



## The European Intercultural Workplace



# HEALTHCARE SERVICES

A comparative investigation into workplace practices  
in the healthcare sector across ten European countries



Education and Culture

Leonardo da Vinci

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## **Preface**

European workplaces are experiencing major transformation. Economic and political changes in Europe over recent decades have resulted in a vast increase in the cultural diversity of those living, working and being educated within its borders. The expansion of the EU coupled with labour shortages in many parts of the continent have brought about a steady increase in mobility both within and from outside the European Economic Area, a trend that is likely to continue and expand.

How similar are the challenges and opportunities of the intercultural workplace in different sectors and in different Member States? What pitfalls to be avoided and examples of good practice can be shared between EU countries? What intercultural training needs exist and how best can these be addressed? These are some of the key questions that inspired the development of the European Intercultural Workplace (EIW) Project (2004-2007). Originally conceptualised in Dublin City University, Ireland, and grant funded by the EU Leonardo da Vinci Programme, the EIW Project was developed and expanded through a network of ten partners from all across Europe, north to south and west to east, from the earliest to the newest EU Member States, from countries with a long experience of integrating foreigners into the workforce to others for whom interculturalism is a wholly new phenomenon.

A core outcome of the EIW Project, and a primary aim of this Healthcare Report, is the establishment of an overview of sector-specific work practices across Europe based on national situational analyses and workplace case studies. In each partner country, research was conducted in a variety of workplaces across the Private sector, Public sector and Education. The perspectives of managers, employees and customers/service users from both host and migrant communities were examined and compared. Subsequently, findings from the ten countries' EIW National Reports were drawn together to produce three trans-national comparative reports in the following key areas: Business and Economy (SMEs), Social Services (Healthcare) and Education and Training (focusing on formal education at primary, secondary and third level).

This Healthcare Report aims to provide information to help policy makers and practitioners identify intercultural training needs and good practice responses within Europe and to inform the production of effective intercultural training materials to a common European standard. To this end, the EIW Project has produced training materials (DVD & Manual) based on the results collated in this Sector-Specific Report and the ten individual EIW National Reports, to help management and employees develop more effectively the process of integration and intercultural harmony in the workplace.

This Report is by no means exhaustive; inevitably the editing process has meant leaving out some material which may be of use to prospective users. For more detailed information, and to find out more about our training materials, please visit the European Intercultural Workplace website ([www.eiworkplace.net](http://www.eiworkplace.net)).

## 1. Introduction

Ethnic diversity is generally not a new thing in healthcare and throughout Europe many policies and practices have been put in place to acknowledge and support differences in this area. In relation to cultural diversity and immigration, the role of health service is not limited to the narrow provision of medical care, but it aims to tackle disadvantage in all its forms, and meet the specific health needs of particular groups, including ethnic minority groups. Improving health remains a priority for all governments and access to healthcare should continue to be in the spotlight of cross-governmental action in Europe.

The matter of accessing health services is of particular concern since many minority ethnic communities, which became established in countries across Europe in the latter half of the 20th century, are ageing, and are likely to have increasing need for such services over the next 20 years. Alas, ethnicity can still be a key factor in health inequalities, and the '*inverse care law*' – where communities in greatest need are least likely to receive the health services that they require – still applies in too many parts of Europe. The matter may have little to do with the governments' actual provision of healthcare, which is in principle equally available to all; more often access is prevented by cultural precepts, as we will see below, and this calls for different means of targeting different ethnic or immigrant groups. In addition, some immigrant or ethnic minority groups may still experience discrimination at the hands of health care professionals. There sometimes appears to be a general lack of cultural awareness on the part of service providers that can lead to discrimination and prejudice.

Cultural diversity is not reflected only at the receiving end of healthcare, i.e. in the make-up of the patient base; throughout Europe hospitals employ an increasing number of non-native personnel to provide health services. This often means that old, established hierarchies are questioned and replaced by new ones. The new heterogeneous work force creates challenges related to cultural differences that affect work life, for instance conflict resolution, differences in viewing the power distance between superiors and subordinates, attitudes regarding work, expectations concerning conduct, or socially acceptable standards and principles.

This report looks particularly at the situation in the healthcare sector across the ten countries that took part in the research, and more generally at some legal aspects related to healthcare in Europe. The aim is not to give an exhaustive picture of European health services, but to compare the experiences of partner countries in terms of the intercultural workplace, focusing on both similarities and differences, and to highlight elements that are helpful to employers on the one hand, and to immigrant employees and their native colleagues, on the other hand. It takes a pragmatic view of what happens in the workplace, and attempts to give some recommendations on how to deal with the daily practical problems that arise in workplaces across the healthcare sector.

The methodological approach used the analysis and comparison of the various case studies presented in the various National Reports from the countries participating in The European Intercultural Workplace-project. The findings should be therefore seen as the result of a second level analysis of this material, drawing out common themes. The report also includes generic information about laws and regulations that foster staff mobility in the healthcare sector, as well as references to measures that need to be implemented at various levels – from decision-makers to individual workplaces – in order to ensure a successful growth of the intercultural workforce.

## 2. Background – the national contexts

The level of cultural diversity varies significantly among the ten countries that form the object of this analysis. There is first of all a clear-cut distinction between countries in Western Europe, which have been receiving immigrants throughout their recent history (e.g. The United Kingdom, Germany), and the countries in Eastern Europe, where emigration has been the main characteristic in modern times (e.g. Bulgaria, Greece). Secondly, some of the countries have a traditionally heterogeneous ethnic make-up due to historical reasons (e.g. Finland, Bulgaria, Poland), while others have traditionally had a more homogeneous population (e.g. Ireland, Norway). Thirdly, some countries have gone through a steady process of cultural diversification through immigration over a relatively longer period of time (e.g. Sweden, Italy), while others have witnessed a sharp increase in immigration over a short, and recent, period (e.g. Finland, Ireland).

In line with these developments, the overall percentage of immigrants in healthcare, both as clients and personnel, varies noticeably from one country to another. Minority ethnic group staff in the healthcare workforce varies also in comparison with the percentage of immigrants in the working population as a whole. In some countries the make-up of the workforce/staff in healthcare reflects the cultural mix, especially in countries with long tradition in immigration; in other countries, typically with a shorter history of immigration or with lower immigrant population, this is not yet the case. In the UK and Ireland the percentage of immigrants working in healthcare fairly reflects the overall percentage of immigrants in the countries; in Sweden and Norway it is higher after having increased rapidly over the past decade; in Finland, Germany and Italy it is lower but increasing steadily; in Bulgaria, Greece and Poland it remains significantly lower.

The reasons for the lower representation of ethnic minorities in the healthcare workforce will be equally varied, and many of them are related to the daily challenges described later in this report (see also Chapter 4). However, sometimes the reasons are of a more general nature, having to do with the legal system of a particular country or with its social structure.

For example, the Constitution of **Greece** provides that only Greek citizens are eligible for positions in the public sector<sup>1</sup>. However the emerging multicultural society requires the establishment of new values that guide the work of healthcare providers; and although currently the demand for the use of public services, such as hospitals, by immigrants has not been excessive, it may change considerably in the years to come because of the legalization of illegal immigrants and the reunification of their families (for full details see also ‘The European Intercultural Workplace: Greece on [www.eiworkplace.net](http://www.eiworkplace.net)).

**Bulgaria, Italy and Poland** also represent interesting cases because, in principle, there are no immigrant workers in the public sector – yet healthcare is the typical exception to the rule in all three countries. Bulgaria and Poland find themselves at the beginning of a previously unknown situation, when the authorities will soon need to attract foreign staff in order to replace native medical staff – especially highly qualified doctors – that leave the countries in search of better paid jobs elsewhere in the EU. Both Bulgaria and Poland also have relatively large Roma ethnic minorities, whose access to healthcare services remains a challenge (for an example of good practice from Bulgaria see Chapter 5 below). Italy, on the other hand, has seen a significant increase in the number of non-Italian nurses and ‘caregivers’ (for a full description of the profession see also ‘The European Intercultural Workplace: Italy’ on [www.eiworkplace.net](http://www.eiworkplace.net)). In 2002, there were 2,600 foreign nurses in Italy, coming from more than 50 states throughout the world; that represented 1% of the total workforce in healthcare. By 2006, this figure will have tripled. This is due mainly to the incapacity of the domestic labour market to provide the necessary employees, but also due to the liberalisation of entry into Italy

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<sup>1</sup> N.B. This seems to contradict the ‘*aquis communautaire*’, which guarantees the equal access to jobs to EU citizens.

with permission to work as nurses: this professional category is no longer subject to yearly quotas in terms of immigrant workers, but it is exempted from any upper thresholds. In terms of the other professional category, the 'caregivers', the estimates place their numbers at around one and a half million caregivers in Italy, 85% of whom are non-EU citizens: 40% of these come from South America, Salvador, Peru, Ecuador, 30% are from the Philippines, 10% are from the Indian subcontinent (in particular from Sri Lanka), whilst the rest are from Eastern Europe (ex-Yugoslavia).

The healthcare work environment in **Ireland** has also undergone major changes in recent years, on the one hand due to a major and rapid increase in cultural diversity in society, resulting in culturally diverse patients, and, on the other hand due to the shortage of Irish healthcare workers, resulting in active recruitment from many different countries. Although general statistics are not available for numbers of staff from different cultures employed in health service, St. James's Hospital (a large academic teaching hospital in Dublin) could serve as a typical example. Here the total number of staff employed is approximately 4,000. There are 1,200 Staff Registered Nursing (SRN) positions, of which 518 are from outside the EU with 16 nationalities represented, and 45 are from within the EU. Overseas staff nurses (SRNs) in the hospital today therefore represent around half of the total nursing staff. Also in the case of non-consultant doctors, overseas staff constitutes 50% of the total number. The majority are recruited from the Philippines, followed by India and South Africa, with small numbers coming from many other overseas countries, including the US, British Commonwealth countries and the EU. The number of non-Irish Healthcare Assistants (HCAs) has also risen sharply in recent years.

In response to these developments, the National Social Inclusion Steering Committee (NSISC) of the Irish Health Service Executive is implementing a National Intercultural Healthcare Project. The purpose of the Project is to create a culture in healthcare settings that supports the delivery of care in a culturally appropriate manner. Central to this is a training programme to develop the capacity of staff managers to work interculturally as well as actions to develop the environment of healthcare settings so that care is delivered in a culturally sensitive manner (the main aspects of the project are presented in Chapter 5.6 below).

The Irish *National Intercultural Health Strategy 2007-2012*, due to be launched by the end of 2007, constitutes a very comprehensive framework document to support staff and service users in working together, and to inform the design, delivery and evaluation of health care to minority ethnic groups. Drawing on international models of good practice, on reports commissioned by the Health Service Executive and on the recommendations of National Consultative Committee on Racism and Interculturalism, the Action Plan included in the Strategy 2007-2012 aims to ensure that inclusive, culturally sensitive strategies are practised in organisations in three key areas: Organisational Ethos, Workplace Environment and Service Elements Necessary to Support Intercultural Training.

