WORK→INT

Assessing and enhancing integration in workplaces

RESEARCH REPORT

WORKPLACE INTEGRATION OF MIGRANT HEALTH WORKERS IN SPAIN

Claudia Finotelli

Emma Mateos

Fleur de Montbel

Universidad Complutense de Madrid

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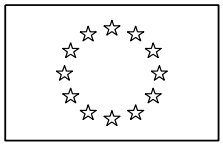

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1. Objectives and methodology

1.1 Research design and objectives

In the last decade, the healthcare sector in Europe has undergone growing labour shortages, which have been increasingly filled by international migrants, although with significant differences according to the various national contexts. Institutional and regulatory framework of the national health systems, highlighted shortages of national staff in the health sector, national policies aimed at filling them and at regulating the recognition of educational and professional titles of -EU and non-EU- MHWs and their access to the health labour market vary sensibly according to the different European countries (see Background national reports). As a result, non-EU and EU migrant health workers (MHWs) contribute to different segments of the health industry, with highly varying degrees of integration into this sector[1], according to the different European contexts.

While most of the studies on the economic integration of migrants into the European labour market and its impact on the broader society has been mostly concentrated on the macro level, mainly using quantitative approaches, little empirical evidence is available on the micro-level, namely in workplaces. However, the contexts where the integration into the receiving economies and the interaction between immigrant minorities and native majorities take place and can be primarily tackled is within firms and specific workplaces.

Furthermore, the research available on the foreign labour force in European countries has been mainly focused on the supply side, i.e. on the analysis of the processes and outcomes of insertion of immigrant workers in European labour markets, while the perspective of the demand, i.e. of employers, but also the concomitant role of other actors, such as trade unions, professional associations and other civil society organisations has been generally downplayed. The latter are key actors in the dynamics of labour market integration of migrant workers at different levels and their perspective and role need to be integrated more systematically in the study of migrants' integration in workplaces.

The WORK-INT project aims at contributing to the broader scientific debate on the labour market integration of migrants in the health sector in Europe, by adopting a research approach, which is: *qualitative*, i.e. allowing in-depth insights on the phenomenon; *micro-level*, i.e. taking workplaces (hospitals) as a main context of analysis; *multi-stakeholder*, where the role, the perspective and the professional and inter-personal relations are taken in consideration according to the different involved actors (employers, national EU and non-EU employees, trade unions, professional associations, etc.).

The MHWs' integration at a workplace level was studied, in particular, as based on four main dimensions

1 See Villosio, 2015, the comparative statistical analysis on Migrant Health Workers in the health sector in the 5 target European countries, based on Eurostat Labour Force Survey (EU-LFS) data.

(Zincone, 2009): the *systemic dimension* (health structure's policies or specific measures concerning the recruitment and integration of MHWs and impact of MHWs on the competitiveness and efficiency of health structures); the *individual dimension* (subjective wellbeing, perception and degree of satisfaction of own integration within the workplace, etc.); the *relational dimension* (considering horizontal and vertical relations, i.e. with colleagues in equal and higher/lower positions); the *transnational dimension* (declined as the ties with the health workers' community in the country of origin and/or in other countries, the contribution to the origin country as a professional while abroad and the intentions to return as a health worker in the country of origin or to re-migrate elsewhere)[2].

The WORK-INT research is an EIF-EU Commission funded project aimed at assessing and analysing the integration of immigrant workers in private and public health structures (hospitals) in five European countries: Ireland, Germany, UK, Spain and Italy[3].

As a first step, background reports were prepared in each target country, with the objective of providing an overview of: the institutional and regulatory framework of the health system in each country; the shortages of national staff in the health sector and the national policies aimed at filling this gap; the active admission policies of non-EU MHWs; the policies regulating the recognition of educational and professional titles of -EU and non-EU- MHWs; the regulations concerning the access of MHWs to the health labour market in each country[4].

As a second phase, a fieldwork research was undertaken in 5 medium-large European cities hosting large numbers of migrant workers: Dublin, Hamburg, Oxford, Madrid and Turin[5]. In each city two health structures (hospitals) were selected as **case studies**. Managers, human resource officers, non-EU/EU/national workers were interviewed using a common protocol of research, including common qualitative guides for interviews for national/foreign workers, managers and other stakeholders.

[2] For further details, please see the Castagnone and Salis, 2015

[3] For further information, see: www.workint.eu

[4] All reports from the WORK→INT project can be downloaded here: http://www.work-int.eu/research-materials/

[5] In each city, the study was undertaken by a local research institution, which is partner of the WORK-INT project: FIERI in Turin, COMPAS in London, Universitat Complutense de Madrid in Madrid, Hamburgisches WeltWirtschafts Institut in Hamburg, Trinity College of Dublin in Dublin. The project includes also a policy dialogue component, coordinated by the IOM Regional Office in Bruxelles.

1.2. Specifics of research methodologies at national level

1.2.1. Selection of hospitals; possible problems encountered and solutions envisaged

The hospitals were selected in three phases. First, a general typology of hospitals in the Community of Madrid was performed (see Background Report). The project coordination subsequently contacted the health authorities at the institutional level (Autonomous Community of Madrid) and provided them with information about the project. A formal request for cooperation to obtain access to the selected hospitals was submitted. However, contacting hospital managements through formal channels turned out to be an ineffective strategy. It was therefore decided to contact people in positions of power at the same hospitals. This type of contact was facilitated primarily by the General Council of Physicians.

The search for contacts focused on large public hospitals that provide medical training for residents (hospitals ranked in group I), since residents are the group of professionals featuring the highest proportion of foreigners. All of the hospitals we contacted were university hospitals, which facilitated access to the public hospital involved in this study.

Applying the same criteria, we contacted a number of private hospitals in the Community of Madrid. We obtained an immediate positive response from a large private hospital in the Community of Madrid.

1.2.2. Interviews undertaken with human resources managers

Several interviews were conducted with the Human Resources Department of the public hospital. During these interviews, the objective of the project was discussed and data about migrant health workers (MHWs) was obtained. An attempt was also made to arrange an appointment with the Managing Director of the public hospital, but this proved impossible. The most important contribution from the public hospital was made by the Coordinator of Internal Medicine, who facilitated most of the contacts with MHWs.

The project was very well received by the private hospital management. The Human Resources Department cooperated with the project team at all times, providing workforce data, searching for MHWs who meet the required profile, contacting them and providing adequate space for interviews. As a result, several interviews were conducted, and communication by phone and e-mail was smooth.

1.2.3. Interviews conducted with workers

The study focused on medical (doctors and residents) and nursing staff (nurses and nursing assistants).

Although the statistical data provided by the hospitals reflect only MHWs with foreign citizenship, fieldwork was also extended to Spanish MHWs with an immigration background.

In both hospitals, the choice of interviewees and the decision on who to contact first to present the project were made by HR managers or the Head of Service. Although this procedure was extremely useful for the contacting procedure, some opinions may have been biased by the desire to give 'correct' answers.

In the public hospital, interviews were conducted wherever it suited the respondent. In contrast, the private hospital provided exclusive rooms for the interviews to be held.

Interviews were conducted as a free conversation, attempting to delve into the details of everyday situations and reaching the micro level, whilst avoiding politically correct discourses wherever possible.

2. Systemic integration of MHWs at the hospital level: policies, practices and discourse

2.1 Organisational structure[6]

The public hospital

The public hospital chosen for the present study is responsible for the patients of 14 primary care health care centres in the city of Madrid, which corresponds to 365,532 inhabitants with an individual health care card. Its structure is that of a "pure" university hospital which, as yet, has no externalised health care services and no private management. The hospital management comprises a general director, his/her deputy director, a medical director, a director of nursing services and a management director. Each director is supported by two or three assistant directors, depending on the area. The medical director, for instance, can rely on three assistant directors in surgery processes, ambulatory processes and medical processes. MHWs in the public hospital represent only 2.2 per cent of the hospital's total health care staff. Most of the foreign doctors employed at the hospital come from Latin American countries. Notwithstanding this, it is also worth noting that the number of MHWs may be higher because MHWs with dual nationality are registered as Spaniards by the hospital management.

The private hospital

The private hospital investigated in this case study (hereinafter referred to as PRIVHO). The company's HR department is responsible for selecting and recruiting health care workers at of all its seven hospitals. However, each hospital has its own medical direction. The medical direction of PRIVHO comprises a medical director, a deputy director and three managers who are responsible for admission, quality and patient attention, as well

[6] Please note that detailed information on the dimension and characteristics of healthcare workforce in the chosen public hospitals has been eliminated from the public version of the report due to the strict anonimity request of the hospitals' directions.

as an administration manager. The medical direction is responsible for managing the clinical units, central services and non-medical units. As with the public hospital, the number of migrants is very small. In total, foreigners represent only 5.3 per cent of the permanent staff. However, as is the case with the public hospital, the number of MHWs may be higher because MHWs with dual nationality are registered as Spaniards by the hospital management.

