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What's the Emergency Here? An examination of emergency room perspectives on Muslim immigrant patients in Berlin

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What's the Emergency Here?

An examination of emergency room perspectives on Muslim immigrant patients in Berlin

By Janet Ma

A thesis submitted to the Pomona College Department of Religious Studies in partial fulfillment of the requirements for the degree of

Bachelor of Arts

in

Religious Studies

Advised by:

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Preface

In August 2010, Thilo Sarrazin's book *Deutschland schafft sich ab* (roughly translated as "Germany does away with itself") inflamed the public discourse on immigration, integration, and Islam. Directly accusing Muslim immigrants of bringing down Germany's progress as a nation, its scathing words made it socially acceptable in Germany to single out and criticize a particular minority group for the first time since World War II.¹

Though the book cost Sarrazin his job at the German central bank and has been heavily criticized, it has nevertheless found startling success, with a million copies sold by the end of September.² Its national influence has been reflected in new polls that show increasing public hostility toward Muslims. Politicians have also been emboldened by Sarrazin's success, as many of their recent public statements echo sentiments expressed in his book. Even German chancellor Angela Merkel has chimed in, publicly stating in October that multiculturalism has utterly failed and urging immigrants to integrate into the *Leitkultur* of German society.³

Such responses following Sarrazin's book show his claims have struck a powerful match to the already hotly debated issues of immigration, integration, and Islam. Since the second half of the 20th century, these issues have emerged at the forefront of political

¹ Michael Slackmann, "With Words on Muslims, Opening a Door Long Shut.," *New York Times*, November, 13, 2010, accessed December 2nd, 2010, <http://www.nytimes.com/2010/11/13/world/europe/13sarrazin.html>.

² Thilo Sarrazin is a prominent German politician of the Social Democratic Party (SPD) and former member of the Executive Board of the German Central Bank, until he was removed from his position due to his book's controversy. While he is most widely known for his inflammatory comments on immigration, he has a history of controversial and arguably racist public remarks, including in 2010 when he told the weekly newspaper *Welt am Sonntag* that "all Jews share the same gene." See "Immigration Provocateur in Germany Crosses the Line," *Der Spiegel*, August 30, 2010, accessed March 4, 2011, <http://www.spiegel.de/international/germany/0,1518,714567,00.html>.

³ --, "Multikulturell? Wir?," *The Economist*, November 11, 2010, accessed December 4, 2010, <http://www.economist.com/node/17469563>.

debate not only in Germany but across Europe and beyond, reflecting the struggles of once homogenous nations to adjust to the diversifying effects of global migration. Germany in particular is the third-most receiving immigration country in the world, after only the United States and Russia.⁴ Its reluctant efforts to adjust to its changing demographics and shifting urban landscapes, especially those related to Islam, can be seen in all spheres of German life. Its struggles with discrimination against immigrants range from areas such as education, employment, and housing to media portrayal and naturalization.

My thesis, then, proposes to examine an often-overlooked field in which tensions relating to immigration also occurs: health care. It aims to better understand how Germany's health care system, particularly its emergency facilities, have responded to the increasing ethnic and cultural diversity of patients as a result of these demographic shifts, and what still must be done to provide equal and satisfactory health care for all patients.

The bulk of this thesis builds on fieldwork I have conducted in the past year. In the summer of 2010, I spent time researching at the emergency facilities of two different inner-city hospitals located in neighborhoods with large immigrant populations. Drawing upon previous literature that reported disproportionately high usage of Berlin emergency facilities by immigrant patients, I sought to understand what challenges and frustrations doctors and nurses faced as a result of this phenomenon, and how they have responded to a shifting patient demographic. With their perspectives in mind, I returned to Berlin in January of 2011 to understand how they aligned with those of immigrant patients.

Though my research over the summer had encompassed all patients with immigrant

⁴ Dilip Ratha and Zhimei Xu, "Migration and Remittances: Top 10 Immigration Countries," in: *Migration and Remittances Factbook, Development Prospects Group, World Bank, 2005*, <http://www.siteresources.worldbank.org/INTPROSPECTS/Resources/.../Top10.pdf>.

background as a research demographic, I decided to focus on Muslim immigrants, especially those from Turkey and Middle Eastern countries, as this demographic has a particularly high visibility compared to other immigrant groups in Germany, due especially to heightening tensions related to Islamophobia and perceptions of cultural incompatibility. I wanted to understand how societal attitudes toward immigration and Islam have had an impact on their experiences in emergency facilities, as well as on their interactions with the doctors and nurses there.

Though my awareness of these issues first stemmed from my first semester of college, when I wrote a paper on Islamophobia in Europe for my *Religion of Islam* course, little did I know that the theme would be so relevant in the health care sector in Germany. However, after conducting interviews with emergency care doctors and nurses and later with Muslim immigrant patients, I began to see how patterns of discrimination outside the emergency room contribute to an environment already rife with tension, and how the high-stress, time sensitive nature of the emergency room also exacerbated subtle prejudices of emergency care staff as well as patients' perceptions of discrimination.

Contrary to the notion of nondiscriminatory medical treatment of “apolitical bodies” that is perpetuated by emergency care staff, I argue that current emergency room practices reproduce racial hierarchies arising from nationally constructed social practices and cultural representations. Furthermore, I show how the clinical gaze of emergency doctors and nurses function to mask their own awareness of and ultimately reinforce these hierarchies in the emergency room, leading to a denial in the need for reform and possible inequities in treatment.

Accordingly, in the first chapter, this thesis provides a rationale for a study on

emergency medical care for Muslim immigrants in Germany. I give an overview of Muslim immigrants in Berlin and briefly explain how, in the last fifty years, Islam has become inseparably associated with the image of the immigrant in Germany. I also discuss previous studies done on immigrant health and the need for further research to analyze doctor and patient perspectives together to gain deeper understanding of the issues related to immigration and Islam in Berlin emergency facilities. Additionally, I explain the methodology for my fieldwork and my research settings, as well as my position as the researcher. Finally, I discuss some of the challenges I encountered during my research.

In the second chapter, I build on Omi and Winant's theoretical framework of racial formation in order to understand the evolution of current racial hierarchies in Germany today regarding Muslim immigrants. Using the works of Joan Scott, Benedict Anderson, Edward Said, and others, I examine Germany's racial dynamics in two analytical dimensions. First, I discuss how historical notions of nationalism have informed current social structures through a brief history of Germany's immigration practices and . Second, I explore how Orientalism has been used to culturally represent the Muslim immigrant in ways that imagines German national identity as diametrically opposed against a constructed "other."

The third chapter explores the identity formation of several of my Muslim immigrant informants as a constant negotiation with their surrounding racial dynamics, framing this process within the context of integration and Meerten and Pettigrew's theory of subtle prejudice. Through examining the construction of identity around citizenship and "not belonging," Islam, and gender relations and the "headscarf debate," I present

individual narratives which together present a plurality of identities that challenges the constructed boundary of “German” and “other” discussed in the previous chapter. In this chapter, I also showcase a German informant’s experience as a Muslim woman, illustrating what a conversion reveals about the racialization of religion in Germany..

The fourth chapter explores how Muslim immigrant identities continue to be negotiated within the context of the emergency room by examining challenges and misunderstandings within the ER that may influence doctor-patient dynamics between Germans and Muslim immigrants. These challenges and misunderstandings stem from issues such as language barriers, (staff-determined) “inappropriate” usage of emergency care by immigrant patients, family roles in emergency treatment, as well as differences in pain expression. I also examine perceived conflicts related to gender dynamics, such as subordination of Muslim female patients by their spouses as well as possible misunderstandings between Turkish or Arab men and female doctors and nurses. I frame these findings with two theories: first, I apply Michel Foucault’s clinical gaze, a theory I argue has particular prevalence in the emergency room due to the immense subjective power of defining the boundaries of life and death; secondly,. I argue that this clinical gaze subsequently leads to the perceived treatment of what Miriam Ticktin calls “apolitical bodies” a notion of patients’ biological “sameness” apart from ethnicity, class, or religion, despite clear observations and frustrations with perceived cultural differences.⁵ Finally, I discuss how, by ignoring the social and political identities of their patients, emergency doctors and nurses also fail to recognize the racial hierarchies that they reproduce in the very act of ignoring the racial dimension that my findings clearly

⁵ Miriam Ticktin, “Where ethics and politics meet: The violence of humanitarianism in France,” *American Ethnologist* 33(2006): 33-49, 33.

reveal within emergency care.

In my conclusion, I reflect upon the limitations of my research and analytical process as a junior ethnographer. I discuss how, despite these limitations, my research has been nonetheless fruitful in allowing me to suggest several ways in which an emergency department in Berlin may improve upon this model and address the systemic factors that exacerbate misunderstandings and frustrations in an already tense atmosphere. I also explain how my own research experience highlights the difficulty of determining the extent to which language barriers or cultural differences influence doctor-patient interactions, or how significant a role immigrant background actually plays in the challenges emergency care staff encounter during treatment. However, I conclude that such difficulties only heighten the importance of further exploring these issues. Most importantly, I discuss the need for emergency care staff to recognize how Germany's current racial dynamics, built on ideas of nationalism and Orientalist representations, manifest themselves specifically within the emergency room. Ignoring these manifestations result in emergency care staff-patient interactions that not only reinforce the existing power structures subordinating Muslim immigrants, but also prevents the emergency department from being able to provide truly equitable and effective treatment.

Introduction

Muslim Immigrants and Emergency Care: a Rationale

In the past year, my thesis topic has often been met with quizzical looks, blanks stares, and occasionally even raised eyebrows. Immigrant patient care in the emergency room, sure, people would say when I told them the subject of my thesis. But then why *Muslim* immigrants, they asked. What does religion have to do with the emergency room?

When posed that question in the first few months of research, I would launch into a quick and hurried explanation that the majority of immigrants in Germany are Turkish and thus usually Muslim as well, and that would be the end of the discussion. While my response was often enough for whoever had asked for it, I soon realized it did not suffice as a foundation for my thesis. The truth was, I didn't yet have a satisfactory explanation for myself.

I soon came to realize, however, that the connection between religion and the emergency room lies in the very fact that this study is *not* about Islam as a religion. And indeed, I make no attempt throughout this thesis to comment on Islamic beliefs and practices. Rather, following Joan Scott, my thesis is an examination of how dominant *attitudes* toward Islam and *associations* of Islam with immigration shape the dynamics of the emergency room between Germans and Muslims with immigrant background.⁶

While the next chapter delves more deeply into these attitudes and associations of Islam in Germany, I will briefly comment here why Muslim immigrants have become especially relevant as a research demographic. When one examines German

⁶ Joan Scott, *Politics of the Veil*. (Princeton: Princeton University Press, 2007), 10.

understandings of Islam that have formed in the last half-century, it becomes increasingly apparent that while other immigrants, such as the Italian and Spanish guest workers or Russians of ethnic German origin, are also certainly exposed to racial discrimination, the existence of Muslim immigrants has added a new dimension of visibility. Thus, in a country whose national identity has historically hinged on an “us-them” mentality, Muslim immigrants, particularly the Turkish majority, have become the new prominent “other”.⁷ As Stefano Allievi observes:

In the last thirty years... a new element of reflection, and a new analytical point of view, has burst on to the scene: privileging reflection of a cultural nature, specifically religious. At the risk of producing a new reductionism: immigrants are always seen more as Muslims, less as workers, students, parents, children, etc., starting, that is, from their (pre-supposed) identities, rather than the roles they have. A way to re-introduce the category not only of diversity, but also otherness, if not extraneousness, and even, as a consequence that is sometimes theorised, incompatibility, in situations in which it was no longer verifiable and demonstrable from other points of view...⁸

Since the publication of Sarrazin’s book, this ideology of Muslim immigrants as the “other” has only been reinforced in Germany’s political debates of immigration and integration. Christian Democratic Union Party (CSU) leader Horst Seehofer stated it was “obvious that immigrants from Turkey and Arab countries face more difficulty integrating into German society than other immigrants”, concluding that Germany does not “need additional immigrants from ‘foreign cultures.’”⁹

Public opinion also echoes the growing anti-Islam sentiments of the political realm. According to a recent poll conducted by the University of Muenster, only 34

⁷ Stefano Allievi, "How the immigrant has become Muslim. Public Debates on Islam in Europe," *Revue européenne des migrations internationales* 21(2005):135-163, 140.

⁸ Allievi, 142.

⁹ Assaf Uni, “Senior German politician calls to stop Muslim immigration,” *Ynetnews*, October 10, 2010, accessed December 4, 2010, <http://www.ynetnews.com/articles/0,7340,L-3966820,00.html>.

percent of Germans in West Germany and 26 percent in east Germany think positively of Muslims. These numbers are a stark indicator of anti-Muslim attitudes in Germany, even more so when compared with results from other countries such as Denmark, France, and the Netherlands, where at least half of the population hold positive attitudes toward both Muslims.¹⁰

It is important to note that these attitudes toward Islam and immigration are not abstract notions, simply confined within an individual's thoughts and having no bearings on their actions. Rather, they permeate into and inform the interactions in every societal sphere--including clinical settings.

Immigration & Health Care--Previous Studies

As migration increasingly becomes a global phenomenon, more and more attention has been given to immigrant health issues. Researchers from Germany and many other countries are becoming more acutely aware of a multitude of factors that may negatively affect the quality of immigrant health care.

In an article examining the role of racism in health and health care in Europe, Bhopal argues that inequalities in health care between racial and ethnic groups are apparent and abundant, and that racism in health care holds unique social, political, and scientific significance, though it is difficult to determine how much it may contribute to health inequality.¹¹ Similarly, Malmusi et al. found strong evidence of correlations with

¹⁰ --, "Poll: Germans feel threatened by Islam," *Daily News Egypt*, December 3, 2010, accessed December 4, 2010, <http://www.thedailynewsegypt.com/.../poll-germans-feel-threatened-by-islam.html>.

¹¹ Raj Bhopal, "Racism in health and health care in Europe: reality or mirage?", *European Journal of Public Health* 17 (2007): 238-241, 238.

social class as well as gender when analyzing migration-related health inequalities among immigrant populations in Catalonia, Spain.¹²

Emergency care in particular faces unique challenges compared with other health care services. Steadily increasing usage of emergency facilities has been found in most metropolises in the world, a number of hospitals report a disproportionately high use of their services by patients of migrant background compared to those with German backgrounds.¹³

This has prompted a number of studies to examine challenges in emergency departments related to patients with immigrant backgrounds. One study done in Sweden, for example, aimed to identify if staff in emergency care experienced problems in the care of migrants, and if so, what types of problems. The main problems experienced were found to be challenges related emergency care for asylum-seeking refugees, including reported unexpected behaviors in migrants related to cultural differences and non-emergency runs by the ambulance staff because of language barriers between the emergency services centre and migrants.¹⁴

In Berlin, Babitsch et al. surveyed emergency doctors' perceptions of doctor-patient relationships, comparing them according to gender and ethnicity. The results suggested that the patient's ethnicity significantly influenced the doctors' satisfaction with the doctor-patient relationship due to problems with communication and a perceived lack of urgency for emergency treatment.¹⁵ Another study examining experiences of Muslim

¹² D. Malmusi et al., "Migration-related health inequalities: Showing the complex interactions between gender, social class, and place of origin," *Social Science & Medicine* 71 (2010): 1610-1619, 1610.

¹³ B. Babitsch et al., "Doctor's perception of doctor-patient relationships in emergency departments: What roles do gender and ethnicity play?," *BioMed Central Health Services Research*, 8 (2008): 82.

¹⁴ S. Hultsjö and K. Hjelm, "Immigrants in emergency care: Swedish health care staff's experiences," *International Nursing Review*, 52 (2005): 276–285.

¹⁵ Babitsch, et al, 82.

communities with health care services in Berlin found that, while overall there appears to be a greater degree of satisfaction with the service people receive compared to other institutions, most poor experiences reported primarily came from the emergency room (as their focus group was in Kreuzberg, most refer to the *Urban Krankenhaus* located in that neighborhood). Respondents reported dissatisfaction they felt resulted from inadequacy to deal with language barriers, neglect or impatience of the medical staff, and perceptions of discrimination.¹⁶

A Snapshot of Berlin & Muslim Immigrants

I was lucky enough to do a closer and more qualitative study of attitudes toward Islam and immigration while studying abroad in Berlin, a city in which a quarter of the population has foreign roots.¹⁷ I soon found that as the capital of Germany, Berlin was an ideal location for the ethnography I wanted to conduct, a place where political discourses on immigration carry a unique dynamism.

While no official statistics exist for the number of Muslims in Berlin, the Turkish population is by far the largest and most visible immigrant group, the majority of whom identify as Muslim. As a result, Sunnis are estimated to be the largest Muslim group, although there is also a substantial Alevi minority and a smaller Shia Islam following.

Muslim immigrants, along with other ethnic minorities with origins in West rather than East Berlin, tend to live in inner city neighborhoods such as Kreuzberg, Neukölln, and Wedding, where there is a higher perception of safety and tolerance by the non-

¹⁶ --, "Muslims in Berlin," in *At Home in Europe Project* (Budapest: Open Society Institute, 2010), 46-47.

¹⁷ --, "One-quarter of Berliners have foreign roots," *The Local*, July 1, 2008, accessed March 12, 2010, <http://www.thelocal.de/society/20080701-12829.html>.

immigrant population.¹⁸As a result, these neighborhoods are often filled with Turkish fast food restaurants, stores, and markets whose signs often have Turkish alongside German. The border between Kreuzberg and Neukölln is often referred to as “Little Istanbul” for its resemblance to the Turkish capital.

Questions for a Study on Immigrant Patient Care

Few studies thus far have conducted in-depth, qualitative assessments of how immigrant populations in Germany evaluate the medical services they receive in emergency departments. Ethnographies such as Anne Fadiman’s *The Spirit Catches You And You Fall Down*, which examines the detrimental effects on an epileptic Hmong child’s life arising from cultural misunderstandings between her parents and her American emergency doctors, illustrate the need to comprehensively explore the social context of a medical setting in order to truly understand doctor-patient interactions.¹⁹ While subjective evaluations rather than surveys provide far greater insight into the dynamics of emergency care, surprisingly little ethnographic study has been done to examine both doctors’ and patients’ perspectives on the challenges both sides face in Berlin emergency facilities, and to compare them side-by-side. My thesis aims to do this by asking both emergency care staff and Muslim patients of immigrant background the following questions:

- 1) What challenges are encountered during patient treatment in a hospital with a significant migrant population? How are these challenges addressed?

¹⁸ “Muslims in Berlin,” 47.

¹⁹ Anne Fadiman, *The Spirit Catches You and You Fall Down*. (New York: Farrar, Strauss, and Giroux, 1997).

- 2) What mechanisms, if any, have been implemented in emergency care to address specific needs of patients with migrant background?
- 3) What can be further done, on both staff's & patients' parts, to enhance communication and treatment of patients with migrant background?

Methodology

In order to address these questions, this thesis draws on ethnographic work from two different research periods in Berlin. The first set of data was collected over a period of ten weeks from July to August 2010. At this time, I conducted eleven interviews with health care staff from the emergency departments of two hospitals (three at hospital 1 and eight at hospital 2). I established contact to these informants using targeted and snowball sampling techniques, sending out e-mails to the head doctors of eight emergency departments in Berlin. Three responded positively, and from two of them I received further referrals for other staff members within those departments.

Interviewees were all of German origin and included head doctors, resident doctors, nurses, and civilian service workers. All interviews were conducted in German and took place in staff offices or empty patient rooms during work hours, lasting approximately from 25 to 45 minutes. I tape recorded all interviews except for three (when interviewees requested that I not record their interviews).

In addition to interviews, I had the opportunity during this time period to conduct limited participant observation at one of the hospitals where I interviewed. I did this in the form of an eight-week long full-time internship, where I participated in the planning, introduction, and implementation of a study measuring satisfaction of outpatients in that

hospital's emergency department. I worked with doctors overseeing the study on improving questionnaire content and the efficiency of the process. I also accompanied doctors when they released their outpatients, handing the patients the questionnaires and assisting them in filling it out upon request. In this way, I was able to see some limited doctor-patient interaction. However, it is important to note that most of what I heard in my interviews--"cultural differences", language barriers, violence, etc. interactions in the waiting room, etc.--I was not able to observe, primarily due to strict patient confidentiality policy in the hospital's facilities.

To better understand the challenges of emergency care from a patient perspective, I returned to Berlin in January 2011 for two weeks to conduct interviews with Berlin residents of migrant background who had emergency care experiences either as a patient or an accompanying family member. I specifically interviewed immigrants who identified as Muslim, as they comprise the majority of immigrants and also have a higher visibility than other ethnic minority groups in Germany due to their religious beliefs and practices. While there, I formally conducted nine interviews altogether, six with Muslims of Turkish origin, and one of Middle Eastern origin, and two of German origin. Two of these were with Muslim men and seven with women. I conducted all of these interviews in German, using a translator (somebody else at the mosque who was willing to do this) for two interviews when the informants did not speak German. Those interviews conducted with a translator allowed me to gain a perspective of patient experiences in emergency care where language barriers may have affected treatment.

The data collected about the patient perspective came from one Islamic community center, where I conducted all of the interviews except for three, one of which

took place in the informant's home and two in a nearby cafe. I had established contact while studying abroad in Berlin, regularly visiting this mosque on the weekends over a period of four months, attending lessons and often staying after to converse with the members there. During this time, I conversed often and developed friendships with several of the female members there and kept in touch with them after my first stay. Though my initial interaction with the members of the mosque was unrelated to my thesis, those I stayed in contact with agreed to be interviewed when I returned as well as refer me to other contacts.

For all interviews with both health care staff and former patients of immigrant background, a semi-structured, non-standardized, in-depth format was used. This meant that I came in with a general set of questions but allowed the interview to flow where the interviewee took it, asking mostly in-depth questions for further understanding or clarification. At the hospital, I began each interview with asking what the nurse's or doctor's responsibilities were as well as what a typical day looked like. I then asked what challenges they experienced from providing medical treatment in a part of the city with a diverse patient population and generally lower socio-economic status. From there, I would follow-up on their answers, trying to understand what *they* perceived rather than imposing my own preconceptions on them.

My status as a Chinese-American female college student noticeably influenced interpersonal communication during the course of the interviews, though in very different ways depending on the context. With interviews at the emergency facilities with doctors and nurses, this influence was seen in both my position as an 'outsider' of the system and also in the fact that I was not a native speaker of the interview language (German). First,

phrasing questions in the context of immigrant background, especially as a non-German, sometimes seemed to bring out a slight tone of defensiveness due to the sensitive nature of the subject. Also, though my German was fluent enough to comfortably conduct the interviews, I would sometimes make small mistakes; because a large portion of the interviews dealt with language barriers, it is likely that my mistakes may have heightened defensiveness in the answers. As a result, I attempted to make my interviews more free-flowing and less structured than previously. Sometimes this resulted in having to clarify a question I would ask hesitantly ask (due to uncertainty with the grammar) which would then not be completely understood the first time. However, this occasional hesitance with the interview language proved to mostly be advantageous, because it often caused the interviewee to freely interpret my questions sometimes even before I finished asking. This then allowed the interview to reflect the true perspective of the interviewee much more, with less influence from the framework of my questions.

