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How do international medical graduates and colleagues perceive and deal with difficulties in everyday collaboration? A qualitative study

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Abstract

Aim: Many medical doctors work outside their countries of origin. Consequently, language barriers and cultural differences may result in miscommunication and tension in the workplace, leading to poor performance and quality of treatment, affecting patient safety. However, there is little information about how foreign doctors and their colleagues perceive their collaboration and handle situations that can affect the quality of health services.

Methods: Individual, semi-structured in-depth interviews were conducted with two groups of informants 16 doctors who had recently started working in Norway, and 12 unrelated Norwegian-born healthcare providers who had extensive experience working with doctors from foreign countries. Interviews were analysed according to the systematic text condensation method.

Results: The foreign doctors described themselves as newcomers and found it difficult to speak with colleagues about their shortcomings, as they wanted to be viewed as competent. The Norwegian colleagues reported that many new foreign doctors had demanding work schedules; therefore, they were reluctant to give them negative feedback. They also feared that foreign doctors would react negatively to criticism. All participants, both the new foreign doctors and colleagues, reported that they took responsibility for the prevention of misunderstandings and errors; nevertheless, they struggled to discuss such issues with each other.

Conclusions: Silence was the coping strategy adopted by foreign doctors and native healthcare professionals when facing difficulties in their working relationships. In such situations, many foreign doctors are socialised into a new workplace in which uncertainty and shortcomings are not openly discussed. Effective leadership and procedures to facilitate communication may alleviate this area of concern.

Keywords: IMGs, cross-cultural teamwork, safety culture, qualitative study

Introduction

Approximately 16% of all practising doctors in Norway are international medical graduates (IMGs) [1], born and medically educated in a country other than the one in which they practice. IMGs have become an important resource for Norwegian health services over the last decades, similar to other European countries [2], USA, Canada and Australia [3], with most IMGs coming from Germany and neighbouring Scandinavian countries and around 3.5% from countries outside the European Schengen area [1]. Many IMGs in Norway work as general practitioners [4], with 25% of senior doctors in Norwegian hospitals being IMGs [1].

Studies show that language barriers and cultural differences can impair communication between IMGs and native health professionals [5-11]. For new IMGs that are unfamiliar with their workplace, working relationships are important to become acquainted with work procedures and local cultural norms [5]. Some studies suggest that challenges associated with the acculturation process may result in vulnerability for emotional difficulties among IMGs such as burn-out, loss of self-esteem and feelings of being outsiders [6, 7, 9, 12], leading to an inclination not to collaborate with colleagues [8]. Fear of negative reactions can make it difficult for IMGs to show potential inadequacy or be open about mistakes [6]. Colleagues may also find that collaboration with IMGs is more demanding than with native doctors due to factors such as language difficulties and cultural background [13]. Extensive research has shown that, in general, there is a risk for IMGs to struggle in their new work context [for reviews, see 7, 8, 14, 15].

Communication between health care providers significantly affects patient safety [4, 5]. Helmreich and Merrits [18] showed that the safety culture is critical for efficient team interaction in hazardous situations; safety culture is generally relevant in most health services and not only in a high risk work environment [19]. Cox and Cox defined safety culture as reflecting the attitudes, beliefs, perceptions, and values that employees share in relation to safety, and involving psychological, social, and organisational dimensions [20]. Common components include acknowledgment of high risk, the error-prone nature of an organisation's activities, a blame-free environment where individuals are able to report errors or close calls without punishment, the expectation of collaboration across ranks to seek solutions to vulnerabilities and a willingness on the part of the organisation to direct resources to address safety concerns [21]. A strong safety culture encompasses colleagues that allocate work appropriately by competence and capacity, handle conflicts, give each other feedback, and do not fear negative reactions to errors or other aberrations [19]. In other words, employees being silent about safety critical issues are considered contradictory to safety culture. Based on Hofstedes cultural studies [22], Helmreich and Merrits

described how people from different countries may vary in their attitudes and behaviour in safety relevant situations; including their willingness to review and report errors or deficient task performance [18]. So, it follows that workplaces with employees from different nations may have to take more care to establish a strong safety culture

To our knowledge, neither IMG studies nor safety culture research have elaborated on how communication between IMGs and native health professionals is perceived by both parties, and how it affects collaboration. In this study, we aimed to provide such information, with an emphasis on how difficulties arise and affect safety and what kind of solutions, if any, the participants usually find. An interview-based study was conducted with new IMGs and Norwegian colleagues from different health service areas to explore this topic. The sociologist Erwin Goffman has provided a useful theoretical framework for understanding of social interactions in difficult situations [23]. This framework has informed our interpretations of participants' descriptions of dealing with such situations.

