidentiality (Srivastava, 2007). Another negative is the inability to provide access to the SU's non-verbal cues (Srivastava, 2007, p.131), such as body language, which may create vagueness in turn-taking process and can lead to role overlapping (Cheng, 2015; Rosenberg 2007). TI has also been criticised based on poor sound quality (Locatis et al., 2010).

3.7.3 RI

Through the development of technology, a new type of interpreting has emerged. RI, as its name implies, does not require the interpreter to be physically present in the assignment. Hence, the interpreter does his/her task while physically distant from the client, but his/her language skills are still required. Mouzourakis (2006) describes RI it as: "Remote Interpreting [...] refer[s] to situations in which interpreters are no longer present in the meeting room but work from a screen and earphones without a direct view of the meeting room or the speaker" (ibid, p.46). Through RI, the SU can have access to interpreters which may save time, travel, and money, and achieve efficiency gains (Braun, 2015a, 2015b; Kelly and Pöchhacker, 2015).

Skype is one of the RI methods used. It is a free communication programme that can be used to make phone or video calls to other Skype users (Skype Limited, 2009). This

programme depends on the 'so-called VOIP' (Voice Over Internet Protocol) (Telekom Austria AG, 2006, p.123). To use Skype, users must download the programme and then create an account. Adding the desired contacts can be done by clicking on the green button in the Skype menu. Pressing on the red button is used to end a call (Korak, 2012). Using skype as a method in interpreting can have positive and negative implications.

3.7.3.1 Advantages of RI

The demand for RI is increasing for several reasons. Cost-effectiveness is one of them (Winteringham, 2010). Participants who took part in a study entitled *Remote Interpreting via Skype a viable alternative to in situ interpreting?* agreed that Skype interpreting is 'time-saving' and 'cost effective' (Korak, 2012). RI is mostly used by the NHS, the Foreign and Commonwealth Office, local government, and police forces (Avon and Somerset Police, 2007; Lanuguage Line Solutions, 2015). While F2F interpreting charges per the hour, TI charges per minute, which means that it is cheaper than F2F interpreting (Language Line Solutions, 2015).

The United Nations and European Union have already shown an interest in this type of interpreting to cut the costs of the interpretation service. Donovan (2005) states: "this seems a very likely development for reasons of cost (saving on travelling expenses) and space […]. There are also environmental considerations, with growing concern about air travel, as evidenced in a recent advertisement (ibid, p.5).

Thus, utilising RI interpretation service can cut unnecessary costs RI means working from home or the office without having to travel. This increases the chance of accepting more assignments by cutting the travel time (Winteringham, 2010). This provides faster access to interpreters in various areas and for languages where no on-site interpreters are accessible (Andres and Falk, 2009).

3.7.3.2 Disadvantages of RI

Despite the benefits of RI interpretation in providing cheaper forms of interpreting by reducing the travel costs and therefore cut down remuneration, RI can suffer from the lack of non-verbal communication (Andres and Falk, 2009; Masland et al., 2010; Veasyt, 2018). RI interpretation may also be of a lower standard than other forms of interpretation due to technical problems (Saint Louis et al., 2003) such as confidentiality of sensitive data, as explained in the following section.

3.7.3.2.1 Skype interviews are an inadequate tool to assess the patient's cultural background

A clinician who took part in the interview argued that Skype does not allow interpreters to provide additional information about patients. The participant argues:

> I learnt to understand cultural values and traditions through interpreters. However, during video interpreting the situation is rather austere. [On site-interpreters] provide me with information on the patient's behaviour before and after [the interpretation] when, e.g., a Muslim refuses to shake hands [...] and one would misunderstand it. In these situations, [...] the cultural interpretation is needed, and this is almost exclusively possible in an on-site interpretation (reported by Korak, 2012, p.92).

Therefore, using RI is inadequate method in communication. This is because using skype can restrict the interpreter's role as a language facilitator communication and without understanding the patient's cultural beliefs.

3.7.3.2.2 Confidentiality and trustworthiness issues

Ess and the Association of Internet Researchers (AoIR) 2004 suggest that creating a safe online environment can incentivise participants to disclose information in interviews (Ess and The Association of Internet Researchers, 2004). However, interpreters who took part in the same study reported that patients seemed to be 'insecure', and it was hard to build trust with them via Skype (Korak, 2012). In a study conducted in 2018, a participant discussed his own experience in Skype interviews as an online tool for interview. He stated: "the one thing to note with skype is I cannot guarantee the confidentiality of the conversation —Skype have the right to record it if they want to." (Chiumento et al., 2018, p.4) Thus, using skype in HCS is inefficient due to the sensitivity of the patient's data.

It was reported by interpreters who took part in a study that the use of RI has negative both 'physically' and 'physiologically'. It has been explained that one of the main cons with Skype is the 'unavoidable loss of visual information' (Mouzourakis, 2006, p.6). Working from a screen, the interpreter is obliged to read the speaker's non-verbal clues through that screen. This can lead to unpleasant experiences on the interpreter's side such as headaches, eyestrain and sickness, inability to concentrate and loss of motivation (Mouzourakis 2006: 52). Mouzourakis (2006) ascribes these issues to 'remoteness' and 'physical distance' rather than insufficient sound and video.

3.8 Conclusion

Interpretation services suffer from weaknesses in several respects. 'Firstly, despite the NHS's strenuous efforts to provide a high standard interpretation service, and despite the strict

vetting of interpreters in the UK. However, in practical terms unprofessional and untrained interpreters are still sometimes hired.

Secondly, while the NHS is aware of models of interpretation and the codes interpreters have to adhere to, such as confidentiality, it tends to replace the F2F interpretation with RI in order to make the interpretation service more cost-effective. This can have a serious impact on the interpretation services. While the NHS saves money, the interpretation service is blamed for its poor performance.

Thirdly, while the NHS is fully aware of different models of interpretation such as the conduit (linguistic) and non-conduit roles (advocate) of interpreters, due to the inadequate training of interpreters and HCPs, insufficient funding, shortage of training providers, lack of trainers for all languages and the use of RI, the interpretation service is still inefficient.

Support, such as in-service annual training of interpreters, is essential to provide an effective interpretation service. Interpretation services must be designed and implemented using the appropriate model of interpretation at the right time. This will be discussed further in the following chapter.

CHAPTER FOUR

THE INTERPRETER'S VARIOUS ROLES IN MEDICAL ENCOUNTERS

4.1 Introduction

In this chapter we will introduce various roles of the interpreter and what does each role entail. It discusses the progress of the interpreter's role throughout centuries and the interpreter's roles in literature. It presents the difficulty of defining the interpreter's role. It defines the interpreter's conduit (channel and machine) and its limitations in HC settings. It also explores the non-conduit roles (the cultural clarifier, the cultural broker, the cultural advocate and role exchange) in HC encounters. Then, it defines visibility and invisibility in interpretation. It concludes by highlighting the difference between the interpreters' various roles.

4.2 The Interpreter's Role in Theory and Practice

The interpreter's role has been a topic of debate for several decades. Community interpretation has undergone a progression in 'professionalization', where new standards have emerged, and new codes of conduct have been developed (Mikkelson, 1996; Mikkelson, 2012).

For Calle-Alberdi, “the conduit model has had the highest impact on practitioners’ understanding of the profession” (2015, p.17). It is believed that the conduit model has had this impact for two main reasons:

- The conduit model can minimise the interpreter’s presence and their impact on the communication and hence claim reliability and authority for their service (Hsieh, 2002).
- The conduit model seems to be a straightforward way of interpretation that requires less training than other models (Hsieh, 2009, p.136).

However, the conduit role has been criticised on the grounds of being difficult to carry out in practice (Roy, 2002). Hence, medical interpreters tend to move beyond their traditional passive role and act as active participants (Angelelli, 2004; Davidson, 2000; Hale, 1999; Hale and Gibbons, 1999; Rosenberg, 2001).

It has been argued that CIs working in hospitals, social security offices or courts tend to go beyond their traditional role as machine interpreters and work as non-conduit interpreters (Roberts, 1997; in Moody, 2001, p.39). Angelelli (2004) indicates that interpreters perceive their role as active participants regardless of their work settings (court, hospital, or conference). Therefore, even though interpreters assume the conduit role in principle, they still in practice work as active participants in the HC setting (Hsieh, 2009, p.149).

4.3 Critical Views on the Interpreter’s Role

Several authors have stressed the need to explore the interpreter’s role (Baker, 2010a, 2010b). Collier (2010), Dragovic-Drouet (2007), and Footitt and Kelly (2012) also stress the importance of the interpreters’ role and the need for it to be investigated. Since the patient’s

needs and circumstances are always changing, so are the requirements of the interpreter (Inghilleri, 2009; Juvinall ,2013). Ozawa, (2008); Palmer (2007); Rafael (2007); Stahuljak (2009). Accordingly, there is a need to keep the interpreter's role under constant observation (Gibb and Good, 2014). Takeda (2009) and Vieira (2014) point out the related need to analyse the weaknesses and strengths of interpreters in carrying out their work. Anderson (2002) strongly believes that "the interpreter's role is always partially undefined" and "inadequate" (ibid, p.211). Despite of the vagueness of the role, however, the demand for, and the significance of, the interpreter remains the same (Baigorri and Mikkelson. 2014a; Delisle and Woodsworth, 2012; Mairs, 2011).

Without the interpreter, the two parties will not be able to communicate with each other. The interpreter is "the man in the middle" (Pöchhacker and Shlesinger, 2002). Being a bilingual individual gives the interpreter the ability to facilitate communication between two monolingual parties (Pöchhacker and Shlesinger, 2002; Napier, 2013), who do not share the same language and culture (Kohn and Kalina, 1996, p.118). However, it has been argued that the interpreter should be not only bilingual but also bicultural (Sigurðardóttir, 2012). The interpreter tries to find linguistic and cultural 'equivalents' to make the communication more effective between the two speakers. Therefore, interpreting requires the interpreter to be proficient in both languages (the source and the target languages) of the participants and have a deep understanding of their culture too. Sigurðardóttir (2012), Kohn and Kelina (1996), and De Johng (1991, 1992) highlight the significance of both language proficiency and cultural knowledge in building effective communication between speakers. Similarly, Gibb and Good's (2014) focus is on the "interplay between language and intercultural communication" (p.396). Thus, interpreters are defined as going beyond a limited role as language switchers or just 'translating', to "developing the results" and "shaping the development of the mediated encounter" (Pöchhacker and Shlesinger, 2002, p.339). Mason and Ren (2012) even view the

interpreter as a “co-constructor of the interaction” (ibid, p.213), contrasting this with the traditional role of the interpreter, which is “[…] transparent, invisible, passive, neutral, and detached […]” (ibid, p. 233).

4.4 Different Views about the Role of the Interpreter in HC Settings

The language and cultural differences between the HCP and the HCU can hinder effective communication (Bischoff et al., 2003; Kale and Syed, 2010; Ngo-Metzger et al., 2003). In HC, language impediments may result in poor HCS which may impact on the patient and the HCS. Patients may be less satisfied with the service and may stay longer in the hospital (Lindholm et al., 2012; Ngo-Metzger et al., 2007).

It has been stipulated that providing a high standard interpreting service plays a crucial role in enhancing the quality of care (Baker et al., 1998; Dang et al., 2010; Green et al., 2005; Kline et al., 1980). To improve the quality of the interpretation service, a fixed definition on the role of the interpreter in HC is required. However, the main issue is that there is no agreement yet among HCPs, HCUs, and interpreters with regards to the interpreter’s role in medical settings (Fatahi et al., 2008; Fatahi et al., 2005; Ngo-Metzger et al., 2007). This results in trouble in explaining the interpreter’s role. Many interpreters explain their role as ‘ambiguous’ (Fatahi et al., 2005). Thus, the difficulty in determining which communication strategy to use (Hsieh, 2008) may result in interpreting errors (Aranguri at al.,2006; Butow et al., 2011; Flores et al., 2003).

4.5 The Complex Role of the Interpreter

The main question researchers raise here is whether the interpreter is an active or inactive participant in the communication process. It has been stated that the complexity of interpreting behaviour lies in his/her 'inter-activity' (Pöchhacker and Shlesinger, 2002, p.339).

Mikkelson (2008) points out, "the interpreter's very difficult role is to attempt to understand the intention of the utterance and portray it as faithfully and 'accurately' as possible in the other language" (ibid, p. 115). 'Accuracy' means focusing on the meaning more than providing a word-for-word translation (Martin and Phelan, 2009). The Irish Translators' and Interpreters' Association code (ITIA) considers 'accuracy' to be crucial in the processing of transforming information to ensure the delivery of the correct message (ITIA, 2009). Hale points out that the interpreter's adherence to ethical norms such as "accuracy" may contradict with providing extra information: "there is a fine line between ensuring accuracy and overstepping the mark by offering too much information that may go beyond the interpreter's role" (Hale, 2012, p. 325).

Felberg and Skaaden (2012, p. 95) discuss this issue through offering an example of a psychiatrist who asked a Somali interpreter if she thought that the patient had mental issue. Giving such a professional opinion contradicts with the interpreter's role. The interpreter could have requested further information or clarification about cultural differences that might be useful for the clinician's diagnosis. At this stage, the interpreter's role may extend to making adaptations to "smooth out any cultural differences" or "bridge a wide cultural gap" (Kondo and Tebble, 1997 p.158). Thus, it is vital that the interpreter knows his/her role limit, so his/her role does not overlap with the HCP.

4.6 The Interpreter's Conduit (Linguistic) Role

In this model, the interpreter role's remains neutral, i.e., the interpreter restricts her role to interpret what is being said by both speakers (Ciordia, 2017, p.4). Hsieh (2009, p.151) defines 'neutrality' as remaining objective in the conversation by allowing speakers to talk, think, negotiate, or argue. In this role, the interpreter uses literal interpretation (Cushing, 2003; Tribe, 1998).

The conduit role is defined as limiting the interpreter's 'activities' to interpreting (Bancroft, 2015, p.225). Interpreters are deemed to act as 'channels', conveying spoken messages which speakers have in their brains. This approach signifies a "monological model of language and mind" (Wadensjö, 1998), in which "[…] words and expressions are understood as entities with a fixed meaning" (Bot and Verrept, 2013, p.119). Thus, the interpreter acts as message transmitter from the source language speaker to the target language speaker (Hale, 2007; Rob, 2007, p.82). Any involvement such as 'decision making' should be left to the speaker (Hale, 2007, p.43). Therefore, the interpreter's invisibility is acknowledged as the optimal method of communication (ibid).

Fatahi et al. (2008) support the interpreter's neutrality, and therefore encourage interpreters to be conduits and faithful transmitters of the spoken message. Since neutrality is a common feature of this role and the core of NCIHC (Kaufert and Putsch,1997, Godon et al., 2007), this role has been accredited as the optimal role for HC interpreters in the U.S. (NCIHC, 2001), the UK, Canada, and Sweden (Mikkelson, and Jourdenais, 2015).

Interpreters adopting this model let HCPs retain authority over the interpretation of the patients' conversation (Hsieh 2010, p.154). Interpreters are 'unseen' (Gadon et al., 2007). This makes some researchers describe them as 'invisible' (Angelelli, 2004a) (which we will explain later in this chapter).

Interpreters using the conduit role act as only voices with no personal opinions and no feelings or emotions when disclosing bad news related to death or illness. An interpreter who took part in a study explained his/her role:

> I interpret everything that is said. ... I function as a machine. I interpret everything and try not to be emotionally influenced by what I hear, no matter how hard .... may seem to be. My task is not to be lenient or embellish ... unfortunately, I have to report the situation as it is. So, I interpret everything (Hadziabdic and Hjelm, 2016, p.225).

Hence, HC interpreters are prevented from establishing relationships or acting as active participants to facilitate HCP-HCU communication (Hsieh, 2006).

Both qualitative and quantitative studies have challenged the conduit role, arguing that interpreters are in fact active participants in the communication process (Angelelli, 2002; Hale, 1999; Rosenberg et al., 2007). Dysart-Gale (2005) criticizes the conduit role on the grounds of being misleading, while Wadensjö believes that interpreters should "convey the key personal, historical, cultural and religious elements that form the context in which a particular problem emerged and is played out" (2006, p.1185). This implies that Wadensjö finds the conduit approach insufficient to transmit elements other than language that are crucial in understanding the interpreted message more clearly. This echoes the view of Bot, who sees interpreters as active participants in the conversation (2007, p.83). It also to some extent mirrors Avery's theory that interpreters should work visibly (2001). He adds that interpreters should act as human beings rather than robots. Gadon et al. (2007) support the non-conduit role of the interpreters, arguing that any involvement in the communication can enhance the 'directness' of communication between the HCP and the patient.

4.6.1 The machine role

The machine role (or robot role) is an extreme version of the conduit role. Here the interpreter acts as a device without any involvement (Tate and Turner, 2002, p. 374). He/she makes an "equivalent rendition of the primary speakers' words" (Bot, 2015, p. 256). Interpreters who adopt this role tend to provide 'equivalent meanings of words as they are in the dictionary (Bot and Wadenjo, 2004). In the machine role, interpreters work as robots with no feelings or thinking their sole task being to provide a high standard (interpretation) translation service by maintaining their neutrality (Dysart-Gale, 2005). It is argued that this role can be an 'illusion' and difficult to accomplish. According to Roy, metaphors such as 'machine', 'telephone', 'bridge' are all "clearly try to convey the difficulty of […] interpreting while reminding everyone that the interpreter is uninvolved on any other level" (Roy, 2002, p. 347).

The 'machine-like process' role has sometimes been considered the optimal role in medical interpretation (Hsieh, 2008), and the major role in mental health (Bot, 2015, p.256).

4.6.2 The channel role

The 'channel' role is a less extreme version of the conduit role than the machine (or robot) role. It recommends interpreters to invisible without any involvement in the communicative process (Kotzé, 2014; Tate and Turner, 2002, p.374). Throughout earlier literature, the 'channel' role received support and was considered by many to be the 'correct' role for interpreters (Kotzé, 2014). Some training programmes and NCIHC of different institutions regard the 'channel' role, as the "prevalent ideology for medical interpreters" (Dysart-Gale, 2005; Kaufert and Putsch, 1997). It is intended to ensure accuracy of the message with no distortion of the content (Dysart-Gale, 2009).

In this role, the main function of the interpreter is to act as a 'channel'. However, due to differences between languages in terms of linguistic structure, the interpreter can play a slightly active role in terms of facilitating the transfer of this structure. In this role, she/he can check clients' understanding, but as noted, his/her active role is restricted to linguistic structure. Despite the interpreter's involvement in making changes in the linguistic structure, this role is considered not significantly different from what might be called a 'machine' role (Avery, 2001).

4.6.3 Limitations of the conduit role

Nowadays, the conduit role is increasingly considered out of fashion (Apostolou, 2009). The 'inadequacies' of the conduit role started to be noted in 1990s and was tackled by those who got involved in the 'articulation' of the NCIHC (Avery, 2001). This role has been criticised for being insufficient and too limited to deliver effective communication (Dysart-Gale, 2005; Kaufert and Putsch, 1997; Hsieh, 2006). Kaufert and Putsch (1997) criticise this model on the basis that it fails to address "social class and belief systems" (ibid, pp.71-87).

Some objected the conduit role for being difficult to achieve and impracticable (Bolden, 2000; Davidson, 2001; Dysart-Gale, 2005, 2007; Watermeyer, 2011). It has been pointed out that this role can be challenging in trying to adhere to NCIHC such as 'neutrality', 'completeness' and 'accuracy' (Dysart-Gale, 2005). Davidons (2000) argues that the interpreter's role in practice is different from what is said to them. Interpreters can work as active participants in communication by editing the spoken message to make it understandable or the receiver. Interpreters report that using the conduit role in interpreting with no human interaction can cause feelings of distress (Hsieh, 2006). Thus, the interpreter's role is still subject to debate. In some situations, interpreters are forced to act as visible interveners for the HCP and the patient (Kaufert and Putsch, 1997; Hsieh, 2006).

4.7 The Non-conduit Role in Medical Settings

Dysart-Gale, (2005) and Hatton and Webb (1993) suggest that to achieve successful communication in a medical setting, interpreters are required to go beyond language switching (Bloom et al., 1966; Brislin 1976; and Ingram ,1978), to 'facilitate' communication between the HCP and HCUs (Dysart-Gale, 2005), the interpreter has to be an active participant in the doctor-HCS' communication in order to deliver ethical and culturally sensitive HCS (Dysart-Gal, 2005; Hsieh, 2010).

Similarly, Kaufert, Putsch, and Lavallée (1998) point out that in medical interpretation assignments when the HCPs and the patients do not share the same cultural beliefs, and have different goals from the consultation, the interpreter works as an active participant in resolving these clashes. Hence, the interpreter's role extends to include the cultural and social aspects (Hsieh, 2006, 2007; Watermeyer, 2011). Likewise, Tribe and Tunariu (2009) highlight the importance of language and culture contexts in HC interpretation. Hale (2014) argues that on some occasions the interpreter is the only one who is aware of these differences because, unlike the HCP, the interpreter is both bilingual and bicultural. Hsieh (2006a) and Temple (2002) indicate that interpreters can 'mediate', 'negotiate' and 'reconcile' the 'speakers' message.

Wadensjö (1998) views the interpreter's role as that of an active participant in the process of making sense rather than being inactive (p.41). According to Linell (1997, p. 53) and Wadensjö (1998, p. 41), the "interactive nature of the communicative" process still needs the interpreter's involvement. Linell (1997) and Wadensjö (1998) add that this involvement plays a crucial part yet has hitherto been ignored in the literature. Likewise, Bot (2003) points out that the interpreter's involvement is required in medical or social settings. Niska (2002) argues

that the CI may spend most of the time as a 'conduit'. However, there are certain situations which may necessitate him/her to adopt move across "a spectrum of roles" (ibid).

Thus, extending the interpreter's role beyond language transfer (the conduit role) can involve things such as the 'clarifier' (Section 4.7.1), 'cultural broker' (Section 4.7.2) or 'cultural advocate' (Section 4.7.3) role (Roat, 1996; Working Group of the Minnesota Interpreter Standards Advisory Committee, 1998; Dowling, 1995).

4.7.1 The interpreter as clarifier

The 'clarifier' role permits the interpreter to depart from the limitations of the conduit model in case of "linguistic incommensurability" (Diversity RX, ND). In some situations, the interpreter may become a 'clarifier'. This could involve the interpreter adding further information to make sure that the message is 'accessible' to the receiver. The clarifier role requires the interpreter's interference during the interpretation process. The main purpose of the interpreter's involvement is to make the message clearer to the receiver (Spencer-Oatey and Xing, 2010).

This can result from the following:

- *On the interpreter's behalf*. The interpreter has a poor understanding of the message. Therefore, he/she asks for further clarifications.
- *On the receiver's behalf*. The interpreter's feels that the client has misunderstood the message, even though the message was correctly interpreted (Ibid).

The Northern Ireland Health and Social Services Interpreting Service (2004) adds that cultural factors can also play a significant role in these circumstances as illustrated in the example below where a different meaning to that intended might have been inferred:

> A health visitor in attempting to determine a date of birth may ask to see a passport. Yet such a request to some clients could imply that their status was being questioned, so an interpreter may intervene by explaining to the client why the request is being made and suggesting that any form containing a date of birth will do, this can then be reported back to the Health Visitor (The Northern Ireland Health and Social Services Interpreting Service, 2004; cited in Kotthoff and Spencer-Oatley, 2007, p. 222).

Thus, in the example above the interpreter's works as a cultural clarifier to resolve misunderstanding and make communication clearer.

The following shows that the interpreter has implied information which is not mentioned:

> A GP may offer a hospital referral to a patient for minor surgery. The patient may be resistant as they are not sure if they can afford to pay for this yet may not say so from embarrassment. The GP may have assumed that the patient is aware such treatment is free. An interpreter could prompt this by stating there may be confusion over the issue and asking for clarification (as cited by Kotthoff and Spencer-Oatley, 2007, p.222).

In this example, the interpreter interferes because he spotted the patient's reaction and therefore requested more information from the GP to resolve any

misunderstanding. The Northern Ireland Health and Social Services Interpreting Service (2004) comments on this:

> Interpreters need to be actively on the look-out for such clarification needs, and whether they (decide to) intervene or not clearly impacts on the way in which the discourse develops (as cited by Kotthoff and Spencer-Oatley, 2007, p.222).

This clarifier role is defined by the California Health Care Interpreters Association (CHIA) (2002) as follows: "the cultural clarifier role goes beyond word clarification to include a range of actions that typically relate to an interpreter's ultimate purpose of facilitating communication between parties not sharing a common culture. Interpreters are alert to cultural words or concepts that might lead to a misunderstanding, triggering a shift to the cultural clarifier role" (ibid, pp. 43-44).

4.7.2 The interpreter as cultural broker

According to some studies, the term 'cultural broker' has much the same meaning as other terms such as 'mediator', 'intermediary' and 'gatekeeper'. According to this approach, the interpreter is required to utilise his/her cultural competence skills, while interpreting – as understood in the more traditional sense only involves 'verbal exchange' (Hale, 2007, p. 45). A cultural broker, by contrast, is a "person who acts as a bridge between two interlocutors of various cultural backgrounds" (Ra, 2018, p. 273).

As a cultural broker, the interpreter aims to 'shape' the exchange between both speakers. In this role, the interpreter is not in charge of the contents of the spoken message between parties but acts as a mediator, only interfering if they feel that the contents of the message may not 'benefit' the speaker's culture (Wang, 2017). For example, in HC situations the

interpreter can act as a 'cultural broker' to offer clarifications to avoid any misunderstanding between the HCP and the HCU.

4.7.3 The interpreter as advocate

Advocacy in interpreting is defined by the Cross-Cultural Health Programme (CCHP), a leading training programme of professional interpreters in the USA, as "any action an interpreter takes on behalf of the patient *outside* [italics added] the bounds of an interpreted interview" (Roat et al., 1997, pp. 17-18). Barsky (1996) points out that immigrants entering Canada need interpreters to work as 'intercultural agents' to 'empower' them. The 'helper' or 'advocate' role is adopted by interpreters working for the government or as freelance CIs working in institutions such as hospitals, social security offices and courts. These interpreters act as advocates by going beyond their traditional neutral role (Roberts, 1997). Katan considers that the interpreter plays a more powerful and active role nowadays than in the past (Katan, 1996).

The advocate role requires interpreters to play a more active role in "smoothing over cultural differences, crossing, and working not only as linguistic but also cultural mediators" (Kondo and Tebble, 1997). Advocacy starts when the interpreter adopts the role of advocate for the speaker and shows his/her wish beyond facilitating communication (Drennan and Swartz, 1999; Baylav, 2003; Razban, 2003). At this point, the interpreter starts speaking on behalf of the patient (NCIHC, 2005).

Moody believes that interpreters who work as cultural mediators should have a thorough understanding of both cultures (Moody, 2011), such that 'faithful' interpretation should be based on "faithful goals and values of the community". This can be accomplished by being

helpful to people having difficulty in communicating (ibid, p. 39). Thus, the interpreter's involvement reflects his/her role as a cultural 'expert,' which is his/her biggest contribution beyond being linguistically competent (ibid). Fozooni (2006) considers that the language 'practitioner's' role as "cultural hermaphrodite, crosses the actual divide via meaning transfer and insists on creating meaning with the original author and audience" (Fozooni 2006, p.283).

Jackson-Carroll et al. highlight the significance of the advocate role particularly for medical interpreters (Jackson-Carroll et al., 1998, p.30). It is stated that the advocate approach can have a positive impact on the quality of both care and communication (Diversity Rx, n.d). It is indicated that the advocate role increases effectiveness in preventive screenings (Graham et al., 2008) and diagnostic interventions (Preloran et al., 2005).

Laster and Taylor (1994) and Mikkelson (1998) have encouraged interpreters to work as active participants while interpreting to ensure that their minority clients' needs are met, and they have an easy access to HCS. Therefore, adopting the advocate role in communication aims to 'empower' patients who are unable to receive 'fair' and 'equal' HCS (Hsieh, 2008, p.1372).

Advocacy allows the interpreter to help HCUs when the HCS fails to provide a quality service to LEP patients. Stacey, an interpreter who took part in a study, stated:

> because I am an advocating for [the patient], because they might be worried, but they don't know what they are worried about. So, I ask them, "Would you like to ask if taking the medication has side effects? So, I help them to understand some of the procedures and foresee something so that they would not worry about [it] later (cited in Hsieh, 2008, p.1372).

Adopting this role implies that the interpreter can provide cultural background to facilitate communication and understand the message, thereby becoming the patient's advocate by acting on his/her behalf (Martin and Phelan, 2019). This role gives the interpreter more freedom to work as an active participant in certain circumstances. Interpreters act as advocates when they are confronted with a cultural barrier (Kai, 2006) which requires the interpreter to work as a facilitator and negotiator of both language and culture, and an active, visible participant in the conversation (Preloran et al., 2005). This can involve talking on behalf of the patient to protect his/her dignity, moral values, and safety (Dušková, 2018).

Unlike the conduit role, where the interpreter's interference is minimised, the advocate role involves maximal interference on the part of the interpreter (Ciordia, 2017, p.175). This role can significantly diminish the interpreter's impartiality (Martin and Phelan, 2010, p.16). Stacey further explains that on some occasions where cultural, educational, and socioeconomic status differences exist they can determine the patient's ability to access HC. Interpreters can ensure that patients receive a quality HC service, which encourages the interpreter to act as an advocate on the patient's behalf to ensure that the patient receives fair clinical results. She argues:

> [the patients] don't ask you questions. I know that they have concerns. So, if I know them, and they have a serious problem, I tell them whatever thing that [appears] in their mind, even though they don't know how to voice their concern to tell me, give me a key, give me a word or something that they don't understand. So, I can be their voice. So, I ask different questions to the doctor on their behalf (Hsieh, 2008, p.1373).

The interpreter in this role can also 'negotiate' for patients to allow easy access to HCUs from different cultural backgrounds (Abdelhamid et al. 2010; Douglas et al. 2014, Shannon et

al. 2016). This can help ensure the delivery of an equal and culturally sensitive HCS that meets the requirements of ethnic minority patients (Tribe and Morrissey, 2004).

4.7.4 Role exchange in HC setting

Role exchange occurs when the interpreter takes the role of the HCP through asking questions not provoked by the doctor (Davidson, 2001; Vasquez and Javier, 1991). This role is also called 'turn exchange' and is believed to cause 'errors' in interpretation (Vasquez and Javier, 1991). Thus, it is advised not to use this role due to the risks that it may entail (Angelelli, 2004; Bolden, 2000; Davidson, 2000), unless the interpreter performs the active role effectively through understanding the 'ethical' and 'practical' consequences of this role (Hsieh, 2006). One of the strategies to avoid the errors that may result from 'role exchange' is that interpreters are encouraged to make this role visible to the other participants. This can be accomplished by explaining and interpreting what is being said in the 'role exchange' to the other participants (Laws et al., 2004).

Hsieh (2007) notes that 'role exchange' is an approach used by some HC interpreters and in this role, they are sometimes called 'co-diagnosticians'. A 'co-diagnostician' is an interpreter whose visible behaviours during interpretation makes them a 'collaborator' in the 'diagnostic' and 'treatment process' (Hsieh, 2007). The term 'co-diagnostician' was first coined by Davidson (2000). In this role, the interpreter acts as an active assessor of the spoken message, then he/she then interprets the message without notifying the source language speaker of the filtering process. The interpreter also acts as an active participant in diagnosing and prescribing the HCU's treatment. The interpreter's role overlaps with that of the HCP (Hsieh, 2007), and may overstep the boundaries between patients and the HCP which may lead to confusion (Hsieh, 2010; White and Barton Laws, 2009).

4.8 Invisibility

Closely related to the conduit role in interpreting is the notion of invisibility. In language interpretation, 'invisibility' means that the interpreter acts as a communicator between the two speakers by transferring ideas of a conversation from one participant to another. However, the interpreter's role should be void of any interaction (Resta, 2013, p.3).

Maria M. Rivera defines the interpreter's invisibility in *Invisibility vs Transparency* (2012) as being neutral in the communication between the speaker and the receiver. She explains that some interpreters tend to remind the patient or the HCP of their invisible role by saying in the pre-session: "imagine I am not present" (ibid). Adopting the invisible approach during interpretation means that the interpreter is physically visible but invisible in performing his/her job as an interpreter (Rivera, 2012). Being invisible is interpreted as taking a machine-type 'conduit' role without being involved in the conversation, by being imprisoned in the text or the dialogue (Clifford, 2004, p.92).

Academic literature frequently describes interpreters as having an invisible, uninvolved, and mechanical role. According to Kaufert and Koolage (1984), interpreters are "direct linguistic translators" (ibid, p.283). Invisibility in interpretation rigidly restricts the interpreter's role to that of message conveyer from the source language to the target language without any involvement in the context (Dillinger, 1994; Gile, 2001). Reddy (1993) relates the interpreter's invisibility to the conduit role (ibid, p.170). According to this, the interpreter should remain invisible and inactive while interpreting (Kotzé, 2014, p. 127). Bancroft claims that "those of them who stay within the conduit role tend to label themselves 'professional interpreters'" (Bancroft, 2015, p. 14).

Metzger (1999) considers the interpreter to be 'neutral', and Chia (2000) believes that the interpreters is a "message-converter" (ibid, p.13). Bar-Tzur (1999) compares the interpreter's uninvolved role to that of a "telephone wire that serves as a conduit information flow" (ibid., p.4).

The common links between all these definitions together are 'accuracy' and 'completeness' (CHIA, 2002, p.30). Barring the interpreter from making any change in the content, adding, or editing the spoken message is another feature that unites these definitions (Abraham et al., 2004). Therefore, despite the different terms used to describe the interpreter's invisibility, all the above-mentioned researchers believe that the role of the interpreter is to deliver the message neutrally, faithfully, and precisely with no emotional involvement that may impact interpretation (Frishberg, 1990).

4.8.1 Invisibility and interpreter's speech style

The interpreter's speech style has been a matter of interest for many scholars. The focus is whether the interpreter uses the first-person or the third person pronoun. More broadly, do interpreters speak as if they are the person whose speech "they are translating, or do they speak about him?" (Angermeyer, 2005, p. 32). Switching to the first person can enhance the interpreter's invisibility, equating the interpreter's voice with that of the speaker. Hence, scholars like Edwards (1995, p. 83) and Colin and Morris (1996, p. 146) encourage interpreters to use the first-person pronoun. It is important to note here, however, that the use of first person is a linguistic convention and differs according to the language used.

González et al., (1991) discuss the interpreter's speech style in using the first and third person and how this may impact the interpreter's invisibility. While the first-person interpreting style correlates with the interpreters' invisibility, and has been favoured in

professional interpretation (Moore, 2007, p. 76), the 'third person' pronoun is classed as 'unprofessional' (Pochhacker, 2004, pp. 151-2; Harris, 1990, pp. 115-116; and Berk-Seligson, 1990, p. 65). It has been pointed out that interpreters who adopt the advocate role tend to use the third person. This is because the advocate role requires the interpreter to involve his/her voice (Lang, 1976).

4.9 Visibility

Visibility is closely related to the non-conduit role in interpreting. It is defined as "having the power to influence the interaction" (Zheng, and Xiang, 2018, p. 4). It has been argued that this allows the interpreter more freedom to intervene. Interpreters are "openly facilitating negotiations over meaning" (Inghilleri, 2013, p. 2). According to some studies, in this role the interpreter is "a full-fledged participant in the discourse" (Rosenberg, 2002, p. 222). The interpreter's visibility has been endorsed by scholars such as Roy (1989), Wadensjö (1998) and Rosenberg (2002). Ren (2010) defines visibility as going beyond the language barrier.

The interpreter's invisibility, which has been valued by some scholars, has thus been rejected by others. Invisibility can be challenging for CI (Hale, 2007). Building effective communication requires the interpreter to be visible; "many of the 'dos and don'ts's' of the prescriptive/proscriptive codes merely serve to inhibit interactions" (Llewellyn-Jones and Lee, 2014, p. 9).

Lang (1975), Wadensjö (1998b) and Tryuk (2004) argue that interpreters depart from their prescribed role at some point while interpreting. Likewise, Zheng and Xiang postulate that despite the interpreter being encouraged to adopt an invisible role, in practice the client

allows the interpreter to 'step out' of the invisible 'ghost' role by becoming visible to ensure effective communication and smoothen interaction (Zheng and Xiang, 2018).

A study conducted in Vienna noted that medical interpreters and service providers perceive the interpreter's role as more than translating. The study revealed that interpreters see their task as including adding clarifications when necessary. Interpreters are expected to "adapt their utterance to client's communicative needs and bridge circumlocutory utterances by clients" (Pöchhacker, 2000, pp. 49-63).