2.2. Recruitment mechanisms

2.2.1. Recruitment mechanisms in the public hospital

Recruitment procedures in public hospitals are highly regulated due to public recruitment procedures. The vacant position is offered by the Autonomous Community in which the hospital is located, and depends on a publicly announced competition. As the deputy manager of the HR department noted, recruitment within the statutory regime limits the public hospital's autonomy and its capacity to select staff itself:

> *In general, our juridical regime prevents free recruitment, not only in the case of foreigners. Because the system here works through public competition. I have never been free to say "I am going to employ this (italics added) person* (PUBHR).

However, the same interviewee noted that new recruitment possibilities for permanent staff have developed "outside" the statutory regime. This occurs in hospitals that belong to the Spanish National Health Care System but are managed privately:

> *Public hospitals with a private management have a free employment regime. Their recruitment options are not limited to civil servants, they also recruit staff through the statutory regime* (PUBHR).

It is worth noting that only very few permanent positions were offered in the past ten years; most hospitals opted to recruit doctors temporarily, sometimes even renewing their contracts from month to month.[7] The same applies to nurses and nursing assistants, who are often employed on a temporary basis because permanent jobs have become less and less frequent in the Spanish healthcare sector. The temporary employment of medical staff is offered publicly, although the HR managers interviewed for this study tend to select candidates based on proposals voiced by the head of services. For the remaining health care professions, including nursing, the hospital resorts to the "job banks" of the Autonomous Community of Madrid. In purely public hospitals, temporary contracts in the form of "eventuales" (casual contracts), interim contracts

[7] As reported by El País on 31/10/2014, four of the five physicians responsible for supervising the nurse infected with Ebola in October 2014 were employed on a very precarious basis (El País, 31/10/2014).

or contracts for temporary replacement are regulated by the statutory system; in public hospitals with a private management, these contracts are not necessarily regulated within the statutory system. As was seen, the public hospital investigated also employs a significant number of resident doctors. This category, whose selection and employment conditions are regulated externally by the Ministry of Health, deserves a special mention. Hospitals are unable to influence the selection of resident doctors, which is undertaken via the central state examination MIR (see Background Report). Both natives and foreigners can take the examination in order to gain access to specialty training. However, there is a 4 per cent cap for foreigners, limiting the number of successful non-EU applicants who can been assigned a specialty slot (see Background Report). As the Ministry of Health expert interviewed for this study noted, the selection procedure for resident doctors is really equalitarian "in terms of capacity and merit" since everybody has the possibility to take the MIR examination and achieve a high score on the basis of criteria that are the same for all (MSSSI). Resident doctors are usually recruited and employed for training purposes. However, their activities often go well beyond mere specialty training. For example, older resident doctors may have to supervise younger ones (see Section 3. of this Background Report). For this reason, the large number of training slots in Spain has also been interpreted as a method of obtaining a 'cheap' temporary labour force (CGCOM; Finotelli 2014). Once employed, resident doctors often assume duties that should remain the responsibility of more experienced doctors. In this respect, it is worth noting that in PUBHOS the number of resident doctors remained constant, while the number of specialists and other healthcare professionals decreased considerably after the crisis (El País 08/01/2015). Taking into account the fact that the bulk of the work has not changed, this may suggest that resident doctors are often used for functions beyond their formal competence. Second, it should also be mentioned that resident doctors are often entrusted with training *new* residents once they have acquired a certain level of experience (see Section 3. of this report).

In the public health care system, only Spanish and EU citizens can apply for permanent positions as doctors and nurses within the statutory regime. This principle also applies to health care staff employed on a temporary basis. However, interviewees mentioned that, during the economic boom, public hospitals bypassed this rule to recruit non-EU foreigners as temporary workers (MSSSI). This procedure was facilitated by the fact that, during the economic boom, most resident doctors were allowed to change their study visas into visas for work purposes during their medical training, making recruitment after training easier. After the economic breakdown, changes in immigration legislation considerably restricted access to the medical profession. Health care professions were deleted from the Catalogue of Hard-to-Find Occupations, meaning that the hospital has to undergo a labour market check (*certificación negativa*) before initiating a recruitment process in a non-EU country. Moreover, it seems that recent legislation changes had particularly negative spill-over effects on resident doctors' careers. For instance, non-EU resident doctors can no longer have their study permits converted into residence permits (Gaceta médica, 13/12/2014). This seems to be a particularly relevant issue in the case of foreign resident doctors who complete their specialty training but cannot be

employed subsequently. As the HR deputy manager noted, resident doctors usually develop a strong labour relationship with their supervisors during their four years of training. However, their team leaders currently feel constrained by existing legislation, which does not allow the hospital to recruit them at the end of the training period:

> *[…] team leaders request the recruitment of foreigners who have trained in the hospital….However, we have to tell them that we are unable to do that. We would be glad to do it, but we cannot do so for juridical reasons, because they do not have Spanish nationality. Out of ten proposals to employ internal resident doctors after their training period, eight involved foreign workers* (PUBHR).

In fact, they would only be permitted to participate in the internal promotion procedure announced by the Autonomous Community of Madrid in 2014 if they managed to obtain Spanish or EU citizenship.

According to the manager interviewed, naturalisations became a useful stabilisation strategy for non-EU physicians who had completed their specialty training. In the public hospital examined, four former resident doctors are currently working on a fixed-termed basis while their naturalisation applications are being processed. The hospital management aims to recruit them once the naturalisation process has been completed.

> *They are currently having their Spanish nationality processed. They are old resident doctors who could be employed on the grounds that they had applied for Spanish nationality. …all four of them have to present the documents, because we will be unable to renew their contract next time, because they are temporary workers.* (PUBHR)

2.2.2. Recruitment mechanisms in the private hospital

In contrast to public hospitals, private hospitals supposedly have greater freedom in the overall recruitment process. The HR manager of the private hospital interviewed for this study stated that most physicians who work at his hospital are employed on a fee basis since they also have a job in a public hospital or run their own private practice:

> *In many cases, doctors coordinate their work in private centres with their own activities, their practices, or work in the private or public sector. This means that their connection [to the work at hospital], which is a fundamental piece of our machinery, can be greater, smaller or relative.*

According to the interviewee, the establishment of a full-time employment relationship may only be of interest in the case of physicians of "renowned prestige". In all other cases, he states that it is fully acceptable for physicians to have more than one job since "*varying occupational activities is typical of the medical profession*"

(PRIVHR). In these cases, the hospital may also use different legal forms to regulate the provision of medical care. According to the same person, the fact that most physicians have no regular employment relationship with the hospital makes it almost impossible to provide information about their exact number.

Very few private hospitals are allowed by the ministry to train internal residents. In the case of the hospital examined, such a permit has been issued for a limited number of specialties such as radiotherapy. Although the number of resident doctors is still very low, the objective is to train more and more in this category:

> *It is also a question of assistance and health care quality since, for us, as a private group, it is like having a plus* (PRIVHR).

However, also in the case of private hospitals it is the resident doctor who selects the hospital, and not the other way around. Moreover, the private hospital is not involved at all in the employment relationship between the hospital and the resident doctor since the employment relationship (including the salary) is regulated by the Ministry of Health, which establishes the salary according to the specialty and the year of training. Nonetheless, resident doctors have an ambiguous labour relationship, being recognised as members of the labour staff without being directly employed by the hospital.

> *It is like a hybrid, a mixed figure. [...] let's say that, considering their way of working, they are ascribed to a certain medical service, they have a team leader, but we can say that they do not report functionally to HR, but to their teaching department.*

Most permanent staff members are nurses and nursing assistants. Nurses are always linked to the hospital by a regular employment relationship since they usually perform their work exclusively in the respective hospital (even if they can combine it with another job in the public sector).

In contrast to what is usually expected of a private company, the private hospital does not rely on recruiting agencies to recruit nurses; none of the non-medical services provided by the hospital are subcontracted. Especially in the case of nurses, one relevant entry channel is universities that train nurses and nursing schools. As is the case in the public hospital, all nurses who graduate from the university associated with the hospital examined do their practical training in the same hospital. In the case of nursing assistants, another recruitment channel is vocational training schools. In all these cases, the hospital pursues the policy of retaining the best workers as staff members:

> *A person who has learned from me his/her theoretical and practical knowledge, who knows how I work, is an excellent source of recruitment. And, moreover, we try to take advantage of it…we cannot keep all of them because we have no capacity for all graduates from a year, but we try to enable those who are really good, who are outstanding, to stay with us.*

In this respect, another "indirect" way of recruiting staff is to keep somebody on who covered for another worker at the hospital, and who proved very good at performing his or her duties. In this case, the hospital HR department attempts to keep this person employed in another position or hospital until the offer of a full-time job with a permanent contract comes up:

> *A contract adequate to his/her profile, qualities and capacities, either to cover maternity leave, work leave, a support, a work peak, until we succeed sooner or later in relocating her/him in some way, because I have a vacancy, because somebody is leaving, because the hospital has been expanded and more jobs have been created, we try to keep these people, whether they are nurses or assistants or technicians, who work well and who you know, and are happy with you, you try to count on them, always, until you manage to keep them in the firm*[8].