I became particularly aware of this positionality when I had my own experience with language barriers at the hospital. Getting a mandatory shot for my internship, I blanked on the meaning of “Faust” (fist) as the nurse, who spoke to me with a voice one would use for a child (although it must be noted that she was a pediatrician’s nurse), instructed me to close my fist after she drew blood from a vessel in my arm. As she repeated it, I quickly racked my brain on what the word was while pressing the cotton ball harder against my arm in an attempt to follow her instructions. “Nein, *Faust*,” she repeated once more, her voice rising slightly with frustration. Finally, clearly exasperated, she took my fist in her hand and closed it for me. Though the interaction had been altogether amicable (“Now you’ve learned a new German word”, she said as I left),

I nonetheless blushed with embarrassment. My first instinct was to feel that my intelligence had been insulted, and it took a very conscious effort to remind myself not to take it personally (after all, she did say a pediatrician's nurse). However, the experience served to illustrate for me how easily it was to create misconstrued perceptions and subsequent distrust across the language divide, and that day I felt just slightly more like an immigrant patient than an intern for Berlin's premier teaching hospital.

On the other hand, this same position as a researcher had very different effects on my interviews with Muslim immigrants. Even though I had developed a positive rapport with my emergency care staff informants, a strong sense of professionalism was always maintained in both casual conversation and interviewing, especially as my interactions with them solely took place in a stressful work environment. In contrast, I had developed much stronger friendships with my Muslim informants before conducting interviews, having spent more time with them and also interacting with them in atmospheres that lent themselves to more intimacy and personal trust, such as the mosque or their homes.

My status as a non-German and an ethnic minority in my home country also made it much easier to gain their trust, as it was clear through their questions about racism and discrimination in America that they felt we shared a common ground. Their acceptance was furthered by my interest in Islam and regular attendance at their mosque. In addition, language was never an issue as it occasionally was in interviews with emergency care staff, as the interviewees either did not speak German as a native language as well or had close family members who did not. As a result, I tended to be much more relaxed and less self-conscious about making mistakes with my language.

The one difficulty in my interactions with them was the fact that I was not a Muslim, which occasionally strained conversations when they would ask me to convert to Islam or puzzle over why I had not done so despite coming to the mosque almost weekly. However, this generally subsided after I explained that I was interested in learning but not ready to commit to the religion in my heart, and also as my friendships with them strengthened.

I found my own preconceptions, however much I tried to keep an open mind, influenced in the interview dynamic, and during my first few interviews at the first hospital, I sometimes felt I was working along different assumptions than those I was interviewing. My initial questions had been constructed based on the underlying premise that, yes, emergency care for patients with immigrant background was something that differed from that for patients of German background and should be therefore be studied. I quickly learned that not all emergency care staff distinguished their patients this way, especially in one interview where the nurse primarily discussed challenges with treating tourists rather than with patients who actually lived in Berlin. As a result, I sometimes wondered if I was being presumptuous in the questions I asked...I also had to remove questions I had originally included, such as whether education was provided relating to treating a diverse patient population.

It is important to keep this positionality and its effects on my research in mind while reading this thesis. Moreover, any work that focuses on Muslims as a research demographic must acknowledge they are not strictly definable as a group and thus cannot be fully generalized. This thesis would therefore like to emphasize that the interviews conducted with Muslim immigrants may not necessarily be representative of the Muslim

population as a whole, as they all took place in one mosque. Even within this one mosque, I found a set of diverse individuals rather than a static group. This same caution against generalization also applies to the emergency care staff. However, I hope that both the interviews conducted with emergency doctors, nurses, and former Muslim immigrant patients will glean some insight into a difficult and complex issue.

Field Settings

The Hospital

Both hospitals I interviewed at are located in inner-city Berlin in neighborhoods of lower socio-economic status. While one is located in a neighborhood with a significantly higher immigrant population and thus encounters immigrant patients much more frequently, the other hospital receives a substantial number of immigrant patients as well, especially those who come from other neighborhoods. As the doctor explained,

The numbers of patients with immigrant background are different, but right now we have many patients of Turkish and Arabic origin who come from --- Hospital to us for whatever reason. We also have from east Berlin many Russian patients, as well as Vietnamese patients. But altogether we theoretically have patients from every land because we also have many tourists. It's a colorful assortment. (Head Doctor 2)

The hospitals comprised mostly of German staff but both were noticeably diverse, with doctors and nurses of Turkish, Arab, Vietnamese, and other backgrounds.

From the start, it became apparent how many difficulties I would encounter from having hospital staff--especially those in emergency care--as a research demographic.

The first doctor I met with in Berlin, a cardiologist at a hospital at which I ultimately did

not get the opportunity to interview, told me directly that no hospital department would let me interview if I blundered even for a minute not knowing *exactly* what I was doing there.

The structure of the emergency room, with its unpredictable schedules as well as stressful and tense environment, inevitably spilled over into my research. As soon as I stepped foot in the emergency room, it became apparent that emergency doctors and nurses are busy, busy people with not a single minute to waste. In the beginning of my internship, some would look annoyed when I asked where the extra staples were (I soon realized who were the right people to ask) and I quickly learned to stay out of their way and make myself as unobtrusive as possible. The intense focus and high pressure of the emergency care staff filled the air with stress and tension. I often felt out of place when asking questions of any sort.

Additionally, it was extremely difficult to schedule interviews, even with a full-time internship at one of the hospitals. Even when someone agreed to be interviewed, I remained, of course, their last priority (or rather, *not* a priority). It was not uncommon for both doctors and nurses to postpone interviews they had scheduled with me, whether for 20 minutes, several hours, days, or even a couple weeks. Interviews often had to be conducted spontaneously as, without scheduled patient appointments, there was no knowing when a doctor or nurse would have a free moment or suddenly be swamped with an influx of patients. During my internship, after agreeing with an interviewee to postpone an interview to an undetermined time later in the day, I found myself trying to be constantly available in the checkpoint room, fearing that if I stayed too long--even spending 10 minutes organizing the outpatient questionnaires in one of the administrative

offices--any free moment he/she might have would pass if he/she failed to see me and went on with other matters, and I would have to then wait again. It took two weeks to finally interview the head nurse at one of the hospitals, who had to move the interview back four times before she finally had a chance (though she did kindly give me an hour of her undivided attention once we met).

Initially estimating 45 minutes for each interview when asked, I quickly lowered my estimation when interviewees visibly balked at the allotted time (“this interview is supposed to take *how* many minutes?”). Some gave me a strict time limit of 30 minutes before the interview, and I only went over when they allowed me to continue asking questions past the time. One doctor, though he gave me his full attention during the interview, literally bolted out the door when I told him I had covered my questions.

In addition to interviewing, I interned at the hospital located in a neighborhood with a greater immigrant population. Where I interned there were two sections of the emergency department, located separately: surgical and non-surgical. I interned in the non-surgical section, which subsequently tended to have more patients that came, according to the staff, without emergency. The waiting room was located in the hall outside the actual department, where one first registered at the front desk, where the receptionist would then let you through the door. Only interning there for eight weeks, I did not have a key and so became very familiar with asking the receptionist to let me through the heavy glass door. Directly in front of the main door was the office where doctors and nurses printed records, answered phone calls, monitored patients.

Next to the office was the checkpoint room, where the doctors and nurses would take their breaks or hold short meetings. The mood relaxed significantly once you passed

through the office and into the checkpoint room. Snacks, usually brought in by one of the staff, would often be laid out on the table, where nurses and doctors gathered to chat and eat. Sometimes they would make small talk with me, asking where I was from and what I was doing, but mostly they talked among themselves in rapid-fire German.

I was responsible for implementing a survey measuring outpatient satisfaction, whose initiation coincided with the start of my internship. There, I developed the process by which the questionnaire went from the printer (each time a patient was released, one would be printed along with the patient records) into the patient's hands, and back to the office. Due to the demanding nature of the emergency room, it was my responsibility to ease the survey into the doctors' routine, and for the several weeks, I accompanied them to personally deliver the questionnaire to the patient and explain its purpose. It was on me to ask the doctors periodically if they had released a patient. In addition, I organized both the filled out and blank questionnaires as well as the numerous extra ones that had been automatically printed for inpatients or printed out twice.

I also helped improve the questions themselves in the questionnaire, some of which were either unclear or missing information. For example, I noticed one question asking whether the patient had felt their "mother tongue" had affected their experience in the emergency room. This question was of course targeted at those with immigrant background, but the hospital was sensitive about not directly asking about the background or ethnicity of the patient because it could potentially be viewed as discriminatory. However, the question then failed to take into account whether the patient filling out the questionnaire spoke German as his/her native language and ultimately was useless. The survey was also initially only offered in German and unequipped to actually

get feedback from those who did not speak sufficient German to fill out the questionnaire (unless they used a translator). Over the next few weeks, the questionnaire was offered in Turkish and later English; however, it was harder to deliver these to patients as they were not automatically printed out like the German questionnaires and had to be requested by the patient, who may not necessarily find it worth his/her time to do so. When I left after my first trip to Berlin, none of the Turkish or English questionnaires had been filled out.

However, I found that things had changed when I returned to Berlin for a second trip a few months later. In order to save paper, the questionnaire was no longer printed out automatically. Now it has become the doctor's imperative to print out the questionnaire when he or she releases a patient, with the option of choosing the language of the questionnaire (German, English, Arabic or Turkish). While this has resulted in far less questionnaires being filled out on a daily basis--most of the time, the doctors feel it is too much of a hassle and can simply press "No"--more questionnaires are filled out in other languages such as Turkish or Arabic.

The Mosque

As one of the largest mosques in Germany (7 stories high), this Sunni mosque is unique in that it has its own building and is thus much more visible in contrast than the typical "courtyard mosques" of Berlin that rent out spaces. As a result, the mosque has a large and diverse, multicultural membership and also attracts many curious tourists, who members welcome to sit in a lesson or receive a tour of the building.

Its first three floors are dedicated to services and lessons, with men and women separated by floor. As a female, I was allowed on the second and third floors. These floors were especially dynamic during lesson times, when women sat attentively in groups as babies and children happily wandered across the floor. Lessons were given in German, Arabic, and Turkish, where instructions were given in Arabic by an Imam and subsequently translated. The other spaces of the mosque are used specifically for social functions, including a restaurant and bakery, boutique, kindergarten, and lecture room. As the restaurant and bakery face the street, it is frequented by many pedestrians not affiliated with the mosque. Because mosques such as this one often provide an intricate communal network where members share information about local hospitals and offer to translate or accompany others to a clinic, I was also able to hold a number of informal conversations with members whom I did not interview.

Conclusion

As issues of migration and health become increasingly prevalent in a transnational society, examining the systemic factors that affect the dynamics of clinical settings becomes all the more crucial. In Germany, rising anti-Islam sentiments and inseparable associations of Islam with immigration give such research even greater relevancy. In order to analyze the tensions within the realm of emergency medical care in Berlin, it is important to first understand the racial dynamics that inform them. The following chapters, therefore, are in large part an attempt to both explore the evolution of these dynamics in German society, their effects on forming Muslim immigrant identities

formation, and how negotiations between identity formation and racial dynamics subsequently manifest in Berlin emergency facilities.

Providing a Social Framework

Shortly before I flew back from my study abroad in Berlin, one of my informants, Fidan, mentioned some frustrations she had with her last visit to the hospital. As a second generation Turkish-German Muslim woman, she felt they had stereotyped her by talking to her as if she didn't know any German--even though it was her first language. The doctors wouldn't even explain to her what was causing her high prolactin levels, instead using "dumbed down" terminology one would only use for a child. It was all because she wore a headscarf, Fidan explained indignantly, and she was convinced that had she been German, the doctors would have explained her condition in a completely different way. "Why should I even go back if they treat me like this?" she concluded.

Fidan's experiences brought me back to an interview I had with a doctor several months earlier, in which he explained how often women with Turkish background, including those from the second generation, are "repressed in their development." There are many who simply cannot leave the house, he told me, and who then they have no chance to learn good German.

Juxtaposing these two conversations opened up a multitude of new questions about the interactions between Germans and Muslims with immigrant background. I wondered if the doctors who treated Fidan harbored similar notions of Turkish-German Muslim women as the doctor I interviewed did, and whether these notions were built more on an empirical understanding or on constructed images of Turkish-German women.

This chapter, then, seeks to understand systemic forces that have shaped both Fidan's experiences with stereotypes and the doctor's discussion of Turkish-German

women through an exploration of racial formation in Germany. However, analyzing the formation of racial dynamics in any country is always somewhat of a Herculean task, as such processes are complex, multi-faceted, and require an acute understanding of the historical and social contexts in which they occur.

However, in order to be able to deconstruct the underlying socio-political tensions of the emergency department in Berlin, this thesis must first attempt to explore the racial dynamics within Germany at large and how they are linked to the social organization of German society. To do this, I will apply Omi and Winant's racial formation theory in *Racial Formation of the United States* to the specific context within Germany.²⁰

Of course, for one to have any discussion on racial dynamics, it is essential to first put forward a definition of "race", an inherently ambiguous term on its own. According to Omi and Winant, race is a fluid "concept which signifies and symbolizes social conflicts and interests by referring to different types of human bodies."²¹ As a result, race must be examined seen not as an objective entity nor a static essence, but rather a variable and evolving construct specific to a particular social and historical context.

Building on this definition of race, the authors argue that racial formation is a "sociohistorical process by which racial categories are created, inhabited, transformed, and destroyed."²² Such a process occurs through historically situated "racial projects"-- interpretations, representations, and explanations of racial dynamics that are given to organize and distribute resources along racial lines.

²⁰ Michael Omi and Howard Winant, *Racial Formation in the United States: From the 1960s to the 1980s*. (New York: Routledge & Kegan Paul Inc., 1986).

²¹ Ibid, 55.

²² Ibid, 56.

Although Omi and Winant formulated and defended their theory specifically within the context of the United States, racial formation is just as applicable to understanding the racial dynamics that have evolved from Germany's current immigration issues. This chapter therefore builds on Omi and Winant's theoretical framework in order to examine racial formation in Germany as a process arising as the linkage between two analytical dimensions: social structures and cultural representations. I make two arguments. First, I argue that the racial dimension of social structures, defined by Omi and Winant as state activities and policies, in Germany stems from the tension between historically formed notions of nationalism and the perceived threat that immigration poses to German understandings of collective identity. Second, I use Said's theory of Orientalism to understand how cultural representation in Germany has contributed to racial formation.

Social Structures and German National Identity

In *Politics of the Veil*, Joan Scott identifies a fundamental challenge for 21st century democratic politics, particularly in European countries where national identity has been historically inseparable with homogeneity: finding common ground, or a "being-in-common," among increasingly diverse populations rather than imposing an idea of "common being."²³ To do this, she argues, these countries must "stop acting as if historically established communities were eternal essences."

While Scott's argument arises from the controversy surrounding the headscarf ban in France, the challenge she observes is one that has found itself at the center of Germany's immigration issues as well. As a country with a remarkably strong sense of

²³ Scott, 183.

national identity despite national boundaries that have been in flux for the past century and a half, Germany has had a unique historical framework for immigration. Therefore, to truly understand current immigration issues in Germany, along with the racial dynamics that have been constructed around them, one must first trace their roots to over two hundred years ago.

Long before its formation as a nation-state in 1871, Germany had for centuries been deeply intertwined with the phenomenon of migration due to its centrality in Europe and its lack of natural boundaries.²⁴ With the emergence of the industrial age in the early 19th century, Germany became a place of both heavy emigration and immigration. However, immigration quickly outgrew emigration as hundreds of thousands of migrants arrived from countries like Italy, Russia, and Poland to fill the growing need for industrial and agrarian labor.²⁵ This migration pattern only became enforced after 1871, when Prussian territories unified to become the modern political entity of Germany today.

Despite this huge influx, Germany transitioned into nationhood eager to enforce its physical boundaries and new political unity. The new nation-state adopted a mentality of ethnocultural homogenization, forgetting the cultural and religious diversity that had come with its long history of migration.²⁶ In *Imagined Communities*, Benedict Anderson characterizes this phenomenon of national identity formation as the spread of what he calls the “imagined communities” of nationality, which are constructed through a number of processes crucial to creating national identity.²⁷ One of the most crucial of them is the

²⁴ Hermann Kurthen, “Germany at the Crossroads: National Identity and the Challenges of Immigration,” *International Migration Review* 29 (1995): 914-938, 917.

²⁵ *Ibid*, 921.

²⁶ *Ibid*, 935.

²⁷ Benedict Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism* (London: Verso, 1991), 8.

development of vernaculars, which began to serve as boundaries for these communities and form collective understandings of a shared “culture”--in other words, the notion of “one among many of the same kind as himself.”²⁸ Eventually, as more and more historical dynasties in Europe settled on languages-of-state, especially through print, a widespread conviction took hold that “languages were the personal property of quite specific groups and that these groups, imagined as communities, were entitled to their autonomous place in a fraternity of equals.”²⁹ For Germany, this meant a collective identity--or “*Volk*”--built on a shared language, from which also came similar values and cultural norms.

Furthermore, Germany’s nationalism was only enforced by the fact that it had relatively little experience with colonization compared with its French and British counterparts. While German colonies were created in a number of territories in Africa and South America, most were conceded to the victors of World War I and had too transient of a relationship with Germany to develop lasting cultural or political ties. Thus, while traditional outward colonizing countries such as Britain and France experienced massive postcolonial immigration movements from former overseas colonies that challenged the national or ethnic identities of these countries, Germany did not undergo any of these processes as a nation.³⁰ Its relative lack of colonization thus allowed Germany’s ethnic homogeneity to stay relatively intact and grow increasingly integral to Germany’s national identity.

So when Germany began to witness large-scale immigration after World War II, either from countries in which ethnic Germans had settled decades ago or countries with

²⁸ Ibid, 84.

²⁹ Ibid, 85.

³⁰ Kurthen, 921.

whom it had established labor agreements, its national identity was bound to be challenged.³¹ In an effort to rebuild its economy following the ravages of World War II, West Germany³² found itself needing manual labor for rebuilding that far outstripped the very shrunken domestic labor force that resulted from heavy losses to the war effort. This need was even further exacerbated by the construction of the Berlin Wall in 1961, halting the steady flow of migration from East to West Germany. To solve this problem, foreign workers--initially from Mediterranean countries, due to contractual agreements between these countries and Germany--were recruited to work temporarily in Germany and return afterwards to their home countries. Though there was a general mass migration from East to West Europe, Germany was by far the primary destination for the vast majority of these migrants.³³ Between 1960 and 1973, over 18 million migrants came to Germany from Italy, Greece, and especially Turkey. As these « guest workers » were only expected to stay for one to three years, over a quarter of these workers who came during this time period would stay permanently--much to the chagrin of the German government.

Alarmed at the impending permanency of their immigrants, Germany and other European countries began to implement similar programs to ban new recruitment of workers from outside Europe in 1973, even offering incentives from 1983 to 1984 to immigrant workers for voluntary departure. Despite these measures, the migrant populations in these countries did not decrease nor did migrants return to their home

³¹ Yagmur Ozkan, "Europe and its others: Immigrants and new racism in Europe" (Master's of Science Diss., Middle East Technical University, 2007), 58.

³² The number of foreigners that migrated to former East Germany remained comparatively small and insignificant, mainly because of strict regulation of return. Unlike West Germany, immigrants in the East are mostly nationals from Romania, Bulgaria, Poland, Vietnam, Hungary, and some asylum seekers from former Yugoslavia. See Kurthen, 923.

³³ Heinz Fassman and Rainer Munz, "European East-West Migration, 1945-1992," *International Migration Review* 28 (1994): 520-538, 523.

countries as intended. Knowing that they would lose their work permits and could not return if they left Germany, many migrants decided to stay.³⁴

Furthermore, migrants either brought their families or started their own in Germany, establishing even more of a permanency for themselves. After 1974, immigration to Germany for family reunion represented 90 percent of the immigrant population. Birthrates among immigrant populations began steadily to rise during the 1970s and 1980s. Thus, while the migrant worker population stabilized, the overall immigrant population increased after 1973.³⁵

By the time that Germany officially declared itself an immigration country in 2005, when it passed its first immigration law (prior to that, labor migrants were subject to the “Alien Law” and were not allowed naturalization³⁶), there were already millions of people in Germany who had an immigrant background (defined as either immigrants or their German-born children), with strong indications that they had already been there for a long time and were there to stay.³⁷ This is especially true when looking at the statistics today, when just five years after becoming “an immigration country,” over 15 million people in Germany have immigrant background background, second only to the United States.³⁸ One in five foreigners (i.e. those without German citizenship) is German-born, 70 percent have been resident for at least eight years, and almost two-thirds have a permanent residency permit.³⁹

³⁴ Kurthen, 923.

³⁵ Ibid, 924.

³⁶ Ibid, 933.

³⁷ Bernd Gräßler, “First German Immigration Law Takes Effect,” *Deutsche Welle*, January 1, 2005, accessed November 30, 2010, <http://www.dw-world.de/dw/article/0,,1442681,00.html>.

³⁸ -, „Multikulturell? Wir?“

³⁹ Johannes von Stritzky, “Germany’s Immigration Policy: From Refusal to Reluctance,” *Real Instituto Elcano*, 2005, www.realinstitutoelcano.org.

Though Germany has long been--and continues to be--one of the top immigration countries in the European Union, both the government and many of its citizens have been reluctant to let go of the idea that the migrants they had initially recruited in the 1960s and 1970s belonged to another nation, could be shipped back once they were no longer needed, and were therefore--by definition of the term "guest worker"--only transiently present.⁴⁰ To use Anderson's understanding of nationalism, these migrants were never accepted into Germany's imagined community despite living and settling within Germany's borders because their image did not fit into imaginations of German national identity. Scott astutely observes that the constructed binary of western countries versus their Muslim immigrants--in Germany's case, primarily its Turkish labor migrants--is indeed an "operation in virtual community building," in which the national identity of the country is enforced through exclusionary political discourse.⁴¹

Such exclusionary practices based on nationalism arising from common language, ancestry, and social values are perhaps most starkly reflected in Germany's citizenship law. Until 2000, a strictly "blood-based" concept of *ius sanguinis* was used to define a German citizen strictly as someone of German blood and ancestry. Only since 2000 has Germany adopted a version of *ius soli* for those born in Germany to non-German parents with a permanent residence permit or at least eight years of residence.⁴² Before then, however, children of Turkish migrants born in Germany and able to speak fluent German were typically not granted citizenship, while immigrants from countries such as the

⁴⁰ Kurthen, 933.

⁴¹ Scott, 7.

⁴² Gabrielle Fröhlich, "Discrimination in German Immigration," *Peace Review* 16 (2005): 475-84, 476.

Soviet Union who had no ties to Germany other than their ethnic origin could become German citizens.⁴³

Despite this recent reform in citizenship law to grant immigrants without German ancestry full membership to society, the citizenship process has still been criticized as practicing more subtle forms of discrimination against certain groups of immigrants, especially those from Muslim-majority areas. Critics point to certain arbitrary local versions of citizenship test that continue to be administered despite the introduction of a national test in 2008, which includes questions specifically targeted toward discriminating Muslims. In addition, language proficiency tests for spouses wishing to join their partners, which are required only for select countries and exempted for others, such as the United States or Japan, has strengthened suspicions of policies specifically aimed at preventing further migration from Muslim-majority areas such as Turkey.⁴⁴

Perhaps the most explicit of social practices contributing to racial formation in Germany, however, rests on the idea of “not belonging” in the most physical and legal sense: deportability. The core of the immigration issues today stem from the long-held notion that the guest workers were just that – guests, and subsequently temporary visitors whom the government could “send back” at any time. This attitude continued to persist well after many migrant laborers, the majority of whom were originally from Turkey, had begun to settle down and raise families. Even after Germany’s reforms in citizenship policy, a political acknowledgment that their “guest workers” were clearly there to stay, the government has extensively relied on deportation practices to establish who can and cannot belong in its country. In 2003, Berlin *Initiative Against Deportations* documented

⁴³ Özkan, 62.

