"I Want a Real, Swedish Doctor:" Exploring Patient Bias Toward Physicians of Foreign Background in Sweden

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Abstract

Increasing diversity in the healthcare workforce has brought to the foreground the importance of addressing phenomena of racism, discrimination, and bias against healthcare workers of diverse backgrounds. This paper aims to contribute to the growing literature on patient bias by exploring the experiences of physicians of foreign background in Sweden. Semi-structured interviews with 17 foreign physicians practicing in Sweden have been thematically analyzed. Four themes pertaining different forms of patient bias experienced by the respondents emerged from the transcripts: 1. refusal of care; 2. questioning language competence; 3. questioning medical competence; and 4. ethnic jokes or stereotypes. Four additional themes dealing with strategies implemented by the respondents to cope with patient bias were also identified: 6. confrontation avoidance; 7. collaboration with Swedish healthcare staff; 8. self-disclosure; 9. active listening. The findings elucidate the need to encourage inclusion in the workplace and targeted support for foreign physicians.

Keywords: health communication, patient bias, prejudice, immigrant physicians, thematic analysis

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Before the COVID-19 pandemic put further pressure on the healthcare systems around the world, two major trends were observable in high-income countries. The first trend deals with the need to broaden healthcare systems to better reflect the increasing diversity of the society at large (Marcelin et al., 2019; Osseo-Asare et al., 2018). For instance, Osseo-Asare et al. (2018) reported that black, Hispanic, and Native American physicians make up only 9% of practicing physicians in the United States, despite the same groups account for one-third of the US population. The ability of healthcare systems to satisfy possible preferences for racially and ethnically concordant consultations is believed to promote better patient-physician relations, hence better health outcomes (Shen et al., 2018). The second trend consists of the international migration of health workforce to meet the needs of the aging population of high-income countries (Bludau, 2021). WHO projected a global gap of 2.4 million doctors, nurses, and midwives, with an additional 12.9 million health workers needed by 2035 (Bludau, 2021). In March 2016, the UN Secretary-General Ban Ki-moon established a "High-level Commission on Health Employment and Economic Growth" to monitor the global shortage of health workers and to make recommendations on how to manage their international migration in an effective and ethical manner (WHO, 2016).

These trends have dramatically brought to the foreground the importance of addressing phenomena of racism, discrimination, implicit and explicit bias against healthcare workers with diverse background. For instance, a recent survey among physicians in the US found that "59% reported having heard offensive remarks from patients about their age, gender, ethnicity, race, weight, or other personal characteristics in the past 5 years and 47% had patients request a

different physician" (Chandrashekar & Jain, 2020, p. 33). A similar survey in the United Kingdom indicated that around 75% of black and minority general practitioners reported having experienced some form of racial discrimination from patients (Snead, 2018).

The bulk of the scientific literature so far focused primarily on the negative impact of prejudice and bias against patients, whereas the attention on the opposite phenomenon, namely patient bias and prejudice against health workers, has been scant (Chandrashekar et al. 2020; Kauf et al., 2021; Wheeler et al. 2019). In addition, the slim research on patient bias was concentrated in Anglo-Saxon countries, and in particular the US. The aim of this paper is to contribute to the growing literature on patient bias by exploring the experiences of physician of foreign background with patients' prejudice and discrimination in Sweden. The present research is based on a thematic analysis (Braun & Clarke, 2006) of semi-structured interviews with 17 foreign-born physicians. The thematic analysis focused on categorizing types of patient bias as perceived by the physicians and adopted strategies to cope with patient bias.

Literature Review

Overt and crude forms of racism in healthcare settings, although still present, tend to be less conspicuous also because socially stigmatized (Marcelin et al., 2019); nonetheless, subtle and sometimes unconscious forms of bias can still hinder healthcare professionals' preparedness to treat effectively their patients due to premature closure and missed diagnosis. Among the many dramatic examples of unconscious physician bias, Marcelin et al. (2019) include the association between the human immunodeficiency virus (HIV) and the white male gay community at the onset of the HIV epidemic. Such association blindered doctors' ability to recognize the disease not only in heterosexuals but also in the black gay community. It is still imperative to address implicit and explicit bias among healthcare professionals (for a systematic

review, see Dovidio et al., 2006; FitzGerald & Hurst, 2017); however, an increasing number of scholars calls for more attention toward the opposite phenomenon, namely bias against healthcare professionals, such as physicians from underprivileged or immigrant backgrounds (Chandrashekar & Jain 2020; Jain, 2020; Wheeler et al., 2019).

