Language barriers and professional identity: A qualitative interview study of newly employed international medical doctors and Norwegian colleagues

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ABSTRACT

Objective: To explore how language barriers influence communication and collaboration between newly-employed international medical doctors and Norwegian health personnel.

Methods: Interviews were conducted with 16 doctors who had recently started working in Norway and 12 Norwegian born health personnel who had extensive experience working with international medical doctors. Analyses were consistent with principles of systematic text condensation.

Results: All participants experienced that language barriers caused difficulties in their everyday collaboration. Furthermore, the participants' descriptions of "language barriers" encompassed a wide range of topics, including semantics (e.g., specialized professional vocabulary, system knowledge), pragmatics (e.g., using language in doctor-patient and interprofessional interactions), and specific culturally sensitive topics. All participants described that language barriers provoked uncertainty about a doctor's competence.

Conclusion: Newly employed international medical doctors and their colleagues are concerned by ineffective communication due to language barriers. Experiences of language barriers threaten professional identity as a competent and effective doctor.

Practice implications: Newly employed doctors who are non-native speakers could benefit from support in understanding and handling the array of barriers related to language.

1. Introduction

A significant number of doctors leave their homeland to work in other countries [1,2]. In Norway, approximately 16% of practicing medical doctors hold foreign citizenship, with international medical graduates (IMGs) comprising a significant proportion of the GP workforce [3] and representing approximately 25% of senior doctors in hospitals [4]. IMGs have become an important resource for Norwegian health services, similar to other European countries [2], USA, Canada and Australia [1]. Doctors from EU/EEA countries are not subject to national language requirements due to the principle of free movement of labor. Most IMGs in Norway are from Germany and neighboring Scandinavian countries[5]; however, 3.5% of practicing doctors are from countries outside the EU and must take a high-level Norwegian language examination for authorization. Ultimately, the employer is responsible for ensuring that their healthcare personnel has adequate language skills. Still, IMGs often have some degree of language difficulty, whether they come from countries neighbouring Norway or from ones that are geographically and/or culturally distant [6-9].

International research has shown that IMGs often experience language barriers [7,10-14] and find that their new patients and colleagues have different expectations regarding professional communication compared to what they have learned and practiced in their homeland [6-9,11]. Schwei *et al.* [15] reviewed the literature regarding language barriers in health care concluding that the topic is well explored and that "researchers worldwide should move away from simply documenting the existence of language barriers". However, they also state, "language barriers adversely affect "quality of care; and patient and provider satisfaction" among other things, calling for more research to understand and rectify such barriers in health services. Indeed, Lineberry's review of educational interventions for IMGs [14] states that the literature on how IMGs learn language skills is insufficient, pointing to a need for interventions to accommodate language barriers.

To understand the implications of practicing health care in a new language, it is important to be aware of the challenges healthcare professionals encounter when immigrating. In general, immigrants report that both the knowledge and the status they had achieved in their home countries have less value in their new countries [16,17]. These and other experiences of loss are common, as are a lack of knowledge about their new host country and its health care services [18]. Far from being immune to these challenges, IMGs who begin their careers in a country other than the one in which they were educated find that it can be demanding, and, for some, it can cause emotional stress and loss of self-esteem [10,19-24]. Language barriers and other acculturation stress factors could threaten the IMGs' professional identity. The concept of professional identity (i.e., a person's experience of understanding and mastering his or her profession, possessing adequate knowledge, and applying that knowledge to their work) has become central to medical education [25,26]. A key element of professional identity is the individual's perception of their own professionalism [26] or "sense of being professional" [25,27]. This perception is neither inherent to the individual nor static; it is an ongoing

process [26] related to one's experience of being able to interact effectively with one's environment [28]. In addition, acculturation stress affects the IMGs' ability to adapt to their new surroundings [20], probably including learning a new language and dealing with language barriers.

This study explores the issue of language barriers using semi-structured interviews with newly-employed IMGs and native Norwegian health providers. This study was explorative, aimed at enlightening experiences and views on everyday professional collaboration. A persistent theme was the wide spectra of experiences of language barriers, in particular how these language barriers could influence the IMGs' sense of self and ability to provide quality healthcare.