⁴⁴ Christian Joppke, “Beyond national models: Civic integration policies for immigrants in Western Europe,” *West European Politics*, 30 (2007):15.

that over 50,000 migrants and asylum-seekers were being deported from Germany each year since 1993, including refugees who are refused asylum, civil war refugees whose right to remain has not been extended, and immigrants who either entered Germany without a valid visa or whose residence permit has expired.⁴⁵

Nicholas DeGenova argues that such practices reveal a larger socio-political process of inclusion through exclusion, in which labor importation is premised upon protracted deportability.⁴⁶ As he observes,

“Their “inclusion,” of course, is finally about the subordination of their labour, which can be best accomplished only to the extent that their incorporation is permanently beleaguered with the kinds of exclusionary and racist campaigns that ensure that this inclusion is precisely a form of subjugation. What is at stake, then, is a larger socio-political (and legal) process of inclusion through exclusion, labour importation (whether overt or covert) premised upon protracted deportability.”⁴⁷

The divide in the conceptual framework that has long guided Germany’s labor migration policies and the reality of permanent settlement by its migrants has ultimately led to the discrimination of Turkish immigrants from the public sphere (e.g. naturalization, etc.), or what Stephen Castles calls “differential exclusion”-- simultaneously introducing immigrants into the labor market and excluding them from other areas of society.⁴⁸ The way that Germany has done this, as reflected in its citizenship and deportation practices as well as discriminatory practices arising from the perceived importance of language to national identity, functions to establish social

⁴⁵ “Germany deports 50,000 immigrants a year,” World Socialist Web Site, accessed April 10, 2011, <http://www.wsws.org/articles/2003/oct2003/germ-o02.shtml>.

⁴⁶ Nicholas DeGenova, “Migration and Race in Europe: The Trans-Atlantic Metastases of a Post-Colonial Cancer,” *European Journal of Social Theory*, 13 (2010): 405–419, 416.

⁴⁷ Ibid.

⁴⁸ Stephen Castles, “How Nation-States Respond to Immigration and Ethnic Diversity,” *The Sociology of Race and Ethnicity*, ed. Malcolm Cross (London: Edward Elgar Publishing, 1995), 4.

structures that ultimately create a racial hierarchy in which certain groups of human bodies--in this case, Turkish and other populations immigrating from Muslim-majority areas--are deemed inferior to other groups.

Orientalism: Cultural Representations of the Muslim Immigrant

Social structures alone, however, are not sufficient to explain the racial formation of a certain society. Rather, as Omi and Winant observe, the social structures that serve to racialize specific groups of people are necessarily complemented by cultural representations of these groups. Thus, the racial hierarchies that are created through a state's activities and policies are not only to be institutionalized but *internalized* within its society. To understand this process in Germany, it is necessary to employ Said's theory of Orientalism as a lens through which to understand the power dynamics of European interactions with the "Orient." As "one of [Europe's] most deepest and recurring images of the Other," Orientalism allows the West to convey its own strength by contrasting it with perceived Oriental weakness.⁴⁹ This sharply constructed division thus creates a tension, even a hostility that serves to "limit the human encounter between cultures, traditions, and societies."⁵⁰

According to Said, though Germany was never a colonizing country of the Middle East, Orientalism has nonetheless long existed in the German mindset. Despite its lack of actual experience in the Orient, Said notes that similarly to Anglo-French Orientalism, German Orientalism perpetuated "a kind of intellectual *authority* over the Orient within

⁴⁹ Edward Said, *Orientalism* (New York: Vintage Books, 1979), 1.

⁵⁰ *Ibid.*, 45-60.

Western Orientalism.”⁵¹ What German Orientalism accomplished, was to refine an approach and subsequently apply it to the texts and ideas that the colonizing British and French brought back to Europe from the Orient. This discrepancy in the influence that several prominent German scholars exerted on academic Orientalism and the complete void in Germany’s empirical understanding of the Orient, Said notes, is particularly ironic when one realizes the two most renowned German works about the Orient were based on “a Rhine journey and on hours spent in Paris libraries,” respectively.⁵²

Thus, even before Turkish guest workers first stepped foot onto German soil in the 1960s, Germany had already constructed an entire system of Oriental representations with which to understand this “Other.” However, Germany’s prevailing notions of the Orient did not remain static, but rather have been altered during the course of over fifty years. As Said notes, Orientalism is a “product of certain political forces and activities,” and indeed, understandings of the Orient in Germany have been socio-politically manipulated by evolving representations that both reflect and shape national attitudes toward immigrants from the Middle East, first from Turkey and later from other Arab lands as well.⁵³ These evolving representations then in turn have guided--while simultaneously also being influenced by—cultural understandings of the Orient in Germany that reinforce perceptions of its differences.

Perhaps the greatest of these cultural representations of Germany’s immigrants builds on a long-held Orientalist consensus on Islam’s “latent inferiority.”⁵⁴ Since the years of economic recovery and the “Gastarbeiter” era in Germany, the image of the

⁵¹ Said, 19.

⁵² Said, 19.

⁵³ Said, 201.

⁵⁴ Said, 204.

“Muslim immigrant” have become increasingly visible along with that of the “Turk” in the public eye, particularly after guest workers began to settle down and make Germany a permanent home.⁵⁵ Islam, along with those who practice it, has increasingly found itself at the heart of German political and public debates about immigration.⁵⁶

Though Islam has had a presence in Germany since the arrival of Turkish recruited guest workers of the 60’s and 70’s (also brought later by Iranian and other Middle Eastern refugees arrived en masse under Germany’s liberal asylum policies in the 1980s and 1990s as well),⁵⁷ reaching a membership in Germany of already 2.5 million, mostly Sunni, Muslims by 1990,⁵⁸ it is interesting to note that practicing Muslim immigrants were not initially identified by their religion but rather by their temporary status. Because nobody thought these temporary migrant laborers or asylum seekers would stay, their customs, practices, and beliefs were subsequently regarded as unthreatening.

It was only with the slow realization that these immigrants were indeed making Germany their new home that Islam soon began to emerge at the forefront of national awareness. Along with shaping German society through their restaurants, stores, and markets, Turkish and Arabic immigrants also constructed religious institutions and communal places that have become a prominent aspect of the urban landscape, making a bold architectural statement of their permanence.⁵⁹

⁵⁵Allievi, 140.

⁵⁶ Patricia Ehrkamp, “Beyond the Mosque: Turkish Immigrants and the Practice and Politics of Islam in Duisburg-Marxloh, Germany.” in: *Geographies of Muslim Identities: Diaspora, Gender and Belonging*, ed. C. Aitchison et al. (Burlington: Ashgate Publishing Group, 2007), 11.

⁵⁷ Özkan, 61.

⁵⁸ Robert Pauly, *Islam in Europe: Integration or Marginalization?* (Burlington: Ashgate Publishing Group, 2004), 69.

⁵⁹ Özkan, 12.

While these changes may be viewed in a positive light, they have also furthered the “otherness” of Turkish and other Muslim immigrants in the public eye. As members of Turkish and other communities began to publicly express their Islamic identities, their perceived foreignness within German mainstream society caused initial public tolerance of their presence quickly to be replaced with suspicion and hostility.⁶⁰

The construction of mosques--especially those with domes and minarets--has been met with contention over and over again in different regions of Germany. A 2008 article in *Der Spiegel* noted that the planned construction of over 180 mosques in Germany incited increasing fear of a completely parallel society among many Germans.⁶¹ One large mosque in Cologne that began construction in 2008 made international headlines due to the controversy surrounding its prominence in the city’s landscape.⁶² Jewish-German writer Ralph Giordano went so far to state that its presence was “a conquest on foreign territory; a declaration of war,” highlighting the extent to which mosques are perceived as foreign occupation of Germany’s spaces--architectural manifestations of “the Other.”⁶³

Among Muslim women in particular, perceptions of otherness have also been highlighted by appearance, distinguished through headscarves and full covering. Images of a woman with a covered head is likely to provoke a negative reaction among Germans, with many viewing it as backwards, un-German, and a sign that Muslims are unable to

⁶⁰ Pauly, 69.

⁶¹ Jochen Bolsche, “Domes and Minarets?: Not in My Backyard, Say an Increasing Number of Germans,” *Der Spiegel*, July 8, 2008, accessed December 4, 2010, <http://www.spiegel.de/international/germany/0,1518,565146,00.html>.

⁶² Mark Landler, “Germans Split Over a Mosque and the Role of Islam,” *The New York Times*, July 5, 2007, accessed December 4, 2010, <http://www.nytimes.com/2007/07/05/world/europe/05cologne.html>.

⁶³ Emily Harris, “Two Mosques, Two Different Reactions in Germany,” *NPR*, October 11, 2007, accessed December 4, 2010, <http://www.npr.org/templates/story/story.php?storyId=15043704>.

integrate into German society.⁶⁴ Furthermore, it perpetuates a strongly held notion that Islam is oppressive against women, with over 90% of respondents to the German Allensbach Institute survey in 2006 associating the religion with gender discrimination.⁶⁵

Such statistics reveal the crucial role that portrayal of Islam's gender relations have played in constructing notions of an incompatible Orient in Germany. Rita Chin's examination of shifting national public discourses on labor migrants over the past fifty years, however, shows how even the western feminist movement has played into Oriental thinking through its representation of Turkish women as the supposedly key insurmountable cultural difference between Turks and Germans.⁶⁶ Tracing back to the *Gastarbeiter* era--a time when the German government sought active labor from foreign countries--Chin discusses manipulation of the media to encourage positive public attitudes toward the arrival of the Turks. In the news, images of the Turkish were primarily male: the dominant portrayal of the Turkish was that of a diligent, disciplined, industrious man, while other mediums speculated over their masculinity and sexual appeal.⁶⁷ Thus, their presence was portrayed as positive not only on an economic basis but also a desirable sexuality that fit into societal norms and expectations.

Only as it became increasingly apparent that the "guest workers" were making a permanent home in Germany did the gendered representation also begin to reverse and grow increasingly hostile. Whereas an assuredly positive male image had initially dominated Turkish representations in Germany, Turkish women soon found themselves

⁶⁴ Ruth Mandel, "Turkish Headscarves and the 'Foreigner Problem': Constructing Difference through Emblems of Identity," *New German Critique* 46 (1989):27-46, 42.

⁶⁵ Elisabeth Noelle and Thomas Peterson, "Eine fremde bedrohliche Welt," *Frankfurter Allgemeine Zeitung*, May 17, 2006,.5.

⁶⁶ Rita Chin, "Turkish Women, West German Feminists, and the Gendered Discourse on Muslim Cultural Difference," *Public Culture* 22 (2010), 557-581, 557.

⁶⁷ Chin, 561-562.

as the symbol of what many called an irreconcilable cultural conflict between Germans and Turks. Within two decades, German debates about the gender relations of Muslim residents had starkly evolved to raise fundamental doubts about the compatibility of Muslim migrants with European culture and society.⁶⁸

According to Chin, Turkish women were used to further perceptions of Turks as clinging to traditional customs and backward social practices. The role of German feminists during this period, Chin ironically notes, was to amplify this major shift in gender representation, insisting on the “independence” Turkish women supposedly needed from their constant “repression” by their male counterparts.⁶⁹

By the 1990s, these issues revolving around gender expanded from its ethnic-specific origins to become intertwined with the Muslim status of Turkish immigrants. Having religion encompass perceived gender conflicts moved Islam into the forefront to explain why the values and customs of primary immigrant group were incompatible with those of the German host society.⁷⁰

It is also interesting to note that these cultural representations of Orientalism have not only been a prevalent political tool for driving perceptions of difference in Germany, but in other western European countries as well. Here, it is useful to engage Scott’s illustration of how representation of Muslim women is used as a means of “proving” the incompatibility between Islam’s and France’s attitudes toward gender and sexuality in order to understand racial formation in Germany through Orientalist notions. As French supporters of the headscarf ban portrayed women with headscarves as “either victims of their families or dupes of radical political Islamists,” Scott argues, they conversely

⁶⁸ Ibid, 564.

⁶⁹ Ibid, 569.

⁷⁰ Ibid, 577-578.

“represented themselves as agents of emancipation... saving the girls from the claims of an outmoded ‘culture’.”⁷¹

Paradoxically, these perpetuated ideas of liberation in both France and Germany ultimately serve to enforce the power structures that have constructed by Orientalism for the very purpose of creating racial hierarchies. Chin aptly shows that in the negative portrayal of Orient through the lens of western feminism, the pushed for the “equality” of their Muslim counterparts ultimately succeeded in oppressing them in the imagination of German society.

Recently, cultural representations of Islam have extended beyond negative images of gender relations to associations that intertwine religion and ethnicity with class. Again, Sarrazin’s book is a prime example of this construction of racial hierarchy in Germany, both encapsulating and furthering popular imagination that the ethnicity and religion of Turkish and Middle Eastern immigrants are to blame for statistics reflecting fundamental problems with Germany’s current welfare system. While Sarrazin observes that Germany has made life too comfortable for those on welfare, his true accusations are pointed at the 67 percent of Muslims with immigrant background residing in Germany who “take far more out of the welfare state than they put in,” as one book review noted.⁷² Furthermore, for Sarrazin, these accusations are couched in objective analysis, facts that can only be interpreted as proof of the inherent inferiority of Islam.

Sarrazin’s argument falls into a class paradigm of racial construction, in which, as Stuart Hall characterizes social divisions which assume a distinctively racial or ethnic

⁷¹ Scott, 148.

⁷² David Goodhart, “The Challenge to German Liberalism,” *Prospect Magazine*, November 17, 2010, accessed February 10, 2011, <http://www.prospectmagazine.co.uk/2010/11/thilo-sarrazin-germany-immigration-multiculturalism-review/>.

character can be attributed or explained principally by reference to economic structures and processes.”⁷³ In Germany, cultural representations of Islam as an entity necessarily belonging to a lower class is yet another a manifestation of Orientalism in that its purpose is to justify a European superiority over the Orient through association with lower socio-economic status.

These various cultural representations of the Muslim immigrant reveal that Orientalism, at its core, serves a purpose for Europe to strengthen its identity and thereby dominate, restructure, and gain authority over the Orient through constructing a representation of what “the Orient” is.⁷⁴ To return to Anderson, nationalistic constructions thus not only serve as the basis for exclusionary practices and policies, but they also uphold the cultural representations that place understandings the Orient as diametrically opposed and inferior to the image of Germany.

Conclusion – Toward Integration and Identity Politics

Through examining how racial dynamics in Germany have been formed through social structures and cultural representations, one can see how nationalist practices and notions are pitted against imagined Orientalist inferiority to construct a social hierarchy placing German national identity over “other” identities. Indeed, to follow Scott, the power and allure of German national identity has heavily relied on, especially in the past few decades, the imagined dichotomy of a negatively represented, fixed “culture” of both

⁷³ Stuart Hall, “Race, Articulation, and Societies Structures in Dominance,” in *Sociological Theories: Race and Colonialism* (Paris: UNESCO, 1980), 306.

⁷⁴ Said, 3.

religion and ethnicity against the myth of Germany as a single “Volk” unified by history, customs, and language.⁷⁵

Using this framework of examining racial dynamics in Germany, the next chapter will then examine how racial formation subsequently influences the sociopolitical identities of Muslim immigrants as they struggle to negotiate themselves against systemically produced subtle prejudices, especially in the midst of the “integration” debate. Far from eliciting a uniform response, the process of racial formation in Germany has brought forth a plurality of identities that challenge the notion of a monolithic, fixed “Muslim immigrant” culture.

⁷⁵ Scott, 7.

Negotiating Identities : Muslim, Immigrant, German

Framing Muslim Immigrant Identities – Integration and Subtle Prejudice

Efforts to build a multicultural society in Germany have “utterly failed,” German chancellor Angela Merkel declared last October to a meeting of young members of her Christian Democratic Union party. The concept of multiculturalism, where Germans and immigrants could happily co-exist and “live side-by-side” did not work, and immigrants had a responsibility to do more to integrate into Germany society.⁷⁶

Merkel is certainly not the only politician who has been making such claims; her statement echoes comments a number of other prominent, right-leaning politicians have issued about immigration in the past year (see Sarrazin’s and Karlshofer’s statements in the Preface & Introduction). However, Merkel’s position as chancellor particularly illustrates how the question of integration has framed the national discourse on negotiating immigrant identity. Friedrich Heckmann provides a useful definition for the concept of integration on a theoretical level, which can be applied to the German national attitude:

“[Integration] is an acquisition of rights, access to positions and statuses, a change in individual characteristics, a building of social relations and a formation of feelings of belong and identification by immigrants toward the immigration society. In the context of immigration, integration refers to the inclusion of new populations into social existing structures and the quality and manners in which these new populations are connected to the existing system of socioeconomic, legal, and cultural relations.”⁷⁷

⁷⁶ --, “Merkel says German multicultural society has failed,” *BBC News*, October 17, 2010, accessed March 3, 2011, www.bbc.co.uk/news/world-europe-11559451.

⁷⁷ Friedrich Heckmann, “From Ethnic Nation to Universalistic Immigration: Germany“ in: *The Integration of Immigrants in European Societies: National Differences and Trends of Convergence*, ed. Friedrich Heckmann and Dominique Schnapper (Stuttgart: Lucius & Lucius Verlagsgesellschaft, 2003), 46.

Using this definition, Heckmann then characterizes successful integration by the extent to which ethnic stratification is decreased and similarities in living conditions between immigrants and non-immigrants subsequently increase.⁷⁸ Applying Heckmann's definitions to examine the integration for Germany's largest immigrant population, the Turkish, there is indeed a multitude of literature that points to striking gaps between ethnic Turkish and German residents in all spheres of life, especially on socio-economic status and education.

In 2000, Marieluise Beck, German Federal Commissioner for Foreigners, stated that the rate of unemployment among immigrants continued to be twice as high as that for ethnic Germans. For Turkish immigrants, this statistic was even more exacerbated, with over a quarter of all immigrants in Kreuzberg (the vast majority being Turkish) unemployed and almost half receiving social support.⁷⁹

Exacerbating the gaps in socio-economic status and persistent unemployment are the discrepancies found in education and housing spheres. Due to "a difficult integration of immigrant children in the German education system," many argue that second and third-generation German citizens of Turkish background as well as Turkish immigrant children do not have equal access to the education system.⁸⁰ According to a 1999 report, Turkish-Germans were found to have 4.5 fewer years of school than ethnic Germans on average and that only half as many of the former had high school degrees compared with the latter.⁸¹ And finally, it has been well documented that Turkish immigrants have

⁷⁸ Heckmann, 47.

⁷⁹ Pascale Fournier and Gökçe Yurdakul, "Unveiling Distribution: Muslim Women with Headscarves in France and Germany," in: *Migration, Citizenship, Ethnos*, ed. Michael Bodemann and Gökçe Yurdakul (New York: Palgrave Macmillan, 2006), 175.

⁸⁰ Fournier and Yurdakul, 176.

⁸¹ Pauly, 71.

traditionally lived and worked as an insular group in Germany, and in territorially defined subdivisions that are generally poorer.⁸²

These trends, among many others, are what led Merkel to declare the death of multiculturalism. However, her expectation of “integration,” which echoes rather than creates an already existent national attitude toward immigration in Germany, reveals a troubling pattern in discourse on integration and immigration in Germany: a strong tendency for the host society to place the responsibility on immigrants to eliminate ethnic stratification while ignoring its own historical (and current) role in the purported failure of multiculturalism through, to return to Castles’s term, differential exclusion.

Simply put, the ethnic stratification has grown to become an undeniable problem, and Germany has turned to blame rather than self-reflection. Such an attitude is perhaps best characterized by the racial dynamics discussed in the last chapter; however, Meerten and Pettigrew’s theory of subtle prejudice further elucidates the manner with which racial constructions are disseminated in the German public discourse.⁸³ As this discourse has, for obvious historical reasons tracing back to the NS regime, been more constrained by various kinds of taboos about national culture than any other western European country, such an examination is not only helpful as a framework but necessary to understand German approaches to race.⁸⁴

⁸² Fournier and Yurdakul, 176.

⁸³ T. Pettigrew and R. Meertens, “Subtle Prejudice in Western Europe,” *European Journal of Social Psychology* 25 (1995), 57-75, 73.

⁸⁴ For me, this became almost painfully apparent from scattered moments in conversation with German friends that revealed an all-too-conscious effort to suppress any verbal expressions of national pride or blatant racial discrimination. During the World Cup 2010, the only time every four years when Germans flaunt their nation’s colors in public, a blithe comment I made to a friend about Germany’s patriotism was quickly corrected: “We’re team patriotic, *not* patriotic.” And when it came to matters of race, I quickly learned the word “race” itself (*Rasse*) had become a taboo word because of its World War II connotations. Ethnicity, I was told, was the politically correct term; race was a term now only used for animals.

As Germany has long encouraged conscious suppression of nationalist sentiment since the end of World War II, imaginations of racial hierarchy are often forced to take more subtle, covert forms. This shift, Meertens and Pettigrew argue, necessitates a distinction between “blatant” and “subtle” prejudice in order to understand how different forms of prejudice shape the attitudes toward treatment of immigrants in a host western European country.⁸⁵ In contrast to blatant prejudice—which consists of open acts or expressions about perceived threats from an immigrant group, subtle prejudice is often expressed as belief in the inherent inferiority of the group, and a mistrust toward intimate contact with members of the group (such as friendships or intermarriages). As such, subtle prejudice is more defined by its less confrontational nature, using seemingly objective rationalizations that carry racialized undertones.

However, the function of subtle prejudice still remains--once again returning to Omi and Winant’s framework--to continue the process of racial formation. While this form may carry a less harmful outward effect, it is arguably even more powerful than blatant prejudice. Indeed, acts of subtle prejudice easily become so commonplace and deeply internalized that it they are not thought to be prejudice but rather objective incompatibility, thus providing a way to avoid acknowledging one’s personal biases.⁸⁶ Thus, according to Meertens and Pettigrew, subtle prejudice allows one the added protection from the “realization that one harbors prejudiced attitudes.”⁸⁷

According to Meertens and Pettigrew, subtle prejudice is practiced in three different ways. First is the defense of traditional values, where members of immigrant populations are portrayed as acting in ways that are incompatible with these values or not

⁸⁵ Ibid, 72.

⁸⁶ Ibid, 58.

⁸⁷ Ibid, 73.

acting according to what is seen as “necessary” to succeed in the host country. Second, subtle prejudice can be seen in the exaggeration of cultural differences, where prevailing stereotypes are reinforced through media and conversation. By doing so, those harboring subtle prejudice serve to perpetuate their assumptions of incompatibility by conveying them in a seemingly objective and nondiscriminatory manner.⁸⁸ Finally, denial of having negative feelings toward certain immigrant populations while also disallowing positive emotional responses may also be interpreted as a form of subtle prejudice.⁸⁹

While studying abroad in Berlin, I often noticed similar patterns of discourse in casual conversations with German friends or acquaintances. Whenever I would bring up the topic of immigration in Germany (which, as someone incapable of compartmentalizing research and leisure, I found myself doing all the time), they would launch into familiar rhetoric that I grew to recognize even before someone opened their mouth. Their argument, typically centered on an unwillingness of immigrants to interact with Germans, would sound like something along the lines of: “They [Turkish or Middle Eastern immigrants] need to integrate more... they should learn the language, have German friends, and what not, but instead they just keep to themselves.” Again, integration was clearly seen as a unilateral process which always emphasized what “they”, the immigrants, failed to do--a manifestation of what Meerten and Pettigrew would likely classify as subtle prejudice.

