Improving Intergroup Perceptions

Assignment: Extensive policy recommendation

Julia Weschenfelder

Title: Intergroup conflict in interprofessional hospital teams

1. Description of the problem

In Germany and other countries, the healthcare system suffers from an increasing shortage of nurses. The German Government promotes the international recruitment of nurses worldwide, for example, from the Philippines, Brazil, Mexico, and India. Special programs have been developed to improve the recruitment process, e.g., the Triple Win program. Nurses who have already finished their education in their home country work for one year, the 'probation year,' in a care unit in a hospital in Germany for reduced pay and acquire the absolute approval of their degree afterward.

Hospitals are a highly complex job environment: different professions of different countries work together under constant time pressure and fast-changing conditions. In addition to chronic understaffing and increasing economic pressure, the work environment is also characterized by a chronic conflict between physicians and nurses, partially arising from status and power dynamics and collaboration and communication issues. Both physicians and nurses describe their relationship as tense, antagonistic, or ambivalent. Due to the increasing employment of international healthcare professionals, another potentially conflicting factor is added to the demanding working environment (see Pütz et al., 2019). Since most international healthcare professionals work as nurses and not physicians in German hospitals, I will focus on interprofessional working environments where non-migrant and migrant nurses and non-migrant physicians work together.

In my portrait of the problem, I especially highlight the role of the migrant nurses as a third subgroup of a problem commonly described as a well-known and historically rooted two-group problem. Collaboration and communication issues between physicians and nurses are associated

with status and power dynamics that can harm employees' health, job satisfaction, and, ultimately, the quality of health care provided in the care units. Migrant nurses are a resource for the German Health Care Sector and society. That's why it is unfortunate to know migrant nurses suffer from low appreciation of their work, high levels of stress, and feelings of exclusion and inferiority to non-migrant colleagues. Nurses report that their skills are undervalued, leading to frustration, disillusionment, and disempowerment. Physicians and non-migrant nurses report that insufficient language skills, culturally shaped work attitudes, and migrant nurses' professional self-understanding are significant issues in communication and performance of work routines. The problem needs to be well understood to create effective group performance and to support migrant nurses in their process of professional and psychosocial integration at the workplace, which ultimately can facilitate or enable integration outside work.

2. Common sense solution to the problem

The range of projects and institutions offering support for integrating internationally educated professionals is wide. The Federal Ministry of Health develops projects among other public and private institutions. Most solutions have focused on barriers and misunderstandings due to culture and language. Migrant nurses have individual mentoring and follow German language courses, courses about socio-cultural communication skills, and courses filling the gap in knowledge about German healthcare policies and practices, e.g., patient care accountabilities. A current pilot project is the project "INGA Pflege," a pilot project that implements language courses among other courses and instructed practice. Migrant nurses receive final approval for their degree after completing the project, which is part of their employment at a healthcare institution. Indeed, language is a central factor enabling integration at work in a new country. Knowledge about culture-specific policies and nursing practices is necessary to work as an internationally educated nurse in Germany. Migrant nurses are not supported in successfully integrating their culture-specific knowledge into their professional identity as nurses in Germany. Still, they are actively supported in

assimilation into the German-specific working environment. It is not surprising that some courses have the title “Anpassungslehrgang.”

The solutions already help to alleviate potential language and culture-related barriers. However, the described approaches also have weaknesses. The difference in migrant nurses’ professional education and cultural background and the attempt to address it with courses opens the doors to justify upcoming issues with a culture-related lack of knowledge, even if the sources of conflict are associated with other variables such as social status and power. All professions are challenged through internationally educated nurses, but it also creates the possibility of social change for more effective and satisfying collaboration. Unfortunately, current solutions overlook non-migrant professionals. The solutions do not acknowledge that communication and collaboration in healthcare teams are already adversarial, which is not a result of culture. This observation should have pointed out that other sources of conflict appear to be of culture-related origin in care units with migrant nurses.