According to Angelelli, who conducted interviews in the USA, Canada and Mexico, interpreters consider themselves to be visible agents (Angelelli, 2003, 2004). Angelelli's (2004a, 2004b), survey methods along with fieldwork, HCPs call for a more visible role of the interpreter. Hence, the interpreter is seen as 'visible agent'. Angelelli (2004b) reported that 100 conference interpreters took part in the study called for an 'active role'.

The interpreter's role includes building trust, "facilitating mutual respect, communicating affect as well as message, explaining cultural gaps, controlling the communication flow and aligning with one of the parties to interactions" (Angelelli, 2003, p. 26). It is worth noting here that all these tasks require the interpreter to be visible.

An Australian study by Slatyer and Chesher (2007) revealed that 65% of interpreters who took part in the study perceive their role as "gatekeepers", smoothing communication and overcoming cultural barriers (Slatyer and Chesher, 2007). Both Angelelli (2003) and Slatyer and Chesher (2007) believe that the interpreters should be a visible mediator in communication. Similarly, Roy (1996) shows that the interpreter's role involves techniques for managing communication. Hence, the interpreter functions as a visible active agent in interaction (Roy, 1996).

Mason (2004) perceives interpreters as “highly visible and active participants in three-way exchanges” (p. 89). The interpreter’s invisibility has been challenged by Merlini and Favaron as follows:

> […] is it realistic to compare a dyadic, linguistically, and culturally homogeneous interaction with a triadic encounter where the interpreter is a visible, ratified participant and the only person with knowledge of both interlocutors? (Merlini and Favaron, 2003, p. 209).

As an active participant who plays a visible role, the interpreter may use both language and culture skills to establish clear and effective communication between participants. This requires the interpreter to act as a visible mediator in the communication.

Angelelli argues that the interpreter’s visibility or invisibility varied according to the context they work in, whether this be medical, conference or court interpretation. The survey results conclude that medical interpreters consider themselves to be more visible than court interpreters (Angelelli, 2004). This accords with Mirdal’s argument on the interpreter’s invisibility as insufficient to build effective communication particularly in medical settings. Thus, ‘machine’, ‘neutral’ and ‘channel’ roles are inadequate in this context. The interpreter’s task should not be restricted to linguistic transfer of the message because “meanings” (in the broader cultural sense) are as equally important: “In a therapeutic situation the interpreter cannot and must not remain invisible” (Mirdal, 1988, pp. 327-328).

Mirdal views the patient as more vulnerable than the clinician. Therefore, a limited amount of personal and emotional involvement by the interpreter is recommended: "most patients are not particularly motivated to start therapy" (Mirdal, 1988, p.329). This personal relationship with the interpreter may have a positive effect on the patient’s adherence to the treatment. This approach implies that providing an explanation when cultural conflict occurs,

advising clients of their rights, ensuring the client's understanding, controlling communication, and resolving disputes are at the core of the interpreter's role and responsibilities (Giovannini, 1992; and Roberts, 1997, p. 26). This goes in line with the advocate model (as discussed in section 4.7.3). It has been reported that this role "is performed more frequently than one might imagine, without being defined as such" (Schneider, 1992, p. 57).

The 'mediator' role of the interpreter is linked to visibility, where the interpreter "goes beyond the role as a language decoder and encoder and acts as an active participant of an intercultural communicative event to mediate the interactional process in order to bridge the communication gap between the two primary parties and help them achieve their communication goals" (Ren, 2010, pp. 125-126). Knapp (1986) indicates that the interpreter acts as a 'linguistic' 'mediator' and an active participant in the conversation rather than invisible and neutral.

Thus, the interpreter's advocacy includes involvement on his/her part, which requires him/her to use other skills other than language, such as cultural knowledge, manage the flow of communication, omit, add clarifications, and show empathy or sympathy all of which make the interpreter more visible in communication.

4.10 Conclusion

As discussed in this chapter, interpreters can work in a conduit or non-conduit role. While the conduit role requires the interpreter to be invisible and not involved in the conversation, the non-conduit role requires the interpreter to be visible and involved. The conduit role can be sub-categorised into two sub-roles: machine (or robot) and channel. The common tie

between these roles is that the interpreter is required to use his/her language skills to facilitate communication. Since the conduit role restricts the interpreter to only using his/her language skills, it is also called the 'linguistic' role (Roy, 2002). While neither of the 'machine' (robot) or 'channel' roles require interference from the interpreter, the channel role allows the interpreter to use his/her language skills and intervene on occasion to resolve language difference issues that may result in miscommunication.

Unlike the conduit role, the non-conduit role gives the interpreter the freedom to be visible by using his/her cultural knowledge in interpretation. This role can be sub-categorised into the 'cultural clarifier', 'cultural broker', 'cultural advocate', and 'role exchange' sub-roles. In all these, the interpreter can use his/her cultural knowledge, the main difference between them being the degree of the interpreter's interference and the reasons for his/her interference. The cultural advocate role (which is the focus of our study) requires more interference than other non-conduit roles (except role exchange).

Since language and culture are interconnected (as explained in Chapter 2 Section 2.2), it is insufficient for the interpreter to restrict him/herself to the conduit role. There are several factors that may allow the interpreter to adopt the advocate role in HC interpretation. Angelelli (2004) believes that using this approach can reduce the cultural gap between the HCP and the HCU,and can therefore improve the HCU's health literacy (ibid), while Hsieh (2006a) argues that this role can help the interpreter to reconcile any conflicts between the HCP and the HCU that may result from cultural clashes. Dysart-Gale (2005) and Metzger (1999) also point out the significance of this role in improving the quality of patient and HCP's interaction.

The following chapter will provide some examples of the significant cultural barriers between Muslim HCUs and UK based HCPs, and the interpreter's role as cultural advocate in minimising cultural conflict between speakers to build an effective form of communication.

CHAPTER FIVE

MUSLIM BELIEFS IN HC

5.1 Introduction

This chapter sheds the light on Islam-related practices, beliefs, and habits in HC. It explores Muslim patients' dietary restrictions as well as restrictions on medications and vaccines. It presents Muslim HCUs' beliefs about medications and vaccines that are religiously prohibited. It discusses Muslim patients' alternative therapies such as folk, prophetic, and herbal therapies, and their impact on HC if not discussed with their HCPs. It outlines Muslim HCUs' views of health and illness. It concludes by exploring the effect of fasting on patients' treatment and illness.

5.2 Issues Specific to Muslim Patients

One of the basic principles in Islam is the issue of 'permissible' *halal* and 'forbidden' *haram*. For Muslims, everything that is clean and pure is considered *halal* and everything that is opposite to this is *haram* (Khattak et al., 2011).

Halal certification involves officially certifying something to be *halal*, this being a term exclusively used in Islam which means permitted or lawful. There are no parties which can claim food is *halal* without complying with Islamic Law. *Halal* and *non-halal* cover all spectrums of Muslim life and are not limited to foods and drinks only (Baharuddin et al., 2015,

p.171). Thus, the term *halal* is used for everything 'permitted' or 'lawful' complying with Islamic law (ibid).

The term *halal* refers to any food that is prepared according to the Muslim dietary rules, including lawful food. *Haram* refers to prohibited food that either contains prohibited ingredients such as pork or alcohol or prepared in a way that contradicts with the Islamic law. For instance, slaughtering a sheep without invoking the Islamic blessings on it is *haram* (Baharuddin, 2015, pp.171-173).

Devoted Muslims are restricted with some dietary rules that they are only allowed to consume *halal* food products including medications. Some Muslim patients in the UK are confronted with difficulty with regards to *halal* and *haram* medications and treatment.

5.2.1 Views of Muslim scholars concerning the use of otherwise *haram* products

Although the distinction between what is *halal* and what is *haram* is generally agreed in Islam, there are different views among Muslim scholars concerning whether it is ever acceptable for Muslims to use products containing *haram* ingredients.

A contrasting view was adopted by some Muslim scholars that the use of gelatine in medication derived from *halal* animal it is permissible to consume. However, in situations where there is no *halal* alternative the patient can take the medication under the 'law of necessity'. In terms of vaccines, they are allowed to be taken as they are used for medical reasons. In Islam, vaccination is important to protect an individual's life therefore its ingredients cannot be classed under diet religious restrictions (Grabenstein, 2013).

Some patients may agree to take medicines that contain *haram* products, as allowances in their religious observance may be made for the sake of their physical health (Department of Health/EHRG, 2009, p. 25).

However, this is not applicable to all patients. Despite the possible health advantages of porcine-derived products, consuming them could impact negatively on the patient's moral and spiritual wellbeing. While some drugs or vaccines are derived from pork can be more effective than other alternatives (nasal flu spray for children is more useful than injection (NHS, 2015). For example, using *haram* derived medications can therefore create moral and spiritual harm for some Muslims because they interact with their religious beliefs.

Therefore, Muslim patients have the right to know about their medication's ingredients whether they include, for instance, any porcine-derived products. Thus, it is not uncommon to hear comments such as, "as a Muslim, I would like to be told if any of medicines comes from pigs" (Mynors et al., 2004, p.22).

It is recommended that "professionals should strive to understand that a Muslim patient may or may not be following recommended treatment because of his or her religious beliefs" (Attum and Shamoon, 2018, p.20). Therefore, prescribing alcohol-free, gelatine-free or porcine free antibiotic or *halal* medications could be an option for Muslim patients. However, in emergency cases where no alternative drugs are available the patient is permitted to use the medication (Attun and Shamoon, 2018).

5.2.2 Prohibited foods, drugs, and medication for Muslim patients

The great majority of *haram* products are derived from pigs or from alcohol. Forbidden substances are utilised in some medicines, immunisations, vaccinations, and other

treatments. In the UK, animal substances, including porcine-derived substances, are not only found in medications, they may be also found in some types of dressings for the treatment of acute wounds and burns, human or animal derived grafts, and in vaccines against diseases such as mumps, measles, and rubella, which may contain animal derived substances such as pancreatic enzymes (Public Health England, 2013).

It has been stated that animal-derived medications raise an issue for five million patients in the UK. This could be due to lifestyle, religious reasons, ethics, or allergy. Under the Equality Act (2006), patients with dietary restrictions should be respected and their ethical and spiritual dietary needs must be addressed (Mehta, 2007). Since doctors in the UK have no access to information on medical products components, they are unable to obtain consent from their patients (Eriksson et al., 2013).

Religious beliefs regarding some diet restrictions and prohibited animal-derived medications may impact medical decisions which can negatively affect medical care (Easterbrook and Maddern, 2008). It has been pointed out that "people conducting immunisation programs may encounter individuals who hesitate, question, or decline some or all vaccines or immune globulins based on religious beliefs or related cultural reasons" (Grabenstein, 2013, p.2021).

Muniba Naeem; a locum pharmacist in South London, UK, who took part in a study called for engaging patients in the treatment plans. She believes that animal-derived medications are allowed to improve health (Ogden, 2016). She further stated that in her experience as a pharmacist, she met Muslim patients who share the same religious beliefs, but they might react differently towards accepting or declining medications that are porcine derived which may impact their HC. According to Naeem, the optimal way to improve clinical 'adherence' for Muslim patients is to "allow patients to make an informed decision" (ibid, p.51).

Therefore, prescribing animal-derived medications, dressings, or implants to patients with certain diet restrictions due to religious beliefs or "animal welfare considerations" raises some concerns (Newson, 2009, p.5). This can result from the HCP's lack of knowledge of the ingredients of some medications and may lead to the patient's mistrust with the HCP which may lead to poor clinical results.

It is important to be aware that the Muslim population is diverse, and that the practice of religion and adherence to its rules can vary from one individual into another, depending on several factors such as ethnicity, age, sex, geography, and education (Fraser Health Authority, 2014, p.21). Level of education, for instance, can have an impact on patients' acceptance or rejection of some medications or treatments that may contradict with their religious beliefs. Thus, The Department of Health/EHRG (2009) recognizes and emphasizes that HCPs have to be aware of stereotyping Muslim HCUs as different patients may react differently to different treatments and procedures that might conflict with their religious beliefs and cultural values.

5.2.3 Effects of Muslim patients' attitudes on their use of medical products

A study conducted in the UK, involved 64% of patients and 56% of GPs, revealed that some Muslim patients occasionally do not adhere to medical advice for one of two reasons; either they are uncertain of the components of the medication (*halal* or *haram*) such as alcohol or animal-derived medications, or they ignore medical advice because they are fasting or for some other religious reason (Nunes et al., 2009). Mynors et al. (2004) argue that animal-derived medications can impact patients' accepting the treatment. This can lead to adverse clinical outcomes such as aggravating the disease, or even death, and may be cost-ineffective for the NHS (Jimmy and Jose, 2011). Misunderstanding and lack of cultural knowledge can be

a factor which could lead to ineffective communication and consequently non-adherence to the treatment.

5.2.3.1 *Haram* products in medicine

Gelatine is one of the ingredients that is commonly used in some medicines and vaccinations. It can be sourced from fish, sheep cattle and pigs. Gelatine which originates from pigs is termed 'porcine gelatine'. A study took place in the UK revealed that about 74 out of 100 prescribed drugs are either bovine or porcine derived of the capsules (Tatham and Patel, 2014). This stress the importance of discussing medication ingredients with Muslim patients who may decline the treatment (Beddis, 2016).

Nowadays, gelatine becomes one of the main ingredients used in the preparation of pastes, pastilles, suppositories, and capsule shells. This can raise some issues for patients with vegetarian lifestyle and religious beliefs (Mehta, 2007). There are numerous medications that are porcine-, or alcohol-derived. For instance, Aamoxicillin capsules are shelled with porcine derived gelatine which may be unacceptable for some Muslim adherent (Beddis, 2016).

Some cough syrups may have ethyl alcohol in. L-cysteine (a mouth wash) and Heparin (a drug helps to treat blood clots) are normally porcine derived drugs (Mynors et al., 2004). Nasal flu vaccine can be also derived from porcine gelatine (University of Oxford, 2017), as well as MMR (Measles, Mumps and Rubella) vaccine. All Medications that treat pancreas are porcine derived (Mynors et al., 2004).

The following sections will look into some case studies, which illustrate issues previously discussed in this chapter.

Example (1)

A 70-year-old Middle Eastern patient, Mr. D., was admitted to hospital. One of the junior doctor's recommendations was to give Mr. D. "prophylactic heparin which may reduce some the risk of developing fatal venous thrombosis" as he would be confined to bed for a few days. Since heparin is derived from pork the doctor consulted with the consultant as to whether he should disclose the drug components to Mr. D. or not. The doctor was left with 3 options:

- Administering heparin components to Mr. D. This may put the patients at risk of declining the treatment.
- Not disclosing the drug porcine origin is. This may impact the clinical outcomes.
- Prescribing an alternative treatment for clot preventing. This drug is easier to administer. This will be more costly, and out of the NHS budget (Newson, 2009, p.1).

This case, however, raises its own problems. One NHS Trust, for example, declared that disclosing heparin components to patients might increase the number of patients declining the treatment and therefore, might have negative clinical results. They also noted that providing 'synthetic' non-animal-derived heparin is twice as expensive as the porcine version, which may increase the NHS drug budget by up to 50% (Newson, 2009, p.5). Nevertheless, disclosing drug ingredients which may clash with patients' religious beliefs increases their trust in HC professionals. This could increase the NHS budget on one hand but could decrease adverse medical results on the other.

Example (2)

Another example about the consequences of giving porcine derived nasal spray to a Muslim patient's children, without taking the father's consent. The Muslim father complained

about the NHS giving his children a flu vaccine, which contained pork without his knowledge. The father has blurted out:

> when I went into the surgery to discuss it, I was just fobbed off. The whole experience made us angry, we were very distressed that the children went through this process without our knowledge. There was no input from the surgery, nothing at all. I think hundreds of other families will have been affected in the same way without even realizing it. For people of the Muslim faith, this is a very serious matter. The doctors must have known what the spray contained but it wasn't brought to light. "NHS England is committed to ensuring patients have access to high quality care and we take concerns seriously," the spokesman said (Harper, 2016, p.1).

In the above example, the Muslim parent shows his agitation towards the NHS for giving his children porcine flu vaccine without his consent. The father's reaction shows that his religious beliefs override his children's health.

5.3 Patient's Folk Beliefs and Treatments in the UK

Traditional and herbal therapies have become widespread in developed countries. Due to the high number of immigrants in the UK dietary supplements are also starting to get popular. Most patients do not consider herbal therapies to be biomedical medications. Therefore, they do not report them to their doctors. Research has shown that 70% of patients use herbal medications without informing their clinicians.

In the UK, research has determined that 33% of the population believe in the effectiveness of traditional medicine and have used it (Zollman, 1999). According to an Australian study, it

is estimated that 30% of patients have used herbal traditional cures in their lives. However, the real figures could be higher than this, depending on age, culture, and religion (Shorofi and Arbon, 2010). About eighty percent of the population in developing countries rely on traditional medicine.

The first source of treatment in the UK is Western medicine. In developed countries such as in South Asia where there is an issue with accessibility and affordability of medications, patients are more likely to consider herbal therapies, as they are more cost-effective. Thus, while some Muslim patients tend to use herbal remedies as an alternative to conventional medicine, others may refrain from taking biomedicine for religious reasons when they are unsure if the prescribed medication is *halal* or *haram* (adheres to the Islamic law or not). Also, most patients with chronic diseases are likely to take dietary supplements or traditional herbal medicines along with their medications, which may put them at risk of drug-herb interactions (Haller, 2006).

5.3.1 The use of traditional remedies among Muslim patients

The practice of using traditional therapies often raises concerns among clinicians. Some Muslim patients still seek traditional healer's advice for a cure that cannot be bio-medically cured such as an ear infection and stomach pain, infertility, diabetes, or chronic aches can be treated with traditional remedies (Popper-Giveon, 2012). This leads to the risk of patients' using alternative medications without being supervised or consulted by their clinicians. The patient's health beliefs and cultural attitudes towards health or their own evaluation of an illness may not match that of biomedicine, which may impact on the effectiveness of communication in a consultation (Pachter, 1994). Traditional healers in Islamic societies can

be used to heal physical, mental, and spiritual diseases such as epilepsy, depression and other diseases (Al-Krenawi and Graham, 2000).

Traditional Arabic and Islamic Medicine (TAIM) is defined as, “a system of healing practices since antiquity in the Arab world within the context of religious influences of Islam and comprised of medicinal herbs, dietary practices, mind-body therapy, spiritual healing and applied therapy, whereby many regional healing practices emerging from specific geographical and cultural origins” (Al-rawi and Fetters, 2012, p.164).TAIM can involve all types of therapies such as herbal, dietary, or spiritual. It is claimed that there are about 250 plant herbs used in TAIM (Saad and Azaizeh, 2005). Dietary practices involve the use of specific foods such as honey (Nagamia, 2003) to cure certain illnesses. TAIM can also include fasting. Muslims believe that fasting provides spiritual purification for the body and mind from all sins. Fasting has a great benefit for the body as abstaining from eating and drinking for certain time gives the body the opportunity to rest (Chishti, 1991). ‘Mind-body’ healing refers the Islamic techniques to boost positivity (NCCAM, 2008b). Praying can be an excellent practice for enhancing physical and spiritual health (Chishti, 1991). Spiritual healing entails the use of physical and psychological means to heal the body which may include so-called ‘prophetic medicine’ (in Arabic *Al-Tibb al-Nabawi*). This refers to healing that is derived from the *Quran* and Sunnah (Sunnah refers to the way the Prophet Muhammed lived). Some TAIMs are mentioned in the *Quran* or in the Prophet Muhammed’s sayings (*Hadith*). For instance, some healers may recite some prayers and blow them on the patient (Al-Krenawi and Graham, 2000). Muslims may also recite over food or water. Muslims believe in the effectiveness of *Zamzam* water for curing diseases. *Zamzam* water is in Mecca, the holiest place for Muslims (Abel-Motey, 1997; Al-Enzi and Khan, 2007).

5.3.2 Risks of using herbal therapy

A study conducted on 17 Middle Eastern patients and their oncology HCPs (from 17 Middle Eastern countries) showed possible negative outcomes of using herbal therapies on cancer patients. This may include “direct toxic effects, negative interactions with anti-cancer drugs, and increased chemosensitivity of cancer cells, requiring a reduction in dose-density” (Ben-Arye, 2016, p.600).

Jones and Runikis (1987) reviewed the interaction between ‘ginseng’ and ‘phenelzine’ and other ‘monoamine inhibitors’ which may cause stimulation in the central nervous system. Conversely, the effects of some medications could be decreased when used in conjunction with some other drugs (Janetzky and Morreale, 1997). Therefore, HCPs are required to be aware of the impact of herbal therapies on patients. This may help patients to be aware of the safety and effective use of such remedies (Ben-Arye, 2016, p.600).

Below are examples of using TAIM therapies and their impact on patients:

5.3.2.1 Nigella Sativa

Nigella Sativa is one of the traditional Prophetic remedies used by Muslim patients. A patient named Maryam reported some side effects because of using prescribed medications. Accordingly, she became discouraged from using them and put her trust in TAIMs. She stated: ‘‘they have been able to give birth control pills, which has side effects, but I stopped them and (have) gone back to traditional medicine’’ (Al-Rawi et al., 2011, p.123).

This example indicates that patient Maryam was discouraged of using biomedicine as represented in contraceptive pills. This led her to turn to use black seeds as an alternative. Using N. Sativa made the patient satisfied.

Despite the benefits of black seed in curing some illnesses, it is found that consuming it can increase the risk of bleeding. Therefore, it is crucial for HCPs to be informed whether patients use it and advise them to discontinue taking it two weeks before an operation to avoid any complications. Moreover, patients with bleeding disorders or those taking some medications may need to be aware of the risks associated with taking N. Sativa along with their drug intake. Patients with low blood pressure should be warned of the side effects of taking black seed, which lowers blood pressure (Hussein et al., 2016).

Comment

For LEPs patients, the interpreter can act as a visible communicator by adopting the advocate model in interpretation. For instance, in pre-assessment sessions prior to an operation, one of the questions that can be asked of the patient is "Are you on any other mediations?" The interpreter can use the advocate model here because the patient may use some herbal therapies that may interact with the procedure. The interpreter can work as the patient's advocate because his/her safety might be affected. Therefore, the interpreter may ask the HCP if he/she can ask the patient if he/she is on any other medications including herbal, prophetic or traditional therapies. This will improve the situation and will not interact with the HCP's role.

5.3.2.2 Khat

Khat is used by some Arabs for social reasons. *Khat* is a "natural stimulant from the Catha Edulis plant" (Masood and Al-Mansoob, 2015, p.28). *Khat* consumption is not a prophetic therapy, it is not practised among all Muslims. Rather it is confined to a few Arabic countries particularly Yemen and some countries of East Africa (where *khat* grows), where people chew *khat* as a social custom (ibid, p.28).

However, consuming *khat* can result in some medical issues if interacted with other medications. Chewing *khat* can also have some side effects such as feeling low, depressed, irritable, emotionless, and weak. These symptoms start four hours after consuming it (Colzato et al., 2011). Some Muslim patients may be unaware of the associated risks from using TAIM in conjunction with biomedicine (Rassool, 2015).

There is evidence that *khat* chewers are at high risk of cardiovascular problems. Some studies have related some gastrointestinal issues such as chronic constipation, 'cytotoxic effects on liver', and kidney (Al-Habori et al., 2002). It is also postulated that consuming *khat* can have a negative impact on health specially for pregnant women which may impact placental blood flow that consequently results in damage of the infant's growth (Mwenda et al., 2003; Abdul Ghani, et al., 1987; Eriksson et al., 1991).

A survey carried out in April-May 2013 in Sana, (the capital of Republic of Yemen) supervised women attending Primary HC in Sana reported that women chewing *khat* during pregnancy are about four times more likely to have a 'history of foetal death' than those who do not (As cited by Masood and Al-Mansoob, 2015, p.30).

5.3.2.3 Kohl

Kohl is a black eye-paint or powder worn by Muslim women from the Indian subcontinent, North Africa and parts of West Africa as well as the Middle East. Some women may traditionally apply kohl on their newborn baby's eyes to protect from the evil eye (Hardy et al., 2004). Nonetheless, some of the *kohl* may be polluted, which may increase the risk of toxicity, which consequently causes lead poison.

In a response to one of the questions in the patient's questionnaire chapter (7), a Muslim woman replied:

I use *kohl* on my baby's eyes, and I wipe it off if I am expecting a visit from the HCS. I believe that *kohl* is effective to protect newly born babies from evil eye. I never tell the midwife as it is unnecessary. It is just harmless. They are English people and may make fun at us.

In the above response, the mother shows her lack of trust in the HCP and fear of being laughed at stopped her from telling the HCP the truth. If the baby has any medical issues such as lead poisoning, it will be challenging for the HCP to identify the cause.

Comment

In this example, the interpreter can use the advocate model in interpretation. This is because he/she feels that the patient's wellbeing is at risk. The patient does not recognize the risks of using *kohl* on a newborn baby's eye. Thus, the interpreter can share the information with the HCP to provide the appropriate advice to the parent by showing respect for her culture to establish trust. This puts the HCP was in a position to explain to the mother the risks of using kohl on a baby's eyes.

5.3.2.4 Honey

Honey is one of the therapies that has a high value amongst Asians. Nonetheless, it is advised to be careful when feeding honey to infants and patients with some medical problems such as diabetes. It was reported that honey is unsafe for infants (Abdullah et al., 2012, p.1). Honey may cause "botulism toxicity" when the newborn could have symptoms like "floppy paralysis" (Abdullah et al., 2012, p.1). The infant could also have symptoms like 'acute floppiness' and 'constipation' which are symptoms of "botulism infantile" which may lead to the patient's death.

It has been postulated that a previously healthy three-month-old baby developed symptoms of 'constipation', 'oral thrush', 'cough' and 'floppiness'. Her parents were originally from Pakistan. After carrying out some tests the infant was diagnosed with 'clostridium botulinum type A'. It was discovered that some honey was left over from the bottle which the baby was feeding from which contained 'C botulinum type A' (Abdullah et al., 2012, p1.). In this case, if the HCP had not noticed the honey left over in the baby's bottle, he/she would not have been able to identify the cause of the baby's symptoms which developed as botulinum type A.

5.3.2.5 Cupping

Cupping is one of the most widely used folk remedies practised by Muslims. Cupping is called *Hijāma* in Arabic is one of the treatments that dates back to the ancient times (Akhtar, 2017). Some Muslims believe that *Hijāma* can cure some ailments such as migraine headache, jaundice, stomach pain, nausea, sprains, muscular pain, insomnia (Hassanein, 2010), blood disorders (anaemia, haemophilia), rheumatic diseases (arthritic joint and muscular problems), fertility, some gynaecological disorders, skin conditions like (eczema and acne) and some other physical problems including psychological health problems (Cui and Cui, 2012; Franco et al., 2012).

Example

A case of an 11-year-old child was reported. The patient suffered from eczema and the doctor prescribed some emollients and topical corticosteroids. When the patient's parents noticed a delay in the results of the medication, they decided to turn to complementary remedies to seek the treatment from a cupping specialist. After receiving cupping and acupuncture the girl suffered from side effects of the treatment such as blistering and oozing.

The doctor had to prescribe antibiotics (Hon et al., 2013, p.1). In this case, the negative consequences of the alternative therapy resulted in serious symptoms.

5.3.2.6 Amulets

Amulets are one of the most important traditional means of spiritual healing and are manifested across different cultures (Ventura et al., 2014). Therefore, it is advised to treat them with respect and 'reverence'. Amulets can be textual or non-textual. While the former can be written verse, a person's name or some words, the latter one's value is derived from its material (Dundes, 1992). Amulets can be made from organic materials like herbs, roots, or feathers, in which case their power stems from the material they are made from. Latino patients believe in placing an amulet called *azabache* around a baby's neck, which is worn as a necklace or bracelet. On some occasions, such as operations or medical procedures, wearing an amulet could be a health and safety issue, and therefore the HCP has to ask the patient's permission to remove it.

Some Muslim patients who believe in folk beliefs may enter the operating theatre with an amulet or a charm, which might be kept in a small bag, pocket, or a purse. This can be worn around the neck or pinned to the arm. Some may be made of blue stones while others carry portions of the *Quran*. This can be a health and safety issue.

Example

In an answer to one of the questions asked in the patient questionnaires for this thesis chapter (7), a Muslim mother of a patient with a terminal illness reported to the current researcher:

> I was very upset when the doctor told me through an interpreter that my one-year-old daughter will die as soon as they will stop the oxygen supply to her lungs. I was

offended when the doctor said: “your child will die within two hours after taking the oxygen off her”. I kept saying in my heart God forbid! I wished the interpreter had shown some sympathy towards us even by words which would be supportive. death termination is not allowed in Islam. However, the doctor said: “we will stop the oxygen machine and give the child morphine to die peacefully. It was difficult situation.

While my child was in the hospital, she was gripping a little portion of the holy *Quran* in her hand. Nurses came and opened my child’s hand saying, “Is this a chocolate? You are not allowed to give food to your child”. I was not even in a mood to explain to the nurse what it was … she took it and put it on the table. I was embarrassed to ask the nurse not to touch it as only people who have performed their ablution can touch this. The doctor said there is no treatment for your daughter. Then, I gave her some *Zamzam* water blessed with a recitation of some *Quran* verses to help the healing process and we believed in the power of Allah as He is the only healer.

In this case, the patient’s parent implied the need for some spiritual support such as sugar-coated words, which are harmless but can be supportive. She also showed her belief in God. When the clinician explained that there is no cure for the patient the mother turned to religious spiritual healing. Cultural sensitivity is required in this critical situation.

Comment

In this example, the HCP can have a private discussion with the interpreter to find out the best way to disclose bad news to the patient. The interpreter can agree with the HCP to use some sugar-coated words such as ‘God forbid’. Dealing with sensitive situations requires the HCP to be culturally sensitive to the patient’s needs. The doctor could have arranged a

meeting with the interpreter prior the consultation to identify the patient's needs and work accordingly. The patient shows concern that the nurse touched the small *Quran* in the patient's hand. The interpreter can work as an active participant at this stage because he/she feels that the patient's religious beliefs are at risk. The interpreter can step out of his/her role by briefly explaining to the nurse that the patient has some concerns. The nurse might apologise to the patient for being culturally unaware of the value of the patient's worries. This can establish mutual respect and trust with the patient.

Some Muslim patients with seizures believe in the power of wearing an amulet, which contains some quotations from the *Quran*, while others believe in drinking water blessed with the recitation of verses from the *Quran*:

> I've had people giving me *taweez*, all sorts, I've been […] I don't know, people say different things, "you should do this, you should do that". I've tried everything. I was having it [seizures] and there was this lady who was giving me *taweez* and I went better for 1 year I didn't have a fit. This *taweez* and she put dam [blood] on water [blessed the water], she used to give me that. (A 31-year-old Muslim female participant in Ismail's et al., 2005, p.2).

The above example shows how the patient's cultural beliefs pushed her to believe in the power of using amulet and blessed water as a cure for her seizure. This had led the patient to non-clinical adherence to the treatment prescribed by her physician.

5.4 Belief in the Evil Eye

In some cultures, the term 'mal ojo' (evil eye) occurs when someone with a 'strong eye' looks at someone else, whether deliberately or not (Pachter, 1992). The cultural

interpretation of this is that the illness results from a strong evil eye cast on the child (Risser et al., 1995).

For Arab Muslims, the main triggers of an evil eye are envy or jealousy (Schoeck, 1992). Therefore, an illness can be attributed to social, or even spiritual, causes such as jealousy or the evil eye, as reported in the authoritative books of the sayings of the prophet (hadith) (Sahih al-Bukhari 71, p. 635; Sahih al-Bukhari 71, p. 636). Muslims use *rukya* to protect them from the evil eye, i.e., the reading of some lines of the *Quran* and blow the breath over the patient's body with the intention of healing).

Khalifa et al. (2011) indicate that 80 % of Muslims in the UK believe that most 'physical' disorders are linked to the evil eye, which causes physical or mental issues. Some patients believe that the evil eye could cause the blood to heat up and may cause symptoms such as sharp cries, feeling sick, pains, aches, and bloated stomach. A study on an American Hispanic population found that folk healers were used to provide herbal cures and ritual remedies, such as rubbing a baby's body with an egg or lemon, a chilli pepper or rue (Risser, 1995).

Examples of evil eye

In one of the responses to the survey questionnaire, a female participant commented:

> I do believe in black magic and evil eye. I hated it when I gave birth and the midwife kept saying, 'your baby is gorgeous'. The midwife had blue eyes and could easily envy my new-born baby. I kept saying 'ma shaAllah' to protect my baby from the evil eye. The midwife kept asking the interpreter what I was saying. I had to keep repeating this. Then, she asked me how many children I had. Fearful of being envied I told her that I had one child, while I have five children.

Comment

In this case, the participant showed her strong belief in the evil eye. Some Arabs believe that people with blue eyes have more power to cause harm through envy than others. The above example clearly shows that the HCP was unaware of the issue, and she thought that she was being friendly by asking the patient, “how many children do you have?” Conversely, the patient culturally misinterpreted the HCP’s question and praising words. Both the patient and the HCP thought according to their own cultural norms, which resulted in mistrust and misinterpretation. Mistrust is evident in the patient’s reply about how many children she had. ‘Ma sha Allah’ (literally; ‘Whatever God wills’) is a blessing Muslims use to be protected from the evil eye.

5.5 Spiritual Beliefs Regarding Illnesses

individuals belonging to the same ethnic groups may believe in a particular folk illness, giving a disease a cultural diagnosis rather than a biomedical one (Pachter, 1992, 1994). For example, a significant number of Muslim patients believe that the cause of diabetes is Allah’s will and it is their religious duty and personal choice to work hard to control the progression of it (Kelleher and Islam, 1996). They consider that diet is one of the most important means of spreading diabetes among ethnic minority patients (Greenhalgh et al., 1998; Khajuria and Thomas, 1992). In addition, some Muslim patients think that the cause of diabetes is stress.

In a study carried out in the UK (2005) entitled *Religious Beliefs about the Causes and Treatments of Epilepsy*, Ismail et al. acknowledged the existence of religious and spiritual beliefs among ethnic minority patients. They concluded that the clinician’s insufficient knowledge of religious beliefs and their impact on diagnosis and treatment may result in poor clinical results.

Some patients from different cultural backgrounds may associate epilepsy with spirit possession (Carrazana et al., 1999). This is a common belief held by many of respondents. A 25-year-old Muslim male stated:

> well, everything comes from up there; everything's from Allah and the one who fixes it is Allah as well. You see that's our Muslim belief, what do you think? You see, the doctor's give you your medication, but the cure comes from Allah. If it's written for you, it's written for you, there's nothing you could do about it, can you? So, when it comes to you, it comes to you, it's in God's hands, so there's nothing you can do about it (As cited by Ismail et al., 2005, p.28).

This example shows how the patient's belief in the cause of epilepsy led him to turn to believe in faith and everything is in "God's hands" regardless of whether he takes medication or not.

According to Muslim belief, although humans cannot see *jinn*, they are thought to be capable of causing mental and physical harm to them, through affliction or possession (Al-Ashqar and Khattab, 2003; Dein et al., 2008; Khalifa et al., 2011). It is widely accepted in Islam that mental disorders in humans can be related to 'affliction' or 'possession.' Symptoms such as fear, memory issues and feeling tired and exhausted all the time are related to *jinn* (El-Islam, 1995).

In response to one of the questions in the patient's questionnaire chapter (7), an Arabic Muslim husband of a patient who was diagnosed with schizophrenia noted:

> well, I believe in medicine for physical illness, but for any kind of spiritual problems such as my wife's situation I am not even convinced that my wife has a mental issue. Last week, she was completely normal until she started having hallucinations after we found black magic hidden in a vase. Doctors do not believe in black magic,

> and they think that my wife has schizophrenia and has to be on medication for that. My wife refused taking medicine, and then the nurse obliged her to take injections instead. They think my wife is getting better because of the medication. However, I know for a fact this is a spiritual issue and I have spoken to the imam in my country to send us amulet to remove the black magic from her. We have to pretend to the doctor that we accept the diagnosis of my wife, so they discharge her from the hospital and then she can stop taking it. I do not believe in the diagnosis or the medication either.

In this example, the participant illustrates how his religious beliefs impact his views towards health and illness. The respondent was strongly convinced that the medical condition his wife had resulted from black magic. Therefore, the best way to cure the patient was by getting rid of the effect of black magic. On the other hand, the physician believed that 'schizophrenia' is related to a mental problem and hence the treatment should be biomedical. The cultural misunderstanding between the two sides, the patient's relative and the doctor, resulted in lack of trust between them. The result of this was non-adherence to the treatment.

