

Working with a Multi-Cultural Staff

In 2004, the Sullivan Commission report on Minorities in the Health Professions underscored the “compelling rationale for increasing diversity in the health care workforce. The underlying principles are: 1) diversity is critical to increasing cultural competence and thereby improving health care delivery; 2) increasing diversity in the workforce improves patient satisfaction; 3) underrepresented minority providers tend to practice in underserved areas thus improving access for the most vulnerable; 4) diversity in the health care workforce has valuable economic benefits; and 5) social justice is served.”¹ Many minorities would be more likely to seek needed services in a health care environment with a more diverse workforce. Further, as minorities continue to grow as a percentage of the general population, health care organizations will need to recruit and retain more people from a variety of cultural groups in order to maintain adequate staffing levels. This requires management to create an environment in which minority groups feel comfortable.

Studies show that a culturally diverse workforce can be more innovative, flexible, and productive. It can also pose challenges in that employees may not feel comfortable with one another and may not work well as a team, impeding the performance of the organization. Simply increasing the number of minorities in an organization can result in increased conflict and turnover among employees with minority employees being the most likely to leave.²³ Employees may benefit from training in how to appreciate personal differences and to work effectively with one another.

The issue of prejudice is addressed in detail in another module in this course. In addition to the problems caused by conscious and unconscious prejudice, different cultural groups possess communication styles and behavioral norms that can cause conflict in an organization. An article published in Harvard Business Review identified four main areas⁴:

- **Direct versus indirect communication.**
- **Trouble with accents and fluency**
- **Differing attitudes toward hierarchy**
- **Conflicting decision-making norms**

¹ Missing Persons: Minorities in the Health Professions, The Sullivan Commission on Diversity in the Healthcare Workforce, September, 2004.

² Riche, Martha Farnsworth et.al. “Literature Review: Empirical Evidence Supporting the Business-Case Approach to Workforce Diversity”, CAN Corporation, July 2005

³ Marqus, Jefferson, et.al. “Managing Diversity in Corporate America: An Exploratory Analysis” The Rand Corporation, 2008, page 26.

⁴ Jeanne Brett, et.al. “Managing Multicultural Teams” Harvard Business Review, November 2006.



Other potentially contentious areas include:

- **How to refer to various racial and ethnic groups**
- **Employees from ethnic groups or countries with a history of conflict**
- **Inadvertently offensive comments**
- **English-only policies**

Direct vs. Indirect Communication

Some cultural groups use direct, explicit communication while others are indirect, for example, asking questions instead of pointing out problems. Staff from some cultures value harmonious relationships and non-confrontational resolution of conflict at the expense of clarity. Others value clarity, even if it requires a direct confrontation. Managers should speak with staff about the pros and cons of direct vs. indirect communication. Instruct employees that for urgent, safety-related matters, it's important to be very direct. For other matters, the appropriateness of using direct vs. indirect communication depends on the situation and the desired response.

For example:

Intubating the patient: You're doing it wrong! (Very direct communication)

Filling in the patient appointment book: "There might be a better way to do that." (Less direct communication)

Commenting on how your co-worker wears his tie: "It's interesting that you wear it that way. I've never seen that before." (Indirect communication)

Trouble With Accents and Fluency

People who aren't fluent in English and those with accents may have difficulty communicating their knowledge or point of view. Such employees may not be valued for what they are able to contribute. Council him or her to say, "I realize that I have an accent. If you don't understand me, please tell me, and I'll say it again using different words."⁵ Encourage such employees to write down their thoughts. Tell English speakers to say:

⁵ Jeanne Brett, et.al. "Managing Multicultural Teams" Harvard Business Review, November 2006.



Teach staff to say: “Forgive me, I’m having trouble understanding your accent. Can you say it again with different words or write it down for me?”

The organization should acknowledge that speaking a foreign language is a strength, not a weakness. Bilingual employees could be offered training in interpreting, so that they can facilitate communication between patients and monolingual English-speaking staff.

Differing Attitudes Towards Hierarchy

In many countries health care providers are more authoritarian, making decisions with little input from the patient. Providers that have not been educated in the US, may find the emphasis on the patient-provider partnership to be strange and may be unaccustomed to spending time explaining the patient’s condition and treatment options. Some may resent yielding power to the patient.

