Dr. Rana Sabbouh and Dr. Kahdem Jallab

Critical Perspectives Discussion of Ethnic Minority Muslim Patients in Newcastle Upon Tyne

Abstract

Despite the efforts the health care providers (HCPs) exert to provide a fair service to ethnic minority patients they still struggle to provide a service that fulfils their patients' cultural needs. Lack of cultural knowledge amongst British HCPs can lead to adverse clinical results and therefore poor quality of health care service (HCS). Hence, providing culturally competent HCS that meets the patient's needs is a key to enhance HC. The interpreter can play a significant role to resolve cultural clash that might be related to gender difference or diet restrictions.

This research is based on face-to-face interviews with HCPs in Newcastle Upon Tyne. Results show that National Health Service (NHS) staff are insensitive to the cultural needs of Muslim HCUs. One of the key issues identified by the researchers' concerns is HCPs' lack of cultural knowledge, resulting in inequality in health care (HC).

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?

Introduction

In recent years, Western countries witnessed a rapid growth of immigrants from non-spoken English countries (International Organisation for Migration, 2016). According to the House of Commons Library (2019), there were approximately 6.1 million immigrants in the United Kingdom. Another study in the UK reported that the number of Muslims increased up to 3,372,966 (Vargas-Silva and Rienzo, 2017).

It has been noted that the increasing growth of cultural and ethnic minorities in the UK creates a communication barrier for HCPs (Bawadi et al., 2020). The language barrier occurs when the HCP and the patient do not share the same native language (Slade and Sergent, 2018). HCUs with limited/no English are defined as patients with limited English proficiency (LEP) (Squires, 2018). The language difference between the doctor and the patient, and ineffective communication may have a significant impact on HC and may result in negative clinical outcomes (Akhavan, 2012).

Literature Review

Studies in the UK reported that diverse communities are at higher risk of receiving considerable consistent health disparities in comparison with British white HCUs (Higginbottom et al., 2017; Simmons et al., 2016; Evandrou et al., 2016). It has been argued that even patients with fluent English may lose their language skills when they are severely ill or have cognitive issues, hence they may need interpretation service (Squires, 2018). It has been postulated that medication adherence can become an issue for LEP patients (Moreno et al., 2016). Another issue LEPs can face is the difficulty in getting access to HCS (Floyd and Sakellariou, 2017). This echoes a study in the United States that shows diverse HCUs receive less quality HCS in comparison to white patients and whose native language is English (Squires, 2017). However, it is not only language differences that may lead to significant clinical errors for LEP patients (Renata et al., 2015), it is also HCPs' lack of cultural knowledge that may have a negative impact on HCUs (Gany et al., 2013). It has been pointed out that lack of cultural knowledge may result in developing adverse attitudes towards HC and may impact HCPs' capability to look after ethnic minority patients (Marshall et al., 2017). This has increased the need to understand the importance of cultural sensitivity amongst HCPs.

The effective use of the interpretation service can play a crucial role to overcome the language barrier, improve HC satisfaction and hence provide a quality of HC for LEPs (Betancourt et al., 2012). It has been noted that medical interpreters' role can go beyond using their language skills where they can work as cultural brokers (Betancourt et al., 2012) to overcome the cultural barrier that separates HCPs from their HCUs. The effective use of the translation process involves that the message delivered from the HCP in a culturally competent way. Cultural competency in HC can be accomplished by understanding the patient's cultural beliefs and values. HCPs can play a crucial role in assessing the quality of HC interpreters' skills

in delivering the message in a culturally competent way (Squires, 2018). Cultural competence in HC is defined as understanding and appreciating others' behaviours, values and beliefs and adapting HC accordingly (Henderson et al., 2018). Cultural competence in HC refers to the ability to deliver HCS to diverse HCUs who have various beliefs, practices, and religion than their HCPs including adapting HC to go along with patients' cultural and linguistic needs (Health Research and Education Trust, 2013).