It is stated that 'age' could be a factor that may influence some patients' cultural beliefs towards an illness. For instance, the older generation tend to have stronger supranational beliefs (evil eye, taʕwīḏ or amulets) than the younger one (Tandon et al., 2002; Saeed et al., 2000). A 29-year-old Muslim man pointed out: "they (the elders) think it's something like an evil spirit, I would say that's the elders, no matter where they are" (Ismail et al., 2005, p.28).

Younger people are more likely to accept a medical explanation for their condition or to attribute it to stress, past trauma and "the will of God". Yaqoob, for example, declared:

> most people think like that that they are jinns (demons) and want to give you *tawiz* [taʕwīḏ] (amulet containing religious verses) or something like that. It's a disease,

> it's not ghost. It's a disease, it's not a ghost giving me trouble. If it's a ghost, it could kill me a long time ago (Rhodes et al., 2008, pp.7-8).

Negative attitudes towards an illness such as epilepsy can vary from one Muslim to another depending on their religious beliefs and their adherence to them:

> other people, sometimes you sense, they just keep away because they don't want to get it [epilepsy]. They think they might catch it. Sometimes you shake hands with other women if you're greeting them, but they don't want to put their hand forward, they don't want to shake hands, so I just think, "leave it". I mean, I know it's not an infectious condition. Our Asian women here, the elderly ones in particular, tend to think that if I mix with their children or sit with them, then, like I say, the children will catch it (Ismail et al., 2005, p.28).

5.6. Risks of Fasting on Medication Intake

This section will examine another factor that may impact Muslim patients with chronic diseases such as diabetes during Ramadan.

Ramadan is the 9th month of the Islamic Calendar (Hijra). It ranges between 29 and 30 days and starts at a different date every year, since the Islamic months follow a twelve-month lunar calendar with 354 or 355 days in each year (compared to the 365 or 366 days in the Gregorian year). It is the month when all Muslim adult followers fast from sunrise until sunset (Norouzy et al., 2010). Fasting times vary from one country into another and from one season into another depending on the time of sunset. For instance, in Britain if Ramadan falls in winter the fasting time may last up to ten hours, but if it falls in summer Muslims fast up to nineteen hours a day (Sadiq, 2008, p.83).

However, some Muslims are exempted from fasting such as the sick, old and fragile patients, pregnant and breastfeeding women, children and travelers. While fasting, Muslims should not eat or drink from dusk to dawn. During Ramadan, some medical treatments and procedures can invalidate the fast (Norouzy et al., 2010). Muslims who break their fast due to an illness are required to donate food to the poor (Sadiq, 2008, p.84).

Some Muslim HCUs tend to randomly change their medication intake times without seeking medical advice may (Aadil et al., 2004, p.781). It was reported that some Muslim patients may feel that a non-Muslim doctor is likely to stop them from fasting. Accordingly, they decide to adapt their medication intakes to fit in with their eating time during Ramadan (Sadiq, 2008, p.84). This accords with results of a study conducted in Kuwait shown that some Muslim patients tend to adapt their medication intake during Ramadan without consulting with their HCPs (Aadil et al., 2004, p.778). This may have a negative impact on patients such as efficacy and toxicity of some medications: "thus, circadian time has to be taken into account as an important factor influencing a drug's pharma" (Aadil et al., 2004, p.779). To avoid such complications the doctor or the pharmacist is required to appreciate Muslim patients' beliefs with regards to fasting (Sadiq, 2008, p.84).

Here are some examples of the consequences of fasting on patients on medications and yet decided to fast.

Example (1)

> A patient was admitted to hospital having had a seizure while driving. Prior to this episode his epilepsy had been well controlled on phenytoin 100gm three times daily. Observing the fast of Ramadan, which had commenced only three days earlier, he had omitted his morning and afternoon doses, on each of the three days (Sadiq, 2008, p.89).

Comment

This patient was marked as 'non-compliant' by staff because he could have altered his medication to 300 mg. once a day rather than 100 mg. thrice a day (ibid, p.89).

Example (2)

> A middle-aged woman suffering from glaucoma; she had been prescribed eye drops to be used four times daily at regular intervals. During Ramadan, she wished to fast and so decided to use her eye drops only during the night: in practice this involved instilling the drops only once daily. During the course of the month her glaucoma deteriorated (Sadiq, 2008, p.90).

Comment

This patient would have been able to take her eye drops as this would not have invalidated her fasting. She eventually ended up losing her vision (ibid, p.90).

Example (3)

> A 54-year-old South Asian man with chronic rheumatoid arthritis, well controlled on daily non-steroid 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 suppositories as inserting medication rectally would have nullified his fast. This resulted in pain and stiffness" (Sadiq, 2008, p.90).

Comment on the above three examples

In these examples we notice that patients reacted differently towards their medication intake during Ramadan. In examples (1) and (2), patients changed the medication intake from

three times to once a day, while in example (3) the patient refrained from sharing his religious concerns in taking suppositories instead of oral medications.

When dealing with LEPs, when the HCP prescribes medication to the patient during Ramadan, the interpreter can act as an advocate. The interpreter's potential for advocacy can be seen in the cases where the HCP prescribes medication three times a day. The interpreter can use his/her cultural knowledge to advocate for the patient whose safety might be at risk. Risks can ensue from non-adherence to the treatment. The interpreter may remind the HCP that it is Ramadan and leave the HCP to decide whether to ask the patient to fast or not and work accordingly to meet the patient's religious needs. In example (3) the patient did the right thing by asking the HCP to change the route of medication administration. The HCP thought that he/she had adapted the patient's medication according to his religious needs. Unfortunately, the outcome was unsatisfactory due to the HCP's lack of cultural knowledge that there are other routes of administering medications that might invalidate in addition to taking drugs orally. Lack of awareness of the patient's culture led all patients to experience unsatisfactory clinical results.

5.7 Medical Problems Associated with the Insistence on Fasting

There are many general medical problems which may be associated with fasting during Ramadan, even among healthy patients. A headache is a commonly reported ailment among Muslim fasting patients during Ramadan. This results from the new life rhythm, sleep fragmentation, lack of sleep, dehydration, and stress (Molla et al., 2014, p.23). Other frequently reported problems during Ramadan are constipation, indigestion, bloating and

headache. These are due to hydration and an unhealthy diet and the type and amount of food intake (Mughal, 2014, p.356).

5.7.1 Illnesses of particular concern during Ramadan

In the following sections, we will consider two illnesses which are of particular concern among patients who fast during Ramadan: epilepsy and diabetes.

5.7.1.1. Epilepsy

Epilepsy is one of the medical conditions which can cause some problems during Ramadan; therefore, a careful follow-up can be given to patients who decide to fast. Maintaining a regular medication intake is essential. Patients should not modify dose times, the number of doses, the time between doses, or the total daily dose. Lack of sleep might severely affect patients with epilepsy. Therefore, it is strongly recommended to avoid sleep deprivation. Drinking sufficient fluids and keeping hydrated is also essential to avoid any epilepsy relapse seizures (Bartolini et al., 2011, p. 432,).

The frequency of epileptic seizures could often be increased during Ramadan. This could be a result of changes in daily routine such as sleep, eating times, tiredness, and day-long fasting. However, a change in the drug regime intake is the main reason for the increase in seizure attacks for fasting patients during Ramadan (Gomceli et al., 2008, p.675).

It has been shown that during Ramadan patients with epilepsy experience sleep fragmentation due to waking up at the time of *suhur* (*Suhur* is an Islamic term referring) to the meal consumed early in the morning by Muslims before fasting, before dawn during or outside the Islamic month of Ramadan. Studies have revealed that the sleep duration of 106 patients was less than six hours during Ramadan while it was more than seven hours before

Ramadan. Eight patients did not have any changes in their sleep duration during Ramadan. Since they woke up at the time of *suhur*, all patients had sleep fragmentation during Ramadan (Gomceli et al., 2008, p.673).

According to a prospective study in the UK, the recurrence and change in frequency of an epilepsy or seizure increased in (124) patients with idiopathic epilepsy during Ramadan. It is documented that twenty out of 124 patients did not adhere to their antiepileptic medications from the sunrise to the sunset (Aadil et al., 2004, p.778).

Fasting can result in some complications for medication intakes for epilepsy patients on drugs such as AED which should be taken at regular intervals to maintain constant blood levels. Changes of daily routine such as eating, drinking water, and sleeping could impact the frequency of 'life seizure' (Gomceli et al., 2008).

5.7.1.2 Diabetes

According to a UK study, 50 million Muslim patients with diabetes decide to fast every year (Al-Arouj et al., 2010, p.1896). However, fasting can be associated with some risks on patients with type 1 diabetes with poor glycaemic control are not advised to fast (ibid, p.2305). It is noted that due to abstinence from food and drink for long hours, blood glucose levels can be affected, resulting in either hyperglycaemia or hypoglycaemia.

Diabetes patients fasting during Ramadan may also suffer from dehydration and a tendency toward hypotension. Moreover, some patients may tend to change their diet lifestyle such as an increase in their carbohydrates and saturated fats intake (ibid, p. 1901).

Fasting for long times could result in blood glucose levels being affected, which might lead to hyperglycaemia. Most patients are at risk of hypoglycaemia because of refraining from

eating for prolonged times and the effect of the drug is to increase the propensity for hypoglycaemia (Karamat et al., 2010. p.141).

Some patients with type one diabetes may suffer from extreme hyperglycaemia (Al-Arouj et al., 2005, p.2305). (*Tarawih* is an extra prayer practiced by Sunni Muslims after sunset during Ramadan) (Qureshi, 2002, p. 489).

It has been reported that a middle-aged female Muslim suffering from heart failure experienced side effects of digitalis after being treated with both a thiazide diuretic and a digitalis compound. According to the authors, the intake of two drugs induced a drop in potassium following a diuretic-induced decrease in water retention, which led to an increase in sensitivity of heart muscle to digitalis (Aadil et al., 2004).

Comment

A patient's decision to fast may cause him/her to alter their medication times or doses or even completely stop, which is very risky, without informing their HCP (Abuelmagd et al.2018; Aydin et al.2012; Mygind et al., 2013). According to findings from the EPIDIAR study, there is an increase in the occurrence of hypoglycaemia cases during Ramadan in comparison to other months (Salti et al., 2004).

5.8 Conclusion

In this chapter we highlighted the importance of Muslim patients' cultural beliefs in health and illness, and how ignoring them could result in adverse clinical outcomes in the following cases;(1). when HCPs prescribe religiously prohibited medications to Muslim patients without disclosing their ingredients or adapting medications;(2). when Muslim HCUs use alternative therapies or stop or change their medication intake without seeking medical advice; (3). when

HCPs of the opposite gender offer Muslim patients' treatment, and Muslim patients decline this treatment without explaining the reason; and (4). when Muslim patients decide to fast and stop or alter their medication without informing their clinician. All these may involve cultural insensitivity to Muslim patients' needs.

HCPs need to be aware of the patient's beliefs, ethics and philosophical values and take steps to accommodate these. Discussing these issues can be time-consuming for an HCP who is under time-pressure during the consultation. However, if these issues are not addressed, the patient will not only be unhappy, but there may ultimately be an increase in the cost to the HCS, through unnecessary admission/referral to hospital, waste of prescribed medications or treatments, or repeated visits to the doctor. HCPs want to fulfil the needs of HCUs, but religious issues are important, and if not taken into consideration might complicate and mislead the HCP. For instance, dietary issues are not only limited to Muslim patients; other religious or non-religious (e.g., vegetarian or vegan) patients may also have certain dietary restrictions. This therefore suggests that HCPs need to discuss individually with patients with regards to treatment plan preferences to avoid any negative clinical consequences.

Properly planned action can help to minimise ethical and philosophical issues. In dealing with LEPs, the interpreter might act as a mediator between the HCP and the HCU to reduce the gaps in relation religious, ethical and philosophical issues. The interpreter can play a pivotal role in resolving these differences to empower the HCU to reduce the cultural gap (Anegelli, 2004) and reconcile any conflict (Hsieh, 2006a). To this end, the HCP can even request the interpreter to adopt the advocate role in interpretation when appropriate.

The next chapter covers with the research methodology. Combining both quantitative and qualitative approaches, a survey and interview questions for Arab, Muslim patients are

constructed on the basis of the points which have been identified in this chapter, in order to identify which, the major issues are in practice.

CHAPTER SIX

METHODOLOGY

6.1 Introduction

In this chapter we will discuss the research methods the researcher used to collect data. Section (6.2) will explain what qualitative research means, Sections (6.2.1 -6.2.2) will discuss the advantages and disadvantages of qualitative research. Section (6.2.3) will define quantitative research, section (6.2.4) will address the advantages of the quantitative research method, section (6.2.5) will explore the limitations of quantitative research. Section (6.3) will talk about the questions given in the questionnaires within the discipline of interpreting studies, and section (6.4) will introduce the reader to the participants who took part in the study. This study will involve Arab Muslim HCUs and British HCPs. Section (6.5) and following will introduce the survey questionnaires, including the outcomes in sections (6.5.1), layout of the questionnaires (section 6.5.2), face-to-face interviews (section 6.5.3) and the covering letter. Section (6.6) will talk about the pilot study, section (6.6.1) the outcomes of pilot study, section (6.6.1.1) the outcomes of the interview questions, section (6.6.1.2) the outcomes of the pilot study with HCPs, and section (6.6.1.3) the outcomes of the pilot study with Arab Muslim Participants.

Ethical considerations will be discussed in section (6.7). Section (6.8) will talk about the reliability of the collected data. Section (6.9) and following will explore the limitations of the study, such as difficulty in reaching out (section 6.9.1), time constraints (section 6.9.2), reluctance to participate (section 6.9.3), lack of trust (section 6.9.4), finding the right

participants (section 6.9.5), participants' literacy level (section 5.10.6), and researcher's motivation (section 6.9.7). Section 6.10 will discuss the research aims and section (6.11) will be a conclusion.

6.2. What is Qualitative Research?

Strauss and Corbin (1990, p.11) say that "by the term, "qualitative research", we mean any research that produces findings, not arrived at by statistical procedures or other means of amplification. It can refer to research about persons' lives, lived experiences, behaviours, emotions, and feelings as well as about organisational functional, social movements, cultural phenomena, and all interactions between nations". Therefore, the results of the findings are not numerically based.

Flick points out that "qualitative research is interested in analysing subjective meaning or the social production of issues, events, or practices by collecting non-standardised data and analysing texts and images rather than number and statistics" (Flick, 2014, p.542). This indicates that this research methodology has to do with people's reactions to something and how they express their feelings. According to Denzin and Lincoln, "qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter" (Denzin and Lincoln,1994, p. 2). Van Maanen regards "qualitative research" as "an umbrella term covering an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world" (Maanen, 1979, p.520). Other researchers agree on the broad nature of qualitative research, arguing that it is challenging to find a clear, unified definition for "qualitative research" (Ritchie et al., 2013). Denzin and Lincoln (2002) suggest that qualitative method does not have its theory or 'paradigm' nor a distinct set of

methods and practices. However, this term involves a variety of methods and approaches within different subjects of research (Rahman, 2016).

6.2.1 The advantages of qualitative research

Based on the above definitions, we notice that using qualitative research can have advantages and disadvantages. The most prominent feature of this research method is that it provides the researcher with detailed, rich material. This involves feelings, opinions, and experiences and transfers them into actions. Similarly, Chalhoub-Deville and Deville (2008) believe that qualitative research methods are used to gain deep insights into problems.

The second benefit of qualitative research is that it examines the human experience against specific backgrounds. Denzin and Lincoln (2002) suggest that qualitative research involves understanding human experiences. Kelin and Myers (1999) argue that through the qualitative approach the researcher will be able to gain a better understanding of people's voices, meanings, and events. Strauss and Corbin (1990) claim that the qualitative method reflects participants' inner experiences. It has been argued that one of the advantages of qualitative research is to engage with data without causing any damage to the context. This method of research is suitable for:

> questions where pre-emptive reduction of the data will prevent discovery. If the purpose is to learn from the participants in a setting or a process the way they experience it, the meanings they put on it, and how they interpret what they experience it, the researcher needs methods that will allow for discovery and do justice to their perceptions and the complexity of their interpretations. Qualitative methods have in common the goal of generating new ways of seeing existing data. If the purpose is to construct a theory or a theoretical framework that reflects

> reality rather than the researchers own perspective or prior research results, one may need methods that assist the discovery of theory in data (Atieno, 2009, p.16).

Almeida et al. (2017) point out one of the major strengths of this research approach is that it is not connected with "numerical representatively". It is instead a method which the researcher utilises to gain a deep understanding of the raised issue in the research (Almeida et al., 2017). In qualitative research, the researcher is the main subject and the object of the research. One of the main aims of this research methodology is to create "in-depth and descriptive information" (Almeida et al., 2017, p.370). Thus, this research approach is centred on building rich and solid results relying on human's experiences.

6.2.2 Limitations of qualitative research

Despite the advantages of qualitative research, it has some disadvantages too. According to Silverman (2010), this research may result in some "contextual sensitiveness", and the focus is on meanings and experiences. It is based upon disclosing the individual's experience and interpreting it (Wilson, 2014; Tuohy et al., 2013). Cumming (2001) echoes the view that this approach is based upon the participants' experience more than other 'imperative' problems. Hence, analysing the experiences could be a time-consuming process for the researcher.

It has also been suggested that qualitative research methodology is not reliable as it only measures small samples which may result in a problem of 'generalizability' to a large amount of people (Harry and Lipsky, 2014; Thompson, 2011). Lam (2015) states that due to the small samples typically used in this research method it cannot precisely measure a wider range of people. Breg and Lune criticise this research approach in terms of its practical difficulty: "qualitative research is a long hard road, with elusive data on one side and stringent requirements for analysis on the other" (Breg and Lune, 2012, p.4).

Flick (2011) considers that qualitative research can be time-consuming; analysing the data can take a considerable amount of time. He adds that another disadvantage of this method is its limitation when the researcher generalises the results to a larger population. Atieno finds the findings cannot be as comprehensive as quantitative analyses (Atieno, 2009). Although qualitative research is a time-consuming process, some researchers might find it more useful than quantitative research (to be discussed below) to probe the participants' insights and find out more about his/her fear and concerns.

6.2.3 What is quantitative research?

Bryman defines quantitative research as "a research strategy that emphasises quantification in the collection and analysis of data" (Bryman, 2012, p.35). According to Rasinger (2013), the main aim of quantitative research is to find answers to the 'how' and 'what'; 'how much?' and 'to what extent?' Payne and Payne point out that "quantitative methods (normally using deductive logic) seek regularities in human lives, by separating the social world into empirical components called variables which can be separated numerically as frequencies or rate, whose associations with each other can be explored by statistical techniques and accessed through researcher-introduced stimuli and systematic measurement" (Payne and Payne, 2004, p.180).

Therefore, unlike qualitative research, quantitative research relies heavily on numbers rather than individuals' feelings and experiences. While the primary currency of the former is words, the main currency of the latter is numbers.

6.2.4 Advantages of quantitative research

Carr (1994) states that one of the advantages of the quantitative method is that obtaining random sampling can increase the likelihood of the findings being more reliable. Thus, a quantitative approach is more reliable regarding generalising the data to the whole population rather than a small sample as in the qualitative method.

Another feature of the quantitative method is its time effectiveness. Connolly (2007) argues that analysing data requires less time which can be accomplished by using software like SPSS. According to Martin and Bridgmon (2012), this research method can be efficient and sufficient to be used as a comprehensive view of the whole population. Gathering information can be achieved in two ways: "structured procedures and formal instrument". The data should be collected structurally and systematically. Thanks to modern technology, researchers can analyse the numerical data results through software such as SPSS, R, and STATA (Almeida et al., 2017). However, this could be challenging for researchers with low IT literacy skills.

6.2.5 Disadvantages of quantitative research

Despite the increasing attractions of quantitative research, it still receives criticisms from some researchers. This method does not provide a deep fundamental explanation. It relies heavily on data rather than explaining the cause of the results of the findings. Knowing the hidden reasons for the results is beneficial for the researcher. The researcher's job is like that of a physician. By finding out the cause of an illness the doctor can diagnose the patient, and therefore advises the patient of the proper treatment plans. Likewise, the researcher's knowledge of the reasons for their findings is a significant stage to reaching solutions and recommendations for future research.

It has been suggested that due to the shortcomings and benefits of each of the qualitative and quantitative research methods, combining both approaches would be an ideal option to avoid these limitations. However, "if the synthesis of qualitative findings remains a challenge, the combination of qualitative and quantitative syntheses remains uncharted terrain" (Sandelowski, 2004, p.1379). Therefore, it is the researcher's responsibility to select the research method that goes along with his/her research: "the researcher is responsible for choosing the research methodology that best suits the situation under analysis. Two methodologies of qualitative and quantitative nature stand out for their usefulness and wide acceptance in the scientific community" (Almeida et al., 2017, p.383).

Due to the pros and cons of each research method the researcher decided to combine both the qualitative and quantitative research methods. She used both approaches; the qualitative and quantitative approaches to gain a deep and solid insight into Muslim patients' experiences. Some of the HCPs and LEPs were quite cooperative by adding their experiences and concerns on a separate sheet of paper.

6.3 Questions of the Questionnaires within the Frame to the Discipline Itself

The questions are built on my work experience as a freelance interpreter in HC sector. They are also enlightened by Rassool's *Cultural Competence in Caring for Muslim Patients* (2014), and Sheikh and Gatrad's *Caring for Muslim Patients* (2008). A comprehensive overview of current problems and issues related to Muslim patients are provided in these books.

Each of the questions in the questionnaire can be considered within the framework of interpreting studies, as follows:

Question (7.1)

"Are you aware that some medications, implants or vaccines may contain ingredients which conflict with a patient's religious beliefs?"

Question (7.2)

"Do you know that treatments containing ingredients which are prohibited for members of some religious groups such as pork or alcohol may impact patients' accepting the treatment?"

Prescribing medications or treatments containing religiously prohibited ingredients without addressing patient's religious concerns may require the interpreter to switch to the advocate model when the interpreter feels that the HCU's needs are unfulfilled. The HCP may be aware of the religious diet restrictions relating to some medical procedures but for some reason he/she may not discuss this with the patient. Using the advocate model can help the patient's voice to be heard by making sure that his/her rights are protected (Abdelhamid et al., 2010).

Question (7.3)

"Have you had a patient declined a flu vaccine because it is porcine derived?"

Using the linguistic model in interpretation as discussed in Chapter (4), Section (4.6), and restricting the interpreter's active role (Bancroft, 2015, p. 225) can leave the Muslim patient at risk of declining the treatment, as discussed in Chapter (5) Section (5.2.1). Therefore, the interpreter's integration between the HCP and the patient through enabling patients' cultural needs to be addressed resolves the primary difficulty resulting from culturally different beliefs about health (Murray and Skull, 2005).

Question (7.4)

"Has a patient ever declined or rearranged a consultation with an opposite gender HCP without explaining the cultural reason?"

The same gender issue was discussed by Donthu and Yoo (1998). Thus, the interpreter can advocate on the patient's behalf by asking if he/she has any gender preference for forthcoming appointments. In this context, according to Tribe and Thompson (2017) advocacy can support the patient on the basis of ensuring that the patient's needs are understood (ibid, p. 8).

Question (7.5)

"Have you ever been in a situation where a patient refused an animal organ such as pig heart valve due to religious reason?"

As discussed in Chapter (5) Section (5.2.1), 'porcine' is not only restricted to medicine, but can also involve other types of treatments. Advocate interpreters can enhance delivering cultural relevance by working as active agents to ensure that HCPs are aware of HCUs' religious beliefs to build effective communication (Afsharzadegan (2016) and enhance the quality of HCS (Verrept, 2008).

Question (7.6)

"Would you prefer that an interpreter explains cultural issues while interpreting such as religious dietary restrictions (e.g., halal diet)?"

As per the advocate model of interpretation, the interpreter needs to deliver a satisfactory service to both the HCP and the HCU to ultimately improve HC (Tsuruta et al., 2013). To accomplish this, the interpreter can work as a bilingual and bicultural (Roy, 2002, pp.345-353)

to overcome cultural barriers such as religious dietary restrictions. In this role, the interpreter can make sure of the effective transfer of information between the HCP and the HCU by acting as a cultural advocate (Campelo et al. 2018; Fenta; Hyman and Noh, 2007).

Question (7.7)

"*Would you like the patient's body language to be interpreted (such as lack of eyes contact with the opposite gender or sensitivity about shaking hands with the opposite gender)?*"

Some types of body language in Muslim culture such as handshake or lack of eye contact with the opposite gender may create discomfort in the HCU and the HCPs including interpreters. These non-verbal communication differences can lead to ineffective communication. Body language interpretation can vary from one culture into another. This goes in line with Fatahi's (2010) discussion about the importance of explaining body language. For instance, a male doctor shakes hands with a female HCU whose beliefs restrict her from unnecessary physical contact with the opposite gender, this may impact negatively on establishing a trusting doctor-patient relationship (ibid). Therefore, highlighting different cultural contexts can help to avoid any misinterpretation which may result in an unnecessary conflict. "It is important to be aware of the role the interpreter plays, not only in the overt communication but also in the non-verbal interactions that take place between the three parties" (Midral, 1988, pp. 327-328).

Question (7.8)

"*Would you like to be informed of the most appropriate cultural ways for particular patients of disclosing bad news to Muslims*?"

This question aligns with Leanza (2005), Abbe et al. (2006) and White and Laws (2009), who argue that interpreters can step out of their role as conduit and invisible to act as active and

visible participants in a conversation to break the cultural barrier by acting as emotional supporter.

Question (7.9)

"*Would you like to be reminded by the interpreter of cultural events such as Ramadan*?"

Question (7.10)

"*Are you aware that adapting medication intake for fasting patients can improve the patient's adherence to the treatment*?"

Question (7.11)

"*Do you know that some Muslim patients who fast during Ramadan either stop taking their medications or charge the times at which they take their medication*?"

These questions link to Haffner (1992) who postulates that interpreters can understand the 'underlying' cultural values of the patient (ibid), that may impact their health or medical treatment in one way or another. These questions are framed within the points made by Tang (1999), Campelo et al. (2018), and Fenta, Hyman and Noh, (2007) who indicate that enhancing communication between the patient and the HCP is essential step for diagnosing and treating LEP patients.

Question (7.12)

"*Are you aware that some ethnic minority patients may take traditional medicine (herbal and other) which may interact with the medication prescribed by the HCP*?"

The adverse effects of some alternative therapies were discussed in Chapter (5) Section (5.3). Thus, the interpreter's role at this point becomes pivotal in explaining cultural beliefs and habits that may clash with the treatment procedures. This goes in line with Souza (2016)

when she highlights the significance of providing a culturally and linguistically sensitive service to reduce health disparities and therefore improve patients' safety.

Question (7.14)

"*Which of the following would you class yourself as?*"

This question was framed based upon the Department of Health EHRG (2009). It is argued that stereotyping people who belong to some religious groups should be avoided. Patients' reactions to medical issues can be result from factors such as the branch of a particular religion they belong to and how strict their beliefs are (ibid, p. 25). The issue of *haram* medication for Muslim patients is discussed in NHS (2015) and was pointed out in Chapter (5) Section (5.2.1).

Question (7.15)

"*Have you ever declined or stopped treatment because you are worried about medication ingredients which may be culturally prohibited?"*

Question (7.21)

"Would you accept a treatment containing a culturally prohibited ingredient such as pork or alcohol if it were the only available treatment?"

These questions are postulated in line with the literature presented in Chapter (5), Section (5.2.1); Mynors et al. (2004, p. 22) discuss the impact of medication ingredients as well as culturally prohibited medicine on some Muslim patients' adherence to the treatment even if it is the only available treatment. These questions also accord with the interpreter's visibility in the conversation as discussed in Chapter (4), Section (4.9) to ensure the patient's safety, as argued by (Mirdal, 1988, p.329). They also relate to the interpreter's advocate role in ensuring

patients' cultural needs are discussed and fulfilled as discussed in Chapter (4), Section (4.7.3), as postulated by Hsieh (2008, p. 1372).

Question (7.16)

"*Have you ever been in a situation where you declined an examination offered by a health care provider of the opposite gender for cultural reasons?*"

This question is based on the literature in Chapter (4), Section (4.7.3); Tribe and Morrissey (2004) indicate that interpreters can act as patients' advocates to ensure delivering culturally sensitive care for patients from ethnic minority patients by respecting their culture. Providing culturally sensitive HC that is adapted to the patient's beliefs and desires helps to satisfy patients' cultural and health needs (Leininger, 2002; Leininger, 2007).

In this context, patients' advocacy is also necessary "for empowering the patient to assert rights that might otherwise be ignored or denied" (Kaufert and O'Neil, 1990, p. 41), and to protect the patient's ethical beliefs as postulated by Dušková (2018).

Question (7.17)

"*Have you ever stopped taking your medication during Ramadan without contacting your doctor?*"

It was noted by Sadiq (2008, p. 90) in Chapter (5), Section (5.6) that Muslim patients' views can be varied with regards taking medications while fasting. This goes in line with interpretation studies that suggest that the interpreter's interference can be helpful because he/she is the only one who can detect any issues related to patients' health and safety (Kaufert and Putsch, 1997; Kaufert, Putsch, and Lavalee, 1999).

Question 7.18

"*Have you ever asked an interpreter to raise any cultural concerns with a health-care provider related to halal diet restrictions and porcine or alcohol derived medications?*"

This question was based on Voyer et al. (2005), who highlight the importance of takings patients' beliefs, practices and attitudes that may impact their health.

Question (7.19)

"*Have you ever accepted a flu jab which is porcine-derived?*"

Question (7.20)

"*Have you ever allowed your child to be given a flu jab vaccine which is porcine-derived?*"

Flu jab vaccines are perceived as porcine-derived and therefore they are *haram* (please see Chapter 5, Section 5.2.2). Children are not excluded from the list, and parents can be informed to ensure patients' rights are protected as discussed by Harper (2016; cf. Chapter 5, Section 5.2.3.1). As discussed in Chapter (5), Section (5.2.1), Mynors et al. (2004, p.22) highlight the importance of informing Muslim patients of medications ingredients that may clash with their religious beliefs. Hence, the interpreter's role is to make sure that LEP patients' rights are protected in HC (NCIHC, 2004).

Question (7.22)

"Do you believe in traditional or prophetic remedies?"

Question (7.23.)

"*Would you consult your doctor if you were taking herbal therapies?*"

Question (7.24)

"*Would you prefer to seek consultation from a herbal healer than a doctor?"*

Question (7.26)

"*Have you ever substituted aherbal remedy for another conventional therapy?*"

Question (7.27)

"If you have substituted herbal remedy for another conventional therapy, have you informed your doctor?"

These questions are formulated based on arguments in Chapter (5), Section (5.3), which discusses how traditional and prophetic therapies are widely used by the Muslim community (Easterford et al., 2005; Ricotti and Delanty, 2006) without their HCPs' knowledge (Easterford et al., 2005). Due to the potential risk that this may entail, the interpreter's interference and advocacy becomes an ethical obligation (NCIHC, 2004, p. 20).

Question (7.25)

"*Do you believe that when someone gets ill, this is Allah's will?*"

This question is formulated in accordance with the discussion in Chapter 5, Section (5.5). It is helpful for the HCP to know patients' cultural beliefs about health and illness to maximise HC results. Empowering HCPs with knowledge of culture and religious beliefs helps meet patients' expectations (Swihart et al, 2020; Verrept, H. 2008). A study conducted at Geneva University stressed the importance of cultural competence in HC. One of the interpreters who took part in the study postulates that some HCUs believe that illness and treatment come from God, which may impact patients' adherence to prescribed medication. However, these patients tend to refrain from sharing their beliefs with the HCP (Hudelson, 2005, p. 313). Thus, understanding the patient's religious beliefs may enhance the patient's safety as discussed by

Hordern (2016), cf. Chapter (2), Section (2.1.1). The advocate model can be utilised here to facilitate communication for the benefit of the patient and the quality of health and safety (CHIA, 2002, p. 14).

6.4 Participants

The researcher's initial thought was to involve interpreters in the study. This would have been very useful. However, the researcher has 'intimate insider relationships' with interpreters, which is discouraged by Taylor (2011, p. 5), on the basis that it engenders significant risks. It has been pointed out that when the research participants have "similar roles and responsibilities in their place of work to those of the researcher, the potential for exploitation exists" (McDermid et al., 2014, p. 29). The 'boundaries' between the researcher and participants can also become blurry when involving colleagues or friends (Dickson-Swift, et al., 2006, p. 853). To ensure positive results in conducting a piece of research, the researcher should have no pre-exiting relationship with the participants as this may lead to bias and 'contaminate' the outcomes (Douglas and Carless, 2012, p. 27). Thus, the researcher refrained from involving interpreters in the research.

There are two groups of participants in this research. Group A comprises HCPs, and group B includes HCUs. Both groups were asked to answer questionnaires. However, seven participants in the latter group also agreed to be interviewed. 50 HCPs and 50 HCUs. Demographic information for group B, the patients, was included such as age, gender, religion, level of education, and ethnicity. Since most patients have limited English, I explained the questionnaire into Arabic to any participant who did not understand them in English, and I guided them throughout the process in case any issues or misinterpretations that may arise. I interpreted and translated the answers from Arabic into English. While patients were only

asked to answer questionnaires, 50 HCPs were asked to answer questionnaire, and in the light of their answers I interviewed 7 HCPs to address further issues they could encounter with ethnic minority Muslim patients. The primary intended outcomes of the questionnaire and interviews are to identify:

1. The main obstacles patients and HCPs face in consultations.
2. How could these obstacles impact HCS?
3. How these difficulties can be overcome to avoid any unnecessary medical problems?

We can use this approach to provide recommendations to help resolve cultural communication issues between HCPs and patients.

6.5 Survey Questionnaires

Survey questionnaires are intended to offer a 'snapshot of how things are' (Denscomble, 1998). They are designed to investigate aspects of a situation in order to gain an explanation and offer data for testing hypotheses (Denscomble, 1998). In designing a survey questionnaire, it is essential for the researcher to:

- Have knowledge of the research area.
- Widen their experience by exploring similar related research areas through talking to or discussing another researcher's work.

Enhancing creativity through utilising some strategies such as 'brainstorming'. 'Brainstorming' was pioneered by the American advertisement company manager Alex (Creative Problem-Solving Institute.1957). 'Brainstorming' is defined as utilising the brain to solve a problem and the aim of it is to find a solution through creative thinking (Jarwan, 2005). 'Creative thinking' is imaginative mental activity used to find an original solution (Jarwan,

2008). Brainstorming has been defined by Hoing (2001) as originating new ideas, expanding restricted understanding and the start of superb ideas. Gardner (1999); Shepard, et al. (1999) believe that brainstorming is unique way of thinking and using creative skills to develop an understanding of the problem and create original solutions.

Since I am the only researcher for this research project, I only had the option to brainstorm individually. In the first step in the brainstorming process, I had to build the objective of the research and identify the goal. The main aim is to address the impact of cultural differences between HCPs and Muslim patients in the UK, to see if the participants in both groups (A and B) are aware of such differences and how this may impact their medical adherence.

Then, I had to draw up a series of questions derived from ten years' experience as a freelance interpreter and from some interpretation studies. The questionnaire questions were designed to measure the HCP's cultural knowledge of Muslim patients' religious needs that clash with some medical treatments and procedures. I had to narrow the research questionnaire questions into a phrase or even a single word regardless of its part of speech, whether noun, verb or adjective. Since the questionnaire and interview questions are directed at two different groups, HCPs and Arabic HCUs, I had to conduct two brainstorming processes, utilise my imagination and creativity and adapt according to the adopted role. The focus at the brainstorming stage is quantity. The main concrete tools at this stage are pen and paper. To boost my imagination, I made sure that the surrounding atmosphere was quiet and relaxing. I valued every idea generated from the conscious or subconscious part of my brain. I let all ideas generate freely with no restriction or filtering. The only restriction I had was time such that I had one hour to brainstorm ideas for each group.

The second stage in developing the questionnaire was filtering information. Any information that seemed irrelevant, unnecessary, ambiguous, complex, or unethical was removed at this stage. For instance, to avoid repetition, all repeated or nearly identical ideas

were amalgamated. Hence, unlike the brainstorming stage where imagination was allowed to operate freely, at this stage I was forced to generate more focused ideas. Moving from general into more specific is another technique I used to almost finalise the questionnaire as well as the interview questions and make them easy and smooth for the reader. I was also careful to design questionnaires that showed respect for participants' views and avoided underestimating their knowledge, for instance, avoiding repeating questions that had already been answered (Robson, 1993).

In this study, I used questionnaires with a combination of closed questions (having a specified and limited number of possible answers) and open questions which were presented as 'follow-up' questions immediately after each of the closed questions. The main aim was to probe HCPs' understanding of their experience with Muslim patients.