Bias against healthcare professionals is observable both from a macro, institutional level and from a micro, patient-healthcare professional interpersonal level. Instances of bias at an institutional level include, for instance, more stringent legal requirements and skill devaluations faced by immigrant doctors (Motala & Van Wyk, 2019; Salmosson, 2013), and discrimination in terms of fewer career opportunities and training admissions in the profession offered to members of minority groups (Marcelin et al., 2019; Nunez-Smith et al., 2009).

The concept of *patient bias* (Chandrashekar & Jain, 2020) captures, instead, forms of racism, discrimination, and prejudice against health workers at the micro level, namely when a healthcare professional interacts with a patient. Patient bias can take both explicit and implicit forms. Explicit refusals of care, for instance when a white patient expresses the desire of not to be treated by a black physician, is the most blatant example of explicit patient bias (Kimani et al., 2016; Rosoff, 2018). In an analysis of a German physician-rating website, Kauff et al. (2021) found that general practitioners with non-German names tended to be evaluated less favorably. Microaggressions, namely "brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group" (Sue et al., 2007, p. 273), are also common examples of explicit patient bias. In Osseo-Asare et al. (2018)'s study based on a semi-structured interview with minority (Black, Hispanic, Native-American, and mixed ethnicity) resident physicians, participants reported having to deal in their practice with a constant stream of microaggressions, such as assumption of lower status, exoticization, and feelings of alienation

in their own land. Espaillat et al. (2019) found that female medical students with a minority background were more likely to experience microaggression on a daily basis. Wheeler et al. (2019) provided a comprehensive categorization of seven types of problematic patient behaviors that emerged during a series of focus groups with U.S. physicians, residents, and medical students: 1. explicit refusal of care; 2. explicit or socially biased remarks; 3. questioning clinician role; 4. non-verbal disrespect; 5 ethnic jokes or stereotypes; 6. assertive inquiry into participants' ethnic background; and 7. contextually inappropriate compliments or flirtatious remarks (p. 1680).

Implicit forms of patient bias are less obvious and, therefore, more difficult to observe instances of discriminations against health workers. Nonetheless, implicit bias can still have concrete repercussions on the career and wellbeing of the health worker. Using an experimental design employing a deception paradigm, Louis et al. (2010) found evidence in a sample of Australian students of European heritage of "selecting discounting of credentials" (p. 1245) against fictitious foreign-born Pakistani doctors, who were systematically evaluated less favorably than fictional Australian native-born candidates with similar qualifications, educational level, work experience, and personality traits. The small yet statistically significant negative evaluations involved areas such as recommendations for an interview, levels of personal and social trust, and assessment of relevance of education and work experience for a position. First world medical education, for instance a medical degree obtained in the United Kingdom, appeared to attenuate nationality bias and to boost positive evaluations, for instance in areas such as perceived competence and trustworthiness. Greene et al. (2018) conducted an online survey on a predominantly Caucasian sample of US citizens and found that respondents displayed a statistically significant preference for a fictitious physician with a distinctly white male name

(Dr. Jack Williams) with equivalent quality performance compared to other doctors with typical white female (Dr. Holly Williams), black male (Dr. Tyrone Williams), black female (Dr. Jasmin Williams), or Middle Eastern (Dr. Raja Fakraddin) names. The preference pattern was particularly distinct in white male respondents. In an experimental study of first impressions of physicians based on photographs using both traditional and online US-based samples, Hall et al. (2020) found that rated competence of physicians of Indian nationality did not differ from rated competence of physicians of US nationality (both Caucasian and Black); nonetheless, Indian physicians received statistically significant lower ratings in patient-centeredness ratings and willingness for future interactions. Baquiran and Nicoladis (2020) tested the impact of foreign accents on perceptions of doctors' competence in a sample of Canadian undergraduates. Doctors with Chinese-accented English were found to receive statistically lower ratings in perceived competence than doctors with standard Canadian English.