Apart from relying directly on schools or experience, the hospital seems to make little use of job advertisements on the company's website or spontaneous applications. Instead, networking seems to be a much more important recruitment strategy in the case of this private hospital. In this connection, the HR Direction tends to favour the submission of CVs of employees' family members or friends, as long as they meet the respective profile, for both medium-skilled and highly skilled positions:

> *[…] and we think that [networking] is a value we have, that the fact that our workers may have family or personal ties is an added value. Because people are more committed, people feel more involved, they integrate more quickly, and people see [the private hospital] not only as a workplace, but as something more. A person who comes here who has her husband, son or father working here or her brother, considers [the private hospital] as a project for the future and the data are better* (PRIVHR).

The centrality of internal networking was explained referring to the fact that the company is a kind of family business. It goes without saying that the candidate concerned must meet the respective profile, which may be a high and medium-low position. In such a case, the company will do everything it can to encourage a worker's family member to submit a CV.

The recruitment of foreign resident doctors does not differ initially from the recruitment of native resident doctors, since they all have to pass the central examination (MIR) before they can opt for a training slot. As previously mentioned, the training capacity and experience of the private hospital concerned is such that their HR managers were unable to provide any information about the recruitment of foreigners who completed their specialty training in the hospital concerned. However, interviews conducted with doctors in the private hospital

[8] Please note that such a strategy is similar to that which occurs in public hospitals, where physicians are employed on a temporary basis until a public slot becomes available and the corresponding public competition can be opened.

revealed that resident doctors, especially those from Latin America, have a strong interest in obtaining a contract in the private sector, probably because private health care is the best healthcare option in their countries.

> *Because, you see, 50 per cent of the resident doctors who choose to do their specialty here are foreigners. What is wrong with that? That these people often have another view, they come from another country [...] They come from countries where private health care is the one that works.*

Notwithstanding this, it is more difficult at present to recruit foreign doctors who have completed their training. According to the public official interviewed on this question, at the moment private hospitals can only recruit non-EU doctors who have completed their medical training if they already have the necessary residence permit and if the contract offered is for at least one year (which is very seldom the case because vacancies are often only for a short period of time) (MSSSI).

In the case of recruiting foreign doctors, the HR manager highlighted the fact that, even though Spain has excellent doctors, hospitals aim to make themselves attractive to renowned international doctors and to provide them with an excellent environment to conduct their research. However, the policy of attracting renowned foreign physicians is limited to a very small number of people.

In the case of nurses, the ability to recruit staff from the nursery school associated with the hospital reduced the need to recruit nurses and nursing assistants from abroad. Most nursing students were nationals or, in the case of foreigners, had the necessary residence permits, or had at least attended a Spanish school. The manager mentioned only a few cases in which the hospital needed to recruit foreigners due to the lack of available natives. This occurred during the economic boom, when native nurses, particularly in summer, preferred to accept temporary positions in the public sector, which was thought to offer better employment conditions in the long term. The private hospital then had to recruit foreign nurses from Portugal, Ecuador and Colombia. As the HR manager explained, the main condition for recruitment was the offer of a permanent contract. The HR manager also stated that it is almost impossible to find foreign nurses in public hospitals because most have their own nursing school, which is very seldom the case for private hospitals. Another possible explanation is that many jobs available in the public sector are still limited to civil servant positions, which are more or less inaccessible for non-EU foreigners.

2.3. Integration and diversity policies

2.3.1. Integration policies in the public hospital

Ethnic and cultural diversity management in Spain is not an institutional priority. According to the public official interviewed for this study, foreign presence in the Spanish health care sector primarily poses organisational

questions "*diversity is relevant in terms of human resources planning – nowadays we are unaware of the exact number of migrant persons from abroad who work in our country*." On the other hand, the low relevance of the diversity question has very much to do with the fact that foreign presence is still a young, unexpected phenomenon:

> *I think that the problem of racial minorities, apart from the problem of gypsies, which has always been there and is not free of conflicts and problems…was that it was such a sudden phenomenon, it occurred all at once so that we had no time to adapt and react…* (MSSSI).

This would explain why diversity is not, and has never been, an issue on the ministry's agenda. In fact, the ministry's HR Commission, which deals with major issues such as planning specialty training, never considered diversity as an issue to be taken into account on the ministry's agenda.

> *What I can say is that the HR recourses commission, a body in which all the collegial bodies, all the HR directors, the health counsellors of the Autonomous Communities participate, never, never raised this question [the question about diversity management A/A] ever since I have been working here* (MSSSI).

Such a lack of relevance can also be found in the workplaces analysed. According to HR staff, there are two possible, only apparently contradictory, explanations for the fact that diversity issues have never been raised. The first may be related to the nature of the hospital which, as a university hospital, has always trained foreign doctors alongside natives ("*This hospital has always been a university hospital, we always had foreign resident doctors*"). In this respect, diversity is seen as part of the hospital's identity. The second explanation is related to the fact that the overall presence of foreigners is still irrelevant, considering that foreigners represent only 2 per cent of the overall healthcare workforce.

Apart from initiatives for disabled people, the only diversity management activities undertaken so far concerned minority gipsies. The aim was to improve the sometimes difficult relationship between doctors and patients belonging to this minority group. Although an increasing number of resident doctors were foreigners, the only initiatives taken by the hospital were to welcome new resident doctors with a hospital guide, and to throw welcome and farewell parties. However, diversity issues do not play a significant role in any of these initiatives. This also applies to the hospital's cultural programme, the objective of which is to offer a special meeting point for health care workers, patients and associations involved in hospital life. With respect to religious differences, prayer rooms are available in the hospital for Protestants and Catholics (but not for Muslims). Religion-related dress codes, such as headscarves, do not seem to represent a problem for workplace integration:

> *We had a girl, a young girl who studies radio, who was Muslim with a headscarf and for whom we are preparing a contract as a nurse. [...] She has a contract because she has Spanish nationality*

> *[...]. She is not fully covered, but only wears a headscarf that covers her hair. If she covered her face, I do not know whether there would be a problem, but the headscarf isn't one at present* (PUBHR).

2.3.2. Integration policies in the private hospital

The private hospital presents a fairly similar situation in terms of diversity policies. All newcomers are introduced to hospital life by their new supervisors; the HR department organises an introductory day during which the department provides information about the hospital's guidelines. The hospital only started thinking about measures aimed at improving internal communication very recently. However, no measures focus specifically on diversity management or favouring the integration of foreign health care workers. The lack of these measures, however, does not seem to have negatively affected hospital life. In fact, the HR manager cannot remember any conflict between MHWs or between MHWs and patients. The HR manager argues that such a lack of conflict may be related to the same characteristics of the medical profession:

> *Maybe it is also due to the fact that, in our case, health care workers from abroad did not have very different habits, or maybe, they already CAME aware of it, or we asked them for something that is quite normal. Since it is more linked to their professional choice than to their status, their origin or nationality* (PRIVHR).

In any case, diversity does not seem to be a problem. Potential areas of conflict, such as different types of politeness phrases or a ban on wearing heels, are more related to non-ethnic factors such as age (young people pay less attention to certain forms of politeness) or the fact that the dress code and professional code are closely related in the medical profession. However, and despite the absence of Muslim MHWs, the HR manager argues that wearing a headscarf would not be a problem for him, and that he would not forbid any health care worker from wearing a headscarf as long as she is able to do her work.

> *I personally would not understand the measure to force her to take off her headscarf, because I would not benefit from it, from the point of view of work organisation, it would not improve, not contribute to anything, and from the point of view of the patient, I think that the patient, a priori the patients we have, they are respectful, too* (PRIVHR).

In line with practices typical for private firms, patients are asked by the hospital to rate their satisfaction with the attention received. In this respect, he does not remember any cases of nurse-patient conflicts (though it is not compulsory for them). According to the interviewee, if something like that did occur, it would be related more to tension caused by the patient's health situation rather than a health care professional's specific attitude. In any case, the best solution in such a case would be to give the patient a different room rather than to change the nurse on duty.

2.4 Impact of MHWs on efficiency

Nationality or foreign origin did not seem to be perceived as a relevant variable for performance and efficiency by the stakeholders interviewed. However, health care workers' preparation and commitment to the health care profession were considered to be much more important than nationality or foreign origin. Consequently, stakeholders interviewed for this study do not feel that the presence of non-EU MHWs need necessarily have an impact on the efficiency of a particular hospital department because this depends on much more important factors.

> *[...] If I have a vacant position for a nurse, I try to select the best one, regardless of the colour of her skin, her origin…I try to keep the one with the best qualities, more attitude, who I think is able to contribute more, to have a better trajectory… (PRIVHR).*

The opinion expressed by the interviewee in the public hospital is fairly similar, since MHWs are considered to represent an "added value", just like any other health care worker.