It has been reported that culturally competent HCPs recognise the significance of cultural difference and have a rapport with their culturally diverse HCUs (May and Potia, 2013). Cultural Competence is defined as the ability to improve HC for patients from various cultural backgrounds (Kutalek,2012; Castillo and Guo, 2011). For instance, requests for cultural adaptations such as asking for the same gender HCP were not given positive acceptance by HCPs who considered these requests as time-consuming process (Aquino et al., 2015). It has been reported that understanding and appreciating patients' culture can have a positive impact on HCUs' engagement with HC services (NHS England, 2016).

Also, the UK HCS aims to deliver culturally competent service to diverse patients to minimise health disparities, it has been demonstrated that the UK HCS still struggles to fulfil the needs of ethnic minority HCUs (Schouler-Ocak, 2015), and the issue of lack cultural competence is still growing (Garneau and Pepin, 2015). Similarly, George et al. (2015) argue that even though achieving cultural competence in HC was highlighted by one of the health policies documents to deliver a high standard practice, however they are still limited in what they can accomplish.

When HCPs have better cultural understanding, they can deliver optimal HC and reduce HC disparities (Henderson et al., 2018). Having cultural understanding can help the HCP to be aware of the impact of culture on certain behaviours, attitudes, and concerns (Ishikawa et al., 2014). It has been pointed out that failure to overcome cultural barriers can have a negative impact on communication (Kapadia et al., 2022).

One of the positive consequences of delivering culturally competent HC is providing quality HCS (Tayab and Narushima, 2015). Medical compliance is another positive impact of providing culturally sensitive HC (Ishikawa et al., 2014; Owiti et al., 2014). Incorporating cultural perspectives make culturally diverse patients feel satisfied (Dungan et al., 2014; Gameau and Pepin, 2015). Furthermore, applying cultural knowledge and understanding while

communicating with ethnic minority HCUs can result in effective communication (Gameau and Pepin, 2015). Hence, receiving quality care, adherence to treatment, patients' satisfaction and effective communication can lead to improved clinical results (Gameau and Pipin, 2015; Tayab and Narushima, 2015).

Research Methodology

It is strongly believed that unhidden answers to certain questions cannot be addressed through survey questionnaires. The appropriate and reasonable answers can be obtained via interviews. The only central point refers to the experience, behaviour and conduct of both the interviewers (researchers) and the interviewee (HCP).

The methodological framework used in this study included qualitative research based on HCPs' responses. This study aims to gauge HCPs' understanding, experience and awareness of cultural issues while providing the treatment to Arab HCUs. The focus of this research is to shed the light on HCPs' experience with the language interpretation service while dealing with LEPs Arab Muslim patients. The goal of research study is to highlight some issues that are related to the language interpretation service in the UK. It will grasp HCPs' experiences with the interpretation services. It will probe British HCPs' cultural sensitivity towards some religious related issues such as the impact of some religiously prohibited treatments on HCUs and the traditional way to overcome this, the effect of the same gender preference on accepting or declining the treatment, and HCPs' awareness of the significance of the advocate model in interpretation in some situations.

Viewing concerns from HCPs' perspective can be helpful to broaden our understanding of British HCPs' experiences in administering HCUs. This will also enlighten us to some solutions to tackle the cultural gap between HCPs and LEPs. One of the possible solutions is be familiar of interpreter's various models in interpretation and when to request the interpreter to switch to the appropriate model when needed. It has been postulated that HCPs need to focus on treating patients regardless of other factors such as ethnic origin including traditions and religious limitations (Hammersley and Traianou, 2012). This implies the significance of understanding HCUs' cultural and religious concerns and work accordingly to adapt them. Involving HCPs in this research survey by sharing their experience can play a significant role to improve the quality of the community interpretation service (Greenhalgh et al., 2019) in the UK and all over the world where Muslim patients are the ethnic minority.

