Foreign doctors in Norwegian psychiatry – is there a need for a mentoring scheme?

BACKGROUND In line with other Western countries, the number of foreign doctors in Norway has greatly increased in recent years. Inadequate language skills and cultural differences may give rise to challenges. The objective of this study was to investigate the views of Norwegian specialty registrars in psychiatry with regard to a mentoring scheme for foreign doctors and how such a support scheme ought to be designed.

MATERIAL AND METHOD Data were collected in focus-group interviews with specialty registrars in psychiatry. Altogether 24 Norwegian and 16 foreign doctors participated in a total of five focus groups. Thematic analysis was used as methodology.

RESULTS One consistent finding pertained to the differing views on the need for a mentoring scheme among the Norwegian and foreign doctors respectively. The foreign doctors perceived few problems in terms of language and culture, while their Norwegian colleagues had occasionally experienced considerable problems in this respect. Moreover, obstacles in terms of attitude to a mentoring scheme were revealed among the foreign doctors, as well as differing opinions regarding the organisation of such a scheme, especially in terms of its voluntariness and having peers as mentors (horizontal organisation) versus having superiors as mentors (vertical organisation).

INTERPRETATION The differences in attitude to a mentoring scheme are partly caused by perception of the problem's extent and partly by varying norms and values among foreign and Norwegian doctors respectively. We propose that various forms of mentoring scheme be tested in a pilot project, in which the foreign doctors are actively involved.

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MAIN MESSAGE

The foreign doctors took a less positive view of a mentoring scheme than did the Norwegian doctors.

Foreign doctors perceived few problems related to language and culture.

Culturally-based attitudes appear to have influenced the doctors' views on both the introduction and the design of a mentoring scheme.

During the last 10–15 years there has been a marked increase in the number of foreign doctors in Norway, to date (2014) approximately 3 900, equivalent to one-sixth of all doctors of working age. A similar trend has been observed in the USA, Canada, Australia and most Western European countries (1). According to the annual report of the Norwegian Medical Association (2), altogether 38 % of all specialist authorisations that were granted in 2013 applied to foreign nationals. Of those who were granted specialist authorisation in psychiatry in 2103, a total of 46 % were foreign nationals.

Differences in language and cultural background among doctors represent a major resource in an ethnically diverse patient population and may bring valuable knowledge and new perspectives to the health services (3). At the same time, deficiencies in a doctor's language skills and culturally related misunderstandings may give rise to problems in his or her relationship to colleagues and patients. Language-related and culturally based communication failure between the doctor and the patient may compromise the quality of the health services. There is a significant need for intercultural understanding (4, 5). Despite the extent and serious nature of this problem, international research in this area has been limited.

In 1997, the Norwegian Association of Senior Hospital Physicians undertook a survey and an opinion poll among Norwegian senior consultants and foreign specialty registrars in hospitals (6). The survey showed that one in four senior consultants believed that language problems arose in the work of the foreign doctors, while these doctors themselves reported significantly fewer problems. Moreover, approximately half (49 %) of senior consultants working in departments with many non-Scandinavian doctors reported that problems occurred as a result of insufficient familiarity with Norwegian culture or cultural differences in terms of norms and values. Three out of four foreign doctors reported no such problems, however. One of the measures recommended by this study was a support network for foreign doctors (6). Such a scheme has yet to be implemented.

International studies recommend various measures to facilitate the professional and personal orientation process of foreign doctors (7–10). Mentoring schemes («mentor» in the sense of adviser, guide) have proven to help promote personal growth, increase job satisfaction and enhance the effectiveness of their work. Such a scheme is one of several measures proposed to help achieve successful integration (8–12). Key topics covered by this guidance include communication problems, views on the doctor's role, relations with colleagues and culturally-based differences in value systems. Help in lear-

ning work procedures and routines, as well as support for social integration are also key elements (9, 10, 13, 14).

Few studies have specifically examined mentoring schemes for foreign doctors in the field of psychiatry (15). To date, no such studies have been conducted in Norway – either in psychiatry, or in other medical fields. The objective of our study was to investigate the interest in a mentoring scheme for specialty registrars in psychiatry in Norway and how it could best be implemented.