2.5 Final remarks

Recruitment strategies in the hospitals examined depend mainly on the type of MHWs and whether they are recruited on a temporary or permanent basis. As both HR managers noted, the recruitment of resident doctors does not depend on the hospital's decision, but on the candidate's score and his or her choice of hospital. In this case, HR managers do not hide their perception of resident doctors as a workers' category that is "out of their control." As far as specialists are concerned, public hospitals are constrained by the recruitment procedure defined at the Autonomic and Federal level, while private hospitals seem to enjoy more freedom, at least in the case of natives. The same applies for nurses. In this respect, however, it is important to note that the recruitment strategy preferred by the HR manager of the private hospital is based on internal networking rather than on open calls, while public hospitals are forced to make public calls even though they may ultimately recruit internal candidates. It is worth noting that both HR managers complained about the increasing difficulties encountered in recruiting foreign workers. In particular, public hospitals seem to have very few possibilities to retain foreign physicians after their specialty training if they fail to become Spanish nationals, which was perceived as an important loss of human capital.

In contrast to the problems related to recruitment difficulties, HR managers did not perceive diversity as a challenge for cohesion in workplaces. This is probably due to the fact that people with an immigration background still represent a very small segment of the health care workforce in Spanish hospitals, even though the number of such workers increased considerably over the past ten years. The absence of formal

diversity policies has been compensated by a 'reactive' approach, which facilitates *ad hoc* solutions in the case of potential conflicts or tensions. However, it is worth noting that diversity plays no role in the agenda of the Ministry of Health either, despite the growth in the total number of foreign resident doctors between 2007 and 2010. There may be two reasons for this. First, the entry of foreign resident doctors to the labour market was perceived as a temporary phenomenon that did not need to be addressed by diversity policies. Second, the lack of attention to workplace integration may reflect a certain disregard for integration and diversity issues at the Federal level.

The next section of this report will demonstrate whether, and to what extent, the absence of diversity policies at the micro and macro level has affected the quality of MHW workplace integration in the public and private sector.

3. (Inter)subjective perspectives of MHWs' workplace integration

3.1. Brief description of migrant interviewees' profiles

Of the 37 interviews conducted with health workers, 20 were immigrants and 17 natives[9]. The interviews were distributed equally between the two hospitals (19 in the public and 18 in the private hospital). Most MHWs were from Latin America (12 out of 20). The sample reflected a rather disproportionate gender distribution (30 women versus seven men).

The largest number of interviews in the public hospital were conducted with resident doctors (six non-Spaniards and three Spaniards). We also conducted five interviews in the category of medical staff: three with Spaniards who supervise the work of residents, and two with Latin Americans who are "outsourced temps". The sample is completed by two nurses (one native and one migrant), a nursing assistant and two native technicians (one of whom is a Muslim).

In the private hospital, we conducted five interviews with resident doctors (three of whom are migrants). Two of the four medical doctors interviewed are Latin American migrants, the other two are natives. Among the nurses, two are native and three migrant, in addition to four nursing assistants (one native and three migrants).

Finally, it should be noted that nine of the MHWs interviewed also have Spanish nationality.

9 One of them was born in Spain, but her parents are from Asia. She was considered "native".

3.2. Workplace integration as a question of ethnicity

3.2.1. Language

Generally speaking, language skills as such do not seem to have negatively affected the workplace integration of the MHWs interviewed in either of the two hospitals. There may be two reasons for this. First, most of the healthcare workers interviewed are Latin Americans. Second, foreign doctors from non-Spanish speaking countries have to hold a certificate proving a high level of Spanish before they can sit the MIR examination. Moreover, the questions asked in the examination are fairly difficult, requiring a medium to high level of Spanish to answer them correctly (Finotelli 2014).

However, interviews revealed the existence of difficulties with respect to the different types of Spanish spoken by health care staff, which (quite surprisingly) concerns Latin American more than European doctors. In fact, none of the EU MHWs felt discriminated due to difficulties with the Spanish language. Instead, the opposite was the case: their colleagues see their faults as something "funny" (PUBREU3), they help them to learn Spanish (PUBREU1 and PRIVNEU2) and respect their work even if some patients are unable to understand them (PRIVDS2 referring to a European colleague).

In turn, Latin American MHWs' different ways of speaking and writing Spanish do not always generate sympathy. They are often urged to change how they speak and to use different vocabulary; somebody even corrected their way of writing and pronunciation (the 'seseo' in words containing a 'c', for instance). This approach leads to the establishment of a kind of hierarchy between different ways of speaking Spanish ("it is like speaking inferior Spanish").

It is possible to perceive some form of superiority towards Latin Americans, very subtle. Latin Americans' way of writing is not funny to Spanish people. It is obviously not a general rule; it is more like 'look how this *pachito*[10] writes…". In turn, the Italian or German thing is funnier."

> *If you say, for instance, something that you have been saying your whole life, they try to comment or correct you. 'You shouldn't talk like that because you are in Spain, you have to talk like the Spanish'. Then I tell them that people from Galicia speak horribly and that people from Sevilla speak horribly, and that nobody tells them that they have to speak correctly.*

The medical management of the private hospital believes it is essential to use the proper native vocabulary in order to improve communication with patients (PRIVDLA1). There is no evidence of a clear position in this regard in the public hospital. In any case, nobody mentioned the possibility that speaking a Latin American variety of Spanish could have a positive effect on Latin American patients. In the public hospital, there were

10 Panchito is a variant transcription of Francisco, which is a pejorative term for Latin Americans.

occasionally cases where patients were unable to speak good Spanish. In these cases, the fact that MHWs can speak other languages, such as French or Arabic, is quite appreciated (PUBTA). In contrast, knowledge of English was considered beneficial for research tasks, for attending international conferences, and so on.

In the private hospital, knowledge of English is particularly appreciated because of the specific profile of the hospital's foreign patients, which often differs to that of the public hospital. Knowledge of other languages such as Chinese or Arabic is also considered quite useful in some cases (PRIVNSA1, PRIVDS1). Nevertheless, the same interviewees noted that there is no formal recognition of MHWs' abilities in this regard (PRIVNEU1, PRIVRA).

It is worth noting that this study was undertaken in an Autonomous Community where Spanish is the only official language. The language issue could be more complicated in other Autonomous Communities with two official languages, such as Catalonia or the Basque country (PUBRLA1 and PRIVRLA1 had difficulty integrating when they worked in Catalonia).

3.2.2. Religious differences

The healthcare staff interviewed (both native and migrant) generally considered religious differences to be fairly irrelevant. The reasons for this may be twofold. First, there is little religious diversity in both hospitals.[11] Spain is traditionally a Catholic country, even though most people do not practice their religion. This also applies to the healthcare staff. Second, religion is considered a personal issue that has no place at work. For this reason, those who practice other religions are very discrete. The general intention is to avoid any discussion that could generate conflict on religious issues between colleagues.

> *I think it depends on the times, I mean, that we are now becoming a very laic country and there are things we speak less and less about in order to avoid conflict. I do not think that there is a lack of respect, there is more a diversity of opinions and this is a 'taboo' issue.* (PUBDS1)

The religious question only seems to be relevant in the case of Muslims. The technician originally from a Muslim country who worked at the public hospital (PUBTA) confirmed that her colleagues always respected her beliefs even though no specific action is taken (in this respect, she would appreciate a place to pray). In her opinion, public hospitals are more respectful concerning religious differences due to their commitment to

[11] Please note that none of the interviewees mentioned having attended to non-Catholic patients. Generally, there is no concern about patients' religious diversity, even though the public hospital has set up a prayer room for Evangelio patients because many gypsies practice this religion.

laicism, whereas she assumed that private hospitals would be more reluctant to recruit Muslim women who, like her, wear a headscarf (PUBTA).

> *They do not differentiate at this hospital. For instance, I wear a headscarf and nobody has treated me differently or made any comments. I go to surgery and they do not say anything to me, as I wear the cap and the mask, and they have never said anything. I've never had any problems. I think they look at this at private hospitals, but not public ones. Because I submitted my CV to private hospitals and, yes, they look at you. My sister, for instance, wears a headscarf and when they see her, they say "If you leave off the headscarf, we will let you work." This discrimination exists because it is a private hospital. In other countries, they do not see it like that.*" (PUBTA)

Her opinion on the acceptance of headscarves is not necessarily shared by other people. One of her colleagues argued that wearing a headscarf is an unacceptable practice that may be rejected by certain patients (PUBNS).

> *Here in the hospital we have no problem, but I think that they [foreigners] should adapt to what we have here. If I go to a mosque I have to cover myself, hence they have to adapt here as well. There are patients who hold resentments, especially against Muslims. You know there are elderly people who do not like them. There haven't been any problems, but they could arise.* (PUBNS)

However, other types of spiritual beliefs and the concept of pain and death may affect MHWs' workplace integration. We have no information on this aspect from the public hospital, but interviews in the private hospital revealed that these beliefs are accepted as long as they are not related to improper belief manifestation. For example, nobody is shocked when a nurse talks about these issues with family members of a patient at the point of death (PRIVNALA). In turn, singing a religious song in such a situation would be considered reprehensible (PRIVNS1).