3. Analysis of the problem

The problem described includes several variables, which I want to elaborate on in my analysis. My analysis focuses on psychosocial variables. Nevertheless, it cannot be overlooked that non-psychological variables also shape the problem. The political climate in different parts of Germany shapes how migrants are welcomed and included and can influence intergroup relations at work. Moreover, the economic pressure, the level of understaffing, and the cultural diversity among staff members highly differ between regions and hospitals in Germany and can shape working experiences. My analysis will not include intraindividual characteristics of nurses and physicians, e.g., conflict management skills, German and English language skills, Social Dominance Orientation, and gender. However, these variables also contribute to the communication and collaboration issues described. Furthermore, there are hierarchies in the group of non-migrant nurses and physicians,

which I will not explicitly elaborate on, even if they further contribute to the complexity of the problem.

In my analysis, I will focus on migrant nurses who begin to work in an interprofessional setting rather than migrant nurses who have already been working in Germany for a while. The beginning of employment and the structural conditions of migrant nurses are significant since they determine that nurses enter their jobs with a lower status than non-migrant nurses due to the reduced salary and mandatory further training. I build my analysis on a path model (see Figure 1) to describe how the three different groups, migrant and non-migrant nurses and physicians, experience social identity threat as a function of their self-identification with their profession and ethnic background. I expect status differences to mediate the relationship between self-identification and social identity threat partially.

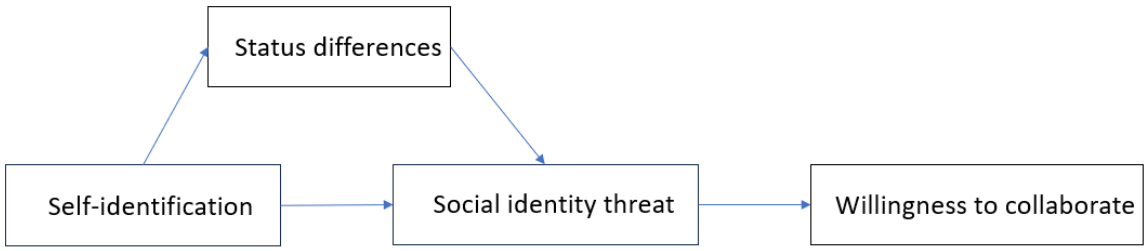

Figure 1: Path model

Social identity theory developed by Tajfel and Turner (see Tajfel and Turner, 1979) argues that people are motivated to maintain or achieve a positive social identity. Branscombe and colleagues (1999) distinguished between four different types of social identity threats: 'categorization threat,' 'distinctiveness threat,' 'threat to value,' and 'acceptance threat.' Social categorization is a process in which people assign stereotypical characteristics of a group to an individual group member. In situations where people seek to be encountered in terms of their characteristics, the experience of being treated in terms of personal characteristics, e.g., ethnicity, can be experienced as a threat. If non-migrant nurses and physicians treat migrant nurses in terms of

their ethnic background, migrant nurses are likely to perceive this behavior as prejudice against them. Migrant nurses might especially feel prejudiced when they interpret their ethnicity as an irrelevant factor at the workplace, especially if they do not share their ethnic background with other staff members or patients. At the beginning of the employment, it is likely that migrant nurses identify with their professional identity but are also emotionally attached to their ethnic background. This is especially likely if migrant nurses move to Germany with family members sharing their ethnic background. The fact that migrant nurses experience a categorization in terms of their ethnicity and not their professional role can have the consequence that migrant nurses do not feel appreciated in the knowledge and skills they will contribute to the team. If the ethnicity of a migrant nurse is associated with a low collective self-esteem and the migrant nurse has a high personal self-esteem, e.g., rooted in their professional training, she will likely perceive a categorization threat. Ultimately, this will result in decreased identification with their ethnic identity.

The categorization in terms of their ethnic background can have detrimental effects on migrant nurses' performance if the categorization is based on a group associated with a stereotype of low performance. Non-migrant professionals might perceive migrant nurses from their countries of origin as less well educated, e.g., the standards of medicine and the nursing practices are not expected to reach the quality of Western nursing practices. Poor performance due to difficulties with the German language and categorization in terms of ethnicity lowers migrant nurses' self-esteem, reinforces stereotypes held by non-migrant professionals (see review, Balante et al., 2019), and impedes collaboration. This is unfortunate given the fact that migrant nurses are highly qualified professionals and often hold an academic degree compared to the three-year training of non-migrant nurses in Germany. Non-migrant professionals who show a low identification with their ethnicity might stress ingroup heterogeneity and their unique personal characteristics, e.g., educational rank, if migrant nurses categorize them in terms of their ethnicity.