The field of medical care in **Germany**, and in the Mecklenburg-Vorpommern region in particular, is also characterised by increasing interculturality. This concerns both the patient-base, which is a natural consequence of increased diversity, but also more and more the management and staff at medical facilities. This latter increase is determined by a shortage of staff at national level that needs to be addressed by attracting and retaining foreign personnel. Qualified personnel are being urgently sought for in hospitals in all five newly-formed German states; the gaps in outpatient care are becoming ever larger. There were 600 empty surgeries in Germany at the end of 2004, and authorities have started targeting campaigns at foreign staff, and also at qualified immigrants already residing in the country, who had been unable to access jobs due to insufficient formal qualifications (for a full explanation of formal recognition of qualifications see Chapter 3.2 below); approximately 400 licences and permits to practise were granted to immigrants by the state examination office by the end of 2004. But apart from these, there are still many qualified personnel, particularly among the tens of thousands of immigrants from the successor states of the USSR, who could be fast-tracked towards recognition of their qualifications and professional integration in the public health system. In

face of a concrete demand situation, the state government sees „a group having particularly good chances and potential for integration into professional life. (...) Acceptance of these men and women among the population is high.”<sup>2</sup> A report commission by the Ministry of Social Security of the state of Mecklenburg-Vorpommern shows that there are 145 migrants with medical and nursing qualifications in the state without work, including 37 doctors and 76 nurses. The majority of them are under 50 and could become active in their professions after adjusting their medical and nursing qualifications to German qualifications.

The three Nordic Countries that took part in the research – **Finland, Norway and Sweden** – present certain similarities in terms of the cultural diversity in healthcare, while there are also a couple of significant differences. The changes undergone in all three countries with respect to their ethnic make-up are reflected in the healthcare system, traditionally a relatively monocultural workplace. Immigration raises the issues of providing culturally competent health care to patients of different cultural backgrounds. According to official statistics 2006, 12.2 per cent of the persons residing in Sweden are born outside Sweden. If we include those who are born in Sweden with both their parents born outside Sweden, the total share amounts to 15.8 (Statistics Sweden). The numbers are smaller in Norway (8.3%) and Finland (2%), yet the situation means that healthcare personnel will be increasingly required to have additional linguistic and cultural competences in order to succeed in providing services to patients with different cultural backgrounds. Strategic planning at government level is underway, the most recent example being that of Norway, where a Parliament Bill passed in 2006 gives clear guidelines on how policies within healthcare should respond to future challenges in relation to ethnic minorities and underlines three central areas of concern: 1) information, language and communication, 2) clarification of expectations and adapted healthcare services, and 3) training, cooperation and guidance of personnel.

Furthermore, apart from the patients, representatives of immigrant groups are seen among healthcare personnel – more so in Sweden and Norway than in Finland. Today, they are numbered not only among assistant nurses and cleaners – low status jobs that traditionally represented a way into the Nordic labour market – but among physicians and nurses as well. In 2004, for example, more physicians educated outside Sweden than in Sweden got Swedish medical license (1109 out of 1868, 59%, see also ‘The European Intercultural Workplace: Sweden’, page 102, on [www.eiworkplace.net](http://www.eiworkplace.net)). On the other hand, Finland has a low percentage of qualified immigrant personnel, due, on the one hand, to the fact that very few immigrants have trained so far as doctors in Finland, and on the other hand, the fact that those that are trained as doctors abroad will not usually have the right to practise in Finland.

However, in order to respond to an increasing need for physicians and medical personnel throughout the Nordic countries, authorities have had to devise programmes to recruit staff from abroad or doctors who already live in the area but do not hold formally recognised certification, and to assist them in having their qualification recognised. For example, special recruitment programmes have been initiated in different parts of Sweden, starting from the year 2000 to attract physicians from Poland, Germany and Hungary. In Finland the government has initiated a special programme aimed at qualified dentists coming from outside the EU who will bypass the formal procedures for recognition of qualification by undergoing a fast in-service training period and receiving a licence to practice at the end of the satisfactory completion of that period.

In terms of immigrants’ access to leading positions in healthcare, the numbers remain very low throughout the three Nordic countries; in fact the situation is similar in all countries studied, with the UK being the notable exception.

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<sup>2</sup> Dr Marianne Linke, M-V minister of social security, speech to the M-V Landtag on 10.3.2005.

In **The United Kingdom** the Minister of State for Health has required all National Health Service (NHS) organisations to set local targets for increasing the representation of minority ethnic staff in sectors of the workforce where they have been under-represented. This and other measures to increase recruitment, retention and development of minority ethnic staff were announced following a summit held with key stakeholders to:

- ⇒ Increase the number of Asian nurses, which is low compared to the working population;
- ⇒ Increase the representation of minority ethnic group staff in certain occupation groups in the NHS where they are currently under-represented
- ⇒ Increase the number of minority ethnic group staff in senior positions in the NHS

All targets are being reached, but worth particular attention is the goal that at least 7% of non-executive appointments to NHS boards and of members of Department of Health Non-Departmental Public Bodies (NDPBs) should come from a minority ethnic background. The Department has surpassed this goal for both sets of bodies, the figure for non-executives on NHS boards now standing at 12.3%, and members of NDPBs having risen to 10.9%. This serves as a commendable example of a government's commitment to achieving better representation on public bodies for people from ethnic minority groups through positive discrimination; an example that could be easily transferred to other countries.

### **3. Legislation**

#### **3.1 International Law**

##### **Guaranteeing the Right to Health**

Any discussion on health legislation will start from the understanding of "health as a human right", and from those specific legal obligations on states that arise out of this and the resulting international law. Under the various health legislation implemented throughout Europe, everyone has a right to healthcare provided by the national health system. What this means in practice is that no hospital should ever turn away someone who is the victim of an accident or illness, whoever that person may be and whether or not they have paid any national insurance contributions. However, only certain treatment is available if one is not a national or resident of the EU, and this has often been contested by human rights organisations as breaching international agreements. International agreements in this context refer primarily to two documents:

- The Covenant on Economic, Social and Cultural Rights, one of the two core covenants adopted under the Universal Declaration of Human Rights, which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"; and
- The European Convention on Human Rights.
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None of the documents refer to an express right to medical treatment. However, there could be circumstances where the failure to provide such treatment or the withdrawal of services could amount to a breach of the right to life (Article 2) and/or the prohibition on inhuman and degrading treatment (Article 3) of the European Convention. Health authorities, special health authorities, regulatory bodies and local authorities all have a duty as public bodies to comply with the provisions of the Convention.

##### **European Union Law**

Health law is intended to create an environment in which the promotion of health goes hand in hand with the protection of individual rights and the general principles of equality and justice. Over the years, the importance of health law has grown, both at national and European level. As health and human rights are closely interlinked, it is important to integrate health law and health policy. It is to be expected that, especially within the European Union, the impact of health law on health policy-making will increase as a result of several developments, e.g. the internationalisation of health care and

health policy, the issue of consumer protection and the legalisation of healthcare services at EU level. The European Union (EU) has become more and more active in the field of healthcare in recent years. This involvement can only increase with the ratification of new instruments by all EU Member States. This requires a strategy to stimulate the fruitful relationship between health policy and health law.

Official EU health policy has been built on something of a paradox. Union leaders have for years wanted the Union to address issues, like health, that are at the core of citizens' concern. Yet health policy is so high on national political agendas that most governments have been reluctant to let EU legislators interfere. A partial solution was implemented through the Maastricht Treaty of 1992, after which the EU was to have a mandate of "encouraging cooperation between member states" and "if necessary, lending support to their actions" in public health (article 129(1)). The EU was given the power to spend money on European level health projects, but practically forbidden to pass laws harmonising public health measures in the member states (article 129(4)).

When the EU's powers over health policy were revised in the Amsterdam Treaty of 1997 the mandate was significantly strengthened. The EU was commanded to ensure "a high level of human health protection" in the "definition and implementation of all [union] policies and activities" and to work with member states to improve public health, prevent illness and "obviate sources of danger to human health" (article 152(1)). Nonetheless, harmonisation of member states' public health legislation—with two small exceptions—continued to be prohibited and the EU was mandated to "fully respect" the member states' responsibilities for "the organisation and delivery of health services and medical care" (article 152(4, 5)).

### **Effect of EU law on health service provision**

The European Community Treaty may forbid the union from using its health policy powers in a way that cuts across member states' rights to run their own healthcare systems, but this does not isolate health care, or health professionals, from the effect of EU law in other areas. There are numerous examples that illustrate the ways in which EU law can affect health policy, from the right of all citizens of the EU to receive medical care in another Member State in accordance with national legislation up to the common network for epidemiological surveillance and control of communicable diseases. Two EU laws that have driven major change in medicine across the EU are particularly worth mentioning, as they are directly related to the workplace: *the doctors' directive* and the *working time directive*, neither of which was conceived as a health policy measure. If the latter aims simply to mainstream the maximum workload for different professions and its effects are well known, the former deserves special attention due to its wide implications on workforce mobility and recognition of qualifications.

## **3.2 Recognition of Qualifications**

### **3.2.1 System of automatic recognition of qualifications obtained in any EU/EEA Member State<sup>3</sup>**

*The doctors' directive* was one of a group of directives proposed by the European Commission in the 1970s and early 1980s as part of a drive to promote the free movement of workers and professional people. The directive was designed to guarantee automatic mutual recognition of most medical qualifications in the EU provided member states implement certain minimum quality guarantees (expressed in terms of the length of training). This was the basis for the Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications. With the expansion of the European Union eastwards, this issue was re-addressed in the Directive 2005/36/EC, which applies to all Member State nationals wishing to practise a regulated profession (not only medical, but all regulated professions are included this time) in a Member State other than that in which they obtained their

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<sup>3</sup> Information based on Chapter III of Directive 2005/36/EC.

professional qualifications, on either a self-employed or employed basis. Although, as we will see below, the Directive encourages the automatic recognition of certification, the process is not entirely automatic and it involves an application procedure, which can be at times fairly bureaucratic.

The main principle behind the recognition of qualifications within the European Union is that if an EU citizen has completed a major part of his or her qualification in one EU country it will be recognised in all EU countries. This principle of recognition also applies to EEA countries, (Liechtenstein, Iceland and Norway) and Switzerland. Each Member State automatically recognises certificates of training giving access to professional activities as a doctor, nurse responsible for general care, dental practitioner, midwife and pharmacist, covered by Annex V to the Directive. The Directive also adopts the principle of automatic recognition for medical and dental specialisations common to at least two Member States under existing law, but restricts future additions to Directive 2005/36/EC of new medical specialisations - eligible for automatic recognition - to those that are common to at least two fifths of the Member States. In other words, any future addition to the list of specialisation mutually recognised by Member States is possible only if 40% of the Member States recognise that specialisation.