Staff from hierarchical cultures expect to be treated differently according to their status in the organization. Some cultures, like the US, are less hierarchical and allow for more informal relationships among people at different levels in the organization.

Conflicting Decision-Making Norms

People from different cultures vary in how quickly they make decisions and in how much analysis they require beforehand. Someone who prefers making decisions quickly may grow frustrated with what may appear to be a lengthy period of analysis and discussion. Depending on their cultural backgrounds, people in supervisory roles may be uncomfortable hearing dissenting opinions from subordinates and may be confused about relative roles and responsibilities. Management may need to provide guidance:

Manager speaking with staff supervisor:

“I realize that it might feel strange to you when your subordinates disagree with your opinion. We believe that openly sharing ideas in an organization is valuable. You have been chosen to be a supervisor for your good judgment in making decisions. We expect that you’ll take into consideration the viewpoint of those who work beneath you. Please encourage them to tell you what they think. If you make a decision that conflicts with their opinions, please explain to them why you have done so.”



How to refer to various racial and ethnic groups

People may have strong feelings about how they call their racial or ethnic group. For example, some African Americans may prefer to be called “Black” or alternatively be offended by the term “Black”. Older White staff may, out of ignorance, use the word “Negro” inadvertently offending patients and co-workers. Asian workers may be uncomfortable if their colleagues are confused about their nationality, assuming that “they’re all the same”. Employees should be encouraged to respectfully ask one another what group they identify with and how they prefer to name their racial or ethnic groups.

Employees from ethnic groups or countries with a history of violent conflict

A diverse workforce may include employees whose ethnic groups or countries of origin have a history of violent conflict. It may be hard for such individuals to put aside negative feelings toward one another. A good manager will meet with them separately and ask, “I am wondering if you feel uncomfortable working with Mr. XX? Is there something we could do to improve your relationship? Would you prefer if I put you in separate work areas?”

Inadvertently offensive comments

It may be useful to establish a system whereby employees can report if they feel offended. For example someone telling a joke may not be aware that he is saying something offensive. Similarly, people may thoughtlessly use generalizations and stereotypes, for example, “Given his cultural background, of course he’s good with money.” Or “Those people are always good dancers.” Such comments may be made without malice or intent to be hurtful, but may nevertheless make someone uncomfortable.

English-only policies

The natural desire of people to speak their native tongue may conflict with the discomfort experienced by other staff and patients when a foreign language is spoken around them. People may feel excluded or fear that the foreign-language speakers are having a secret conversation about *them*.

Requiring employees to speak English can conflict with Title VII of the Civil Rights Act, which prohibits discrimination based on national origin. The Equal Employment Opportunity Commission states that English-only rules are permissible when: a) speaking a common language is imperative for safety, and b) it’s a matter of “business necessity”. For example, as a matter of safety, a nurse who assists with



surgeries must be able to speak English to communicate with the medical staff. A more ambiguous example is to assume that business will suffer if English-speaking patients are uncomfortable hearing staff speaking other languages in patient areas, and choose to seek services elsewhere. State and federal policies regarding English-only policies are often debated and challenged. Health care organizations with English-only policies should stay abreast of current developments. Some organizations use diversity task forces as a sounding board for policies such as English-only rules. The task force can be charged with the job of coming up with a solution that is acceptable to all.

Whether or not there's an English-only policy, all staff should be reminded that it is never useful to blame people for not speaking English well and for preferring to speak in their native tongues. Native English-speaking staff should be told how unnatural it feels for immigrants to speak to a compatriot in a foreign language. Staff that are not native English speakers should be helped to understand that when they converse in their native language, co-workers and patients feel uncomfortable.

References

Wilson-Stronks, Amy, et.al., *One Size Does Not Fit All: Meeting the Needs of Diverse Populations*, The Joint Commission, 2008.

Nielsen-Bohlman, Lynn, et. al., *Health Literacy: A Prescription to End Confusion*, Institute of Medicine, 2004.

What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety, The Joint Commission, 2007.

Tackling Health Inequities Through Public Health Practice: A Handbook for Action, The National Association of County and City Health Officials, 2006.