> *I have my beliefs and I have adapted them. I have dreamed with patients before they died. That they look at me and that I go to their room the day after, I talk to them, I open the window to them, I tell the families. [...] I told a lady that had her husband, she had two children, and I told her "Do not tie him any more, do not tell him that he is doing well, that he is going to be better. Take him, talk into his ear and tell him "Go, rest, I will take care of the children." Give him the peace he needs.* (PRIVNALA)

3.2.3. Racial discrimination

None of the Latin American MHWs felt they had been a victim of racist behaviour, attitudes or opinions by their colleagues or superiors. However, some interviewees (PUBREU1, PRIVNALA, PRIVNS1, PRIVRLA2) noted

that the term "*panchitos*" is used too frequently. This word is considered offensive because of its racist connotations, which is why native colleagues avoid using it in the presence of their Latin American colleagues.

As far as MHWs of African origin are concerned, interviews[12] provided no evidence about possible cases of discrimination. In the public hospital, references to Guinean workers[13] were respectful. In the private hospital, the nursing assistant of African origin declared that she felt "totally integrated" in her workplace.

> *I suppose that it has been a benefit for me; to be from abroad: you have the traits of a foreigner, but when you speak nobody notices it. You are fully integrated; you know the customs here perfectly and how to deal with people, the education and everything. Hence, I think it has been a benefit. And then, of course, if you provide an ethnic, exotic point (laughing) even better, isn't it? [...] As far as employment conditions are concerned, supervisors and so on, the truth is that I have never had any problems. In fact, not even with patients. What's more, sometimes they look surprised and say "How good your Spanish is, you speak even better than me!* (PRIVNAAF)

Patients' attitudes are quite a different matter. Patients usually seem to be respectful and even grateful to MHWs. However, some interviewees (PUBDS1, PRIVNAS, PRIVDS2) mentioned a couple of racist or xenophobic incidents. Such cases are more frequent in emergency or oncology because patients and their family members are often in bad moods.

> *We, in emergency, we also have to take patients' data. Hence, once a patient came out saying that he had been attended to by a Chinese person and that the Chinese know nothing about medicine. It is true that some patients have quite a discriminatory attitude towards some people, despite the fact that there are not many "races" in my department. If there was more racial diversity, including black people and so on, I think that there would be much more [racism].* (PRIVDS2)

> *Many patients do not like foreign doctors and nurses. They tell you "I was attended to by a panchito in emergency, in a kind of despising tone, as if I would be less competent at it [being Latin American].* (PRIVDS2)

Discriminatory attitudes may occasionally occur at any hospital regardless of whether it is in public or private ownership. Nonetheless, some of the interviewees' testimonies (PUBDLA1, PUBRS1, PUBNS) suggest that health workers in public centres may be less tolerant to such behaviour, either due to the larger number of foreign resident doctors or the lack of a customer relationship with patients (PRIVNAEU).

[12] The sample contains an insignificant number of African interviewees. However, interviewees refer to old colleagues from Africa.

[13] Equatorial Guinea is the only African country in which Spanish is an official language.

> *In these 18 years, I experienced only one episode [of racism]. It was when I was working in emergency, a R1 (resident doctor), I don't remember which South American country he came from, after going out to talk to (a patient's) family members, came back and told me that these family members wanted to nothing to do with a foreign doctor. What I did, obviously, was to go out with him (the resident doctor) and let them see that this is a university hospital and that we have all types of specialists here and that this was the doctor who would be in contact with them and me. That this is what it is.* (PUBDS2)

In any case, the perception of ethnic references being offensive depends on the degree of trust and professional esteem between individuals. For example, a Spanish physician can refer to a Latin American worker as "*la morena*" (the brunette) without being perceived as being offensive if she believes that her boss is happy with her work.

> *He called me and told me "Where are you from, how long have you been working here? You are a good worker. I would like you to work here (…)." The same thing happened another day. A patient, I saw her, she was unconscious, I called him, etc… And he says "since the 'brunette' called me, I am sure that something is serious.*" (PRIVNALA)

Another example refers to a Spanish resident doctor who called his Mexican colleague "Pocahontas"; she thought it was funny, rather than being offended.

> *Once a Spanish colleague told me, "look, Pocahontas." This made me laugh, but my R5 reprimanded him, asking him to apologise immediately. Often it depends on how you take it, because it is often just a joke. I have never felt discriminated in this respect.* (PUBRLA3)

3.2.4. Forms of socialisation

According to some of the EU resident doctors interviewed, the existence of "nuances" or "small cultural differences" between people belonging to different countries may occasionally produce "*little misunderstandings related to the way of speaking*" (PUBREU3, PUBREU1). However, this does not prevent relationships between MHW and their peers from usually being positive. One obvious example of this is the existence of close friendships between resident doctors from different countries in Internal Medicine at the public hospital (PUBRS2, PUBRLA2).

Certainly, one cannot deny the existence of certain social stereotypes about how people from different countries relate to each other. However, these are not always negative for MHWs or disadvantageous for coexistence with Spanish people. In the private hospital, for instance, Latin American MHWs are considered to be optimistic and conciliatory (PRIVRS2, PRIVDS2), whereas the Spanish (or Madrilenian, according to

PRIVNEU1) are sometimes considered to be gossipers, complainers, trouble-makers, and so on (PRIVDLA1, PRIVDLA2, PRIVRLA2).

> *The work environment (with Latin Americans) is much more relaxed, you are not so tense, and perhaps you can talk to them about other things. I think it is easier at the personal level.* (PRIVRS2)

> *I try to avoid problems, in turn the Spanish are like very…They are very vehement in their way of speaking. Maybe they do not want to argue, but they break the conversation.* (PRIVDLA1)

> *Here […] people complain about everything. This is something that, to tell you the truth, exhausts me a bit, but I have learned to live with it. Sometimes I complain that I want to be at the same level.* (PRIVDLA2)

> *Madrid is already embedded in a culture, a stress, a way of being, an internal Che Guevara that at the minimum bla, bla, bla!* (PRIVNEU1)

In both hospitals, interviewees felt that Latin American MHWs are used to treating patients intimately and affectionately. However, some interviewees noted that native patients do not always appreciate this treatment, although this may depend on the patients' age. No mention was made of how patients from Latin America (or other countries) perceive this.

> *In this sense, they have a warmer personality, particularly the Colombians in this case. Portuguese people maybe not so much, they are a bit cold towards patients.* (PRIVNAS)

> *I have seen two types of patients: patients who very much like how we treat them, especially because we speak more, we are more attentive, we are more affectionate, maybe also due to our nature…and others who do not.* (PUBDLA1)

> *It is true that you cannot tell to a 90-year-old woman who is out of breath "well, my love, I am going to hospitalise you." Not for nothing, because maybe he [the doctor A/N] is being the most respectful in the world, this has nothing to do with it, but we are not used to it. And not only that, but a 90-year-old patient who grew up under Franco, you cannot pretend that she thinks it is right. Because she would not think it is right and that's it. Apart from this, I have never seen any supervisor saying to this person "Listen, do not talk to patients like that." In fact, she keeps on doing it.* (PRIVRS2)

3.2.5. Work habits

Interviewees in both hospitals mentioned the existence of social prejudices concerning work habits in countries other than Spain (German and Chinese people are hard-working, Latin people are slow, etc.). In this context, there are stereotypes about Latin American immigrants and their low level of qualifications and slowness (PUBDS3 identifies them as manual workers or bricklayers). This image, which negatively affects the image of Latin American resident doctors, may be conjured up at the start of their residency, but is quickly dismantled in daily working life (PUBREU3, PUBNS, PUBRLA2).

Ultimately, daily professional work and exchange enables these prejudices to be overcome, so that Latin American MHWs experience no relevant obstacles to their workplace integration in this respect. On the contrary, those who work with them at both hospitals value their knowledge, efforts and cooperative attitude (see Section 3.3.).

> *They are workers and are very willing to work. They do not care whether it is for one job or another, it is very easy to ask them: Will you come with me to do this? And they don't mind getting their hands dirty. Other people are not like that. I notice it very much. And I am very obliged to all my colleagues. They are very kind, very nice and I have no problems working with any of them.* (PRIVNS1)

3.3. Workplace integration as a question of workplace (hospital) organisation

3.3.1. Worker profile and professional competence

Several MHWs interviewed have a good career background with a high level of qualifications in their country of origin. Some of the doctors interviewed have a high socio-economic profile, and came to Spain to strengthen their professional career or to do their speciality training in better conditions than in their country of origin, where specialty training is often not remunerated and working conditions are harder. Doctors and nurses interviewed at both hospitals affirm that Latin American MHWs have more (and even better) practical experience than Spanish resident doctors in their first year of specialty training. This is due to the one-year "rural service" that Latin American doctors have to perform after having obtained a degree in medicine. In the course of this year, they practice their profession with full responsibilities, sometimes in very complicated situations and with very few means.