For the purposes of equivalence in qualifications, this Directive sets minimum training conditions for the following professions:

In the case of a **doctor**, **basic medical training** is recognised if it comprises at least six years of study or 5,500 hours of theoretical and practical training provided by, or under the supervision of, a university. Completion of basic medical treatment is obligatory in order to qualify for specialist medical training or the training of general practitioners. **Specialist medical training** involves additional full-time theoretical and practical training at a university or other recognised centre for a minimum duration that should not be less than the duration in Annex V of the Directive (such as, for example, 5 years for specialisation in general surgery). In order to have their qualification recognised, **general practitioners** need to have completed, on top of basic medical training, full-time practical training in an approved hospital, as follows:

- for a minimum duration of two years for certificates issued before 1 January 2006,
- and for three years for certificates of training issued after that date.

It is to be noted that different parts of the training can be completed in different EU Member States, and the latest Certificate issued will be the one that goes through the process of recognition.

**Nurses responsible for general care** need to have at least three years of study or 4,600 hours of theoretical and clinical training on a full-time basis, and the Directive describes in Annex V, point 5.2.2, the minimum requirements for the training programme.

Diplomas of **dental practitioners** are recognised if the training leading to it comprises a total of at least five years of full-time theoretical and practical study and includes at least the programme described in Annex V of the directive, point 5.3.2.

**Midwives** will have their professional qualifications recognised if:  
their certificate includes specific full-time theoretical training and practical study as a midwife for at least three years; or  
in the case of possession of evidence of formal qualifications as a nurse responsible for general care, they have undergone at least a specific full-time training as a midwife of 18 months' duration.

**Pharmacists** will have their qualifications recognised if their certification is based on training of at least five years' duration, including at least four years of full-time theoretical and practical training at a university and a minimum six-month traineeship in a pharmacy which is open to the public or in a hospital.

### **Procedure for the mutual recognition of professional medical qualifications**

An individual application must be submitted to the competent authority in the host Member State, accompanied by certain documents and certificates. According to Directive 2005/36/EC, the competent authorities have one month to acknowledge receipt of an application and to draw attention to any missing documents. A decision has to be taken within three months of the date on which the application was received in full. Reasons will have to be given for any rejection and it will be possible for a rejection, or a failure to take a decision by the deadline, to be contested in the national courts.

It should be mentioned that all requirements and the procedure stated above only apply to qualifications obtained in a EU/EEA Member State. For qualifications obtained in third countries, different regulations apply in every Member State. Moreover, the Directive does not guarantee that Diplomas obtained in third countries and recognised by a Member State will automatically be recognised throughout the EU (e.g. a Doctor's diploma obtained in Serbia and recognised by the competent authorities in Austria will not automatically be valid in all EU Member States, but will have to undergo separate recognition procedures in each state where the diploma holder intends to practice the profession; in these cases each Member State applies different regulations).

### **3.2.2 Mutual recognition of qualifications under The Nordic Agreement**

The latest agreement on the joint Nordic labour market of professionals in health care and nursing came into effect at the beginning of 1994. The agreement is applicable to professional practitioners who are citizens of Iceland, Norway, Sweden, Finland or Denmark. The qualifications for the healthcare professions are similar in the different Nordic countries and have been approved between the countries. Therefore, the agreement is applicable to the practitioners of healthcare professions so that by virtue of the right to practise a profession granted in some Nordic country, the corresponding right is automatically recognised in any other country included in the agreement, without any further procedures being necessary. This particular agreement facilitates the mobility of Nordic citizens to a much larger extent than among EU/EEA states, since citizens of Nordic countries do not need a separate decision of recognition for eligibility to posts or positions in the public sector if their qualification has been taken in a Nordic country.

### **3.2.3 Accreditation of qualifications obtained outside the EU/EEA**

Unlike the healthcare professionals from the EU countries, who may start working in another EU country almost immediately, a doctor who is not a citizen of an EU/EEA country or a Nordic country has no rights guaranteed by treaty to automatic recognition as a doctor in any of the countries that took part in the research; they will have to apply for an authorization depending on an individual assessment. This assessment will generally include an evaluation of their medical education, its improvement with some further courses if needed, and – in most cases – the passing of a licence exam. This process has proved to be rather tedious for many physicians, taking between 2 and 8 years. It is not surprising that many of the non-EU physicians have had to start working outside their education, and often remain outside the professional circle for much longer than necessary.

Some action is being taken to make the process of recognition of diplomas faster. For example, the process of obtaining a Swedish medical license is becoming more structured, and several fast-tracking projects have been initiated between 2000 and 2003, such as "Projekt utländska läkare" ("Project Foreign Physicians"), "Legatimation.nu" ("Registered Professions), the Stockholm project and the Malmö project (for more information see also The European Intercultural Workplace: Sweden on [www.eiwokplace.net](http://www.eiwokplace.net)). In Italy, special arrangements are being made to allow faster responses to the lack of professional staff on the domestic labour front. Thus, in a country where qualifications in healthcare obtained abroad are normally recognised through decisions of the Ministry of Health, in the past two years the central authority has been obliged to delegate formal recognition of professional qualifications to regional bodies, with the aim of accelerating the procedure and of filling empty posts faster with foreign healthcare staff.

### 3.2.4 Language requirements

According to EU law, Member States may require migrants to have knowledge of languages necessary for practising the profession. This provision must be applied proportionately, ruling out the systematic imposition of language tests before a professional activity can be practised. It should be noted that any evaluation of language skills is separate from the recognition of professional qualifications. It must take place after recognition, when actual access to the profession in question is sought. In other words, the right to practice in healthcare does not depend on the knowledge of the official language of the country where work is sought; however, employers are allowed to require a certain level of language proficiency before assigning an applicant to a post.

For example, all overseas employees of the National Health Service in the UK are required to speak English along with having a nationally recognised qualification. English language testing is carried out and overseas recruits are advised of this before applying for posts. However, if a foreign doctor with recognised qualifications but lacking language skills wants to open a private practice, no legal impediment exists. The situation is similar in most other countries, where employing authorities will regard the language requirement as having been satisfied when the doctor has passed certain required examinations, which often suppose a very high level of fluency in the language.

The rules are slightly different for nurses, whose level of proficiency in the language can be lower. For example, in Ireland, up until 2003, no minimum level of English was required in the recruitment of nurses, which resulted in some overseas nurses with very weak English language skills being employed. Although there is still no required minimum standard of English for Health Care Assistants, it is now mandatory for Staff Registered Nurses to have reached an acceptable level of proficiency in either IELTS (International English Language Teaching Standards) or TOEFL (Test of English as a Foreign Language).

## 4. Challenges in the Intercultural Workplace

This chapter focuses on the challenges that people of different cultural backgrounds face when sharing a workplace. In the particular context of healthcare, the issues will refer both to interaction between co-workers and to contact between staff and patients coming from different cultures. It is evident that such encounters in an environment as sensitive and stress-prone as healthcare will give rise to numerous challenges; we have selected those that have proved to be fairly similar across the partnership, even if within the same category differences will occur. In some cases, we have also been able to identify pragmatic solutions adopted by practitioners themselves, and these are mentioned as responses to the challenges encountered.

### 4.1 Language

The most common challenges in all countries in the healthcare sector were related to language. This result is not surprising, because language difficulties are probably among the easiest issues to perceive in an interaction; and noticing these differences does not mean that one is especially sensitive to intercultural differences. Language difficulties are also the ones that probably have the most influence in communication in healthcare: not understanding at all or misunderstanding verbal utterances easily leads to communication breakdowns and potentially dangerous situations.

#### 4.1.1 Language proficiency

**A low level of language proficiency causes uncertainty**, both among patients and among staff. It is generally known and accepted in all case studies analysed that doctors have an excellent level of official medical language, due to the requirements set by the employing agencies. The doctors themselves feel competent in the language, but do not fail to point out certain language barriers. Approximately 60% of the doctors interviewed declare that they understand everything and only have problems with the pronunciation of a few patients. Around 40% only find the dialects difficult to

understand. Almost all doctors indicated difficulties with pronunciation, but are of the opinion that they have a sufficiently active vocabulary. Therefore the language problems were not significantly related to the use of the language among doctors, but to using it when communicating with foreign nurses – who do not generally need the same level of proficiency in order to get the right to practice – and with immigrant patients. Another significant problem refers to the use of a third language, like English in most countries, when communicating with immigrant patients. The situation that occurs typically when in a situation like this is the patient's inability to describe their symptoms, making the process of diagnosis extremely complicated. The fact that none of the interacting parties has English as their native tongue causes uncertainty on both sides – the doctor not being sure that he has understood the symptoms correctly, and the patient being uncertain about the instructions.

A Finnish doctor pointed out how important it is that the patients understand correctly what the doctor says about taking medicines, e.g. self-medication in cases of diabetes. The problem is amplified when the patient is an immigrant whose level of Finnish is not sufficient, yet their cultural rules of communication stop them from asking the doctor to repeat or to give additional details. In these cases it is extremely important that the doctor checks feedback from the patient, and uses auxiliary means to explain (body language, images). A series of intelligent solutions has been identified in the Italian and Irish hospitals studied. These are fundamentally flash cards based on information written in simple language and in an informal style with a series of associated illustrations. At the same time, as an experiment, some doctors have been provided with boards with visual illustrations of situations that correspond with the most common symptoms of illnesses. These will be shown to the patients when necessary and have captions that contain a brief description of the symptom and illness. They are translated into the languages of the majority of the nationalities residing locally. The work had required some of the doctors' time during the editing process, but it has had a highly positive effect from the initial stages of the experiment. At the same time, there has been a considerable improvement in the effectiveness of the communication, by working on some gestures which cover similar meanings in different cultures and that help to describe the patients' symptoms.

Speaking with immigrant co-workers also requires a **deviation from the normal use of one's mother tongue**, and most interviewees were aware of this aspect. The biggest challenge in this case is to adopt the correct tone and language without patronising the non-native by using 'child language'. One of the Finnish doctors interviewed said that sometimes she couldn't be absolutely sure if the foreign nurses have understood what she has said. In this case she also needs to check feedback by using simpler language, but sometimes her own cultural background stops her from that, because she is afraid she might hurt the nurse's feelings by 'treating her like a child who doesn't get what you are telling her'.

