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BEING A NON-SWEDISH PHYSICIAN IN SWEDEN: A COMPARISON OF THE VIEWS ON WORK RELATED COMMUNICATION OF NON-SWEDISH PHYSICIANS AND SWEDISH HEALTH CARE PERSONNEL

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Abstract

Sweden is rapidly changing from being a monocultural to a multicultural society. The effects of this process can also be seen in health care which has, up till now, been one of the most ethnically and gender segregated working places, compared to the industrial sector. Increasing multiculturality places the issue of intercultural communication on top of the agenda for Swedish society in general and for the health care sector in particular.
This article is based on the results of two interrelated questionnaires, one directed at non-Swedish physicians, a relatively new but rapidly growing group in Swedish heath care, and one directed at Swedish health care personnel, a traditionally ethnically homogeneous group. The respondents' answers have been summarised and compared in order to get a comprehensive picture of intercultural communication in Swedish health care.

Keywords: Communication, culture, non-Swedish physicians, Swedish health care personnel, language proficiency, misunderstanding, gender.

Background

Non-Swedish physicians in Sweden

Today, the chance of hearing Swedish with an accent in hospitals and other health care institutions is fairly high. One of the reasons for this is the shortage of health care personnel, caused by a relatively low number of newly examined physicians compared to a relatively high number of physicians retiring. The fact that there is an increased interest among Swedish health care personnel in working abroad, for example in Norway, motivated by better education opportunities, shorter working hours, higher salaries, lower taxes, makes the picture more complete. The shortage of health care personnel results in long queues for patients as well as stress and work overload for health care personnel.

One of the ways to solve this problem is to recruit health care personnel from other EU/EES countries. Due to extensive recruitment processes, many German, Hungarian, Polish and Spanish physicians are now working in different parts of Sweden. In addition, a number of support projects have been initiated for health care personnel from non-European countries, whose medical licences are not automatically approved like the licences for physicians from EU/ESS. Examples of such projects are "Project Foreign Physicians" (2000-2001), Project "Legitimation.nu" ("Registered Professions") (2003-2004) in Västra Götalandsregionen (Western Sweden), the Stockholm project and the Malmö project, etc.

Foreign physicians in other countries

Globalisation and increasing rates of migration in the world result in more and more physicians working in foreign countries.

Foreign physicians are therefore quite common in Australia (Metherell 2004), Germany (Medknowledge 2004), Finland (Finnish Medical Association 2004), the USA, etc. In the latter country, roughly one out of five physicians received their initial medical qualification outside of the USA (Miller et al 1998).

Working in different countries, foreign physicians experience different, but at the same time similar problems, such as cultural differences, learning new routines, foreign language usage, etc. Intercultural communication therefore becomes an important issue in today's health care practice and in

the education of health care personnel. The analysis of communication between foreign physicians and their patients and colleagues (in our case Swedish) can provide material when setting up training programmes, which can minimise a possible negative impact of cultural differences, which in turn can lead to improved health care services. In addition, this analysis can be a valuable contribution to intercultural communication theory and research.

Health care communication is not a new field of research. It has been studied in many different disciplines, such as anthropology, sociology, medicine as well as linguistics, each of them investigating both the physician-patient and the physician-health care personnel relationship from different angles. However, research where *the physician is a foreigner* is quite rare. The vast majority of studies, which investigate the influence of cultural differences on physician – patient communication, focus on the more common situation where *the patient is a foreigner*. This means that cultural differences between the physician, who has institutional power and usually belongs to a dominant group in society, and the patient, who usually is a representative of a non-dominant group and experiences language difficulties reinforces the power gap between the participants in the interaction.

One of the few studies of foreign physicians communicating with native patients is a linguistic study by Erickson, F. and Rittenberg, W. (1987) that analyses "topic control" in interaction between Vietnamese and Polish physicians and their American patients. In addition, the handbook for Foreign Medical Graduates issued by the Educational Commission for Foreign Medical Graduates (ECFMG) in the USA as early as 1976, can be mentioned. It provides suggestions for successful communication with colleagues and patients aimed at newly arrived foreign physicians.

