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Professional Dilemmas for Caregivers in Turkish Home Care Settings in Germany

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Abstract

While calling for culturally sensitive healthcare services in migrant communities, the international nursing literature on intercultural care predominantly describes nursing staff as lacking cultural competences and immigrant customers as lacking cleverness to navigate the labyrinths of national healthcare systems. Congruences in language, culture and religion in the customer-caregiver relationship can decisively improve the quality of care. However, they do not automatically guarantee smooth working processes in monocultural in-home settings. On the contrary, new problems occur here for Turkish caregivers which are unknown to the legions of native professionals who feel challenged by migrants and which go beyond differences such as age, sex, income or education. While no cultural or religious brokering is necessary between customers and personnel in the given context in Germany, new challenges arise when caregivers are expected to legally broker between customers and insurance companies or doctors. Conflicting expectations of customers and management as well as their own colliding social and professional roles put the caregivers in a quandary and must be competently managed.

Keywords: caregivers; home care; intercultural competence; migration; Turkish; Germany.

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Introduction

Dozens of shelf meters of nursing literature have already been written about challenges concerning the relationship between immigrants with various national healthcare systems. Specialized scientific and not so scientific journals have been founded, while hundreds of regional manuals for culturally competent care was published. The focus point, however, have almost exclusively been communicative and procedural barriers or conflicting mutual expectations when, for instance, immigrants in general and elderly Turkish migrants in particular are commonly described as using care available to the general public disproportionally. Public health statistics for the German capital Berlin show different numbers. Here, the exponentially growing number of elderly migrants may be underrepresented as to medical specialists and complementary services, e.g. home treatment for psychiatric patients, but they are rather proportionally represented or even overrepresented in hospitals and emergency units. In its consequence, the latter numbers seem to confirm one of the predominant factors mentioned in nearly all publications on cultural aspects in nursing: the importance of information, of practical knowledge, about possible services and the general structure of the respective national health care system, or rather the lack of information. As we will see, evidence from focus group participants in this study demonstrate different findings.. Other factors, however, such as "[understanding of] illness, family structure, decision making, pressure from the community [...] and formal referrals" (de Graaff and Francke, 2003) still play an important role.

What is overlooked in this perspective are manifold peculiarities, which only occur when the patient and nurse share similar lingual, cultural and religious backgrounds. Therefore, several aspects of the customer-caregiver relationship will be examined here. We will show that not even total congruence between customers and caregivers necessarily lead to care-free care, and even though such a seemingly perfect match undoubtedly has the potential to make large parts of current nursing literature superfluous, specific problem constellations may lead to serious professional dilemmas for caregivers.

There is, unfortunately, only exiguous data on Turkish professional home care services (Mergen et al., 2013) which may serve as a background of experience for both customers and staff. With the exception of community nurses, professional home care controlled and paid for by national insurers or the government does not yet exist in Turkey. Its medical and home care market is still traditionally in-patient and institutionalized. Suspicion against the quality of out-patient private care arrangements is widely shared and reinforced by physicians (Kisa and Ersoy, 2005). While national schemes administered by the SGK as the Turkish national authority do finance nursing homes, social centres, community nurses and lump-sums for privately organized home care, the execution of individual long-term care at home is mostly left to the families and without much quality control (Basche and Ergün, 2013). As a consequence, in-home support in Turkey is too often delegated to unexperienced daughters-in-law or foreign housemaids from Bulgaria or other neighbouring countries.

What we find so far in the scant literature are discussions about a hypothetical future of private in-home services. While professional training on home care apparently does not happen yet in Turkish nursing colleges, distinctions known from the German healthcare system, e.g. between health (medical) services and home support (general care) services or in the levels of qualification, are common (Kisa, 2008).