Patients have expressed in several cases **doubts about staff that do not speak their language**. For example, the Swedish participants emphasize problems with understanding the "broken Swedish" of their non-Swedish communicative partners. In such cases uncertainty and stress might occur. Lack of language competence and a slower tempo of interaction, unfortunately, often lead to the native speakers becoming suspicious and thinking something like "Is s/he a good doctor? If s/he cannot talk, and comes from a poor third world country, can I be sure that s/he can help me?" Overseas nurses in Ireland explained also that lower language proficiency is often mistakenly taken to indicate a lower level of professionalism. In Germany, the doctors' difficulties in using German lead to uncertainty and to the feeling that if the doctor cannot speak German well, he may also understand the patients poorly and therefore not treat them appropriately. The patients often withdraw with their health problems, do not open up as usual, and question the effectiveness of specific therapies more often than in the case of fluent German speakers.

To overcome language problems with some patients, particularly with newcomers and elderly immigrants, the **use of an interpreter** may be needed. It may seem simple to use an interpreter, but both the interpreter and the health care provider need special skills. Moreover, the services of

interpreters are costly, the consultation takes a lot more time if an interpreter is needed, and sometimes diagnosis and giving instructions become even more complicated. And there might also be cultural issues related to using interpreters: some patients want to hear the doctor explain to them what to do, and will not trust an interpreter. Therefore the health care provider should be particularly careful about the choice of interpreter. The following persons may function as interpreters: the patient's relatives, e.g. husband/wife, child, brother, etc; health care personnel with the same linguistic background as the patient, or an authorized interpreter. All of these alternatives have their strengths and weaknesses, which are briefly presented below.

### **Patient's relatives as interpreters**

The patient's relatives know the patient, and, if the patient is unable to report the symptoms, etc, they may be able to provide useful information. Furthermore, the presence of relatives or friends often adds to the patient feeling secure. However, the patient's relatives might not possess sufficient language skills to interpret correctly. Moreover, they might not translate everything, considering some pieces of information to be unnecessary. Sometimes they might even have own unexpressed motives that result in missing information. And in several countries it is a matter of personal privacy – the doctor is not allowed to communicate information on a person's health to anyone without the patient's express consent; it is obvious that the interpreting relative would get the information before the patient, in which case the doctors could be taken to court for breaching the law. At the same time, doctors might face an ethical issue – how much of a person's suffering are they supposed to share with relatives?

### **Health care personnel with the same linguistic background as the patient as interpreter**

Having a range of languages spoken by staff has been seen as an advantage when dealing with patients who themselves do not have a good grasp of the host language and so need language support when in hospital. This has proven to be a positive, albeit unpredicted, outcome of the multicultural workforce. For example, a Bosnian employee can interpret for a Bosnian patient during his stay in hospital. And a concrete example given in Finland refers to an Indian patient who could not speak any English or Finnish, and whose life was saved by an Indian man health worker who could interpret what the patient said. In another example, a nurse interviewed in the UK who originated from Bangladesh reported that on a number of occasions she had assisted with the language requirements of Bengali speakers, but she seems to see this as extra work. Her ambivalent comment was *'It really helps them (the patient) to explain in Bengali especially when they first arrive and are a bit confused. I'm not always here though and that can cause a problem. Anyway it's not really part of my job'*.

On the other hand, one of the physicians interviewed in Sweden, originally from Iran, expressed his annoyance with always being the one who has to take care of all the non-Swedish patients, and above all patients from Iran. He pointed out the fact that there often are dialectal differences, and that he would prefer to use Swedish as a lingua franca rather than Farsi (Persian) in order to understand the patient better. Moreover, he felt that being the one to whom all the non-Swedish patients were "sent" confirmed his status as a foreigner and added to his being singled out. Moreover, he experienced that the patients from his country of origin were more demanding than his Swedish patients, motivating it by "we come from the same country, you must help me!" However, often he could not do anything and they felt frustrated.

Some doctors also wondered about the reliability of non-professional interpreters, who might not translate the whole information.

### **Authorized interpreter**

Being the best choice, the involvement of an authorized interpreter still requires certain skills from the health care provider. The physician should keep in mind to speak to the patient, not to the interpreter (avoiding leaving the patient and talking to the interpreter). Further essential aspects are to avoid interrupting the interpreter, and to inform the patient about the professional secrecy.

Among the case studies undertaken, several hospitals try to provide professional on-site interpreters whenever possible. For example, in the UK hospitals offer professional interpreters when and where they can, but this service often relies on volunteers, while in Finland hospitals employ interpreters, as a rule, in healthcare centres that cater mainly for asylum seekers. The Irish hospital case study mentions providing interpreters where possible, and it has a list of in-house interpreters available, as well as a 24 hour-a-day telephone interpreter facilities available. Several hospitals offer training for staff in the correct use of interpreters, as well materials to assist them. However, the case studies show that, in all countries, supply of the service can be patchy at times as it does depend on the availability of suitably skilled people.

#### **4.1.2 The use of dialects, accents and slang**

Local dialects have been reported as a challenge in many cases. The native patients are likely to speak a dialect, and will not consciously replace it with the standard language when addressing a non-native member of the staff. This can lead to misunderstandings or to a lack of easy communication between the patient and healthcare worker. For example, the regional accents spoken in Ireland are reported to pose serious comprehension problems for overseas staff, as can the widespread use of colloquialisms and slang. Overseas staff also complained about the speed at which Irish people speak, a fact confirmed by the Irish nurses. Differences in intonation patterns can also lead to misunderstandings. An Indian nurse explained that when she made a request to an Irish nurse without the typical Irish/English rising pattern at the end, she was considered rude: *'she thought I was giving her an order'*.

If in some countries learning the dialect is a difficult process that finally helps the immigrant healthcare worker integrate in the workplace, in Italy the situation is slightly different: the dialect is the most commonly used language, even more so than standard Italian. Hence immigrants will learn to speak the dialect of the area where they settle, and this aspect causes subsequent problems of integration, when one moves away from the province or into another region. Apparently the dialects are so strong that the immigrants would have to learn another dialect, i.e. start the learning process again, if they want to understand and be understood by patients.

In terms of using slang, communication can also suffer significant breakdowns. As an example from the UK, interaction between foreign nursing staff and other staff and patients can sometimes be problematic due to misunderstandings. The English are indirect when discussing some body parts and bodily functions and have developed a range of euphemisms to cover these areas that are not generally taught in English classes. For example one nurse reported, *"The patient said she needed to 'spend a penny' and I had no idea what she meant by that. I think I embarrassed her a bit because I made her explain herself – now I know it means urinate"*.

#### **4.1.3 The use of medical jargon**

Word-finding problems are common in intercultural medical consultations between physicians and patients, and the data shows that both parties attempt to solve it. The physicians use gestures as well as try to use medical terminology. However, problems with patient's lack of understanding of medical terminology might occur, as mentioned by a Polish female physician in Sweden:

*"Maybe in the beginning it was a lot more difficult because of language. The real difficulty is to know the ordinary familiar language that the patient uses at home. For example, we usually use the word 'colon' instead of 'large intestine', but not all patients understand. So these ordinary words that one should use with the patient. We understand the patient well, but the patient cannot understand us."*

In Bulgaria, 56% of minority nurses interviewed identify the use of professional jargon as the main cause of misunderstanding between them and Bulgarian doctors.

Another language-related issue is **the use of languages other than the official language** in the hospital. Although English is the only language officially allowed among staff while on the ward in Ireland, foreign staff sometimes speak their native language when working together, even in front of patients. While it may seem perfectly normal to the overseas nurses from the same culture to communicate with each other in their native language, it can be off-putting or intimidating for patients, and interpreted as exclusionary by Irish colleagues.

## **4.2 Communication style**

In addition to language, the communication style can also be a source of intercultural challenges in the workplace.

### **4.2.1. Directness/Indirectness**

In most of the cases analysed, directness is preferred or at least appreciated, starting from the way of addressing colleagues, which is very informal in the Nordic countries, for example, and ending with the amount of information given to patients and their relatives. The major differences between the indirect and direct communication styles have been, however, identified in the Nordic countries and in Ireland and the UK.

Communication is very direct in the North of Europe, with issues being tabled fairly quickly after they arise. This contrasts with the communication style of many of the immigrant groups present in these countries today. And although fairly glad to accept directness coming from others, immigrants often need encouragement before they adopt a direct style of communication themselves. This is especially true if the immigrants' culture is based on a high power distance or is very hierarchical. Some physicians also describe that some patients do not report pain in the same way as the patients from their countries of origin, i.e. they do not cry loudly, they are calm and inexpressive, which makes it difficult to understand how serious the patient state of health is. Similarly, management reported that compared to Irish norms the communication style of some South African nurses *can be very abrupt* to the extent that *an elderly patient once thought she was being verbally abused*.

It is evident that there will be differences between cultures in the amount of information given to patients and the way this is delivered. Some ethical issues are dealt with very differently in Finland compared with the home country of two foreign doctors interviewed. For instance, one doctor said that in her home country, if a patient is going to die, this is told first to the patient's relatives, and they will advise the doctor if the patient should be told as well; in most cases the patient would not be told the news. And when the patient is eventually told that they are going to die, it has to be expressed in an indirect way, avoiding a clear confirmation. In Finland this is done the other way around, and it may even be that the patient does not want to tell the truth of the situation to the relatives at all. This can cause misunderstandings between patients and doctors of different cultural backgrounds, and might ultimately lead to accusations of unethical behaviour. It is important to make sure that internal rules are strictly followed, but at the same time the cultural sensitivity of the patient should also be taken into consideration.

Another interviewee gave another example of an ethical question. In her country it would be immediately reported to the parents if a 13-year old girl was pregnant but wanted to hide it. Once again, in the Nordic countries it is possible to keep this information from the parents, and this would lead to accusations from parents who come from cultures where they should be told. The doctor admits that she consults the senior doctor when faced with these kinds of questions, to make sure that he backs her decision. Once again, while following strictly internal rules, doctors might also need to pay attention to cultural sensitivity and analyse each case separately.

#### **4.2.2 High vs. Low Context**

This refers to the amount of details and information included in the spoken message, and to how much the speaker assumes that the listener already knows about a certain situation. Norwegian interviewees stated, for example, that for ethnic minority staff it is sometimes necessary to explain things that usually are taken for granted, things that Norwegians would never ask because they already know them. Similarly, some interviewees pointed out that, even though foreign doctors are well trained and their language skills might be close to perfection, there are still some differences in the way things are understood and done, and things should never be taken for granted. For example, when requesting a foreign colleague to examine a patient, one should not assume that the foreign doctor would automatically do it in the same way as doctors are taught in European universities. It is important to communicate clearly what sort of exams need to be done in order to avoid misunderstandings, later accusations and embarrassing situations. It is in the interest of both parties working together to assume nothing and to communicate all details clearly. Even if this has sometimes been criticised as a pointless waste of time, in the long run the effects will be positive.