In view of this, Latin American doctors applying for specialty training in Spain may already have been working for several years in their country of origin, whereas Spanish doctors in the same situation lack practice with patients. For this reason, Spanish trainees may have more difficulties in their first year of specialty training, as the tutor of resident doctors in the public hospital pointed out:

> *Foreigners, in contrast to ours, come much more prepared from a practical point of view. Hence, initially Latin Americans are generally those where you can observe a greater difference, they are more brilliant, more determined and then there is more balance [...] You can see that they work well, that they manage well, therefore you trust them more (...) If somebody comes to me...I don't know, somebody, from Peru, telling me "listen, a murmur" then I believe him. If someone else comes to me to say the same thing, I say "Well, let's see." What I am saying is that they have more experience, more practice [...].* (PUBDS2)

The professional education and experience of Latin American nursing assistants is also valued very highly. In fact, the training and responsibilities in their country of origin is considered to be almost equivalent to that of Spanish nurses:

> *Nurses in Spain are supposed to be very prepared or at least they say so, that nurses are well prepared compared to other countries, however, my colleague who studied in [country] knows things, because you talk to her, that only a nurse would know. And has worked in the intensive care unit, in the way only nurses work. She does things that here, for instance, only a nurse can do.* (PRIVNS)[14]

The good professional education of Latin American doctors enables the stereotypes that are often associated with this ethnic group to be overcome. Hence MHWs' labour profiles and hospital practice experience ultimately predominate over origin. Such predominance can also be observed with respect to the doctor-patient relationship. What really matters is a good professional performance: "*When [patients] realise that healthcare staff are prepared and you are speaking with someone who is prepared, that you are not speaking with someone who does not know anything, then they feel more comfortable and calmer, regardless of whether you are a foreigner or not*" (PRIVNS).

This kind of perception is clearly related to particularly pressing and personalised hospital work, where "*the important thing is that [patients] are well cared for, no matter who takes care of them*" (PRIVNEU2). Such a view is particularly strong in the private hospital, where native staff (including supervisors and HR staff) value professional competence over any other variable such as origin. This corresponds to the HR and medical management's philosophy ("*You employ the person you think is the best choice; regardless of his or her origin. That is why I say that prejudices are not very frequent in the medical sector.*").

The high level of internal organisation of healthcare professions is certainly another important element for assessing workplace integration. Every hospital (and even every hospital service) has its own protocols and

[14] The speaker is talking about a Latin American colleague who is a trained nurse, but can only work as a nursing assistant because her credentials were not recognised.

idiosyncrasies. In this respect, anyone coming "from outside", that is to say anyone who has trained or worked in another hospital, needs an adaptation and integration period. "Being from outside" can mean coming from another hospital, even from another service (as in the case of a nurse who changed from emergency services to the intensive care unit), or having trained in another speciality (in the emergency service), or it simply means that somebody has no professional experience at all. Hence for both native and migrant health care workers, "being from outside" means something different to having a distinct ethnic origin.[15]

The case of new resident doctors who join the hospital for the first time is a prime example. Anyone is new, "from outside", regardless of their country of origin. They all have to integrate and learn how the hospital works. This is how a native nurse in the public hospital describes it: "*Always in May, for instance, when new resident doctors start their training, well it is horrible; I don't care where they come from. It's horrible! Because they do not know where to find the offices, the referral notes or anything. They are doctors, yes, but… until they adapt and so on, well… summer is very bad*" (PUBNS). Such an adjustment period, which is more individualised in the private hospital due to the small number of resident doctors, occurs under the supervision of tutors and other doctors. During this period, resident doctors "make a great effort to absorb their protocols."

Nursing staff at the private hospital stressed that this integration period is vital for anyone starting a new job. However, it is easier for those who already know the hospital after having completed their practical training there.

> *Let's say that yes, there are differences in tasks, customs [between health care workers educated and trained in Spain and those educated and trained abroad], but whenever someone joins a new workplace with new fixed protocols, you always have to adapt, you have no choice […] you know that it is up to you to ensure that your colleague really learns, you do it for him (her), you do it for you, you do it for everybody at the end of the day.* (PRIVNAEU)

3.3.2. The relationship between different professional categories

Interviews highlighted additional examples of the complex framework of variables that affect workplace integration and that are mainly embedded in a hospital's organisation. Hierarchic relationships, for instance, seem to play a more important role for integration, socialisation, work accomplishment and any possible conflicts than ethnic origin. Once again, the ethnic variable seems to remain in the background.

[15] That is why, unsurprisingly, the management and HR of both hospitals consider recruiting people who already know the hospital and its protocols over whether or not they are foreign (see Section 2.2.).

> *I think that if there are workplace conflicts, they are related to the fact that you do not know exactly what your functions are, you do not know other people's functions, there is little will to lend a shoulder and make things progress […]. Coming back to the norms of conflict management, I think that it is not worth separating [foreigners and natives A/N], that the thing is that everybody has to know which professional category he/she belongs to, what to do, how to do it, if there are any problems, who to report to, how to solve them. I think that people should be told such things. It doesn't matter if they come from Coslada (a suburb in Madrid) or Sebastopol, it's the same.* (PUBNS2)

The use of coloured uniforms (dressing-gowns or pyjamas according to the service) and/or badges according to different professional categories dissolves the ethnic category in favour of others, as the testimony of a foreign nursing assistant illustrates: "*Here, they look at your degree. Here, they only look at whether I am wearing orange or blue*."

3.3.3 Relationships between medical and nursing staff

The importance of hierarchic relationships is particularly evident in the case of medical and nursing staff.

> *Because there are physicians, well, you can't with them...it is not that you cannot trust them, they are people like you, but their status is above everything. Where nurses and nursing assistants do not differ much, the difference between nursing and medicine is huge. Because I have been working with a neurosurgeon in surgery, and the difference of staying with your surgery colleagues, the nurses and all...the neurosurgeon comes in and there is a moment of silence, the moment of "that was it." And it is like that because, with physicians, you indeed notice the hierarchical difference, it doesn't matter whether they are foreigners or not, it is the same.* (PRIVNS1)

Relationships between nursing and older (male) doctors are more distant than with resident doctors. Furthermore "young resident doctors" are not very confident at the start of their residency, which is why they are doubted by more experienced nurses:

> *When you are a newcomer and, in addition, you look like an innocent person who has no idea, well from time to time they doubt what you are saying […] And this is logical, I think, because if you are nurse that is responsible to give a medication, you are not going to do something you are told to do by the first person passing, even if he is a doctor, aren't you?"* (PRIVRA)

Nevertheless, this can sometimes cause tension, as another (native) resident doctor at the private hospital observed:

> *There are some who resent the fact that they have been working for years, and then you come as a newcomer and you give an order (...) and if the third time they give me a bad answer, then I tell them "listen, I am not your enemy, this is a job and the more we get along well the better." Because at the end of the day you have to deal with me and I have to deal with you. I am not going to be a burden on you, nor I am going to be your boss. Since you are going to ask me for something, I am going to ask you, but that's it.* (PRIVRS2)

Sometimes doctors have to resort to nurses' specific competence to work with patients. In this respect, foreign nurses may be responsible for translating or explaining what doctors say to patients since medical language can be more complicated than any variant of Spanish.

Relationships between nurses and nursing assistants seem to be more collaborative even though they are also subject to a hierarchical order. As interviewees noted, the higher degree of collaboration is related to the need to get on well despite hierarchical differences due to the specific type of nursing tasks. A nurse at the private hospital sees it this way: "*But really, on the ward, the boss would be the nurse. For sure. What happens is that, well, I am comfortable if we are ... if I treat them more as companions than as 'I am the boss and you are going to do this*'". There is a thin line between respecting the distribution of tasks and carrying out teamwork due to the pressing nature of hospital work:

> *As in all workplaces, there is always a little bit of everything, there are problems, discrepancies, but it is team work that always gives better results when done in a team, you finish earlier, and it is always done better. If there is collaboration, good communication. And in services such as intensive care (...) well, it is very important* (PRIVNAEU).

In this respect, interviewees at the private hospital[16] stated: "*we work more collaboratively than in public hospitals. We don't make such a difference between the status of a nurse and a nursing assistant*."

3.3.4 Peculiarities of working in a hospital

The peculiarities of work organisation and the idiosyncrasies of services in hospitals seem to affect workers' relationships more than ethnic difference, as the medical director of the private hospital observed:

> *A peculiarity of the health care sector is that you have to work in a team, nobody works alone. People interact with each other, the doctor with the nurse and the nurse with the nursing assistant, and I do not believe that there are ghettos. Maybe in other professions, in those in which you can work alone, they say "I am interested in talking to this Colombian in the office" and you form a*

16 We have not interviewed nursing assistants in the public hospital.

> *team. Here you cannot choose your team; the type of job forces you to work with everyone, and inevitably you get along well after a while.* (PRIVDLA1)

Hospital teamwork also entails specific forms of socialisation. Some heads of service used to have breakfast with their team. This occurs more often in the public hospital, and concerns both doctors and resident doctors. It is a way to socialise, but especially to continue working outside the ward. In the private hospital, this occurs more often at lunch time. Most foreigners realise that these are very important opportunities for socialising in which they have to participate.

Many people also referred to friendships that grew from working together regardless of national or ethnic differences. In fact, the hospital can even become a real provider of social life, especially for people who come from outside Madrid. This is the case for resident doctors in the public hospital: many are not from Madrid, and share so many working hours together that their team tends to turn into their social group.

Spending a lot of time with colleagues, doing a lot of team work, experiencing a great deal of tension, stress, and also common feelings make it very difficult to distinguish between personal and professional spheres at the hospital. This is why interviewees ended up talking about personal relationships when asked about their professional relationships.