2. Methods

To gain insight into experiences of working relationships between native Norwegian health providers and new IMGs (who would be unfamiliar with the Norwegian health care system and practicing in the Norwegian language), we planned qualitative interviews. Our intention was to work inductively to explore and present health providers' experiences and views about a topic we know concerns health providers, patients, and government administration. We conducted semi-structured interviews that focused on the participant's background, personal experiences of collaboration between IMGs and Norwegian providers, and the meaning people associate with these experiences [29]. Consistent with a phenomenological interview approach, we placed emphasis on the description of specific personal experiences rather than on general comments [30].

2.1 Participants and data collection

Twenty-eight participants were recruited: 16 IMGs (who had been working in Norway between a few months and 2 years) and 12 Norwegian medical doctors and nurses who had extensive experience working with IMGs. Participation was anonymous, both because it can be difficult for people to speak freely about sensitive topics, such as experiences and feelings [30] and because the study involved exploration of incidents that health personnel often find difficult to talk about [31]. IMGs were recruited from the National Health Personnel Registry of doctors who had been given Norwegian authorization or license. This also allowed a purposive sampling strategy to ensure sufficient variation on factors that could influence their experience of coming to Norway as an IMG (i.e., participants' age, sex and nationality; see Table 1). Eighteen IMGs were contacted by phone. All were willing to participate; however, two were geographically too far away to participate in a face-to-face interview. The remaining 16 IMGs were from all parts of the country and their position ranged from intern to specialist. Other main findings of this IMG study have been published previously [19] with this paper focusing on the aspect of language barriers.

Table 1: Demographic characteristics of the study sample - IMG participants (N = 16)	
Nationality (4 reported double citizenship)	
Scandinavian	4
EU	4
Russia/Former U.S.S.R	3
South and Central America	3
Asia	3
Africa	2
USA/Australia	1
Gender	
Women	9
Men	7
Age	
20 – 30	5
30 – 40	8
40+	3
Place of work	
Public or private hospital (5 different)	8
General practitioners/municipal health service	5
Currently unemployed (Was working in Norway recently)	3
Last or current type of position	
Specialty registrar or doctor in the primary health services	7
Hospital specialist	5
Foundation doctor	4

The Norwegian health care professionals were recruited through the researchers' own professional networks. Although not all responded to the initial contact about participation, all 12 who

did and heard more about the study agreed to participate. This group of colleagues had experience collaborating with several hundred IMGs in different hospitals and community services throughout Norway. For both interview groups, recruitment was stopped when participant diversity was reached in terms of gender, work experience, and place of work (Tables 1 and 2), and when the data collected was deemed to consist of a purposive amount of relevant descriptions.

Table 2: Demographic characteristics of the study sample - Colleague participants (N = 12)	
Gender	
Women	6
Men	6
Work experience	
More than 10 years	9
Less than 10 years	3
Place of work	
Public or private hospital (5 different)	8
General practitioners/municipal health service	4
Profession	
Doctors	7 (3 in leader position)
Nurses	5 (2 in leader position)

The first author conducted the interviews, which lasted from 30 to 90 minutes. All interviews were audiotaped and transcribed in full text by first author. After the interviews, participants were given the opportunity to contact the researchers with any supplementary information and to read and comment on their interview transcripts. Data also consisted of the interviewer's notes about topics, such as his experience of the interview and language challenges affecting the interviews.

2.2 Analysis

Malterud's method for systematic text condensation (STC) was used, as it is suitable for the analysis of meaning and content [29,32]. STC is inspired by Giorgi's descriptive phenomenological method in psychology [33] and is empirically based and suited for inductive analyses intended to develop descriptions of a field across a dataset. In this case, the field was the experience of being a new IMG in Norway and of collaboration with new IMGs. To ensure quality and trustworthiness in

the analysis, PG and ES read all transcriptions and met to discuss, code and synthesize results from the interview data, according to the STC method [29,32]. Other researchers (e.g. JG) reviewed analysis to ensure the relevance of the results and to contribute their expertise. Since the data are extensive, comprising many topics, the focus of this paper is limited to participants' explicit descriptions of language and language barriers. Descriptions of these experiences provide valuable, new knowledge about IMGs' language barriers and are thus suitable for the aim of an explorative study. In Malterud's terms: "we do not head for a complete description of all aspects of the phenomenon we study. We are satisfied when a study open some doors to unknown territory by presenting examples that contribute to new understanding"[29].

2.3 Ethics

The regional committee of medical and health research ethics deemed that the project did not require a formal submission. The study protocols for data collection and storage were approved by the local data protection officer and written consent was obtained from all the participants.