Besides a 'categorization threat,' people can experience a 'distinctiveness threat.' According to optimal distinctiveness theory (Brewer, 1991), people are driven by two conflicting motives:

inclusion and distinctiveness. The ‘distinctiveness threat’ occurs when people perceive their social identity as not sufficiently distinctive from comparison groups. Status differences between migrant and non-migrant nurses partially determine the allocation of tasks in the care unit. Migrant nurses are often obliged to do the least complex or comfortable tasks, e.g., simple routines that do not require verbal communication. Performing the most simple tasks can impose a ‘distinctiveness threat’ for migrant nurses who have an academic degree and perceive themselves as more qualified than non-migrant nurses. Migrant nurses begin to perceive their professional identity as overlapping with non-migrant nurses. It can be expected that migrant nurses strongly identify with their social identity as academically educated healthcare professionals. Consequently, the ‘distinctiveness threat’ can elicit derogation towards non-migrant nurses. This response to a ‘distinctiveness threat’ is especially problematic because it can decrease non-migrant nurses’ willingness to collaborate with migrant nurses. Collaboration is necessary for good team performance and migrants’ training and feedback. If non-migrant nurses develop a low willingness to collaborate with migrant nurses, the training of migrant nurses is of poor quality. This ultimately hinders their career chances, such as becoming the manager nurse of the care unit. Poor performance due to ‘categorization threat’ further contributes to the fact that migrant nurses can become trapped in their initial status (see review, Balante et al., 2019). Physicians are expected to identify with their profession highly. They may show derogation of migrant nurses because migrant nurses tend to engage in physicians’ tasks and responsibilities based on their prior academic education. Physicians try to restore the boundaries between migrant nurses and themselves and increase the status differences to the usual level by derogating them. In general, a self-enhancement motive may underly the response to a ‘distinctiveness threat’ (see Abrams & Hogg, 1988). The social enhancement motive might come into play, especially for physicians who are generally higher in status than nurses. The outgroup derogation described can also be observed because people experience a threat to the value of their social identity.

Physicians might experience a threat to the value of their social identity when migrant nurses' professional activities impede their own. The expectation of lower qualifications of migrant nurses can explain this. Since physicians' status strongly depends on actual or perceived competence and competence differences compared to nurses, a threat to the value of their social identity might be especially alarming for physicians. The responses to a 'threat of value' might be even stronger for physicians who highly identify with their profession and ethnicity. Non-migrant nurses might perceive a threat to the value of their social identity for the same reasons because they expect migrant nurses to be not as skilled as themselves. Migrant nurses who strongly identify as academically educated healthcare professionals might show derogation of non-migrant nurses since they expect non-migrant nurses to be not as skilled as themselves. Since competence differences are deeply intertwined with status differences but also stereotypes held towards migrant nurses, a threat to competence is especially meaningful when a migrant nurse enters a care unit of formerly non-migrant professionals.

Another form of threat is the so-called 'acceptance threat.' I expect that physicians rarely experience an 'acceptance threat' to their professional identity. Due to initial status differences between migrant and non-migrant nurses and potentially low fears of exclusion, non-migrant nurses strive less for acceptance by migrant nurses. The 'acceptance threat' might be mainly relevant in the interaction between non-migrant and migrant nurses. Migrant nurses who highly identify with their professional identity as academically educated healthcare professionals might show derogation of non-migrant nurses to strive for acceptance among physicians. Migrant nurses who highly identify as nurses and hold a self-understanding of their role and status, similar to non-migrant nurses, might show derogative behavior in interactions with physicians. Migrant nurses' behavior then serves as a behavior proving loyalty to the group of nurses. At the beginning of their employment, demonstrating loyalty or even trying to slime as a strategic behavior might be especially important since migrant nurses have an insecure place among nurses, at least in the probationary period. Migrant nurses' responses to social identity threats partially depend on their self-understanding as a

nurse and the status and value they attribute to their education. If migrant and non-migrant nurses accept each other in their social group of nurses, they will be more willing to collaborate. According to Ellemers and colleagues (1992), members of high-status minorities like academically educated migrant nurses are highly identified with their ingroup when group boundaries are permeable. Since the hierarchy in German hospitals can be considered relatively impermeable, migrant nurses are not likely to strengthen their ties with physicians to become part of an alternative majority group.

