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Evaluation of Foreign National Cases from a Forensic Medicine Perspective

Abstract

Background: Global migration has increased the number of foreign nationals residing in Türkiye, creating challenges for healthcare services, particularly in forensic medicine. Cultural, linguistic, and socioeconomic barriers often hinder migrants' access to appropriate trauma care, emphasizing the need for culturally competent approaches in forensic practice.

Aim: This study aimed to evaluate the sociodemographic characteristics and trauma histories of foreign nationals in Türkiye, addressing the limited research on forensic cases involving migrants from a transcultural nursing perspective.

Methods: A retrospective analysis was conducted on hospital records between October 10, 2021 and August 30, 2024. The sample included 120 foreign nationals who presented to the emergency department, had forensic notifications filed, and subsequently attended the same hospital's forensic medicine polyclinic. Data were collected using an "Individual Information Form" and analyzed using descriptive statistics and Chi-square tests with KNIME software.

Results: The sample consisted of 120 foreign nationals, including 78 males and 42 females, with mean ages of 37.6 years (standard deviation [SD]=12.3) and 41.0 years (SD=14.8), respectively. Among the cases, 50.83% were related to traffic accidents and 31.67% to physical assaults. Significant differences in trauma types were observed across nationalities and genders ($p<0.05$). Sociodemographic factors such as age, gender, and nationality influenced the nature and context of trauma.

Conclusion: Nationality and other sociodemographic variables significantly shape traumatic experiences. Integrating transcultural nursing principles, interpreter support, and cultural sensitivity training into forensic medical practice can improve the accuracy of evaluations and enhance the quality of trauma care for migrant populations.

Keywords: Cultural sensitivity, forensic medicine, foreign nationals, migration, transcultural nursing, trauma

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Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), the global number of forcibly displaced persons reached 117.3 million by the end of 2023, with Türkiye hosting approximately 3.6 million Syrian refugees, the largest refugee population worldwide.[1] This demographic shift has coincided with a 45% increase in emergency department visits by foreign nationals in Turkish healthcare facilities between 2019 and 2023, with forensic cases representing an increasing proportion of these visits. These figures underscore the growing demands on Türkiye's healthcare system and highlight the need for targeted approaches in forensic medicine.[2]

Migrants often face cultural, linguistic, and socioeconomic barriers that hinder access to healthcare, and these challenges are particularly pronounced in forensic cases involving trauma, assault, or accidents.[3] Despite international attention to migrant health, a critical gap remains in understanding how cultural factors influence trauma documentation, treatment adherence, and the accuracy of forensic evaluations. Previous studies in Türkiye have examined healthcare access barriers for migrants,[4,5] but none have systematically investigated trauma patterns in forensic medical services through a culturally sensitive lens.

This study addresses this gap by applying Leininger's Transcultural Nursing Theory, which emphasizes culturally congruent care (care aligned with patients' cultural values, beliefs, and lifeways) to improve health outcomes. The theory's three modes of action (cultural care preservation, accommodation, and repatterning) provide a framework for understanding how cultural factors shape trauma disclosure, help-seeking behaviors, and forensic documentation accuracy (Fig. 1). The model was operationalized to guide nurses in providing culturally congruent care during forensic assessments, ensuring that trauma evaluation aligns with patients' cultural values. In forensic contexts, culturally competent care is essential for both accurate assessment and effective intervention.[6]

Traumatic experiences among foreign nationals are influenced not only by individual factors (age, gender, personal history) but also by external factors such as violence, occupational accidents, family-related violence, and forced displacement.[7] Many migrants present with complex trauma histories related to conflict, war, or persecution in their countries of origin, necessitating culturally informed approaches to care.[8] Accurate documentation and culturally sensitive evaluation are therefore critical, particularly as the number of foreign nationals in Türkiye continues to rise.[9]

The present study examines the sociodemographic characteristics and trauma histories of foreign nationals presenting to emergency and forensic medical services in Türkiye, with an emphasis on culturally sensitive nursing. By integrating transcultural nursing principles into forensic practice, the study aims to improve trauma care quality, enhance patient recovery, and inform inclusive health policies for diverse migrant populations.