In terms of its effects, patient bias was found to negatively affect the mental well-being of healthcare professionals, in particular in terms of increased perceived levels of stress (Kaltiso et al., 2021). Healthcare professionals that experience patient bias also report emotional burden (Wheeler et al., 2019), and feelings of degradation (Chandrashekar & Jain, 2020) and powerlessness (Espaillat, et al., 2020). Respondents in Wheeler et al. (2019)'s study also reported decreased learning and practice and withdrawal from roles and rotation (Wheeler et al., 2019). Han and Humphreys (2005) found that perceived discrimination in the local community affected the willingness to stay in immigrant doctors assigned to rural communities in Australia. Hall et al. (2020) noted that "prejudices and stereotypes held by patients can create unfair and self-perpetuating disparities for physicians" (p. 296), and patient bias is believed to represent a contributing factor in explaining why healthcare professionals from ethnic or underprivileged

backgrounds have comparable lower incomes (Greene et al., 2018) and lessened opportunities for career advancement (Chandrashekar & Jain, 2020).

Despite the extent and the severity of patient bias clearly emerge in the scientific literature, it is nonetheless complex to identify effective strategies for addressing this phenomenon. First and foremost, there is a complex balance to strike between the rights of the patient and those of the health worker (Chandrashekar & Jain, 2020; Paul-Emile et al., 2016; Rosoff, 2018). For instance, in the United States there is the paradox between on one hand the American Medical Association (AMA) Code of Ethics, which explicitly states that patients have the right to choose their physicians, and on the other hand Title VII of the 1964 Civil Rights Act, which entitles health workers to perform their duties in a workplace free of discrimination (Chandrashekar & Jain, 2020). Also, the physical and mental conditions of the patient need to be taken into consideration. As Paul-Emile et al. (2016) explained, "[p]atients with significantly impaired cognition are generally not held to be ethically responsible" (p. 710). Also, on one hand discrimination is not easy to pinpoint, and on the other hand racial and ethnic patient-physician concordance foster better communication, improved trust, and better health outcomes (Shen et al., 2018). For instance, can the request from a black patient to be treated by a black physician be equated *tout court* with a similar request from a white patient for a racially concordant physician? According to Chandrashekar and Jain (2020), it is critical to investigate patients' rationale on an individual basis. An understanding of a black patient's preference "may reveal an understandable distrust of healthcare professionals stemming from the medical establishment's historical exploitation of Black patients" (p. 37). At the same time, the request of the white patient may have been triggered by a posttraumatic stress disorder because the originally assigned doctor clinician share the "same ethnic background as a former enemy combatant" (p.

37). In both cases, accepted medical guidelines states that accommodation of the request is justifiable (Chandrashekar & Jain, 2020; Paul-Emile et al., 2016). However, if the investigation of a patient's motives highlights uncontroversial evidences of bigotry, a wide range of options are available, such as ignoring derogatory comments, persuasion, negotiation, and trust-building, but also responding to demeaning comments, and referring the patient to other hospitals or clinics. Simply bowing to discriminatory demands from patients make healthcare institutions appear complacent to bigotry (Chandrashekar & Jain, 2020; Paul-Emile et al., 2016; Rosoff, 2018). In sum, there is no easy, one-size-fits-all solution to the many paradoxes that come with patient bias.

Purpose of the Present Study

Patient bias is a relatively novel area of research, and scholars have called for more studies on prejudice and discrimination against healthcare workers and effective ways to respond to patient bias (Chandrashekar et al. 2020; Wheeler et al. 2019). The vast majority of the research on this topic originated from the United States. Therefore, the current study extends the literature by focusing on the experiences of immigrant physicians in Sweden. Like in many high-income countries, general life expectancy in Sweden is growing, hence the relative proportion of its elderly population. According to the Swedish Statistics Agency (SCB, 2018), "the share of people aged 80 and older will increase most, and in 2028, their share is expected to be 255 000 more people than today, an increase of 50 percent" (par. 1). In addition, the population of Sweden is becoming more ethnically, religiously, and linguistically diverse as a result of immigration, with 30% of the population aged 25–64 projected to be born abroad also by 2028 (SCB, 2018). The composition of the Swedish healthcare workforce reflects these demographic shifts toward a more diverse society. In 2018, about 34% of physicians were educated outside

Sweden; foreign-trained physicians stand for 44 % of medical licenses issued in 2020 (Socialstyrelsen, 2021). Foreign physicians come to Sweden from both the EU / EEA area, primarily Poland, Finland, and Denmark, and from countries outside Europe. Among the overseas doctors, Iraqis dominate due to the refugee wave to Sweden caused by the 2003-2010 Iraq War (Gevelin, 2015).