6.5.1 Questionnaire layout

It is recommended that the layout of a questionnaire should be simple and clear. Capitalisation must be avoided because this may come across as offensive or demanding. Ambiguity must be avoided to allow for clear results (Kelley et al., 2003). Designing survey questionnaires can be challenging for the researcher. Since the questionnaires in this research are directed at two groups, HCPs, and Muslim patients, level of education may be an obstacle. Muslim patients might be literate or illiterate. Accordingly, questionnaires must be as clear as possible to avoid any miscommunication or misinterpretation which may impact negatively on the research results. Another challenge which may confront the Arabic participants is their limited English. Using Arabic as the language of the questionnaire may not resolve the problem, as most of the participants are illiterate in both Arabic and English.

6.5.2 Face-to-face interviews

It has been argued that “the interview is an important data-gathering technique involving verbal communication between the researcher and the subject” (Mathers et al., 1998, p.1). Interviews are conducted in survey designs and in ‘exploratory and descriptive studies. There are various types of interviews, ranging from highly structured to unstructured. Participants in a structured interview are allowed to freely answer without limitation or restrictions, while in a structured interview the interviewee’s answers are limited (Mathers et al., 1998).

Unstructured interviews are typically used to discuss one or two topics in depth. In this type of interview, the interviewer seeks some information about a topic but has no plan, structure, or expectation of how the interview will proceed (Mathers et al., 1998). An unstructured interview is rather like a spontaneous discussion whose aim to gain specific knowledge towards a specific topic.

In contrast to unstructured interviews, structured interviews are tools for asking different participants the same questions in the same order. A structured interview has a lot in common with a questionnaire. The questions are pre-planned. On some occasions, a pilot study is used to test the questions. Face-to-face interviews require that the researcher approaches respondents directly. This may be in a variety of venues, ranging from public places or to the respondent’s or researcher’s home. The researcher asks questions of the participants and makes a note of the participants’ responses and comments (Kelley et al., 2003).

In this research, I have conducted seven in-depth face-to-face interviews with HCPs to gain further information about their experiences with Arab Muslim patients. These are intended to provide a detailed analysis of the main cultural issues confronted by HCPs in dealing with Muslim patients.

6.5.3 Covering letter

Before being asked to take part in a questionnaire or interview, participants must be provided with a 'covering letter'. Information such as the organisation behind the study, the researcher's contact details, reasons for selecting the participant, the target of the study, and any benefits and risks that may result from taking part in the research survey should be included in this covering letter. The aim of the letter is to motivate the participant to take part in the study. It should also involve an informed consent (Kelley et al, 2003).

6.6 Pilot Study

Conducting a pilot study, where possible, is a crucial step in research. A pilot study helps the researcher ensure that all the relevant topics are addressed, and the so-called preceded questions ('pre-codes') are correct. "Preceded questions refer to survey items for which response categories may be identified and defined exhaustively, or very nearly so, prior to data collection activities. Precoding questions involves specifying the coding frame (i.e., the set of possible answers) and associating each response category within the frame with a value label (which is typically, but not necessarily, numeric)" (Lavrakas 2008 https://methods.sagepub.com/Reference//encyclopedia-of-survey-research-methods/n392.xml). A pilot study can also help the participant not to forget or omit crucial issues for the study. Using a draft version of the questionnaire is the best way to carry out a pilot study. The main target is to test the questionnaire on a sample. The recommended sample number should be between ten and fifty.

To ensure that one has covered all the relevant issues, that the pre-codes are correct, and that one has not forgotten or omitted some issue that is very important to the respondent, it

is necessary to conduct a pilot study using a draft questionnaire. The interview language must be simple and clear. Testing the language of the questionnaire is a crucial step towards ensuring effective communication (Mathers et al., 1998).

This research tool enables the researcher to check the respondents' understanding of the questions and instructions. Piloting used closed questions highlights whether the questions are likely to be easily understood by all respondents. This method can help the researcher to highlight whether there are sufficient responses, and whether more questions are required (Kelley et al., 2003).

Piloting is a method used to gauge the recipient's understanding and to make sure that the questions are clear, simple, and free from ambiguity and repetition. In this study, I tested the survey research on fifteen medical students (as representatives of HCPs) and ten Arab Muslim patients.

In this research the term 'pilot study' is used according to Mackey and Gass' definition:

> a small-scale trial of the proposed procedures, materials, and methods, and sometimes also includes coding sheets and analytic choices […It] is an important means of assessing the feasibility and usefulness of the data collection methods and making any necessary revisions before they are used with the research participants (Mackey and Gass, 2005, p.43).

According to Burns and Grove (2011), a pilot study helps to refine the methodology of the research. Similarly, Prescott and Soeken (1989) believe that it is a means to "refine any of the steps in the research process" (cited in Burns and Grove, 2011).

Miandehi similarly argues that "piloting data collection and data analysis process help the researcher to save time, costs, and to avoid irretrievable damage in the main stage of the

work. There are many minor issues that in the first place may seem to be unimportant or may not be taken seriously, but in practice they may create serious problems" (Miandehi,1997, p.124). It has been suggested that there are several factors which make the pilot study easier such as the nature of the case study:

> the case study approach is a very flexible method of research because its design tends to lend itself to exploration rather than to prescription or prediction. Thus, researchers are comparatively free to discover and address issues as they arise in the course of the research (Kumar, 2008, p.5).

The pilot phase started with testing and finalising the format and wording of the questionnaires and interviews. This was a significant stage in this research. It gave me feedback on the research questionnaires. Accordingly, some of the questions were modified following the pilot study.

The pilot study conducted in this research involved assessing Muslim patients' knowledge of the HC system in the UK. It aimed to measure their understanding of how some medical procedures and treatments may clash with their religious beliefs. It demonstrated the main issues faced by Muslim patients while receiving the treatment. It also helped to measure HCPs' knowledge about Muslim patients' culture and how this could impact HCS.

The pilot study used in this research proved to be very informative for me as a researcher but also potentially for other researchers doing similar research. In this research project, I tried to gather information from both HCPs and HCs through quantitative and qualitative methods. Then, I produced a set of recommendations considering the results.

6.6.1 Outcomes of the pilot study

Before conducting the main study, the survey questionnaire and interview questions were tested on patients and students at various GP surgeries and hospitals in Newcastle-upon-Tyne. The interview questions were tested on HCPs. The survey questionnaires for groups (A) and (B) were tested in the same way as in Van Teijlingen et al. (2002), who highlights the importance of conducting a pilot study on midwifery research to test the feasibility of the data. Teijlingen et al. (2002) used two data collection methods: quantitative questionnaires and qualitative interviews (ibid).

6.6.1.1 Outcome of pilot study for interview questions

Five HCPs were approached, two senior nurses, two doctors and one midwife. Only three took part in the study; two nurses and one doctor. The volunteer doctor commented that he appreciated the language used in the questions and did not object to the time length of the interview. The interview questions were tested, using the principles outlined in Sampson (2004). Sampson's main principles in embarking on a pilot study are:

- Evaluate pilot study and appreciate participants' feedback
- Filter research methods like questionnaires and interview questions by highlighting the gaps to avoid data wastage and "minimise the researcher's risk" (ibid, p.400)
- Consider any omission or unnecessary elements when needed
- Reduce "observational bias within the project" (ibid, p.395)
- Seek participants' feedback about the interview to make sure that the process does not sound 'demanding' (ibid, 395).

6.6.1.2 Outcomes of HCPs, group (A)

The researcher's initial plan was to involve thirty participants in each group. However, only twenty-three medical students took part in the pilot study: fifteen from medical schools and eight from a dental school. Seven students refrained from taking part due to time constraints Students were approached in Newcastle-Upon-Tyne Medical and Dental Schools. All participants were British citizens. None of the volunteers who took part in the pilot research found any obstacles that would increase the time needed to fill in the survey questionnaire. Participants who agreed to take part in the pilot study for the survey questionnaire also agreed to the language used in the survey questionnaire without any hesitation. However, three of the participants recommended leaving a space under each question for respondents to add comments when they wished to.

6.6.1.3 Outcomes of Arab Muslim patients, group (B)

The researcher approached thirty Arab Muslim students (undergraduate and postgraduate) to take part in the pilot study, but only twenty-seven accepted. The researcher approached participants on the Newcastle University library, Northumbria University library and Newcastle University prayer room. Seven volunteers recommended providing a copy of the questionnaires translated into Arabic, in addition to the original English version.

For question two in group (B) "Which of the following would you class yourself as?", two participants suggested adding the option "I prefer not to say option". For question seven "Have you ever accepted a flu jab which is porcine-derived?" three of the participants suggested adding the phrase "porcine-derived", which was not in the original wording.

The researcher appreciated the constructive feedback given by participants. She also amended the format of the questionnaires by leaving a blank space for participant's additional comments. She changed the wording for questions two and seven for group (B). This helped to improve the final version of the questionnaires.

6.7 Ethical Considerations

Researchers collecting data from patients have to be ethically sensitive to each questionnaire respondent or interviewee taking part in the survey. All surveys should be carried out in an ethical manner. Participants' confidentiality and informed consent are crucial aspects in conducting survey research. Obtaining interviewees' permission by signing a consent form is very important in the survey. Explaining the aims of the survey questionnaire to participants is essential (Kelley et al., 2003).

Hence in this research, ethical considerations have been considered, with a view to not causing any physical or emotional harm to respondents, and not exposing them to problems by disclosing their personal details such as names. Emotional support was provided to all interviewees showing any signs of emotional distress. Withdrawal from filling the survey was permitted at any time to protect the participant from any physical or emotional harm.

In the following paragraphs, I will consider the notion of ethics, and other subsidiary notions which are relevant to my research. The term 'ethics comes from ancient Greek philosophy and refers to 'moral life'. It is a set of rules which can significantly change others' thoughts about choices and actions (Johnstone, 2009). Ethics is "a branch of philosophy which deals with the dynamics of decision-making concerning what is right and wrong. Scientific research work, like all human activities, is governed by individual, community, and social values. Research ethics involve requirements on daily work, the protection of the dignity of

subjects and the publication of the information in the research" (Fouka, and Mantzorou, 2011, p. 4). Hack in (1997, p.37, in Blaxter et al., 2001) stresses the importance of ethical considerations in research: "it is worth standing back for a moment and considering what effect your actions might have on others as the results can be quite damaging to yourself".

Different ways of contacting people carry different risks. For instance, the researcher may contact people face to face. Or he/she may use other methods of communicating such as contacting participants electronically. This can be risky because the information can be easily breached by hackers who may gain access to the information (Blaxter et al., 2001). Generally, face-to-face contact is the safest way where the researcher can record the information and maintain the participant's confidentiality. All the collected information is handled with care and stored appropriately. Participants' privacy is highly protected.

Hammersley and Traianou (2012) list five main principles for ethical consideration:

'Minimising harm': this entails that the researcher's strategy causes minimum harm to the participant and only if there is a way to justify it. It is worth noting here that this harm could include the participants who took part in the research or any other future researchers.

'Respecting autonomy': this entails whether the researcher shows respect to the people involved in the research.

'Protecting privacy': the main aim of each piece of research is to make its results available to other researchers. However, the researcher has to be aware of maintaining data confidentiality. He or she has to adhere to privacy policy; knowing which details can be disclosed to the public and which information cannot be shared and should be protected.

'Offering reciprocity': like any other piece of research, filling in a research survey or being interviewed involves effort. Hence, some participants might not attend the interview or fill in

the questionnaire. Hammersle, and Traianou raise the question about whether participants should be paid to avoid any participants being withdrawn from participating in the research.

'Treating people equally': this involves that all participants must be treated fairly. Hammersle, and Traianou add that these are not the only issues for social research, but they are the focus (Hammersley, and Traianou, 2012).

Ethical concerns have been addressed in this research in relation to both groups of participants: HCPs and patients. All interviewees were required to sign consent forms before filling in the questionnaire or being interviewed. Even though, there was no harm or risk to any of the participants, a withdrawal was accepted at any stage at the participant's request. All interviewees were treated equally.

This research did not originally intend to restrict non-Arab Muslims from taking part. However, after consideration, the researcher decided to focus on Arab Muslim patients only. This is due to the fact that she can only translate for Arab Muslim patients. Although she had some Muslim Pakistani and Indian colleagues, who could translate this would have been a breach of confidentiality. Newson and Lipworth, (2015) highlight the importance of obtaining 'ethical approval' to avoid any potential risks that research may entail (ibid, p.170). Thus, I submitted an ethical approval form to the local HCS Committee along with a supporting letter from my supervisor who vetted the research proposal for onward submission to seek approval for this research. I also got the approval from the Leeds University Faculty of Arts, Humanities and Cultures Research Ethics Committee, as required for all research which might involve ethical issues at the University of Leeds. In this case, no issues arose during the research process, and each aspect of this research was completed as approved by the Research Ethics Committee.

Some patients required some guidance in filling in their questionnaires, as many patients were not educated enough to understand or read the questionnaire. Hence, further

explanation was required. During conducting the research, the researcher adhered to ethical guidelines by ensuring no intervention on my part would result in biased responses (Fowler and Mangione, 1990). Developing trustworthy professional rapport from the outset is crucial (Kvale, 1996). This created a safe and comfortable atmosphere to enhance respect with the participant (DiCicco-Bloom and Crabtree, 2006), and to remove any tension with the participant by establishing trust and assuring them that their data would remain confidential and anonymous (Trochim, 2005). Her presence at the time of answering the questionnaire and the support given to the participants were limited only to assuring them that no answers would affect their residency status in the UK, and the answers would only be used for my PhD study.

To ensure the accuracy of the data, judging or commenting on the participant's answers was avoided (Gorden, 2003). However, some participants showed some hesitation and uncertainty in understanding a few multiple-choice questionnaire items. For instance, in question (2), which measures the participant's religious adherence, participants were unsure of the difference between "very strictly religious", "fairly strictly religious" and "not very strictly religious". My answer was "very strictly religious" is used for very devout Muslims who adhere closely to their religious duties and the five pillars of Islam despite of exemptions. "Fairly strictly religious" implies believing in the five pillars and performing them when they can and accept exemptions when required. "Not very strictly religious" refers to Muslims who still believe in God and the five pillars without practising them.

Because of the different cultural background, the participants came from, some did not know what a flu jab means because they do not have it in their country. This shows in question (7) "Have you ever accepted a flu jab vaccine which is porcine-derived?" The researcher briefly explained that a flu jab is a vaccine to protect patients from flu. She made sure not to

influence the participants' answers to minimise bias and ensure accurate data were collected. After they had filled in the questionnaire, the researcher thanked participants for their time and cooperation.

The initial plan was to involve participants from other Muslim backgrounds such as Pakistani, Indian, Bangladeshi and Malaysian. However, due to data confidentiality and to the cost of providing interpreters for all participants, I decided to involve only Arab Muslim patients. I used a copy of the questionnaire translated into Arabic to read to participants who were unable to read the questions either due to the language barrier or their poor literacy level.

HCPs were given the option to be guided as well, but they were able to fill the questionnaire independently. The researcher allowed participants as much time as they need to fill in the questionnaires. However, she also respected the respondents' time constraints. None of the obtained information will be saved for longer than a year after the completion date of the thesis. All participants' details such as names will be anonymised and kept confidential. No obtained information will be saved for longer than one year from the publication date of the thesis.

6.8 Trustworthiness

All the results of the collected information will be as reliable and valid as possible, as I will check the accuracy of the gathered information. All the questionnaires will be signed, timed, dated and consented.

6.9 Limitations

Being a new researcher, I expected to encounter some difficulties. Rimando et al. stress the importance of gathering information and interpreting it accurately: "data collection is critical to the social research process. When implemented correctly, data collection enhances the quality of a social research study. However, doctoral students and early career researchers may encounter challenges with data collection" (Rimando et al., 2015, p,2025).

It has been reported that "there is a need to share and report the data collection challenges of public health doctoral students. This knowledge can assist doctoral students and early career researchers when facing data collection challenges in the future" (Rimando et al., 2015, p.2026). Learning from others' experiences will help future researchers to avoid some challenges. It could also put researchers in a better position and make them prepared for the obstacles which might be similar to/different from this research depending on the subject and the target community.

In this research I was confronted by the following challenges:

6.9.1 Difficulty in reaching out

One of the main challenges I confronted while conducting this research is the difficulty of carrying out the original research method. Initially, I planned to record interviews carried out between HCPs, ethnic minority patients, and interpreters. I attended a meeting with the head of equality and diversity for the NHS, who informed me that due to the sensitivity of the research with the NHS, I was requested to go through NUTH (Newcastle Upon Tyne Hospitals), R and D (research and development) and put it in an IRAS application (Integrated research application system). This would require ethical approval from the local committee too. I got

in touch with the IRAS team and was informed that carrying out this type of research through recording patients may be a breach of patients' confidentiality.

Accordingly, I decided to change the original research tool from recording participants into research surveys and conducting interviews. This research requires ethical approval from the Leeds University Ethical Review Committee, which took almost a year to be obtained. However, gaining ethical approval from the committee was not the end of the problem. I then had to find a way to contact participants. The first point of contact was local hospitals in Newcastle-Upon-Tyne. I contacted the lead chaplain who was unable to help. I had contacted the Health and Research Authority for the NHS who could not point me in the right direction either. Eventually, I managed to get in touch with some GPs surgeries which were of great help.

6.9.2 Time constraints

Even though carrying out questionnaire surveys can be a useful method to collect data, they might be seen as intrusive by the participants. Wallace argues that they also "eat into other people's time" (Wallace, 1998, p.128). Hence, most of us do not enjoy filling in survey questionnaires. It has been pointed out that postal surveys are a crucial method to learn about HCPs' attitudes, knowledge, and experience on various matters. However, they are well known as a technique that researchers find challenging to gain a high rate of response (Thorp et al., 2009). Rimando et al. argue, "completing a survey may be mentally taxing for the participant" (Rimando et al., 2015, p.2031). Several factors explain why HCPs frequently refuse to take part in surveys: time constraints, low perceived significance of a study, a high number of surveys they are required to respond to, and worries about confidentiality (VanGeest et.al., 2007).

Since this research involves HCPs, it was a challenging task for me as a researcher to get participants to fill in the survey. It was even more challenging to conduct qualitative research. Fifty HCPs were contacted to take part in qualitative research, but only seven participants accepted. However, in the quantitative research part, I contacted one hundred HCP, and fifty filled in the survey. Some participants in the interview questions declined to answer additional questions because of limitations on their time. Time limitation was not only an issue for HCPs but was a concern for HCUs too. Interestingly, I contacted 100 patients, but only fifty showed interests in taking part. In this research, I had to make the time to conduct interviews with participants and record data. Since most of the HCUs had LEP. I had to guide them in filling in the research survey and interpreting the questionnaires.

6.9.3 Reluctance to participate

There are several reasons why participants may resist taking part in research. Robson (2002) suggests respondents might be confined by "social desirability response bias", which means that doubt in the researcher concerning data confidentiality can be an obstacle. Participants' concern has been "focus of debate in the social sciences" (Lee-Treweek and Linkgolo, 2000). Participants' fear of loss of confidentiality is one of the major issues in conducting questionnaire research.

One of the primary values of the Hippocratic oath is to "maintain confidentiality and never to gossip" (Harding, 2015, p.2). Thus, confidentiality was an issue for HCPs who had taken the Hippocratic oath as they have to adhere to its rules. Clause 10 of the ICN (Information Council nurses) code for nurses highlights that all patients' details must be kept confidential (Burnard and Chapman, 2005). The professional code requires nurses to be committed not to disclose confidential details even to a researcher (Hunt, 1992).

One of the main obstacles I confronted in carrying out this research is participants' fear of breaching confidentiality. I had contacted fifty HCPs for interviews, but only 10 HCPs showed interest and only seven took part in the qualitative research. Thus, fear of confidentiality was one of the leading causes of declining participation in the research. In order to minimise the risk of respondents not filling in the questionnaire, I highlighted the importance and benefits of this research to improve HCS for minority patients. Otherwise, more participants might have refrained from providing accurate answers due to their lack of trust in the researcher.

6.9.4 Lack of trust

Some participants might fear that their answers could risk their personal information. This might have resulted in them refusing to take part in the survey or distorting their responses to put themselves in a better light. Therefore, the researcher took it upon herself to reassure participants that their confidentiality was essential, and all the details would be kept in a safe place where only the researcher can access them. Assuring participants that all the details will be anonymous is another way to lessen the participant's worries and therefore to avoid any rejection or withdrawal from taking part in the survey (Adams and Cox, 2008). Disclosing personal information could be a breach of confidentiality in HC. Thus, participants may be anxious about revealing information to the researcher (Bonevski et al., 2014).

In this project, the researcher contacted one hundred patients but only fifty responded. Lack of trust in the researcher and fear of confidentiality could be the cause of this. She found out that group B (patients) lacked knowledge about the rules of confidentiality in the UK. This was entirely expected as UK rules are different from those of the country the participant originally comes from. She had to abide confidentiality principles particularly in the light of the consequences of breaching UK law.

6.9.5 Finding the right participants

New researchers find it challenging to find the right participants, to convince them to take part in the research, and to make them feel comfortable during the research (Dearnley, 2005; Hoskins and White, 2013). In this research, my challenge was to find participants. For group A (HCPs), I approached GPs surgeries in areas that are not highly populated with Muslim communities. My primary aim behind this was to assess the cultural knowledge of HCPs who have less interaction and experience with Muslim patients.

6.9.6 Participants' literacy level

It has been postulated that participants with poor health literacy struggle to understand questions in both quantitative and qualitative research (Bonevski et al., 2014). Some studies have reported that the health and language literacy of participants might have an impact on their understanding and consequently influence the data research results (Bonevski et al., 2014; Mayer and Villaire, 2007).

In this research, both questionnaires were designed and auditioned according to the target audience's literacy level. However, communicating with participants was still challenging for me. While group A (HCPs) found the questionnaire very straightforward, I faced difficulty in communicating with group B (patients). Due to the low literacy level of group B (patients), I had to explain questions and adapt them according to participants' educational background to avoid any misunderstanding.

Another important issue is related to participants is their emotional state. This goes in line with the views of Ashton, who argues that participants may be subject to distress when sharing their experience with the researcher (Ashton, 2014). A few participants from group B (patients) showed feelings of agitation when discussing sensitive issues such as death. I kept

checking that participants felt well enough to carry on. Showing care and respect to others' feelings and being considerate of their efforts in making the time to take part in this research was crucial at this stage.

6.9.7 The researcher's motivation

The above factors might impact the researcher's wellbeing. This could result in researcher 'fatigue', which is classed as a significant element in the success of the data collection process (Dickson-Swift et al., 2007; Fern, 1982). In this research, the researcher's primary target is to collect data to solve a problem, to help participants and other researchers. Nevertheless, she found herself surrounded by numerous challenges and had to overcome multiple obstacles to achieve a successful study.

During the questionnaire and interview period the researcher's main challenge was to keep herself motivated and to keep on going despite the workload. Maintaining motivation was one of the obstacles the researcher faced. The ultimate aim of this research is to benefit both HCPs and HCUs and other researchers. This goal filled me with determination and persistence to achieve my target.

6.10 Improving Clinical Outcomes

The ultimate practical goal of this research is to improve clinical outcomes, by making the results available to HCPs in this thesis, and by other means of dissemination. In addition, it is hoped that the outcomes of this research will help interpreters to boost their work efficiency in providing positive and better facilities for ethnic community patients. It is, of course, also hoped that this research will provide a basis for future research in this field.

6.11 Conclusion

In this chapter, we have discussed the difference between inductive and deductive and qualitative and quantitative research methods and the benefits and disadvantages of using each approach. Due to the nature of this research, we have decided to use the inductive approach. While the qualitative research gives us deep results without distorting the context or relying on numbers, this method lacks reliability, as it is only applied on a small sample of participants and is a time-consuming process. On the other hand, the quantitative approach is more time-effective but does not probe into the causes of the results. The former is a human tool the latter a more robotic method.

To avoid the limitations of each method I have combined both methods in data collection. I highlighted the importance of ethical considerations. I have explored the steps I had to go through as a researcher starting from the pilot study, then auditing, wording, and finalising the questionnaires and ending with the primary challenges. I have examined the difficulty of reaching out to the participants to carry out the research, and the way in which the need for a high level of confidentiality impacted to change the research tool from recording patients to doing a survey questionnaire. I have considered the risks of confidentiality and how this affected participants' participation in this research. I have illuminated the skills I had to use as a researcher minimise and if possible, avoid associated risks in the research, such as reminding participants of the benefits of the research and the confidentiality of their personal details.

CHAPTER SEVEN

EMPIRICAL ANALYSIS OF CULTURAL PROBLEMS IN MEDICAL INTERPRETING

7.1 Introduction

This section presents an empirical study of the research survey as answered by Arab Muslim patients and HC professionals. This study was developed to explain and improve the HC for ethnic minority Muslim patients in the UK. It highlights an empirical test of the English limited patients' experiences. It presents the communication issues faced by HCPs and patients. All the questionnaires were focussed on the HCP's familiarity with the religious and cultural issues the Muslim patients may face. We will address the main issues faced by Muslim patients as discussed in Chapter (5) and apply them on the discussion of the study. The Muslim participants' responses were utilised to assess their understanding of the HC system in the UK and to measure the impact of their religious beliefs on the treatment plans.

Fifty HCPs and fifty Muslim patients completed the research survey questionnaires. Seven HCPs took part in the interviews. The results were validated based on the interviewees' responses and comparing them with the research survey's results. The findings provide empirical support for the protentional usefulness of the advocate role of the interpreter.

7.2 Data Analysis

Section (7.2.1) discusses the results of the HCP questionnaire (Sections 7.2.1.1-7.2.1.12), the results of the patient questionnaire (Sections 7.2.2.1-7.2.2.15), and the results of the HCP interviews (Sections 7.2.3.1-7.2.3.10). (Section 7.3) discusses discussion of the findings, (Section 7.4) is a summary of the questionnaire results and finally the conclusion is in (Section 7.5).

7.2.1 HCP questionnaire

The first set of questions below, Q.7.1-Q.7.12, were given in a questionnaire to HCPs. One hundred HCPs were asked to complete the questionnaire, but only fifty completed it. The results from these 50 respondents are as follows:

7.2.1.1 Q.7.1: Are you aware that some medications, implants, or vaccines may contain ingredients which conflict with a patient's religious beliefs?

The results for this question are as follows:

a) 88% (44) of the HCPs answered yes.
b) 6% (3) were unsure.
c) 6% (3) said no.

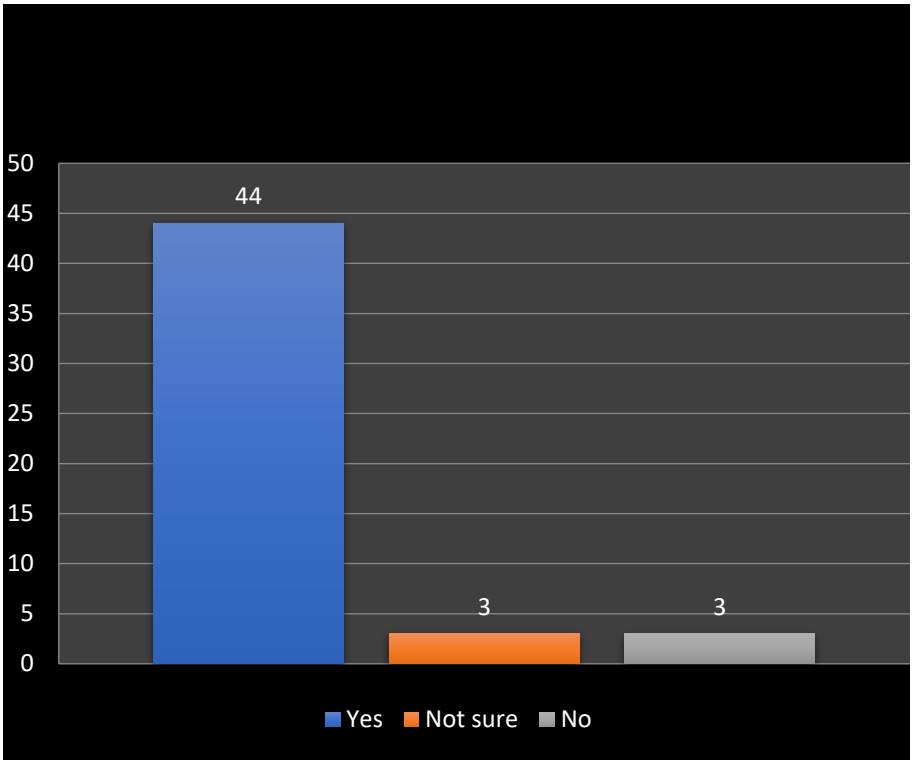

Figure 7-1 Are you aware that some medications, implants, or vaccines may contain ingredients which may conflict with a patient's religious beliefs?

The answers to the question show a high percentage of 88% (44) of the total number of the respondents know some medicines, implants and vaccines may contain ingredients that clash with the patient's religious values. This is reassuring, as it shows that most HCPs are aware of these issues.

One of the participants pointed out: "it is important to be aware of faith contents of medications dispensed, and nut allergies, vegetarians and vegan". Another HCP mentioned: "patients will often ask if what we prescribe has animal and alcohol-derived ingredients". Out of 50 participants, only 6% (3) are unsure. This could be because the participants either have not dealt with a lot of ethnic minority patients or they are not qualified to prescribe

medications. One participant explained: "I am aware that there are some religious diet restrictions. However, I think it only limits patients from eating food that is religiously prohibited and never know that this could contain medication ingredients". Another clinician stated: "my knowledge about different cultures/ religions is limited and sometimes when I prescribe medication, I am unsure if it contains ingredients that are forbidden". 6% (3) of the total respondents said that they lack knowledge of patients' religious concerns. One participant stated: "I am aware that some animal-derived medications could be a problem for vegetarian patients due to their lifestyle".

7.2.1.2 Question 7.2: Do you know that treatments containing ingredients which are prohibited for members of some religious groups such as pork or alcohol may impact patients' accepting the treatment?

The results for this question are as follows:

- **a)** 86% (43) of the participants said yes.
- **b)** 6% (3) were unsure.
- **c)** 8% (4) answered no.

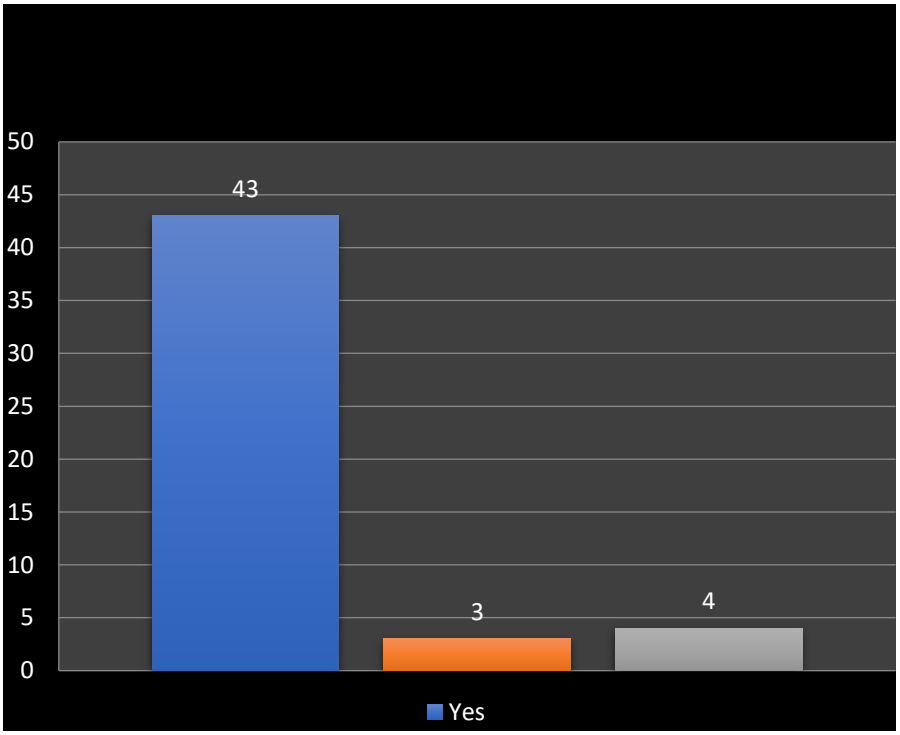

Figure 7-2 do you know that treatments containing prohibited ingredients such as pork or alcohol may impact patients' accepting the treatment?

Figure 7.2 shows a positive response, such that 86% (43) of the participants were aware of the impact of religiously prohibited ingredients in some medications on patients' compliance with the treatment. However, 6% (3) of the HCPs were unsure. This could be because participants represented in the red bar have never come across a situation where a patient stopped taking medications due to religious reasons. One nurse stated, "this is interesting to know, but I never come across this during my experience in HC". 8% (4) of the HCPs ticked "no". One doctor believed, "what I say to the patient is to ask the pharmacist". This could be challenging, particularly for those with no or limited English. Since the patient does not speak English, effective communication could be impossible with the pharmacist without an interpreter.

7.2.1.3 Q.7.3: Have you ever had a patient decline a flu vaccine because he/she believes it to be porcine-derived?

The results for this question are as follows:

a) 4% (2) ticked “yes frequently”.

b) 6% (3) stated “yes occasionally.”

c) 4% (2) said “yes but only once.”

d) 8% (4) replied “not sure.”

e) 78% (39) of the HCPs answered “no.”

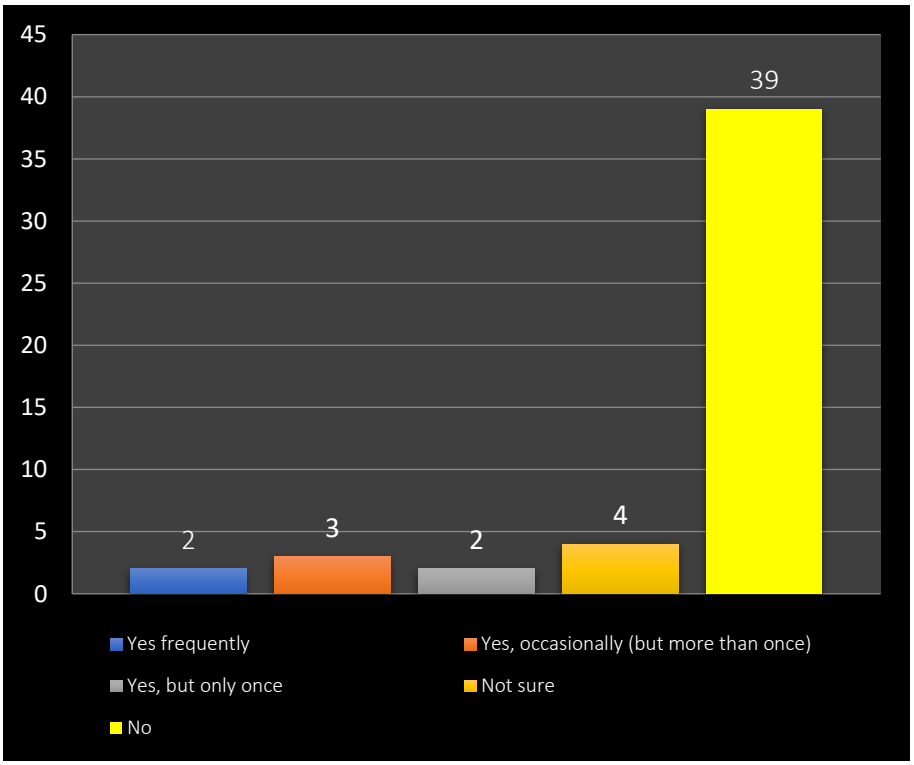

Figure 7-3 have you ever had a patient declined a flu vaccine because he/she believes it is porcine-derived?

In figure 7.3, an overwhelming percentage of the respondents,78% (39 respondents) answered "no" they never had a patient decline a flu vaccine. This could be because most patients are either unaware of the ingredients of flu vaccine or despite their awareness of the vaccine's ingredients, yet they accept it for medical reasons or because it is acceptable regarding their level of religious adherence. Some Muslim patients accept porcine or alcohol-derived medications for treatment purpose. This could also be because they have never been in this situation as some participants pointed out, "I have not encountered this situation". One of the participants said, "every religion has expectations for health advantage. The choice is for the patient to decide the pros and cons".

7.2.1.4 Question 7.4: Has a patient ever declined or rearranged a consultation with an opposite gender HCP without explaining the reason?

The results for this question are as follows:

a) 22% (11) of the HCPs answered yes.
b) 46% (23) ticked “yes occasionally but only once.”
c) 16% (8) replied yes, but only once.
d) 4% (2) were unsure.
e) 12% (6) said no.