Material and method

As our method of investigation we used *focus groups* and *thematic analysis*, with specialty registrars in psychiatry as our informants (Box 1) (16–18). Focus groups have proven to be well suited for investigating attitudes, experiences and opinions (16, 17). We wished to use focus-group discussions to capture the different ideas about and attitudes to the chosen topic among the doctors involved.

A focus group tends to include 6–10 participants and is led by one or two «mediators» (group leaders). The focus-group method is different from other interviews in that in a focus group, the participants to some extent form their opinion during the group discussion. For further information on the method, see Liamputtong (16) and Malterud (17).

The focus-group sessions took place at three national foundation courses in psychiatry, held in various locations across the country. Because of their participation in the foundation course, the doctors were known to each other beforehand, although they were not personal acquaintances – in focus groups, it is recommended that the participants have no personal relationships as friends, since this is assumed to be an impediment to a free and critical exchange of opinion within the group (17).

Participation was voluntary, and the study was anonymised in accordance with ethical guidelines. The informants were selected with a view to obtaining a broad range in terms of place of residence, type of workplace and gender. A total of 40 doctors participated, whereof 24 were Norwegian and 16 from other countries. The course participants were provided with oral and written information about the project. All doctors consented to participate. The foreign doctors represented a wide range in terms of their countries of origin, which included Scandinavia, Northern Europe, Eastern Europe, the Middle East and Southeast Asia.

A total of five focus group sessions were implemented with 6–10 participants in each. At the first two foundation courses we held separate sessions for Norwegian and foreign doctors respectively, in a total of four groups. We chose to use a mixed group at the third foundation course, thus to see whether any other attitudes and opinions would come to light.

The selection to the groups was undertaken on the basis of surnames (ethnically foreign-sounding surnames and Norwegian surnames). None of the participating doctors defined themselves out of the group to which they had been assigned. The reason for choosing such a group composition was based on experience from international studies, showing that group homogeneity is crucial for bringing attitudes out in the open and promoting good discussions (17). We were afraid that the doctors would be more cautious in their statements when having to discuss a topic that would be perceived as sensitive in a group consisting of foreign and ethnically Norwegian doctors.

Each focus group discussion lasted for approximately 60 minutes and was recorded on an audio device. The groups were led by two doctors – the mediators (the first and second authors). We sought to keep the discussion between the participants as free and open as possible. First, they were asked to describe their personal experiences as a foreign doctor/their personal experiences with foreign colleagues. They were then asked to recount their views on the need for a mentoring scheme and if relevant, how such a scheme should be designed.

Immediately after each group session the two mediators exchanged their impressions from the discussion. After transcription and printing, the audio files were deleted. Names of group participants were not written down or stored, and statements from the audio files could not be linked to specific persons.

Analysis

The transcribed material was analysed with the aid of *thematic analysis* (17, 18). Each focus group interview was reviewed in detail and statements were coded according to the recommended systematic and stepwise procedure. The interviews were subsequently collated.

We searched through the entire data set to identify recurring patterns of meaning, and the topics were interpreted in accordance with applicable principles (18, 19). In addition, the topics were interpreted independently by the third and last authors, who both possess scientific training. The coding of the content, the topics and the interpretations were subsequently compared and discussed in the research group until consensus was achieved. Only very few discrepancies were detected.

Results

The analysis revealed two recurring topics that in combination formed the basis for the doctors' views on the need for a mentoring scheme: perceived communication problems and attitudes and values. Each of the main topics in turn contained sub-topics.

Communication

Language problems. The Norwegian doctors claimed that the language skills among the foreign doctors were poorer than the foreign doctors held them to be. They often had difficulty understanding the language and pronunciation of their foreign colleagues, and had experienced that many of them had an insufficient understanding of Norwegian. They had observed that such problems also recurred in communication with patients.

In particular, problems would occur when foreign doctors had to convey messages by telephone or write notes for the patient records. In their opinion, insufficient understanding of the content was the hardest issue to detect, since this would often go unnoticed until clinical collaboration took place.