#### **4.2.3 Small-talk and Humour**

An issue raised by the non-native physicians and nurses in all countries is the problem of small-talk. Requiring language and cultural competence, informal conversation might be problematic, as an Iranian female physician in Sweden mentions:

*"In my home country I could joke a little bit with the patient, it made him a bit happy and me too, we laughed... maybe I can a little bit now... it is a little bit milder atmosphere..."*

**Humour** is almost always culture-bound, and it seems to be a challenge at most intercultural workplaces. Firstly, one must be extremely careful about jokes concerning cultural values and artefacts, e.g. men with turbans or women wearing veils. Secondly, the idea of raw or 'rude' humour is very different in different cultures, and care is needed in order to make sure no one gets offended in the communication process. Thirdly, it was remarked that understanding a joke can be very difficult if the listening party does not understand correctly the vocabulary used. Most of the immigrants who answered questionnaires or took part in interviews agreed that in the beginning they had difficulties in understanding and telling jokes. And finally, humour can distract the listener from the main message, since the pressure to understand the humour will be higher than the pressure to follow up on the actual message, which can lead to serious misunderstandings of healthcare instructions. As a result, it was recommended that humour be used sparingly in intercultural encounters, and only when the level of proficiency in the language of communication is sufficiently high.

### **4.3 Cultural values and practices**

The influence of cultural values and practices on communication is uncontested. In healthcare misunderstanding resulting from such issues as respect for authority or attitude to health can have tragic consequences that need to be avoided.

#### **4.3.1 Religious clothing and food**

As far as dress codes were concerned, when staff are recruited in all the participating countries, they are advised that uniforms must be worn and that there are few exceptions allowed. Headscarves are almost unanimously considered by hospitals to be unacceptable due to health and hygiene issues. This has led to a small number of respondents reporting these issues as a slight concern. A typical response in this area was in the UK: *'I like to wear the hijab and I don't think it is a problem for carrying out my job. They could change the uniform if they wanted to'*.

The management's response to this was generally that regulations covering uniforms, hair, nails and jewellery were driven by hygiene considerations and that any exceptions could only be endorsed by the national authorities in question. The fact that the issue had not been raised in a formal way in any of the participating countries suggests that there is an acceptance of the need for these regulations. However, a recent positive development in the area comes from Norway, where authorities have started implementing changes to rules regarding uniforms in order to reflect cultural diversity. Thus, in

the largest hospital in Norway, Ullevål University Hospital, the hijab is made a part of the hospital uniform for those who want to wear a headscarf.

#### **4.3.2 Collectivism vs. Individualism: the role of the family**

In many cases, belonging to a community, to a family, plays a more important role for an individual than their own health. Correspondingly, the family is likely to want to participate fully in the healthcare procedures required in the case of an individual.

A number of respondents in various countries express their non-understanding of the family role in patient treatment. In many cultures, family involvement in the patient's treatment process is essential. Often the physician is expected to talk to the family rather than to the patient about the treatment, diagnosis and possible complications. This was commented on by a Ukrainian physician in Sweden, who pointed out that all news, but especially bad news, is told to the family, not to the patient. One of the reasons for this is that it is the family's responsibility to cover the treatment costs, e.g. in Ukraine, where there is often a shortage of medicines, the relatives have to provide them for the patient. In Sweden, and in most European countries, on the contrary, it is the patient, the individual, who is in focus, rather than integrated in the family. Naturally, in some cases, it might be problematic for the personnel to understand the family involvement, which sometimes seem to subdue the patient's voice. An Italian doctor reported that "it certainly isn't easy when a whole Chinese family arrive in front of you, not one of them speaks your language and they all want to come into your practice together."

The issue of who the patient is can become difficult at times: does the doctor deal with an individual or with their extended family? This is a cultural issue that often sets doctor and patient at odds. One interviewee gave an example of a situation where the whole family (six persons) had come to see the doctor, and only one of them was the patient. Due to an irregular communication style, with everybody taking turns to present the problem, the doctor needed a while before realising whom he was going to examine. Moreover, the family refused to leave the room to allow the patient to be examined in private, and, because this was also the patient's wish, the doctor conceded. Most certainly these questions are related to the concepts of individualism and collectivism. In more collective cultures it is expected that the next of kin are much more concerned with the patient's issues, and have a right to know about them. Yet in cultures that subscribe to a more individualist approach medical staff will have to find ways to deal with this in light of the increasing number of immigrants.

A Norwegian doctor also noted sensibly that for the member of a collective culture it may be extremely difficult to leave their parent at a nursing home because traditionally children take care of their old parents in these cultures. It is equally hard for the parents to feel that their children have abandoned them, and therefore particular extra care needs to be given to these patients.

#### **4.3.3 The concept of face**

In spite of the fact that in some countries the physician's work is underpaid, which often results in migration, being a physician is prestigious and physicians represent a highly educated and respected social group. Naturally, coming to a new country as a physician from outside the EU, after a long "waiting time" spent learning a new language and, in some cases, completing medical education, one tries to do one's best to succeed at the work place. Asking for help is often seen as a sign of lack of knowledge, and, as some personnel reports, many non-native physicians attempt to solve their problems themselves and avoid asking for help. Furthermore, in conversations they might not be eager to express their lack of understanding, and some may nod and say "yeah, yeah" instead, as for example a Chinese physician, who by doing so prevents losing face and saves his interlocutor's face as well. However, this might raise concern about medical safety, given that lack of understanding or complete misunderstanding could have serious consequences.

#### 4.3.4 The concept of time

As hospitals generally run a 24-hour, 7 day a week, shift system, timekeeping is an important issue but one that the staff throughout the countries studied had coped with comfortably. Rather than punctuality, it was culturally different attitudes to time and the ideal pace of work that emerged as a source of potential frustration and cross-cultural misunderstanding. Foreign nurses in Ireland, for example, commented that Irish staff place too much emphasis on doing everything fast, and make themselves unnecessarily busy all day. On the other hand, foreign nurses in Finland pointed out that Finnish staff place too much value on time, and do not allow for flexibility between work-time and leisure: Northern Europeans in general will tend to work on the clock, rather than on the task, while other cultures focus more on completing the task, and will neglect the time input as long as the result is achieved.

#### 4.3.5 Power distance/hierarchy

The culture of the European organisation and the business-model as a whole assumes that hierarchies will exist and as such are not challenged to a large extent. It is generally accepted that conflicts between the various levels of hierarchy in any workplace are natural. However, a culturally diverse workforce is likely to bring about an increase in the number of such conflicts.

The European working environment (less so in Bulgaria and Italy) did come as a surprise to some non-native staff who saw it as more relaxed than that prevalent in their countries of origin. A response from one person surveyed was *'It's much more relaxed here. People call one another by their first names and it's much more friendly.'*

and from another: *'The atmosphere is more relaxed and friendly than at home. As a woman I've got more freedom and respect.'*

For example, communication in Finland is based on a very flat hierarchy. This was pointed out by an immigrant employee, who said it was "unusual but really nice" that in Finland a higher status person like a doctor calls him by his first name. In his own country, this would never happen, because there is a clear distinction in addressing people of different social status. Again, being on first-name terms with a superior might be more easily accepted when it comes from the superior, but employers should be aware of the fact that many immigrants find it insulting, or at least uncomfortable, to adopt this style, and sometimes more time should be allowed before moving to first names. It would be also advisable to give the immigrant full information on why such a direct communication style, devoid of formalities, is adopted.

Some staff found this aspect to be a serious problem in that the relaxed and less formal atmosphere was misunderstood and they felt that proper respect for their position was undermined by it. Relations between doctors and nurses are generally regulated by the hierarchy, and a very low power distance could lead to problems of authority. Although work together was largely characterised as unproblematic, flat hierarchy was blamed for some managers or doctors losing respect. For example, the immigrant doctors interviewed in Germany have the feeling that patients in their home country regard and respect doctors more. They believe themselves to have lost authority in Germany, and they have the impression that many nurses do not follow doctors' orders, and that many patients ask too much and are extremely self-pitying. A similar example comes from Sweden, where non-Swedish physicians report that in most of their countries of origin the physician's word is not questioned. However, in Sweden where the health care system is less hierarchical, the physician might experience that s/he has to motivate her/his decision to the nurse and other personnel. In many countries the nurse is "serving" the physician and has considerably lower education, but their role is significantly more important in most parts of Europe (e.g. in many countries outside the EU the nurse education is not a tertiary education, while within the EU a nurse licence requires a three-year tertiary nurse education). The patients might require the same sort of motivation. Finnish, Norwegian and Swedish patients in particular are often reported to be eager to be involved in decision making, i.e. the physician doesn't have "the sole right" but is expected to provide all the necessary information to

the patient. In some cases, the non-native physicians reported it to be difficult to change into this way of communicating with patients from a more "paternalistic" one, when the physician solely decides upon the treatment.

In terms of doctor-patient relationship, a less patronizing style, shorter power distance, and the physician's informal tone, can be seen as less professional by non-native patients in many countries, e.g. the Nordic Countries, the UK, Ireland. In Sweden, for example, it is acceptable for a physician to check medical books or medication catalogues in front of the patient, but it is uncommon in other countries, which might result in the patient thinking: "This doctor is not good!"

In the north of Europe, it is also essential to involve the patient in the decision-making. The physician has an advisory role, rather than being an authority. This might create anxiety and lack of confidence in patients who are used to a different communicative style, i.e. the physician being the one who gives orders and makes decisions, the patient being rather passive. This difference in expectations concerning communicative styles might result in an unsuccessful consultation.

"Traditional western medicine is set down according to a different logic," agreed some of the doctors interviewed. "For a complaint, after having seen your doctor, you are often obliged to see a round of specialists until you find one who can place your problem from a functional point of view". Scepticism appears, because some patients regard the doctor as an authority, and do not trust doctors who send patients from one to the other for additional consultation. In these cases doctors need to explain to patients the reason for specialist examinations.

#### **4.3.6 Gender roles**

This issue appears to be linked with the levels of informality existing in the workplace and the way that hierarchies are managed. Foreign nurses, particularly those from Asia and Africa, generally declared that they were unused to working alongside men and that they were unsure as to how to establish a working relationship particularly when giving orders. A typical example comes from the UK, where a nurse stated *'I wasn't used to mixing with male nurses in my country and find it hard to tell them what to do. It goes against my nature and I was unhappy to do this to start with'*.

In another example from Sweden, research shows that there are differences in the treatment of female and male doctors when it comes to respect and what kind of help they receive from the nurses. These differences are even greater if the doctor comes from a foreign country. Thus, besides the ethnic cultural perspective, in many cases, there is also the gender perspective to consider.