3. Results

3.1 Overview

All participants, both IMGs and Norwegian health personnel, spontaneously described language barriers as the most prevalent problem in their everyday collaborations. Indeed, many of the participants brought up the topic at the beginning of the interview, some even before it had formally begun. Further description and specifications of these difficulties revealed a wide spectrum of situations where they had experienced such barriers. An important phenomenon in both IMGs and native Norwegian colleagues' accounts was that the experiences and feelings regarding such barriers were not coherent with their expectations of professional communication.

3.2 The participants' descriptions of language barriers

The descriptions of the participants' personal experiences revealed a variety of topics that could be considered language barriers (Table 3), including topics related to proficiency in the Norwegian language (lines 1-4, Table 3). These categories deal with the semantics of language used, both in general (line 1) and in relation to healthcare-specific terminology (lines 2-4). Other challenges were more pragmatically oriented: Lines 5-7 touch on difficulties due to Norwegian patterns of language use that would be needed for doctor-patient interaction and inter-professional communication. These have to do with subtle cues regarding how the semantic content of language is to be understood: Successful use of these cues in interaction tend to be invisible and unnoticed. However, errors in these cues create misunderstandings that tend not to be recognized as linguistic error, but rather can lead participants to see each other as uncooperative, rude, or impertinent [34 p. 132]. Finally, we included a category of language used in culturally sensitive topics (line 8). As can be seen in Table 3, according to our informants, descriptions of these categories was linked to their

effects, such as, less effective communication, problems with relationship building, and a decreased sense of the professionalism and competence of IMGs.

Table 3: The participants' descriptions of language barriers*****

Topics and subtopics	**Description of topic**	**Statements from IMG that fits the topic**	**Statements from Norwegian colleagues of IMG that fit each topic**
Semantics: Insufficient Norwegian language proficiency			
(1) General	*Language barriers due to lack of general Norwegian skills (e.g., vocabulary, conjunctions, idioms dialects, accents, tempo, and intonation)*	I think there are many things that might have been done faster if I had spoken better Norwegian, for instance, some expressions are difficult when you are making phone calls (Junior IMG from Scandinavia)	Some can speak Norwegian well, but they speak so unclearly that patients have trouble understanding them. We had a doctor here who is very skillful, but he spoke Norwegian too fast (Nurse in leadership position)
(2) Biomedical Terminology	*Language barriers due to not acquiring professional biomedical language used in Norway (e.g., use of Latin, or different names of medical states and name of medicines)*	I would have supported medical related Norwegian courses, also for us with Scandinavian background. Language barriers have not led to any errors on my part, but I can see how they could have done (Senior IMG from Scandinavia)	Doctors educated abroad have read all in English and they have established a professional terminology, which is in English. They are not accustomed to speak about patients in Norwegian with colleagues. In the beginning, they have problems with finding the right word and naming the correct symptoms (Junior doctor)
(3) Discipline-specific terminology	*Barriers due to lack of relevant subject-area language in some sectors such as psychiatry, geriatrics, and general practice*	Every day, I am challenged when I meet patients because of my language barriers. Psychiatry is different from ordinary medicine; you have to conduct a dialog to understand the patient's illness. In somatic you have a stethoscope with a heart and a stomach to touch but here there is nothing to touch or listen to (Senior IMG from Asia)	A leader tells about a doctor that she find medical competent to the job, but who do not have the suitable practical language skills to do the job: We have a medically gifted doctor, a woman who came from a European country but she interacts differently with patients than what we are used to. She had very good references from a research institution but was not trained to be a general practitioner at all (Senior doctor in leadership position)
(4) Health and welfare System terminology	*Barriers due to lack of language referring to the Norwegian health and welfare system (e.g., does not know the name of institutions, how to describe*	How the system works and which form you have to use, all such things are hard when you are new, not only for foreigners but also for everyone. When you are new, you	It is not necessarily about medical competence, but work related logistics, patient communication, language and understanding of the Norwegian health care system, of course. When coming from