Language! I find this to be a considerable problem that I have felt all the time – the frustration in patients who would prefer to consult with a Norwegian foundation doctor rather than a foreign senior consultant ... They can be highly skilled as doctors, but then there is communication, you see!

Although some of the foreign doctors would also acknowledge that some language problems could occur, most of them claimed that these problems were minor and insignificant – some claimed that they were non-

BOX 1

Investigation method

Focus groups (16, 17)

Focus groups are informal group interviews where the discussion provides insight into the participants' attitudes to and interpretations of a given topic.

Focus groups provide a methodological advantage in allowing space for group dynamics, which may help elucidate the topic from different angles and discover unforeseen issues.

Thematic analysis (18)

Implies a thematic categorisation of statements from the group interviews and identification of patterns of meaning across the group interviews.

The categorisation of meaning forms the basis for the interpretation of the results.

existent. They perceived themselves to be «as good as everybody else» and felt that the Norwegian language requirements were far too strict. Many of them referred to their successful completion of the mandatory language test as evidence that they had no language problems:

May I ask you: is there no limit? Should I continue for three years, five years?? Will I ever speak the same way as you? No!

Culture-related problems. In the Norwegian doctors' experience, foreign colleagues could misunderstand Norwegian ways. They might interpret clinical situations differently, emphasise other aspects of the therapy, and their medical assessments would be different. Some had also noticed that doctors from non-Western countries had other attitudes towards women and showed less acceptance of women as leaders. This was explained with reference to cultural differences. There was nevertheless some uncertainty as to whether this should be regarded as an expression of cultural differences or as an effect of the personality of the particular doctor.

Very few of the foreign doctors had any perception of problems in understanding Norwegian culture. Many of them claimed that the cultural differences across the world are smaller than in previous times and warned against cultural stereotypes among their Norwegian colleagues.

Attitudes and values

Seeking help. The ideal of self-reliance. When asked whether special support schemes for foreign doctors would be desirable, the groups of foreign doctors expressed a clear preference for self-reliance. Independence of others appeared to be an ideal. Asking for help was perceived as being a burden on others, and dependence on support from others was seen as evidence of weakness. In preference to this they would consult dictionaries or the Internet.

Then I come back to the basic attitude that one should be self-reliant. That is, one needs to learn how to cope and stand on one's own two feet. And obtain information by oneself

There were many who claimed that *independence* was a feature of many foreign doctors' personalities, and that this had helped them emigrate and advance as far as they had done.

Their own role as doctor. Most of the foreign participants regarded the doctor as being at the top of a hierarchical system and wished to maintain this status. The role of doctor implied that they were the ones to guide and support others, and that this signified their competence. Accepting help and guidance was difficult for them.

Some also reacted to the Norwegian mental healthcare system, in which the doctors often work at the same level as nurses and non-medical professions. This could be perceived as humiliating. The Norwegian doctors, on the other hand, were accustomed to working in a culture that in comparison to other cultures is fairly egalitarian.

Attitudes to colleagues with another ethnic background. Ethnic integration versus exclusion/isolation. Several of the Norwegian doctors felt that they themselves could tend not to be inclusive and to exclude their foreign colleagues from their private lives. The foreign doctors, on the other hand, felt that it was important for them not to isolate themselves. They were of the opinion that the working environment should be more socially inclusive, and there were some who expressed a feeling of being unwanted – they were wanted only for as long as there was a need for their labour.

The fact that we constitute a major resource is not the impression that this country imparts to us. All the signals we receive from the training committee and the Norwegian Medical Association indicate that they don't want us. Perhaps we need to start from there?

Conflict avoidance. Non-confrontational attitudes. Inadequate language and cultural skills in foreign colleagues were a highly sensitive topic among the Norwegian doctors. They were reluctant to point out problems for fear of conflicts.

... because then one is afraid of suddenly being branded as a racist, and of course one is against racism. One dares not say: You're not doing the job well, you don't have sufficient language skills.