Terminology

We chose to speak of "customers" instead of "patients" or "clients" because, other than in a hospital, rehabilitation center, nursing home or in a hospice, the focus group here has a legal, conceptual and social role that differs from a patient. In all cases of home care, customers in Germany are party to the contract between the health care companies that offer the services and the insurance companies which pay for them. They are given written information by the insurers explaining how much money is available for their care and where they can get help and advice in case they are running into trouble with the health care companies serving them. If the local municipality is additionally involved in cost sharing, customers even receive a minute plan of exactly what kinds of care the respective health care company is obliged to offer them, including a comprehensive price list. In urban areas with very dynamic and extremely competitive care markets, that has led to fundamental power shifts and an extraordinary market power of the customers. The situation looks different in rural areas where there may be only two or three oligopolist care services. In our context, however, these cases are neglectable as most immigrants in Germany live in urban settings. When we say "Turkish customers", we explicitly talk about majority (Sunni) Turkish, not Kurdish or Süriyani families, relying on our own actual experience in a culturally specialized private home care company and in order to avoid unnecessary generalizations. As there are distinct lingual, cultural and religious differences between the various peoples living on or having migrated from the territory of Turkey, this is not without significance.

We also chose the term "caregivers" instead of "nurses" because of a peculiarity in the German health care system where two distinct schemes are applied to health care services for the elderly. Both imply different contracts with the insurance companies (and sometimes local municipalities), different tasks and responsibilities, different levels of qualification of staff and, most importantly, are quite differently perceived by the customers with high formally qualified staff such as nurses receiving higher recognition compared to care assistants such as in-home caregivers.

One scheme applies to strictly medical conditions like diabetes or chronic wounds and is centered on prescriptions by doctors. Prescriptions contain not only medication but also certain medical services like insulin injection, wound therapy, catheterization etc. In most cases, the services prescribed must be executed by accredited nurses. Medical prescriptions often contain nursing aids (decubitus mattresses, wheelchairs etc.) and physical therapy or occupational therapy. These services, however, are not executed by nurses but by other professions like physiotherapists or social workers.

The other scheme applies to affected long-term general conditions which restrict the customers‘ abilities to execute routine daily activities like housekeeping or meal preparation and entitles them to lump-sum budgets, depending on their level of help. The lump-sum can either remain at the disposal of the customers who may want to use it for disbursing neighbors or family members helping them out with their daily needs, or it can be autonomously awarded by the customers to health care companies that are officially accredited by the respective insurance company. In this case, the lump-sum available for contracting services more than doubles, as an elaborate and costly system of legal requirements on the health care companies concerning quality and availability. This second scheme is meant when we say "care" here, and these non-medical long-term services like housekeeping etc. are not executed by nurses but by care assistants, i.e. professional caregivers with short-term training in basic care techniques.

When Turkish immigrants in Berlin do not use professional home care services even when all lingual, cultural and religious requirements are met, it is not because of a lack of supply or knowledge. Instead, it is a conscious decision against one form of help in preference of another.

Immigrants are still statistically poorer than the average population and, accordingly, more in need of the lump-sum provided by the insurers than autochthon customers. That there is sufficient supply of home care on the local level and a strong tendency against institutionalized care among Turkish elderly in general (Ayranci and Ozdag, 2004; Ozer, 2004) has contributed to the fact that until now, no nursing residence in Berlin was successful in establishing specialized services for the Turkish community. Customers are almost entirely served at home, either by family members or by contracted professional services, even though there is a history of nursing residences in Turkey dating back to the Ottoman empire (Esendemir and Ingman, 2011).

Dilemmas of Homogeneities between Customers and Caregivers

Home care is a multi-faceted challenge in which personnel must constantly incorporate ever-changing technologies and devices, new laws and regulations and a more and more complex framework of participating professions. Caregivers, however, are structurally left alone with these requirements as one of their main job descriptions is that they are out on their own with the customers in their respective private homes. Their professional reality are overcomplex demands and undercomplex support. They are expected to provide a favourable and safe physical environment for their customers, to help them with their social and economic well-being and to professionally react to phenomena of self-blame or behavioral disengagement (Tuncay et al., 2008). This is a heavy burden. And other than qualified nurses who usually spend a couple of minutes per day with each customer while executing medical services, care assistants are often present for several hours daily in a customer's home. Therefore, they are valuable sources of information concerning customers' general well-being and must be specifically trained to be aware of potential risks like the prevalent abuse of medication among Turkish elderly (Ayranci and Ozdag, 2004) or symptoms such as fatigue or depression, which play a decisive role in the quality of life of the customers (Tanrverdi et al., 2010).