	routines, how to provide system information).	may also have problems with communication and not know how things work, nobody will tell you, it is hard then to understand (Senior IMG, south/central America)	abroad it is pretty difficult to work in an unknown, relatively streamlined Norwegian healthcare system (Senior doctor)
Pragmatics: Using Norwegian language			
(5) for social relations	*Language barriers due to proficiency levels impeding good relations*	In the beginning, I cried several times, I felt insufficient because of the language. Normally, as a doctor I am "easy going" to break the ice during a patient visit (…) but I did not manage to do that, because of language barriers all my personality was lost (Junior IMG with a background from both the EU and Scandinavia)	A psychiatrist tells about what he has observed in consultations together with a newly employed IMG colleague: "I saw that she did make positive progress, but the patients were more reticent, partly because they did not understand what she said, that made them insecure" (Senior doctor)
(6) for navigating and expressing inter-professional roles	*Barriers due to the lack of understanding of sociocultural aspects that influencing proper communication with other healthcare providers*	I said to the nurses "can you" and ended my sentences with "please". However, the way I formulated my questions were understood as commands. They thought that I instructed them to do things like take blood pressure at once, which made them complain. It was very difficult in the beginning (Senior IMG from Asia)	I think some felt that we had an informal tone between us. You probably do not have to travel farther than to our neighboring countries to meet nurses that treat the doctor with different respect and form of address than we practice here. However, when they have been here for a while the impression is that they realize that they have professional respect even if we have a communication form that is a bit more "hey you!" That could be difficult to grasp, it could be understood as "I am not respected", a few times some of them responded with signals of "I want respect" (Senior Doctor in leadership position)
(7) for navigating and expressing doctor and patient roles	*Language barriers due to role expectations of both the doctor and patient*	I have learned from my colleagues how to communicate with patients, learning how to deliver bad news to a patient. After I started to work at this hospital, I also learned which information that should be given to which relatives. (Senior IMG from Asia)	A nurse tells about an IMG colleague from a European country that told her: "I have to learn to speak differently to the patients here because you speak so kindly to the patients. In my homeland, if the patient had been angry I would have said "You can go, if you do not want to do as I say, you can just go." I have to

			communicate differently, bearing in mind that the patient makes demands and may have knowledge about their condition. In my homeland, the doctor is the one with knowledge." (Nurse in a leadership position)
Language associated with cultural context			
(8) Sensitive topics	*Barriers due to lack of acquiring "ritual language", i.e., culture related patterns of communication in particular missed in sensitive situations (e.g., around death, sexual health and orientation*)	Once I had to verify a death, there were many relatives and I had very little to say but I wanted to show sympathy, but I did not know what to say. It was so difficult, I did not do anything wrong, but it was hard to talk to the relatives. What should I say? (Junior IMG from Asia)	A colleague described how a senior IMG came into a room of relatives together with a patient who recently passed away: "He comes into the room, he pulls out the medical chart, turned on his heel and left the room without any communication with the relatives; that seems to be really wrong in that situation" (Senior doctor)
*Statements are translated from Norwegian to English and edited for readability by the authors. Presented examples are illustrative excerpts from longer statements of from when participants described language-relevant topics.			

The participants reported that learning to communicate as a Norwegian doctor is an individual process (i.e., without organized support); that is, it was the individual's responsibility to learn the language adequately, with little direction as to what should be considered "adequate". Neither IMGs nor native Norwegian professionals were clear about whether the IMGs' mother tongue and nationality had an impact on the severity of communication barriers they experienced. However, IMGs from neighboring Scandinavian countries expressed that they found the differences between languages more extensive than they had anticipated.[1] Many reported language challenges and uncertainty about how to improve them. Colleagues confirmed that IMGs had to take responsibility for learning the language themselves and described how some IMGs struggled, while others became competent in Norwegian quickly.

3.3 Meeting one's own and others' expectations of professional communication

Participants' views of what constitutes a well-functioning doctor were often related to mastering communication with patients. One IMG, who did not speak Norwegian as well as she desired, lost confidence in herself as a professional communicator: "I am not myself when I speak Norwegian. I enjoyed communicating with patients in my homeland. That may be one reason why I do not thrive as a doctor in Norway. I'm losing what for me was a big part of what I liked about the job:

[1] Scandinavian languages are closely interrelated, and when visiting one of the other Scandinavian countries you can usually get by as a tourist using your own language.

the fact that I thought I was a good communicator" (Junior IMG, from an English speaking country outside the EU). Several IMGs were concerned that their patients and colleagues might find them cold and insensitive because they did not manage relationship and communication skills as effectively as they desired. Among the IMGs, language difficulties caused them to avoid communication with both patients and colleagues. A Scandinavian male doctor illustrated this passivity: "When I sit there in the morning briefing and have something I really want to say, but do not dare, I am afraid of not being understood. I am afraid to say something wrong; it had been wonderful to just say things straight out and know it was understood" (Senior IMG, from a Scandinavian country). The majority of IMGs stated that they avoided tasks that they thought would be overly difficult because of their insufficient language skills (e.g., telephone calls). Some participants also described situations in which they were aware that they not had understood what had been said, but had not been forthcoming about it.