The project this study is based on

The research project "Communication and Interaction in Multicultural Health Care" was initiated in 2003 at the Department of Linguistics, Gothenburg University, Sweden. The purpose of the project is to describe and analyse intercultural communication between non-Swedish physicians and their Swedish communicative partners, patients and colleagues, i.e. physicians, physiotherapists, nurses, assistant nurses and other personnel. The project focuses on different kinds of phenomena and difficulties encountered by non-Swedish physicians and their Swedish communicative

partners in the process of communication, as well as on the positive effects of cultural differences. Iranian and Hungarian physicians have been especially selected for the study. Additionally, a number of physicians from other countries, such as Germany, Russia, the former Yugoslavia, Columbia, etc have been involved. The hope is that an analysis of the communication of these physicians (taking into account issues of gender and power), in combination with a comparison of the communication of Swedish physicians with their patients and colleagues, might throw light on some strategies foreign physicians use in communicating with their Swedish counterparts. In a later part of the project we will also focus on the process of language learning in the working place, i.e. analysing whether and how foreign physicians get "informal tuition" from patients and colleagues, and the impact of such tuition on communication.

Methods used in the project

Qualitative and quantitative methods used in the project

The methods that are used in the project are both qualitative and quantitative. The qualitative methods comprise video recordings of work related activities, such as medical consultations and staff meetings as well as a number of semi-structured interviews. The quantitative method is a survey consisting of three questionnaires, i.e. one to non-Swedish physicians, one to Swedish health care personnel and one to Swedish patients. The survey is conducted in order to support (wherever possible) the qualitative data obtained from the recordings and interviews. Thus, many phenomena, mentioned in the interviews as important, are taken up again in the questionnaires, in order to see how representative they are.

In this article, a comparison and analysis of the results of two of the questionnaires (one directed at non-Swedish physicians and one directed at Swedish health care personnel) is presented.

The survey

As mentioned above, non-Swedish physicians and Swedish health care personnel are focused on in the survey. In spite of the variety of non-Swedish physicians represented, e.g. German, Hungarian, from the Baltic countries, from the Middle East, Mediterranean and Scandinavian countries, the main interest in this article are the characteristics of the non-

Swedish physicians as a group and gender related issues. The Swedish health care respondents include the following six groups: "physicians", "male nurses", "female nurses," "assistant nurses", "physiotherapists", and "other personnel."[1] The latter group includes care assistants and laboratory assistants.

The data obtained includes 85 completed questionnaires from non-Swedish physicians and 108 from Swedish health care personnel. Of the non-Swedish physicians, 55 are male and 30 are female respondents.

The questionnaires directed at the non-Swedish physicians and Swedish health care personnel contain about 30 questions each, divided into three parts. The introductory part (participant's background) includes questions on age, gender, education and working experience. Part two contains questions about the respondent's views on communication with patients and part three questions concerning communication with colleagues. Multiple choice and open questions have been used. After each question, there is free space for comments. To make comparison possible, a number of similar questions (with some modifications to fit the different groups) have been used and the analysis of these questions is our main goal in this article. An extra space at the end of the questionnaire made additional comments possible.

The respondent's answers have been counted, categorised and summed up. Note that in some cases the respondents have chosen more than one alternative. The consequence of this is that sometimes the total percentage is over 100. All comments have been taken into account when analysing the answers.

Results

The results obtained in the two questionnaires are presented below. They are subdivided into three sections. First, questions related to communication in general are presented, followed by sections on communication with patients and communication with colleagues.

For this article, the questionnaires have been translated from Swedish and the questions have been modified for clearer presentation of the results.

[1] The division into male and female has been done for the groups where the number of respondents was large enough to make a division meaningful, i.e. "non-Swedish physicians" and "nurses."

General views on communication of non-Swedish physicians and Swedish health care personnel

To minimise the number of tables we restrict our presentation to include only the most frequent responses for each question and group. The responses are presented more in detail when this is needed to understand the result.

The first result is that the majority of non-Swedish physicians (66%) and Swedish healthcare personnel (the percentages range between physiotherapists 27%, other personnel 50 %, female nurses 62%, assistant nurses 65%, male nurses 71% and physicians 83%) are generally satisfied with their work related communication.

If we consider gender differences, non-Swedish male physicians are relatively more satisfied with their communication with Swedish health care personnel than female non-Swedish physicians are, i.e. less than 9% of the male respondents answer "less satisfied," compared to the female's 13%. Among Swedish health care personnel, those least satisfied are female nurses (20%) and other personnel (25%).

In spite of a generally positive view on communication, problems can occur in terms of misunderstanding (Table 1).