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Aim of the Study

This study aims to assess the role of culturally competent care in forensic medical practice and to identify key sociodemographic and trauma-related factors that influence the accuracy and effectiveness of forensic evaluations for foreign nationals in Türkiye.

Research Questions

1. What are the sociodemographic characteristics (e.g., nationality, gender, age) of foreign nationals presenting with trauma to emergency and forensic medical services in Türkiye?
2. How do trauma histories (e.g., previous traumatic experiences, trauma types) influence forensic medical examination and outcomes among foreign nationals?
3. How do cultural differences influence foreign nationals' trauma disclosure, compliance with treatment, and experiences in forensic medical care?

Materials and Methods

Research Design and Location

The research design was retrospective and descriptive, following a quantitative research methodology. This design enabled the quantitative analysis of demographic variables (independent variables) and trauma outcomes (dependent variables), with nationality, gender, and age serving as primary independent variables, while trauma type, severity, and treatment outcomes served as dependent variables. This design was chosen to analyze healthcare utilization patterns, identify demographic trends, compare trauma types and outcomes, and inform evidence-based policy recommendations. The study was conducted at a primary healthcare provider in Western Türkiye, which handles over 200,000 annual emergency visits and includes a forensic medicine unit with multilingual staff.

Research Population and Sample

The study population consisted of individuals who presented to the Hospital Emergency Service and Forensic Medicine Polyclinic between October 10, 2021 and August 30, 2024. Sample size was determined using a convenience sampling methodology based on the total number of foreign nationals meeting the inclusion criteria during the study period. A post-hoc power analysis was conducted using G*Power 3.1.9.7 software. With a sample size of 120, an alpha level of 0.05, and observed effect sizes (Cramér's V ranging from 0.30 to 0.45 for Chi-square tests), the achieved statistical power ranged from 0.82 to 0.95, indicating adequate power for detecting significant associations. The sample included 120 foreign national cases aged 18 and over, all of whom had a documented history of trauma. Excluded from the study were Turkish citizens, individuals under 18 years of age, those without a documented history of trauma, and cases with incomplete medical records.

Data Collection Tools

Data were obtained from the individual case files by the researchers. The "Individual Information Form" was developed based on a comprehensive literature review and validated through expert consultation (including eight nurses, three forensic medicine physicians, and seven emergency physicians) to ensure content relevance and clarity. The form included structured questions covering demographic characteristics (age, gender, nationality), trauma details (type, location, severity), perpetrator information, medical intervention requirements, and timing of healthcare presentation (Table 1). The information collected specifically included the following:

- Sociodemographic Characteristics: Age, gender, nationality.
- Trauma Histories: Type of trauma, location where the trauma occurred, and whether the trauma resulted in a bone fracture.
- Information About the Perpetrator: Identity of the perpetrator.
- Medical Intervention: Whether the trauma could be treated with simple medical intervention.
- Timing of Presentation: The time elapsed between the occurrence of trauma and presentation to the Forensic Medicine Polyclinic.

Data Collection

The research team collected data between September and October 2024. Medical records were accessed via the hospital's electronic health record system following institutional approval. Each case was systematically reviewed using a standardized form. To ensure inter-rater reliability, two researchers independently assessed a random sample of 20 cases (16.7%), achieving 95% agreement; discrepancies were resolved through consensus with a third researcher. Data were anonymized, coded numerically, and cases with missing critical information (demographics or primary trauma outcomes) were excluded.

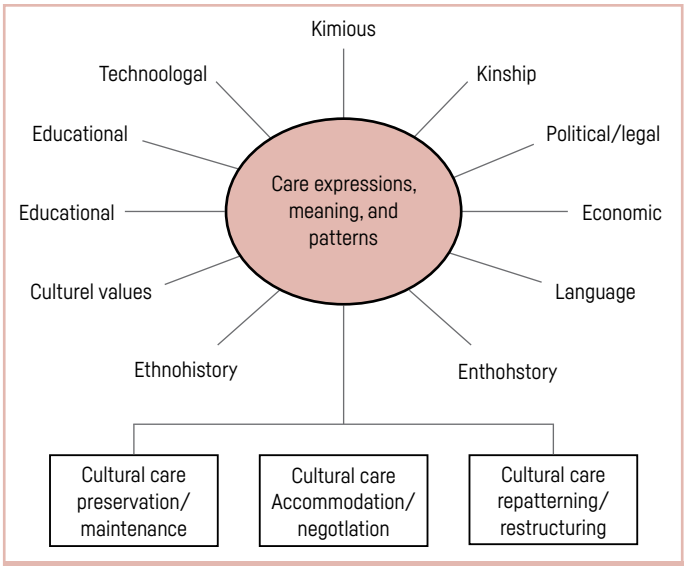

Figure 1. Leininger's transcultural nursing theory (adapted Sunrise Model).