> *I get along well with everybody, because I think that we spend many hours together and to get along poorly is counterproductive in daily practice.(...) Sometimes there were conflicts between colleagues, work is very hard, very intensive. Because you do not talk to each other in the same way, you do not work in the same manner with this person, or in a certain moment you need help and this person does not help you because you do not have this....it is not that you argue, but you do not get along well with everybody [...] Hence, I think it is better to get along well with everybody.* (PRIVNS2)

On the other hand, such an intense work rhythm in difficult circumstances (emergency, oncological patients in their terminal phase, etc.) over many hours can also turn the hospital into a fertile terrain for friction, clashes, a gossipy atmosphere, and so on. "*I believe that, since we spend so many hours together, we have the opportunity to notice each others' defects and therefore have so many more possibilities to clash*" (PRIVRLA2). And this is where certain discriminatory attitudes may come in.

> *It is more the continuous friction in daily work (…) I think that our job consists of many hours, a lot of tension, and at the end you do not see the person. Maybe you do not get along well with someone from abroad [...] and you say "she is from abroad." But in reality it is not because she is a foreigner, but you simply say something, like I would say 'you are ugly'.* (PRIVNS2)

The tendency to play down offences with xenophobic connotations as a way of letting off tension or/and conflict and to consider it like any other contemptuous comment reflects the interviewees' will to minimise the

ethnic component. In fact, both native and migrant staff seemed keener to tell anecdotes about gender, age or professional discrimination rather than ethnic discrimination. The issue of gender discrimination was considered a more relevant issue with respect to worker/patient relationships as well with respect to hierarchy, managerial styles, and so on. It is true that some people are aware of the possible effects of the intersection between gender and nationality: "*If women already find it difficult to show what they are made of against the average patient's expectation, well, I suppose that foreigners may experience the same, not to speak about foreign women…*" (PUBNS).

The need to "get along well with everyone" is also determined by the existence of two hospital organisation levels: a formal one (that of hierarchy, protocols, formal supervision by HR, medical management and supervisors in general); and an informal one (that of daily practice, teamwork beyond individual responsibilities, informal supervision between colleagues, etc.), which becomes very relevant during the adjustment period, the management of doublets,[17] shifts, or guards and vacations.

For this reason, it is advisable to get along well in order to obtain "favours" at an informal level to organise holidays, swap shifts or do doublets. Even though interviewees initially referred more to favours requested by supervisors, most such exchanges of favours (e.g. swapping shifts or days for personal reasons) occur between colleagues, favouring the creation of affinity groups. Moreover, the HR manager of the private hospital argued that there is no indication that being a foreigner (or a woman) has any influence on their willingness to do extra shifts, which are usually voluntary, or to perform other types of less attractive duties.

3.4. Workplace integration as a question of immigration legislation

3.4.1. The general recruitment system

EU doctors currently working in the public hospital very much appreciated the opportunity of doing their specialty training in Spain (PUBREU1, PUBREU3, PUBREU2). They particularly valued the fact that they are not affected by the cap on foreigners, as is the case for non-EU doctors. As stated above, the current 4 per cent cap on foreigners which was *de facto* dropped between 2007 and 2009, facilitated access to specialty training (see Background Report). In this respect, some native colleagues thought that this decision to lift the cap was far too permissive, leading to the entry of foreign doctors, even though interviewees did not always seem to know the exact functioning mechanisms of this instrument. However, critics or conflicts about *cupo* did not seem to affect daily coexistence in the hospitals examined.

[17] "Doublets" (dubletas) are double shifts.

> *[...] when one is in, nobody raises this question. It can be raised at an abstract level, about whether or not the threshold is necessary, and here the majority opinion would probably be that this limit is necessary. But once you have them on your side, then there is no more discussion, I swear.* (PUBDS1)

The relaxation of recruitment barriers during the economic boom not only affected access to the medical specialisation, it also permitted the entry of fully trained staff, particularly nurses. In this respect, the Romanian workers in the private hospital (PRIVNEU2 and PRIVNAEU) stated that their recruitment procedure was quite easy because it occurred after the accession of Romania to the EU in 2007. By contrast, the recruitment of Latin American nurses to work in private nursing homes was facilitated by bilateral agreements between Spain and countries such as Morocco and Colombia (PRIVNLA and PRIVNALA initially came to Spain to work as eldercare providers). Such recruitment procedures during the economic boom were perceived by trade unions as a form of salary dumping and deskilling:

> *We think that the Catalogue contains too many specialised doctors and nurses at present, who will probably go to centres for the care of elderly or dependent people instead of hospitals or ambulatories. We have tried to organise various meetings with the Ministry of Health to clarify under which conditions these people are brought into the country and are employed in the private sector because we are convinced that their employment represents a method of reducing costs* (UGT, 2011).

Despite criticism, access by non-EU MHWs to the Spanish healthcare sector was only restricted after the economic crisis: health care professions were deleted from the Catalogue of Hard-to-Find Occupations; the cupo for non-EU resident doctors was lower than before, and so on... Second, resident doctors lost their residence permits linked to specialty training after completing their specialty training. These steps represent an important barrier to labour market integration for non-EU MHWs without a residence and work permit or Spanish nationality. A significant number of Latin American MHWs in both hospitals, for instance, were able to progress in their careers after obtaining Spanish citizenship through naturalisation.[18] Changes in legislation have also promoted the use of alternative legalisation strategies. For this reason, two of the resident doctors interviewed hope to regularise their administrative situation through legal or common-law marriage with their partner. Other ways to circumvent the legislation, such as fake contracts in domestic service, are more questionable (PUBRLA3).

> *My R5 has just told me that it is much easier for somebody to sign a work contract as a domestic worker to clean houses, that it does not matter whether or not you are a doctor, and with this you*

[18] Recall that Latin American citizens in Spain can only apply for Spanish citizenship after two years of legal residence.

> *have your work permit, you regularise your situation to then sign a contract as a physician. Another colleague of mine says that no, that he would rather leave than legalise his situation with a contract stating that he cleans houses, that he is a doctor and that he has his specialty training*. (PUBRLA3)

Changes in legislation have also affected recruitment strategies in the private sector. One of the doctors employed at HOSPRIV believes that the company prefers to recruit people whose administrative situation is already regularised, rather than having to do the "paperwork" (PRIVDLA2). Another doctor stated that he is still "indebted" to his employers for having offered him a permanent contract, resolving the administrative problems he had to face (PRIVDLA1).

> *For this reason, I think that if you have a good CV, the question whether you are a foreigner or not…except if the papers imply some kind of trouble for the firm. [...] If you have these paper troubles, well if you have it, then it is understandable. I mean, you do not want trouble, you already have trouble looking for capable or incapable people, hence if it is easier in some way, and more so today, I understand that.* (PRIVDLA2)

One of the nurses interviewed (PRIVNLA) stated that other private centres tend to dismiss foreign employees before Spanish ones, which does not occur in her hospital.

> *In other workplaces, well, you hear about the things they do…I don't know. That they prefer to fire a foreigner before a Spanish person, or that they prefer to employ a Spanish person rather than a foreigner, in elderly care, for instance, where I still have friends, hence they tell you stories. But now, generally speaking, I think that things are bad for everybody.* (PRIVNLA)

In general, it seems that most interviewees are deeply affected by administrative issues such as the need to constantly their renew residence and work permits, which has an adverse effect on non-EU MHWs' sense of social belonging (as explained by PUBRS2).

> *I have several Latin American friends who have problems with their work permit from time to time; they are always dealing with paperwork. From this perspective, I indeed see inequality. I do not see it with colleagues or patients. But all the paperwork required by Spain [meaning the Spanish authorities] makes them feel very bad. They have to renew their NIE every year. But all the paperwork they ask, Spain makes them feel very bad.* (PUBRS2)

Problems especially arise at the end of specialty training. This seems to affect the public hospital in particular because of its very large number of resident doctors. The current healthcare legislation restricts the number of foreigners who can take vacant permanent positions because most of them are reserved for nationals and EU citizens. For this reason, recruiting foreign doctors as "*eventual non-permanent staff*" *(adjunto fuera de*

plantilla) is an absolutely exceptional situation, requiring a great deal of discretion. And this may create conflicts between workers (PUBDLA1, PUBDLA2).

> *I think that immigrants' problems lie more in the state and the laws that make everything more and more difficult. They realise that it will get worse in the future, they make things difficult and the majority of the difficulties are caused by them rather than by colleagues.* (PUBDLA1)

In sum, restrictions due to immigration laws and regulations for non-EU healthcare workers as a consequence of the economic crisis have affected the integration of MHWs and their sense of belonging. Moreover, spending cuts in healthcare are reinforcing the image of MHWs as a labour surplus that can be cut (PRIVDLA2, PUBRS2, PRIVNAEU). In this regard, it is worth noting that some non-EU MHW are sympathetic to the principle of national priority (PRIVRLA1, PRIVRLA2, PUBRLA3). On the other hand, some nursing assistants are concerned about this situation and try to defend themselves against these opinions, blaming them for "*taking jobs away from Spaniards*" (PRIVNAEU, PRIVNALA).