Table 1. Misunderstanding in communication between non-Swedish physicians and Swedish health care personnel

Question	***Most chosen alternative(s)***
Have you experienced difficulties in communication with Swedish health care personnel/non-Swedish physicians?	*Misunderstanding*
Non Swedish physicians	47%
Swedish physicians	83%
Physiotherapists	80%
Female nurses	78%
Male nurses	100%
Assistant nurses	70%
Other personnel	67%

Non-Swedish physicians also stress the fact that there can be difficulties in communication with personnel in terms of "understanding implied information" (21%). As can be seen in Table 1, compared to non-Swedish physicians, Swedish health care personnel to a greater extent than non-Swedish physicians, experience difficulties regarding communication. It is also worth noting that the native speaking group, i.e. the Swedish health care personnel, has provided more detailed information i.e. the respondents have ticked more boxes in the questionnaire per person than non-Swedish physicians.

Table 2. Language proficiency and professional competence

Question	***Alternatives***		
Do you think that poor language competence can be mistaken for low professional competence?	*Yes*	*No*	*Sometimes*
Non Swedish physicians	18%	54%	28%
Swedish physicians	100%	0%	0%
Physiotherapists	73%	27%	0%
Female nurses	82%	18%	0%
Male nurses	71%	29%	0%
Assistant nurses	68%	32%	0%
Other personnel	75%	25%	0%

As we can see in Table 2, the views of non-Swedish physicians and Swedish health care personnel concerning language difficulties and their influence on the view of professional competence are quite opposite. The majority of Swedish health care personnel compared to only 18% of the non-Swedish respondents think that linguistic difficulties could have a negative effect on the patient's view of a physician's medical competence.

Non-Swedish physicians and Swedish health care personnel on communication with patients

In response to the question "What is most important in the first meeting with a new patient," non-Swedish physicians rank "to listen" and "to take the patient problems seriously" highest (about 65% each). "To show a genuine interest for the patient" is the third most chosen alternative for this group. No differences between male and female respondents can be observed.

In the Swedish group, both physicians and physiotherapists stress the importance of "taking the patient's problems seriously" (83% and 100%). Other health care personnel and male nurses choose "calmness" (100% and 83%) and male nurses stress the importance of "trust" (83%). For female nurses and assistant nurses "to listen" has the highest frequency (74% and 88%).

Another question concerns possible effects of the presence of a patient's family and relatives during a consultation. Here 48% of the non-Swedish physicians think that communication with patients becomes easier if family members are present. Male physicians are more positive (about 50%), while the female respondents´ answers are evenly divided between "becomes easier", "becomes more difficult" and "makes no difference." Among the Swedish health care personnel, the same pattern is found, i.e. equal distribution of answers among the three alternatives.

Non-Swedish physicians and Swedish health care personnel on their communication

Being new at work can be related to some problems, in the case of non-Swedish physicians the problems can occur in communication with both patients and colleagues. How do the non-Swedish physicians solve these problems? Whom do they seek help from?

The answers of the non-Swedish physicians to the question of how they deal *with problems regarding colleagues* show clear gender differences. Male respondents answer that they usually find out themselves what they need to know (34%), 16% of the female choose this alternative. The female respondents tend to ask "other non-Swedish physicians if there are any who work at the same place" (23%), while only 15% of the male respondents choose this solution. 29% of the female non-Swedish physicians ask Swedish physicians compared to 16% of the male respondents.

The views of the Swedish health care personnel on how non-Swedish physicians deal with problems related to colleagues are the following. 100 % of other personnel, 50% of the physiotherapists, 50 % of the female nurses answer that non-Swedish physicians "find out themselves what they need to know." 33% of the physicians answer that the non-Swedish physicians tend to contact a superior. 50% of the male nurses choose the alternative "other non-Swedish physicians" and 50% choose "nurses". The answers of the assistant nurses are roughly equally distributed between

"find out themselves what they need to know" and "other non-Swedish physicians" (33% each).

The answers of the non-Swedish physicians concerning how to deal with *problems regarding patients* show gender related differences. The majority (71%) of the male respondents turn to Swedish physicians and 24% to nurses. The female respondents turn to other non-Swedish physicians (43%), or find out themselves what they need to know (30%), 18% for male respondents.