Statistical Analysis

Data from foreign national individuals were coded and analyzed using the KNIME Analytics Platform (Version X.X, KNIME AG, Zurich, Switzerland). Descriptive statistics were calculated for sociodemographic and trauma variables. Associations between categorical variables were assessed using Chi-square or Fisher's Exact tests as appropriate, and standardized residuals were examined to identify significant deviations. Effect sizes were calculated using Cramér's V to assess the magnitude of associations, with values of 0.1, 0.3, and 0.5 interpreted as small, medium, and large effects, respectively. Cases with missing critical data (e.g., demographic variables or trauma outcomes) were excluded from specific analyses, while partially incomplete records were handled on a case-by-case basis. This approach ensured that missing data did not bias the statistical results. Statistical significance was set at $p<0.05$ (95% confidence interval).

Ethical Considerations

The study protocol was designed in accordance with the principles outlined in the Declaration of Helsinki. Ethical approval was obtained from the Balıkesir Atatürk City Hospital Non-interventional Clinical Research Ethics Committee (Approval Number: 2024/09/50, Date: 19.09.2024). Written informed consent was obtained from all individuals included in the study during their clinical assessment, in line with ethical approval procedures.

Table 1. Independent and dependent variables of the study

Independent variables	Dependent variables
Age	Type of trauma
Gender	Location of trauma
Nationality	Bone fracture occurrence
	Perpetrator identity
	Medical intervention requirement
	Timing of healthcare presentation

Table 2. Distribution of participants by gender and nationality (n=120)

Nationality	Gender				Total
	Female		Male		
	F	%	F	%	
Syria	5	16.1	26	83.9	31
United Kingdom	0	0.0	1	100.0	1
Ukraine	1	33.3	2	66.7	3
Azerbaijan	11	100.0	0	0.0	11
Afghanistan	6	35.3	11	64.7	17
Iraq	4	28.6	10	71.4	14
Iran	4	36.4	7	63.6	11
Russia	6	42.9	8	57.1	14
France	2	22.2	7	77.8	9
Germany	2	40.0	3	60.0	5
Netherlands	0	0.0	2	100.0	2
Austria	1	50.0	1	50.0	2
Total	42	35.0	78	65.0	120

Mean age (SD): Male=37.6 (12.3), Female=41.0 (14.8), Overall=38.85 (13.2). Statistical analysis: χ^2=32.45, df=11, p=0.001, Cramér's V=0.52 (large effect size). F : Frequency; SD: Standard deviation.

Table 3. Gender distribution across multiple variables (n=120)

Variables	Gender				Statistical analysis
	Male		Female		
	F	%	F	%	
Treatment type					
Medical	67	85.9	36	85.7	χ^2=10.12, df=1, p=0.001
Surgical	11	14.1	6	14.3	
Reason for admission					
Assault	29	37.3	9	21.4	χ^2=8.25, df=3, p=0.008
Traffic accident	36	46.2	25	59.5	
Work accident	8	10.3	5	11.9	
Fall	5	6.4	3	7.1	
Location of incident					
Home	28	35.9	14	33.3	χ^2=12.34, df=4, p=0.001
Urban open area	36	46.2	13	31.0	
Intercity highway	5	6.4	6	14.3	
Workplace	9	11.5	5	11.9	
Hotel	–	–	4	9.5	
Perpetrator relationship					
Unknown person	33	42.3	19	45.2	χ^2=11.56, df=3, p=0.013
Friend	16	20.5	5	11.9	
Relative	9	11.5	8	19.0	
One-sided	20	25.6	10	23.8	
Simple medical intervention status					
Treatable	42	66.7	21	33.3	χ^2=5.78, df=1, p=0.016
Not treatable	36	63.2	12	36.8	

F: Frequency.