The issue of gender roles also reverberates at societal level, outside the workplace. All the above mentioned problems, e.g. language, cultural differences, recognition of qualifications, lead to problems in career development for the non-native physicians. It is often even more complicated for females than males to succeed with their career in the health sector. For a non-native female, her attempts to build a career, e.g. through long night shifts and overtime, and at the same time "keep up" with the requirements on females posed in her culture, e.g. being a good mother and wife, might be a burden and lead to both physical and psychological problems, but ultimately to a narrowing down of female's options in healthcare.

#### **4.3.7 Spirit of initiative**

Another issue that is important to know is "team work." In Sweden, for example, it is common to work in teams, which are often characterized by a rather democratic atmosphere. You are often expected to take your own initiative and not await detailed orders from the management. Non-Swedes who are used to a less democratic way of work may experience this as lack of organization and security.

#### **4.3.8 Attitude to health**

One thing that stands out as a problem in the integration process, not least in medical care, is the lack of cultural understanding when it comes to, among other things, attitudes to diseases, death, medication and symptoms. The more knowledge both counterparts have about the other party, the greater the chances for successful communication, both between patient and personnel and between different groups of staff.

This aspect is important as it explains the reasons why certain ethnic groups will refuse to go to medical check-ups ('I'll go when I'm sick!') or will prefer to take their own medication than that prescribed by physicians. Another example of how medical care can be influenced by certain groups' attitude to health comes from Bulgaria, where one of the biggest challenges is the negative attitudes among the Roma community towards vaccination, who maintain that they are 'immunized by birth' and show considerable neglect in this respect. Such attitudes need to be dealt with sensibly, by the involvement of community members, as Bulgaria has done in the programme presented below as an example of good practice (see Chapter 5).

Another problem is the difference in views on **health and disease**, and such "modern diseases" as "burnout" or "increased sensitivity to electricity" are not always seen by the some physicians as a "disease". A physician from Germany pointed out that the Swedish patients have a tendency to demand "to be put on the sick-leave for minor complaints".

#### **4.4 Racism, discrimination, prejudices**

It was clear from most of the case studies analysed that some immigrant employees may be subject to discriminatory or racist attitudes. It is also evident that certain ethnic groups are generally targeted, and there can be both negative and positive prejudices involved. Discrimination happens most often at individual level, while system-level discrimination has only been alluded to in a couple of cases.

##### **4.4.1 Racism and discrimination**

Individual cases of racist attitudes or discrimination could be identified in all countries, to a larger or lesser extent. This represents a danger in itself, especially because it seems to be tolerated as 'lack of education'. Such attitudes seem to occur also among immigrant groups, not just between natives and immigrants.

For example, in informal conversations, many non-Swedish physicians pointed out that it was difficult even to get a chance to come to an interview ("it is enough that you have a name that is not Swedish"), and, unfortunately, cases where immigrants change their names into Swedish ones are not uncommon. As mentioned earlier, language problems can be taken for lack of professionalism, and the fact used as an excuse to hide discrimination. This has been identified in most countries. Verbal comments on a person's culture are also reported. Comments like "We do it like this in our country" are mentioned sometimes when a non-native physician presents her or his view on something common in her/his country of origin. Two doctors interviewed in Poland also identified several cases of discrimination at personal level, but they were not ready to complain about them as they did not see it as being the system's fault – rather a personal issue.

As another example, the case studies in Finland and Ireland, *inter alia*, pointed out that there are customers (i.e. patients) who do not like foreigners in general, and find it difficult to accept being attended by immigrant healthcare assistants. There have been some cases in which the patients addressed the staff with racist names. Some Finnish employees (the example given was young caretakers) have complained about the fact that they have to work with immigrants who "do not do anything and do not understand anything and we do not understand what they say" (for details see also 'The European Intercultural Workplace: Finland' on [www.eiworkplace.net](http://www.eiworkplace.net)).

As mentioned, these examples were singular, and often mentioned outside the formal setting of the research conducted. They have not been confirmed by all interviewees, sometimes being even contradicted: one immigrant employee stated that he had never felt any sort of racial discrimination or experienced racist behaviour in his current position in the Finnish hospital studied. This points at the sensitivity of the issue, and the care with which it must be addressed.

Apart from the individual cases of discrimination or racism, a couple of system-wide examples have also been identified. The bureaucracy associated in many countries with the provision of healthcare services causes problems in terms of access; for example, the completion of forms and the provision of information, such as dates of birth and history of previous health care, cause difficulties for immigrant and ethnic minority groups who do not have fluency in the official language or for groups that lack sufficient literacy skills. Although the situation of Roma, Gypsies and Travellers is notoriously difficult, it is worth mentioning a research project on the objective health status of the Roma quarters of the towns of Sofia, Vratsa and Targovishte found an ill person in about 80% of the visited Roma households. In one-third of the households, the number of persons with health problems is 3 or more, while in 7-8% of the households, 5 or more persons suffer from health problems. The basic obstacle identified in the case of the Roma is often their low level of education (only primary education or none at all), combined with a traditionally negative attitude of natives towards these communities. On top of this, they may not be familiar with medical terminology, they have a difficulty communicating with the medical staff, and they sometimes do not understand how to conduct the treatment that has been prescribed to them. By extension some of these obstacles to access to healthcare can be presupposed also in the case of other ethnic minority groups that settle in Europe coming from the third world, even if not clearly identified by the reports.

#### **4.4.2 Prejudices**

Various types of prejudice affect interaction in the medical workplace, starting from generalised assumptions made by staff about certain ethnic groups and ending preconceptions about the education level of doctors coming from certain regions. Questions such as “Do you have operation rooms in Iraq?” might make the Iraqi surgeon think that people perceive her/him as coming from a completely uncivilized country, while some overseas nurses in Ireland expressed surprise at the lack of knowledge Irish people sometimes demonstrate regarding other cultures – for example, a Filipino nurse reported being asked whether they have TVs and bananas in the Philippines.

The German staff tend to place higher demands on the education level of their colleagues with a migration background than on Germans. Prejudices towards people from Eastern Europe are extraordinarily pronounced, particularly with Russian and Polish staff, probably partly due to media reports on catastrophic standards in Eastern Europe. The trend of increasing numbers of Eastern Europeans working in German health facilities is producing an underlying fear. This may result from the fact that a sensitive issue as one’s own health leads to an extremely critical attitude and causes even the smallest signals of a possible lack of competence to be registered. Medical personnel from Eastern Europe do not have the bonus of the “special”, sometimes almost “supernatural” aura of doctors from the Asian region as particularly characterised by the media, where the patients tend to accept certain treatment methods, even those seeming strange at first glance, and not to question them. Eastern European medical staff are viewed according to traditional ideas of the orthodox medical practitioner and there is often the question in the background of whether training in their home country is up to the standards of that in Western European countries. For some patients there is clearly the further thought that particularly competent doctors would also have had career prospects in their home countries and thus the medical personnel coming from these countries would be those not able to get a foothold at home.

There is a quite a different reaction to be observed toward Scandinavians in Germany. Their conduct is judged very positively. And the Scandinavian culture and way of life is held in high regard by many patients. The investigation showed that their performance was also evaluated much more positively,

even if the medical competence was probably similar to that of Eastern European staff. Scandinavians seem therefore to have no barriers of prejudice to overcome; or, if any, they would have a positive prejudice attached to them, which might have the effect of raising patients' expectations too much, and thus communication breakdowns may still occur.

Prejudices can only be broken down with difficulty through provision of information and education. It is a long-lasting process, which involves direct interaction between the groups, as well as an adequate level of knowledge – devoid of stereotypical assumptions – regarding the cultural or ethnic groups in question.

#### **4.4.3 Host-conformity pressure**

Across-the-board adaptation is expected and also demanded of medical staff with a migration background in practically all countries covered by the study.

The reports have revealed that there is a lot of pressure on immigrant employees to conform to the established rules of the host culture. The immigrant job seeker is most often told at the application or interview stage how things work in the organisation, and what cultural aspects they are supposed to be aware of and follow, starting from the use of certain clothing to the fact that no rituals related to their religion should affect their work, which always needs to be the priority. The most repeated comment from interviewees was that an immigrant employee hired to work for the organisation should act according to the rules, including cultural rules, previously established in the hospital.

Another interesting phenomenon was the importance that the immigrant employees themselves gave to conforming to the host culture. There were many cases when immigrant interviewees emphasized the need to try and be more in line with the host culture. An interviewee in Finland said, "When I came here I had to change myself", declaring that any immigrant must change when moving to a new country, because he or she cannot change local culture. Some others also expressed the opinion that, even if some immigrants want to stick to their own cultural system, if they cannot deal with the new culture, their social integration will fail.

This attitude on behalf of the immigrants themselves is surprising in a positive way, and worrying at the same time. It might be the result of willingness to integrate fully into the local culture – and often this is the case. It is also likely to be the result of social and economic pressure put on immigrants, who find themselves ostracised from social groups or refused any job if they do not adopt certain cultural patterns. Although this might seem like the easy solution to integration of immigrants into a consolidated labour market, the long-term results will be inevitably negative, and employers will either find it hard to replace their retiring labour force, or they will have to cope with an outburst of latent cultural frustration once the proportion of immigrants in the workforce increases sufficiently.

To conclude this discussion of challenges, it can be stated once again that the situation in healthcare, and in the particular units scrutinised by the reports, is ambiguous when it comes to intercultural relations. The workforce and client base are getting increasingly heterogeneous, yet there is a lot of host-conformity pressure that tends to assimilate employees into the mainstream culture. At the same time, patients are treated as coming from different cultures, and their different cultural background seems to be more easily accepted. The workplace does not seem prepared for an influx of immigrant labour, imminent due to a reduction in the workforce available nationally in each country studied. If it is to respond to these challenges, and to avoid troublesome times ahead, the healthcare system will have to implement changes urgently, especially in relation to foreign personnel's access to jobs and in relation to the acceptance of cultural diversity as the norm.

## 5. Good Practice

The various reports produced in the participating countries have also identified cases of good practice in intercultural communication at the workplace, or examples of actions taken at different levels to further the development of inclusive, integrated intercultural workplaces. This section will highlight these examples of good practice from the National Reports, strongly recommending them as starting points for countries still looking for ways of dealing with the challenges described in the chapter above.

### 5.1 Resolving Language Issues

The National Health Service (NHS) in the UK gives commitments to tackling health inequalities for minority ethnic groups by offering a free and nationally available translation and interpretation service, available from every NHS premises through NHS Direct. NHS Direct sites already have contracts in place with interpreter services so that they can provide the NHS Direct service in languages other than English. This means in practice that the healthcare professional will place a call to the interpreting service, and an interpreter will interpret communication between the doctor and patient over a loudspeaker phone. While having to deal with the problem that the interpreter does not see the body language of the two participants involved in communication and might therefore miss or misinterpret certain messages, the service solves the problem of anonymity and confidentiality, it is significantly less costly for the overall budget, and it also ensures an almost continuous availability of interpreters. NHS Direct has already provided its service in over 30 different languages, and the caller is not charged for this service.