The topic of patient bias in Sweden recently gained media attention at national level after an exposé run by a leading Swedish newspaper, Dagens Nyheter (DN). Swedish national guidelines do not explicitly prohibit patients to choose physicians based on ethnic origins, and when a DN reporter, posing as a patient, called 120 public and private health centers around the country and requested to be visited by an ethnic Swedish doctor, 51 health centers agreed to meet the request. DN's exposé sparked a heated debate that led to revising national and regional guidelines (Sadikovic, 2021; Dagens Magazin, 2021).

Salmonsson and Mella (2013) researched bias against immigrant doctors in Sweden with a qualitative analysis of the journal of the Swedish Medical Association using a human capital perspective. According to the authors, "there seems to be a devaluation of human capital which might lead to marginalization of immigrant specialists in the case of immigrant doctors in Sweden" (p. 8). Immigrant doctors, especially those from outside the European Union, need not only to have qualifications equivalent to their Swedish peers, but also to obtain an implicit "cultural authorization" that demonstrate their ability to manage Swedish cultural codes. Salmonsson and Mella (2013)'s study explored the phenomenon of bias against immigrant health workers in the Swedish context from a broader, institutional perspective. The present study focuses, instead, on immigrant physicians' experiences with patient bias, hence at the interpersonal level. The following Research Questions guided the study:

RQ1. Which forms of patient bias do foreign physicians experience in Sweden?

RQ2. What strategies do Swedish foreign physicians use for coping with patient bias?

Method

Our data include 17 semi-structured interviews with foreign physicians working in Sweden. The respondents (8 females and 9 males) spent between 1 and 24 years in Sweden. Nine respondents came from the EU/EEA countries such as Hungary (five physicians), Germany (two physicians), Poland and Finland (one physician per country). Eight physicians came from countries outside the EU/EEA area such as Iran (five physicians), Iraq, Russia and the former Yugoslavia (one physician per country). Their medical specialties includes anesthesiology, radiology, geriatrics/rehabilitation, general surgery, ophthalmology and general medicine. Work experience in Sweden ranged from 1.5 to 19 years.

All the participants from European Union/European Economic Area (EU/EEA) countries came to Sweden under the recruitment program of the Region Västra Götaland in the western coast of Sweden. Since their medical licenses were automatically approved due to EU/EEA regulations, they started to work right after coming to Sweden, underwent a three-month Swedish language course for medical professionals, and passed a dedicated language test. The respondents from outside the EU/EEA started working in Sweden after they completed their medical education and a mandatory internship. They were also required to pass a compulsory language test for physicians from outside the EU/EEA in order to get their medical licenses approved (for details about the different procedures for EU/EEA and non-EU/EEA physicians, see Salmonsson & Mella, 2013, and Sturesson et al., 2019).

The interviews were collected at a number of public healthcare institutions in the Region Västra Götaland. The paper does not mention the names of the participants or institutions

in order to assure anonymity. The interviews were primarily conducted in Swedish. English, Russian, or German were also used in certain instances to ensure correct understanding of the responses.

The total interview time is 28.5 hours. Interviews were audio recorded after obtaining written consent from the participants before and after the interview. The interview guide included open-ended questions covering five areas: 1. work experiences in Sweden and in their home country, 2. communication in the workplace with patients and colleagues, 3. experiences of prejudice and discrimination in workplace from patients and colleagues, 4. mitigation of challenges, and 5. additional comments.

Data were collected within the research project "Communication in intercultural healthcare: Non-Swedish physicians in Sweden" financed by the Swedish Council for Working Life and Social Research (2005-2008) and within the frame of the project "Breaking the Swedish cultural code" (2008-2017) organized by the Region Västra Götaland and Sahlgrenska Academy for supporting professional development of the physicians educated outside Sweden.

The interviews were transcribed verbatim and analyzed with a thematic analysis (Braun & Clarke, 2006). Firstly, by both listening to the recordings and reading the transcripts, the first author gained a sense of the participants' experiences, extracted from the transcripts the parts that were relevant to the study, and translated them into English. Then, the two authors of the paper jointly reviewed the extracts and discussed the initial coding based on different categories. The categories that had a high degree of agreement between the authors were then collaboratively discussed and progressively aggregated into overarching, distinct themes. Table 1 summarizes the eight themes that emerged from the thematic analysis. Four themes pertained to

forms of patient bias experienced by the physicians and four themes to coping strategies employed by the physicians to deal with patient bias.