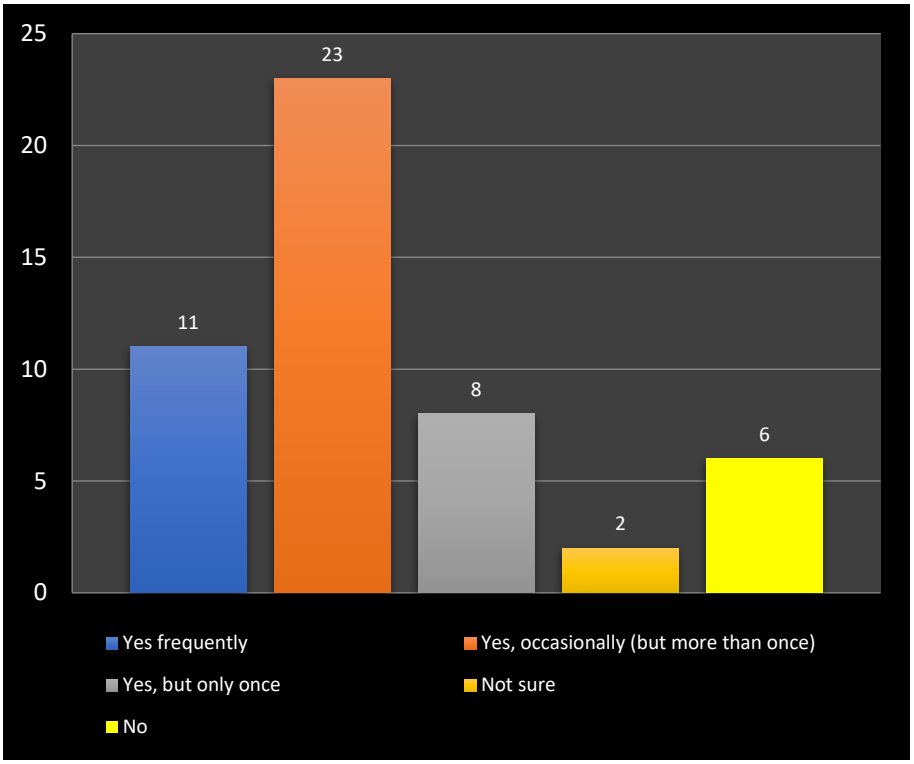

Figure 7-4 Has a patient ever declined or rearranged a consultation with an opposite gender hcp without explaining the reason?

Figure 7.4 shows that 46% (23) of the participants said that Muslim patients declined a consultation with the opposite gender more than once. About 22% (11) of the HCPs reported the frequent occurrence of these situations, while 16% (8) participants stated this had happened only once. This indicates that same-sex HCP could cause an issue for Muslim patients, which may, therefore, impact the patient's adherence to appointments or late diagnosis process. Thus, it is essential to ask the patient if he/she has any gender preference to avoid missing appointments or even declining a consultation. Missed appointment and declined consultations could be costly for the NHS. Taking the advocate role in interpretation by asking the patients whether they have any concerns could be beneficial at this point. Only

12% (6) of participants, as shown in the yellow bar, noted that the gender of the HCP has never been an issue.

Nonetheless, only 4% (2) stated that they are culturally sensitive to the patient's needs. A nurse in sexual HC postulated, "I am aware of these issues, and I always ask patients if they have any preference for the gender of the HCP". This signifies that some HCPs have some cultural awareness of their patient's religious beliefs.

Same-gender preference is not necessarily linked to religion. Other factors can also contribute to shaping patients' preferences for a same gender HCP such as medical situation and intimate examinations like gynaecological examination, endoscopy, and colonoscopy (Varadarajulu et al., 2002, pp. 170-173). This is due to patients' embarrassment, which is one of the most prominent causes for same-gender preference (Varia et al., 2014; Lahat et al., 2013, pp. 897-903). In clinical encounters that involve psychological counselling same-sex HCP preference has also been identified as issue for some patients (Roter et al., 2002, pp. 756-64; Hall and Roter, 2002, p. 224).

7.2.1.5 Q 7. 5: Have you ever been in a situation where a patient refused an animal organ such as a pig heart valve transplant due to religious reasons?

The results for this question are as follows:

a) 10% (5) of the respondents said yes frequently.

b) 4% (2) answered yes occasionally.

c) 32% (16) responded yes but only once.

d) 8% (4) were unsure.

e) 46% (23) ticked not relevant.

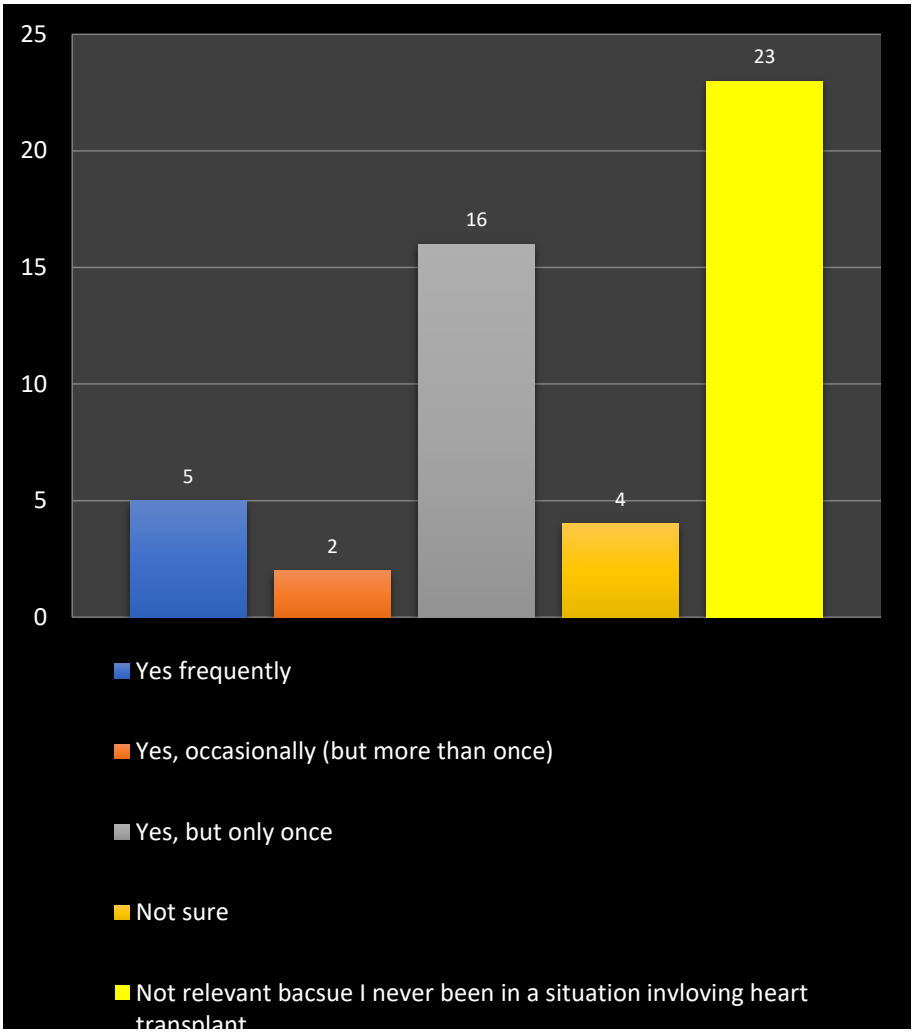

Figure 7-5 Have you ever been in a situation where a patient refused an animal organ such as a pig heart valve due to religious reasons?

Figure 7.5 shows that 10% (5) HCPs stated that they had had patients who declined the treatment because the heart valve transplant was derived from a pig. This shows that some patients are quite strict about procedures involving pigs. The NHS always makes sure that HCPs inform their patients about the components of any transplant involves pig, and it is the

patient's responsibility to accept or decline the treatment. One HCP pointed out, "once I had a Muslim patient, and we communicated through an interpreter. At first, the patient was very hesitant then he asked for more time to think about it. In a few days, the patient rang and confirmed that he would go ahead with the treatment".

The results show that 32% (16) HCPs answered that this has happened on one occasion only. One cardiologist said, "yes but only once, I had a patient with IHD. He refused a heart valve transplant for life improvement". Another nurse practitioner mentioned, "media covers this". Discussion in the media could be useful for English speaking patients, but it could be a significant issue for patients with no/limited English. Results show that only two cases when patients refused porcine derived medications more than once, and 8% (4) HCPs were unsure. This could be because HCPs never dealt with this issue.

In life threatening situations and when no alternative treatment is available, Muslim patients allowed to use porcine-derived medications However, some Muslim patients may still refuse the treatment. Their religious beliefs overpower their health. It all depends on the patient. Therefore, it might be worth giving the patient some extra time like a few days to think about the matter properly and ask some religious scholars (imam) when necessary.

7.2.1.6 Q. 7.6: Would you prefer that an interpreter explains cultural issues while interpreting such as religious dietary restrictions such as *halal* diet?

The results for this question are as follows:

a) 82% (42) answered yes.
b) 10% (5) were unsure.

c) 8% (4) said no.

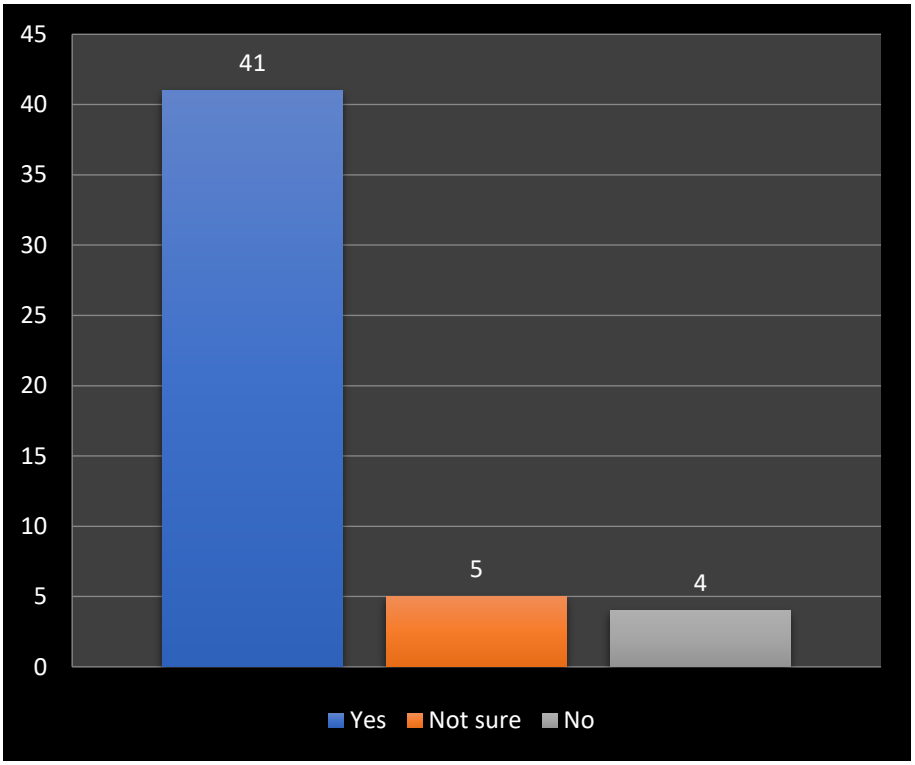

figure 7-6 would you prefer that an interpreter explain cultural issues while interpreting such as religious dietary restrictions such as *halal* diet?

Despite most HCPs preferring the linguistic (conduit) model in interpretation surprisingly the results show that 82% (41) prefer the interpreter to explain cultural differences. A doctor commented, "not all doctors know every aspect of every religion". Another HCP stated, "every day we deal with various ethnic minority patients; it will be useful if the interpreter highlights some points of concern and asks me first before discussing them with the patient". One HCP said, "this could be helpful on certain occasions".

The results also show that only 10% (5) of the HCPs were unsure. Participants falling under this category indicated that they were unsure if this could cause some risk for patients. One

HCP declared, "I am not sure, I would like to be guided by the patient's preference". A sexual health specialist added, "it is the patients to answer if they want their needs to be addressed". One HCP left the patient to decide: "it is up to the patient". A community matron stated, "I am not sure how this fit with confidentiality if the patient has not volunteered information".

Figure 7.6 shows that the lowest percentage 8% (4) responded "no". A nurse supported her opinion, "I have some awareness. The interpreter could check the understanding of the HCP before the appointment". Another nurse noted, "the NHS has already trained us about cultural issues, and I always make sure that the patients' cultural needs are addressed".

Nevertheless, not all the patients are aware of the cultural differences and dietary restrictions of the UK. Patients who have just been admitted to hospital or diagnosed with some serious health issues may forget to highlight their religious beliefs; therefore, they might need some cultural advocacy to support them.

7.2.1.7 Q.7.7: Would you like the patient's body language to be interpreted (such as lack of eye contact with the opposite gender or sensitivity about shaking hands with the opposite gender)?

The results for this question are as follows:

a) 84% (42) said yes.
b) 8% (4) were unsure.
c) 8% (4) answered no.

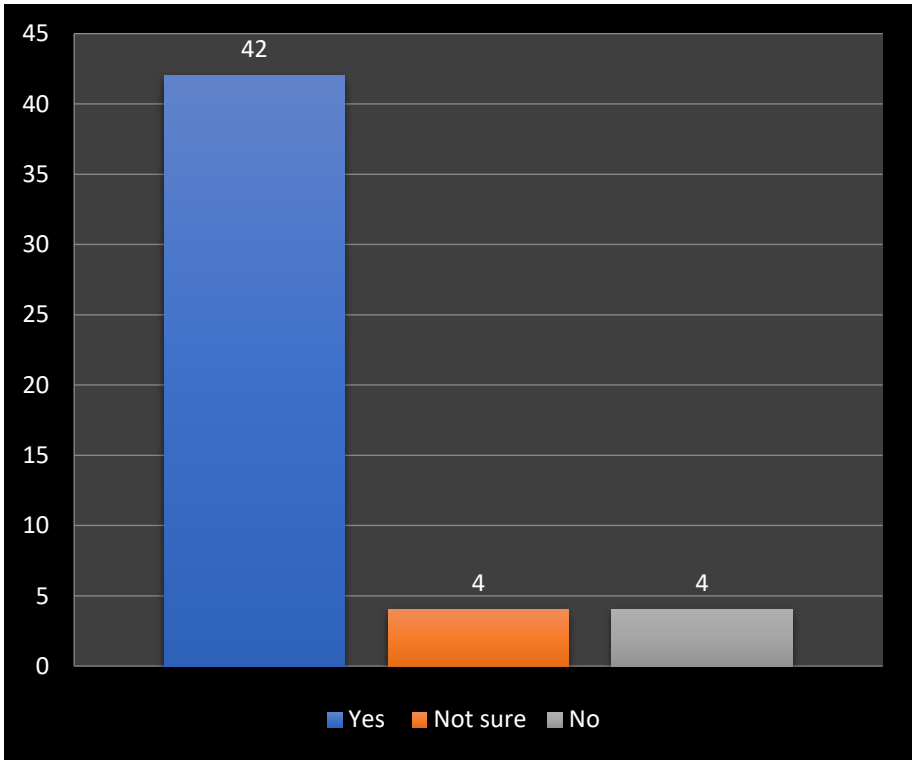

Figure 7-7 Would you like the patient's body language to be interpreted such as lack of eye contact with the opposite gender or sensitivity about shaking hands with the opposite gender?

Figures 7.6 and 7.7 show quite similar results. For instance, the highest percentage in Figure 7.6 was 82%, which is very close to 84% as the highest percentage in figure 7.7. In both figures, most of the HCPs agreed that the interpreter should be interpreting the patient's body language.

One sexual health specialist nurse explained, "other cultures may use body language in different ways that could be interpreted differently". A doctor added, "if the HCP misses non-verbal clues, then anything helps both the HCP, and the patient is positive". A nurse thought

that body language could have a positive and negative impact at the same time on the patient: "this would be helpful or maybe interpreted inaccurately".

Only 8% (4) HCPs were unsure, and 8% (4) HCPs said, "no." One nurse pointed out that interpreting the body language can be misinterpreted. Lack of eye contact could not only result from cultural issues such as low self-esteem. Low self-esteem could be the cause of not making eye contact, "because there could be other reasons for the lack of eye contact such as low mood". Another HCP believed that HCPs have sufficient knowledge and capacity to explain the patient's body language: "we use words as well as interpreters in person. Therefore, I can visualise the patient's body language". Another HCP agreed with this, "I am aware of these issues."

7.2.1.8 Q 7.8: Would you like to be informed of the most appropriate cultural ways for disclosing bad news to Muslim patients?

The results for this question are as follows:

a) 88% (44) of the participants answered yes.
b) 10% (5) were unsure.
c) 2% (1) said no.

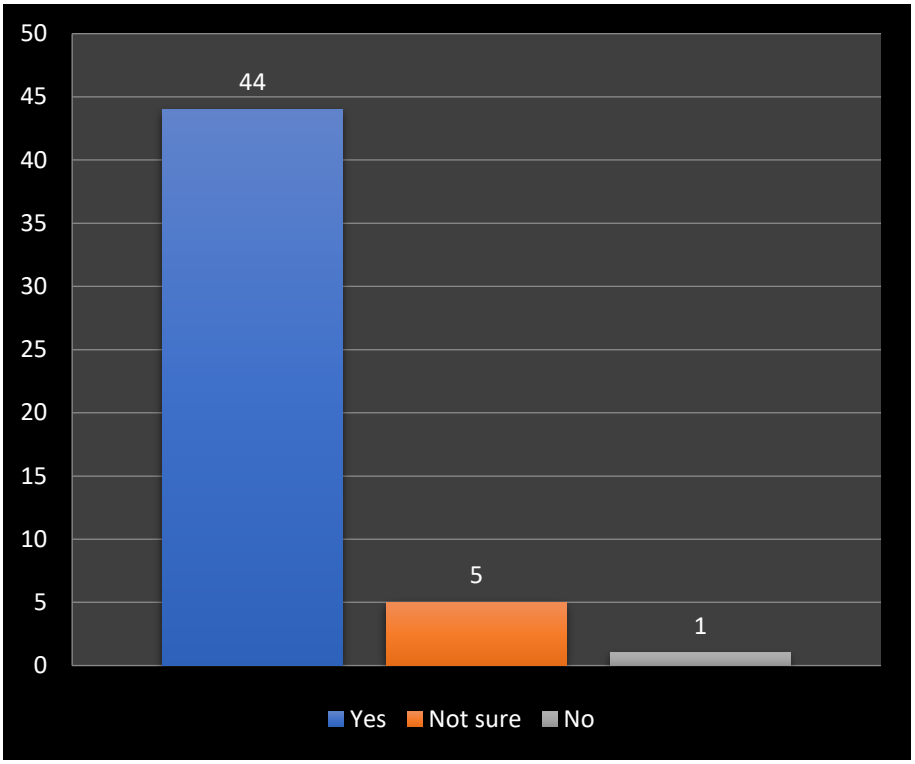

Figure 7-8 Would you like to be informed of the most appropriate cultural ways of disclosing bad news to Muslim patients?

The results in Figure 7.8 show that most participants 88% (44) thought that they would like some guidance about the most appropriate cultural ways to disclose bad news to Muslim patients. One of the respondents noted, "I appreciate being aware of the patient's cultural beliefs in receiving bad news, but I am worried about stereotyping as not all Muslim patients have the same beliefs". A sexual health specialist explained: "I feel this is important, although everyone reacts differently to bad news cultural gap could be different". One doctor commented on this: "if this helps then of course yes". One HCP pointed out: "I am not always aware of rules of different cultures". 10% (5) of the participants ticked unsure. "I wonder if the interpreter's general beliefs about disclosing bad news overpower the patient's beliefs",

as one HCP put it. Another HCP stated, "usually I am aware of Ramadan, many patients inform us". The chart indicates that only 2% (1) of the HCPs believed there should be no involvement of the interpreter in disclosing bad news.

7.2.1.9 Q. 7.9: Would you like to be reminded by the interpreter of cultural events such as Ramadan?

The results for this question are as follows:

a) 92% (46) answered yes.

b) 0% (0) were unsure.

c) 8% (4) replied no.

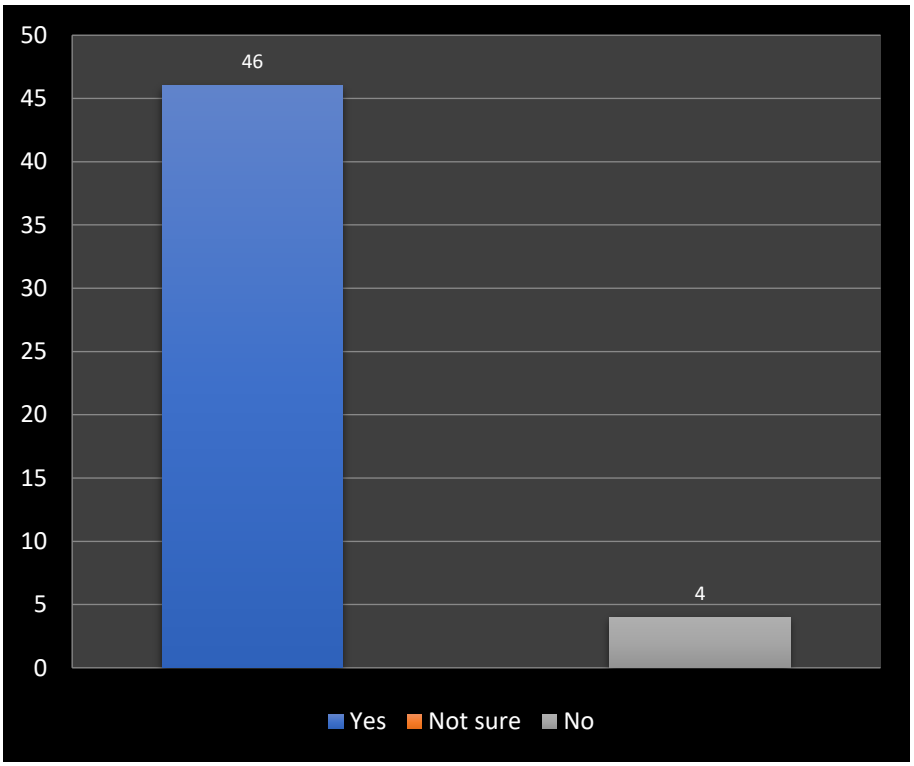

Figure 7-9 Would you like to be reminded by the interpreter of cultural events such as Ramadan?

Results show that 92% (46) of the HCPs requested to be reminded of religious activities of Muslim patients that may require adapting medication times or routes of administration. A doctor declared, "Ramadan, I know these cultural issues, e.g., Christian events and Jewish events would help the HCP to be aware of". A nurse reported, "it is not something I would think of otherwise", and HCP commented, "I am fully aware of Ramadan and how this could impact some patients". Another participant added, “Ramadan occurs at different times during the year. Therefore, it will be useful if the interpreter brings this to my attention". The graph shows that out of the 50 respondents only 8% (4) said "no". A nurse said, "I always tend to discuss these issues with the patient openly". Similarly, another HCP stated, "I am familiar with Ramadan". None of the respondents ticked "not sure". It is crucial to highlight here that not all Muslim patients observe fasting during Ramadan. Therefore, asking the patients if they are fasting is significant before making any assumptions.

7.2.1.10 Q.7.10: Are you aware that adapting medication intake for fasting patients can improve the patient’s adherence to the treatment?

The results for this question are as follows:

a) 88% (44) of the respondents said ‘yes’.
b) 4% (2) were unsure.
c) 8% (4) replied ‘no’.

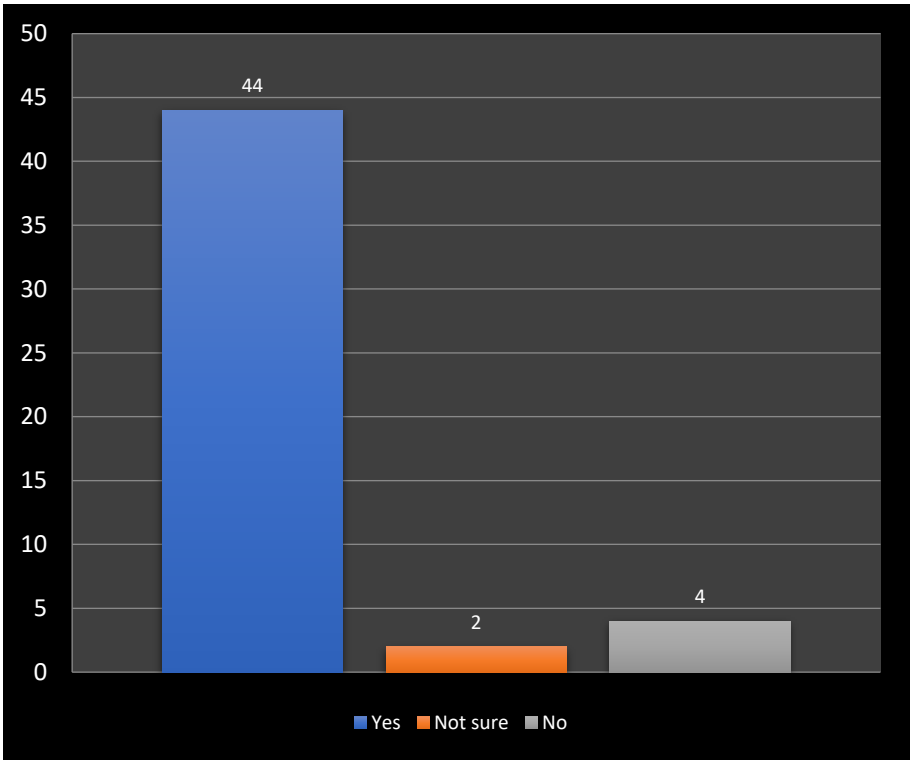

Figure 7-10 Are you aware that adapting medication intake for fasting patients can improve the patient's adherence to the treatment?

Figure 7.10 indicates that 88% (44) of the HCPs have the cultural knowledge of fasting and how adapting medication intake could improve the patient's adherence to the treatment. This shows that most of the HCPs agree on the influence of fasting on the patient's treatment. Therefore, this indicates the importance of adjusting medication during Ramadan to enhance the patient's commitment to the treatment plan. One HCP noted, "I have some Muslim patients with diabetes, they book appointments two weeks before Ramadan to address these issues and check their capability to fast".

The above figure shows that 8% (4) HCPs are unaware of these issues and only 4% (2) are unsure. One health advisor stated, "I would hope that a patient can disclose any additional needs during the consultation that they would feel comfortable to do".

7.2.1.11 Q. 7.11: Do you know that some Muslim patients who fast during Ramadan either stop taking their medication or change the times at which they take their medication?

The results for this question are as follows:

a) 6% (3) of the HCPs answered yes.

b) 12% (6) were unsure.

c) 82% (41) said no.

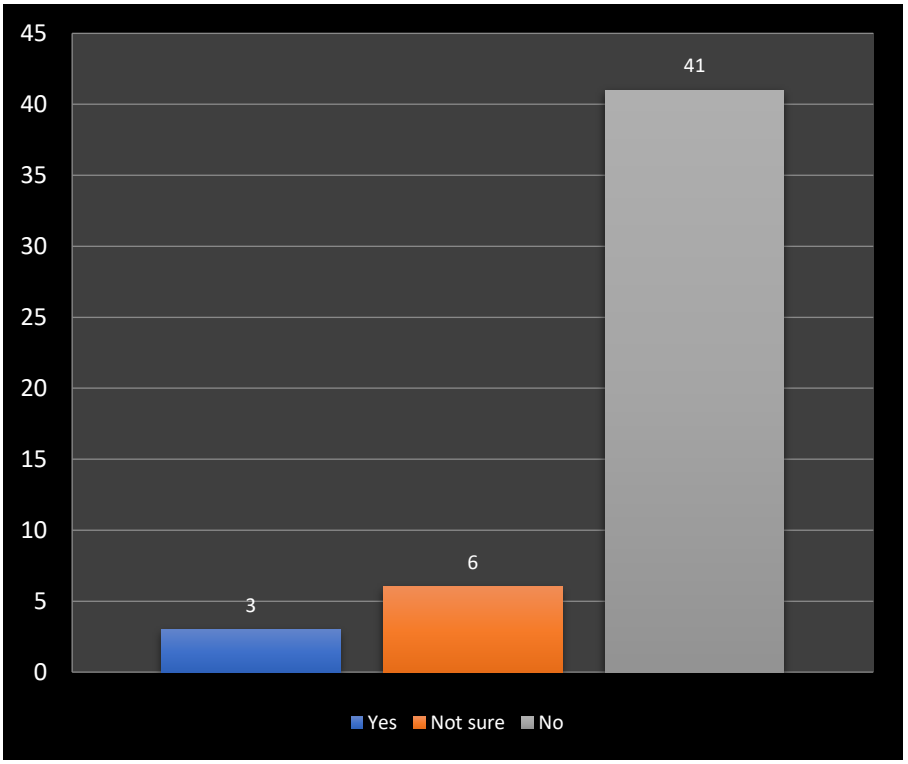

Figure 7-11 Do you know that some Muslim patients who fast during Ramadan either stop taking their medication or change the time at which they take their medication?

The results for Figure 7.11 show that only 6% (3) of the participants are aware that some Muslim patients either stop taking their medications or change their intake times without consulting their doctors. One sexual health nurse stated, "yes, however, possibly they may make expectations for certain medications that are important like insulin". Another participant said, "yes, I try to have these discussions with my patients before Ramadan".

The figure also shows that 82% of the participants are unaware that some patients either change their medication intake or stop altogether. This is worrying, although most of the HCPs are aware of Ramadan, and how fasting could impact patients, cultural sensitivity to the patient's beliefs is required. One HCP mentioned, "no, it is not something I have thought of".12% (6) were unsure.

7.2.1.12 Q.7.12: Are you aware that some ethnic minority patients may take traditional medicines (herbal and other), which may interact with the medication prescribed by the HCP?

The results for this question are as follows:

a) 28% (14) of the respondents said yes.
b) 8% (4) were unsure.
c) 64% (32) answered no.

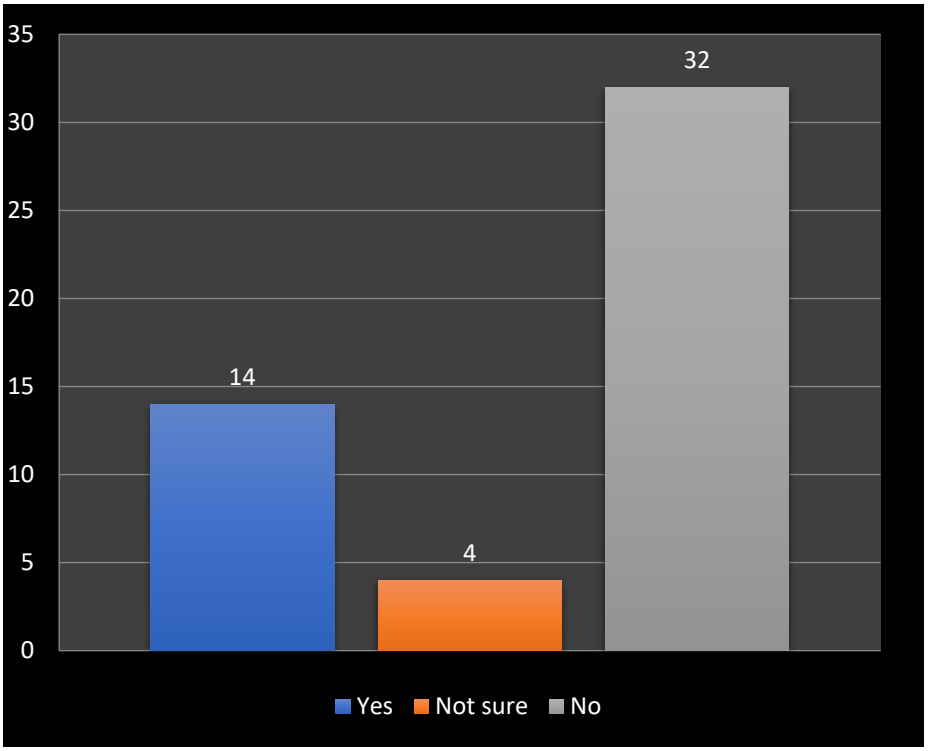

Figure 7-12 Are you aware that some ethnic minority patients may take traditional medications (herbal and other), which may interact with the medication prescribed by the HCP?

The high percentage of those who said "no" raises a concern. One HCP answered, "I only ask the patients whether they are on prescribed medications or vitamins". A sexual health nurse commented, "I am aware of this, many people could use herbal remedies regardless of their ethnic minority". Similarly, a health visitor noted: "this could apply to all patients. If a patient does not disclose this, then we are not aware of this".

7.2.2 Patients' Questionnaire

The questions below, Q.7.13-Q.7.22 was given to patients. The patient's questionnaires were distributed to one hundred Muslim patients, but only fifty completed them.

7.2.2.1 Q.7.13 What level of education do you have?

The results for this question are as follows:

a) 60% (30) completed their primary school.

b) 10% (5) completed their secondary school.

c) 30% (15) completed their university degree.

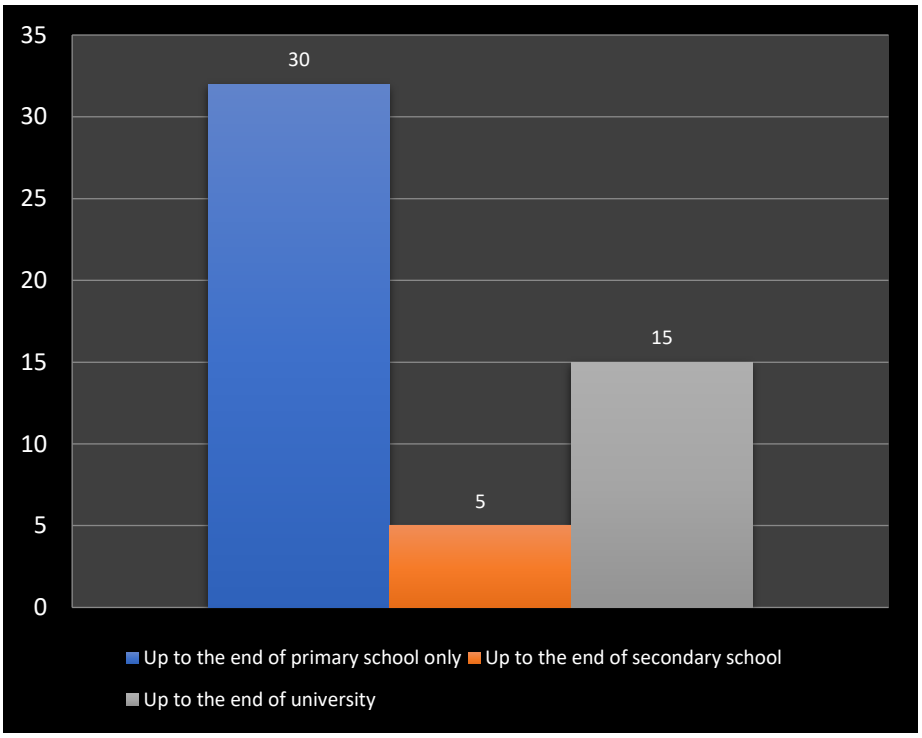

Figure 7-13 What level of education do you have?

Figure 7.13 shows that the highest number of the participants represented in the blue bar, 60% (30), had completed only their primary schooling. This shows that most of the respondents were not born in the UK, as in the UK education is compulsory up to the end of secondary school. The graph also shows that 10% (5) of the Muslim patients completed their secondary schooling and 30% (15) got their university degrees. From the participants' responses, we can grasp where most of the participants grew up and in which culture. For instance, people born in Arabic countries have different cultural and religious backgrounds than those born in the UK. Hence, this could impact on their familiarity with the HC system in the UK.

7.2.2.2 Q.7.14: Which of the following would you class yourself as?

It is important to note here that there are differences in religious adherence within the Muslim community (Röder, A. 2014, p. 2632.). Schneider et al. (2012) say that there is a division between Muslims who practise Islam and those who do not (ibid, pp.206-232). In my categorisation *Strictly religious* refers to strictly adherent Muslims who perform the five pillars of Islam: belief in one God (*shahada*), prayer (*salat*), pilgrimage (*hajj*), fasting (*sawm*), and donating money to the poor (*zakat*) (Eliasi and Dwyer, 2002, pp. 911-913; Regenstein et al., 2003, p. 111). Such Muslims also strictly refrain from consuming products that contain religiously prohibited ingredients and do not accept exemptions where “necessity allows the need” (ibid). *Fairly strictly religious* refers to Muslims who perform the five pillars of Islam (Ibrahim, 2014), but do not so strictly refrain from consuming products that contain religiously prohibited ingredients. Kamali defines this as “the desirable middle between two extremes, one of excess and the other of deficiency” (Kamali, no date, p. 37). This category of Muslims uses exemptions when required. For instance, Muslim patients on medication may break fast

during Ramadan. *Not strictly religious* refers to Muslims who do not adhere consistently to any of the religious pillars (Schneider et al. 2012, pp. 206-232).