Method

Study setting and design

This study is part of the research project "Meeting Migrants in Health Care" funded by the Norwegian Research Council, with an overall aim to gain an insight into IMGs' perceptions of entering the profession in Norway and explore IMGs' and Norwegian colleagues' experiences of working together. The acculturation process of IMGs in Norway has been described previously [12]. In this paper, data on the IMGs' experiences of collaboration with colleagues in a new country are combined with native born professionals' descriptions of how they experienced collaborating with IMGs. The data were collected via qualitative semi-structured interviews with IMGs who had been in Norway less than two years, and Norwegian health providers experienced in collaborating with IMGs. Qualitative, in-depth, face-to-face interviews were used as the methodological approach as they are suitable to explore people's experiences and their own reflections on those experiences [24].

Sample and recruitment

During interviews, it is essential to ensure that the participants feel comfortable in sharing their thoughts and experiences. Since the doctors' community in Norway is small, anonymity was a concern, so only IMGs unknown to the researchers were recruited and their participation was anonymous. The IMGs were recruited from the National Health Personnel Registry of doctors given authorisation or license from 2010 to 2011. This also allowed a purposive sampling strategy to ensure sufficient variation of participants' age, sex and nationality, factors that could influence

their experience of coming to Norway as an IMG (Table 1). Eighteen IMGs were contacted by phone and all were willing to participate; however, two were geographically too far away to participate in a face-to-face interview. The remaining IMGs were from all parts of the country and their position ranged from intern to specialist. The IMGs chose the time and place for the interview. Recruitment was stopped when a sufficient range of descriptions to address the research questions had been collected.

In the study of native Norwegian colleagues' experiences, our intention was to recruit a purposive sample of key personnel experienced in cooperating with IMGs, therefore, nurses and doctors, as well as those in leadership positions were recruited. As with the IMG study, the participants in the colleague group were recruited from a wide spectre of health services (Table 2). Recruitment was accomplished via the professional network of the researchers. Recruited participants altogether had experience of collaboration with several hundred IMGs. Similar to the IMG study, additional participants might have provided more information but it is our opinion that descriptions collected provided purposive and manageable data with which to explore and describe common experiences from different perspectives.

Data collection

Separate interview guides for the two groups of participants were developed and pilot-tested prior to the data collection. The semi-structured interviews focused on specific personal experiences rather than general considerations; both groups of participants were encouraged to describe and reflect on positive collaboration as well as critical incidents from their everyday work. The interviews were conducted by the first author in 2012–13, and lasted from 30 to 90 minutes. They were conducted individually and face-to face, digitally recorded and transcribed by the first author. Data also consisted of the interviewer's notes of issues that may have influenced the interview situations as such information could be important when analysing transcriptions[24].

Data analysis

Malterud's method for systematic text condensation (STC) was used as it is appropriate for the analysis of meaning and content [24]. STC is inspired by Giorgi's descriptive phenomenological method in psychology [25] and proceeds through the following stages: (1) reading all the material to obtain an overall impression, bracketing previous preconceptions; (2) identifying units of meaning, representing different aspects of the collaboration between IMGs and colleagues, and coding for these in the Nvivo software; (3) condensing and abstracting the meaning within each of

the coded groups; and (4) summarising the contents of each code group to generalise descriptions and concepts. First, the data from the IMG interviews were analysed and then the same procedure was applied to the colleague interview transcriptions. All interviews with both IMGs and Norwegian providers focused on giving the participant the opportunity to present and reflect on their daily work experiences. For the purpose of this paper, the analysis was restricted to what participant described as challenging situations in their everyday work collaborations. Other important interview topics such as language barriers, lack of system and role-knowledge and how the IMG can be a resource in Norwegian health care were beyond the scope of the present paper. The analysis alternated between the various stages throughout the entire analysis, which was essential to ensure that results were grounded in the transcripts. All authors read some of the transcripts and participated in the final choice of theory and the writing process. Two of the authors (ES and PG) performed most of the early analysis.

Ethics

Written consent was obtained from the participants and they had the opportunity to read the transcript from their own interview. The procedure for data collection and storage was approved by the local data protection officer. The Regional Committee of Medical and Health Research Ethics deemed that the project did not require a formal submission.

Results

IMGs and their native colleagues described difficult situations that they believed occurred because of the IMGs' foreign backgrounds. Their descriptions indicated that these situations were managed without dialogue between the involved co-workers about the incident. Furthermore, these difficulties and ways of handling the situation were prevalent across nationalities, professions and position level.