The literature reflects similar manifestations of subtle prejudice in discussing perceptions that immigrants were simply unwilling to participate in German society. For example, some attribute the presence of the isolated ethnic and religious enclaves,

⁸⁸ Ibid, 60.

⁸⁹ Ibid, 58-59.

especially those of Turkish orientation, as a sign of refusal on the part of immigrant families to try and fit in productively with the rest of German society.⁹⁰ Such attitudes then lead to one of the greatest contentions with regards to the integration debate: the perceived cultural incompatibility between Turkish (or other Middle Eastern) immigrants with German society.

Heckmann also extends his definition of integration in a cultural context, stating that “the cultural dimension of integration is a process that encompasses the acquisition of cognitive abilities and knowledge of a society’s culture. Cultural integration also includes internalization of values, norms, attitudes, and the formation of belief systems.”⁹¹

However, some argue that such a definition for cultural integration, echoed in the sentiments of Merkel and her fellow politicians, simply disguises Germany’s desire and push toward total acculturation or assimilation. One of these critics, Joyce Mushaben, differentiates acculturation and integration as two separate concepts: acculturation holds immigrants and their descendants to a standard of “‘sameness’ in values, behaviors, and perhaps even appearance,” while integration should be seen as a “process of mutual cultural adjustment, a kind of ‘change through drawing closer’ that finds both sides moving toward common ground on core values...but allowing for reinterpretation of others, based on contribution of new entrants.”⁹² Ayse Karabat further applies this distinction to Germany, stating that in order to have successful integration, “the countries

⁹⁰ Pauly, 82.

⁹¹ Heckmann, 65.

⁹² Joyce Marie Mushaben, *The Changing Faces of Citizenship: Social Integration and Political Mobilization among Ethnic Minorities in Germany* (New York: Berghahn, 2008), 19-20.

of immigration have to be changed and have to adapt themselves, too.”⁹³ Germany, Karabat argues, is not ready to do this.

Whether integration is the correct term or not for the German attitude toward immigration, these critics nonetheless reveals how Germany’s notion of integration rests on the concept of universality and homogeneity in constructing a national identity, as discussed in the last chapter. The acceptance of "others" into German society thus fundamentally challenges the historical foundation of German notions of identity itself.⁹⁴

Perhaps the greatest flaw in Germany’s integration debate is that it attempts to deny the possibility of hybridity--a concept defined by theorist Homi Bhabha as a new cultural paradigm of “colonial anxiety,” emerging from multiculturalism with the potential to shift the authority of power.⁹⁵ Rather, a dominant perspective of the host society is consistently provided, while the immigrant narrative often remains overlooked or ignored. Such a tendency then only continues to perpetuate the current power structures which prevent the success of Heckmann’s theoretical definition of integration and promote differential exclusion.

And indeed, the national question of integration inevitably becomes a powerful force in shaping not only structural barriers such as ethnic stratification, but also the individual identities throughout their lives. As Katherine Ewing, author of *Stolen Honor: Stigmatizing Muslim Men in Berlin*, observed, “identities are negotiated in interaction.”⁹⁶ First, second, and even third generation immigrants in Germany must constantly struggle

⁹³ Ayse Karabat, “Germany Never Applied Multicultural Policies, Says Kenen Kolat,” *Today's Zaman*, October 31, 2010, accessed February 5, 2011, <http://www.todayszaman.com>

⁹⁴ Ibid, 37.

⁹⁵ Homi Bhabha, *The Location of Culture* (London: Routledge, 1994).

⁹⁶ Katherine Ewing, *Stolen Honor: Stigmatizing Muslims in Berlin* (Stanford: Stanford University Press, 2008), 108.

to understand themselves in the face of a discourse that strives to control their identities through dictating what choices they make are and are not acceptable for the “host culture.”

In addition, as Muslim immigrants build on their interactions to define who they are, this constant formation of identity takes place not just within their own selves, also in the midst of racial constructions that surround them. As Simone Hary notes, “The construction of identity is an ongoing interplay; making identities are situational, depending on self-perception as well as outside reflection.”⁹⁷

Much of the integration debate, however, comes primarily from this “outside reflection”; it becomes therefore only a limited version of what Germany defines as integration, what is expected of its immigrants rather than what immigrants expect themselves. The interviews I had with my Muslim immigrant informants serve to trouble the dominant discourse by providing a plurality of narratives that question the objectivity many Germans purport to have when discussing who has successfully “integrated” into the host society. Each of my informants revealed a unique response to the struggles of constructing hybrid identities that are simultaneously German, immigrant, and Muslim.

Without Citizenship: Existing but not Belonging

While researching in the winter, I first met Nadim on the steps to the mosque as he was picking up his 3-year-old daughter from his wife, a good friend of mine. Although I had known her for months and even gone to her home multiple times, because they lived separately I had never seen him before. I felt it was my lucky day, as I had just told

⁹⁷ Simone Hary, “Kyopo (Korean-German) Daughters in Germany: The ‘Self’ as an Analytical Tool” (paper presented at the UK Postgraduate Conference in Gender Studies, University of Leeds, UK, June 21-22, 2006), 9.

her how I was looking for a male perspective on being Muslim with immigrant background in Berlin but felt hesitant about simply approaching the men at the mosque. And of course, she was delighted to offer him as my next informant.

Though I was excited to talk with him, he didn't make any strong first impressions from our brief meeting. Besides the fact that he was from Lebanon, I didn't know a single thing about him. In my field notes that day, I simply scribbled, "nice, polite, respectful...seems like a good father," noting his affection for his daughter as he played some form of "peek-a-boo" with her.

Even when I had a spontaneous opportunity to get to know him better before my interview when we both had lunch at my friend's home, he was so mellow and unassuming I could only characterize him as a "nice, ordinary guy...and friendly and hospitable." While his wife cooked, we chatted about a variety of everyday topics: I talked about what I was studying back in the States, he told me he had just began an apprenticeship, and when the conversation lulled a bit we poked fun at what was on TV.

A few days later, I met up with Nadim in a Turkish café down the street from the mosque. It was far too early in the morning, especially for winter break, and I showed up still half-asleep and even a little grumpy. Within minutes of turning on the tape recorder, however, I found myself wide awake and trying my best not to stare. Not allowed to attend university in Germany, not allowed to even leave Berlin--was I hearing this correctly?

I learned that Nadim is a Palestinian refugee in his mid-20s, whose family fled from Lebanon almost 18 years ago. Though he says he was too young to remember life in Lebanon, he can still recall the perils his family went through to reach Germany. "I was

still small, and we ran through the woods, dangerous stuff,” he told me. “The snow was so high, up to our knees, in the woods...”

For them, the risk was worth it. His grandparents had first fled from Palestine to Lebanon to escape war, but his family was still not accepted by the country as Palestinians.

In Lebanon we also weren't really recognized because the Lebanese had begun to hate us because we were coming into their land, and so they had a neighborhood for us [Palestinians]. And there things were also going badly for us, there was also violence, with Palestinians and Lebanese and Israelis. Yeah, and so I came with my parents here...over there we have no work. Well, you can work but you won't be paid for it-- or example, they work 11 hours and get maybe 1 Euro or so. It was a difficult situation and always so. We thank Germany that we're here.

He and his family are considered *Geduldete*, meaning their application for political asylum has been denied. He has no legal status and is currently on a *Duldung*, which is a suspension of deportation, or toleration. This means he is officially deportable any day, but cannot be due to the continuing conflict in his home country. He must renew this *Duldung* every 1-6 months, and even then it is not a legal title and entitles those who have one to very little. Nadim and his family cannot study or leave their *Landkreis*, or county, which for them is Berlin.

The laws for refugees are miserable. For example, we've been here since 1992, here for almost 20 years. We are homeless. No papers, no land. And yet they only [officially] tolerate us here. They don't give us German citizenship when we want to apply. We are very poorly treated by the government agency. And we're not allowed to leave Berlin. We're not allowed to go to Hamburg, only in Berlin. I went anyway, but on my papers it says that it's forbidden... I went anyway.

Luckily, for those who have lived on a *Duldung* for many years--and Wissem and his family have lived here for almost 20--a recent policy has been implemented where

they have the possibility to receive legal status if they manage to find work. However, the ban on studying makes it very difficult for many to find work and thus receive a status, especially for those who have not been allowed to study and work for 10 years or longer.

And indeed, Nadim later told me he had already visited the *Arbeitsamt*, the employment bureau, but that they had been giving him a hard time. This is a typical story among irregular migrants, who even with the law on their side often find themselves at the whim of the agency employees. According to Nadim, even extending his *Duldung* depends on their mood.

I don't know what kind of mood they have now, the people there. They might say, "yeah, you all are getting deported"--but where to? There is no Palestine, so they can't send us all away. My little sister was also born here. You can't just send her away, because she was born here...that's why I don't understand, why they can't just give us a German passport. They treat us poorly and such. I'm thankful that I can live here, that my family live here. But the way they deal with us, that's all not good.

If Nadim does find work, he would first get a *befristete Aufenthaltsgenehmigung*, or temporary residence permit, then an *unbefristete Aufenthaltsgenehmigung*, a legal resident status that permits him to stay permanently. Finally, only after eight years of living with a legal title can he try to pass the test for citizenship.

For countries like Germany, in which individual identity is so deeply intertwined with the identity of the nation-state, citizenship has become one of the most crucial markers of belonging to a society, definitely indicating a person's full membership in that society. However, Aradu et al. notes that "European citizenship is marked by a tension: between a citizenship that is derivative of the nation-state, and a citizenship that is

defined by free movement.⁹⁸ If this is true, then deportation--the act or threat of forced removal--reflects the manifestation of that tension in the lives of those who do not hold citizenship.

Deportation has become increasingly examined as a mechanism of state control, particularly in Europe but also in the United States. The threat of deportation not only reflects but reproduces notions of territorial citizenship, enforcing the cultural, racial and ethnic definitions of who are citizens, and subsequently non-citizen, within a nation-state.⁹⁹

Until recently, researchers treated deportation primarily as an inevitable aspect of migration and little else. Compared with other expulsion practices, such as ethnic cleansing or transportation of criminals, William Walters observed that “deportation, because it remains embedded within the contemporary administrative practices of Western states, strikes us as less remarkable.”¹⁰⁰

However, in some ways it is *because* deportation has become such an institutionalized response to migration that it reveals how deep the lines of ethnicity and race run in defining citizenship within European nation-states. This is especially true when one realizes that irregular migrants like Nadim are not the only ones who live in fear of deportation.

When I sat down at the mosque to interview Yağmur, a 63-year-old Turkish woman, she made clear she did not want to be tape-recorded, shaking her head vigorously

⁹⁸ C. Aradau, J. Huysmans, V. Squire, “Acts of European Citizenship: A Political Sociology of Mobility,” *Journal of Common Market Studies* 48 (2010): 945-965.

⁹⁹ J. Berman, “(Un)Popular Strangers and Crisis (Un)Bounded: Discourses of Sex Trafficking, the European Political Community and the Panicked State of the Modern State,” *European Journal of International Relations* 9 (2003): 37-86, 40.

¹⁰⁰ William Walters, “Deportation, expulsion, and the international police of aliens,” *Citizenship Studies* 6 (2002): 265-92, 266.

(she does not speak German, and I interviewed her through a translator). Despite my efforts to ensure her privacy, she told me she had “bad experiences” with such types of things.

However, once Yağmur saw me trade the tape-recorder for pen and paper, she quickly opened up about her life in Berlin. Though she has lived there for over 16 years, she has never received an *unbefristete Aufenthaltsgenehmigung*, or permanent resident status. Instead, her resident status has always been *befristet*, or temporary. “Before,” she said, “I could renew it every 2 years, 2 years, and now it’s always 3 months, 3 months, 3 months.” Along with this, she can also only leave for 3 months; after that, she “isn’t allowed here anymore.” The shortened time has created nothing but more stress for her, she lamented.

Though she has lived in Berlin for so long, what has changed in the past two years is a growing fear of being deported. Yağmur told me the *Auslaenderbehörde*, or immigration office, had informed her she could stay in Germany--if she found work. Otherwise, she would have to go back to Turkey.

Yağmur is particularly afraid of being sent back to Turkey because all her family now lives here. According to her, her husband first came over 20 years ago, when she first came as a tourist in the 1980s and then officially reunited with her family through *Familienzusammenführung*, or family reunion. She has four children, who are now between 24 and 37 years old; they have all grown up and gone to school here.

Despite such threats of deportation, Yağmur has neither found work nor been actively seeking it. This is because, she told me, she has various ailments, including osteoporosis, gout, and high blood pressure. As I was interviewing her, the others around

her interjected--this was an injustice! they exclaimed. The unemployment rate is so high and there are so many younger people who do not have work--why should she be forced to work?

Both she and Nadim illustrate identities that have been formed around the threat of deportation, where a sense of self and belonging must be constructed without full access to the society around them. However, it is important to acknowledge the differences between Yağmur and Nadim as non-citizens subject to deportation, the biggest one being of course the level of deportability itself. Yağmur has a legal status; Nadim, as a refugee denied political asylum, does not and therefore has far less rights. And yet, ironically, it Yağmur is the one who lives in constant fear; Nadim, as a Palestinian refugee from a country of unrest, goes about his daily life with a slightly greater sense of security. He belongs to a category of irregular migrants liable to deportation and yet whom the state cannot yet deport. According to Gibney and Paoletti, such a discrepancy reveals an emergent predicament of liberal democratic states which results in their limited capacity to exercise their deportation powers, thus creating “new forms of quasi-members of the polity.”¹⁰¹

This predicament is, in essence, what has shaped the course of Nadim’s life. His deportability—or, one might say, current lack thereof--is what has allowed him to harbor a sense of membership and belonging on a day-to-day life, even as he is officially denied recognition by the government as anything but a foreigner. When I asked him how he identified himself, I couldn’t help but notice the discrepancy between his official status

¹⁰¹ M. Gibney and E. Paoletti, "Deportation, Non-Deportability and Ideas of Membership" (Paper presented at the annual meeting of the International Studies Association Annual Conference, Montreal, Canada, 2011).

and his answer: “As a mix between Arab and German,” he said. Germany, the country he has made his home, “has also had an influence on me,” he told me modestly.

What exacerbates the differences between Yağmur’s and Nadim’s situations is language. Yağmur is one of many who feel the social burden placed on her for not knowing the language despite living in Berlin for the past 16 years. Logistically, it has been feasible enough for her to get by only knowing Turkish on a day-to-day basis. Her neighborhood has a substantial Turkish population, so that activities such as grocery shopping or visiting the mosque, where she spends most of her time, do not require German. And because she has a Turkish doctor, she does not need German for that either. For situations where she does need German—for example, going to the bureau or filling out paperwork—she can rely on her family members her translation, such as her sister, who has lived her for over 30 years, or her daughters.

“With this age one can’t learn any German,” she told me. She feels that if she were here earlier and came at a younger age, she would’ve learned German and taken German classes and could speak with me, but now she considers herself too old.

Thus, for her, language poses less of a problem of practicality than it serves to subordinate her social status in the eyes of those who point to her inability to speak German as a failure or refusal to integrate.

As the most definitive sign of foreign status, and one that may often be difficult to overcome, incomplete mastery of the German language not only represents a problem of function for an individual immigrant but inevitably also becomes tinged with socio-politically charged implications in the larger context of immigration and integration as a whole. I heard the same phrase, with the same subtle undertone of disdain, in countless

conversations, uttered by everyone from doctors and nurses to my university friends to even several German Muslims at the mosque: “If you live in Germany, you should master the language.” Some would go on to describe how they would obviously learn a host country’s language—say, in Bostwana or Thailand—if they moved there. Others illustrated that when they had lived for an extended period in America, they used English. To live for twenty years and not learn German in Germany, in their minds, showed a clear unwillingness on the part of the immigrant to “integrate” into Germany. Such attitudes thus reveal how, on a subtle level, language has evolved to be used as a means of directing blame or justifying claims of incompatibility.

A significant reason for emphasis on language as the key marker to measure an immigrant’s integration success is the crucial role that linguistic identity has played in Germany in the construction of nationalism. According to Anderson, “languages appear rooted beyond almost anything else in contemporary societies.”¹⁰² Thus, those who immigrate to and live in Germany without learning German are perceived as a threat to one of the most sacred institutions of the nation-state, on which the very sense of national identity is formed.

Nadim therefore has an advantage that even though the German government may recognize him strictly as a foreigner, he has grown up speaking the German language. He completed his *Realschule*, or secondary school, but stopped after that. And though he speaks Arabic with his parents, at the mosque he prefers to go to the lessons translated into German rather than ones given in Arabic--“to make sure I don’t understand something wrong,” he said. “I like going to the German lessons so I understand everything.”

¹⁰² Anderson, 145.

From his and Yağmur's points of view, both feel they have integrated over the course of their many years in Germany. After all, Nadim knows no other land than Germany and Yağmur has raised her entire family in Berlin. In their own ways, they have managed to successfully weave between differences in ethnicities and cultural expectations to create a strong sense of identity that is strongly rooted in Germany. As Nadim observed:

I just find it rather unfortunate; they see I've been here for 20 years. I went to school here, I'm doing vocational training. I don't understand it. I've integrated into this land by going to school here, by doing an apprenticeship here, but still for them, it's not enough...it's really a shame.

Despite the fact that he and Yağmur have made Germany their home for so many years, the lives of both continue with a looming sense of uncertainty, heavily defined—and confined—by the politics of deportation and “not belonging” that govern them. Juxtaposing their narratives of identity alongside that of the government reveals, as Nicolas DeGenova observed, the production of ethnic, racial, and cultural differences under the guise of “apparently race-neutral and presumptively ‘legitimate’ politics of citizenship.”¹⁰³

Being Muslim: The Role of the Mosque in Immigrant Identity

As discussed in the last chapter, much of the opposition toward Islam in Germany and other western European countries lies in the assumption that “integration” means adopting all the secular values Europeans hold, even if it contradicts fundamental Islamic beliefs. There is also an inherent suspicion, as authors Joel Fetzer and J. Soper state, that being “too much” of a Muslim means “not to be really and completely integrated into the

¹⁰³ Nicholas DeGenova, “Inclusion through Exclusion: Explosion or Implosion?”, *Amsterdam Law Forum*, 1 (2008), 33.

Western way of life and its values”. This leads to the popular ideology of “Islam vs. the West”, in which many do not think the two can coexist successfully.¹⁰⁴

Fidan, however, is one of the many Muslims in Germany whose lives challenge this ideology while also illustrating the tensions of being at the crossroads of Turkish ethnicity, German nationality, and Islamic faith. A German citizen, she has lived all 34 years of her life in Berlin, first in Wedding for 28 years with her younger sister and six brothers and now in Kreuzberg with husband, a Turkish man. She is the daughter of Turkish immigrant parents from the *Gastarbeiter* era and speaks both fluent German and Turkish.

Fidan has grown up as a devout Muslim all her life, and is one of longest-attending members of the mosque. Even from my first visit to the mosque, she stood out as a leader in the community, either translating Turkish to German for younger members or teaching Arabic pronunciation of the Qur’an. Almost everybody I met at the mosque knew her, and several times our conversations would be interrupted when she had to be called for translation--we often joked that she was so popular and always had to be everywhere at once.

While she feels that Germany is very racist and discriminatory, she said it ultimately is her home. She could never live in Turkey. As a result, she doesn’t identify either as German or Turkish, but chooses instead to define herself as Muslim. As she lives only five minutes from the mosque, she goes almost every day both to pray, teach, or learn Arabic.

¹⁰⁴ Joel Fetzer and J. Christopher Soper, *Muslims and the State in Britain, France, and Germany* (Cambridge: Cambridge University Press, 2005), 164.

Like many Turkish-Germans, Fidan married a man from Turkey. She told me her brother went to Turkey and met him, and her now-husband liked his character so much that he said if he had a sister, he would like to marry her – no reservations. They were then set up online and started chatting; he saw a picture of her and she got to see a videoclip of him (she laughed when she told me this recollection). They got along online and decided to get married. However, the process was a long and tedious one.

“It took us several years to get him a marriage permit to be able to come to Germany and get married, so we went to Turkey to get married “by Islam” first. Then once we got the permit, he came to Germany,” she told me. She pointed this out indignantly as a sign of discrimination toward Turkish immigrants: “If he were American, he would’ve gotten it right away, but they don’t want more Turkish people to come.”

While Fidan has always grown up as a devout Muslim in the Islamic tradition, many in the second generation have consciously appropriated Islam as an integral part of their identity as an collective act of defiance toward the racial formation taking place around them. To understand this phenomenon, it is useful to return to Omi and Winant, who discuss cultural nationalism as a reaction of an oppressed community which gives rise to a stronger sense of collective identity, or “peoplehood,” through various cultural elements. Kaan, a 25-year-old frequent mosque attendee with a Turkish mother and German father, described the mosque as an important institution that not only brought the community together, but conferred a collective sense of power just through its architectural prominence.

Melike, a 26-year-old Turkish-German woman and currently doing her *Abitur*, or her diploma requirement before college, is one such member of the second generation who did not grow up practicing Islam but felt drawn to the mosque. While her mother immigrated to Germany as a child and still has difficulties with the language, Melike speaks German perfectly with a soft voice. Having been both born and raised in Germany, she identifies as more German than Turkish. However, there are situations and aspects of her life where Melike says she identifies as more Turkish.

I would say sometimes I feel German and sometimes Turkish, but I'd say more German simply because I've grown up here. I've taken up the German culture more. When you grow up, you do it automatically. When I'm in Turkey, they can tell from the way I talk that I grew up here.

For example, this feeling of family—that, the Germans don't have as much, that the kid stays with the family until marriage, and such, or with Germans it's more common that as soon as they are independent that are sent out. Those are aspects that I don't identify as much with German. And also with respect to this openness, I don't like that—there I'm also more Turkish. But for other things, German.

Despite those differences, Melike does not see this biculturalism as clashing, but rather as opening her mind to accepting other cultures.

I don't really see a conflict, because I think that depends on the person himself and if you're open to other cultures and know who you are and how you think, what you know, what you want. When I was an au pair in America, it was a different culture, and with a Pakistani family it was yet another culture. And there was a mix, but going about it with openness and acceptance and tolerance, it was never a problem. There are always things, issues, where you can't go deeper into because then your opinions differ and you simply have to stop, or—yeah, it's hard. When one is “so” [closed], then it's difficult.

She also sees her foray into Islam as deeply personal and individualistic, apart from her ethnicity or the surroundings in which she was raised. Though she grew up with a practicing Muslim mother and Islam in the household, she does not think of Islam as

much of a cultural tradition but rather as something she learned much later. In fact, she told me, only for the past year has she begun seriously exploring her religion. While her mother has worn a headscarf since she was married, at 19, for Melike the path to Islam—and this particular mosque—has been, in her own words “a long story.” When I met and interviewed her, she was fully covered, with a long jean skirt and a silky purple shawl. However, she told me she had only begun dressing like this in the past year.