Results

The sample comprised 120 foreign nationals, including 78 males (65.0%) and 42 females (35.0%), with mean ages of 37.6 years (standard deviation [SD]=12.3) and 41.0 years (SD=14.8), respectively. Syrian nationals represented the largest group (n=31, 25.8%), followed by Afghan nationals (n=17, 14.2%) and Iraqi nationals (n=14, 11.7%). Gender distribution varied significantly across nationalities (χ^2=32.45, df=11, p=0.001, Cramér's V=0.52, large effect) (Table 2).

Traffic accidents were the most common trauma type (50.8%), followed by physical assaults (31.7%). Most incidents occurred in urban open areas and homes. Gender differences were significant: males experienced more assaults, whereas females experienced more traffic accidents. Perpetrator patterns also differed by gender, with females more often assaulted by unknown persons or relatives, while males were more frequently involved in incidents perpetrated by friends. Forty-six percent of cases presented within 24 hours, 26.7% between 25 hours and 7 days, and 26.7% after more than 7 days, with no significant gender differences (χ^2 values: 2.45–11.89, df=2–4, p<0.05, Cramér's V=0.30–0.40, medium effect) (Table 3).

Medical intervention was required in the majority of cases (85.8%), while surgical treatment was needed in 14.2%. No significant gender differences were observed in treatment type or intervention complexity (χ^2>0.18, p>0.67) (Table 3).

Unknown persons were the most frequent perpetrators (43.3%), followed by unilateral trauma without a perpetrator (25.0%), friends (17.5%), and relatives (14.2%). Nationality influenced perpetrator patterns (χ^2=45.32, df=30, p=0.01, Cramér's V=0.35, medium effect) (Table 4).

Discussion

In this study, males comprised more than half of the sample, and the mean age of females was higher than that of males. This male predominance aligns with regional migration patterns and occupational exposure to high-risk activities, consistent with findings from European studies.[10,11] The slightly higher mean age among females may reflect family-based migration through reunification programs.[12] Factors such as greater mobility in public spaces, higher participation in hazardous occupations, and cultural norms influencing help-seeking behavior may explain these patterns. According to the results of this study, Syrian nationals accounted for one-fourth of the cases, reflecting Türkiye's role as the primary host country for Syrian refugees since 2011.[13] Populations from conflict zones experience cumulative trauma (pre-migration violence, perilous journeys, and post-migration stressors) necessitating specialized forensic assessment. Gender distribution varied across nationalities; for instance, all Azerbaijani cases were female, whereas Dutch cases were male. These variations likely reflect migration purpose, occupational roles, and sociocultural context.

Traffic accidents were the leading cause of trauma in the present study, exceeding the national average for Turkish citizens.[14] Contributing factors include unfamiliarity with local traffic patterns, language barriers, and employment in high-risk sectors. Males experienced more assaults, while females were more affected by traffic incidents. These findings highlight the need for gender-targeted prevention strategies, such as assault prevention programs for males and traffic safety education for females.[15] Analysis revealed culturally mediated patterns: female victims from Western countries were primarily assaulted by strangers, whereas Syrian women more often reported acquaintances as perpetrators.[16,17] These trends reflect differences in social integration, reporting behaviors, and vulnerability. Leininger's cultural care accommodation model emphasizes adapting forensic protocols to recognize how cultural norms influence trauma disclosure.[18] Culturally sensitive interview techniques are essential to collect accurate information without reinforcing stereotypes.