=== Insert Table 1 here ===

Findings

Forms of Patient Bias

In general, respondents reported to perceive Swedish patients as polite, friendly, kind, and quiet. Swedish patients also appear to avoid direct confrontations and conflicts. Nonetheless, two respondents mentioned that some patients were open about their refusal (Theme 1) to be treated "by us, foreigners, and asking for a Swedish doctor instead" [Iraqi physician]. Much more common is the fact that patients express refusal of care indirectly, for instance by talking behind the physician's back. The foreign physicians may get to know from their colleagues, e.g., the nurses who book appointments, assistant nurses, and other doctors that "such and such patient got worried when he heard your foreign name and asked for a Swedish doctor" [Iranian physician]. A physician originally from Russia commented:

> Some patients refuse to be treated by us, foreign doctors, but they rarely tell us directly. They tell the nurse before consultation and ask if there is a Swedish doctor available instead. Then that nurse or another colleague might mention it to me during lunch or coffee break.

A second form of patient bias experienced by the respondents dealt with patients questioning the physicians' Swedish language skills even before having met them (Theme 2). Elderly patients, often with self-reported hearing problems, and their relatives were especially

concerned, fearing potential problems with understanding “broken Swedish” [Iraqi physician]. Though respondents acknowledged that “a foreign accent can be difficult to understand for older people” [Hungarian physician], they still felt being singled out. Respondents who spent a longer time in Sweden felt that, despite speaking fluent Swedish, passing medical license exams, and having an extensive professional experience in Sweden, they were still regarded “not good enough” [German physician] and treated as “second-rate healthcare providers” [Hungarian physician]. Three respondents mentioned their patients showed impatience when they were “trying to find the right word or formulate what we want to say” [Russian physician] and made derogatory comments such as “have you taken any Swedish language courses at all?” [physician from former Yugoslavia]. However, also in this case some patients took an indirect route to express their dissatisfaction: They sat through a consultation and then “talked behind my back to my colleagues that I can’t speak Swedish” [Hungarian physician]. Patients also filed formal complaints after the consultation and our respondents felt stressed out about never really being able to know what their patients are thinking “as the Swedes don’t like showing their emotions openly” [Iraqi physician]. The physicians emphasized that, in some consultations, making just a small language mistake, saying that you don’t understand what your patient says, or having a small misunderstanding during an interaction can have devastating consequences because many patients believe that “speaking good Swedish means being a good doctor, and speaking poor Swedish means being a bad doctor” [Finnish physician]. The Finnish physician commented further:

> Because of failing language, a patient questions the level of medical knowledge. One mixes them up. Someone who doesn’t know the language can’t be good at medicine either. That

> is why I never show that I don't understand. I tried to listen and, if there is a nurse present during a consultation, I ask her for explanations right after the consultation.

Patient bias was also expressed by questioning foreign physicians' medical competence (Theme 4). Respondents from countries outside the EU/EEA area reported this form of bias more frequently. A doctor originally from Iran explained that "doctors educated in poorer countries" were perceived by their patients as not competent enough and "not able to provide proper patient care in a developed country like Sweden". A senior physician from Iraq, with over 10 years working experience as a surgeon in several countries, mentioned that a patient once asked him about working in his home country:

> Once a patient asked me, "do you perform surgeries in operating rooms in your country?" I was shocked. I tried to make a joke out of it and said, "no, we simply put patients on the floor and cut them open!" The patient got scared, as he didn't understand that it was a joke. He thought I was serious about it. I had to apologize and tell him that it was not true. I am not sure if he believed me or not.

The fourth and final form and patient bias experienced by our respondents involved ethnic slurs and jokes cracked by patients even during consultations (Theme 4). For example, a physician commented that he was accused of being "an authoritarian German oppressor" when he refused to give a patient a sick note; a Russian doctor was asked about her affiliation to the Communist Party; a female Iranian physician was "sick and tired of the questions why I don't cover my hair." Even if respondents acknowledged that these comments were rarely hostile and harsh, they still felt like being singled out. As a respondent from the former Yugoslavia commented: "I am a foreigner here, I am a refugee, and I still feel it every day. Especially when

they [the patients] ask me about the reasons why I came here, about the war, what I am doing here in Sweden."

Adopted Strategies for Coping with Patient Bias

The vast majority of our respondents indicated that their most commonly adopted strategy when they experienced forms of patient bias was confrontation avoidance (Theme 5), or, in simple terms, "swallowing it and being quiet about it" [Finnish physician]. None of the interviewed physicians reported to have actually confronted patients, fearing that this may escalate conflict with both patients and their relatives. Some respondents also mentioned that they were unsure if their colleagues would take their side in case of direct confrontation, worrying of potentially being described as inflexible, too sensitive, and overemotional. A Finnish physician commented:

> You may not show that you are sad or angry. Sometimes, it is difficult just being quiet, even if you are treated unfairly. If you complain too much, your colleagues will not respect you. You will be singled out even more. Even if I am offended and hurt, I still treat my patients with respect and give them the treatment they need.