Most of the IMGs were concerned about patients' reactions to their language skills. Several IMGs reported that they were regularly asked about where they were from; some found this difficult, as it took a considerable amount of time to answer and detracted from the purpose of the consultation. IMGs also described such questions as stressful reminders that their language and communication skills might be inadequate. A GP said she noticed that patients were surprised when they heard her accent, often asking her where she was from: "When I tell them where I come from, people become surprised and some less accommodating. I think it has something to do with bad descriptions in the media about my homeland and the political situation there. There have been no personal insults, but there are patients who are mentally unstable, but you learn to deal with such patients" (Senior IMG, from the EU). Generally, the IMGs described Norwegian patients as benevolent and not xenophobic. When conflicts occurred, IMGs attributed it to patients' illness, age, or other problems with interaction, rather than them being difficult or unfair.

Colleagues shared examples of how working with an IMG who did not communicate well with patients influenced the whole workday. As described by one doctor: "If he had been on rounds, I sometimes asked patients afterwards if there is something they are wondering about; usually there is. Then I have to explain it. I have been together with the IMG doctor at rounds; I listen but see that it is obvious that patients do not understand. Afterwards I go back to the patient and explain what the doctor meant; I often do that" (Senior Doctor, small local hospital). Colleagues found it especially difficult to cooperate with IMGs who did not take into account their own communication limitations, yet they admitted rarely commenting directly on the IMGs' language themselves. These accounts suggest wider effects of language barriers than just difficulties with understanding, revealing implications for relationships, clinical quality, and thoughts about self-efficacy.

4. Discussion and conclusion

4.1 Discussion

Literature shows that both IMGs [6,7,10-12,19,35] and colleagues of IMGs [12] experience language barriers. The results from this study reveal that IMG and Norwegian health care providers have concerns regarding a number of topics that could be considered language barriers; therefore, remediation relies on a multifaceted approach. In addition, language shortcomings by both participant groups were associated with feelings of insecurity during interactions and potential loss of self-esteem for IMGs.

IMGs are an important part of the workforce in many countries [1,2], but knowledge of how to facilitate IMG training and language skills is incomplete [14]. The language barriers participants described do not have clear associations with the IMGs' nationality or position. This illustrates that IMGs are individuals, and language barriers are contextual and multifaceted, involving aspects that are more complex than language issues alone. Indeed, an interesting finding in our study is that what participants described as merely language barriers actually included a range of topics that included semantics, pragmatics, and cultural aspects of language use (Table 3), encompassing much of what they experienced as difficult or different in their everyday collaboration. These findings indicate that courses limited to a focus on language skills do not (and will not) meet their needs. Our conclusion that such a limitation exists is further supported by IMGs, who reported that general Norwegian classes were inadequate for addressing their professional communication needs; even doctors from neighboring countries requested relevant work-related language courses because of the complexity and multiple contexts related to doctor-language. This necessity is supported by well-established research on second language learning, showing that language learning associated with learners' everyday life is often felt necessary and therefore often becomes effective [36]. Participants reported that arrangements that address both language issues and issues around being a new doctor in Norway do not currently exist, neither formally nor informally. Instead, each individual IMG is left alone, to learn both the Norwegian language and gradually figure out, through trial and error, their new role as a doctor. As a result, both colleagues and IMGs struggle to address and overcome what they perceive as language barriers.

Working as a doctor in a new country is often described as being demanding and emotionally stressful [6,21,37]. This study shows that language barriers are an important stressor. All participants reported that language barriers were intertwined with uncertainty about an IMGs' competency as a professional Norwegian doctor. One reason for an association between language difficulties and competency could be that professional communication skills are important for patient safety and an essential element in enhancing patient satisfaction [31]. It is important to note that our data contain

few descriptions linking language barriers to serious incidents, yet both IMGs and colleagues described many situations where IMGs did not meet their own or others' expectations of a doctor's professional communication skills. An additional factor that may lead to questions about professionalism has been revealed in basic research on perceptions of non-native speakers with accented speech, who are generally considered by members of the majority population as less credible than those who speak Norwegian fluently, even when the content of their speech is accurate [38]. It is possible that a doctor who is not a native speaker, simply by virtue of his or her accent (i.e., not actual medical competence), can both be perceived by others and themselves as less competent. Further, the kinds of language difficulties that informants described involve interpretive processes that can lead to misunderstandings that cast the IMGs in an unflattering light, perhaps making them appear uncooperative or unfriendly [34]. We found that colleagues felt that IMGs understated their own language shortcomings, a phenomenon supported by other research as well [12]. Both IMGs' and colleagues' experiences support the need for training that offers the IMGs the ability for reflection so that they can gain an insight into their own language skills and role as a Norwegian doctor.