IMGs: To be new and stay silent to avoid conflict and appear competent

The lack of language skills, little insight into the doctor's role in Norwegian health services, insufficient knowledge of workplace routines, and, in general, limited knowledge of the Norwegian health system were factors that the IMGs had experienced which made interaction with colleagues and patients difficult. Some doubted their own professional abilities and described emotional reactions, such as crying and sadness. Most IMGs said that they knew about other IMGs who had quit their jobs due to difficulties in working relationships, and expressed concerns that this could also happen to them.

The Norwegian colleagues were, in many ways, characterised as friendly. Nonetheless, IMGs found it a strain to be unaware of what colleagues thought about them and whether they would get support in a difficult situation, as expressed by a senior doctor (with experience from two continents outside Europe) "I am not sure if my colleagues and boss think I do my job well. I have not received any feedback, but a couple of times I have found post-it notes on my PC indicating that I need to work on the language in the medical records. (...) But there has been no system for training or follow-up, and no introduction to procedures and systems for me as a new temporary employee".

Certain workplaces offered training and supervision, but typically, the IMG had to notify others of their needs and to actively ask for help to receive such services. Many said they were reluctant to request assistance from colleagues because they felt unfamiliar and uncertain, experienced language challenges, and worried about what their colleagues would think about them.

All IMGs were concerned about not creating situations that could become uncomfortable for patients, colleagues, or themselves. Many said they worked long hours to learn and incorporate necessary procedures. Difficulties related to being a newcomer were seen as natural but also demanding, a young woman described these difficulties as follows "In the first month, the first six weeks, it was horrible. The nurses helped me to translate so that patients could understand what I said. I was completely dependent on their help. (...) Some misunderstandings occurred; no big mistakes, but misunderstandings. I heard afterwards that my qualifications had been discussed [within the management]" (Junior doctor with background from Scandinavia and EU).

Moreover, all IMGs had been in situations where they had hidden their lack of knowledge or avoided seeking appropriate help from colleagues. No one believed that it had led to serious consequences for patients, but some suggested that it could have delayed efficient treatment or resulted in higher resource consumption. As most IMG participants held temporary positions and had experienced being evaluated, they considered it crucial to be seen as successful to acquire further employment. Others had tried to avoid drawing attention to themselves by adopting an anonymous role. Due to fear of making mistakes or being subjected to critical judgments, all IMGs reported that they had deliberately avoided some tasks, such as taking medical decisions, making phone calls, or speaking to patients. Avoidance or delay emerged as a common strategy when they did not know how things were going to be solved. A Scandinavian doctor described "I have been in situations where I have not asked [colleagues] for help, because I did not want to show that I did not understand" (Senior doctor with background from Scandinavia). This was also common among IMGs from countries that are geographically and/or culturally distant from

Norway "You do not want to look like you are stupid in front of other colleagues. You dare not ask, you try to avoid making a telephone call, or doing things you would otherwise do. Then you lose self-confidence" (Junior doctor from an English-speaking country outside Europe).

Several IMGs had experienced disagreements with colleagues about how the job should be done or who should do it, especially challenging was the distribution of tasks between nurses and doctors. A minority of the IMGs said that it had been necessary to demonstrate authority and competence to colleagues using verbal correction or reprimands. Three doctors had experienced conflicts that forced them to change jobs. One of them described the situation as follows "The nurses had submitted handwritten notes from my consultations [he had not been informed about this before]. I was summoned to a meeting with the professionally responsible doctor to discuss these issues. It was terribly insulting" (Senior doctor with background from Asia). In addition, several IMGs had difficulty describing how they could have reduced or avoided the challenging interaction; they did not understand when and how these events developed.

Colleagues: To appear benevolent and stay silent to avoid discomfort

Participants in the colleague group agreed that new IMGs were welcome at their workplaces and confirmed the view of the IMGs that training targeted at newcomers was lacking. All said that they had experienced working with IMGs who made great efforts to become familiar with the workplace and the Norwegian health services. Nonetheless, they had also observed errors or misunderstandings related to IMGs, with language barriers perceived to be the main challenge. They described that some IMGs did not recognize or took into consideration their own language deficiencies and that they had been in situations in which they had to resolve misunderstandings, like this nurse "You have to pay close attention when you do rounds in order to know what she [the IMG] has said so that you can possibly explain it later [to the patient]. There have not been any major problems, but misunderstandings happen. She [the IMG] means, for example, to say that the patient could go home soon, but the patient thought she meant that she could leave now" (Nurse).