The results for this question are as follows.

a) 20% (10) are very strictly religious.
b) 40% (20) are fairly strictly religious.
c) 30% (15) are not very strictly religious.
d) 10% (5) prefer not to say.

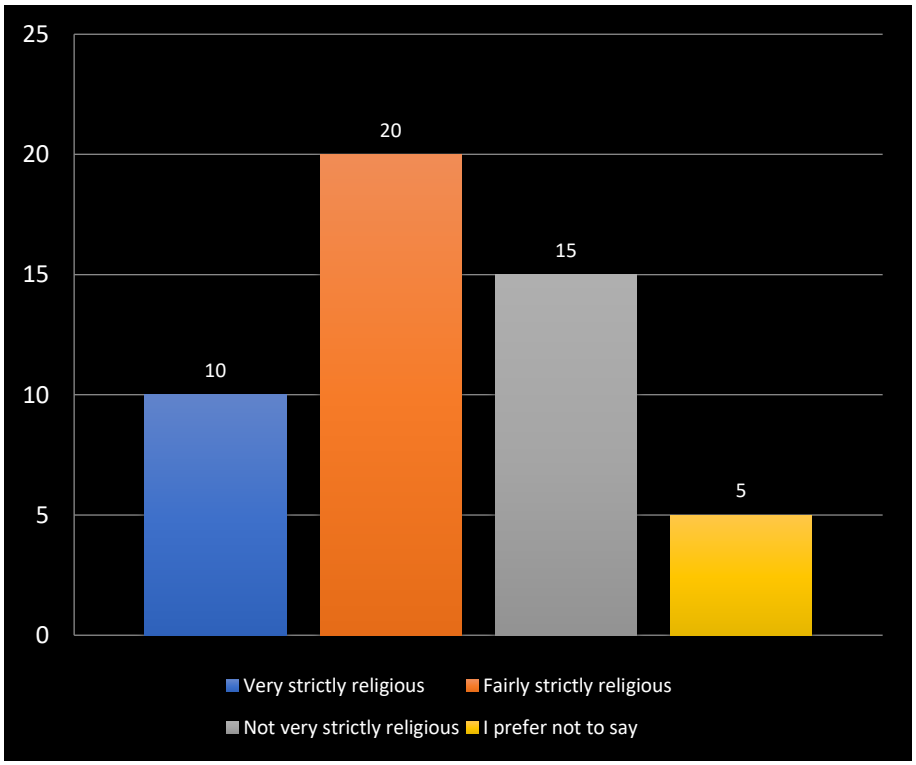

Figure 7-14 Which of the following would you class yourself as?

From the above results, we conclude that most of the participants state that they are still practising their religion in the UK. However, the degree of their religious adherence varies. Thus, all the three options, A, B, and C, imply that Muslim patients share the same

fundamental belief in Islam; ‘shahada’ reciting the Islamic profession of faith by saying ‘there is no God but Allah and Muhammed is the messenger’. However, they may not all practise the other foundations of Islam, i.e., praying ‘salat’, fasting ‘sawm’, giving charity to the poor ‘zakat’, and pilgrimage to Mecca ‘haj’ (all capable Muslims should do once in their lifetime). Thus, religious adherence to dietary restrictions could vary between groups A and B and group C. One of the participants from group B commented, "I do not class myself as strictly religious. I believe in one God, and I pray five times a day and observe fasting. I only eat *halal* food".

7.2.2.3 Q.7.15. Have you ever declined or stopped treatment because you are worried about medication ingredients, which may be culturally prohibited?

The results for this question are as follows:

a) 6% (3) of the participants said, “yes frequently”.
b) 16% (8) of the patients answered, “yes, occasionally but more than once”.
c) 14% (7) of the patients said, “yes, but only once”.
d) 18% (9) of the respondents were “unsure”.
e) 46% (23) of the participants said “no”.

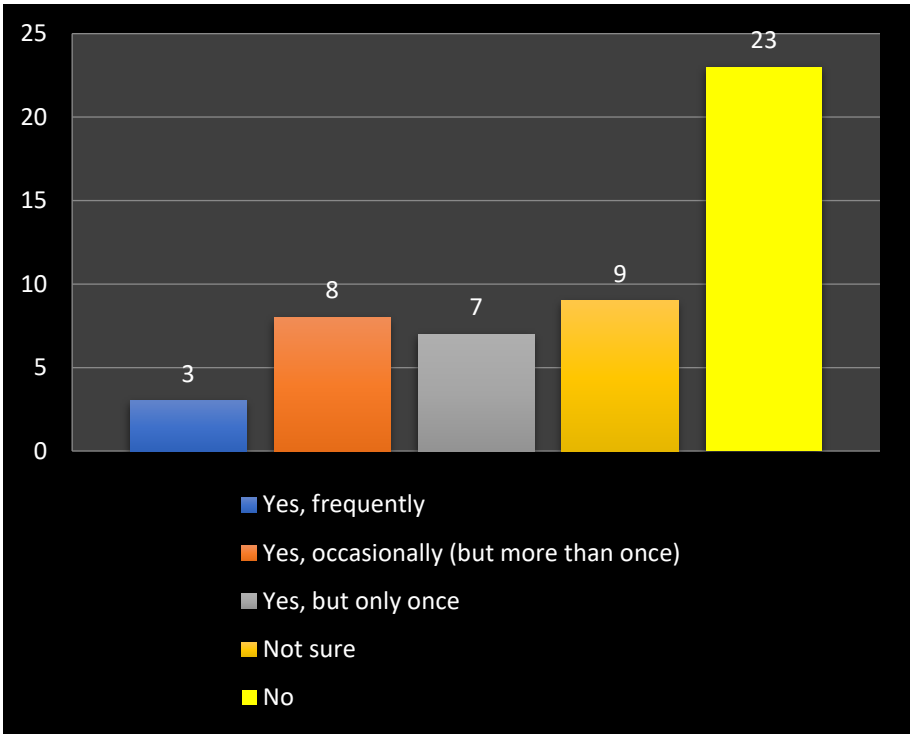

Figure 7-15 Have you ever declined or stopped treatment because you are worried about medication ingredients which may be culturally prohibited?

Figure 7.15 provides interesting and contradictory results in comparison with figure 7.14. This raises questions. Although most Muslim patients in figure 7.14 mentioned they are still practising Islam, yet they accept the porcine-derived vaccine. The comments of some patients may give us a clue about these findings. A recently graduated female participant commented: "I try not to look into things too much. I do not believe that I should go looking for things if they are not already obvious. For example, if my doctor prescribes me medication, I intentionally would be looking at the ingredients just in case it contains something prohibited. However, if I already know that a medicine contains ingredients, then I will be trying to find an alternative medicine". This shows that the participant's English is good enough to communicate with her HCP without an interpreter. It also implies that she is aware of the

porcine-derived medications. Many of the participants who answered "no" and "not sure" were shocked by the fact that some medications could be porcine- and alcohol-derived. A 58-year-old female patient noted, "I never been told that some medications could contain pork or alcohol". Another 62-year-old male patient said, "I never heard about this in my life. However, I would accept medications containing a small amount of alcohol, but I will never take porcine-derived medications whatsoever". One of the participants who answered "yes" commented: "since I found out that some medications may contain *haram* gelatine, I started rejecting medications that contain gelatine. I always request gelatine-free medications". Another participant said, "I reject taking medications that contain gelatine that is not defined as vegetarian". A post-graduate student added, "If I face a situation where my health is compromised, I believe that in Islam I must be as healthy as possible as Islam advocates my sanctity of life".

7.2.2.4 Q.7.16: Have you ever been in a situation where you declined an examination offered by a health care provider of the opposite gender for cultural reasons?

The results for this question are as follows:

A. 52% (26) of the participants ticked "yes frequently".
B. 24% (12) ticked "yes occasionally but more than once".
C. 10% (5) ticked "yes but only once".
D. 6% (3) were unsure.
E. 8% (4) ticked "no".

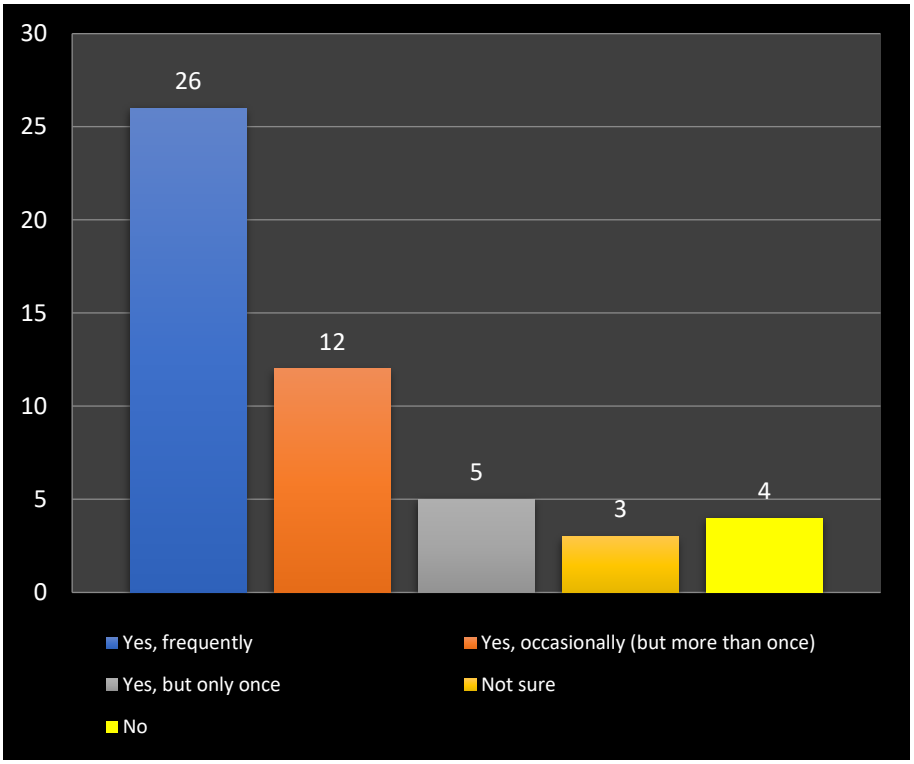

Figure 7-16 Have you ever been in a situation where you declined an examination offered by a HCP of the opposite gender for cultural reasons?

The results show that most of the participants would prefer the same gender HCP. A middle-aged patient noted, "due to religious and cultural reasons I prefer to be examined by a male HCP". A female patient said, "I had to rearrange my appointment with the doctor because he was male". A participant who answered "no" commented, "I asked for a female doctor for my birth examination, if a female doctor were not available, I would have accepted a male doctor". Another male participant said, "a doctor is a doctor whether female or male. I trust all doctors".

7.2.2.5 Q.7.17: Have you ever stopped taking your medication during Ramadan without consulting your doctor?

The results for this question are as follows:

a) 46% (23) of the participants answered “yes”.

b) 18% (9) answered “yes occasionally but more than once”.

c) 16% (8) answered “yes but only once”.

d) 2% (1) were unsure.

e) 18% (9) said “no”.

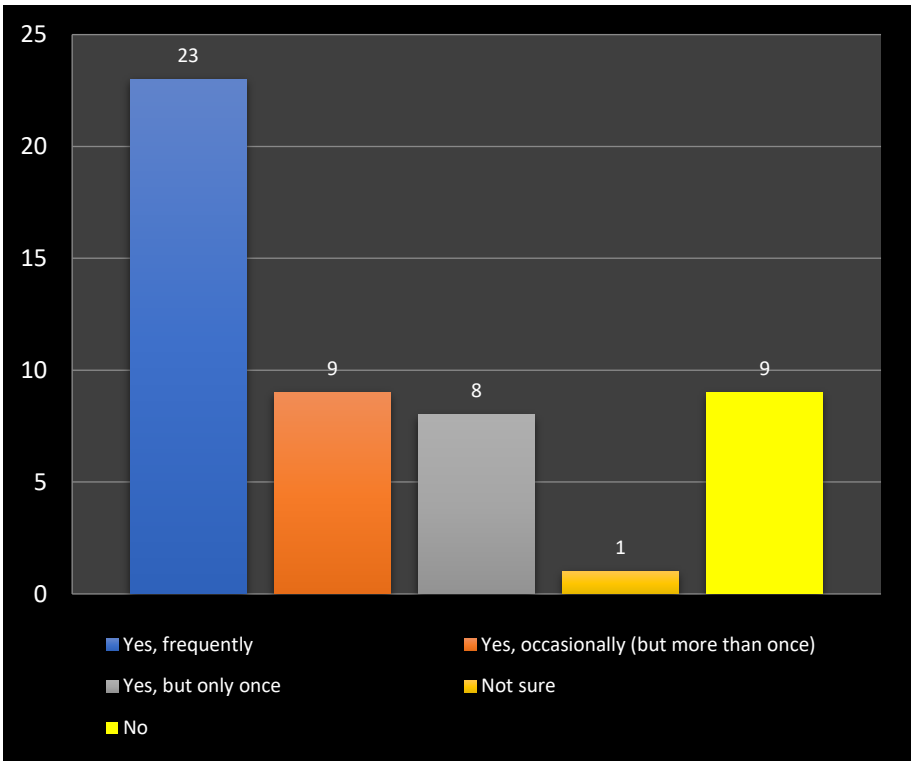

Figure 7-17 have you ever stopped taking your medication during Ramadan without consulting your doctor?

Figure 7.17 clearly shows concerning results as most of the participants stop taking their medications during Ramadan. Discontinuing medication intake without consulting the HCP could be a matter of concern which may lead to adverse outcomes. A 46-year-old male patient declared, "I stopped taking my medications during Ramadan as it is not possible to open my fast, but if it is necessary, I will take it because my religion allows me to do so". Another 49-year-old male patient echoed: "I stop taking medications while I am fasting because insulin makes me feel hungry. Hence, I adapt my medication intake accordingly". Another participant responded: "once I was prescribed to take antibiotics three times a day during Ramadan. I have not mentioned to the doctor that I was fasting I just took three capsules at the same time". One female participant who answered “no”, said, "I believe that fasting and not taking medication will cause my health to get worse. I am willing not to fast and take the medication. For example, UTI infections can be worsened by fasting".

7.2.2.6 Q. 7.18: Have you ever asked an interpreter to raise any cultural concerns with a health-care provider related to *halal* diet restrictions and porcine- or alcohol-derived medications?

The results for this question are as follows:

a) 8% (4) of the respondents said: “yes frequently”.
b) 16% (8) responded: “yes occasionally but only once”.
c) 18% (9) replied: “yes, but only once”.
d) 4% (2) were unsure.
e) 54% (27) answered “no”.

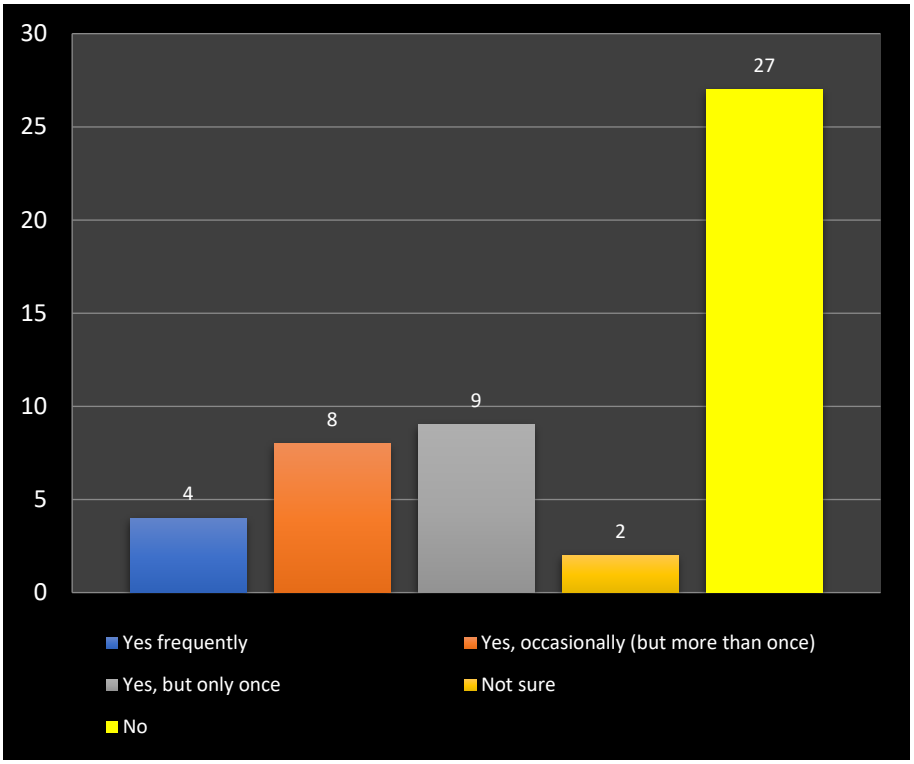

Figure 7-18 Have you ever asked an interpreter to raise any cultural concerns with a hcp related to *halal* diet restrictions and porcine- or alcohol derived medications?

One of the patients who answered "no" commented: "this could be useful, but it never came to my mind". Another patient reported: "there are many things to discuss, and the doctor asks too many questions. I completely forget to ask". Figure 7.18 shows that more than the half of the respondents (27 out of 50) answered "no".

7.2.2.7 Q.7.19: Have you ever accepted a flu jab vaccine which is porcine-derived?

The results for this question are as follows:

a) 64% (32) of the participants answered “yes”.

b) 16% (8) replied “yes occasionally but more than once”.

c) 6% (3) responded: “yes but only once”.

d) 0% (0) were unsure.

e) 4% (2) said “no”.

f) 10% (5) chose “not relevant, because I have never been in this situation”.

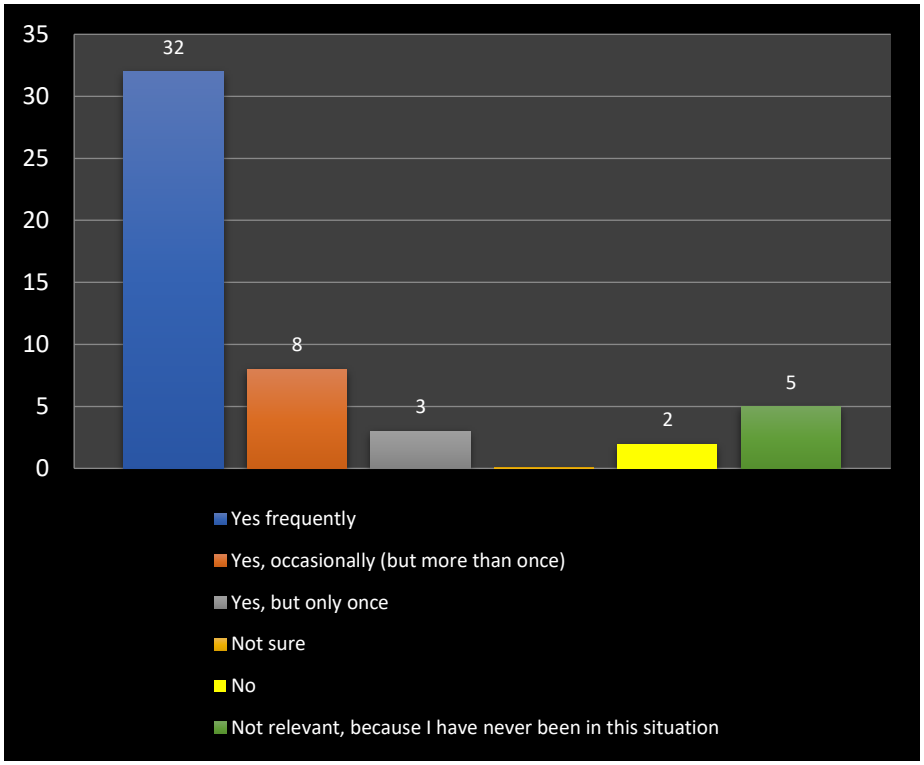

Figure 7-19 have you ever accepted a flu jab vaccine which is porcine-derived?

Figure 7.19 shows that 43 out of 50 participants have accepted a flu jab vaccine at least once in their lifetime, while 9 participants have not accepted one for various reasons. It is worth noting here, that respondents were unaware that some vaccines might be porcine-derived. One respondent stated, "yes, I did accept a flu jab, but I was never told that it contains

pork. If I had known I would have declined it". Similarly, a female patient noted: "one time I was given a flu jab, but I did not know at that time that it contains pork; and if I had known this, I would have declined it". One patient said: "once I consented to give my child a flu jab. I did not know at that time that it contains pork. if I knew back, then I would have not allowed it." Based on the patient's comments above we notice that most patients in categories A, B and C were not informed of the vaccine's main ingredient.

7.2.2.8 Q.7.20: Have you ever allowed your child to be given a flu jab vaccine which is porcine-derived?

Results of figure 5.20 show:

a) 32% (16) of the participants said, “yes frequently”.
b) 18% (9) of the respondents answered, “yes occasionally but more than once”.
c) 0% (0) of the patients responded, “yes but only once”.
d) 8% (4) of the participants were unsure.
e) 14% (7) said “no”.
f) 28% (14) answered “not relevant, because I have never been in this situation”.

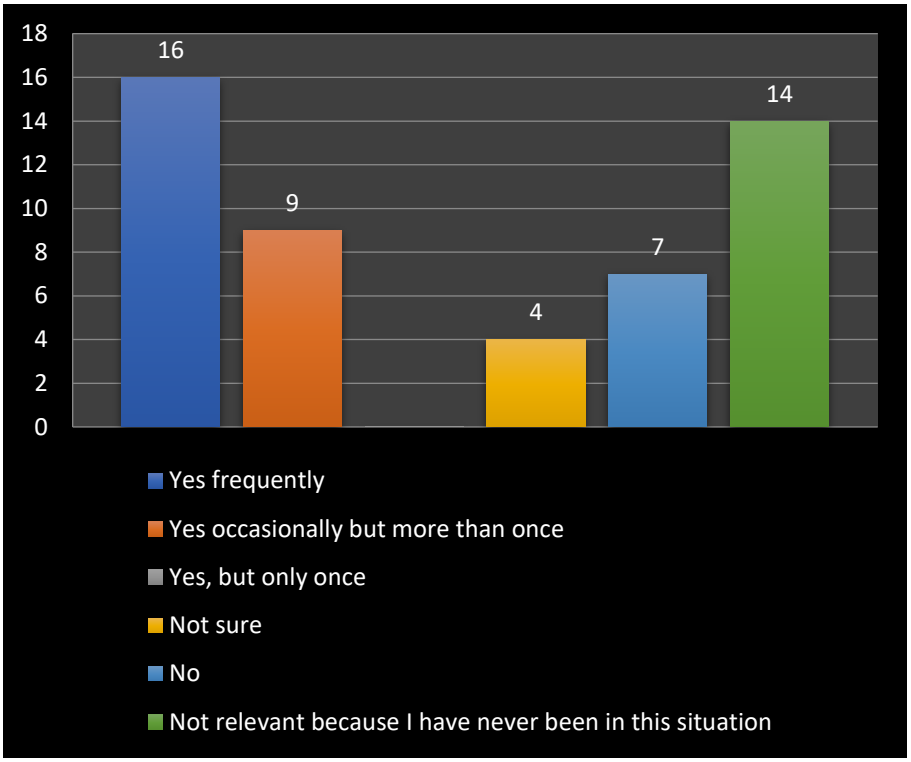

Figure 7-20 have you ever allowed your child to be given a flu jab vaccine which porcine derived?

The chart clearly shows that 16 of the participants consented to their children being given a flu jab. One participant stated, "I did not know it contained pork until now". 7 of the respondents declined the vaccine, and 14 answered, "not relevant". One of the parents answered, "no, I do not allow my children to be given the porcine-derived vaccine as I do not think it is necessary". It seems that participants who answered "yes" to the above question were not informed about the vaccine's ingredients.

7.2.2.9 Q.7.21: Would you accept a treatment containing a culturally prohibited ingredient such as pork or alcohol if it were the only available treatment?

The results for this question are as follows:

a) 34% (17) would accept the treatment.

b) 18% (9) were unsure.

c) 48% (24) would not accept the treatment.

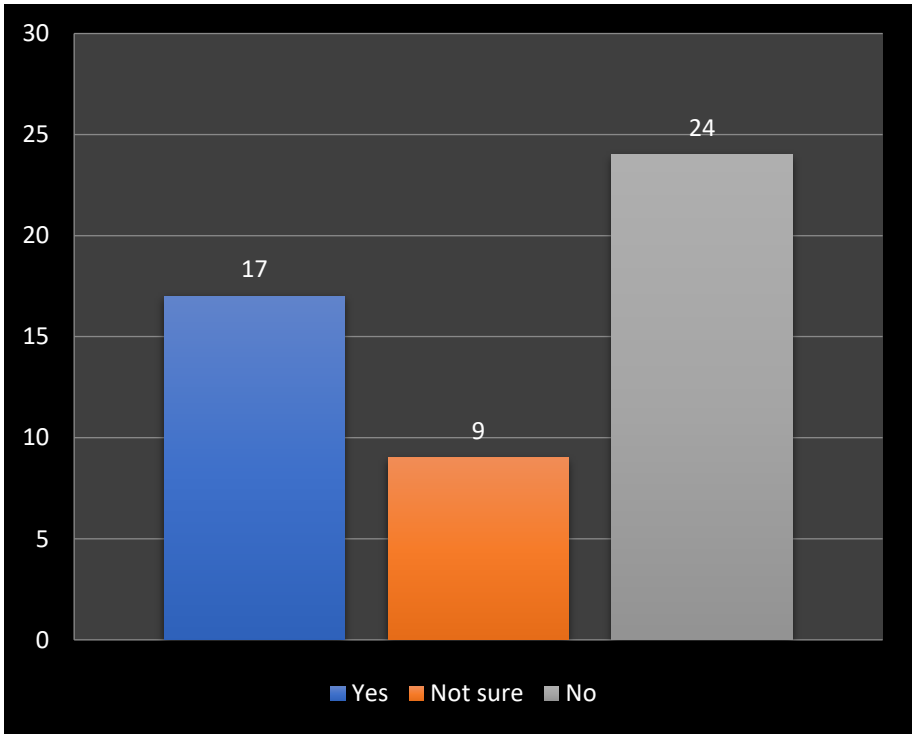

Figure 7-21would you accept a treatment containing a culturally prohibited ingredients such as pork or alcohol if it were the only available treatment?

Patients were asked whether porcine and alcohol derived medications could be an issue in accepting treatment in cases of life and death. The results show that 48% (24) of the patients said "no". Some patients showed more concerns about pork than alcohol. One participant said, "I am worried about porcine ingredients, but I am not worried about alcohol". Similarly, another patient stated, "I have a problem with pork, but alcohol is less of a problem".

The above figure indicates that 18% (9) of the patients were unsure. This might be because they may need to be given some extra time to think or to ask for the second opinion of a religious scholar or a partner. However, 34% (17) answered, "yes". Most of the patients accepted the treatment options in cases of life or death: "if my health situation was serious and there was no alternative then, yes, I would accept as necessity permits forbidden things"; "I would only take it if it were going to save my life"; "yes, it all depends on how critical the situation is. I would evaluate the consequences"; and "yes, it is allowed in Islam if it is a matter of life and death".

7.2.2.10 Q.7.22: Do you believe in traditional or prophetic remedies?

The results for this question are as follows:

a) 68% (34) of the participants believe in traditional therapies.
b) 4% (2) were unsure.
c) 28% (14) answered no.

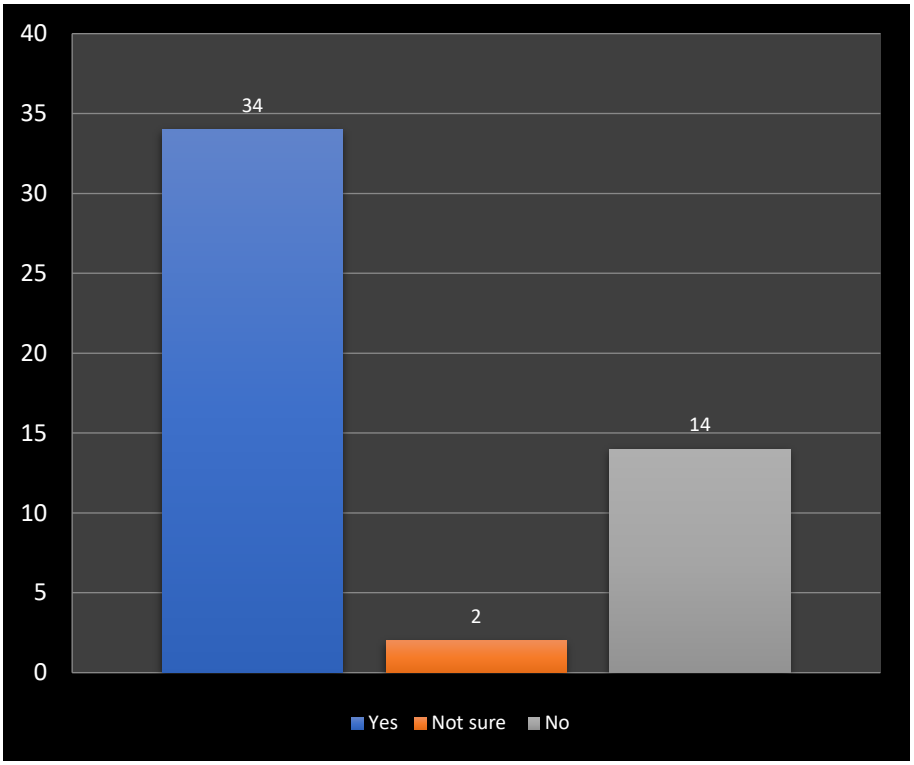

Figure 7-22 Do you believe in traditional or prophetic remedies?

As seen in Figure 7.22, 68% (34) of the patients reported that they believe in traditional or prophetic treatments. 28% (14) answered "no", and 4% (2) were unsure.

Patients who answered "yes" to the question listed some of the herbal remedies and what they are used for as follows. One of the participants answered, "I use baking soda for kidney problems, as I have used all sorts of prescribed medications and nothing works for me"; "I use *hijama* (cupping treatment) for my anxiety attacks and have had better benefits than taking prescribed medications, which have side-effects"; "I use *Zamzam* water"; "I believe in black seeds and honey for everything"; "I do believe in prophetic remedies, but would only accept them for someone who is really expert in this field. I do not trust those who claim to use prophetic remedies but are not experienced or educated in this field"; "I use grapefruit for

diabetes; it is better than metformin"; and "I give my baby blossom water when I do not have breast milk. I also boil cumin and anise seeds and mix it with honey and use it as a therapy for colic pain or to get rid of wind".

7.2.2.11 Q.7.23: Would you consult your doctor if you were taking herbal therapies?

The results for this question are as follows:

a) 20% (10) answered they would consult their physicians.

b) 14% (7) were unsure.

c) 64% (32) replied 'no'.

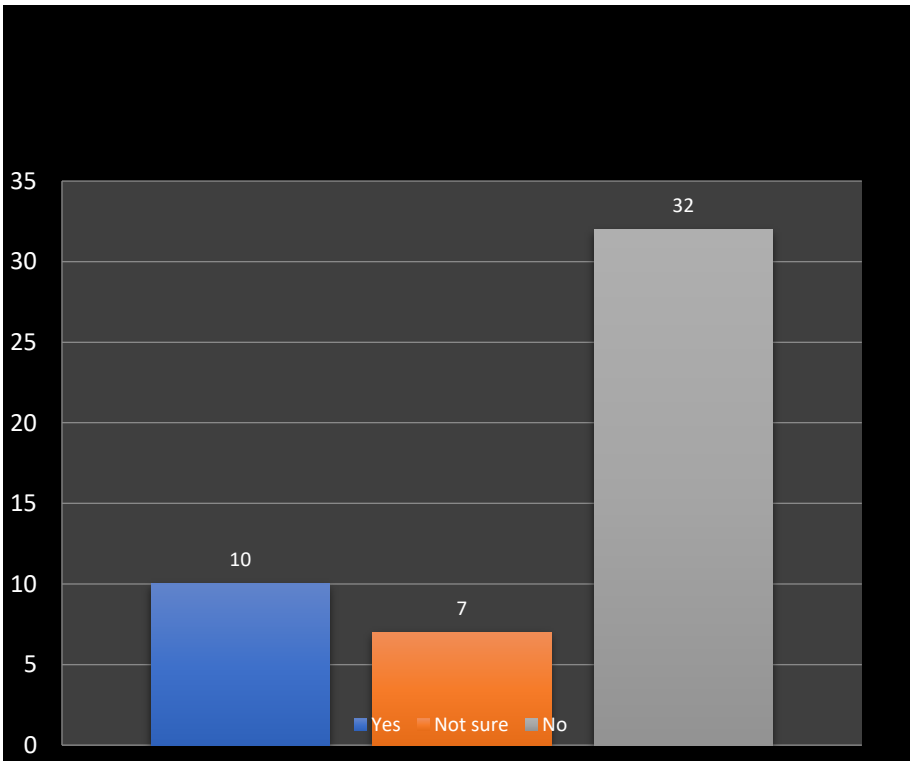

Figure 7-23 Would you consult your doctor if you were taking herbal therapies?

The results in figure 7.23 show some concerns, as most of the participants stated that they do not share information about any herbal therapy intake with their HCPs. One female patient said, "I do not tell my doctor, I do not think that herbal remedies have any side-effects". Another participant pointed out, "every time I take my child to the doctor, they never prescribe antibiotics. I beg for them, and they never do. Then, I end up giving my child some herbal remedies". One graduate participant who replied "unsure" in relation to question 23, mentioned, "maybe if I have doubts about the safety of the herbal remedies. Then, I will consult my doctor".

7.2.2.12 Q.7.24: Would you prefer to seek consultation from a herbal healer than a doctor?

The results for this question are as follows:

a) 26% (13) answered ‘yes’.
b) 28% (14) were unsure.
c) 46% (23) responded ‘no’.

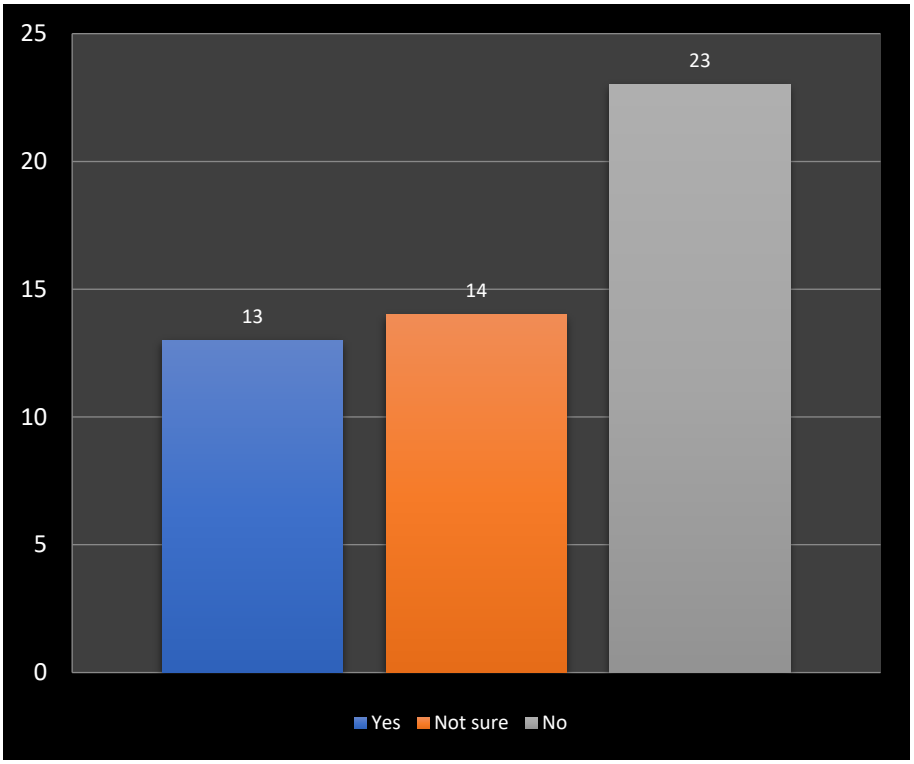

Figure 7-24 Would you prefer to seek consultation from an herbal healer than a doctor?