Lingual Dimensions

We have epitomized that the congruence or homogeneity of language, culture and religionsimplifies not just professional relationships within the healthcare system but any form of relationship (van den Brink, 2003). The advantages of being able to employ personnel who inherently understands what to talk about and, even more importantly, what not to talk about, thus avoiding potential offences to the customers, are obvious. However, exceptions to this rule are plenty. Most importantly, Turkish customers are often hesitant to let Turkish caregivers into their homes as they may know somebody who knows the family so their lives may become too public and private information may be disclosed to the community through someone who understands what the family is talking about, a potential problem that usually does not occur with German staff.

Complex taboos of communication are naturally not as perplexing to Turkish caregivers as to autochthon staff. However, triads between customers, family members and doctors are often unpleasant experiences for the caregivers who have to play multiple roles as interpreter and representative of both the customer and the health care company at the same time (de Graaff et al., 2012). When physicians prefer to talk to relatives instead of directly communicating with the customer, the burden of delivering the message remains with the caregivers who are then unvoluntarily obliged to transfer information but feel uncomfortable doing so because it is mutually perceived as culturally inappropriate. And due to their mostly imperfect German, caregivers often cannot help with bureaucratic challenges, e.g. with finding and approaching

support groups organized by the muncipality or with appointments with regional assessment agencies. These agencies carry out formal tests of exactly what amount of home care services a customer requires. The results of these appointments are therefore of highest importance to the future care. In the eyes of customers, a lack of German devaluates the otherwise appreciated benefits of lingual congruence and, more generally, the excellent work of the caregivers. What used to be an advantage suddenly turns into a disadvantage.

Balancing different communication strategies is another common problem in dealing with Turkish customers. While authoritative language and behavior is commonly expected from healthcare professionals, it neither matches the cultural roles of the caregivers nor their professional identities. In addition, caregivers with the same background of migration are often much more critical of the costumers and the lack of adaptation to their new place of living than politically hypercorrect German social workers. Therefore, they tend to speak out to them in a way unimaginable to official newspeak and unexpected by the customers.

Cultural Dimensions

Apart from community nurses and volunteers organized in community day centers, caregivers with lower qualification levels than nurses do not yet exist in Turkey (Saka and Varol, 2007). Thus, there are no professional, only cultural role models for caregiving. In the context of our focus group, caregivers are often seen as helping friends. Customers in this context have been observed to be disappointed when caregivers did not pay a visit even after a contract had ended (de Graaff and Francke, 2003). While becoming part of the family obviously seems to be a benefiting factor in the beginning, it often turns into a problem later on. As the burden of daily care is mostly on the shoulders of one fermale family member, the usually female caregivers are expected to give additional social and emotional support to the family. Instead of one customer, the elderly patient, there is often one more customer: the informally caregiving family member with her increased risks of depression and burn-out, especially when there is inappropriate or even violent behavior by customers with dementia (Yurtsever et al., 2013).

Not every caregiver, however, no matter their cultural background, is willing to accept the *kız* (daughter) or *kardeş* (sister) role. There are things that are easier to say to a friend and things that are harder to say to a friend. Having an additional social bond can both ease and complicate the working relationship, especially when staff take pride in their newfound role as a professional and do not want to lose it by repeating the patterns of subordination they may have experienced in their own social lives. They may witness behavioral routines they know from their private environment but still dislike, e.g. a hyper-demanding older lady who seems to enjoy her secondary gain, reminding them of their own mother-in-law. Against this background, family is not always a positive ressource. The presence of relatives may even hinder customers' participating in care because they want to show off to their family how well pampered they are. And in the special case of urological care, customers may prefer to have services executed with only the caregiver attending, while the caregiver may prefer to have another family member present.