In general, IMGs were considered as clinically competent. Nonetheless, a small number were described as having practical deficiencies or outdated knowledge that caused difficulties. Challenges in interaction resulting from cultural differences were also mentioned, for example, that some IMGs were prejudiced towards women, gays, or elderly people.

Furthermore, colleagues described some IMGs, both from neighbouring countries and further afield, as "old-fashioned" in their communication. This also made interactions difficult, "They have a different way to relate to people. Sometimes it seems like it is in the same vein as it

was here thirty to forty years ago when there was a more hierarchical division. Then, the doctor always had the final word; now, it is more as we are a team together. It is about solving things as well as possible and then everyone has to be involved. Some IMGs still practice the old culture especially when it comes to lack of acceptance for suggestions from subordinate personnel, to be overconfident in their attitudes and have a tendency to put a lid on discussion. They simply decide and can play the trump card of saying: That is just the way it is" (Senior doctor 1).

Most colleagues reported experiences of IMGs making decisions too fast, dismissed talking about professional subjects, were unwilling to listen, or became loudmouthed or angry. One hospital doctor described how an unfortunate culture of non-collaboration had evolved in her department because of several authoritarian IMG senior doctors showing little transparency about their own professional uncertainty, "In general, they exude certainty, regardless of whatever they are going to do. Whether it is cultural, or a defence mechanism because it can be difficult to work as a doctor in Norway, I do not know. It is rare that they open up to show uncertainty, I think. They are very, "chest forward" and go on, anyway. They certainly never indicate anything else" (Senior doctor 2).

Many had experienced that IMGs, to a greater extent than Norwegian doctors, protested or denied having deviated from normal practice, making dialogue difficult. An experienced doctor reported that feedback was often not understood by IMGs, "They do not understand people complaining about them. They get upset and are outraged by the patients and furious about the system that accepts patient complaints - or they become quiet. On one level they recognise that it is serious, but they do not understand why" (Senior doctor 3). Those experiences led him, like the other colleagues in the study, to avoid correcting IMGs as directly as he did Norwegian colleagues. Senior doctors had mostly positive experiences with regard to conversations with IMGs about medical subjects, but refrained from talking about inappropriate behaviour. Junior doctors talked about seniors with foreign backgrounds that repeatedly made mistakes but they did not comment due to a fear of their reaction. Some nurses said they hinted or had open confrontations.

Many colleagues gave examples of how they spent considerable time attempting to prevent, resolve and process difficult situations without mentioning it to the IMG responsible for the situation. Colleagues often sought support and talked to each other about such situations, for example, there were reports from three different workplaces of leaders agreeing to take notes about events where IMGs created difficulties but in all three cases, the colleagues did not believe that the IMG was informed about their concerns. Colleagues also described situations that led to

written complaints by management, nurses, patients, or relatives, about the IMGs. Nobody described situations where a doctor outside a leadership position wrote complaints about IMGs.

Discussion

The results from both participant groups in this study are consistent and support previous research showing that many IMGs and colleagues experience that language barriers and cultural differences interfere with efficient cooperation [10-15], contributing to psychological stress [11, 12, 16] for the IMGs in particular. Furthermore, in accordance with previous research, stress among IMGs was often associated with a lack of openness about mistakes and their own shortcomings [6]. A lack of effective collaboration between healthcare personnel and a refusal to raise concerns or disagreements has the potential to affect healthcare quality and safety [16, 26].

This study provides information, from the perspectives of new IMGs and colleagues, on how such collaboration is experienced and affects working life. All participants gave tangible examples of difficulties in collaboration between IMGs and colleagues which they attributed to cultural differences, particularly in situations perceived as having the potential to create conflict, discomfort, or which could expose a lack of competence.

Previous research has shown that IMGs can experience exclusion and discrimination from colleagues [23]. In this study, participants did not describe an unwillingness to work with each other. Nonetheless, communication about difficulties was generally perceived to be uncomfortable and therefore, avoided. In his widely recognized paper "on-face-work", Goffman [23] described how "the law of consideration and self-respect" are general human rituals of "getting through" and preserve face in unfamiliar interactional situations. From this perspective, colleagues' silent management of difficult encounters can be understood as a consideration not to impede IMGs' initial work phase in Norway. In addition, they save themselves from awkwardness or discomfort that may arise when bringing up problems in interactions. IMGs' silence, on the other hand, can be perceived as a means to maintain or protect their own dignity by avoiding acknowledging inadequacy or being inconvenienced by their colleagues.