I first started out dressing open, like normal. And then at some point I started to ask my mother’s family in Turkey a lot of questions, like the cousins, aunts, etc. And when I was here in Germany, a cousin of mine took a lot of time for me to answer my questions via MSN—what happens when we die, why one should cover herself, how important it all is—as if I came from another religion. I found everything really interesting, and over time I started having a fear, a fear of God in my heart. I started having a fear of doing something wrong, because I started gaining a greater understanding of why we are here, what’s expected of us, and such.

It was clear Melike felt inextricably drawn toward Islam, though she couldn’t quite explain why. Soon after, she felt compelled from within to start acting on her faith.

My first prayer came spontaneously – it wasn’t planned... I was on the computer once and read a prayer. And so I began to praying. I stood up – it wasn’t really logical, I didn’t know how to pray or any of the positions. I just situated myself – it wasn’t even a real prayer, I didn’t say anything out loud and didn’t know anything. But nonetheless, I prayed. And after that, I felt good, and that was the beginning. That was on August 10, 2009.

Her learning came to a pause when she traveled to New York for four months to work as an au pair for a Pakistani family, but even then she observed the different aspects of Islam from a Muslim family. When she came back, she was eager to continue learning.

Since December, I started going to the mosque. But I didn’t want to go the mosque without covering myself. So first I was with a group with a friend, she had a friend there who brought me to this group. And I was there for a few months, and I went regularly and asked a lot of questions there. Why should we wear a headscarf, how important it is – some of them had their necks showing – if that was okay, a lot of little things. And they answered them, and after maybe 5-6 weeks later, I began to cover myself. And I

found it so beautiful--[the women in the group] wore such beautiful, long clothes.

Around that time, she received an invitation for the dedication of this mosque at the weekly Turkish open air market. “We went out of curiosity to the opening, and I’ve been there ever since.”

Before that, however, she tried out several other affiliations, none of which seemed to be what she wanted.

I went several other groups, private groups before this one. I was also at another mosque. They didn’t have so many lessons. It was pretty empty, and I didn’t like that. I wanted to learn a lot, and I didn’t have any patience. I wanted to learn a lot and quickly. And here, I also asked a lot of questions. And they really took time for me, were very patient, and answered my questions. Because in the other places, they would say, for example, ‘Stay here for a couple of weeks, and you’ll see that this is the right place.’ This mosque didn’t do that. They told me, ‘Pray to God that you are on the right path, and you will see with time.’ I liked that. And I liked how they talked and their lessons, yeah. It was so warm and comforting.

Since then, she has gone regularly, and sure enough, I saw her almost every day at the evening lesson given in Arabic and translated.

Yağmur, on the other hand, attends the mosque every day because she views it as a safe haven where she feels comfortable with her surroundings, the language, and most importantly a shared culture and religion. Nadim, too, turns to the mosque for direction and stability amid the uncertainty and restrictions imposed on his life. Except for when he feels sleep deprived and doesn’t want to “misunderstand the lesson,” Nadim has attended this mosque almost every day for almost 10 years.

This mosque plays a biiiig role [in my life]. If I didn’t have it, I might be a criminal or something, in jail or something. Because they teach us what the prophet said—that you shouldn’t steal, that you shouldn’t do this...they have really already taught me so much. If I didn’t have it, I would break down, I’d be like so many other youth--either in prison or something else

along those lines. That's why they've played such a big role in my life. When I'm there, I also feel good. When I don't go there for a week, I feel really bad inside. I feel completely different. It's really great, this mosque, I can definitely recommend it to you.

For Nadim, the mosque is also especially significant as a source for support and guidance because he feels both have been lacking from his parents. "The parents are essentially supposed to teach their kids, and I didn't have that," he told me a little wistfully. "So that's why the mosque has been such an important part, and if they didn't exist I'd be broken. Really."

For many Muslims immigrants--and especially for those like Nadim and Yağmur, whose official status of "not belonging" makes having a place of belonging even more important--the mosque serves functions far beyond the strictly religious. One of these is to meet the needs of immigrants transitioning between two very different cultures, providing comfort and a sense of belonging. Furthermore, these religious institutions offer social capital to Muslim immigrants, allowing them to still find meaningful social positions, both religious and nonreligious, in spite of the downward social mobility they often experience in their host society.¹⁰⁵

Islam, Gender, and the Headscarf "Problem"

In the words of Chin, "Muslim gender relations, in short, now serve as the most telling symptom of the supposedly intractable clash between European civilization and Islam."¹⁰⁶ And as Scott observes, "the ultimate proof of the inassimilability of Islam thus comes down, or adds up, to sexual incompatibility."¹⁰⁷

¹⁰⁵ Ehrkamp, 14-17.

¹⁰⁶ Chin, 558.

¹⁰⁷ Scott, 174.

However, it is important to note that the sentiment of sexual incompatibility is not unilateral. Not only has it become a widespread notion among Germans, but one I noticed also expressed by my Muslim informants. In explaining to me how he feels “German” or “Arab”, Nadim gave the example of women:

The Germans are more – well not all Germans – but they are much more open, which for us and in our religion doesn’t fly, that a woman [shows herself]. So in that respect I’m more in my religion, and in that respect more Arab...how should I explain that to you, it comes out so macho, but I want that my wife clothes herself in that only I can see her. That kind of thing. These people, they are a little more – another culture. Yeah, the Germans are very different.

As discussed by Chin, historical literature shows such perceptions of incompatibility are not rooted in objectivity but rather constructed, evolving as perceptions of Turks and Muslims in Germany have gradually shifted. Nadim’s comment suggests that the discourse on perceived cultural differences in gender relations may be internalized by not only Germans but Muslim immigrants as well.

Yet while my Muslim informants often acknowledged differences in approaches to sexuality, they often spoke about the subject with a defiant edge in their voice, eager to distinguish between “difference” and “incompatibility.” Throughout the time I attended the mosque, I would notice tensions between my own preconceptions and the self-consciousness my Muslims informants sometimes displayed toward these preconceptions. When I observed something that made me just a tad bit uneasy, I would force myself to reflect on how much my mind instinctively sought to reinforce notions that had no empirical basis. My friends, in turn, would never lose an opportunity to reassure me of their “independence,” clearly a conscious retort to the notion of Islam’s

repressive nature that Chin attributed in part to German feminism.¹⁰⁸ Time and time again, they would tell me that both the mosque and its members emphasized gender equality as well as an openness to those who choose to not cover themselves, giving me countless examples of women at the mosque who didn't wear headscarves but nonetheless were strong Muslim women with strong faith.

Yet while nobody looked twice at those who came without a headscarf to the lessons, I couldn't help but sometimes feel the pressure to wear one. I sometimes had a sneaking suspicion that many of them simply assumed those not wearing the headscarf were not Muslim but coming to learn and eventually convert (though I later learned that some of the women also didn't wear a headscarf outside of the mosque). And incidents here and there would make me wonder what really constituted "gender equality"--when Fidan's husband came back from a business trip to China, for example, Fidan scrambled to find me a headscarf before I met him.

Given the centrality of gender relations in constructing a cultural incompatibility between Muslim immigrants and their host society, it should therefore come as no surprise that the headscarf in particular has become one of the most contentious symbols of Islam in Germany and the rest of Europe, for both Muslims and non-Muslims. However, it is important to note that discourses surrounding the headscarf illustrate far more than a dichotomy between Germans and Turks. Rather, the controversy is a reflection of the ways that identity, as well as inequality through the process of

¹⁰⁸ Chin, 557.

“othering”, are constructed by both those who oppose headscarves and those who wear them.¹⁰⁹

Many in the German host society also have adopted rhetoric through which the headscarf becomes a symbol of a Muslim woman’s unwillingness to participate in the host culture or an incapability to integrate. And in Germany, some Turkish women even perceive an *expectation*, however subtle, from Germans to wear headscarves as an indicator that they are Turkish.”¹¹⁰ The headscarf, then, has evolved in the debate of integration to signify not only a religious identity but an ethnic one as well, seen by the host society as something inherent to not just Islam but also Turks. Thus, as Mandel notes, “the act of uncovering...strips Turks of some of their Turkishness to allow them to join a homogenized German whole.”¹¹¹

Scott’s observations of the headscarf debate in France may also be applied to that in Germany. As she noted, those who supported banning headscarves argued an objectivity and universality to their particular notion of gender equality--their ideas were not simply French, but universally accepted as being correct. In doing so, these supporters inevitably relied on generalization and caricaturizing the beliefs and practices of Muslim women.¹¹² As Scott observes:

The attack on the Islamic headscarf leaves another veil in place, one that covers over the contradiction between a highly particularistic (“singular”) claim to a universalism that can and must only be French and the insistence on the elimination of difference (in this case, the difference of Islam) as the only viable way to maintain the integrity of the nation-state.¹¹³

¹⁰⁹ Mandel (1989), 29.

¹¹⁰ Ruth Mandel, “Second-Generation Noncitizens: Children of the Turkish Migrant Diaspora in Germany,” in: *Children and the Politics of Culture*, ed. Sharon Stephens (Princeton: Princeton University Press, 1995), 275.

¹¹¹ Mandel (1989), 38.

¹¹² Scott, 168.

¹¹³ Scott, 182.

For Muslim women, on the other hand, the headscarf has become to embody the variety of meanings Muslim women in Germany find in wearing it. Some may see it simply as an expression of Muslim faith and praxis. Some may regard it as an identifier in a non-Muslim space, a clear sign to other Muslims of her religious identity. For others, it may serve as a guide for how to engage with their surroundings.¹¹⁴ And finally, in reaction to the perceptions and pressures of the host society to unveil, the headscarf has also come to serve as an act of resistance.¹¹⁵ Such plurality challenges, as Scott notes, the “deep uneasiness evoked by Islam’s different ways of regulating sex and sexuality,” which arises from a prevailing notion that Islam does not regulate sexuality the way as expected by its host society and therefore its approach to sexuality must show that “something excessive, even perverse, was going on in Muslim communities and households.”¹¹⁶

The first time I went to the home of a Muslim woman, Fidan’s, it was immediately apparent the notion of perverseness within the Muslim household was simply untrue--and yet there *was* something new that I had never experienced before. I had already known Fidan for three or four months when she invited me to cook dinner. Though we had already established a strong friendship, when I stepped into her home for the first time I felt like I was entering a whole new world of hers. It was her hair that made all the difference.

Before, I had always met her at the mosque, where she always had her hair covered under a headscarf and her body carefully covered by a long jean skirt, a black top

¹¹⁴ Ozyurt, 15.

¹¹⁵ Mandel (1989), 38.

¹¹⁶ Scott, 168.

over a white long undershirt. At home, she seemed much looser and comfortable with her clothing and herself, wearing a tan sweater to match tan sweats. Her hair, pulled back in a braid, barely fell past her shoulders. An outfit I would deem publicly wearable by my own clothing standards seemed like pajamas on her.

Fidan's sister also joined us for dinner. She had a sharply defined face, with dark eyeliner and thick mascara to match that bold look she often had in her eyes. But again, it was the hair that caught my attention. I had never given much thought to what Muslim women might do with the hair they kept covered all the time, but I was surprised to find how *chic* her hair was – she had long, silky dark brown hair except for the blonde part she had dyed, which she pulled back and clipped on the top.

Over dinner, they eagerly shared their lives and thoughts with me, and we had a lengthy discussion about what their headscarves meant to them. They had worn grown up wearing it, and their mother wore an even more traditional version that Fidan called a “creative variation on the burka.” However, they told me they wear it because it is required by God and it is a sin, albeit a small sin, to “go open.” Furthermore, as only family and female friends are allowed to see them with their hair, Fidan and her sister feel that the headscarf helps distinguish between their private and public lives more strongly. Never once have they thought of it as a sign of subordination; rather, it acknowledges the differences between men and women.

Like Fidan and her sister, Melike chose to don a headscarf ultimately because it was what she feels God wants her to do. But while her mother has worn a headscarf for all of Melike's life, it was never imposed on her or her sisters. And though she had had experience wearing it as a child, it was something she had to rediscover as an adult:

My three sisters and I covered ourselves when we were younger. For three years or so. I think starting when I was 6. Without being forced. It was out of curiosity; for kids, that was normal. And then we stopped when we were 13 or 14. And so for me the headscarf wasn't completely new. It was for me a different experience, because I didn't know why I wore it before and now I know. My mother had always prayed, but she never sat down and taught us anything, that was missing. I had the headscarf but we were also often on the balcony open or didn't pray. We didn't know *why* we did anything, not the way as an adult I've learned why you do something.

Interestingly enough, Melike's story--rather than that of Fidan or her sister--echoed the experiences of most of the Muslim women I interviewed who had immigrant background. Though Mandel takes note of Muslim Turkish girls who, in "taking off their scarves in secret once they are out of sight of their families' might be resisting their parents, who insist that they wear it,"¹¹⁷ my interviewees suggested a reversal of this narrative. One of them told me of how she needed to build up the courage to begin wearing a headscarf in public, as she had worried for a long time about how those around her would react to what was so often perceived as subjugation to men:

I haven't worn [the headscarf] for that long. For 6 years now. Before I didn't really practice [Islam] and also didn't learn that much. And then at some point I was ready to wear the headscarf. I even set a date, put it on my calendar, but then I started to wear it even earlier. It just happened, when I was coming from the mosque, and I felt so great and so safe and so secure...because already whenever I went into the mosque, I had put on a headscarf, and then...it was for me like, I should wear it now. It came completely on its own.

I found that this last assertion, that the choice to wear a headscarf "came completely on its own", was a conscious addition to many narratives I heard concerning headscarves. Each was clearly aware of the perceptions of gender inequalities and subordination of women that are so closely associated with the headscarf. Fidan even directly assured me of her equality in her marriage, and many others asserted their

¹¹⁷ Mandel (1995), 275.

independence and free will apart from men. Many told me of interesting benefits that came with wearing the headscarf beyond the usual privacy and protection from prying eyes; for example, living with the headscarf in a non-Muslim space nurtured their patience for the intolerance around them, gave them a higher purpose, a duty to act for something more than their individual selves. One woman at the mosque told me the headscarf made her consider any action she took, especially because she knew people would take her actions to reflect Muslims as a whole; she appreciated the accountability it gave her for every step she took, forcing her to think through each and every decision she made.

The Islam factor--What a Conversion Reveals about Ethnicity & Religion

Ulrike, a 26-year-old German woman who converted to Islam at age 14 and began donning a headscarf six years ago, provides a stunning case study to examine the effects of religion for a covered woman and the inevitable associations with ethnicity and immigration status.

Though I had already met Ulrike several times at the mosque, I only began to really get to know her the first time she invited me along with another German Muslim woman, Julia, to her home for her dinner. They were longtime friends; both had adorable one year-old daughters who served as playmates for each other. Ulrike had a Middle Eastern husband, whom she specifically requested to be away that night so we could talk freely. Julia had a German-born Turkish husband.

Though I felt self-conscious stepping into her home in a short plaid skirt with no headscarf, Ulrike only laughed warmly when I told her so. "We're all women," she said. Both she and Julia were dressed casually but modestly without headscarves, revealing

Ulrike's strawberry blonde and Julia's silky light brown hair. As with Fidan, I felt like I was stepping into a different, more intimate, world of theirs.

Both of them were eager to answer any questions I had for them, with Ulrike jumping right into her conversion experience. Though Ulrike had a Muslim husband, she emphasized the conversion was an independent decision years before she had met him. As a young child, Ulrike told me, she had always been curious about different faiths. Though her parents were Christian (though they never baptized her) and she wore a cross, she rejected the religion because it didn't click with her. She exploring other religions started ("more subconsciously than consciously"), but none of them spoke to her; somehow the warmth was missing. Then a friend of a friend, recognizing her interest in religions, invited her to the mosque she now attends, where we met. And one day, on the subway, she made the decision to declare the profession of faith aloud. Though she had had the intention to officially convert for a while, at the urging of her friends at the mosque and thoughts about what would come after her death, she made the bold and simple move.

It was something that was small and yet not small at all...and then I said [the profession of faith] and it was the most beautiful moment of my life, more beautiful than the birth of my daughter. Because I did it from my heart, and it was as if my whole body was cleansed from top to bottom, a truly beautiful feeling.

The moment she said the words to the profession of faith, she told me, tears poured down her face. Though she would continue her old lifestyle—"not treating [her]self well, taking drugs"—and did not begin practicing Islam for several years after that night ("I was 'undercover'," she said with a smile), that night she felt an utter release from the troubles in her life.

Indeed, it was a difficult transition. Her family, unsurprisingly, objected. Several months later I would meet her mother when we all had a delicious lunch at Ulrike's home. It was clear that time had eventually cultivated a kind of begrudging acceptance, as her German mother silently acknowledged her fully clad daughter cooking Mediterranean cuisine.

Practicing Islam also became, whether Ulrike liked it or not, a way of finding out who her true friends were. She still maintains a strong friendship with her closest non-Muslim friends, who have always been supportive of her decision, though there are some who disapproved of her decision and avoided her. She grew closer to those non-Muslim friends who supported her. Now she feels that the mosque community is her primary source of support. Without it, she told me, she probably wouldn't be here today. And the friends she made there have also tremendously helped her as the people around her slowly began accepting her new identity.

Along with her struggles to find acceptance from her family and friends as a Muslim, Ulrike also began to experience discrimination on a first-hand basis. She shared a couple of short anecdotes about getting rudely shoved or shouldered on the account of her appearance, while other times she will be mistaken for and called a Turk.

And all on account of her headscarf and dress, Ulrike noted, shaking her head.

I don't know [where all the discrimination] comes from. It's essentially a piece of cloth, what's supposed to protect from the gaze of men, or from jealous looks. You do it simply because you choose to do so and to get reward in heaven, not so that people get angry with you or wear you down. You just want to live peacefully in quiet. And I've noticed that before I [wore the headscarf], I was treated differently—people flirted with me maybe, or were nicer, or simply mellower. It was different. Now it's not so anymore.

Ulrike felt the media had a distinct influence on this difference in treatment, for “when people see something from some terrorist, then they immediately incriminate all Muslims...it’s painful.” From her observations and experiences, however, she strives to convey a good impression of Muslims through her own interactions. She has come to see her headscarf as showing her solidarity with other Muslims. Moments of acknowledged solidarity when Muslim immigrants recognize that she is German make all the discrimination and struggles she must go through worth it.

She has also found the headscarf to strengthen her morality by making her more self-aware; her actions do not simply represent just her individual self anymore, but Islam and Muslims as a whole. What she does, she told me, is always to some extent how people will perceive Islam—this knowledge reminds her to think twice before reacting impulsively because it will only reinforce the negative perceptions people already have of the religion. “I have to make up for what other people, the terrorists [do]...I didn’t do anything wrong, but I want to convey a good impression of Muslims, and I can only do that when I am nice and don’t talk to others aggressively and so forth.”

Moreover, she and Julia both told me that in the grand scheme of things, their lives and freedoms have not been that compromised by choosing to cover themselves. They still do the things that they love to do—especially shopping. And now that they both have daughters, they often go to the playground and participate in “mommy activities” just as any German mother would.

Ulrike is no stranger to the emergency room, having been there seven times in the past year. She only goes there when she really has a problem or acute pain, she told me,

especially when it's five or six in the morning and she can hardly move. Furthermore, her general practitioner is far away, while the hospital is located much closer to her home.

Generally, she feels her experiences have been positive, though she has noticed the differential treatment she has received since she began wearing a headscarf. As a German Muslim woman, Ulrike is in an interesting position to notice how much ethnic and immigrant associations have been imposed on her despite the fact that she is fully German.

Once they called my name, "Frau ----", and because I have a pretty German name and I was the only woman in the waiting room, the nurse looked, called my name, and looked past and didn't see me...she obviously associated the name with a German person, one that didn't have a headscarf. When I said that I was Frau ---, at first she laughed. And then she and the other nurses began asking me why I would wear such a thing, why I would do such a thing, if it was because of a man." And I said no, of course not... They react that way, they don't understand it.

Ulrike described to me the transition she often noticed in the attitudes of doctors and nurses who treated her, from mistrust and caution toward her apparent "otherness" to talking to her like any other German, expressing curiosity and interest. At first, the doctor will brusquely ask her, "what kind of problem do you have?" Sometimes they will even talk to her as if she doesn't know German, she told me. However, as she begins to explain exactly what her symptoms are in a calm and exact manner, they slowly realize they can "let their guard down and act normal with her like with anybody else." Is she German? they ask hesitantly, and then the interest and questions start to come through. The doctors always ask her how she became Muslim.

At the same time, however, Ulrike realizes that the way she presents herself makes all the difference in the rapport with her doctors and nurses. "If before I had not said as much, if I just explained in plain language what had happened, or wasn't so

friendly, then they would continue to still be a little bit aggressive,” she told me. As a result, she feels she must always be nice so they don’t think poorly of Muslims in general.

Conclusion

The identity politics of Muslims with immigrant background in Germany, as shown through the narratives of my informants, are both a product of and reaction to the expectations of integration set by a host society that is hostile to a presence it perceives as threatening to its sense of national identity. My informants, ranging from second generation Turkish Germans like Melike to refugees whose residency is only “tolerated” but not recognized by the German government such as Nadim, weave elements of their ethnicity, faith, race, and culture together with the host society that both influences and rejects them. However, in constructing a unique hybrid identity and sense of “belonging” from these “irreconcilably incompatible” elements--even without recognition from their host society--they succeed in blurring the lines of a constructed dichotomy between “Muslim” and “German” or “foreigner” and “native.”

This chapter, in examining how Muslim immigrant identities are formed in response to the racial dynamics of integration discourse, creates a foundation to explore tensions between identity and social order. Taking off from this point, the next chapter explores the tensions and misunderstandings that occur when Muslim immigrants are brought into the emergency room in conflict with the imagined identities that German emergency staff project onto their bodies, as well as the racial hegemonies that are subsequently replicated in that space.

Politics of the Emergency Room

Providing medical treatment 24 hours, 7 days a week, and 365 days a year on a walk-in basis, doctors and nurses at emergency departments face unique challenges compared to other health care services. The job of an emergency doctor is notoriously demanding, and I quickly saw this for myself during my internship. Not only must emergency doctors treat patients under life-and-death circumstances, not only must they have a fundamental understanding of almost every possible non-surgical issue (essentially, the entire medical spectrum), but strains on time and resources often prevent doctors from establishing a human connection with their patients. As one doctor noted, “you see the patient only after three or four hours, and he can’t give information himself while the fire department [that brought him here] didn’t take any numbers down for you to contact, which is also very time consuming and sometimes a huge pain.” (Doctor 2) And on top of all this stress, patients using emergency facilities often bring their own sense of urgency along with the expectation of immediate treatment.

Initially, listening to the frustrations expressed by both emergency care staff and former Muslim immigrant patients or their accompanying members felt like seeing two sides to the same coin. Doctors and nurses tended to make broader, matter-of-fact statements about the obstacles they perceived, due surely in part to the professional setting in which interviews took place but also because such challenges were so ingrained in hospital procedure and occurred on such a regular basis that they were often spoken about in the same way one might talk about traffic jams on the way to work--an annoyance, for sure, but one that simply had to be dealt with. Patient informants would echo these generalized problems described by the emergency care staff; the difference

was that, punctuated with more singular and highly personal experiences, their accounts gave me a glimpse of the frustration and emotional factors that play into such interactions.