Some physicians admitted that they avoided approaching senior physicians and managers in their units, fearing that complaining about patients would have made things even worse and turned their colleagues against them. Uncertainty was also due to lack of knowledge about laws and regulations about discrimination in the workplace in Sweden, which was mentioned primarily by the respondents who spent shorter time in Sweden. For instance, a respondent commented that he didn't know so much about "the Swedish anti-discrimination law and he was not sure where to find the information or whom to ask" [Hungarian physician]. The same respondent mentioned that he really wanted to show that he was a good doctor and avoided

complaining about anything. In particular, those physicians who did not have permanent contracts explicitly mention that the best approach was "flying below the radar" [Polish physician], in fear that a more direct approach could have a negative impact on their career development.

If the most common way to deal with patient bias was to simply turn a blind eye, some respondents tried to implement a more proactive approach, for instance by collaborating with the Swedish staff and in particular nurses (Theme 6). In many cases, nurses are, in fact, responsible for finalizing a consultation appointment and handle initial inquiries and concerns from patients and relatives. One of the respondents described nurses as "the gatekeepers who have much power in Swedish healthcare" [Iranian physician]. A Columbian physician explained:

> Some patients are unsure… a foreign name you know, and they ask the nurse "Is this doctor good?" The majority of nurses say "Yes he is good!" The nurse often tells me "this or that patient asked if you were good". Thus, you know in advance that the patient was worried and unsure. Therefore, you are prepared.

Nurses can provide assistance during consultations, helping with language problems, e.g. finding a word, providing clarifications, and additional explanations to patients. Respondents mentioned that being humble and asking nurses for help is essential for getting their support with patients. Some respondents referred to the so-called "Law of Jante" (Cappelen & Dahlberg, 2017), a modesty code that captures the Scandinavian mentality according to which "one should never try to be more, try to be different, or consider oneself more valuable than other people" (p. 419). Following the "Law of Jante", even if physicians have on paper a higher rank and expertise than nurses, they should nonetheless avoid "show off and tell that you are good" [Finnish physician] if they want to forge alliances with the nurses. However, nurses can also play the role

of foes against the foreign physicians, openly questioning their authority and decisions, sometimes in front of patients, relatives, and staff, and contributing to exacerbating patient bias and distrust:

> Nurses can be enormously helpful and can help you with everything in contact with patients. At the same time, they can completely destroy your relationship with patients and relatives. If they like you, trust you, and see that you are a competent doctor, trying to learn Swedish, they will help you. If not, in the best case, they will leave you by yourself. In the worst-case scenario, they will be against you [physician from the former Yugoslavia].

A third strategy employed by foreign physicians to deal with patient bias was self-disclosure (Theme 7), for instance by sharing with the patients where they come from, the reasons for moving to Sweden, and their future plans. According to the respondents, self-disclosure can be strategically used to make patients become less suspicious. For instance, a Hungarian physician explained: "I told my patient about my education, my family, my career plans, and why I came to Sweden. I felt that the patient became more relaxed and felt more secure."

Finally, some respondents mentioned active listening as a successful strategy for overcoming patient bias (Theme 8). An Iranian physician commented:

> I spend a lot of time with patients. I really try to understand their problems in detail and to help them. I know that I am being judged. They feel unsure if they feel I am not able to understand what they are talking about. That is why I listen well.

Active listening is also displayed, when possible, by taking extra time during consultations with patients and relatives to make sure that everything is clear as much as possible. According to a Finnish physician:

> Patients measure time in factual time. If you take 10 to 20 minutes more of your time, then the patient perceives that you have devoted yourself 10 to 20 minutes more than another physician. That's why I think many patients say: "Yeah, my doctor is so thorough, this doctor really listens."

Discussion

This study aimed at exploring how foreign physicians in Sweden experience patient bias in their professional practices (RQ1) and which strategies they employ to cope with patient bias (RQ2). Regarding the different forms of patient (RQ1), four themes emerged, namely: 1. refusal of care; 2. questioning language competence; 3. questioning medical competence; and 4. ethnic jokes or stereotypes. As for the coping strategies (RQ2), we identified four themes: 6. confrontation avoidance; 7. collaboration with Swedish healthcare staff; 8. self-disclosure; 9. active listening.