The need for a mentoring scheme

When asked directly whether a mentoring scheme for foreign doctors was needed, most of these doctors regarded it as unnecessary. The challenges involved in language and cultural issues were not so great that they were unable to cope with them on their own. If any problems occurred, they would prefer to ask someone they trusted – if they felt the need to do so. Others nevertheless argued that a mentoring scheme could have its benefits, but primarily as a form of assistance in practical and administrative matters.

Some may of course have such needs at first – we are new to Norway. When I was new myself, however, my nurse, my friend and my supervisor were there for me. There is no need to establish such a scheme, which in reality would mostly portray something as a major problem when it really is no problem at all.

Many of the foreign doctors perceived the proposal for a mentoring scheme as an overreaction on the part of the Norwegian doctors, who were unfamiliar with their situation. It was described as «silly and patronising». They argued that the problem existed among a very small group of foreign doctors, and that this was generalised to apply to all of them.

Even some of the Norwegian doctors were uncertain of its real extent. However, most of them found that many foreign doctors faced problems related to language and culture, and thought it problematic that their foreign colleagues often failed to recognise this fact. They therefore welcomed a mentoring scheme. Many also pointed to the problem that employers put the doctors «into production» as soon as possible, without the necessary investment in language and culture training.

There was agreement across all groups that a mentoring scheme could fulfil an important social function. The scheme was regarded as an opportunity to establish a social network among colleagues across cultural affiliations and create a forum for mutual cultural enrichment. Moreover, a mentoring scheme might be suitable for addressing relational conflicts that would otherwise remain undercommunicated.

Content, implementation and organisation of a mentoring scheme

Finally, the participants were asked how a mentoring scheme for foreign doctors should best be organised, if adopted. The topics that emerged centred on *content*, *implementation* and *organisation*, with the following sub-topics:

Definition and delimitation of content and objectives. Most of those who favoured a mentoring scheme argued that a specific content and a clear objective needed to be developed. Many believed that this type of guidance should be separated from the usual training in procedures, routines and record-keeping, which instead should be provided in the form of a general introduction course for all newly employed doctors. Nor should regular language training be included in such a mentoring scheme, but provided as separate training courses instead. In terms of content, the scheme should mainly focus on communication problems and sociocultural support.

Horizontal versus vertical organisation.

Most of the doctors in the Norwegian groups argued that the mentor and the foreign doctor should be at the same level in the hierarchy – meaning that a subordinate doctor would advise another subordinate doctor (horizontal organisation).

Many of the foreign doctors objected to the prospect of having colleagues at the same level of competence as mentors. Many felt that it would be humiliating to be guided by another foundation doctor, one who may not have reached the same level of training as themselves. They would prefer to have a senior consultant as their mentor – someone higher up in the hierarchy with more status and medical competence than themselves (vertical organisation).

Incorporation of a mentoring scheme into the existing supervision scheme. Many argued that the clinical supervisors (senior consultants) could have an additional role as mentors to foreign candidates. In this case, the supervision should have an explicit additional content, with an opportunity to address language, cultural and social issues. One of the arguments in favour of this type of organisation is that problems related to language and culture are primarily discovered during clinical supervision. In addition, the reporting of such problems by a senior consultant would not give rise to a conflict of loyalties to the same extent as when reported by a colleague at the same level in the hierarchy.

A mentoring scheme organised as group sessions. There were also proposals to organise a shared mentoring scheme among several workplaces in the form of group sessions. The Norwegian and foreign doctors both supported such a scheme, which was believed to reduce the number of mentors and have the additional advantages of providing more concentrated guidance and taking place outside the clinical setting. In particular, it would provide the foreign doctors with an opportunity for mutual exchange of useful experiences from their job situation.

Discussion

The scope of communication problems and the need for a mentoring scheme

A striking finding in this study is that the Norwegian doctors felt that the communication problems faced by the foreign doctors were greater than what the foreign doctors themselves felt. This concurs with findings from the national survey undertaken by the Association of Senior Hospital Physicians (6). In both studies, the Norwegian doctors were the ones who tended to argue in favour of a support scheme for foreign doctors, not the foreign doctors themselves.