However, as I juxtaposed what I learned from both emergency care staff and patient interviews, it became clear that the tensions in the emergency room stemmed from something more than simple ethnic, linguistic, cultural, and religious misunderstandings in the emergency room. I began to notice a paradoxical tendency for emergency care staff to project their own imaginations of the Muslim immigrant onto their patients' bodies, while simultaneously subordinating these sociopolitical identities in favor for a strictly biological, "apolitical" view of these bodies.

With this observation in mind, the goal of this chapter is therefore to review my main findings in interviews both doctors and former patients of Berlin's emergency facilities, and how they have led me to believe that the unique structure of the emergency room may inadvertently support the racial dynamics initially constructed by systemic forces outside of clinical settings.

Theories of Clinical Gaze & the Apolitical Body--a Framework for the Emergency Room

In his monumental book *Birth of the Clinic*, philosopher and social theorist Michel Foucault provides a theoretical framework to critically examine the power dynamics that have evolved between physician and patient by following the history of clinical work in French hospitals.¹¹⁸ Before the French Revolution in 1789, doctors heavily relied on verbally communicating with patients and listening to their illness narratives to make a diagnosis, because there was little medical technology to provide

¹¹⁸ Michel Foucault, *Birth of the Clinic: An Archaeology of Medical Perception* (London, 1973), xiv.

direct evidence. However, after the Revolution, new medical techniques emerged, including the stethoscope, as well as more advanced methodology such as examining dead bodies to understand the connection between patients' symptoms with organ dysfunctions.

According to Foucault, modern physicians began to rely on their "gaze" to diagnose disease, a term he coined to describe a shift in clinical medicine. The advancement in diagnosis technique led gradually altered physician-patient interaction, as physicians focused increasingly on the disease and began to perceive the patient more as a body through physical examination. Carefully observing bodies--rather than patients--would allow physicians to learn "truths" of disease than had previously been obscured by outdated theories. This trend led then to doctors paying less attention to the words and symptoms described by the patients themselves, which was perceived as being outdated. As a result, physicians increasingly gained greater authority in clinical settings; patients' own experiences and perspectives, trumped by the precision of medical technology, fell to lesser importance in the face of the physician's all-knowing decisions.¹¹⁹

Miriam Ticktin's ethnography *Where Ethics and Politics Meet: the Violence of Humanitarianism in France* further builds on Foucault's work through a critical analysis of humanitarianism and compassion as a means of allowing undocumented immigrants with life-threatening pathologies in France to attain legal status.¹²⁰ Humanitarianism, she argues, causes undocumented immigrants to sacrifice biological well-being for political recognition, thereby becoming a form of politics while being asserting its practices as "apolitical."

¹¹⁹ Foucault, 128-133.

¹²⁰ Ticktin, 40.

This notion of the apolitical body is problematic, Ticktin asserts, because contrary to its claim of transcending politics, it instead becomes “the very center and grounding of the new politics of citizenship in France.” As Ticktin astutely notes:

This shift to seeing the suffering body as more legitimate than the threatened or deprived person reveals the desire to recognize the universality of biological life above all else: that is, to find common humanity in apolitical suffering, a universal humanity that exists beyond the specificities of political and social life.

In adopting this concept, humanitarianism introduces new biopolitical practices which transfer the power to define what it means to be human entirely to the physician. However, Ticktin shows that those who advocate humanitarianism in clinical settings fail to recognize the inherent biopolitics that take place when those in the very position to differentiate between the political and biological realm, wield the power of sovereignty itself, in which the individual body and its relationship to the population must be controlled, managed, and cultivated. Biology, then, as Ticktin notes, “is not the domain of the incontestable,” but rather a realm in which norms and standards are created by those in power.

Ticktin thus found that undocumented immigrants in France are placed more at the mercy of physicians’ subjective and biased perspectives as a result of constructed biological norms, in which “the standard of able-bodiedness...is exposed as fictional, constructed and normativized for a certain type of economic and civic functionality.” Ticktin draws upon this argument to show that “political subjects can be found in the most ‘apolitical’ of spaces”--in this case, the ‘apolitical’ space is the hospital.

Applying Foucault’s clinical gaze together with Ticktin’s theory of the apolitical body creates a useful framework to better understand the manifestation of racial

dynamics in Berlin's emergency facilities. The emergency room, even more so than other clinical settings, is particularly structured so that clinical gaze naturally becomes the dominant perspective that physicians develop. Emergency care staff are given absolute power to determine what a life-threatening "emergency"-- and consequently to define the very nature of life and death itself--yet are also often forced to exercise such power within extreme time constraints. The necessity of physicians to take swift, decisive action under such pressure then subordinates communication further, giving patients even less input in their own treatment. The less and less intentional interaction emergency physicians have with their patients, it easier it is for them to think that they have attained the ability to objectively and categorically differentiate their patients' biological conditions from their sociopolitical identities.

As my interviews reveal, however, emergency care personnel are anything but objective in describing their challenges and frustrations with patients of immigrant background. I found that a variety of obstacles that are either directly or indirectly associated with immigrant background (indirectly meaning that patients of immigrant background may follow a larger, general trend), many of which also are reflected in patient recollection of emergency room experiences. The greatest of these obstacles are language barriers, possible disproportionately inappropriate usage of the emergency room by immigrant patients, perceived cultural differences regarding pain expression and the family role in treatment, and gender dynamics.

Treating Non-Emergencies in the ER – an Immigrant Problem?

My initial interest in migrant patient care in Berlin's emergency facilities stemmed from the prevailing notion I had heard in casual conversation of significantly

high emergency room use by migrants (as compared to “native” Germans), even for "non-urgent" health problems, instead of going to see a general doctor. And indeed, over half of the doctors and nurses I interviewed expressed that a great frustration for them in the emergency room was treating patients who, according to them, did not have an actual emergency. Whether or not these patients are disproportionately of migrant background, however, remains unclear.

Although little research has been conducted on emergency care usage by immigrants in Germany, what studies have been done suggest a disproportionately high use of emergency facilities by immigrants compared to native Germans.^{121,122} Another study examining false utilization of emergency departments in Berlin showed similar results. However, the article also speculated that such a correlation may not result from differences in utilization between patients of German and non-German backgrounds, but rather be in part caused by language or cultural barriers which may influence doctors' assessment of severity.¹²³

Similar studies done in Spain also show conflicting results. Buron et al. found that emergency room utilization rate among foreign-born residents was 38% lower than that among Spanish-born residents, suggesting that immigrant status is not correlated with higher utilization rates, and that recent population increases due to immigration do not directly correspond with higher utilization of emergency facilities. Immigration

¹²¹ M. David, G. Pette, H. Kantenich, „Unterschiedliche Inanspruchnahme einer gynäkologischen Notfallambulanz durch deutsche Patientinnen und Migrantinnen,“ *Geburtshilfe und Frauenheilkunde* , 58 (1998): 319-23, 319.

¹²² T. Borde, T. Braun, T. David, „Unterschiede in der Inanspruchnahme klinischer Notfallambulanzen durch deutsche Patienten/innen und Migrantinnen/innen“ (Schlussbericht für das BMBF [Final report], Berlin, 2003).

¹²³ M. David, T. Braun, T. Borde, „(Fehl)-Inanspruchnahme von klinischen Rettungsstellen: Eine Analyse unter besonderer Berücksichtigung der Ethnizität der Patienten,“ *Notfall Rettungsmed* 9 (2006): 673-678, 677.

therefore has a lower impact on emergency departments than would be expected if one only considered the increase in the overall population.¹²⁴ Another study done by Rue et al., however, found that “when immigrants are from low-income countries their use of emergency services is even higher, which might be attributable to greater needs, barriers to access or reflect the way that immigrants access health care in their countries of origin.”¹²⁵

While it remains unclear whether rising immigrant populations have contributed to increased usage of emergency services, there is much literature that does at least point to a definitive increase in overall emergency care utilization, particularly in metropolises not only in Germany around the world.¹²⁶¹²⁷ According one of the head doctors, his emergency department has seen an increase from a little over 30,000 annual patients in 2001 to just under 50,000 in 2009, with a steady increase each year. This has caused strain on resources, prompting the hospital to begin new construction.

When patients come, however, emergency rooms cannot simply turn them away. As a policy, emergency doctors must examine and handle all patients--even if they “belong in a different part of the system,” as one doctor put it, such as a general practitioner’s office or at specialist department*. Furthermore, according to another doctor, those that do come without anything severe often do so without having first sought out a general practitioner.

¹²⁴ A. Buron et al., “Hospital emergency department utilisation rates among the immigrant population in Barcelona, Spain,” *BMC Health Serv Res*, 8 (2008): 51.

¹²⁵ M. Rué, et al., “Emergency hospital services utilization in Lleida (Spain): A cross-sectional study of immigrant and Spanish-born populations,” *BMC Health Services Research*, 8 (2008): 81-88, 81.

¹²⁶ C. Burchardi, M. Angstwurm, S. Endres, „Diagnosespektrum in einer Internalen Notaufnahme,” *Der Internist*, 42 (2001): 1462-64, 1463.

¹²⁷ Babitsch et al., 82.

According to a head doctor, only a third to at most half of their patients use emergency services ‘correctly’ (for life-threatening emergencies) as perceived by health staff, though patients may consider otherwise, an observation which echoes the findings of the David et al. study that only 43% of patients at three urban hospitals in Berlin met their criteria for “appropriate” emergency room usage.¹²⁸ When there are too many patients that do not qualify as emergency cases and some are left impatiently waiting, the doctor observed, frustrations inevitably rise on both sides of the treatment.

The challenge [with that] is that they’re there, and our resources limit us because we unfortunately have to let them wait because we have to see the most important patients, the ones need more urgent treatment. And the patients who are then often not sick, they get indignant and are very impatient and ask, ‘yeah, when am I going to finally be treated?’ And so on and so on. And we have to then talk a lot and say, ‘pay attention, you only have, what do I know, an uncomplicated UTI or a light throat infection, but it’s nothing bad and we have to treat the heart attack patients’... And that’s something difficult because despite this the demand of these patients are that ‘I would like to be treated right away, I also would like to have this and that’ and such. (Head Doctor 1)

In a study examining the effect of patient origin and relevance of emergency care visit on patient and provider satisfaction in Denmark, Mygind et al. found that regardless of the patient’s ethnic background, the appropriateness of emergency care utilization plays an important role in determining both patient and provider satisfaction. According to the study, “the fact that more visits by patients of foreign origin are not relevant in the ER explains a large part of the differences in patient satisfaction...when the contact is considered relevant in the ER, both patients and caregivers are more satisfied with their mutual contact.” The study concludes by suggesting differences in patient satisfaction

¹²⁸ David et al. (2006), 673.

across ethnic backgrounds could be significantly reduced simply by eliminating differences in the share of visits considered not relevant in the emergency department.¹²⁹

When it came to discussing the possible disproportionate use of emergency facilities by patients of migrant background, I found that perceptions of the topic were varied and sometimes conflicting among the doctors and nurses I interviewed. It is probably important to note, however, that only two of them brought up the subject on their own; the rest only offered their analysis after I brought up the literature.

Four of my emergency care informants stated they had indeed observed that patients with migrant background tended to come more often without emergencies. Two of them offered a cultural explanation--perhaps patients who have immigrated to Germany, especially those from Turkey or Arab countries, mistakenly come to the emergency room due to differences in health care systems from their home countries. One of the head doctors also attributed the apparent disproportion of non-emergency migrant patients to cultural differences, explaining to me that a patient's expectations are influenced by where he or she comes from. "German patients tend to know the healthcare provider system from their childhood on, he said. "They tend to have a fundamental understanding of which institution is responsible for what service within the healthcare system." In contrast, he added, "It's common that patients with migrant background don't understand that the acute treatment doesn't incorporate the complete diagnostic of a clinical picture." (Head Doctor 1)

When I asked if it could possibly be related to socio-economic status, he said he did not see them in conjunction with each other. "Here in Berlin there are a lot of German

¹²⁹ A. Mygind et al., "The effect of patient origin and relevance of contact on patient and caregiver satisfaction in the emergency room," *Scandinavian Journal of Public Health*, 36 (2008): 76–83, 82.

patients also with low social status that despite this find a general practitioner. I don't think [socio-economic status] is connected to [incorrect usage of the emergency room].”

Another doctor, though he felt he could not discern from observation alone whether incorrect usage was related to migrant background (after all, he noted, the neighborhood in which the hospital is located also has a high percentage of immigrants), also did not think socio-economic status played a role. “There are even very many, very educated people that come here because they googled something on the Internet and notice that they have similar symptoms as a horrible illness. And they come here panicking and wanting it cleared up.” (Doctor 2)

However, other doctors voiced opinions that directly contradict this statement. Another head doctor stated that he felt socio-economic status rather than ethnicity contributed to the growing overall number of patients and increasingly incorrect usage of the emergency room.

[Incorrect usage of the emergency room] is connected more, I believe, with the socio-economic status of the patients. Because unfortunately it's the case that patients with migrant background are socio-economically weaker and have less money. And that's why perhaps they also don't receive good health care...and as an alternative they come to us. (Head Doctor 2)

He ultimately speculates that the causes behind this trend of increased (as well as inappropriate) usage of the emergency room are complicated and multi-faceted, offering several possible factors as well. One of these was lack of access to a general practitioner, which he attributed to the weaker socio-economic status of the neighborhood and the closing of many general practices (either due to retirement or insufficient earnings). This head doctor echoed several other interviewees when he

observed a general trend in changing attitudes of patients, with or without migrant background, with regard to utilizing emergency care:

Altogether there's also change in the motto, with people now saying, "Oh, I now have Saturday free and I wanted to get examined so I'll go the emergency room." And that's been a trend in reasoning that people like using. Many patients also often come with certain requests and say '...I've had back pain for half a year,' for example, 'and now I can't get a CT for six weeks. But it's still hurting me now and now I'd like a CT.' That will be very openly communicated. (Head Doctor 2)

To this doctor, the trend of increasing and often inappropriate usage of emergency services does not seem to be directly related to ethnicity, but is caused more by other factors, particularly socio-economic status, that influence perceived accessibility to an emergency department compared to other health services. This perception of accessibility then leads, as the head doctor noted, to a strain on resources. Although this was only discussed in one interview, it warns against basing a study exclusively on ethnicity, such as that conducted by David et al. in determining causes of inappropriate usage of emergency departments.¹³⁰

Although my findings regarding to inappropriate usage in the emergency room conflict with each other, the study conducted by Babitsch et al. showed that doctors' perception of urgency for emergency treatment was significantly lower for Turkish internal medicine patients compared with their German counterparts. Consequently, the study found that German internal medicine patients were more often admitted to inpatient treatment than Turkish patients.¹³¹ This may then also imply longer waiting times for a greater fraction of Turkish patients in the study, though Babitsch et al. do not directly allude to the possibility.

¹³⁰ David et al. (2006), 673.

¹³¹ Babitsch et al., 82.

The results of the Babitsch et al. reveal how powerful such perceptions may be in perpetuating misunderstanding and mistrust between patients with immigrant background and German emergency care personnel. Framing the issue in such a way, it is only inevitable that inappropriate usage of the emergency room will lead to a number of frustrations both on the side of health care personnel and patients. In an article discussing how emergency departments define their functions, Murphy showed that inappropriate visits of emergency departments as deemed by the provider may negatively impact the doctor-patient relationship, noting that patient dissatisfaction, at its core, is a result of failed expectations.¹³²

The most common and well-known aspect of this can be seen in frustration or impatience with waiting times in the emergency room, a well-known fact among health care staff. Though I am in no position to judge the “appropriateness” of any visit to the emergency room, six of my patient interviewees recalled being frustrated by a long waiting time of several hours (though two informants, who had had multiple emergency care experiences, said they were brought in right away on other occasions).

Furthermore, one doctor noted those that don’t have an emergency are ultimately also unhappy because their problem often times is chronic (“or hypochondriac”), which cannot be treated in emergency facilities. He summed up what he feels is his observation of patients who incorrectly use emergency facilities.

[The patients] are disappointed, of course, because they think that everything goes faster here, here everything will get done because it’s an emergency room, and they also don’t have any understanding when you tell them, you’re in the wrong place... but that is due to the fact that A) the outpatient care doesn’t work so well anymore, and B) because the patients

¹³² A. Murphy, “Inappropriate attenders at accident and emergency departments: definition, incidence and reasons for attendance,” *Family Practice*, 15 (1998): 23-32, 32.

are not as informed what the function of the emergency room really is.
(Doctor 2)

Two doctors also discussed the tension they observed with some of their patients when they inform them they are in the wrong place. One of them shared how she handles patients who have not come with an emergency:

I ask the patients--often those with migrant background--why they weren't at a general practitioner and then they say for this or this reason. And then I tell them that in my opinion, they should generally first go to a general practitioner because here I can't offer them the kind of treatment that they are essentially looking for--patients with diarrhea who otherwise don't have any problems have to also give multiple stool samples over a duration of time, for example. That's something I can't provide for at all. I can't collect stool samples from someone here, just as I can't justify a blood pressure measurement and the other things that are important and that a doctor uses to examine. I make it clear to them that their problem requires longer-term care, a case that needs with more appointments, which is something that we can't do here. (Doctor 1)

The reaction she gets to this advice is varied. Some patients get offended, feeling like they are not "acute enough" or enough of an emergency in addition to having to wait a long time. Others are "very open...and change what they're doing." Generally, however, she says some may return to the emergency room again and again, which happens "all the time." While this is often frustrating, especially when there are many such patients, she and other staff try their best to stay professional.

Although this doctor has the kindest intentions, her description of the situation subconsciously echoes the dominant political discourse of integration, as I discussed in the last chapter. Her expectations place sole responsibility on the patients, and she gives no further consideration as to why they may return time and time; these acts are subsequently perceived as a small refusal to integrate into the German health care system.

Many of the doctors, however, readily acknowledged the difference in perceptions between clinical diagnoses of an emergency and what the patient defines as an emergency. One doctor directly attributed misuse of emergency facilities to the ambiguity of defining what an “emergency” really is. “We assume that the patient has an important reason to come,” one head doctor said. “That the important reason is perhaps not medically founded is another matter, because that is our evaluation.” (Head Doctor 1) According to another doctor, it’s not just the patients who don’t understand the function of an emergency room: “Many medical colleagues that don’t work here don’t really know that either. (Doctor 2)”

In general, all the doctors asserted their authority to determine what constituted as an “emergency”; they also agreed that a high percentage of their patients harbored different (and therefore false) understandings of how an emergency room functions and consequently misused the facilities. Yet there seemed to be very little consensus as to whether patients with immigrant background were disproportionately responsible for such misuse. Indeed, such little agreement--particularly among those with the greatest empirical understanding--leads one to wonder if perhaps the notion of immigrant patients misusing emergency facilities is but another Orientalist image, constructed to further perceptions of incompatibility between Muslim immigrants and their host society.

In addition, emergency care staff unanimously recognized the importance of adequately informing patients what decisions have been made for equal patient satisfaction. In the next section, however, their verbal emphasis on communication is questioned in light of structural language barriers many patients with immigrant background face.

Language Barriers

Once, a staff member told me, a Russian patient came in the emergency room requiring urgent care. She spoke no German and had brought no one with her. None of the doctors or nurses spoke Russian; the one colleague who did was not on shift. With no translator, the doctors depended entirely on body language to communicate. They spoke German while she spoke Russian. Somehow, though he can't even recall how, it worked out and they treated her.

In discussing difficulties associated with serving a diverse population, the majority of my interviewees explained to me how they often struggled with situations like these as a result of language barriers. Just how many is unclear, as no official statistics are measured, but it is clear that the staff feels the linguistic pressure consistently. According to one head doctor, "I would say we have up to 30% of patients that (don't) speak German as a first language. That's already a lot."

However, he was quick to qualify that the hospital did not officially quantify the number of patients due to the difficulty of carrying out such a measurement, and also cited possible discrimination if they tried to do so.

We don't have any official count because that data isn't collected – we will note "can speak German" or "language difficulty" but ... it is very hard. Let's say, with you for example, what one would say with you. We say you speak good German, but perhaps someone else would say for whatever reason that you don't speak good German. There are essentially no criteria. (Head Doctor 1)

Despite a lack of statistics, most staff members acknowledge that this issue occurs regularly and consistently. Under the head doctor's estimate, cases with "real" language barriers—where there are neither translators among the staff or accompanying family members—occur once a day.

Because emergency care patients do not come on a predictable schedule, language issues are dealt with on an individual basis. Currently, there is no systematic solution to ensure verbal access to all patients. This in large part is due to the unique nature of an emergency room. Because there are no appointments, patients come in spontaneously and without warning. It is then difficult to predict when a patient who may need a translator will come in. And when a patient needing a translator does come in, the urgent nature of his or her visit does not give the staff enough time to call a translator; decisions must be made with immediacy. “Of course, one tries to translate,” a head doctor told me. “But we are not in a position to get a translator for every patient because that would simply be too expensive and too costly, and they would also not always be available.” (Head Doctor 1)

The doctor’s sentiments reflect an observation of a clinical review that the perceived cost of providing professional translation services ultimately becomes a primary obstacle to advancing a systematic solution that effectively addresses language barriers.¹³³ Although the perceived costliness of professional translators for emergency facilities was a notion strongly purported by both head doctors I interviewed, a number of studies have actually suggested long-term benefits in significantly lowering costs. In a study examining the impact of interpreters and bilingual physicians on emergency department resource utilization in Chicago, Hampers and McNulty found that having limited English-speaking patients who do not use an interpreter results in making decisions that are much more cautious and therefore also more costly, with increased utilization and subsequently costs for testing. However, the costs resulting from testing were able to be eliminated when these patients either utilized professional translation or

¹³³ D. Ramirez, K. Engel, and T. Tang, “Language Interpreter Utilization in the Emergency Department Setting: A Clinical Review,” *Journal of Health Care for the Poor and Underserved*, 19 (2008): 2.

had a physician who spoke their native language.¹³⁴ Additionally, Jacobs et al. conducted a study examining a health maintenance organization in Massachusetts, in which they suggested from their results that offering translation services on a systematic, 24-hour basis in the primary care setting may lower costs over the long-term due to the benefits of greater access as well as enhanced communication between patients and physicians. The study acknowledged, however, that establishing the cost effectiveness of a systematic translation service in the emergency room would require further investigation.¹³⁵

For the doctors and nurses in Berlin emergency facilities, one of the greatest consequences of language barriers is the time doctors must ultimately expend to overcome them without a standard procedure of doing so. According to one doctor, who estimates that every 12th patient can't speak "good German—that is, one can't get his medical history from him," the only true way to overcome a language barrier is to take "even more time for examination." He described a particularly frustrating experience in which he had to treat an asylum seeker from Armenia.

It was his very first day in Germany, and he was at the office, where he wanted to register as an asylum seeker. And it was known that somehow he had contractures, and strong but chronic pain (*). Somehow he complained, said „aua aua“, they called the fire department, and [the emergency department] took him in. He couldn't speak English or German, only speak Russian and Armenian. And I had no idea what to do with him. I couldn't speak with him—he could only say ten words of English. I understood a little, that he had contractures and for approximately ten years. That is severe pain, but it's chronic. And then I sent him back... ten minutes later the fire department calls me and says, we are bringing him again because he has pain. (Doctor 2)

¹³⁴ L. Hampers and J. McNulty, "Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization," *Arch Pediatr Adolesc Med*, 156 (2002): 1108–1113.