Our findings are in line with the literature on patient bias (Chandrashekar & Jain, 2020; Espaillat et al. 2019; Osseo-Asare et al., 2018; Wheeler et al., 2019) and show that foreign physicians in Sweden also experience a variety of forms of discriminatory and racist behaviors, ranging from explicit refusal of care to more subtle forms of microaggression in form of ethnic jokes or stereotypes (Sue et al., 2007; Wheeler et al., 2019). In comparison with the findings with U.S. samples, our data point that patient bias in Sweden tends to be expressed in a more indirect and covert manner. A possible explanation of this peculiar phenomenon may be due to cultural traits such as conflict avoidance and indirectness that are peculiar to Swedish culture (Herlitz,

2009) and, therefore, shared by Swedish patients. From an institutional perspective, Salmonsson and Mella (2013) also highlighted that immigrant physician in Sweden are expected to gain a "cultural authorization" in the process of gaining full professional status. The fact that patient bias takes an indirect route in Sweden does not nonetheless mean that it is less damaging for the physicians' wellbeing. Our respondents appeared, in fact, to "walk on eggshells" in their professional practice and to deal with an additional level of stress (see Kaltiso et al., 2021), as they need to second guess conversations with their patients, over-interpret silence, and manage unexpected "back stabbing."

Also consistently with the literature, the findings indicate that foreign physicians in Sweden employ a range of strategies to deal with patient bias (Chandrashekar & Jain, 2020; Osseo-Asare et al. 2018; Wheeler et al., 2019). Collegial support plays a pivotal role for the integration of foreign healthcare workers (Eriksson et al., 2018; Haponiemi et al., 2018). Fostering effective alliances with Swedish nurses seem particularly effective in mitigating patient bias. Nurses are often called "patient advocates" (Gerber, 2018), as in their role they mediate between patients and physicians. Nurses often spend more time with patients than physicians do and support patients and relatives in communication, making their voices heard and defending their rights (Ersoy et al., 1997). The present study highlights the positive role of nurses in particular when the foreign physician experiences language challenges. In sum, collegial support represents a crucial prerequisite for mitigating prejudice and enhancing workplace inclusion (Motala & Van Wyk, 2019).

The findings also support the value of physician self-disclosure in mitigating patient bias. Previous research in monocultural encounters showed no impact of physicians' self-disclosure on trust in physician-patient relationship (Arrol & Allen, 2015; McDaniel et al., 2007). In cross-

cultural consultations, self-disclosure can, instead, make patients more comfortable and trust their physician more (Cherbosque, 1987). Although self-disclosure can represent an effective strategy against patient bias, we also found that some of our respondents perceived talking about their own background with their patient as a sensitive topic.

Finally, communication and in particular listening skills can contribute to overcome patient bias and to foster physician-patient relationships based on trust (Alpers, 2016; Thom, 2001). As Swedish patients might experience higher uncertainty and an increased risk of misunderstanding in their interactions with a physician being a foreigner, the importance of active listening is enhanced in intercultural medical consultations (Berbyuk Lindström, 2008).

Although our respondents reported a range of possible coping strategies, it is important to point out that the most frequently reported strategy is conflict avoidance. Guidelines on how to respond to patient bias (Chandrashekar & Jain, 2020; Paul-Emile et al., 2016; Rosoff, 2018) also include a similar option but within a larger context in which physicians are called to make an assessment of the situation based on an investigation of the patient's perspective and to pick the most suitable coping strategy, including more assertive ones, such responding to demeaning comments and pointing the patient to other healthcare institutions. Based on our available data, our respondents seem not only to refrain from strategies that are more assertive but also to make decisions on how to handle patient bias on a trial-and-error basis, instead of referring to systematic guidelines. It may be understandable that the use of assertive strategies in conflict avoidance cultures like the Swedish one can be problematic and not straightforward (Holmberg & Åkerblom, 2007). However, immigrant physicians should not be left on their own devices considering that patient bias is a phenomenon that, like it or not, immigrant doctors need to

handle in their practices and that can have repercussions, for instance in terms of perceived stress and burn out, among others.

Practical Implications

Despite the explorative nature of the present study, some practical implications can be drawn from our findings for both immigrant physicians, who intend to address patient bias effectively, and healthcare institutions, which strive to foster better work environments for their increasingly diverse workforce.