The educational landscape educates physicians and nurses in separate institutions in Germany. During their education and socialization, professionals develop a professional identity isolated from the professional identity of other professionals. This has undesired consequences, such as impaired collaboration. Moreover, professionals' lack of knowledge about the roles of different professionals and the potential overlap of role-associated tasks and competencies contributes to impaired collaboration. Due to the development of strong self-identification with the own profession during the educational path but an interprofessional practice in hospitals and increasing employment of international health care professionals, it is reasonable to intervene in identity development by strengthening an overarching identity and simultaneous identification with subgroup identities, profession, and ethnicity. In the literature, Khalili and colleagues introduced interprofessional identity as a more inclusive professional identity (2013). I will use the term interprofessional identity to describe the overarching identity of a healthcare professional. My intervention will build on the dual identity model described by Dovidio and colleagues (2012). A dual identity allows nurses and physicians to simultaneously identify with their subgroup identities and an overarching interprofessional identity. The dual identity recognizes the strengths and weaknesses of the superordinate and subgroup identities. It values the resources from all three subgroups, leading them to complement each other in a cooperative framework.

4. Do's and Don'ts

Suppose migrant nurses experience a 'categorization threat' in terms of their ethnicity. In that case, migrant nurses who strongly identify with their ethnicity will likely distance themselves from their ethnic background even if this subgroup identity is a resource in their nursing practice, e.g., in the context of migrant patients. Hospitals should connect migrant nurses with another migrant nurses as their mentors to uphold this subgroup identity.

A hospital can use the internal hospital news feed or newspaper to draw associations between the superordinate identity of healthcare professionals and the subgroup identities. Personal interviews and portraits of employees discussing the identities involved in one person and one job strengthen the associations between the identities but also signal positive distinctiveness. In-depth interviews can demonstrate the strengths and weaknesses of the identities and a successful career as a health care professional.

Hospital policies should provide training or supervision not only for migrant nurses but also for the other two subgroups to tackle impaired collaboration. Since all three subgroups contribute to the problem, it is advisable to provide training or supervision for the whole care unit. This approach avoids sources of conflict easily attributed to one subgroup, the migrant nurses. Suppose a migrant nurse enters a care unit. In that case, regular team meetings with supervision should be implemented for a specific time instead of supervision, mainly for migrant nurses during their first year. This will help strengthen an interprofessional identity instead of tackling the problem individually.

Migrant nurses receive feedback, especially from non-migrant nurses. Migrant nurses are not yet used to specific nursing practices in Germany and are likely to receive more negative than positive feedback. This experience makes them question their acceptance in the group. It is advisable not to assume that non-migrant nurses are already skilled in giving constructive feedback. Hospital policies should implement training for non-migrant nurses on how to provide feedback to migrant nurses to reduce the 'acceptance threat,' especially during the probation year when their migrant

nurses' future group membership is insecure. If non-migrant nurses are mainly perceived as patronizing teachers, migrant nurses will not feel accepted.

5. Intervention

In my proposed intervention, I aim to investigate how learning experiences in the form of shadowing influence professionals' self-identification with their profession and ethnicity and their self-identification as a healthcare professional. I aim to benefit from the effects of intergroup contact by choosing shadowing as a learning experience and not passive education on professional roles and differences. Before any data collection, the study will be approved by the Ethical Committee of the University Hospital. In my intervention, I aim to recruit physicians and nurses from different care units at the University Hospital in Heidelberg. The study will be announced as training for nurses and physicians on interprofessional collaboration, and all meetings will occur during working hours. Moreover, the study will be announced as a training possibility for professionals at the beginning of their careers. I aim to focus on migrant nurses at the beginning of their employment in Germany and limit differences in status due to rank, position, and professional experience as much as possible. The learning experiences will be scheduled over six months because I expect the effects of an intervention on identity development to take time to unfold. During the study, participants can reach out for help or support to a team of migrant nurses, non-migrant nurses, and physicians who are supposed to help as a team.