¹³⁵ E. Jacobs., D. Shepard, and J. Suaya, "Overcoming language barriers in health care: costs and benefits of interpreter services," *Am J Public Health*, 94 (2004): 866–9.

While he noted this was a more extreme case, he said similar incidents that arise from miscommunication are not uncommon, estimating they occur once in ten days. In this particular situation, the biggest complaint he had was how much time such a simple case had taken. Exasperated, he told me “so are such situations, where the patient also can’t do anything, but where you think that it wouldn’t be bad if those who brought him here thought a little more about what we do with him, what one *can* do with him, or at least bring someone that can translate.” (Doctor 2)

In addition to the strain on time, a head doctor I also noted how language barriers inevitably lead to a constraint on resources:

And [the language barrier] leads to the patients needing more diagnostic resources. We did an analysis of Turkish patients once to see how CTs were needed for patients with headaches and we could see that for Turkish patients more CTs were needed because the assessment of the medical history is difficult, and the symptoms cannot be determined as precisely. And that’s the main challenge for patients with immigrant background. (Head Doctor 1)

Despite having no standard procedure of overcoming language barriers with patients who do not speak German, most doctors and nurses discussed various ways one can communicate. One emergency department has tried partially to address the language issue by offering an English language course to ensure its staff has at least a foundation in the “universal language,” especially with regards to medical terms. This at the very minimum opens a possible way to communicate with patients whose first language is not German but who may have a stronger grasp in English. Nonetheless, the head doctor at this hospital also acknowledged that this measure was inadequate, saying that ultimately, “we don’t have a systematic way [to overcome the language barrier].” (Head Doctor 2)

Fortunately, most doctors and nurses noted that the language problem is often mitigated by the fact that patients with language difficulties typically are either accompanied by family members who speak better German than they do, even if not fluently.

However, while every doctor and nurse felt having family members translate was of course better than no one at all, six of them cited its unreliability. As one doctor noted,

What can also be hard is of course when patients come that can't speak German at all and then yet another third person must translate, who often is a younger family member. For example, the 13-year old daughter that can't really handle certain questions like an adult but has to translate anyway... What also hinders the whole situation is when one asks a kid, do you have stomach pain, heart pain? And sometimes one gets a very different answer than what one had asked because the translation was different and the kid didn't understand the question, and the father then interpreted differently again. So often the direct way of communication is missing, which is very important to ask with heart pains, etc... (Doctor 1)

Another doctor noted that while she was confident about being able generally to understand where a patient's pain was located or to make a correct diagnosis, what was less certain was how much what she explained was understood by the patient, even when translated by a family member. "It's much harder to explain to them what they have," she told me. "I'm much more upset by this aspect of communication – what they now have to do [after their ER visit], what they have. Then sometimes it's much easier to despair, because then they don't understand what they have to do at all. That often makes me sad." (Doctor 3)

Three of the staff members discussed certain times when family members cannot accompany the patient. One of these times is when the patient is taken to the emergency department by an ambulance, where nobody but the patient is allowed in. However, as the head doctor observed, "It might be that they're so sick that they come in the

ambulance where family members aren't allowed to accompany them, but then typically the family members come very quickly after." Another time is often during the preliminary examination, where language is not needed to check vitals.

These times when a translator is not felt to be needed by the staff, however, may not always be understood by patients and their family members. As a second-generation Turkish German who has many relatives and friends who do not speak German in Berlin, Fidan often finds herself accompanying various people to the hospital for translation. When I first asked her about her experiences, she launched into a heated rant before I could even take out my tape recorder--it was clear she had a full repertoire of frustration and misunderstanding that I had until then only heard from the emergency staff's perspective. One such experience occurred a year earlier, when a Turkish woman she didn't know had an accident in front of the mosque and needed to be taken to the emergency room. As the woman did not speak "a single word of German" and the person with her didn't speak much either, Fidan accompanied her to the hospital to translate until the patient's husband, who did speak German, could come and take her place. But when they arrived, the emergency room did not allow her in with the patient for the entire duration of her time there.

"I waited for over an hour and they never let me in," Fidan said. "Eventually the husband came and I left, but I never even knew what had happened to [the patient]." Fadiman aptly categorizes such cases as the one described above as "veterinary medicine," in which patients are almost reduced to animals without their capability of communication and nobody has enough information to really understand the situation.¹³⁶

¹³⁶ Fadiman, 168.

Ideally, emergency departments can avoid such practices of “veterinary medicine” by having someone among their staff or from another department who can speak the language act as a translator. According to one head doctor, his staff consists of doctors or nurses who can speak Turkish, Arabic, and Russian. While he emphasized language capabilities are not a consideration when hiring staff, these staff members become very valuable in advising patients who do not speak German. However, another doctor observed that the need for multi-lingual staff far outweighed their availability, noting that in the past, Turkish and Arabic colleagues were split up in the schedule to address language issues, but “not so much anymore, because now there are so many migrants every day in the emergency room. (Doctor 1)

A head doctor explained the process in which one tries to overcome the language barrier, where the presence of a bilingual staff member is ideal but alternatives must be found if one is not available:

When a colleague is working a shift, and he speaks the language [needed], perfect. But ... he must also have a break, do you understand? So, we have the colleagues that we have. When we have a patient that for example only speaks Turkish or Russian and at that moment none of us can, well, we're a big hospital. We call the [Stationen] [and ask], which of you can Russian or who can speak Turkish? Often we also have cleaning personnel who can then, for example, speak Turkish, and we call them knowing that one can't discuss everything with them – the patient must give his [or her] consent and it has certain limitations. If it's about decisions for therapy, then we concern ourselves with getting a translator and there we have lists. We cooperate with a translator institute, and there is a list where we find someone, but that takes time. However, that is usually not available in the emergency room, so that we often have to make decisions in the sense of the assumed will of the patient. Or by verbal agreement as well as that works. And when he [the patient] has to make further decisions, then we also have a little more time and then a translator can also come by. (Head Doctor 2)

Despite the general acknowledgment that there are not enough bilingual staff members to provide a systematic solution for language issues, one head doctor discussed the hope that such a solution could become more systematic over time as more and more people with immigrant background entered the health profession.

It progresses on its own a little bit because of course with a large fraction of patients with migrant background, there is also a large fraction of the general population with migrant background. And some of those will become doctors, and through that alone a little bit of progress is made. (Head Doctor 1)

While such a statement shifts the responsibility of communication barriers in such a way that partially absolves the hospital from taking decisive and immediate action, presuming that a natural progression of educational attainment among generations descended from immigrants will solve the existing language issue, it willfully ignores factors such as racial and gender stratification, economic opportunities, and human and social capital, all of which have found to significantly correlate with education.¹³⁷ A 2003 study focusing on the educational attainment of German born children of immigrants shows that the educational gap between them and children of Germans is significantly large, and furthermore, suggests that the group overall is falling increasingly behind in that sector.¹³⁸ A similar study done in the Netherlands showed comparable results and suggests that many of these second-generation immigrants have a lower educational attainment due to the lower level of education attainment of their parents,¹³⁹ a conclusion challenging the natural progression purported by the doctor.

¹³⁷ Carol Schmidt, "Educational Achievement, Language-Minority Students, and the New Second Generation," *Sociology of Education*, 74 (2001): 71-87.

¹³⁸ Regina Riphon, "Cohort effects in the educational attainment of second generation immigrants in Germany: An analysis of census data," *J Popul Econ*, 16 (2003): 711-737.

¹³⁹ J. Van Ours and J. Veenman, "The educational attainment of second-generation immigrants in The Netherlands," *J Popul Econ*, 16 (2003): 739-75.

Besides such solutions addressing direct communication problems, however, other indirect measures have been implemented. One doctor mentioned how brochures are translated into other languages, as are pamphlets with explanations and pictures corresponding to various conditions. Patients who do not speak German can then identify and point to what they feel they have. The medical office assistant also mentioned that if patients who do not speak German must sign something, they will be given a translation of it, though they still must sign the German document.

When listening to my interviewees--especially the doctors and nurses--discuss language barriers in emergency care, I began to notice a seemingly paradoxical trend. Every doctor and nurse I interviewed stated that communication and access to the patient were very important aspects of emergency care. They also acknowledged that language proved to an obstacle for both. Yet most of them expressed satisfaction with the current solution of addressing such challenges on an individual basis with whatever resources available at that time.

This kind of “paradox” may be best summed up one of the head doctors, that “Somehow we find some kind of way to communicate with the patient, because communication is ultimately the most important.” In other words, communication is acknowledged as an important aspect of treatment in the emergency department, and yet very few measures have been taken to ensure that it is equally effective across language barriers and background differences in expressing pain.

Thus, while most of the doctors and nurses certainly note that “[the language barrier] doesn’t make work any easier (Nurse 1),” many do feel that the current system gets them by and they are able successfully to treat patients despite communication

difficulties. According to one head doctor, the [medical record] can often be discerned by physical indicators from taking vitals such as blood pressure and heart frequency.

Thus, when it comes down to it, the need is not deemed pressing enough to find a systematic solution. In the words of one staff member, while patients come in every day not speaking the language, the interactions between patients with migrant background and doctors “functions somehow...it works okay. (Nurse 1)” And that, for many of them, seems to suffice.

Interestingly, though each interviewee among medical practitioners stated that there was no difference in the way they communicated to patients of migrant background, other studies examining language barriers in the emergency room indicate otherwise. In a study examining the impact of gender and ethnicity on emergency care staff perception toward doctor-patient relationships in Berlin emergency facilities, Babitsch et al. suggest that ethnicity and communication barriers do negatively affect doctors’ satisfaction with treating their Turkish patients. According to the study, doctors experienced significantly more communication problems in their encounters with Turkish patients compared with German patients, with language cited as the dominant reason for dissatisfaction.¹⁴⁰ Similar studies conducted in the United States with limited English speaking patients found that they were less satisfied with their emergency care experience and as a result less willing to return to the same emergency department they had visited for a problem they deemed as an emergency.¹⁴¹ In addition, a study examining communication between Dutch doctors and immigrant patients suggests that ethnic and cultural differences do result in altered medical communication patterns toward immigrant patients as compared

¹⁴⁰ Babitsch et al., 82.

¹⁴¹ O. Carrasquillo et al., “Impact of language barriers on patient satisfaction in an emergency department,” *Journal of General Internal Medicine*, 14 (1998):82-87.

with Dutch patients. Consultations with immigrant patients (from non-western countries), for example, were significantly shorter, while major differences were also observed in verbal communication.¹⁴²

Furthermore, a systematic review of “culturally competent health care systems” by Anderson et al. showed that in health care systems with diverse populations, the inability to communicate with doctors results in barring patient access to adequate care, generates mistrust in the quality of treatment, and subsequently decreases patient compliance.¹⁴³ Rao et al. also provided a review of communication interventions that suggested communication between doctors and patients was significantly linked to a greater health status of patients as well as patient satisfaction.¹⁴⁴ As an estimated 20% to 50% of Turkish immigrants who live in Germany have very limited German language ability, they are would therefore be a demographic who falls under the findings of both reviews.¹⁴⁵

Yağmur tells a story that reaches a much more pessimistic conclusion than that of the emergency care staff. When she had to go to the emergency room for high blood pressure, the hospital would not let her sister come in to her room to translate. Unable to speak a word of German (except for “eat”), she lay silently in the hospital bed for several hours as the doctors and nurses presumably took her vitals and treated her.

“They didn’t try talking to me at all; they knew I couldn’t speak German and they didn’t speak Turkish,” she told me.

¹⁴² L. Meeuwesen, et al., “Do Dutch doctors communicate differently with immigrant patients than with Dutch patients?,” *Social Science and Medicine*, 63 (2006): 2407-2417.

¹⁴³ L. Anderson et al., “Culturally Competent Healthcare Systems. A Systematic Review,” *Am J Prev Med* 24 (2003): 68-78.

¹⁴⁴ J. Rao et al., “Communication interventions make a difference in conversations between physicians and patient,” *Medical Care*, 45 (2007): 340-349.

¹⁴⁵ Babitsch et al., 82.

Having zero communication made the experience especially uncertain for Yağmur, and she told me she worried they were doing the wrong thing. They finally sent her to the cardiology department in the hospital, but not without first giving her nine tablets meant for her blood pressure. Though Yağmur will never know what exactly these tablets were, she told me after that she was “not normal anymore” for a whole year afterward. According to her, the tablets caused her blood pressure to have abnormal fluctuations: one moment, it would be too high; the next, too low. She went to her general practitioner, who is Turkish, and she said he told her what they did was “not right...they shouldn’t have given [her] so many tablets.” It took her seeing a cardiologist at a different hospital to make it better.

Though one will never know the details of Yağmur’s specific case--what pills she was actually given, the processes by which the doctors made such a decision--her account provides a powerful example of how language barriers in the emergency room may ultimately enforce racial dynamics produced by systemic factors outside of clinical settings.¹⁴⁶ As Yağmur’s doctors rely completely on clinical gaze rather than any form of communication, they also inevitably reconstruct a racial hegemony that is based on the association of language with ethnicity. This can be further seen in the following section, in which perceived cultural differences are discussed.

“They have another mentality”: Expression of pain and the role of family in the ER

Almost every single one of the health care personnel I interviewed also brought up the difficulties they encountered with patients of migrant background often bringing

¹⁴⁶ Y. Shenker et al., “Navigating Language Barriers under Difficult Circumstances,” *Annals of Internal Medicine*, 149 (2008): 264-269.

too many accompanying family members. Most emergency rooms have the policy of only allowing one accompanying member with a patient due to limited space. Three even cited it as the first issue that comes to mind when asked about the challenges of serving a diverse patient population. As one put it,

Patients with migrant background ...come often in threes, and all want to come in [at once]... as do all the relatives and all the friends. And because the emergency room is already full, you can't let more than one accompanying member in. And there are always these discussions, 'we want to go in and we have to go in because the patient doesn't understand German or doesn't speak that well,' and so on... And sometimes they are somewhat impatient... but I don't think that's just for patients with migrant background. (Doctor 2)

These issues are most associated with Turkish and other Mediterranean patients, and are chalked up to being a cultural difference. One head nurse expressed a mistrust for accompanying members of patients with migrant background. They were doing this knowingly and manipulatively even when they knew it was not allowed, she told me. They had their tricks to get in. One of them was to claim they needed to translate, even when, according to the nurse, the patient could indeed speak German. Or they would tell her the patient needed them and their company, a statement she pinpointed as the difference between their and German culture, which gives patients quiet. This was a practice proven, she told me, by patients who clearly wanted to be left alone even as their family members clamored to be able to be with them.

The nurse's explanation echoes Meerten and Pettigrew's second categorization of subtle prejudice, in which cultural differences are exaggerated to strengthen assumptions of incompatibility. Rather than seeing the divergent interpretations of the family's role in

treatment as “differently ethical,” as Fadiman put it, the nurse created a binary construction that placed the “Turkish culture” below “German culture.”¹⁴⁷

Likewise, when it came to communicating pain, which is given as the most common reason for emergency care use,¹⁴⁸ patients with migrant background also sometimes seemed to have a “different mentality.” Eight of the doctors and nurses I interviewed remarked how differently patients describe their symptoms depending on what kind of cultural group one has been raised in. One doctor noticed that patients of Asian background are much more withdrawn and suffer silently while patients of Mediterranean descent (particularly Turkish as the immigrant majority) are notorious among the health care staff for differences in expressing symptoms “They’re very loud,” one nurse commented straightforwardly (Head Nurse 1). As one head doctor discussed,

It sounds a little mean, but there is a saying here that we call „the Turkish whole-body-ache” or “Mediterranean whole-body-ache.” It’s common that older women from the Mediterranean who come and one asks what they have and they say “everything’s bad.” And the head and the breast and the stomach and the legs and arms--everything’s not working...meaning it’s relatively difficult to determine organ-specific symptoms. (Head Doctor 1)

Someone thinks she’s dying because the pain is so strong, and then you ask: how long have you had this pain? And then all of sudden you get the answer: 2 years. And then of course you’re relieved because it looked so dramatic. That’s always the problem, that one has the feeling that it’s being overly dramatized...but the feeling can be wrong, and it could really be serious and very extreme and new. (Doctor 3)

Here, returning once again to Meerten and Pettigrew’s definition of subtle prejudice allows one to see that such comments undoubtedly qualify as a covert practice of discrimination, reproducing racial dynamics through Orientalist representations. As one study examining pain expression in Berlin emergency facilities noted, such

¹⁴⁷ Fadiman, 242.

¹⁴⁸ M. David et al., “Ethnic Differences in Reported Pain Regions—Results of a Survey at Three Clinical Emergency Rooms in Berlin/Germany,” *Geburtsh Frauenheilk*, 71 (2011): 44-52.

“deviations from the norm” in pain expression are more likely the result of a Eurocentric standard of determining the norm without acknowledging itself as such.¹⁴⁹

Troubled Gender Dynamics

The most frustrating experience Fidan recounted from the ER was a few months before I began interviewing her in January, when her sister-in-law got into an accident, in which a bike collided with her; she fell and had sustained a concussion. An ambulance came to take her to the nearest emergency room but denied her husband’s request to accompany her, explaining that it was an “intimate atmosphere.”

“Maybe it’s because I’m a man that they won’t let me in--you try,” Fidan recounted him telling her. They wouldn’t let her in either, though.

“My stepsister hardly speaks German!” she told me. “She was in shock after the accident and clearly in a frightening situation. And she had nobody to help her translate.”

Of course, she and her brother (sister-in-law’s husband, obviously) rushed over to meet her at the emergency room as soon as they realized they couldn’t accompany her in the ambulance. But when they arrived, the doctors would not let either of them to go in to translate either. It wasn’t necessary right now, they told her. Fidan was so unhappy with how the situation had been handled that when a staff member finally emerged into the waiting room to ask who was with her sister-in-law, she not only informed him but complained very loudly, so that the whole waiting room could hear.

“I wanted to let them know they were wrong, and people around us started to agree with me, saying ‘yeah, that’s not right!’” she recalled, laughing at the memory of the ruckus she had caused.

¹⁴⁹ M. David et al. (2006), 674.

Fidan's experience illustrates how acutely aware Turkish men and women are of German stereotypes of Turkish gender relations, using such moments to negotiate their identity against these stereotypes, as Katherine Ewing explores in her the book *Stolen Honor: Stigmatizing Muslim Men in Berlin*.¹⁵⁰ Manipulating stereotypes, Ewing states, is an "interactional strategy to gain maneuvering room...an experience of knowing how to interpret as insiders, in contrast to the German discourse of otherness, which ignores the extent to which everyone uses similar maneuvers to delay making a decision or avoid confrontation."

Interestingly enough, while not a single person I interviewed felt religion had any contribution to misunderstandings in the ER, representations of Islamic gender relations arose as an issue in both interviews with patient interviewees and health care personnel. This observation is supported by the Babitsch et al. study, emergency doctors' satisfaction with the course of treatment were also to have shown sex-related variations, with male doctors more frequently dissatisfied than female doctors.¹⁵¹

Most Muslim patient interviewees did not perceive religion to directly influence their emergency room experiences; however, those that did were all women who chose to wear a headscarf and felt such an appearance lent itself to a change in doctors' and nurses' demeanors. Fidan observed that she was treated differently by her doctors than other non-Muslim patients.

It's the look alone...There's always a--not aggressive, that I wouldn't say-- a cautious look, as if one has to be careful around me, as if I'm something bad. One is very often spoken to with an undertone. It's never, "Yes, Frau ___, what can I do for you?" No, it's more "what is your problem?" as if they have to stand ready to battle....

¹⁵⁰ Ewing, 103.

¹⁵¹ Babitsch et al., 82.

On the other hand, when doctors and nurses explained challenges of treating patients, three discussed treating female Muslim patients who request to remain covered.

As one head doctor stated,

With Muslim patients sometimes it's hard because they are so in their religion that one can hardly examine them. Introverted in a lot of ways. And you can't just say, remove your clothes, I must examine you. It has to all be closed. You aren't allowed to see anything of the patients and so you end up doing Ultrasound...I've done this a number of times and they really have to keep covered...It's hard, it's time consuming, but so it goes. (Head Doctor 1)

Another one female doctor echoed similar sentiments, explaining that “what for somebody is essentially normal, for the Muslims would be like being examined naked in the hall (Doctor 1).” However, when the issue of covering did arise, it was almost always in the presence of either a husband or male family member.

I had such a female patient, who had the headscarf and everything. And as I was examining her, there was a little part of her forearm showing, and the man immediately covered it back up. She also had her gown on very tightly...but she never doubted my medical authority or not let me examine here. So one has more freedom with that, but one has to be attentive, definitely.

Despite these instances, what surprised me was the extent to which the covering of some female Muslim patients was considered a non-issue, both by health care personnel as well as patient interviewees. Most of my patient interviewees who covered themselves discussed positive experiences with little misunderstanding—as long as they took the initiative to ask for female doctors, their requests were usually respected. Similarly, as one might expect, the issue was perceived to be greater for male than female doctors. All female nurses, when asked about it, stated that they did not encounter any challenges specifically related to Muslim patients (though it is important to note that this difference in perspectives is just as likely due to a difference in their jobs as to gender, as

nurses do not physically examine patients.) Female doctors also did not regard it as an obstacle, and even two of the male personnel remarked at the relative ease with which they could handle female Muslim patients. A nurse at one of the hospitals noted that--“oddly enough”--while he is always careful to ask covered female patients if they are okay with him doing something that involves physical contact (e.g. bringing them to the bathroom) or if they would prefer a female nurse, the majority of them say they are okay with him.

On the other hand, two female doctors also expressed frustration with interacting with males of Middle Eastern origin who do not initially acknowledge her position as a female doctor:

What’s problematic of course is when one isn’t recognized as a female doctor by a man or a Muslim, or an Arab man sometimes. That has also happened to me. ‘Where is the doctor?’ And I’ll say, ‘I’m here.’ ... And that is sometimes a problem, but one certainly gets through it. So I’ll say then, I am now the doctor, I’ll be doing the examination, and generally that works there on out...But when I’m not recognized as a doctor because of cultural problems, it’s hard. Then the communication gets even worsened with either false translations or terribly slow translations, and of course that disturbs the doctor-patient relationship. (Doctor 1)

Another nurse expressed similar sentiments when either treating male patients of Middle Eastern background or accompanying male family members of patients. She told me she got “the feeling that some foreign men--particularly Arab men--do not want to be treated by women nurses or doctors, or do not recognize them as such. (Nurse 4)” A couple days before the interview, she said she had had “issues with an Arab man” she treated. She suspected had to do with the fact that she was a woman, though he denied it.

For most of the female doctors and nurses who have experienced this frustration, the difference in gender dynamic results in their perception from women in some cultures not having the same equality or not being of the same social status as “here,” in Germany.

While those who point to Islam's gender relations as fundamentally incompatible with German culture tend to focus on the "oppressed Muslim woman," such cases aptly illustrate how these notions are also projected onto Muslim men, who are subsequently seen as "oppressive" in their interactions not only with Muslim women but all women. Following Said's theory of Orientalism, these Muslim men may often already be subject to Orientalist constructions of their oppressiveness by western women, before they even speak or regardless of their actual behavior.