Turning to the answers of the Swedish health care personnel on the same issue, i.e. how non-Swedish physicians act when experiencing problems with patients, we find that 100% of the male nurses, 71% of the assistant nurses, 46% of the female nurses, 40 % of other personnel answer that non-Swedish physicians turn to Swedish physicians. 50% of the physicians answer "to a superior" and the physiotherapists have 40% on both "Swedish physicians" and "find out what they need to know themselves."

Concerning the question whether there are any differences in communicative behaviour between male and female non-Swedish physicians, Swedish health care staff do not think that there are such differences.

We have also looked at possible differences concerning power distance between subordinates and superiors and their effects on communication.

The non-Swedish physicians were asked to compare the power distance between subordinates and superiors in Sweden with their respective home countries. The answers show that the majority of non-Swedish physicians consider the distance to be smaller in Sweden (80%). Only 15% (13 respondents) have answered that there is no difference, 10 respondents in this group are female.

The answers of the Swedish health care personnel to a similar question, i.e. if there is any difference between the views of non-Swedish physicians and Swedish physicians on power distance, are presented in Table 3.

Table 3. The responses of Swedish health care personnel concerning views on power distance

Question	***Alternatives***			
Non-Swedish physicians' view on difference between superiors and subordinates is	*More hierarchical than the view of Swedish physicians*	*Less hierarchical than the view of Swedish physicians*	*No difference*	*No experience*
Swedish physicians	100%	0%	0%	0%
Physiotherapists	42%	8%	33%	17%
Female nurses	38%	0%	40%	22%
Male nurses	50%	0%	67%	0%
Assistant nurses	12%	0%	85%	8%
Other personnel	11%	22%	22%	45%

Do non-Swedish physicians think that shorter power distance leads to increased informality in communication with superiors as well as with subordinates? On the question if they have changed their style of communication, 63% of the male and 43% of the female respondents (among the non-Swedish physicians) answer that they have not. The female respondents show a tendency to have more answers on both "become more informal" and "become more formal". On relation to superiors the female respondents have 33% and 30% on more and less informal respectively, while the male respondents have become generally more informal 44%.

Finally, regarding a more general question about how to integrate successfully in the Swedish health care environment, 62% of the non-Swedish physicians choose "coffee breaks" and 55% emphasise the importance of avoiding conflict as the most important strategies. A slight gender difference can be observed. 30% of females choose "be indirect" compared to only 7% of the male respondents. Additional answers to this question are "be yourself and do not play act", "have informal contacts", "be correct and friendly", "have time to listen", "show understanding for cultural differences", "be clear" etc.

On the same question, 67% of the assistant nurses and 46% of the female nurses emphasise the importance of "taking coffee breaks together". Male nurses, physiotherapists and other health care personnel mainly choose the alternative "other" (80, 64 and 57% respectively), adding comments like "be direct", "be a better communicator, a better physician", "meet with respect", "ask if you do not understand", "be direct, clear, open to

conversation and discussion" etc. 67% of the physicians choose the alternative "be neutral".

Discussion

Our aim in this article is to analyse two questionnaires directed to non-Swedish physicians and Swedish health care personnel, in order to see how they view their communication in the Swedish health care working environment. Non-Swedish physicians are a relatively new phenomenon in traditionally monocultural Swedish health care, but they are a factor to count on and their presence is needed. Their successful integration is essential not only for themselves but also for their colleagues and patients.

Before discussing the results presented above, some points concerning questionnaires as a research method should be stressed. First, one might question the sincerity of the answers of the respondents. On one hand, non-Swedish physicians might be unwilling to show possible dissatisfaction, in this way avoiding to be seen as less competent or even inflexible. On the other hand, Swedish health care personnel can hesitate to express possible negative thoughts for fear of being seen as racists. In both groups, there is thus a risk that in spite of promised anonymity the respondents might feel insecure and choose to answer more neutrally. Concerning the Swedish group, one of the typical features of Swedish mentality, namely conflict avoidance and neutrality (Daun 1989, Phillips-Martinsson 1981) can influence both the way this group answers the questions as well as their communication itself. However, conflict avoidance might be tempered by another typical Swedish feature, namely an attempt to strive for honesty and to tell the truth even if it is not the whole truth.