In this study, while nearly half of the cases presented within 24 hours, more than half experienced delays in accessing care, which may compromise evidence integrity and legal documentation. Barriers include fear of authorities, language difficulties, and lack of trust in the healthcare system.[7,19] Proactive outreach, multilingual resources, and trust-building initiatives are crucial to ensure timely and equitable care. Bridging the gap between timely access to care and culturally sensitive forensic practice requires integrating both systemic and cultural perspectives. Leininger's three care modalities (preservation, accommodation, and repatterning) provide guidance for culturally competent forensic care.[20] Preservation involves maintaining culturally supportive practices while ensuring forensic requirements; accommodation entails adapting protocols to patient needs, such as providing gender-concordant examiners or prayer spaces; and repatterning includes educating patients about proce-

Table 4. Trauma exposure by nationality and perpetrator relationship (n=120)

Nationality	Perpetrator relationship	Number of cases	% Of total cases	% Within nationality
Syria	Unknown person	13	10.83	41.93
	Friend	14	11.66	45.16
	Relative	1	0.8	3.22
	One-sided	3	2.5	9.66
United Kingdom	One-sided	1	0.88	100.00
Ukraine	Friend	1	0.88	33.33
	Relative	2	1.66	66.66
Azerbaijan	Unknown person	6	5	54.54
	Relative	3	2.5	27.27
	One-sided	2	1.66	18.18
Afghanistan	Unknown person	7	5.83	41.17
	Friend	6	5	35.29
	Relative	4	3.33	23.52
Iraq	Unknown person	2	1.66	14.28
	One-sided	12	10	85.71
Iran	Unknown person	5	4.16	45.45
	Relative	1	0.83	9.09
	One-sided	5	4.16	45.45
Russia	Unknown person	7	5.83	50.00
	Relative	6	5	42.85
	One-sided	1	0.83	7.14
France	Unknown person	8	6.66	88.88
	One-sided	1	0.83	11.11
Germany	Unknown person	4	3.33	80.00
	One-sided	1	0.83	20.00
Netherlands	One-sided	2	1.66	100.0
Austria	One-sided	2	1.66	100.0

Statistical analysis: χ^2=32.45, df=11, p=0.001, Cramér's V=0.52 (large effect size).

dural necessity while respecting cultural concerns.[21] Cultural competence should be viewed as an ongoing learning process rather than a static skill.

The findings of the present study underscore the need for culturally tailored forensic protocols, mandatory staff training, professional interpreter services, multilingual documentation, and trauma-informed care approaches. Gender-sensitive interventions, including assault prevention programs for males and traffic safety education for females, are recommended. Expanding access to post-trauma support services may improve recovery outcomes and mitigate long-term effects. Coordinated efforts among healthcare authorities, migrant organizations, and policymakers are required to ensure interventions are culturally appropriate and effective.[22,23] Furthermore, the findings suggest that transcultural nursing education programs and policy frameworks should explicitly address forensic scenarios involving foreign nationals, promoting equitable, culturally sensitive, and evidence-based healthcare delivery.

Limitations

This study was conducted in a single hospital in Balıkesir Province using a retrospective design. Therefore, the findings cannot be generalized to all hospitals or foreign national populations in Türkiye. Data were limited to variables recorded in the medical files, and information on patients' previous medical history or detailed socioeconomic factors, such as income, education level, and working conditions, was not available. The retrospective design also limited the ability to establish causal relationships between trauma exposure and long-term outcomes. Prospective, multi-center studies following individuals over time would help clarify recovery trajectories and better account for cultural and socioeconomic factors. Additionally, some potential influencing factors, such as mental health issues or substance use, were not assessed. Including these variables in future research could provide a more comprehensive understanding of foreign nationals' trauma experiences.

Conclusion

The increasing presence of foreign nationals in Türkiye adds complexity to forensic healthcare. Our findings indicate that gender, age, nationality, trauma type, and timing significantly shape case evaluations, highlighting the need for transcultural approaches. In clinical practice, integrating transcultural and trauma-informed nursing training into healthcare can strengthen cultural competence, enhance communication, and improve patient outcomes.[8,20,21] Future research should address psychosocial factors, social support, intergenerational trauma, and digital or language-accessible interventions.[3,20,24] At the policy level, equitable forensic care and migrant-sensitive regulations are essential to ensure fair access for diverse populations.[22] Bridging forensic medicine with culturally competent nursing is key to meeting the needs of a multicultural society.

Ethics Committee Approval: The study was approved by the Balıkesir Atatürk City Hospital Non-interventional Clinical Research Ethics Committee (Approval Number: 2024/09/50, Date: 19.09.2024).

Informed Consent: Written informed consent was obtained from all individuals included in the study.

Conflict of Interest: The authors have no conflicts of interest to declare.

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