Participants will be randomly paired up with a migrant nurse, a non-migrant nurse, and a physician. The professionals the participants will be paired with will not work in the same care unit. This will ensure that participants have no prior positive or negative experiences with the professionals and are not afraid that the training could negatively interact with their work in a specific care unit. Participants will be informed about the training structure at the first meeting and will complete questionnaires. Six equally distanced meetings will be scheduled as interprofessional learning experiences and one last meeting as a meeting where each participant will reflect on the study and again fill out some questionnaires. The participants will be asked to schedule equally

distanced meetings with a migrant and a non-migrant nurse and physician. The first meeting with those three partners will be scheduled in the first half of the intervention, and the second meeting with the same three partners in the second half.

During each meeting, the participant will shadow the healthcare professional for two hours in the hospital. Shadowing is a standard educational tool in the education of health care professionals. Based on a lifelong learning perspective, I argue that using those educational tools can also be beneficial even after people have finished their education. After each shadowing experience, participants will be asked to hand in a written report about their experience. This design is inspired by the study of Kusnoor and Stelljes (2016). In this report, participants will be asked to answer the following question depending on if they are a nurse or physician and if they have shadowed a nurse or a physician: “How does your role as a nurse/physician integrate with the physician’s/nurse’s role in caring for the hospitalized patients?”. The participants will be asked to elaborate on this question with a report of one page in length. Participants' weekly working hours will be reduced by one hour for each report. The participants will be asked to submit the report no later than one week after the shadowing experience. Inspired by the assessment of dual identities in the studies by Fleischmann and Verkuyten (2016), participants will answer three measures at the first and last meeting. Two measures will measure their identification with their ethnicity and their profession. A third measure will measure the perceived collaboration within the care unit. The self-identification measures are helpful as a manipulation check to determine if the effects of the shadowing experiences operate through dual identification.

I will analyze how reflections change as a function of participants’ profession and ethnicity and the shadowed person’s profession and ethnicity using natural language processing. Furthermore, I will analyze if participants score differently on the measures before and after the shadowing experiences and how changes in self-identification measures relate to changes in perceived collaboration. In conclusion, I expect shadowing to give participants a broader perspective on the work of healthcare professionals and identify each professional’s contribution to patient care.

References

Abrams, D., & Hogg, M. A. (1988). Comments on the motivational status of self-esteem in social identity and intergroup discrimination. *European journal of social psychology*, *18*(4), 317-334.

Balante, J., van den Broek, D., & White, K. (2021). How does culture influence work experience in a foreign country? An umbrella review of the cultural challenges faced by internationally educated nurses. *International Journal of Nursing Studies*, *118*, 103930.

Branscombe, N. R., Ellemers, N., Spears, R., & Doosje, B. (1999). The context and content of social identity threat. *Social identity: Context, commitment, content*, 35-58.

Brewer, M. B. (1991). The social self: On being the same and different simultaneously. *Personality and Social Psychology Bulletin*, *17*(5), 475-482.

Dovidio, J. F., Gaertner, S. L., & Saguy, T. (2009). Commonality and the complexity of "we": Social attitudes and social change. *Personality and Social Psychology Review*, *13*(1), 3-20.

Ellemers, N., Doosje, B., Van Knippenberg, A., & Wilke, H. (1992). Status protection in high-status minority groups. *European journal of social psychology*, *22*(2), 123-140.

Fleischmann, F., & Verkuyten, M. (2016). Dual identity among immigrants: Comparing different conceptualizations, their measurements, and implications. *Cultural Diversity and Ethnic Minority Psychology*, *22*(2), 151.

Khalili, H., Orchard, C., Laschinger, H. K. S., & Farah, R. (2013). An interprofessional socialization framework for developing an interprofessional identity among health professions students. *Journal of Interprofessional Care*, *27*(6), 448-453.

Kusnoor, A. V., & Stelljes, L. A. (2016). Interprofessional learning through shadowing: Insights and lessons learned. *Medical teacher*, *38*(12), 1278-1284.

Pütz, R., Kontos, M., Larsen, C., Rand, S., & Ruokonen-Engler, M. K. (2019). *Betriebliche Integration von Pflegefachkräften aus dem Ausland: Innenansichten zu Herausforderungen globalisierter Arbeitsmärkte* (No. 416). Study der Hans-Böckler-Stiftung.

Tajfel, H., Turner, J. C., Austin, W. G., & Worchel, S. (1979). An integrative theory of intergroup conflict. *Organizational identity: A reader*, *56*(65), 9780203505984-16.