Methods

The data collection tool chosen for this study was in-depth interviews. The researchers conducted face-to-face interview. It has been pointed out that “the interview is an important data-gathering technique involving verbal communication between the researcher and the subject.” (Mathers et al., 1998, p.1)

In this research, the researchers conducted seven in-depth face-to-face interviews with seven HCPs. The researchers use qualitative research methodology via open-ended questions in the structured interviews to gain a broader understanding of issues confronted by HCPs while delivering care to HCUs.

Qualitative research implies that the findings in the research might not be arrived at by statistical procedures or other means of amplification (Almeida et al., 2017). It has been pointed that this research approach helps the researcher to obtain a profound knowledge of the raised issue in the research (Almeida et al., 2017).

Thus, this research approach is centred on building rich and solid results relying on HC professionals’ experiences. This research method helps the researchers to gain more in-depth knowledge (Chalhoub-Deville and Deville, 2008) about HCPs’ experiences with LEPs.

One of the main reasons that the researchers used qualitative research method because it provides the researchers with detailed and rich material. This involves feelings, opinions, and experiences and transfers them into actions. Chalhoub-Deville and Deville (2008) believe that qualitative research methods are used to gain deep insights into problems.

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.

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). 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).

In this research, the researchers conducted seven in-depth face-to-face structured 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 while delivering care to Arab HCUs.

Pilot Study

To ensure that one has covered all the relevant issues, that the pre-codes are correct, and that one has not forgotten or omitted any issue that is very important to the respondent, it is necessary to conduct a pilot study using a draft questionnaire. The researchers used simple and clear language. The researchers tested the language of the questionnaires to ensure effective communication (Mathers et al., 1998). The interview questions were tested, using the principles outlined in Sampson (2004). The researchers evaluated participants' feedback, considered omitting any unnecessary elements when required.

Ten HCPs were approached: three doctors, four senior nurses, two dentists and one midwife. Seven HCPs took part in the pilot study: two doctors, three senior nurses, one dentist and one midwife. The volunteer doctor commented: "I appreciate the language used in the questions and I do not object the time length of the interview." Two senior nurses commented that the questionnaires are smooth to answer.

Ethical Considerations

The researchers ensured ethical sensitivity to each interviewee took part in this research. All interviews were carried out in an ethical manner. Participants' confidentiality and informed consents were obtained from participants. The researchers obtained interviewees' permission by signing a consent forms. The aim of the of the interview questions was explained to all participants as advised by Kelley et al., (2003).

Sample and Setting

The targeted audience of this study is British HCPs. Participants were interviewed in their workplace (hospitals or GP surgeries).

To maintain 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. The interviews ranged from 30 to 40 minutes.

The researchers 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. The researchers briefly discussed a convenient possible time and asked each interviewee to individually agree that some additional questions might be asked and answering them depends on participants' permission. Doctors agreed to additional questions, but the nurses declined to be asked extra questions.

Responses to Face-to-face Interview Questions

1. The UK is a multicultural country, have you ever dealt with Arab Muslim patients? What was your experience?

All participants show that they already had experience in dealing with Arab Muslim patients. However, their experience in dealing with Muslim patients was 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". Hassan et al. (2012, p.6) reported a similar experience in a study where a 24-year-old lady who had been examined six times by four 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 hospital 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 Muslim patients was interesting. The researchers 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 interviewee's F and G were asked the same questions, and their experiences in dealing with Muslim patients were 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 male. 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. The researchers asked them about the cause. They emphasised that speaking a second language, and then translating the conversation requires 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.

2. Have you had any experience where interpreter failed to communicate effectively with the patient, how did you overcome this situation?

The researchers 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.”
- The researcher 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 must 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. The researcher 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.

3. How do you deal with Muslim patients who decline medication/treatment?

Three of the interviewees working in different surgeries reported their experiences with some 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 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. The patient declined the treatment because I was present in the same room."

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."

4. **Muslim patients who strictly follow their religious restrictions cannot accept the opposite gender to deal with them, please highlight the significance of this.**

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. The researcher 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.

5. Tell me about your experience (if any) when you considered using the advocate model in interpretation.

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 advocate 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 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."