The Irish hospital studied has introduced several measures to address the language and communication issues outlined above. An interpretation service has been established, whereby an interpreter can be booked in advance from an agency. Information on the service has been distributed to nurses and training in its effective use has been given to 130 staff. There is also a list of in-house interpreters. Since 2004, there have been a number of translation initiatives in order to make essential information available to patients with little or no English in the areas they need most; for example the x-ray department has leaflets in ten languages. In conjunction with Dublin City University Language Services (DCULS), they have recently run a pilot course in Cultural Training as part of the induction for overseas nurses. It deals with many of the basic language-related difficulties, which have arisen, as well as introducing overseas nurses to Irish culture's communication norms, such as how to make small talk and use appropriate body language. If the feedback is sufficiently positive, this will become a standard module of induction.

### 5.2 The Roma Health Mediators

An interesting initiative meant to improve access to healthcare and eliminate obstacles posed by cultural prejudice comes from Bulgaria. The Ministry of Health and Bulgarian NGOs initiated the introduction of the Roma health mediators (RHM), which started with the training of 57 RHMs, 30 nurses, and 30 GPs in 15 towns. The role of the health mediator is to facilitate the access of minorities, and in particular the Roma minority, to health and social services, but also to help overcome discriminatory attitudes. Health mediators are in fact social workers who help those not familiar with the health system and the social assistance system to gain better access to health and social services.

The mediator is a member of the Roma community who helps illiterate Roma or Roma who are not familiar with the healthcare or social assistance systems get better access to healthcare and social services. The mediator performs the following activities:

- ⇒ Accompany Roma to healthcare and social assistance institutions in order to help them solve a specific health or social problem.
- ⇒ Explain to both parties (medical staff and Roma) their respective expectations and facilitate communication during consultations.

- ⇒ Provide social assistance and patronage to families at risk (e.g. families of chronically ill people or people with disabilities, socially disadvantaged and poor families, families of drug users and people suffering from tuberculosis). The task of the mediator will be to get to know the healthcare and social problems of the family. An important activity will be to register medical cases and work with these families.
- ⇒ Lobby healthcare institutions and social services, protect patients' rights, report violations and acts of discrimination. Mediators are supposed to lobby local institutions, as well as national institutions, if necessary, to solve specific problems and address specific cases.
- ⇒ Help Roma fill in different types of documents and cope with bureaucratic procedures. Practice has shown most Roma have serious difficulties coping with medical documentation, scheduling medical examinations and consultations. Mediators help such people organize all the documentation they need, and work to ensure that all Roma are covered by the health insurance system.
- ⇒ Explain to Roma what rights they have and how the healthcare and social assistance systems work.
- ⇒ Explain to medical staff and social workers what are the needs and the status of Roma.
- ⇒ Participate in various health prevention programs: vaccinations, prophylactic measures against tuberculosis, hepatitis, etc.
- ⇒ Communicate with institutions - local authorities, general practitioners, regional hospitals, regional offices of the National Health Insurance Fund - and inform them on the health status of Roma.

The mediators are differentiated as follows: community-based mediators, mediators who work in healthcare institutions and mediators who work in social assistance institutions. The requirements that prospective mediators must fulfil in order to get the position are:

- ⇒ Candidates should belong to the Roma community.
- ⇒ They should have completed secondary education.
- ⇒ They should have worked at least two years for the Roma community.

A similar initiative has been implemented in Ireland. The Primary Health Care for Travellers Project (PHCTP) has been in operation since 1994 to facilitate Traveller participation in their own health care. The concept of Primary Health Care (PHC) was established at the joint WHO/UNICEF conference in Alma-Ata in 1978, and has been identified and used as an innovative approach to health care in the developing world. In the last decade there has been a growing interest and demand for such a service in the developed world, as evidence indicates that the expanding marginalized populations in developed countries are suffering disproportionately from poor health and have less access to health care services.

“Based on practical, scientifically sound, and socially acceptable methods and technology made universally acceptable to individuals and families in the community, through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development....It is the first level of contact of individuals, the family and community with the national system, bringing health care as close as possible to where people work, and constitutes the first element of a continuing health care process.”<sup>4</sup>

The strategies of the PHCTP include continuous consultation with the Travellers in defining their health care needs, both locally and at national level, training members of the Traveller community to facilitate interaction between the community and health care workers, developing culturally appropriate health education materials, providing in-service training for a range of health professionals, as well as advocacy and lobbying. While there remain significant challenges to real health gains in the Traveller community, the project has made a significant contribution to improving

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<sup>4</sup> [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)

health service delivery to Travellers<sup>5</sup>, and its results can serve as basis for similar initiatives throughout Europe, not only in relation to the indigenous minorities, but also new immigrant groups.

### **5.3 Mentoring and peer-support systems**

In several countries a mentoring system has been put in place, through which the immigrant employee taking up a job for the first time is assigned a native employee (or a non-native employee with longer experience in the workplace) to guide them through the adaptation period.

The system has been used efficiently in Finland. The pairing of employees in the hospital has given both parties the possibility to grow personally and professionally. The scheme should be extended to other workplaces, and the role of the Native Mentor developed to encompass more tasks than work related. The examples provided point out that the role of the Finnish counterpart has gone well beyond that of a co-worker, and this could be recognised through official integration programmes.

The mentoring partner also indirectly assumes the role of language mentor, ensuring that work is accompanied by a continuous learning experience for the immigrant. Thus, the employer would not expect the immigrant to speak the official language from the beginning, but would create conditions for them to learn it day by day, at the workplace; and the time spent at the workplace could count as language training for the immigrant. And this learning experience refers not only to language, but naturally and indirectly, also to workplace rules and cultural issues. Understanding rules and orders correctly and communicating with the partner employee seems to be the most important aspect of this mentoring process, yet the others are not to be neglected. An immigrant interviewee described that co-workers (and his partner in particular) were supportive, provided information, guided and corrected him, repeated whenever he did not understand, and this support even extended beyond the professional sphere (he had been helped with some personal matters like reading an official letter in Finnish). It is an example of good practice that could be extended to other sectors, and preferably the person assuming the mentoring role should also be given training in intercultural communication that would foster a faster learning process for the incoming immigrant and would help the mentor avoid sensitive issues that could turn into conflicts.

This system of pairing new employees with more experienced ones has been used also in order to fast-track the recognition of qualifications. For example, in Ireland, if the nursing qualifications of overseas nurses reach EU minimum standards they are registered immediately after a mandatory two-week induction period, and proceed to work on the wards. If however they are below the minimum standard set by the EU, they must undergo a 6 –12 week adaptation period, during which they work on the wards as supernumeraries and are assigned to an Irish nurse, known as a 'buddy', who is responsible for assessing their level of competency across a wide range of skills, medical and non-medical. They cannot be registered as nurses until their 'buddy' declares that they have reached the required standards. While in theory this buddy system may appear to constitute a practical solution to bridging any existing gaps in nursing standards and cultural practices, in reality it has several drawbacks. Irish nurses complained that acting as a 'buddy' greatly increases their workload, is a highly responsible task for which they are untrained and have little support in conducting. These drawbacks could be eliminated relatively easily, and at a lower cost than having separate assessment and induction procedures for incoming staff.

### **5.4 The recognition of qualifications**

This issue remains a thorny problem, as it has both legal and ethical implication. While there is a growing need for foreign staff in all countries that took part in the research, it is vital that recognition of qualifications is given the necessary weight in order to avoid serious consequences for the patients' health later on.

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<sup>5</sup> <http://www.paveepoint.ie/pdf/PrimaryHealthCare05.pdf>

A number of projects have been initiated to manage the need for medical personnel, especially for physicians, which exists in Sweden today. The ambition has been to recruit doctors who are already residing in Sweden but who do not hold Swedish certification. Municipalities and regional councils have also gone abroad to recruit personnel. A collaboration project running between 2003 and 2005, Legitimation.nu (Registered Professions), worked to facilitate access to the Swedish labour market and speed up the process of gaining Swedish medical certification and integration for foreign medical personnel. The project offered Swedish language courses with medical terminology, occupational training, preparation for medical knowledge tests, compilation of resumes and competence profiles, validation of professional skills, as well as professional guidance. The road to Swedish professional certification and eligibility for persons with a non-European degree in the health sector has been shortened significantly and the competence of the target group has been taken care of to a great extent.

At present, the project lives on in the form of a collaborative network. It would be desirable if funds could be found allowing the project to live on as a permanent operation, as the operation means a safeguarding of resources of great personal relevance for many individuals as well as for society as a whole. Currently, developmental work is being carried out in the so-called validation field, which is trying to develop functioning methods to measure real competence.

The model should be studied in detail and possibly adopted as starting point by other countries.

### **5.5 Cultural Diversity Officer (CDO)**

With cultural diversity increasing exponentially both at societal level and in the healthcare institutions as microcosms of the wider society, it is clear that hospital managements need to implement policies that they hope will lead to good practice in effectively meeting the needs of culturally diverse staff and patients. One significant gesture towards acknowledging the need to address intercultural issues was the appointment by an Irish hospital of a Cultural Diversity Officer (CDO) in 2004, to assess and deal with the intercultural needs of all staff and patients.

The role of the CDO is to develop and deliver initiatives aimed both at celebrating the cultural diversity in the hospital and at preventing racism, cultural intolerance and discrimination. One of the first initiatives to determine the needs generated by cultural diversity among staff and patients was to conduct a staff survey based on a representative sample of all positions and backgrounds, and a patients' needs assessment. The survey revealed that most staff thought cultural diversity made a positive contribution to their work environment, despite the challenges it entailed. However it also revealed that staff knew very little about the concept of equality, or legislation or policies relating to equality and diversity. The clearest finding to emerge was the need expressed by staff for training to help them deal effectively with cultural diversity. They were concerned about causing offence through ignorance of other cultures and wanted to be taught: *'things like how to deal with Muslims or Africans'*.

In response to this need, the CDO designed an introductory module on the topic of intercultural communication for the hospital. To date the hospital has already delivered an interactive cultural competence training module for smaller groups of from 15-16 to 150 staff, and a shorter lecture version of the module for larger groups up to 700 health care workers.

In collaboration with an Irish trainer, the CDO also presents a module on Cultural Diversity to overseas nurses and doctors during their induction period. The most high profile and widely successful event she has instigated so far is a Cultural Diversity Day, where staff wear their national dress, there is food, art, music and dance from all countries represented in the hospital, and diversity is openly celebrated and enjoyed. All participants interviewed spoke positively about this event, and expressed a wish for more such opportunities to learn about and appreciate each other's cultures in a social relaxed atmosphere.