According to Goffman, such silent situations represent "working acceptance" that those involved respond to later [23]. Colleagues often talked to each other about the IMG following a difficult situation, although not with the IMG involved. The interviews also revealed that colleagues had collected evidence of IMGs without their knowledge. For IMGs, their later responses seem to be a reluctance to interact with colleagues, a feeling of insecurity, and personal

difficulties. Some IMGs in the study had been aware that their shortcomings were a topic of conversation among the staff. They described anger and loss of face, and that they had remained silent about difficulties in their daily work throughout their employment. Face-work, including Goffman's concept of face-work, is recognised as a universal phenomenon and a relevant perspective when exploring interaction and conflicts [28], but face concepts also have cultural peculiarities based on predominant values in different societies. In this study, common descriptions have been collected and individual participants' different cultural values were not examined. Our results indicate that "silent managing" of difficult situations in face-to-face collaboration emerges more as a consideration of each other than as antipathy.

The results must be considered in the context of Norwegian working life. The Norwegian culture is distinct from many other countries by lower power distance and a stronger emphasis on what Hofstede calls "feminine values" [22]. In a work context, these values are expressed by a focus on cooperation and concern for the wellbeing of others [29]. This indicates that the Norwegian work life is consensus oriented and conflict avoiding, and not well equipped to address cultural differences that could appear as challenging. Such egalitarian values were also observed in a study of lower-educated personnel in a Norwegian hospital that described a culture with a lack of awareness about cultural differences and diversity among the employees [30]. For IMGs, the "low power distance" of the Norwegian working life may be difficult to understand and adapt to, especially if it is associated with higher prestige and authority to be a doctor from their countries of origin. Lack of feedback and poor working relationships can give both colleagues and IMGs limited input for developing mutual cultural understanding and learning.

From a safety culture perspective, silence as a coping strategy gives reason for concern. Language barriers and cultural differences may affect handling of difficult situations and professionals should be aware of and be prepared to remediate this [18]. The findings from the present study show that new IMGs and their colleagues were entrusted with the responsibility of maintaining quality and safety in their work without supportive structures. Safety literature describes how a lack of leadership and structure can result in employees who "become aloof, disregard team-mates, and take undue risks" [18]. This may increase the risk of "random errors" and generally, a "higher probability of accident or incident" [18]. In our data, there were few descriptions of serious mistakes, rather many situations where participants experienced difficulties and took significant personal responsibility to avoid mistakes. Nonetheless, there are potential safety risks associated with a culture in which errors and problems in collaboration are not recognized and openly discussed.

Methodological considerations

IMGs in Norway are a diverse group. The possible impact of individual variables such as nationality, position and gender was not addressed in this study. Nevertheless, the results indicate that newly employed IMGs encounter many of the same challenges irrespective of their background or other characteristics selected for the purpose of this paper. Interviews do not provide evidence for what actually happened in interactions and maybe influenced by retrieval bias. A compilation of descriptions may give a deeper understanding of typical difficulties and how these tend to be handled. It is possible that participants' statements might be incomplete or influenced by social desirability [31]; however, the similarities between descriptions made by the IMGs and the Norwegian born health personnel, respectively, underpin that silence as a coping strategy is commonplace in Norwegian healthcare.

Future research could determine if these results reflect the peculiarities of the Norwegian health service or represent a common challenge when healthcare professionals cross borders for work. Such research should include larger populations and both disciplinary and interdisciplinary perspectives. From a safety perspective, our results highlight the need for knowledge to better facilitate interactions between new IMGs and colleagues.

Conclusion

IMGs represent a resource for the Norwegian health care system in terms compensating for the shortage of medical doctors in different areas. Research indicates that diversity in teams may positively influence on problem solving by giving access to a large variety of perspectives and experiences. Nonetheless, such benefits may be hindered by problems in communication as indicated by the present study. IMGs and colleagues appreciated the need for collaboration and dialogue in relation to difficult situations but experienced barriers that made them avoid difficulties by remaining silent. This behaviour is in keeping with Goffman's description of general human consideration and self-respect and face maintaining. However, silence about such situations could contribute to unexpected events, reducing the quality of health services and potentially fatal from a safety perspective. Dialogue about uncertainty and defects is a hallmark of professional practice [18, 32], so it is paramount that leaders in healthcare today create a safe climate for disclosure of such difficulties. This includes mentoring of newcomers, in particular, when one can expect challenges related to a lack of familiarity with local norms.

Practical implications

There is a need for more research to investigate how health professionals with different languages and cultural backgrounds interact. The findings from this study indicate that the Norwegian

healthcare professionals require training on how to handle such difficulties in their working relationships. This training should be derived from a safety culture, in which responsive leadership and colleague feedback are crucial components; such systems could lead to more open dialogue with less effort spent on uncertainty and face-work, ultimately improving patient care and safety.

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