6. How do you deal with Muslim patients fasting during Ramadan?

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. The researcher 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. The researcher 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 the researcher 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, handshakes, 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. Tell me about your experience (if any) with patients who altered or stopped their medication intake due to religious diet restrictions?

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. The researcher 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."

Discussion

The same gender preference of the HCP has been touched on in responses to questions (1-C), (3-E) where interviewees' comments show that the interpreter's use of the advocate model can play a pivotal role in explaining the patient's cultural concerns with regards to getting examined by the opposite gender HCP. Also, responses to questions (4-D, 6-C) interviewees indicate that cultural sensitivity towards the opposite gender physician such as declining handshake or maintaining eye contact as illustrated in question (4-B). In response to question (4-G) interviewee pointed out his experience with female patients who decline or rearrange the treatment offered by the opposite gender.

These responses go in line with Attum et al., (2022) in pointing out the importance of following certain cultural guidelines while dealing with Muslim HCUs of the opposite gender such as minimising eye contact and physical touch between the HCP and their HCU. Parveen et al., (2016) postulate that failing to take cultural factors into a consideration may have a negative impact on the quality HC. Hence, it has been recommended that HCPs must have cultural awareness towards their Muslim patients to deliver optimal HC (Attum, et al., 2022). According to a study, most Muslim patients (both female and male) have expressed their preference for the same gender physician specially during intimate examination (Kamani et al., 2021). Addressing cultural needs and religious expectations of Muslim patients can increase patient's trust in HCP, satisfaction in HC and therefore optimise HCS (Kamani et al., 2021). Thus, some non-verbal communication acts can involve various interpretations in different cultures that could hinder interaction between HCPs and their patients (Kwame and Petrucka, 2021). Delivering HCS that respects HCUs' values and fulfils their needs can play a crucial role in promoting HCS (Kwame and Petrucka, 2021). Thus, to build trust with the HCU 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. Hence, the interpreter's role can extend beyond an invisible language facilitator into being an advocate by talking on behalf of the patient to protect his/her dignity, moral values, rights, and safety (Abdelhamid et al., 2010).

Response to question (1) interviewee (B) comments on the patient's answer "thank you God" means that he was feeling well, and his symptoms improved. The interpreter's use of the advocate model by elaborating the HCU's implicit meaning in a religious context helps the HCP to have a better understanding of the patient's response.

In this context, establishing effective communication between the HCP and the HCU can ensure optimal HCS (Ratna, 2019). Research shows that building effective communication between the physician and HCUs is crucial step to improve the patient's health (Crawford et al., 2017; Schöpf et al., 2017). It has been suggested that the existence of the language barrier in HC can reduce HCPs and HCU's satisfaction, and may impact patient's safety (Al Shamsi et al., 2020).

The issue of lack of training of medical interpreters was flagged up in responses to question (1, F-G), and again in participant's response to question (2-F). Similarly, the issue of lack of training and inefficacy of HC interpreters has been highlighted by Jungner et al., (2021); Pines et al., (2020); Guerrero et al., (2018); Williams et al., (2018); Cheng et al., (2020).

Remote interpretation has been introduced to enable the HCP to communicate with LEPs via videos or telephone interpreting at any time (Marcus et al., 2020; Gutman et al., 2018, Lion et al., 2021). However, response to question (2-F) goes along with another study where HCPs found both telephone and video interpretation as unreliable (Choe et al., 2019) and unsatisfactory (Patriksson et al., 2017) tools of communication. This could be due to the absence of eye contact and body language of the patient. However, the superiority of video interpretation over telephone interpretation has been recognized due to the ability to make body language, eye contact and non-verbal clues visible to the HCP (Marcus et al., 2020; Patriksson et al., 2017). Also, video can provide visual picture of the patient (MacMillan et al., 2020), but still face-to-face provides a better way in capturing full picture of the patient's body language.