The identity of being a doctor is strong, whether the doctor is an IMG or not [39,40]. A recurring theme in all interviews was that for IMGs, a language barrier created a "sense" of not living up to their own ideals of being a professional doctor. Also, native Norwegian colleagues implicated language barriers to IMGs' competence in handling everyday work. In literature on what it means to be a professional, main elements include having the right knowledge and sets of skills [41]. In modern health services, such skills include handling professional communication and collaboration. The IMGs were formally licensed to practice medicine as doctors in Norway, and their employers considered their language skills as adequate for practice. However, compared to what Edmund describes as important factors for being considered a professional, several IMGs considered themselves to be outsiders who fall short of the ideal: "It is not just about demonstrating a meeting of standards in practice. It is about relationships with colleagues and participating in and contributing to the development of professional communities" [42]. Participants provided several examples of how IMGs' insufficient Norwegian language skills affected their participation within their peer community, feeling that their participation was inadequate. Most of the participants also described how language barriers made changes in their everyday practice. Norway and several other countries worldwide are in need of IMGs. This study from a Norwegian setting indicates that to successfully overcome language barriers, IMGs require a system to support their adaption and learning. Neglecting such supports seems to be stressful for both IMGs and their colleagues. Moreover, professionals' ability to provide good care has been shown to be dependent on well-functioning communication and effective role management [43], both of which become vulnerable without system support. In the multilingual context of Norwegian healthcare, care must be taken that the IMGs are not dealt a double blow of being inadvertently penalized for their low linguistic capital while being offered neither the means for

identifying and remediating language difficulties nor socialization into their Norwegian workplace[44].

This study was exploratory and several limitations affect interpretation of the results. One limitation is that it focused mainly on IMGs' work life. From a cultural perspective, in order to explore the IMGs' identities, their life outside the workplace should be taken into consideration. Other studies have shown that IMGs may misjudge their own communication skills [12,45]. A limitation of this study is that it did not address how IMGs' experiences concord with their actual language skills and ability to communicate as healthcare professionals in Norway, though all IMGs struggled with Norwegian language skills in the interview. Finally, the interviews could have been more extensive, exploring more in depth how both groups of participants' experiences and views were influenced by their values and their way of seeing the world.

Nonetheless, interviews are suitable for providing insight into the participant's experiences and self-understanding [30]. This study did not aim to present an exhaustive knowledge about language barriers, but instead, its aim was to describe some elements that could be important for better integration and language learning for IMGs. The main strength of the study is that IMG and colleague participants who worked in a wide range of Norwegian health services provided similar practical examples and reflections about the topic. The findings were consistent with regard to their experiences, concerns, and understanding of the phenomena of professional communication and communication barriers. Furthermore, the study opened some doors to unknown territory that not only contribute a new understanding of that territory, but also show that deeper exploration could be fruitful.

4.2 Conclusion

Newly employed IMGs and their colleagues experienced that a lack of proficiency in the working language brought the new IMGs' professional competency and professionalism into question. Lack of language proficiency, included a range of underlying challenges, such as the lack of familiarity with the healthcare system, expectations for the role of both doctor and patient, specific subject area knowledge, and ritual and cultural expressions necessary to provide adequate care. Our findings reveal that IMGs' learning needs are not only about learning the language, but also about how to adapt to their current situation and new work context. For most IMGs, this learning process seems to involve redefining their identities as professional doctors and communicators, a process that in Norwegian health services has been left to the new IMGs to facilitate for themselves.

4.3 Practice Implications

To counteract experiences of psychological stress and insufficient communication that could lead to possible mistakes or misunderstanding, the findings in this study indicate that IMGs need continued professional language training after they have started working. Such training should be

multi-faceted, including specific communication skills related to the IMGs' work context and ongoing, professional mentoring targeted to the needs that our participants revealed. Effective language and communication training should allow reflection on individual concerns and experiences.

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