## 5.6 National Intercultural Healthcare Project

The National Social Inclusion Steering Committee of the Health Service Executive in Ireland is currently implementing at the moment a National Intercultural Healthcare Project, whose purpose is to create a culture in healthcare settings that supports the delivery of care in a culturally appropriate manner.

The objectives of the project are

1. To ensure that a commitment to interculturalism is embedded in the ethos and systems of healthcare organisations.
2. To support and develop the capacity of staff to deliver healthcare in an effective manner to service users from diverse cultural communities.
3. To support and develop the capacity of managers to plan and support the implementation of culturally appropriate services.
4. To develop and support an environment that reflects how diversity is valued in healthcare delivery systems and processes.

Each participating institution is developing its own plan for the implementation of the project locally to address the objectives above. The local plan reflects the stage of development of the organisation itself, as well as local needs. Some types of initiatives being developed include:

- ⇒ A local implementation structure to include representation from minority ethnic communities and other key stakeholders.
- ⇒ Senior management commitments secured for the project.
- ⇒ Specific health care settings identified for impact evaluation purposes (e.g. local health centres, hospital units etc).
- ⇒ Stage of development of the organisation in supporting an intercultural approach assessed (with the assistance of an external evaluator).
- ⇒ A high-standard training and development programme is being implemented in all sites. ***This is the key initiative of the work of the project.*** Initial feedback from the institutions who have completed training with some groups has been highly positive, with staff welcoming the training, high attendance rates, senior managers engaging and participating etc.
- ⇒ Some initiatives to make the environment of health care accessible and inviting to members of socially excluded groups are in progress, including universal accessibility auditing, user-friendly information available in various languages etc.
- ⇒ Some hospital settings have assessed resource needs for minority ethnic service users and created responses including interfaith facilities, culturally appropriate food initiatives, etc.

The evaluation of this initiative is expected in the winter of 2007<sup>6</sup>, and should it prove successful, the project could be implemented as starting point in other countries that witness an increasing cultural diversity.

## 6. Conclusion and Recommendations

The empirical research in all the participating countries was carried out during 2006. Due to the rapid development in terms of cultural diversity at the workplace, the situation will be different in some countries at the date of publishing this analysis, and some of the statistical data might be obsolete. Workplaces might have already implemented some of the recommendations below of their own initiative. However, the general added value of the publication will lie in the fact that it unearths some of the major challenges and issues related to the intercultural workplace in healthcare, and it attempts to recommend some solutions or pre-emptive measures based on examples of good practice identified in the organisations and countries studied, as well as the main challenges facing the European labour market in terms of cultural diversity.

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<sup>6</sup> For updated information visit [www.eiworkplace.net](http://www.eiworkplace.net).

As a general conclusion, we can state that there was a lot of heterogeneity in the challenges identified, the good practice selected and, consequently, in the recommendations that follow. As the report is not exhaustive, there will be other examples that would equally well suit the purposes of the report – those included here are a selection made by the researchers. Some of the most important recommendations resulting from the study touch on the following levels:

- the employee level, i.e. workers in healthcare;
- the management/workplace level; and
- the policy-making level.

### **6.1 Recommendations to employees in healthcare**

Since **language** issues have been the most frequently mentioned sources of intercultural conflicts or misunderstanding, below are some suggestions that the reports found useful for health care personnel to follow in order to minimize the risk of lack of understanding/misunderstanding due to language problems:

- *Talk slowly and clearly!* This is important to remember for non-native staff in order to enhance the possibility of mutual understanding in an intercultural setting, given that a rapid speech rate in combination with an accent might be problematic for the listener to understand.
- *Avoid terminology and slang!* Learn medical terminology and the corresponding terms in everyday language. It is essential to be able to talk to the patient in “ordinary language” – not by using Latin terms or medical jargon. Slang and expressions used in spoken language should be avoided, but make sure you are familiar with them in case the patients use them.
- *Listen actively!* Do not interrupt since you may miss much information and, as in many countries interruption is a sign of impolite behaviour, it will not make a good impression on the patient/colleague.
- *Wait for the answer!*
- *Be aware of your body language!* Of course, it often happens automatically that when a person cannot express her/himself verbally, s/he uses gestures or other body movements to find a way out. However, in some cases it is not easy to do, and can be misinterpreted. Some training in this ability would be useful for the participants.
- *Use open questions!*
- *Ask if you don't understand!* Ask the listener to repeat what s/he has just said. Of course, it might be a delicate thing to do given that nobody wishes to show lack of language knowledge, but it is better to ask for help than to make mistakes due to lack of understanding.
- *Give feedback!*
- *Use an interpreter when required!*

**Cultural differences** should not be ignored, and workers should seek individual training in intercultural communication if such training is not offered systematically at the workplace. On a practical level, employees should

- be aware of differences in hierarchy between the host-country and their country of origin. Avoid as a matter of principle giving orders to subordinates, and try to ask them for help instead, as this would avoid misunderstandings.
- be aware of possible differences in communicative styles. Do not take anything personally right away, but try to look at the cultural context of the message.
- be aware of the strong role that family plays in some cultures. Do not try to take the patient out of his safe surrounding, the family, by refusing to discuss matters with them – this will inevitably lead to a breakdown in communication.

### **6.2 Recommendations at workplace/management level**

To start again with the **language** issues, there are several actions that management in healthcare can implement to avoid problems or deal with challenges.

- As a matter of policy, official documents should be at least partly translated into the languages spoken by the main minority groups using the institution. This translation service will naturally depend upon the local needs of the population, and it will probably not be possible to cover all languages present; the cost involved might also be significant, but at least some of it will be recovered by a reduction in the amount of time doctors spend trying to explain medical concepts or rules to patients of a different linguistic background.
- Hospitals could extend translation to some of the signage around the hospital, to create a safer environment for patients.
- Wherever possible the hospital should offer interpreters; it should also clearly recognise the valuable contribution that non-native staff make in this area by offering voluntary, albeit non-professional, interpreting services.
- Language dictionaries should be provided in Emergency Rooms. Since the number of foreign patients is going to increase, it would be helpful to have cross-language dictionaries available in all hospitals, particularly for those languages spoken by the largest immigrant groups in the area. The practice would be commendable because, even if there were doctors of the same ethnic background working in the hospital, they cannot always be present to interpret. A simple enough idea, but likely to save lives.

In terms of **cultural differences**, some training would be required to emphasise, *inter alia*, that respect for those in authority could still be paid even though the forms of address and general demeanour do not appear to convey respect in some cultures (see also the discussion on power distance/hierarchy above). This training might focus on the needs of foreign staff who expect a more authoritarian work environment and often misunderstand the perceived informality in some countries.

More cultural training is also required to explain different attitudes towards gender between cultures, aiming to illustrate, for example, that it is acceptable for a woman to address a man in a friendly and familiar way without causing offence and discomfort.

When it comes to **discrimination and prejudice**, managers should pay particular attention to the implicit reasons behind complaints from staff and patients about non-native colleagues. If a general complaint like “He is no good!” is received, the complainant should always be asked WHAT about him is not good. The manager should always seek an explanation of such a statement, and try to find a reason why the problem might have occurred, rather than simply putting it down to different standards. If the problem appears to be deep-rooted, the manager should seek advice from professionals with expertise in intercultural relations.

A mentor should be provided for immigrant employees when they start working. The mentor should be able to assist with both language and other problems, whether cultural or administrative. It would also be advisable for Trade Unions, possibly with the support of the employer, to organise special training sessions for immigrant employees in their mother tongue. In these sessions immigrant employees could be initiated into their rights and obligations as workers, informed about how the labour laws protect employees, and offered assistance with bureaucratic matters.

### **6.3 Recommendations at policy-making level**

Once again, the most relevant issue to address at policy-making level is **language** and language support for immigrant workers and patients. Generally language support and training is not offered by the workplace, which expects recruits to have reached an acceptable standard before being offered a post. With fewer recruits available in the home markets in the future, this is something that will have to be done as a matter of national, or European, policy: learning the host language at the workplace. Policy-makers should offer incentives to institutions that agree to organise peer-led language courses for immigrants. Such incentives could include a reduction in the number of working hours for the parties involved, recognition of the extra workload for the native employee, or possibly extra remuneration for the task.

Although there is apparent agreement on the need for all doctors practising in a country to speak fluently the official language in order to be able to function properly, the reports have revealed some disagreement with the policy. The researchers would recommend therefore an **exemption from language proficiency tests for highly-skilled doctors**, i.e. highly-qualified surgeons and specialist doctors, who do not necessarily need to interact with the patient but could perform difficult operations. This was compared to the academic world, where professors and lecturers are employed based on their professional skills, and not linguistic capacity. If Europe is to benefit from the wealth of knowledge and expertise brought in by some members of her immigrant community, such positive discrimination is more than welcome, and policy makers should consider its implications.

In order to deal with **cultural differences** arising from increasing diversity, decision-makers should put in place mechanisms that encourage workplaces to adopt **culturally diverse human resource policies**, both for recruitment and retention of staff. This would mean that each workplace that employs a designated percentage of immigrants would be required to assign a **Cultural Diversity Officer** to enhance cultural relations between employees. We also recommend the implementation of certain minimum standards of quality management in relation to the intercultural workplace, which could include the obligation, *inter alia*, to provide information materials and forms in different languages, to allocate prayer rooms for different religions, to reflect cultural diversity in the food offered and in the allocation of working shifts, to have clear paths for identification and elimination of racist and discriminatory behaviour, etc.

We also recommend that **intercultural training be made an integral part of initial and further training** of healthcare professionals. Intercultural teams in the field will become ever more part of everyday life, and at least a European dimension must absolutely be taken into account in training, as cross-border mobility of medical staff is a declared priority.

Policy makers should also consider the use of **health mediators**, similar to the system of Roma mediators in Bulgaria – a model for the improvement of the minority communities' access to health and social services. Thus governments would involve representatives of ethnic minority groups in the formulation of health policies that respond better to the attitude to health of various groups. Although permanent employment of such mediators will prove costly, we consider it worth the financial effort at least during the transitional period, when healthcare workplaces are affected most by a paradigm shift in its client and workforce base. Since the number of immigrants is likely to grow, and the elderly in these groups will need more care, health mediators' tasks could easily include preventative work, meant to reduce the costs of treatment at later stages.

Finally, I would like to quote the words of Ranjana Srivastava and Declan J. Green from their article about foreign medical graduates in Australia – originally quoted in 'The European Intercultural Workplace: Sweden' report:

*In medicine, the road is long for us all, but for the foreign medical graduate it is inevitably more winding and rough. It is our obligation to not abandon our colleagues along the way, but to seek to ease their journey with small, personal gestures and larger, administrative measures. While they tend to society's sick, we must not deny them their own bruises that often lie just beneath the surface. It is only then as physicians we can truly call ourselves healers. (Srivastava & Green 2004)*