Feelings of shame, pressure from peers and the extended family, questions of honor etc. are more easily and more efficiently understood by caregivers who share the same cultural background. These factors are most deeply rooted in the so-called first cohort of migrants but not restricted to it. Due to the phenomenon of chain migration, i.e. a steady succession of new immigrants who quickly perpetuate the cultural beliefs and habits of their already settled relatives, most of these challenges should not be expected to disappear any time soon. Thus, the decision whether to accept home care services into the house or not is rarely made by the customers themselves but usually by their children or sometimes a head of the family. In this

context, the whole immediate family is gradually becoming part of caregiving and with it their respective problems: rental problems of the grandson, banking problems of the daughter, TV bills. This makes caring much more complex and demanding than just fulfilling the jobs specified in the care contract. When such problems arise, caregivers often have to try some very basic triangulation by blaming occurring problems on German law or the German insurance companies as the third party. This is, by the way, quite often an effective strategy because it matches the pre-modern perception of the state, and government in particular, as a distant, merciless, incomprehensible entity that many first-generation Turkish labor migrants have brought with them and still harbor.

Religious Dimensions

Religious values and beliefs shape notions of health and illness and, therefore, health outcomes (Koenig, 2009). Intertwined with traditional Turkish culture, the Muslim faith undoubtedly plays a crucial role in the lives of most Turkish people, both customers and caregivers. A true congruence between the two helps avoid cultural mismatches like interrupting prayer sessions because of a tight work schedule and the resulting "cultural pain" (Dayer-Berenson, 2011). Most requirements from the Qur'an and the Hadith such as modesty and privacy of the house are realized in the settings of private home care and need no further deliberations by staff. In addition, there are many examples where religious and cultural factors overlap, as in washing Muslim customers with running water only.

While open to medicine and most forms of medical treatment because life is a gift of God and its sanctity is worth protecting, death has its time and value and is almost universally accepted as a sacred opportunity to begin the journey to meet God (Dayer-Berenson, 2011). To not only understand but also accept this fact which in the nursing literature has often been described as fatalistic is of great relevance, especially for adequate terminal care. More important yet is a respecting approach to the holistic and, in its consequences, rather complex understanding of health which is predominant among Muslims (Rassool, 2000). To be healthy means to live in harmony, and harmony encompasses all aspects of life, social and physical, private and economic (Ypinazar and Margolis, 2006). To heal, then, means to help recalibrate and rebalance the aspects mentioned before, to solve and settle literally every imaginable problem.

Knowing this, mastering the codes, being aware of the cultural and religious subtleties do not spare the caregivers trouble. Customers may ask when exactly to pray. Incorporating the five pillars of Islam in the daily care activities have led to not just medical but religious discussions between customer and caregiver when, for instance, fasting during the holy month of Ramadan / Ramazan is involved in cases of customers with diabetes and, while arguing, one Sura is countered with another. There have been many other arguments about religious details between the two which would not be imaginable between Muslims and non-Muslims, had been reported by our staff back to management and required additional counselling for personnel and customers by the back office. Most challenges, however, are structural. To console and comfort is not part of the legally standardized contract between care companies and customers but is expected from families, as in general it is expected that wishes are fulfilled beyond medical best practice and the exact wording of the contract.

Staff may be disappointed by a lack of gratitude from the customers when whatever happens is the will of God and not a result of the caregivers' work (Halligan, 2006). Caregivers have to take into consideration that not only their customers but also they themselves may believe that illness is predestined, a test from God, an atonement for sins or an opportunity for spiritual reward with each participant in the caregiving process viewed as God’s instrument (Padela and del Pozo, 2011). We assume here that professional care is already accepted and not avoided or

refused for religious or cultural reasons. As we have seen, the caregiver burden (Karlikaya et al., 2013) is often transmitted from the informal to the professional caregivers. If this transmission happens within a religious framework, it is often impossible for the personnel to protect themselves against it. Even more important is to transparently discuss possible limits of religiously grounded demands. It is, for instance, a colossal misunderstanding by some customers that their needs are "not a big deal" (Padela et al., 2011) because finding matching sexes for all services is an often insurmountable hurdle for healthcare companies.

Economic Aspects of Cultural Care

As we have shown above, immigrant customers enjoy an unprecedented market power when it comes to home care services in Germany. That has also led to a remarkable shift in contractual roles. While the nursing literature is still full with self-affirming examples of information deficits due to ignorance by the elderly migrants or inadequate ressources in the respective national health care systems, Turkish elderly migrants – or at least their families – in Germany are usually well informed about their rights within the framework of the social system and make proportionate use of it.