One possible explanation could be that the Norwegian doctors generalise and ascribe poor language and cultural skills to an entire group (i.e. foreign doctors), while this in reality applies only to a few. Stereotypes and generalisations are well-known human phenomena. In addition, foreign doctors may be at risk of more critical assessment than their Norwegian counterparts. Failings and mishaps may thus be exaggerated. For example, one reason why foreign doctors appear to be overrepresented in complaints cases could be that they are more likely to *incite* complaints – they are easier to attack than their Norwegian colleagues (20).

On the other hand, it is also a very human phenomenon to interpret reality in a way that reinforces one's own self-esteem. Acknowledging one's own linguistic and cultural shortcomings may feel threatening, especially if this may have an effect on one's career. Moreover, anybody may have difficulty judging how well they function and communicate with others. A doctor may feel that he or she communicates well with a patient, while the patient thinks the opposite. This has been shown to occur in encounters between *Norwegian* therapists and patients from minority cultures, for example the Sámi (21).

Views on a mentoring scheme and how it should be organised

Many of the foreign doctors rejected the idea that Norwegian specialty registrars should act as mentors to them, since they felt it to be degrading and humiliating. This concurs with international findings, for example in the UK, indicating that pride, fear of losing face and a perception of being continuously watched could act as barriers to learning in the workplace (14).

An alternative solution could be to include the mentoring scheme in the existing mandatory supervision scheme for specialty registrars, and let the clinical supervisor fulfil an additional function as mentor for foreign doctors. The literature contains no references to such a form of organisation. The reason may be that mentoring schemes have been described for specialties whose supervision schemes are less formalised and close than those of psychiatry.

International studies that have investigated the organisation of mentoring schemes for foreign doctors recommend preparation of a detailed description of the mentor's role and tasks, as well as thorough training of those who assume this role (9). Similar recommendations were made by the informants in our study, and the findings therefore concur well with those made by other studies.

Many of the doctors – and the foreign ones in particular – favoured a voluntary scheme in which the mentor preferably should be selected by the mentoring candidate. This accords with recommendations made in some international studies (9). The problem inherent in such a voluntary scheme is that it may fail to capture all those who have a need for it. In light of the attitudes that emerged from the groups of foreign doctors, this apprehension may possibly be justified.

Limitations and strengths of the study

Similar to findings made by other types of qualitative studies, findings that emerge from focus group sessions cannot be generalised to a larger group. They may nevertheless provide important insights into how people perceive reality and a picture of the attitudes and opinions that govern their behaviour (16, 17). Our study must be regarded as being of an exploratory nature with no ambition to provide a complete description. Other informants and another composition of the groups would have led to other findings. Other qualitative methods, such as participant observation or individual in-depth interviews, would have done the same.

A weakness in terms of methodology is that the two mediators had no previous experience as leaders of focus groups. It is therefore conceivable that the quality of the resulting material would have been better if those two had been more experienced. On the other hand, the chief mediator is an experienced psychiatrist with competence in group dynamics, and both mediators were advised during the process by a colleague with competence in qualitative research (the last author).

Another limitation is that the data analysis consisted only of a thematic analysis of the *content* of the discussions, with no analysis of the interactive situation and its context. This may have weakened the interpretations. It should be noted, however, that like our study, most focus-group analyses made internationally are purely analyses of content (18, 19).

A further objection could be that our group of informants included only doctors and no patients or hospital administrators. Including other groups of informants in the study would have provided a more complete understanding of the problem complex and could possibly have generated more ideas. Because of scarcity of resources and time, a more comprehensive design was unfortunately not possible.

A significant methodological strength of our study is that the coding, topics and interpretation of the material were undertaken individually by all co-authors and subsequently compared and discussed in the whole group until a consensus was reached.

The fact that the authors themselves come from a variety of cultural backgrounds, and that the third and last authors possess research competence, all help strengthen the validity of the study.

Conclusion

This qualitative study gives support to previous findings showing that the language and cultural skills of foreign doctors are assessed differently by the Norwegian doctors and their foreign colleagues. The foreign doctors included in the study felt that they had few problems. They were therefore mainly sceptical or dismissive of a mentoring scheme. Attitudinal barriers to organised support schemes were also demonstrated by the target group.

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