The results show that despite the high percentage of believers in herbal therapies, as shown in figure 7.22, patients still tend to seek treatment from the HCP. Results indicate that 46% (23) of the participants said, "no", 28% (14) were unsure, and 26% (13) answered, "yes". Although figure 7.22 showed that most participants (68%) believe in herbal therapies, the data show unexpected results in figure 7.24. One patient who answered, "yes" noted, "since therapeutic remedies have no side-effects, what I would normally do is to take my prescribed medication along with my alternative remedy". Another added, "it depends on the situation. When I was in Syria, I used to turn to a herbalist because I could not afford to see a doctor. When I came to the UK, I found that doctors do not prescribe medications for everything. All they advise is to take paracetamol. Therefore, I use herbal therapies". A fifty-year-old patient

who responded "unsure" commented, "if the matter is serious, I would rather see a doctor as herbal therapies take longer to work than medication". Thus, responses imply that even patients who answered "no" still use alternative remedies.

7.2.2.13 Q.7.25: Do you believe that when someone gets ill, this is Allah's will?

The results for this question are as follows:

a) 82% (41) answered yes.

b) 4% (2) were unsure.

c) 14% (7) said no.

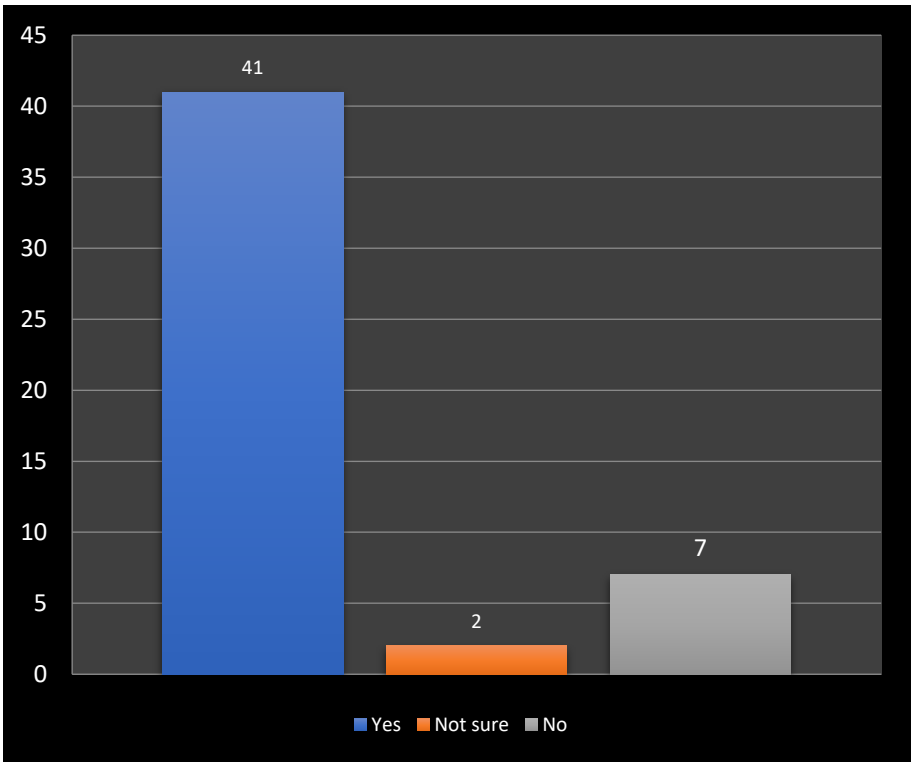

Figure 7-25 Do you believe that when someone gets ill, is Allah's will?

In figure 7.25 one patient who responded "yes", commented, "but we should seek medical attention and look for proper treatment". Another stated, "there is always a specific reason why we get ill, and there is always Allah's will too". A third participant added, "I believe that there are always causes for illnesses, but ultimately everything is under Allah's will". Similarly, another reported, “we do believe there is a cause for every illness" and "Allah plans everything in our life". This question was asked to see how Muslim patients’ beliefs towards an illness could impact their attitudes towards the treatment. Although, most patients answered "yes", the comments reflect the view that their beliefs do not clash with seeking treatment.

7.2.2.14 7.26: Have you ever substituted herbal remedy for another conventional therapy?

The results for this question are as follows:

a) 56% (28) answered “yes frequently”.
b) 12% (6) replied “yes frequently but more than once”.
c) 6% (3) said “yes but only once”.
d) 2% (1) was unsure.
e) 24% (12) replied “no”.

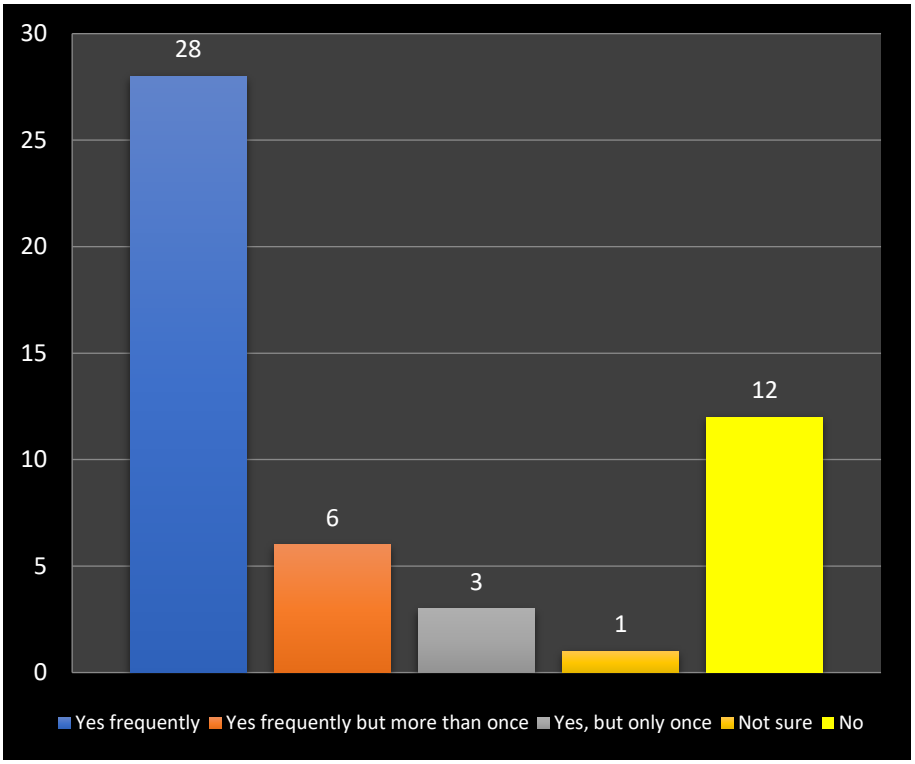

Figure 7-26 Have you ever substituted herbal remedy for another conventional therapy?

Figure 7.26 shows concerning results as most of the participants have substituted a prescribed therapy with herbal remedy. One patient commented, "I have used *hijama* for my anxiety attacks as I did not get any benefits from the medication, plus it has so many side-effects". A female patient added, "I stopped using my topical cream and started using turmeric for my acne treatment". A 48-year-old pointed out, "I suffered from knee pain and all the doctor gave me strong doses of painkillers and referred me to a physiotherapist. Unfortunately, none of them worked for me. Then, I decided to stop visiting the doctor and stopped my pills and started taking cress seeds for my knee pain, and it made a huge difference". A diabetic patient stated, "taking olive oil on an empty stomach was the best

treatment for my diabetes". Another added, "there is no harm in combining prescribed medicine with conventional therapy. For instance, I use honey with antibiotics".

7.2.2.15 Q.7.27: If you have ever substituted herbal remedy for another conventional therapy have you informed your doctor?

The results for this question are as follows:

a) 18% (9) answered 'Yes'.

b) 4% (2) responded 'No'.

c) 78% (39) were unsure.

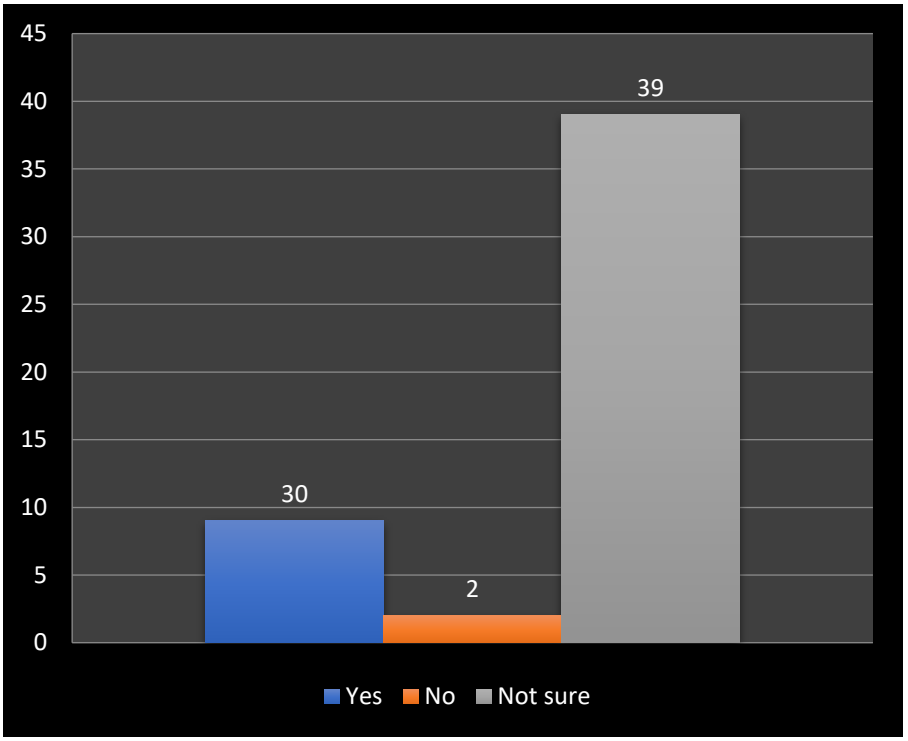

Figure 7-27 If you have ever substituted herbal remedy for another conventional therapy have you informed your doctor?

As figure 7.27 shows, most participants were not sure if they informed their doctor if they substituted herbal remedy for another conventional therapy. One interesting comment from one of the respondents was, "no, I do not tell my doctor. He is not Muslim, and he may make fun of my prophetic remedies". Another one mentioned, "since there is no harm in doing this, there is no need to inform the doctor". Such comments imply lack of education on the patient's part and lack of trust in the HCPs. One of the participants who answered "unsure" stated, "I have not used herbal therapies before, but I will check with my doctor if I decide to".

7.2.3 Responses to interviews with HCPs

This section presents the responses of seven interviews with seven HCPs: four doctors, one dentist and two senior nurses.

Question Q. 7.28: "*Have you ever used the interpretation service*?" was asked to check if the interviewee had experience with patients from ethnic minorities. **Questions7.29**: "*Have you dealt with a Muslim patient and what was your experience?*", **Question** 7.30: "*Have you come across an experience where a patient has declined the treatment due to any religious restrictions*?" **Question. 7.31**: "*Have you ever come across a situation where the patient has declined the consultation due to the gender of the health care provider?*" **Question 7.33**: "*Are you aware of the month of Ramadan and how fasting could affect the patient's medication intake*?" **Question 7.34**: "*Have you ever had a patient who suddenly stopped his/her medication intake due to religious diet restrictions or fasting during Ramadan?*"

These questions were chosen to test HCPs' cultural knowledge about Muslim patients' religious beliefs and their impact on their HC.

Question. 7.32: "*Would you consider using the advocate model in interpretation such as a sugar coating to disclose bad news to the patient?"* This question is asked to check participants' knowledge of models of interpretation.

Questions: 7.35: "*Would you think explaining some cultural concerns by the interpreter would be useful to the patient's treatment according to his/her religious needs/concerns?*" **Question.7.36:** "*Do you know that some Muslim patients may use some alternative or herbal therapies, which may interact with their medications or cause some medical issues?*" These questions were raised to probe HCUs' awareness of the significance of taking Muslim patients' beliefs in HC.

Question.7.37: "*Have you ever changed the medication/treatments or route of administering medication due to a patient's religious beliefs?*" This question is chosen to check HCPs' cultural understanding in adapting HC to meet Muslim HCUs' expectations.

Thus, I obtained the views, ideas and perceptions of doctors and senior nurses of HCS to see if there is any disparity between the responses to the quantitative questionnaires (HCPs) and in interviews (managerial staff). Interviews were conducted with HCPs (a different group to the participants in the quantitative questionnaires) The common tie that brings all these interview questions together is to obtain the views of HCPs to further strengthen the research questions answers. It is also believed that senior nurses and doctors are aware of policy implementation in a HC organisation such as GP surgeries and hospitals. Broadly, the interviews were conducted to find out whether the policy of facilitating HC for ethnic minority patients is in place or not. This research conducted the interviews in line with the recommendations of Lambert and Loiselle (2007) who emphasize that during interviews, perceptions, experiences, views, and beliefs are tested by asking one-to-one questions of the interviewees. Senior nurses and doctors were the interviewees in this research, and their

beliefs about policy were tested by asking one-to-one questions about their experiences with Muslim patients. One-to-one interview questions allowed the interviewer to obtain in-depth information from the policy practitioners (Frances et al., 2009, p. 309). There were ten questions in the interview question list and each question was framed around focal issues involving culture, tradition, and practice. Where appropriate the researcher also asked supplementary questions during interviews to test the extent to which official policy was in place.

To maintain the confidentiality of the participants and due to ethical reasons, the seven participants who took part in the interviews were labelled as A, B, D and E for the doctors, C for the dentist, and F, G for the nurses. I had a verbal and written agreement with the interviewees that their details would not be disclosed to any related or unrelated authorities.

All the interviewees were interviewed individually as per their availabilities and convenience. All interviews were conducted face to face. I briefly discussed a convenient possible time and asked each interviewee to individually agree that I could ask any additional questions with the participant's permission. The doctors agreed to additional questions, but the nurses declined to be asked extra questions.

7.2.3.1 Q. 7.28: Have you ever used the interpretation service?

I asked the above question to seven interviewees. Their responses were as follows:
Interviewee A agreed in principle for the recruitment of an interpreter. She asked, "do you mean a sign language interpreter or just a language interpreter?" Her reaction was quite positive. She further stated, "without the help of the interpreter, it is impossible to communicate with patients with no English". She added, "the interpreters of the same ethnicity can be the pillars of the NHS".

- Interviewee B commented, “yes, I used the interpretation service several times”.
- Interviewee C added, “since we deal with a lot of ethnic minority patients in the dental clinic, I use the interpretation service on a regular basis here”.
- I approached interviewee D in his surgery. He was highly cooperative and self-motivated. Exceptionally, this interviewee himself gave me the chance to ask further questions about the interpretation service. For instance, he said that he understands the differences between culture, religion, and tradition among the various ethnic communities. Therefore, he stated that he has always supported the idea of requesting the same interpreter to maintain consistency. He thought that interpreters should work permanently on the NHS payroll. Nonetheless, this interviewee fully recognised the importance of the interpretation services in the UK. He further elaborated that interpreters bridge the gap between the patient and the doctor.
- Interviewee E noted, “yes, I used the interpretation service many times, both face to face and over the telephone. However, I would prefer the face-to-face interpreter than telephone interpreting. I believe that the interpreter has to see the patient’s body language gestures, etc. and interpret it to the HCP”.
- Nurse F was very experienced. She had worked for twenty years for the NHS. She was very quick in answering the questions. I reminded her of the importance of this research many times. This made her more cooperative. She maintained that the interpreter’s assistance and help are of great value and importance. She also mentioned during the interview that the ethnic minority community in Newcastle-upon-Tyne are not professionally trained. This creates a massive gap between the HCPs and their patients. At this point, she accepted that there is a big demand for interpreters for the smooth functioning of medical procedures and treatment.

- Interviewee G pointed out that she has used the interpretation services quite a lot.

7.2.3.2 Q. 7.29: Have you dealt with a Muslim patient and what was your experience?

All doctors maintained that their experience in dealing with Muslim patients was extremely varied. Interviewee A stated, “once, I had a female Muslim patient who has a gynaecological problem. Upon examination, I asked her to uncover herself from the waist to the bottom. I felt that she was uncomfortable. The patient explained she was conscious if someone could enter the room or see her through the window, as the curtain was not closed. Then, I reassured the patient that no-one could access the room without permission. However, the patient was still anxious even after explaining that no one can see through the window. I carried on with the examination, but the patient was agitated”. A similar experience was reported in a study conducted by Hassan et al. (2012, p.6). A 24-year-old lady who had been examined 6 times by 4 different providers reported, “I felt pain and discomfort especially if the examiner was a male physician. I think VE is necessary to be done. But there should be more privacy, i.e., closing the door, curtains on the window”.

Interviewees C and E indicated that their Muslim patients often miss their appointments but never call the surgery or the clinic to rearrange or cancel their appointments. Missing appointments can be a culturally related issue. Participant C commented, “this increases the costs of interpreter’s booking and is for sure time-consuming for the doctor but in fact for all the staff members”. On the other hand, interviewees B and D pointed out that their experience in working with the Muslim patients was interesting. I asked participant B to elaborate on his experiences in more detail. The doctor noted, “once I had a Muslim patient diagnosed with a terminal illness. I asked him about his health. He kept saying, “thank you

God". The patient constantly repeated this phrase to the point that made me think that he was feeling well. The interpreter explained saying this does not always mean that he was feeling well. It is a religious phrase shows strong faith and acceptance of his illness".

Both of the interviewees F and G were asked the same questions, and their experiences in dealing with Muslim patients was slightly similar to the doctors. One of the nurses reported that her female patients declined to get her blood pressure tested because the doctor was of the opposite gender. The second nurse had similar views about Muslim patients. Both nurses were also asked individually additional questions about language and communication.

Both criticised the interpretation services. Their reason for criticising interpreters was their lack of training and experience. I asked them about the cause. They emphasised that speaking a second language, and then translating the conversation needs training and specific skills. Though the interpreters are bilinguals, they lack the training. The interpretation services should provide professional training to interpreters working in HC.

7.2.3.3 Q. 7.30: Have you come across an experience where a patient has declined the treatment due to any religious restrictions?

Three of the interviewees working in different surgeries reported their experiences with some Muslim patients who declined treatments due to religious reasons. Interviewee A pointed out her experience with few Muslim patients who declined flu jab vaccine. She commented, "the patient said that his friend informed him that the flu vaccine contains pork gelatine, and this is prohibited in Islam. Therefore, the patient declined the vaccine".

Interviewee B mentioned, "once we had to tell bad news of the result of a down's syndrome test to a Muslim couple. We asked if the wife would consider an abortion. The patient declined the idea completely, saying: "it is not allowed in Islam to have an abortion at

this stage of pregnancy, and I would accept the baby even if the test shows a problem. I accept everything from Allah with strong faith".

Interviewee E reported a similar experience, "once I requested the female nurse to do a blood test for a female Muslim patient. I left the consultation room. Then, I suddenly entered the room without knocking the door. The patient jumped and hid under the table. I was shocked by the patient's reaction, and I did not know what was going on! Then, I asked the interpreter to ask if the patient was OK. It seemed that she was embarrassed because her arm was fully uncovered".

Interviewee C stated, "during a dental procedure, the patient constantly wanted to rinse his mouth. Every few seconds he kept getting up to spit. I was wondering if the patient had a medical issue, or he just felt uncomfortable. The interpreter said it was Ramadan and the patient was concerned if he swallowed any water, as it would break his fast. We had to stop the treatment and book the patient for another appointment after Ramadan ends".

Interviewee F showed serious concern about a Muslim patient who declined his endoscopy procedure after being informed of the numbing throat spray, which may break his fast. Interviewee G said, "yes, I had few experiences with quite a few Muslim patients regarding treatments that clash with their religious beliefs. The most recent one was when a Muslim lady with her one-year-old son came for an MMR jab, and she asked if the vaccine was suitable for her religious beliefs. I advised the patient that I would find out, and I would get back to her. Then, when I realised that the vaccine contains ingredients that are religiously forbidden, I informed the patient. The patient had to decline the vaccine on the grounds of her interpretation of religious requirements".

7.2.3.4 Q. 7.31: Have you ever come across a situation where the patient has declined the consultation due to the gender of the health care provider?

Interviewee D said that his female patient complained of back pain. I asked her through the interpreter to take her coat off to examine her back. She immediately got up and asked the interpreter to rearrange the consultation for the next time when a female doctor would be available. Interviewee E added, “Out of politeness, I introduced myself by extending my hand to shake a Muslim lady patient’s hand. She did decline the handshake. The interpreter saved the situation by explaining how a handshake is not allowed with the opposite gender for some Muslims. It was an awkward situation though”.

Interviewees D and E also reported different situations where their patients complained and did not participate in the process of consultation. I asked interviewee D a question about giving appointments to such patients without asking them their preferred doctors/nurses (female instead of male). The interviewee accepted the lack of communication and further indicated that in future his surgery would take necessary steps in relation to the booking system.

It can also be noted here that though the interpretation services are available, the patients book their appointments on their own, which causes distress and stressful situations for the HCPs. The health carers take the full responsibility for having a proper consultation process for Muslim patients, as noted by interviewees F and G, who are nurses. One of the nurses, G, responded positively to the query raised by me. She said: “yes I did, I had a Muslim female patient who came for a hip and neck pain problem and when the doctor asked her to uncover

her hip and head-wear she declined and requested a female doctor. We did not have any female doctors at that time, so we had to rearrange the appointment".

I asked extra questions about declining treatment individually. Only interviewee B highlighted the importance of understanding the gender role and modesty of the patient. For example, asking the permission of a female Muslim patient to enter the room enhances trust with the male clinician. Lack of engagement with the opposite sex may create some complications in the patient's adherence to their appointments or even accepting the treatment. The interviewee believes that body language must be interpreted. The interpreter must culturally interpret non-verbal communication. Maintaining eye contact with the opposite sex might be misinterpreted by Muslim patients. While giving eye-contact in Western culture could be a sign of politeness and respect, Muslim culture has strict rules regarding eye-contact with the opposite sex which can be a sign of sexual interest.

7.2.3.5 Q. 7.32: Would you consider using the advocate model in interpretation such as a sugar coating to disclose bad news to the patient? (Please note this will not affect the context of the message.

To inform the patient about the outcome of their test is a simple way to keep the patient informed in case the results of the consultation and tests suggest that the patient is suffering from some medical problems such as cancer, diabetes, or any other serious medical issues. It is simple to inform the patient or his/her next of kin. However, the advocate model can help health carers as well as patients to understand their health issues. Thus, the interviewees were asked the above question.

Interviewee A maintained that "in case the results of tests indicate a serious disease, I arrange for the interpretation services and interpreter to inform the patients respectively. The

linguistic model is quite useful for Muslim patients to be adapted and practised by the health carer. There are some weaknesses faced by the interpreter because of the language barriers. The Arab speakers deal and share the bad news in a different way than the non-Arab Muslims". Generally, the interviewee acknowledged that the interpretation services play a significant role in disseminating the messages given by the HCP to the Muslim patient.

Similarly, interviewee E reported his experience of culture and the advocate model, "I believe that every culture has its norms, which make it unique. Through my experience, I learned that the patient's culture must be taken into consideration. The cultural needs should be addressed during the consultation process. The HCPs must be effective in cross-cultural skills and be open-minded to their patient's culture. Adapting the advocate model in interpretation is helpful in explaining some situations".

7.2.3.6 Q. 7.33: Are you aware of the month of Ramadan and how fasting could affect the patient's medication intake?

Interviewees A, D, and E were aware of the fasting month of Ramadan positively. They explained during the interviews that before the start of Ramadan, their Muslim patients attended surgeries and through the help of interpreters, they advised accordingly about treatment before starting and after breaking the fast. I asked all the interviewees, "how do you know about Ramadan?" They responded that media and social networks were the primary sources of information about Ramadan. I also asked whether surgeries ask Muslim patients about altering their medications or whether such patients make appointments for advice. The interviewees maintained that surgeries do not have a system which can alert doctors about Muslim patients. Therefore, those Muslim patients willing to observe fasting should contact the surgery to alter their medications.

Interviewees D and F informed me of their individual experiences with some patients. Interviewee D said, “yes, last year I had a patient with severe anaemia. After one month the patient was admitted to the hospital due to low iron and sugar levels which led to low blood pressure. Later, we found out that the patient was not getting enough nutrition due to fasting. I suggested asking for advice two weeks before fasting to move forward”. Besides, the nurse interviewee, F, had a patient, who was fasting, but his blood pressure was not stable. Hence, the patient was advised to alter their medication accordingly. The patient agreed and fasted the rest of Ramadan.

Interviewee B stated, “I do not recommend modifying medications during Ramadan. I give the option for patients to decide to fast or not and refer them to diet educator about general medications and how to handle hypoglycaemia”. Interviewee B also stated, “the interpreter could help to bridge the gap in areas such as Ramadan, gender, hand-shakes and eye-contact. I had a patient whom I shook hands with, and I felt that she got offended. Then, I stopped shaking hands with female patients wearing a head cover to avoid this embarrassment in the future”.

Interviewee C added, “from my previous experience I learned to avoid booking appointments during Ramadan”.

7.2.3.7 Q.7.34: Have you ever had a patient who suddenly stopped his/her medication intake due to religious diet restrictions or fasting during Ramadan?

The responses to this question are relatively similar to question 5.33. All the interviewees were clear and confident that if Muslim patients have any issues related to medication, especially during Ramadan, they contact them before beginning fasting. Also, none of the

interviewees believed that their patients stopped taking their medications while they are fasting. I mainly asked about Muslim diabetic patients. The interviewees categorically emphasised that their surgeries and hospitals have not experienced any cases where Muslim patients stopped taking medications while they are fasting. They also mentioned that when Muslim patients decide to observe fasting, they precisely know their medications and times. They make their schedule during the fasting month and strictly follow the chart.

When the interviewees were asked about their experiences, interviewees C and E added, "alcohol cannot be avoided in some medications". Interviewee C added, "I advised one patient to use Corsodyl for gum disease. The patient asked if it is alcohol-free. So, my advice was to purchase the red Corsodyl because it is alcohol-free". Interviewee B stated, "I had a patient who attended the clinic with a sore throat and cough. I suggested taking buttercup syrup. The patient attended another appointment and she asked for another medication as the syrup contained alcohol and her religious beliefs did not permit her to take alcohol-derived medications. Thus, I advised the patient to use Covonia herbal cough syrup, which is alcohol-free."

7.2.3.8 Q: 7.35: Would you think explaining some cultural concerns by the interpreter would be useful to the patient's treatment according to his/her religious needs/concerns?

Most of the respondents answered, "yes" to this question. Interviewees A, B, C, D and E appreciated Muslim patients' religious beliefs and diet restrictions. However, interviewees A and C asked for more elaboration about what religious needs/concerns imply? I explained that 'religious needs' could be diets restriction-related such as *halal* medication free from alcohol and pig ingredients. Interviewee D commented, "this could be a time-consuming process. I

would think that the interpreter's interference might be useful, but sometimes we do not know some medication ingredients". Interviewee E argued that all patients should be treated with respect. Understanding their cultural needs are required to ensure mutual respect between the clinician and the patient. Meeting the patient's needs is crucial in providing an optimal HCS. Cultural sensitivity and understanding the patient's cultural concerns are advisable.

Interviewee E said that he encourages doctors to disclose to their patients any culturally prohibited ingredients in medication or treatment as this impact on the patient's compliance with the treatment plan. The interviewee commented, "once I had a Muslim patient who had an infection and had a problem with his heart valve where an implant of a pig heart valve was the only option. Due to the infection, the metal heart valve was not suitable for him. I advised this is the only available treatment to save his life. Finally, the patient was convinced to accept the pig valve design implant".

7.2.3.9 Q.7.36: Do you know that some Muslim patients may use some alternative or herbal therapies, which may interact with their medications or cause some medical issues?

Interviewee A, who is a British doctor, appreciated the question and he was not surprised that some Muslim patients might use herbal remedies along with other prescribed medications. Interviewee B explained that one of his patients also informed him that he was additionally using turmeric powder and black seed oil to control blood pressure. Hence, he had to reduce the original dose for the medication of his blood pressure. He also agreed that herbal treatment is not objectionable if the patient is getting benefit from it. On the other hand, though interviewees D and E were aware of herbal remedies they did not have any

experience of them in dealing with patients in their clinics. Both interviewees F and G also agreed that herbal remedies intriguing are widely known in practice.

Interviewee C, the dentist, mentioned an experience with a Muslim patient who suffered from jaw pain which could be related to temporomandibular joint disorder. He asked the patient if he had been chewing something hard which triggered the problem. The patient responded, “no.” Then, the interpreter informed him that frankincense chewing is quite common in some Arab countries and offered to ask the patient if he used it. It turned out that the patient used frankincense, which was the cause of the jaw problem.

7.2.3.10 Q.7.37: Have you ever changed the medication/treatments or route of administering medication due to a patient’s religious beliefs?

Interviewee E answered, “the use of spray for patients with asthma can break the fast during Ramadan. Therefore, some alternative treatments can be prescribed during fasting to avoid breaking the fast”. Changing the route of administering medications or treatment to adapt it to go with the patient’s cultural needs improves clinical adherence. For instance, the use of a mask fluid mixed with air which changes into vapour (a nebuliser) to be inhaled from the nose rather than the mouth, as highlighted by interviewee E. This treatment can be used for Muslim patients during Ramadan. Interviewee E noted, “sometimes, I would prescribe GTN patches for angina patients instead of tablets or spray, which can be an ideal option for Muslim patients who choose to fast. In this case, we can satisfy the patient’s spiritual needs and adherence to the treatment at the same time”. By contrast, interviewee A did not have any experiences where the patient approached him to change medication based on religious and cultural beliefs. The nurse interviewees, F and G, did not answer this question and

generally maintained that if Muslim patients used alternative therapies, this is entirely between the patient and the doctor, not them.

7.3 Discussion of the Findings

Our results cast light on the HCP's cultural knowledge of Muslim patients in the UK. Notwithstanding media coverage and training programmes provided for HCPs, lack of cultural sensitivity still exists. "Despite the increasing attention paid to cultural competence, providing culturally competent services can often be challenging" (Grandpierre, et al., 2018, p. 2).

However, it has been concluded that interpreters can play a crucial role in building effective interactions (Dickinson and Turner, 2008; Metzger, 1999; Roy, 2000; Wadensjö, 1998). For instance, resolving cultural conflict between two speakers can be accomplished through using the advocate model effectively by highlighting any cultural misunderstanding between the two parties (Kondo and Teble, 1997). This can be a solution to offer culturally competent HCS that meets the patient's needs (Graham et al., 2008).

From the interview responses, it seems that most of the interviewees used the interpretation service. Responses included the following: "Yes, I used the interpretation service many times; both face to face and over the telephone. However, I would prefer the face-to-face interpreter than TRI I believe that the interpreter has to see the patient's body language gestures and interpret them to the HCP". This shows that the HCP is aware of the importance of non-verbal clues (The British Psychological Board, 2008). These clues may include cultural, religious, or traditional beliefs that may impact the prescribed treatment, diagnosis or flow of the consultation. This can enhance the communication which is a crucial

element in providing an efficient interpretation service (Routes into Languages, 2015; The British Psychological Board, 2008).

Another HCP respondent answered: “yes, I used the interpretation service several times”. This indicates that HCPs have dealt with quite a few Muslim patients. One interviewee explicitly stated, “yes, I have dealt with quite a lot of Muslim patients”.

Our findings demonstrate that HCPs are aware of religious concerns such as:

7.3.1 Same gender preference

Attum and Shamoon (2018) state that HCPs should be aware of some guidelines while dealing with Muslim patients. This may involves avoiding making eye contact with the opposite gender. Exposing parts of the body for examination could raise some concerns with Muslim patients. Therefore, it is advised to ask permission before uncovering the area and exposing as small an area as possible (ibid). Failing to adhere to these guidelines may result in patients’ declining the treatment, distress, lack of trust in the HCP, or non-adherence to future appointments.

However, receiving the treatment from the same gender is not only an issue for Muslim patients; it also affects British and other patients from various nationalities. However, the level of sensitivity and religious adherence might vary. This can be seen in response to Q.5.29 “*Have you dealt with a Muslim patient and what was your experience?*” One HCP reported that a patient had attended the clinic for a gynaecological examination. The patient was asked to uncover herself while the window curtain was still open. Reassuring the patient that no one could see her through the window and “no one can access the room without permission” did not culturally satisfy the patient. Thus, this put the patient in a stressful situation: “the patient was still anxious even after explaining that no one can see her through the window”. Despite

knowing that the patient was still anxious the patient was very tense, the doctor still carried on with the test. The HCP was fully aware of the patient's concerns, yet she failed to put the patient at ease by closing the curtain. In this case, gaining the patient's trust could have reduced their level of physical stress when communication with HCPs (Brody et al., 1989).

Another incident about with regards Muslim HCU's modesty was highlighted by a male doctor interviewee's E, in response to question (7.30) in (section 7.2.3.3). Seeking help from the interpreter to ask if the patient was okay indicates that the HCP did not realise that the patient was anxious because of her religious concerns with regards to her modesty.

This example accords with Attum and Shamoon's advice: "When entering a room of a Muslim patient, obtain permission before entering the room" (Attum and Shamoon, 2018, p.11). Accordingly, HCPs are strongly advised to follow some guidelines such as: "announcing the arrival of the healthcare professional allowing a female time to cover herself" (Attum and Shamoon, 2018, p.12).

These two examples would raise some other concerns if they were left unexplained. The interpreter's interference could be crucial to establishing effective communication. In these cases, the interpreter can adopt the visible role by informing the patient of the arrival and the sex of the clinician. Patients might be advised that they will be seen by the consultant without explaining the gender of the HCP. Thus, the interpreter can adopt the advocate role by asking about the sex of the HCP to make the patient aware in case he/she would like to make any religious adjustments such as putting a headscarf on.

Before the current study, there was empirical evidence of links between providing culturally competent HCS and its significant impact on HCS:

> understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of

> the health care delivery system; and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations (Betancourt et al., 2003, p.293).

Providing culturally sensitive HCS by adapting the service according to the patient's cultural needs and concerns is crucial. Thus, this will improve HCS and impact positively on the adherence to the treatment and attending appointments (Yeowell et al., 2010). Tailoring patients may lead to a feeling of comfort and establish trusting relationships with the HCP. Therefore, this will improve satisfaction with the care they receive (Joffe et al., 2003; Sorensen et al., 2005). Research suggests that trust in the HCP is linked to care satisfaction (Tucker et al., 2011).

According to Islamic law, any unnecessary physical intimacy such as a handshake with the opposite gender is not allowed (Hassan, 2013). One of the main culturally sensitive issues is that cultural awareness of the opposite gender can reduce trust between the HCP and the patient. Declining a handshake with a patient may make the HCP feel uncomfortable. As interviewee G stated, "it was an awkward situation".

While the HCP was trying to show respect to the patient, the lady patient misunderstood it and took it the wrong way. Using the advocate role in interpretation by explaining and clarifying some cultural issues such as handshakes, modesty towards the opposite gender of the HCP, the importance of the head cover for Muslim women, or lack of eye contact could build mutual respect with the HCP and reassure both sides that nothing is personal; it is just a cultural difference. Therefore, body language and non-verbal communication should not be ignored in some situations. This will enhance trust, adherence to appointments and respect between the HCPs and patients.

7.3.2 Religious dietary restrictions

It has been argued that cultural sensitivity towards the food served in hospitals is important in relation to Muslim patients:

> this includes offering medications that don't contain pork or alcohol. Implementing sensitivity training to better educate workers about traditions and customs helps in maintaining cultural sensitivity in food preparation (Attum and Shamoon, 2018, p.8).

The issue of Muslim patients' religious dietary restrictions was discussed earlier in chapter (5) sections (5.2) where we defined *halal* and *haram* according to Islamic law, views of Muslim scholars and patients concerning the use of *haram* products medications as discussed in sections (5.2.1, 5.2.2). We discussed the possible consequences of Muslim patients' religious beliefs on medical adherence in section (5.2.3).

Interviewee A pointed out a case where a Muslim patient refused a flu jab vaccine because his friend had told him that it contained pork. Another patient asked about the ingredients of an MMR vaccine concerned about the religious dietary restrictions. In this example, the patient left the clinic without any treatment, while waiting for further information about the vaccine ingredients. This is a time-consuming process for the HCP and the patient.

Without any doubt, most of the HCPs are fully trained and have cultural knowledge of Muslim patients, as it can be seen in responses to Q.7.6: "*Would you prefer that an interpreter explain cultural issues while interpreting such as religious dietary restrictions (e.g., halal diet) to the HCP even if these have not been mentioned by the patient or doctor?"* One of the participants in the survey research pointed out, "I have some awareness. The interpreter could check the understanding of the HCP before the appointment". A nurse noted, "the NHS

has already trained us about cultural issues, and I always make sure that patients' cultural needs are addressed". There are still some cases that show how the HCP might need the interpreter's support to build mutual trust and respect between the HCP and the HCU. An example was provided by interviewee B of a patient who came back to the clinic to request alternative medications that accorded with his religious beliefs. First, the HCP advised the patient in the appointment "to take buttercup syrup". Then, the interviewee added, "the patient attended another appointment, and she asked for another medication as the syrup contains alcohol". In this example, booking another appointment could have been easily avoided by offering the patient advice during the initial appointment. If the interpreter had asked the patient if he/she had any religious concerns in the first place, the culturally appropriate treatment could have been prescribed from the beginning. This could have saved the NHS time.