The issue of diet restriction has been highlighted in responses to question (3-A-G) interviewees question (7-C-B) which echo Attum et al.'s (2022) in highlighting the importance of disclosing porcine or alcohol medication or treatments ingredients to Muslim patients. Attum et al., (2022) and Attum and Shamoon (2018) add that it is vital for the HCP to replace the religiously forbidden ingredients such as pork or alcohol derived medications with

treatments that go with Muslim HCUs' beliefs when Muslim HCUs show concern or reluctance to accept the treatment. According to Tribe and Thompson (2017), the advocate model in interpretation can ensure that the patient's needs are identified. The interpreter can build effective communication between the HCP and the HCU by acting as a cultural advocate (Campelo et al., 2018).

In Islam, performing some medical procedures can be prohibited. Interviewee (3-B) touched on his experience with Muslim patient who declined abortion. This accords with (Queensland Health, 2010) in pointing out that the HCP should try to provide treatment that does not clash with HCUs' religious beliefs and practices.

Ramadan is the month when all Muslim adult followers perform fasting from eating and drinking from sunrise until sunset (Norouzy et al., 2010). During this month, some medical treatments and procedures can invalidate the fast (ibid). In response to question (3) interviewee (C) showed concerns about the patient's repeatedly rinsing his mouth until the interpreter used the advocate model in interpretation to add more information to get a clearer picture for the dentist about the patient's religious concerns that swallowing water could break his fast. Hence, the HCP had to rebook the patient for another appointment outside Ramadan. Another example was highlighted by interviewee (F) where the patient declines the throat spray for his endoscopy procedure because it invalidates fasting.

These two examples show that using the advocate model in interpretation by asking about the patients' attitudes, behaviours and religious practices can help the HCP to obtain better understanding about patients' needs and accommodate them accordingly. This 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, and therefore optimal HCS (Wheeler and Bryant, 2017). In these situations, using the linguistic model in interpretation may result in confusion and vague information. This aligns with de Moissac and Bowen's (2019) argument that language barriers in HC can result in inadequate understanding of HCUs' situation, prolonged treatment or misdiagnosis (2019).

In response to question (5) all interviewees show interest in using the advocate model in interpretation while disclosing bad news to their patients. Delivering bad news becomes more challenging for the HCP when communicating with LEP HCUs. Adopting the advocate model

allows the interpreter to provide cultural background to facilitate effective communication, thereby acting on behalf of the patient and becoming the patient's advocate can improve delivering culturally competent HC by working as active participants to ensure that HCPs are sensitive to HCUs' religious beliefs to deliver effective communication (Afsharzadegan, 2016).

Responses to question (6) show that even though all the participants are aware of Ramadan, yet two participants demonstrated their experience with Muslim patients while fasting. Participants D and F's responses indicate the impact of fasting on diagnosing patients. The interpreter may remind the physician of Ramadan and leave the HCP to decide whether to ask the patient further questions. In these situations, using professional and trained interpreter can save money by avoiding unnecessary tests (Flores, 2005), and can also decrease hospital stays and admission rates (Lindholm et al., 2012).

Conclusion

Having discussed the results above we can conclude that HCPs are aware of religious restrictions involving some medications, and some religious events and the consequent results on patients. However, HC professionals still go ahead with treatment plans without discussing these issues with HCUs. Religious beliefs may involve gender preference, diet restrictions either due to observing fasting or *haram* ingredients. Overall, this study suggests that HCPs have some cultural awareness in dealing with Muslim patients. Yet, lack of cultural knowledge still exists and some assistance in explaining some cultural barriers is required. Finally, results of face-to-face interviewees show that HCPs have insufficient knowledge of training in using HC interpreters (Dungu et al., 2019; Jungner et al., 2021). Results of this study also show that HCP's have inadequate agreement of the interpreter's role as advocate or only language transfer (Williams et al., 2018). There is need to reinforce the importance of cultural competence amongst HCPs. The results of this study show that it will be useful to use the advocate model in HC interpretation to improve cultural competence.

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