Firstly, we support Chandrashekar and Jain (2020)' suggestion of implementing institutional response framework to patient bias and to systematically educate physicians on "(1) their rights and responsibilities as caregivers and employees and (2) how to respond when facing or witnessing discriminatory patient behavior" (p. 40). Immigrant physicians should be trained on available options on how to deal with patient bias and should be able to respond with confidence to occurrences of patient bias by referring to the accepted framework. Patients also should be informed of anti-discriminatory guidelines, for instance through leaflets and posters affixed in the healthcare institutions.

Second, proficiency in the local language, including accent training like suggested in Baquiran and Nicoladis (2020), should be made available to immigrant doctors, including dedicated time to allow immigrant doctors to master the local language at a fast pace. However, mere linguistic training is not enough. Specific cultural and active listening training (Tennant et al., 2020) should be provided to immigrant doctors, also because these trainings can increase the physicians' effectiveness in navigating the host culture faster, while in parallel taking formal language training.

Third, systematic partnership and closer collaboration between foreign physicians and Swedish staff, in particular nurses, should be systematically fostered with the aim of providing targeted additional support for foreign physicians to enhance their ability to engage with the patients effectively.

Limitations and Future Research

The present study represents an initial investigation of the phenomenon of patient bias in Sweden; hence, findings are difficult to generalize. The use of a qualitative approach based on a thematic analysis is consistent with the exploratory nature of the paper (Braun & Clarke, 2016); however, future studies will benefit from research designs that allow robust reliability tests, such as Cohen's (1960) kappa statistics. Future research with larger samples employing a survey design will allow systematic collection of information regarding foreign physicians' experiences of patient bias and will be key in understanding the nature and prevalence of these experiences with patient bias in order to mitigate them in practice. Finally, the study is based on self-reports and does not provide evidence on the actual effectiveness of the strategies to deal with patient bias mentioned by the respondents. Future studies that, for instance, employ an experimental design can shed light on what strategies are better suited to respond to specific types of patient bias.

Conclusion

Healthcare workplaces are becoming increasingly multicultural, and this process necessitates better strategies for promoting workplace integration of foreign healthcare staff (WHO, 2016). Foreign healthcare workers will increasingly play an increasingly central role as healthcare systems in high-income countries need to find effective solutions to emerging societal changes, such as increasing both multicultural and aging population. However, patient bias

represents a challenge that needs to be addressed to encourage inclusivity in healthcare workplaces and to promote better health outcomes in patient-physician relations. Addressing patient bias should not be left in the hands of the individual foreign physicians with the risk of promoting a culture of silence and denial; instead, there is a need to set a supportive environment, clear guidelines, and specific procedures for how biased behavior by patients should be effectively managed in order to prevent fear and uncertainty for both patients and physicians. Systematic research on patient bias can hence support healthcare institutions in balancing "their duty to provide high-quality care and tend to the vulnerability of patients, with their responsibility to cultivate a supportive, respectful work environment" (Chandrashekar & Jain 2020, p. 41).

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Table 1

Foreign Physicians in Sweden: Experienced Forms of Patient Bias and Adopted Coping Strategies

Themes	Illustrative Quotation
Experienced Forms of Patient Bias	
1. Refusal of care	"The patient's daughter told the nurse that her mother was worried and prefers a Swedish female healthcare provider." [Iranian physician]
2. Questioning language competence	"The patient told the nurse that she did not understand me and my 'strange' accent." [Hungarian physician]
3. Questioning medical competence	"They (patients) think that if I come from a poor country, my medical training is poor. I took the medical license exam to practice in Sweden and I passed it! I cannot show it to every single patient I meet to prove my competence." [Colombian physician]
4. Ethnic jokes or stereotypes	"She (the patient) asked me if all Russians like alcohol and drink vodka all the time." [Russian physician]

Adopted Strategies for Coping with Patient Bias

5. Confrontation avoidance	"I tried to avoid conflicts and turn a blind eye even if it is sometimes hard to accept some comments." [Hungarian physician]
6. Collaboration with Swedish staff	"Nurses are very important for managing suspicious and biased patients and relatives." [Finnish physician]
7. Self-disclosure	"I thought if I tell him (the patient) about myself, it will break the ice between us. He will not be that suspicious and worried." [Hungarian physician]
8. Active listening	"Communication is important. To listen to them (patients) and their relatives helps to make them less judgmental and develop a positive attitude." [German physician]