Offering initial advice to the patient could be more cost-effective for the NHS. The interpreter could adopt the advocate role by asking the patient about any religious concerns. Some patients might either stop taking medications or book another appointment with the HCP to have another medication prescribed as in the case described by interviewee E where the patient came back to the clinic. The patient had to book another appointment to find out more about the medication ingredient. This required booking an interpreter and taking an appointment from the doctor's slots.

However, most of the interviewees agreed on adapting the patients' treatments according to the patient's religious needs. Interviewee E stated, "it will be beneficial for Muslim patients to know if their medications are porcine- or alcohol-derived. This has a positive impact on the patients' adherence to the treatment plan". The HCP agreed to disclose any religiously prohibited ingredients in medications and to leave the patient to decide. The interviewee

noted: “once I had a Muslim patient who had an infection and had a problem with his heart valve where an implant of a pig heart valve was the only option”.

In this case, the HCP disclosed the fact that the heart valve was made from a pig. The doctor acted professionally by being honest and explaining the ingredients of the heart valve. The interviewee enlightened the patient with other available options such as a metal valve. This would fit with the patient's religious beliefs but was not suitable for the patient's medical condition as discussed by interviewee E in response to question: (7.35) in section (7.2.3.3). The HCP explained other possible options for the treatment and gradually introduced the patient to the most appropriate treatment. This established trust in the HCP which led to positive clinical results and quality HCS. Interviewee E added that all HCUs should be treated respectfully.

Some of the interviewees considered finding out the medication ingredients a challenging task and time-consuming for the HCP. For instance, interviewee D commented in response to question (7.35) in section (7.2.3.8).

Similar results appear in response to **Question 7.2:** “*Do you know that treatments or procedures containing ingredients which are prohibited for members of some religious groups such as pork or alcohol may impact patients' accepting treatment and consequently their adherence to their treatment plans?*” One of the participants pointed out that the patient should seek more information from the pharmacist.

In response to **Question.7.6** “*Would you prefer that an interpreter explains cultural issues while interpreting such as religious dietary restrictions (e.g., halal diet) to the HCP even if these have not been mentioned by the patient or doctor?”* 82% of the participants, as well as the interviewee, encouraged the interpreter's involvement. However, this could be useless as HCPs are unaware of all the medication ingredients. The high number of participants who

preferred the advocate model in interpretation indicates that the interpreter's visible role could be useful. Using the advocate model was encouraged by some of the participants in their response to Question (7.2.1.6)

To avoid all these complications, the interpreter can ask the patient about religious restrictions, which could impact his/her medication intakes and work accordingly. In case the HCP is unsure of the contents he/she can prescribe the *halal* or vegetarian option.

7.3.3 Ramadan

Interestingly, the majority of the survey research participants and interviewees are aware of Ramadan and its impact on the patient's health. In response to **Question.7.33**: "*Are you aware of the month of Ramadan and how fasting could affect the patient's medication intake?*" Most of the respondents' answered that they are aware of Ramadan through social network and media.

Similar results appear in response to **Question. 7.9**: "*Would you like to be reminded by the interpreter of cultural events such as Ramadan, which may require medication adaptation such as routes of administration or intake times?*" Most of the participants show that they are aware of Ramadan as answered in **Question 7.9** in Section (7.2.1.9).

Interviewees D and F informed the researcher of their individual experiences with some patients (please see Section 7.2.3.6, Q. 7.33). Also please see, the senior nurse interviewee F's comment in Section 7.2.3.6, Q. 7.33). Hence, the patient was advised to alter his medication accordingly. Also, interviewees B and C (Section 7.2.3.6, Q. 7.33) and interviewee B's comment (Section 7.2.3.6. Q. 7.33). Changing medication intake without consulting the HCP could be another issue faced by patients. Interviewees believed that patients do not change their medications while fasting. Nonetheless, the findings show different results in response to

Q.7.34 than to Q.7.17. Regarding Q.7.34 "*Have you ever had a patient who suddenly stopped his/her medication intake due to religious diet restrictions or fasting during Ramadan?*" Most of the responses show that HCPs are relatively confident that their patients adhere to their medication intake during the fasting month of Ramadan. They emphasised that their surgeries or hospitals never face situations where patients stopped their medication intake during Ramadan.

Different results, however, appear in patients' responses in the research survey, Question 7.17 "*Have you ever stopped taking your medication during Ramadan without consulting your doctor?*". The responses to Question (7.17) in Section (7.2.2.5) indicated that a high number of respondents discontinued their medications during Ramadan without asking their doctor's advice.

In response to Question.7.36 "*Do you know that some Muslim patients may use some alternative or herbal therapies, which may interact with their medications or cause some medical issues?"* Interviewee E listed several alternative options such as changing the routes of administering medications to allow the patient to take the treatment and perform the fast at the same time. This may be possible on some occasions, while in other cases the HCP may not be able to find alternatives.

We can take interviewee D's response to Question.7.33, "*Are you aware of the month of Ramadan and how fasting could affect the patient's medication intake?*" As an example, the interviewee gave the patient with anaemia advice as discussed in response to Question (7.33) in Section (7.2.3.6). So, the patient does not to fast during Ramadan, as this could save the patient being admitted to the hospital. This could be very cost-effective to the NHS.

As discussed earlier most of the HCPs are aware of Ramadan, while some HCPs faced situations where some patients rearrange appointment or stop some treatments procedures

which may break their fast. See interview's C's comment (Section7.2.3.3, Q. 7.30). Similarly, interviewee F mentioned a case where a Muslim patient declined his/her endoscopy treatment because it broke his/her fast. Interviewee F showed some concerns about a Muslim patient who declined his endoscopy procedure after being informed of the numbing throat spray, which might break his fast.

7.3.4 Use of alternative therapies

Again, the HCPs were aware of the alternative remedies that are widely used by the ethnic minority patients, yet they do not ask their patients. Using herbal therapies could help the HCP in the diagnostic process as illustrated in the responses to Question.7.36: "*Do you know that some Muslim patients may use some alternative or herbal therapies, which may interact with their medications or cause some medical issues?*" Interviewee C pointed out a case where a Muslim patient used frankincense, which resulted in temporomandibular. Frankincense is a kind of gum which is hard to chew and can cause jaw pain. In this case, disclosing the use of a traditional remedy facilitated communication and benefited the patient. One of the HCP's recommendations to the HCU was to stop using frankincense.

It could be important for the HCP to advise patients before some medical procedures such as operations to stop specific alternative therapies, such as black seeds which might cause blood thinning during the operation.

7.4 Summary of the Questionnaire Results

Patients The results of the survey of the HCPs indicate that HCUs may have the cultural knowledge with regards Muslim patients' cultural beliefs and religious restrictions. However, the results of the interview questions along with the research questionnaires suggest that

they still accept the interpreter to use the advocate model of interpretation to clarify cultural issues.

Interestingly, despite the professional HC workers' cultural knowledge of Muslim HCU's beliefs, different. The questionnaires results show that Muslim HCUs' acceptance for treatments that clash with their religious beliefs can be resulted from their lack of cultural knowledge of the HC system in the UK. The results of the HCU's questionnaires reveal that a high number of patients were unaware of the HC system in the UK. This can imply that the HCP may not discuss Muslim patients' religious concerns which may lead to adverse clinical results. Thus, Muslim patients' beliefs, attitudes and practices can play a crucial part in improving HC if addressed with the patient. Asking HCPs if they would like to ask about the patients' cultural practices, concerns and attitudes can sometimes assist the doctor to obtain better understanding of the patients' needs and adaptations that may cause serious results if not addressed with the HCP. Using the advocate model in interpretation can save the situation. This research indicates that it is advisable for the interpreter to be visible and to use the non-conduit role in interpretation to deliver a culturally competent HCS.

7.5 Conclusion

In the context of the study, having reviewed the results above it can be seen that HCPs are aware of religious restrictions involving some medications, and some religious events and the consequent results on patients. However, doctors still go ahead with treatment plans without discussing these issues with patients. Religious beliefs may involve gender preference, diet restrictions either due to observing fasting or *haram* ingredients, beliefs in health and illness, and using some conventional therapies along with some medications. The survey results demonstrate that the most HCPs are unaware of the influence of Ramadan on medication

intake for some Muslim patients. Overall, this study suggests that HCPs have some cultural awareness in dealing with Muslim patients. Yet, lack of knowledge still exists and some assistance in explaining some cultural barriers is required. Most HCPs show an interest in the interpreter adopting the advocate role on some occasions such as disclosing bad news to patients or finding out more about patients' preference due to religious constrains. Also, HC workers confirmed the significance of interpreting patients' body language by the interpreter.

We have also examined Muslim patients' understanding of the HCS in the UK. It appeared that most Muslim patients who took part in the study were unaware that some medications, vaccines or implants might contain ingredients that may conflict with their religious beliefs. It appeared that most of the patients would decline porcine-derived treatments even if it is a matter of life or death. Consuming pork is a major religious taboo for Muslims, even more so than alcohol. Despite patients' beliefs in herbal and prophetic therapies and their strong faith in Allah (God), they still seek the treatment from the doctor.

The qualitative research results conducted with HCPs match the results in the qualitative ones. This research also points to the potential value of the advocate role in interpretation as a form of enrichment for the HCS. From the previous survey research and interviews we conclude that it is not only words that need to be interpreted to facilitate communication. What is behind words like culture is equally important. This supports Angelelli's theory (2003) in which interpreters are considered as cultural brokers.

Although data collected in this study involved only a small sample of respondents, the results give us some valuable initial insights into Arabic Muslim patients' major issues and HCP's cultural awareness. However, it is advised that a further study is required using a larger number of participants to determine typical patients' and HCPs' perspectives more precisely before generalised conclusions can be drawn.

CHAPTER EIGHT

CONCLUSION AND RECOMMENDATIONS

8.1 Brief Overview of the Study

The broad aim of this study was to highlight the significance of the interpreter in facilitating communication between the HCP and the HCU. Using purely linguistic interpretation which avoids addressing cultural issues is inadequate because of the shortcomings that it may involve. The patient's cultural values need to be identified and addressed wherever possible to provide an efficient care. Despite the efforts that have been made to improve the quality of HC in the United States, Australia, the United Kingdom and Canada, researchers have found that they have not been fully successful as risks still exist threatening patients of minority culture and language (Johnstone and Kanitsaki, 2006). These risks may arise from cultural differences between the patient and the HCP. Therefore, underestimating cultural, as well as linguistic, barriers may hinder effective communication and reduce the quality of HC for patients of minority racial, ethnocultural and language backgrounds. Misinterpretation and lack of awareness of patient's culture can have bad results for the patient and the HCP's reputation. Improving the quality of HC for minority patients starts with recognising and identifying these cultural and language conflicts (ibid). Using the advocate model in cross cultural communication is important to minimise any misunderstandings and therefore enhance optimal care for the HCU.

In Chapter One we discussed the need to improve medical interpretation service for Arab Muslim patients in the UK to enhance the quality of HC. In Chapter Two we highlighted the

importance of culture, religion, and tradition. Then, we focused on the importance on cultural sensitivity in HC for ethnic minority patients' safety and wellbeing.

Chapter Three considered HC interpretation in the UK, the vetting system for recruiting interpreters, and the required qualifications, skills, and experience for interpreters. It also addressed the issues of interpreter training. Then, we introduced most common methods of interpretation such as F2F interpreting, TRI and video-interpreting including their advantages and disadvantages.

Chapter Four focused on the interpreter's different roles in HC settings; the conduit role (linguistic), the channel role, and the machine role. We also addressed the shortcomings of the conduit role in HC. Then, we defined the non-conduit role, which involves the interpreter as cultural clarifier, the interpreter as a cultural broker, the interpreter as advocate and the co-diagnostic role (role exchange). These roles were discussed in HC settings. We concluded with the interpreter's visibility and invisibility.

Chapter Five illuminated Muslim patients' beliefs about HC: attitudes towards *haram* medications and treatments, alternative therapies amongst Muslim community, beliefs about health and illness and the risks of fasting for Muslim patients. Chapter Six described the methodology of the research including the research methods used in this study, the sources of the questionnaire questions and the ethical issues which the researcher considered in conducting her research. Chapter Seven introduced the research questionnaires and interview questions and discussed the findings of both qualitative and quantitative research methods.

8.2 Training

It is postulated that providing appropriate training programme for both HCPs and interpreters can improve the HCS (Tribe, 1999, p.567). This is recognised by more experienced interpreters; hence they tend to advocate training for themselves and for the HCPs they interpret for (Granger and Baker, 2003).

Tribe and Raval (2003) provide a template for a possible training curriculum. It is argued that some appropriate training and information sessions are required for both the interpreter and the HCP to ensure that the interpreter is conversant with the organisation's aims (Kiramayer et al., 2003, Tribe and Morrissey, 2003; Williams, 2005). Thus, providing joint sessions for both HCPs and interpreters could be beneficial to allow effective communication about each other's role (Professional Practice Board, 2008). It has been noted that access to trained language interpreters or bilingual providers may increase the patient's satisfaction and reduce errors in general practice. It has been advised that the use of a professional and trained interpreter may save money by avoiding unnecessary tests of patients (Flores, 2005), and can also reduce hospital stays and admission rates (U.S. Census Bureau, 2014).

Participants who took part in a study reported the benefits of using trained interpreters such as 'clear' interpretation, enhanced 'comprehension' and patients' satisfaction (Bagchi et al., 2011). Flores (2005) states that better quality care and 'compliance', and less risk of negligence are other benefits of using trained interpreters. According to NHS rules, the HCP has to undertake a training course to learn how to work with an interpreter. The interpreter should be qualified and appropriate for the consultation. Allocating 10-15 minutes prior to

the consultation is highly recommended by the NHS. This helps the HCP to gain basic knowledge about any cultural issues that might be useful for the session.

Amongst the solutions to overcoming the shortage of training materials is to implement a curriculum centred on 'language-independent courses. This is already done at some institutions in the UK such as South and City College Birmingham, which offers a Certificate in Community Interpreting Level 3, Heriot-Watt University in Edinburgh, and London Metropolitan University (Valero, 2016, p.325).

Another way of improving training opportunities is to provide practice opportunities for public service interpreters (Rabadán-Gómez, 2016). Using a trainer who speaks the same language as the interpreter is one possible solution. However, there is limited availability for certain languages. Thus, it is recommended to deliver the modules in English (Rabadán-Gómez, 2016). It has also been suggested that having a single core-curriculum with a common language could upskill most interpreters (Rabadán-Gómez, 2016). These modules could be made available online through collaboration between various educational institutions, resulting in a standardised training package accessible remotely for everyone regardless of where they live (Rabadán-Gómez, 2016).

Thus, improving the interpretation service can be accomplished through training programmes that involve educating both the HCP and HCUs about the availability of the service and how to use it, along with educating HCPs about how to use the interpretation service effectively (Jimenez, 2009). It has been suggested that HCPs should have guidance that instructs them in the interpreter's various roles and provides sufficient training (Hales and Filipović, 2016).

8.3 Outcomes of Research Questions

8.3.1 To what extent is cultural awareness crucial in caring for LEPs?

The answer to this question was first introduced in Chapter 2, Section 2.2 in highlighting the significant connection between language and culture in interpretation to adapt HCS according to HCUs' religious needs. Section 2.2.1 emphasizes the important role of culture in bringing individuals together by allowing people to enjoy their well-being.

Section 2.2.2 stresses the importance of cultural awareness of patients' religious beliefs. Section 2.2.4 offers examples to differentiate between culture, religion, and tradition by illustrating examples of some Muslim practices which might be religious, cultural, or traditional. Section 2.2.4 also argues that it is important for HCPs to discuss any religious, traditional, or cultural practices that may interfere with HC in caring for Muslim patients. Sections 2.3- 2.4 consider the negative consequences resulting from lack of cultural awareness. Sections 2.3.3-2.5 stress the need to be culturally aware of HCUs' beliefs and practices because of the impact they may have on understanding symptoms, decision making, and diagnosis and therefore improving the service.

8.3.2 What are the steps the UK took to improve the interpretation service, and have they been successful?

This question was answered in (Chapter 3), (Section 3.3), in referring to the inefficiency of the interpretation service. Section 3.4 refers to the rigid NHS criteria in hiring qualified (Section 3.4.1) and experienced (Section 3.4.2) interpreters. (Section 3.4.3) also shows that the UK aspires to ensure confidentiality in

interpretation. However, the NHS still uses ad-hoc interpreters (Section 3.5). Section (3.6) explains the obstacles to providing trained interpreters. Sections (3.7, 3.7.1-3.7.2-3.7.3 and 3.7.3.2) consider the disadvantages from using RI and the lack of awareness of the interpreter's physical presence in improving the service.

8.3.3 How can the advocate model help the interpreter to build effective communication in HC?

The advocate model can involve some risks if used inappropriately, such as 'compromising' the HCP's authority (Hsieh, 2009, p.156) through overstepping the HCP's role by answering the patient's requests and offering recommendations, clarifications, and information without consulting the HCP (Hale, 2012, p.325).

To use the advocate model effectively, the interpreter has to know the right time to interfere in the interaction. The best way to do this is to ask himself/herself: is advocacy really needed? If the answer is 'yes', then he/she can use advocacy skills (Section 4.7.3). This accords with Martín and Phelan (2009) who postulate that the interpreter can be an advocate when he/she notices that the patients' wellbeing or "dignity is at risk" (ibid, p.10) or to promote HC (NCIHC, 2005, pp.11-12).

The interpreter has also to be aware of his/her role boundaries; his/her role is only restricted to using his/her language or cultural skills to facilitate communication (Section 4.7.3). Thus, using the advocate model requires the interpreter to avoid any role interaction with that of the HCP. The interpreter cannot provide medical advice, but he/she can use his/her cultural skills (Section 4.7) to help the clinician to diagnose the patient's condition (Section 7.2.3.9; interviewee C's comment) or prescribe the right medication (Section 4.5).

8.3.4 What are the possible consequences of lack of cultural awareness of Muslim HCUs, and who is responsible for this lack of awareness?

This question was answered in Chapter 5, Section 5.2.1 in explaining the adverse clinical effects of practicing some religious beliefs such as declining *haram* medication or treatment (sections 5.2.1-5.2.2, 5.2.3-5.2.3.1), using alternative therapies without consulting one's doctor (sections 5.3-5.3.2.5), the negative clinical outcomes resulting from spiritual beliefs regarding some illness (Section 5.5), and fasting or altering medications without the HCP's consent (sections 5.6-5.7).

While HCPs have medical knowledge in adjusting medications, treatments and procedures, the interpreter has the language and cultural skills as shown in Chapter (4). in Section (7.2.3.7), the participant (HCP) states that he changes medications in a way which accords with the patient's religious needs. Our findings (Section 7.2.3.10) also show how the HCP participant changes the routes of administering medications in a way that does not invalidate the fast. This shows that that the HCP sometimes uses his/her medical knowledge to satisfy Muslim patients' cultural needs. However, cultural knowledge is a missing element among most of the participants in both the research questionnaires (Sections 7.2.1.6- 7.2.1.7-7.2.1.8-7.2.1.9) and interviews (Section 7.2.3.8). HCPs show interest in the advocate model. However, it is the job of the HCP to consider a patient's medical history and to refer to it when deciding on treatment (Martín and Phelan, 2009). It is postulated that providing an appropriate training programme for both HCPs and interpreters can improve the HCS (Tribe, 1999). Thus, bridging the cultural barrier is work involving the entire 'team': the interpreter by using the advocate model effectively, the HCP and the patient.

8.4 Contribution of the Study

As mentioned in Chapter (1) this study contributes to improving HCS for Muslim patients in the UK. To my knowledge, combining the interpreter's advocate role with Muslim patients' experiences has not been studied before. The research questions in Chapter (1) Section (1.4) along with the survey questionnaires as shown in Chapter (7) are new. There are other studies in which researchers have investigated the interpreter's role in improving HCS, as discussed in Chapter (4). However, their methodology is different from that of the current study. Similarly, the aims of data collection in this study are different from those in other studies. In addition, what inspired the researcher is that there are very few studies that deal with interpreters' role in improving HCS for Muslim patients.

8.5 Limitations of the Study

Despite of the benefits of this study, it has some limitations. The small number of participants in the research is one of the limitations. The number is limited to 50 HCPs and 50 Muslim participants in the survey research, while to (7) HCPs participants took part in the interview. Involving more participants in the study could have enriched our data further.

The second limitation in this study is location. The study is restricted to participants from Newcastle-Upon-Tyne as discussed in Chapter (7). Further research needs to involve participants from more locations in the UK.

The third limitation of this study, due to the researcher's language limitation, as explained in Section (6.8), is that the study is restricted to Arab Muslims. It would have been useful if other Muslim ethnic minority participants had taken part in the study. This would have

enabled the researcher to look at cultural issues in the Muslim community more broadly. Additionally, this may have provided deeper insights into the cultural issues from different Islamic points of views given that tradition is involved in formulating some religious beliefs.

The fourth and most important limitation of this study is the absence of interpreter input. Due to some ethical issues (Section 6.4), the researcher refrained from involving interpreters in the study. The study would have benefited from sharing interpreters' experiences.

8.6 Implications for Future Study

In the light of the above limitations, the researcher sees the following implications for future research. This study explored many aspects of how to improve the interpretation service to deliver quality care for Muslim patients. However, many issues around these subjects still need to be addressed and researched, so that researchers can understand various types of interpreter roles. Therefore, future researchers can consider involving more participants from various Muslim ethnic backgrounds in different parts in the UK. Involving interpreters in future research would also be useful, making it possible to look at Muslim patients' experience from three perspectives: the HCP, the interpreter, and the Muslim patient. Another area that needs further investigation is educating HCPs and interpreters to share their experience and knowledges to meet patients' cultural needs.

8.7 Concluding Remarks

This research aims to explain how the existing conceptualisation of the interpreter's invisible conduit role can clash with the interpreter's task in providing an efficient service. While the UK has worked strenuously to upgrade the quality of its interpreting service, the findings of this study indicate that some challenges and shortcomings may still exist. For instance, the

NHS believes that providing accurate interpretation to HCPs and HCUs can be accomplished by encouraging interpreters to use the invisible role. However, the outcomes of this research indicate that there are certain situations that may oblige interpreters to step beyond their role as mere language-switchers and act as non-conduit visible communication facilitators to bridge both the cultural gap between both parties. Thus, more skills are required to reconcile communication misunderstanding between participants. Also, more than one party needs to be involved to give the interpreter the permission to move from the traditional invisible role of the interpreter into a more visible one. The HCP can ask the interpreter to use the non-conduit visible role when cultural conflict between the HCP and the HCU impacts the patient's health or well-being. Also, since, the interpreter is the only bilingual communicator, he/she can seek the HCP's permission to adopt the non-conduit role when the invisible role fails to deliver the speaker's message accurately.

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APPENDICES

HCP's Questionnaire

This questionnaire is designed for Health-Care Providers in the NHS.

Please help me by filling in the questionnaire. I will use the results in my PhD thesis, Cultural Issues for Ethnic Minority Muslim Patients in Medical Translation and Interpreting, the ultimate purpose of which is provide an evidential basis for improving the interpreting service for ethnic minority patients and improve the quality of health care.

Thank you in advance for agreeing to fill in this questionnaire. It will only take you 10 minutes of your time.

Please give the following information:

A. Your job title: _____

B. The type of institution where you work (hospital, health centre, general practice, etc.):

C. Your gender (male or female): _____

1. Are you aware that some medications, implants, or vaccines may contain ingredients which conflict with a patient's religious beliefs?

Yes	Not sure	No

Please add any other comments which you have in this regard:

2. Do you know that treatments or procedures containing ingredients which are prohibited for members of some religious groups such as pork or alcohol may impact patients' accepting treatment?

Yes	Not sure	No

Please add any other comments which you have in this regard:

3. Have you had a patient decline a flu vaccine because it is porcine-derived?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No

Please add any other comments which you have in this regard:

4. Has a patient ever declined or rearranged a consultation with an opposite gender HCP without explaining the cultural reason?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No

Please add any other comments which you have in this regard:

5. Have you ever been in a situation where a patient refused an animal organ such as a pig heart transplant due to religious reasons?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No	Not relevant, because I have never been in a situation involving a transplant

Please add any other comments which you have in this regard:

---

6. Would you prefer that an interpreter explains cultural issues while interpreting such as religious dietary restrictions (e.g., halal diet)?

Yes	Not sure	No

Please add any other comments which you have in this regard:

7. Would you like the patient's body language to be interpreted (such as lack of eye contact with the opposite gender or sensitivity about shaking hands with the opposite gender)?

Yes	Not sure	No

Please add any other comments which you have in this regard:

---

8. Would you like to be informed of the most appropriate cultural ways for particular patients of disclosing bad news to Muslim?

Yes	Not sure	No

Please add any other comments which you have in this regard:

9. Would you like to be reminded by the interpreter of cultural events such as Ramadan?

Yes	Not sure	No

Please add any other comments which you have in this regard:

---

10. Are you aware that adapting medication intake for fasting patients can improve patient's adherence to the treatment?

Yes	Not sure	No

Please add any other comments which you have in this regard:

---

11. Do you know that some Muslim patients who fast during Ramadan either stop taking their medication or change the times at which they take their medication?

Yes	Not sure	No

Please add any other comments which you have in this regard:

---

12. Are you aware that some ethnic minority patients may take traditional medicines (herbal and other) which may interact with the medication prescribed by the HCP?

Yes	Not sure	No

Please add any other comments which you have in this regard:

THE END

Thank you for answering this questionnaire

Patients' Questionnaire

This questionnaire is designed for Ethnic Minority Muslim Patients in the NHS.

Please help me by filling inthe questionnaire.I willuse theresults inmy PhD thesis, Cultural Issues for Ethnic Minority Muslim Patients in Medical Translation and Interpreting, the ultimate purpose ofwhich is provide an evidential basis for improving the interpreting service for ethnic minority patients and improve the quality of health care.

Thank you in advance for agreeing to fill in this questionnaire. Itwillonly takeyou10 minutes of your time.

Please give the following information:

a. Your gender – male or female (leave blank if you prefer not to say):

b. Your age(leave blank if you prefer not to say):

c. Marital status–married or single(leave blank if you prefer not to say):

1. What level of education do you have?

Up to the end of primary school only	Up to the end of secondary school	Up to the end of university

---

2. Which of the following would you class yourself as?

Very strictly religious	Fairly strictly religious	Not very strictly religious	I prefer not to say

3. Have you ever declined or stopped treatment because you are worried about medication ingredients which may be culturally prohibited?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No

Please add any other comments which you have in this regard:

4. Have you ever been in a situation where you declined an examination offered by a health care provider of the opposite gender for cultural reasons?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No

Please add any other comments which you have in this regard:

5. Have you ever stopped taking your medication during Ramadan without consulting your doctor?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No

Please add any other comments which you have in this regard:

6. Have you ever asked an interpreter to raise any cultural concerns with a health- care provider related to halal diet restrictions and porcine- or alcohol-derived medications?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No

Please add any other comments which you have in this regard:

_____

7. Have you ever accepted a flu jab vaccine which is porcine-derived?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No	Not relevant, because I have never been in this situation

Please add any other comments which you have in this regard:

_____

8. Have you ever allowed your child to be given a flu jab vaccine which is porcine- derived?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No	Not relevant, because I have never been in this situation

Please add any other comments which you have in this regard:

9. Would youaccept a treatment containing aculturally prohibited ingredient such as pork or alcohol if it were the only available treatment?

Yes	Not sure	No

Please add any other comments which you have in this regard:

10. Do you believe in traditional or prophetic remedies?

Yes	Not sure	No

Please add any other comments which you have in this regard. If you do use traditional orprophetic remedies,it wouldbe useful in particular ifyou couldsay:

1. what types of remedies you use,
2. what you use them for, and
3. when you tend to use them:

11. Would you consult your doctor if you were taking herbal therapies?

Yes	Not sure	No

Please add any other comments which you have in this regard:

12. Would you prefer to seek consultation from a herbal healer than a doctor?

Yes	Not sure	No

Please add any other comments which you have in this regard:

13. Do you believe that when someone gets ill, this is Allah's will?

Yes	Not sure	No

Please add any other comments which you have in this regard:

14. Do you believe that it is religious obligations of a Muslim to seek treatment for an illness?

Yes	Not sure	No

Please add any other comments which you have in this regard:

15. Have you ever substituted herbal remedy for another conventional therapy?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No

Please add any other comments which you have in this regard:

16. If you have ever substituted herbal remedy for another conventional therapy have you informed your doctor?

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No

Please add any other comments which you have in this regard:

THE END

Thank you for answering this questionnaire!

Arabic Version for Patients' Questionnaire استمارة المرضى

This questionnaire is designed for Ethnic Minority Muslim Patients in the NHS.

هذه الاستمارة مصممه للمرضى من الاقليه المسلمه في الصحة البريطانيه

Please help me by filling inthe questionnaire.I willuse theresults inmy PhD thesis, Cultural Issues for Ethnic

رجاء ساعدني باكمال هذه الاستمارة. ساستخدم النتائج فقط لاطروحتي للدكتوراة وعنوانها:

Minority Muslim Patients in Medical Translation and Interpreting, the ultimate purpose of which is provide

الترجمه والترجمه الفوريه لمرضى الاقليه المسلمه

an evidential basis for improving the interpreting service for ethnic minority patients and improve the quality of health care.

الهدف الاساسي هو الحصول على معلومات لغرض تطوير الترجمه الفوريه للمرضى من الاقليات الاثنيه وتطوير المساواة في العنايه الصحيه.

Thank you in advance for agreeing to fill in this questionnaire. Itwillonly takeyou10 minutes of your time.

شكرا مقدما على موافقتك لاكمال الاستمارة .

Please give the following information:

رجاء اعطي المعلومات الاتيه:

d. Your gender – male or female (leave blank if you prefer not to say):
جنسك _ذكر او انثى (اترك الحقل فارغ اذا لا ترغب ان تقول)

_____

e. Your age (leave blank if you prefer not to say): _____
عمرك (اترك الحقل فارغ اذا لا ترغب ان تقول)

f. Marital status – married or single (leave blank if you prefer not to say):
حالتك الزوجيه _متزوج او اعزب(اترك الحقل فارغ اذا لا ترغب ان تقول)

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY TICKING THE BOX WHICH APPLIES TO YOU:

رجاء اجب على الاسئلة الاتيه بوضع علامة X في المربع الذي يناسب اجابتك:

1. What level of education do you have? **ما هو تحصيلك الدراسي**

Up to the end of primary school only	Up to the end of secondary school	Up to the end of university
مرحله ابتدائيه	مرحله ثانوية	شهاده جامعيه

2. Which of the following would you class yourself as? **كيف تصنف نفسك وفقا للفقرات ادناه**

Very strictly religious	Fairly strictly religious	Not very strictly religious	I prefer not to say
ملتزم دينيا جدا	معتدل بالتزامي الديني	غير ملتزم دينيا	افضل ان لا اقول

3. Have you ever declined or stopped treatment because you are worried about medication ingredients which may be culturally prohibited? **هل رفضت في يوم ما او توقفت عن اخذ العلاج لانك تشك بمحتويات الادويه واحتمال تعارضها مع محرمات حضارتك؟**

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No
نعم، باستمرار	نعم في بعض الاحيان (ولكن اكثر من مرة واحدة)	نعم، ولكن فقط مره واحدة	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

4. Have you ever been in a situation where you declined an examination offered by a health care provider of the opposite gender for cultural reason **هل تعرضت لموقف عند مراجعتك لمؤوسسه صحيه جعلك ترفض الفحص الطبي لان الطبيب من الجنس الاخر؟**

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No
نعم، باستمرار	نعم في بعض الاحيان (ولكن اكثر من مرة واحدة)	نعم، ولكن فقط مره واحدة	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

5. Have you ever stopped taking your medication during Ramadan without consulting your doctor?

هل حصل و توقفت عن اخذ الادويه خلال شهر رمضان وبدون اخذ راى الطبيب؟

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No
نعم، باستمرار	نعم في بعض الاحيان (ولكن اكثر من مرة واحدة)	نعم، ولكن فقط مره واحدة	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

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6. Have you ever asked an interpreter to raise any cultural concerns with a health- care provider related to halal diet restrictions and porcine- or alcohol-derived medications? **هل حصل وانك طلبت من المترجم ان يخبر مسؤولي الصحه عن اهمية الاكل الحلال لك وان لا تكون الادويه فيها محتويات من الخنزير او الكحول؟**

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No
نعم، باستمرار	نعم في بعض الاحيان (ولكن اكثر من مرة واحدة)	نعم، ولكن فقط مره واحدة	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

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7. Have you ever accepted a flu jab vaccine which is porcine-derived?
هل حصل وقبلت سابقا جرعة الوقايه من الافلونزا مع علمك ان فيها مشتقات من الخنزير؟

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No	Not relevant, because I have never been in this situation
نعم، باستمرار	نعم في بعض الاحيان (ولكن اكثر من مرة واحدة)	نعم، ولكن فقط مره واحدة	غير متاكد	لا	لا علاقة لي بهذا، لاني لم اتعرض ابدا لهذا الموقف

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

---

8. Have you ever allowed your child to be given a flu jab vaccine which is porcine- derived?

هل وافقت في السابق ان يحصل طفلك على جرعة الوقايه من الافلونزا رغم احتوائها على مشتقات الخنزير؟

Yes, frequently	Yes, occasionally (but more thanonce)	Yes, but only once	Not sure	No	Not relevant, because I have never been in this situation
نعم، باستمرار	نعم في بعض الاحيان (ولكن اكثر من مرة واحدة)	نعم، ولكن فقط مره واحدة	غير متاكد	لا	لا علاقة لي بهذا، لاني لم اتعرض ابدا لهذا الموقف

Please add any other comments which you have in this regard

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

9. Would you accept a treatment containing a culturally prohibited ingredient such as pork or alcohol if it were the only available treatment?

هل ستقبل علاج يحتوي على بعض الممنوعات في حضارتك مثل الخنزير او الكحول اذا كان هذا هو العلاج الوحيد الموجود؟

Yes	Not sure	No
نعم	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

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10. Do you believe in traditional or prophetic remedies?

هل تؤمن بالعلاج التقليدي او النبوي؟

Yes	Not sure	No
نعم	غير متاكد	لا

Please add any other comments which you have in this regard :

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

11. If you do use traditional or prophetic remedies, it would be useful in particular if you could say:

اذا كنت من مستخدمي العلاجات النبويه او التقليديه ، من المفيد اذا تخبرني عن الاتي:

4. what types of remedies you use, ما نوع العلاجاجات التي تستخدمها
5. what you use them for, and لاية حاله تستخدمهم
6. when you tend to use them: متى تستخدمهم

12. Would you consult your doctor if you were taking herbal therapies?

هل ستستشير طبيبك اذا كنت تتناول علاجات عشبية ؟

Yes	Not sure	No
نعم	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

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13. Would you prefer to seek consultation from a herbal healer than a doctor?

هل تفضل استشارة المعالج بالاعشاب او طبيبك؟

Yes	Not sure	No
نعم	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

14. Do you believe that when someone gets ill, this is Allah's will?

هل تؤمن عندما يصاب شخص بمرض انها ارادة الله؟

Yes	Not sure	No
نعم	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

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15. Do you believe that it is religious obligations of a Muslim to seek treatment for an illness?

هل تؤمن انها مسؤولية دينيه على المسلم ان يبحث عن علاج لمرضه؟

Yes	Not sure	No
نعم	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

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16. Have you ever substituted herbal remedy for another conventional therapy?

هل قمت سابقا بتبديل علاج الاعشاب بعلاج اخر تقليدي ؟

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No
نعم، باستمرار	نعم في بعض الاحيان (ولكن اكثر من مرة واحدة)	نعم، ولكن فقط مره واحدة	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

17. If you have ever substituted herbal remedy for another conventional therapy have you informed your doctor?

اذا كنت سابقا قد غيرت علاج الاعشاب باخر تقليدي ، هل اخبرت طبيبك عن هذا؟

Yes, frequently	Yes, occasionally (but more than once)	Yes, but only once	Not sure	No
نعم، باستمرار	نعم في بعض الاحيان (ولكن اكثر من مرة واحدة)	نعم، ولكن فقط مره واحدة	غير متاكد	لا

Please add any other comments which you have in this regard:

رجاء اضف اي تعليقات اخرى عندك حول هذا الموضوع

THE END

Thank you for answering this questionnaire!

النهايه

شكرا على اكمالك هذه الاستماره