The analysis of the questionnaires shows that both groups are relatively satisfied with their communication, though they think that misunderstandings and problems in understanding implied information can occur. The responses also indicate that Swedish health care personnel more often experience difficulties than do their non-Swedish colleagues. There are several possible explanations for this. First, as has already been mentioned above, the non-Swedish physicians might feel reluctant to answer this question. Second, the non-Swedish physicians may not always notice that misunderstanding takes place due to lack of language competence. Third, the Swedish fear of criticism and the presence of conflict avoidance strategies could result in even more "hidden"

misunderstandings, that are more difficult to detect both for Swedes and non-Swedes. The same problem can continue to occur without the involved parties being able to do anything about it. The situation is not made easier by the fact that the Swedish respondents mainly consist of persons who in their work are dependent on good communication with the physician.

Least satisfied with communication are the female respondents. This dissatisfaction can perhaps be related to the idea that females are more critical and have a more sensitive view on communication. One of the typical features of a female communicative style is the desire to have a more intimate and emotional relationship, which Tannen thinks is the opposite of a male more task oriented communicative style (Tannen 1991). This desire can be difficult to satisfy when cultural differences as well as language difficulties are obstacles to a development of more close relationships.

Another explanation is connected to the traditions of Swedish health care. Today more and more female physicians are working in health care institutions and the former traditional male physician-female nurse pattern is no longer always valid. However, research shows that female physicians often experience that being a female in a higher position with nearly only female subordinates creates more tension than if the superior is male, in terms of receiving less "service" and help from, for example, female nurses (Lichtenstein 1998, Robertsson 2003). Being a female and a foreigner doubles this burden for non-Swedish female physicians and the risk of being seen as "the odd one out" increases.

We can also see that language competence is a touchy and difficult issue from the fact that non-Swedish physicians do not think that their possible lack of language competence can be mistaken for lack of professional competence, while the vast majority of Swedish respondents think the opposite. As we have already seen this discrepancy can perhaps be explained by the uneasiness of the non-Swedish physicians' regarding questions concerning their own professional competence.

Both Swedish and non-Swedish respondents have similar views on communication with patients (especially during the first meeting). Their answers are quite similar. "To listen", "calmness," and "to show genuine interest for the patient" are most frequent answers.

Gender seems to play a role in how the different groups answer some of the questions. The male non-Swedish physicians have a tendency to be more positive to the presence of relatives than do the female physicians. They also prefer to solve problems regarding colleagues themselves while the females would rather ask other Swedish physicians for help. The answers of Swedish health care personnel show same overweight on "find out themselves what they need to know." Regarding problems concerning patients, female non-Swedish physicians ask other non-Swedish physicians for help or find out themselves what they need to know. The male respondents are more inclined to turn to other Swedish physicians or nurses. This is consistent with research that shows that male members of staff are favoured at female-dominated working places (Robertsson 2003). Turning to the Swedish respondents (other than physicians) their answers show that they think that non-Swedish physicians most often ask for help from Swedish physicians, while the Swedish physicians answer that their non-Swedish colleagues turn to superiors.

The majority of non-Swedish physicians consider power distance at working places to be shorter in Sweden. This is consistent with the relatively low Power Distance Index for Sweden in Hofstede's taxonomy (Hofstede 2001). At the same time, non-Swedish respondents state that they have not changed their communicative style into a more informal one which would be the typical consequence of shorter power distance. This can be related to the answers of the Swedish respondents that indicate that the non-Swedish physicians are used to a larger power distance. We may now ask why non-Swedish physicians prefer to keep a larger distance even being aware of the "flat hierarchy" in Sweden? Two possible reasons for this are the following. First, in spite of the fact that Swedish hierarchy is "flat", it exists, and keeping a larger distance can be a more secure strategy when roles appear to be unclear. Habit and a life-long experience of working in a more hierarchical system is probably a second reason.

Having coffee breaks together with colleagues in the lunchroom and avoiding conflicts are mentioned by all our respondents as successful strategies for integration in a Swedish working place. This probably reflects the well-known Swedish coffee drinking tradition. Coffee drinking probably goes hand in hand with conflict avoidance since they both probably aim for the same goal – the familiar, pleasant and peaceful working environment which is so highly valued by Swedes (Daun 1998).

Conclusion

The new heterogeneous workforce creates challenges connected to cultural differences, which have an impact on working life, e.g. conflict solving, differences in views on power distance between superiors and subordinates, attitudes to work, working conditions, expectations of appropriate behaviours, attitudes, socially accepted norms and beliefs, etc. In addition, to cultural differences, language difficulties add to the complexity of the situation. It is therefore fairly clear that future educational programs for the groups involved should benefit from more information regarding many of the factors discussed above.

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Biography

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