As Abu-Lughod writes, "the 'oppressed Muslim woman' is a trope of great symbolic power, restricted...under the thumb of her religion and her men," and the underlying tensions discussed reveal the extent of that power in the emergency room.¹⁵² The image of the restricted Muslim woman (and consequently the restricting Muslim man) is perhaps even more dominant in clinical settings, where control over one's body is constantly negotiated, and it becomes all the more apparent as a subtle undercurrent in doctor-patient interactions between German emergency care staff and their Muslim patients.

Training Cultural Sensitivity & Awareness

Although all the doctors I interviewed acknowledged sensitivity toward different backgrounds was important and enhanced their interactions between patients (none of the nurses suggested they found formal training necessary, so it was not a topic in our interviews), they also all felt that formal training in that area was either not necessary or a low priority in comparison to other needs.

There is a lot about cultural understanding from other cultures, from other religions that we can't systematically teach, because we have to learn so

¹⁵² Lila Abu-Lughod, *Writing Women's Worlds: Bedouin Stories* (Berkeley: University of California Press, 1993).

much. We have to regularly do “Reanimation-Training”, we have to inspect the medications, and so forth, so that there’s not much time left at all. (Head Doctor 2)

Instead, they often relied on either their accumulated personal experiences during their time as a doctor, considering this empirical learning to be sufficient.

One learns [cultural understanding] from one’s own experience in the practice. It’s commonly automatic that the students start here so that they go through daily routine. Whether or not that’s integrated in the nursing or medical education, my schooling was so long ago. The hope is, I think, that it is. Here in the practice we experience it directly in our daily routine, but I can’t really say for sure about a training strategy. (Doctor 1)

One of the head doctors cited the diversity of their fellow staff as a way to cultivate cultural awareness.

We have the luck, however, of having staff from all the major religions—we have a Middle Eastern colleague, we have colleagues from Poland, we have a colleague from Spain. And this mix alone, with staff who come from different ethnic backgrounds, helps us already to have a little bit of understanding for “otherness.” (Head Doctor 2)

A head nurse echoed these sentiments, citing the two Turkish employees—a doctor and a nurse—that had been working there at the time of the interview. Interactions with patients, she noted, were completely different when they spoke to the Turkish patients compared with when German staff attempted to. “I don’t know what [the doctor] says to the patients,” she mused. “But somehow he calms them down...with us, they’ll sometimes be impatient or unruly or even aggressive.”

When asked whether differences in ethnic, cultural, or religious background played a role in the delivery of medical care, all but two interviewees indicated that such differences played a secondary role, if any at all, in either communication or relationship between doctor and patient. Five of my informants insisted that all patients are fundamentally the same in a medical context. Furthermore, that would be unjust to

differentiate them based on ethnicity or culture or religion, for objectivity in treatment and respect for the individual person is essential for equality. Talking about the doctor-patient relationship, one of the nurses stated that “one has to really say that everyone is the same [in that respect]. There one can’t make distinctions.”

One shouldn’t simplify these matters, a head doctor echoed, as he began to show a little irritation at my questions about patients with immigrant background. It wouldn’t do the individual human being justice. Perhaps someone has a different ethnic background or a different religion, he told me, but the needs with regards to health and illness are the same for all human beings. Every person wants his pain to be taken away, and every person functions similarly when he has an illness. A doctor can therefore also treat a patient in similar ways, and patients with immigrant background are not a big topic among his staff or hospital boards.

Perhaps it is wrong [that we don’t consider treatment of patients with immigrant background such an important subject], but...when a patient with immigrant background comes and he has an illness or some kind of disturbance in the body, then we treat the patient with his disturbance. And then often the immigrant background doesn’t play a big role. It’s other factors then are the most important...but the medical treatment of a patient functions because he is a human being, regardless of what religion or background. (Head Doctor 2)

This can also be seen in an interview with one of the nurses, where when discussing cultural differences in cooperation, she stated that the existing difficulties transcended ethnicity and culture. “One has the same difficulties with Germans. There are also those that don’t want to listen, but those are everywhere. There everyone is the same--there are nice people and also mean people, but there are those in every country.”
(Nurse 3)

This insistence of the “sameness” of patients apart from ethnicity, class, or religion despite yet clear observations in differences of pain expression among patients struck me sometimes as paradoxical. Their assertion that a patient is ultimately viewed as an individual human being starkly reflects the attitude of the “apolitical body,” the notion that bodily pain or ailment and thus the medical treatment transcend social contexts. As discussed earlier, Ticktin thoroughly undermines the notion of an apolitical suffering body as a false construct because the very determination of what is “apolitical” is an exercise of political power in and of itself.¹⁵³

The Babitsch et al. study once again provides concrete support for Ticktin’s argument, showing that doctors' satisfaction with the course of treatment was significantly lower when attending Turkish patients than with German patients. Approximately 18% of the doctors expressed dissatisfaction with the course of treatment when attending Turkish patients compared with just under 11% with German patients.¹⁵⁴ Furthermore, the results of the Mygind et al. study indicate that both patient and provider express significantly less satisfaction with the encounter when the patients are of Middle Eastern origin, and that patient satisfaction is generally lower if patients immigrated from a non-western country.¹⁵⁵

Conclusion

In this chapter, I have done a comparative investigation of the challenges both medical providers and Muslim immigrants with ER experiences encounter during emergency treatment. From my interviews, emergency care staff do not seem to consider

¹⁵³ Ticktin, 40.

¹⁵⁴ Babitsch et al., 82.

¹⁵⁵ Mygind et al., 83.

challenges in language and migrant background to be structural barriers such that a systematic approach would be necessary to address the dissatisfactions noted by both medical staff and patients. Instead, half of them stated communication through individualized solutions—whether using body language or finding aid from a staff member or even a janitor—is sufficient, in some part because the physical ailment can be determined through physical tests. However, interviews with patients suggest that even if emergency care providers feel they have a situation under control, this may not translate into adequate communication and understanding on the side of the patient.

My interviews of emergency care staff and former Muslim immigrant patients, especially when juxtaposed with each other, indicate that German emergency care has still not adapted to a patient population that has become increasingly diverse over the past several decades, and that ethnic stratification, whether on the basis of language or perceived cultural differences, remains a hindering obstacle to equitable medical care.

I have found, then, that the emergency room as a highly socially charged atmosphere where tensions stemming from immigration, integration, Islam (specifically, language barriers, social expectations imposed on immigrants to learn the language and adopt certain values or customs) are exacerbated due to the already unpredictable, high-stress, time sensitive nature of the emergency room. In an environment where misunderstandings may occur frequently by its very organizational structure, these social issues then inevitably leads to greater miscommunication and misunderstanding between doctors and patients, even when they are sometimes built more on perceptions than actual fact, which subsequently lowers both doctor and patient satisfaction.

This conclusion has been echoed in a number of studies done looking at the impact of immigration on western medical care systems. According to Hudelson, who conducted a study exploring professional medical translators' experiences about patient-doctor communication difficulties in Geneva, three main factors contribute to communication problems and misunderstandings: first, misconceptions about patients' health problems; secondly, that patients have unrealistic expectations of emergency medical care; and finally, differences in verbal and non-verbal communication styles.¹⁵⁶ These three factors are strongly reflected in the results of this ethnography as well.

The observations made by the translators in Hudelson's study qualitatively highlight the need for a systematic procedure for dealing with communication barriers, showing that professional medical translation services are the safest and most superior choice to overcome language-related communication issues.¹⁵⁷ Based on my interviews, I, too, would recommend that professional translation service in the emergency department be implemented as a standard service.

However, the most important action to be taken by emergency care staff is the open acknowledgment that the racial hierarchies formed in German society have clear manifestations in the emergency department as well, and that subsequently the emergency room *is* a sociopolitically charged atmosphere rather than a space filled with apolitical bodies. Only when this discrepancy is corrected in doctors' and nurses' awareness can more substantial, concrete reform take place in the emergency room.

¹⁵⁶ P. Hudelson, "Improving patient-provider communication: insights from interpreters," *Family Practice*, 22 (2005): 311-316.

¹⁵⁷ Chan et al. 2010.

Conclusion

From my interviews with both emergency care staff and Muslim immigrants who have visited the emergency room, I found that emergency departments in Berlin are rife with social and political tensions, revealing the struggles of a health care system transitioning between a clinical model which has traditionally served a homogeneous population and a new system that adequately responds to the needs of a diversifying patient demographic. Before a conclusion about this argument can be made, however, this thesis must first recognize several limitations in both the ethnographic research as well as the analysis.

As this thesis is my first major ethnography, I have realized that the process of researching and writing itself has been the greatest source of learning. The most obvious limitations, then, are hinged upon the amount of time I had for this process. Anybody with only several months of ethnographic research in the field site runs (and indeed, I found that it took me as long to establish contact with hospitals and find informants as it did to conduct the actual research) into the difficulty of collecting sufficient data with which to make a confident analysis. Furthermore, the framework for my thesis is based on the research I conducted my second time in Berlin; I wish that I had had more time than the three months since to truly explore my interviews. Because of these time constraints, my thesis cannot offer any definitive conclusion about how significant a role religion and ethnicity truly play in the experiences and challenges of both patients and emergency care staff.

Ideally, I would have liked to conduct interviews with emergency care staff at one or two more emergency departments in order to gain a better understanding of how

different variables such as socio-economic status or geographical location impacted ER dynamics. And with the informants I did have in the emergency room, I wish I had the opportunity, if not the luxury to have more in-depth interviews lasting longer than half an hour, to conduct more follow-up interviews, and also the time to have gained their trust as a researcher. Indeed, trust was an important aspect of my staff interviews with that, especially for the interviews at the hospital where I did not do an internship, I had to struggle for simply throughout the course of the interview--with informants at this hospital, I did not have the opportunity to interact with them outside of the interview.

While the interviews with emergency care staff I did have were certainly fruitful, some were tinged with a professionalism that occasionally felt contrived. With these interviews, I would often come away with the feeling that I was being presented with a carefully modified picture of what my informants felt the dynamics of the emergency room *should* look like to me.

Along these lines, I also would have altered my interview approach and question methodology in order to improve informant receptivity to a sensitive issue. Upon finding through asking too-direct questions in my first few interviews that the assumptions my ethnography rested upon (that immigrant background *does* influence emergency care experience in Berlin, that the social context of Islam and immigration in Germany *does* carry into the emergency room), I began to doubt the validity of the research topic itself. The blank stares, defensive tones, and terse answers did not help. Although I conducted much better interviews using indirect, open-ended questions, I would occasionally still catch myself trying to clarify or follow-up on a statement made with a more direct

question that might have put some informants on the defensive as in my initial interviews.

I also liked to have had more participant observation to be able to gain a better visual understanding of what I was hearing in my interviews. While what limited participant observation I had allowed me to distinguish between perceptions or interpretations put forth in my interviews and the “reality” of a certain situation (or, at least, my own interpretation of it), I was not able to witness interactions that would have greatly enriched my ethnography, such as those between female doctors and male Muslim patients, doctors and patients who “dramatized” expressions of pain, or doctors and patients who disagreed on the role of family in treatment.

My ethnographic research is also limited in its ability to determine the particularity of the issues I discussed to German doctor/non-German patient interactions. I was lucky to have informal interviews with both a Turkish nurse as well as one of my German friends about their experiences in the emergency room from a doctor and patient perspective, respectively. Though each was only one informant in the categories of “non-German staff” and “German patient” and therefore cannot be used representatively, my interviews with both of them already challenged certain conclusions I had begun to make about how ethnic or cultural differences may influence doctor-patient interactions in the emergency room. If I could return to this research, I would conduct several interviews with non-German emergency care staff members as well as Germans with to establish that the trends I observed in doctor-patient interactions were contingent upon differences in ethnicity, religion, race, or language.

For my research analysis, one of the greatest limitations I encountered is the role of socio-economic status in the issues I discussed. Universal coverage is one of the greatest distinctions between the German and American health care systems, and because all residents of Germany have health insurance coverage--even Nadim does not have to worry about seeing the doctor without a legal status, as he is covered by the government--socio-economic status plays a much more subtle and indirect role in the emergency room dynamics of Germany compared with those in the States. Understanding this role is would have required far more deconstruction of Germany's health care system than this thesis could provide.

Finally, this ethnography also brings into a personal question of not only how an issue is studied or even what is being studied, but *who* is chosen to be studied as a research demographic. During this ethnography, I have constantly had to reflect on the importance of distinguishing between so many factors of identity that I wonder if perhaps a better research group should have narrowed some of these down.

Looking back, choosing such a broad research demographic for ten and two weeks of research ultimately produced this ethnography, which as a result can only scratch the surface. I found that every word I wrote could only serve to simplify a complex and multi-faceted truth, and though I could identify distinct patterns among my data, I found every one had glaring exceptions due to the incredible diversity within my chosen research demographic. As a result, in order to discuss and dissect these patterns, I felt that I had to leave others' experiences and viewpoints behind to silently mull over at a later time.

Indeed, when examining the experiences of both health care personnel and patients with immigrant background in the emergency room, I found the diversity of responses—especially from a patient perspective—to be overwhelming. This was particularly true when analyzing the issues brought up by doctors and nurses, such as language, perceived cultural differences, incorrect usage of emergency room.

The more I began to delve into the issues and concerns brought up in my interviews, the more I realized that these are not challenges that can be attributed to the umbrella research demographic “patients with immigrant background” or even the slightly more narrowed “patients with Muslim immigrant background.” I found that challenges and perspectives vastly differ across genders, generations, and language abilities (not to mention ethnicities), and to write a thorough ethnography that includes all of these factors is trying to do the impossible.

The emergency care experience of a second generation Turkish Muslim man, who is fluent in German, compared with that of a first generation elderly Turkish Muslim woman, who cannot speak a word of German and is veiled, are likely to be completely different. After all, the identity politics that surround their perceptions and interactions may often be worlds apart. Though they may be tied by ethnicity and religion, using these common threads alone as markers to judge their experience in certain settings—in this case, emergency facilities in Berlin—will inevitably perpetuate the essentializing notions of “otherness.”

In this sense, I have come to realize that I, as the researcher, am also just as subject to the same Orientalist influences I noticed in so many of my interviews with the emergency care doctors and nurses. Within the power structures embedded in the doctor-

patient interactions according to race, religion, gender, and class, I have found how my ethnography, in the very issue it strives to study, may in turn play its own part to perpetuate a prevailing notion of “otherness.” As Abu-Lughod observed, “The problem is about the production of knowledge in and for the West...as long as we are writing for the West about “the other,” we are implicated in projects that establish Western and cultural difference.”¹⁵⁸ This is because, she notes, the very power of Orientalism arises from its ability to construct whatever subject it discusses and thus establish a “regime of truth” about the other.¹⁵⁹

Despite these limitations, my ethnographic study did yield some useful insights with respect to the Muslim immigrant population’s experiences with emergency room healthcare and some possible initiatives that could be taken to address the issues raised.

The first step is that emergency facilities must develop a mechanism for addressing issues of translation. Due to the time-sensitive nature of medical care, emergency departments have typically avoided systematically instituting professional translation services, which head doctors have cited as being too costly. However, the current way of overcoming language barriers, as many observed, often results in a greater cost of resources as well as an increased expenditure in time. Translators are needed who not only understand and are able to interpret the nuances of each language, but also have enough familiarity with the culture to maintain sensitivity. Further research in Germany should be conducted to determine whether a systematized translation service for at least the most common languages--Turkish, Arabic, and Russian--would ultimately lower emergency care costs. In addition, research should examine what kind of interventions

¹⁵⁸ Lila Abu-Lughod, “‘Orientalism’ and Middle East Feminist Studies,” *Feminist Studies*, 27 (2001): 101-113, 113.

¹⁵⁹ Ibid.

and in what situations would most facilitate effective communication between patients and providers. According to studies done by Bernstein et al. (2002) and Hampers and McNulty (2002) on the effects of interpretation in American emergency facilities, having professional interpreters lowered costs and utilization of resources in emergency facilities compared with either having no interpreter or an untrained, casual interpreter (such as another family member).^{160,161}

Third, to address increased staff-determined inappropriate usage of the emergency room, one doctor felt a multi-faceted approach across the medical network was the only way such a large-scale issue could truly be mitigated. He expressed a desire to see greater collaboration with general practitioners, perhaps in the form of a seminar that discussed how the “current trend in simply sending patients to emergency room without even a diagnostic or anything” has subsequently put serious strain on emergency doctors and nurses. In addition, a stronger media campaign—for example, implementing a TV program—could be used to inform patients of both German and immigrant background. One way to do this would be to implement a TV program in different languages that describe what an emergency department is and how it functions. Patients should be given a fact sheet or brochure, the doctor said, explaining the functions of an emergency room and other alternatives.

In addition, emergency care departments should be supplemented with 24-hour non-emergency general clinics, a trend that several doctors mentioned as a possibility. As one of the head doctors noted, one such clinic is open and available for non-emergencies that occur at times a patient’s general practice is closed (such as the weekends or at

¹⁶⁰ J. Bernstein et al., „Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-Up,” *Journal of Immigrant Health* 4 (2003):171–76, 175.

¹⁶¹ Hampers and McNulty, 1110.

night). However, it is often underutilized due to a lack of knowledge about its services and also its relatively far location from the hospital, which is where most patients go during normal daytime hours.

Emergency care would benefit from training doctors and nurses in how effectively to communicate with patients from all different backgrounds. This could be implemented in sessions that address concerns about perceived cultural differences, such as how to most effectively respond with differing modes of pain expression. Moreover, such training could shift emphasis away from simply explaining “cultural differences” and rather encourage awareness about the possible structural barriers that may result in the interactions that take place in the emergency room. In order to truly deliver effective health care, according to Arthur Kleinman, a physician must have a concern “for the psycho-social and cultural facets that give illness context and meaning”--something I found not emphasized within the medical care system in Berlin.¹⁶²

Finally, while ethnography suggests that these barriers do indeed seem to exist as a subtle but defining undercurrent of one’s emergency care experience, it can only continue to raise important questions that must be researched with much greater depth. There is a dire need for more research on what exactly these structural barriers are and to what extent they influence the effectiveness of emergency care treatment. For example, my interviews with both emergency care personnel and former patients challenge the prevailing notion in the literature that suggests ethnicity (and thus perhaps culture) plays a significant role in the rising usage of emergency care as well as increasing incorrect usage. More rigorous studies should be conducted that test either for significance by controlling for variables of socio-economic status, education level, gender, and

¹⁶²Kleinman, Arthur as quoted in Fadiman, 265.

generation. Furthermore, there is a dire need for studies that use more qualitative methodology rather than simply compile categorical answers from a questionnaire. From my internship over the summer, I saw how many confounding factors could distort the data of a voluntary survey measuring outpatient satisfaction. Instead, it would be much more useful to conduct interviews from a random sample of emergency patients discussing the details and motivations of their visits.

Most importantly, however, emergency medical doctors and nurses must recognize the issues discussed in this thesis, ranging from translation issues to differential modes of pain expression, as structural issues rather than isolated incidents to simply be dealt with when they occur. They must realize that their interactions with Muslim immigrant patients are not immune to the racial hierarchies that are formed and negotiated within the context of integration, and that the emergency room is a sociopolitical space in which racial dynamics, built on broader societal notions of nationhood and Orientalist imaginations, are constantly reinforced.

As Fadiman observes, medical staff cannot successfully deal with other cultures without first recognizing the interests, emotions, and biases of their own culture.¹⁶³ This must be done by communicating directly with patients more and trying to understand *their* perspective. Here it is useful to return to Foucault, whose theory of “clinical gaze” is particularly relevant in the emergency room due to the authority given to emergency care staff to define what an “emergency” is, meaning they have the power to determine the very extent to which something is “life-threatening.” Ticktin illustrates the necessity of recognizing such definitions are recognized as subjective and influenced. “What qualifies as “life threatening” when life itself remains undefined?” she asks. “...Biological

¹⁶³ Fadiman, 261.

life is more malleable in its abstractness than those who insist on its universality may realize. There is room for play.”¹⁶⁴ In addition to this power conferred onto emergency doctors, clinical gaze is also particularly strong due to the loss of communication that is already inherent in the structure of the emergency room and compounded even further by language barriers as well as social and cultural misunderstandings. Because doctors must make decisions on a far more urgent basis, in an emergency room, their patients--both German and non-German--have subsequently far less negotiating power over their experiences when they visit.

With far greater clinical gaze and less verbal communication between patients and their doctors, several layers of paradoxical treatments of the patient occur. On the one hand, emergency care staff insist on viewing the patient as an “individual”--to make any generalizations along ethnic, racial, and cultural lines would be to do individual persons an injustice. And yet, my thesis illustrates that doctors and nurses openly acknowledge or perceive difficulties associated specifically with immigrant background. To resolve this contradiction, these difficulties are prioritized as secondary and less important, especially when compared with the biomedical aspects of emergency care. Problems relating to immigrant background are thus either not recognized or ignored as systemic issues and subsequently dealt with on an individualized, case-by-case basis (as most clearly illustrated by the handling of language barriers). By de-emphasizing these issues, doctors and nurses can comfortably state that implementing standardized solutions for them are too costly and unfeasible, ultimately deeming them unnecessary.

Yet by constructing a hierarchy in which biomedicine is given paramount importance to the point of completely overshadowing other aspects of emergency care,

¹⁶⁴ Ticktin, 42.

doctors and nurses present an attitude toward dealing with these issues that reveals yet another paradoxical mentality: the idea that the emergency room, because its function centers on preserving one's biological being at the very edge of life and death, is therefore a space full of apolitical bodies, isolated from socio-political associations that surround a person in the any other realm of his or her life. Ironically, such an assertion relies on the universality, not the individuality, of the patient through a strictly biomedical lens. Furthermore, its end result is to strip a patient of his or her social, cultural, and political identity--indeed, the very dimensions that make the patient an "individual."

Both the claims of embracing the singular and universal qualities of a patient are presented to serve the same purpose: to deny that issues related to ethnicity, religion, language, and race exist structurally rather than as individual incidents, to consequently reduce both personal and institutional responsibility to address these issues, and finally, to assert that the current approach to these issues within emergency facilities sufficiently "functions."

The clear contradictions in such an argument, however, unfortunately suggest that these assertions are simply not true. On the contrary, they imply the opposite. It is in the very denial of these issues' importance as structural barriers that the power structures found serving to enforce differential exclusion along ethnic, religious, and racial lines outside the emergency room are just as evident in the emergency room. And in allowing the prevalence of clinical gaze and the notion of the apolitical body to dominate the mentality of emergency medical care, doctors and nurses perpetuate conceptions of

Orientalism and subsequent practices of subtle prejudice in their interactions with Muslim immigrant patients.

Moreover, especially in situations with language barriers, these power structures carry over from the larger social context to possibly exacerbate tensions and misunderstandings that are generated from the larger systemic factors at play. In a medical setting such as the emergency room, where decisions on the doctors' part are often unable to be clarified due to time constraints and doctor-patient interactions are already often tinged with urgency and frustration by the sheer nature of a given situation, even actions and interactions made solely on a medical reason may play into the power dynamics of one's ethnicity, religion, gender, or immigration status. Thus, in an emergency room, the misunderstandings between both provider and patients may serve to reinforce existent racial dynamics far more than even the initial perceptions and biases themselves.

If issues associated with emergency medical care for Muslim immigrants are not acknowledged as systemic and arising from existent power structures, the emergency room will only continue to reproduce and reinforce such structures. And until the differential exclusion is addressed as such, emergency medical care in Berlin will be incapable of ensuring all of its patients get effective and equitable treatment.

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