Several aspects play a role here. Not only is healthcare in Germany, other than in most other European countries, with very few exceptions totally free of charge, which makes it attractive to all socioeconomic groups while the good reputation of Germany's healthcare system is a bonus. Thus, there is no reason to be suspicious of the general quality of services. Equally important may finally be another point: healthcare companies – mostly the private, to a much lesser extent also the tax-privileged charitable ones – have widely and successfully specialized in migrant-oriented services and lead robust PR offensives specially tailored at the migrant communities in order to convince potential customers to decide for their respective services. The same is true, by the way, for the big national insurance companies in Germany which lead multi-lingual marketing campaigns aimed at Turks, Russians etc. Where ethnomarketing meets ethnonursing, there are not much uninformed elderly migrants left anymore whom ever-concerned social workers would have to worry about.

A dilemma requires circumstances with a need of choice between two equally unattractive alternatives. One alternative is fulfilling Turkish customers' demands to the desired maximum by at least temporarily accepting the social identity of the *kız* (daughter) with all its cultural implications and, at the same time, potentially contravening conditions set by management or German law. The other alternative is putting into action rational rules dictated not just by the quality manual and best practice standards but also by the caregivers' own professional identities while at the same time making the customers feel like their cultural and religious needs are ignored. These contradictions are not easy to resolve. They contain, however, real opportunities: Never have professionally unqualified migrant women, and among them in particular women with traditional lifestyles, orthodox dress codes and very limited German, been so attractive to the labor market as in today's circumstances of an exponentially increasing demand for low-level home support services where social qualities are more effective and sought after than formal qualifications.

In the last couple of years, the health care sector has turned into a job machine for Turkish women of all ages who live culturally segregated lives and until recently had enormous problems finding sustainable career paths for themselves. This development is in itself a success story which so far has remained largely unobserved by media and politics. There are, of course, also men working among Turkish caregiving personnel, but they are an absolute minority and vastly outnumbered by their female colleagues (Can, 2010). This, again, is especially true in the context of in-home support services. For most customers, male and female, it is unthinkable

men could properly deliver the services they are entitled to, e.g. cleaning the house, buying food, preparing meals or changing diapers. The picture, again, is different for hospitals and other institutions where customers, no matter whether autochthon or allochthon, have much less or no leeway at all as to who they accept for their individual care

Conclusion

International nursing literature on intercultural care predominantly describes nursing staff as lacking cultural competences and immigrant customers as lacking cleverness to navigate the labyrinths of national healthcare systems (Halligan, 2006) while calling for "*culturally sensitive healthcare services*" in migrant communities (Padela, 2011). We do not follow this call. Being sensitive does not make one competent. We have seen that congruences in language, culture and religion in the customer-caregiver relationship can decisively improve the quality of care but do not automatically guarantee smooth working processes in monocultural in-home settings. On the contrary, new problems occur here for Turkish caregivers which are unknown to the legions of native professionals who feel challenged by migrants and which go beyond differences such as age, sex, income or education (Findik et al., 2010). While no cultural or religious brokering is necessary between customers and personnel in the given context, new challenges arise when caregivers are expected to legally broker between customers and insurance companies or hesitantly prescribing doctors. Conflicting expectations of customers and management as well as their own colliding social and professional roles put the caregivers in a quandary.

None of these problems, however, equals a mission impossible. They have to be seen as chances to improve both the understanding of customer anticipations and the overall quality and reliability of the provided in-home services. Simultaneously, management and back office of contracted healthcare services have to be aware not only of the economic and legal ramifications of these quandaries but have to pay special attention to the needs of staff in this environment. Qualified, culturally competent care for customers helps avoid misunderstandings, disruptions in the therapeutic process, revolving-door effects and inefficiency. Qualified managerial support for staff and a well-functioning back office result in reduced burdens of personnel and an enhanced outcome quality. Openly and competently discussing problems occurring in the workplace, i.e. the private homes of the customers, will enable staff to better and more sustainably balance both cultural and professional requirements that they are confronted with and provide them with the necessary help for successfully communicating with customers, their families, other professions and government workers. Sharing good and bad experiences in an atmosphere of trust and understanding is not just a prerequisite for giving good care to customers. It also means caring for the caregivers. Only integrating and balancing these correlative dimensions can close the professional dilemmas.

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