3.4.2. Foreign credentials recognition

Medical staff

According to Spanish legislation, foreign credentials recognition is conditio sine qua non to participating in the MIR examination or working as a specialist doctor. For doctors trained in the EU, the recognition process is simple, easy and fast (PUBREU1, PUBREU2).

> *There was an enormous difference between being and not being an EU citizen. We started our credential recognition in Argentina, before we were EU citizens (my husband is also a doctor, from Bulgaria) and it was a very cumbersome procedure, which took a lot of time. We almost gave up. Suddenly we became members of the European Union and in six months, or something like that, a very rapid issue, the problem was resolved.* (PUBREU2)

In general, the recognition procedure of non-EU doctors' qualifications is more demanding. However, in the case of Latin Americans, the recognition procedure depends to a large extent on agreements with Spain and on the university where they studied (PUBDLA2, PUBRLA1, PRIVRLA2). However, most interviewees d that the procedure is unreasonable, slow, cumbersome and expensive (PUBRLA1, PUBRLA2, PUBRLA3), even though some interviewees still considered it quite simple (PRIVRLA2). It is worth noting that one of the Latin American doctors interviewed (PUBDLA2) had difficulties in getting his visa due to delays in his foreign credentials recognition procedure.

In general, interviewees had no idea about the criteria applied during the recognition process. Some felt that the duration and outcomes of the process are random, and that luck plays an important role (PRIVDLA2,

PRIVDLA1). They did not understand why some people managed to have their credentials recognised before others, which consequently produces a feeling of vulnerability and uncertainty (PUBRLA1).

> *She and me, despite having an almost similar grade, good grades, and despite coming from the same university, she was required to present her exams for some kind of equivalence test, but I was not.* (PRIVDLA2)

> *I succeeded, but it may have been a different case and I would not have been able to take the job. The feeling we have is that everything is random. If you are lucky in that your official is quicker at processing your file, then…* (PRIVDLA1)

In the past, candidates could apply for the specialty training examination while their foreign credential recognition was being processed. Applicants were only required to prove that they had initiated the recognition procedure (Finotelli 2014). However, things have changed, and it is now necessary to obtain recognition three months before sitting the examination (PUBRLA2). According to some interviewees, a number of private hospitals seem to be more careful at present about recruiting healthcare professionals with no professional experience or training in Spain (PRIVDS2).

Some of the doctors interviewed also felt that recognition procedures lack a fair and objective evaluation scale in order to recognise adequately the grades obtained in their country of origin (PUBDLA1, PRIVDLA2, PRIVDLA1). According to them, this reduces their possibilities of gaining a training slot because the score obtained in the MIR examination is the average grade of the examination and the academic average grade (PRIVDLA1).

> *It is a very protectionist system because of its strong filter for foreigners. First, the cut-off grade is established by adding the average of your grades to your exam result. These two things are added and give you a number. The problem is that Latin Americans' degrees are always homologated with "sufficient". My grade was "excellent", if in [the interviewee's country] the maximum grade was 5, I had 4.7. But the grade on my credentials recognition certificate was "sufficient". Maybe different things happen in the case of other countries, maybe with Japan or the U.S. things are different. For this reason, we Latin Americans are forced to do a different exam, which puts us under greater pressure.* (PRIVDLA1)

In the past, the problem of recruiting doctors without an officially recognised qualification[19] sowed distrust towards non-EU MHWs trained outside of Spain (PRIVDS2). In fact, the period in which more falsification

[19] This problem regarded mainly doctors that did their specialty training abroad. However, none of the interviewees did his/her specialty training abroad so that it was not possible to further develop this question in this study.

cases occurred corresponded to the years when there was the greatest demand for healthcare workers (PUBDLA2, PRIVDS2). Foreign doctors also have to bear in mind that they would have to have their Spanish specialty training recognised in their country of origin if they wanted to work as a specialist there. Hence the choice of specialty also depends on the existence of the same specialty in the country of origin.

Nursing staff

Nursing staff belong to two different professional categories: nurses (with a university degree) and nursing assistants who do not need to have a university degree. Recognition procedures mainly concern nurses with a university degree. Again, EU nurses (PRIVNEU2 and PRIVNEU1) had no problems having their degrees recognised, even though in two cases the procedure took between eight and nine months. As far as Latin American nurses are concerned, recognition depends on how long they studied for (PRIVNLA studied for five years and is now a recognised nurse, while PRIVNALA only studied for two years and may only work as a nursing assistant).

In principle, all nurses in Spain should have an officially recognised qualification in order to be able to work as a nurse. However, there were feelings that some private centres may have been less demanding in that regard during the economic boom (PRIVDS2).

3.5. How MHWs perceived their added value and contribution to the hospital and the relevance of diversity management

3.5.1. Perception of MHWs' added value

The first part of this report highlights the fact that supervisors and heads of services do not think that "being an immigrant" is a value *per se*. However, the MHWs interviewed, especially those working at the private hospital, argued that their native colleagues and Spanish employers particularly value foreign workers because they are not problematic, they do not create conflicts or complain, they are always ready to help, they adapt quickly and get along well with the rest of their colleagues. In this respect, the perception of their supervisors' opinion is in line with the stance taken by the private HR management about how healthcare workers should behave: "*healthcare workers must be very flexible*".

Moreover, several MHWs considered their clinical experience in the country of origin as an added value compared to the deficiencies they observed among native colleagues in this respect (see Section 3.3.). As was seen, native colleagues as well as doctors and supervisors in both hospitals share such a perspective in the case of Latin American resident doctors and nurses (whose more extensive training and practice are recognised by their superiors, doctors and colleagues alike) (see Section 3.3.). Some MHWs also stress the importance of knowing other languages, such as English (together with Arabic or Russian), which is useful for

research tasks, translating, and treating important patients. In fact, the private hospital managers also consider the knowledge of foreign languages an asset: "We have more and more Arab patients and I also have Arab doctors. I also have a Russian doctor. It is an asset."

Native colleagues, supervisors and the HR management think that MHWs are beneficial for organisational issues such as vacation planning. Indeed, South American MHWs do not insist on taking leave in summer, preferring to take it in autumn when prices are lower. People from countries with different religions (Arab or Eastern European countries) also make vacation planning easier because their festivities do not coincide with Spanish ones. As the (Latin American) medical manager outlined, this positively affects organisation in the company: "*We foreigners make their life easier!*"

Finally, MHWs thought that their presence represents an added value for the Spanish National Healthcare System because they can provide a new vision and some constructive criticism for its improvement thanks to their knowledge of different healthcare systems. In this respect, many critics referred to the excessive specialties 'compartmentalisation' of the Spanish system, which is bound to restrict doctors' professional future and to accentuate the fragmentation of patient care. There is also criticism of the obligation to choose a specialty without any previous medical practice (previous medical practice would be useful to enable the physician to develop a preference for a particular specialty). All in all, foreign resident doctors prove to be more critical towards the Spanish training system and have suggestions and initiatives to improve it. This is what a former resident of the public hospital reported:

> *I did my specialty à la carte (italics added) in this way. Many people 'took my neck' for being a foreigner, "you come here and you set your own norms." But I simply asked the hospital and teaching (the department of teaching, A/N) gave me permission. I rotate in surgery and they told me: "What are you doing in surgery?" The same occurred in other clinical fields that I considered of interest to complete my knowledge. But they took it badly, because here they rely on customs and the custom is to take on laboratory work in your final years. When they realised that I got out of the lab to go to other services, they got a bit angry. Now I see that other resident doctors are doing the same thing. But I think I was the one who paved the way.* (PUBDLA1)

The debate on the added value of foreign workers seems to be particularly relevant for nursing staff. Several MHWs belonging to this category reported that nurses in Latin America are much more valued by doctors due to their training, their wide experience and fields of work, as well as their close and continuous treatment of patients. They believe that nurses in Latin America are allowed to think and contribute more than in Spain. This is why some of the Latin American healthcare workers interviewed, for example, urged their companions to change their daily attitudes towards doctors and trainees:

> *And I tell them. Do not be conform with what the doctor tells you. Ask him! Ask him! […] It is not about being gossipy, but to learn. […] In this way, he sees something different in you than a nurse. They see that you can react, that you also think that you can also take a decision. Or that they sometimes do not notice something after having checked a patient. It is this I am referring to. There are many things, this is a cycle. A small cycle from the nursing assistant to the doctor, a cycle that has to go on. And with one common good: the patient.* (PRIVNALA)

3.5.2. Perceptions of diversity management

Perceptions of diversity management are somehow contradictory. On the one hand, interviews indicated that diversity management is not considered a relevant issue in both hospitals. In both hospitals, the small number of MHWs is deemed to allow a certain degree of improvisation without the need for formal regulation in this respect. Nevertheless, at the same time they suggested that if the number of MHWs was higher, diversity would certainly become a problem. Some interviewees – both doctors and nurses – admitted that the limited number of foreigners in hospitals could explain why some patients are not used to dealing with foreign staff and why potential refusals and conflict situations could arise.

In the same vein, both native and MHWs stated that there is no need for diversity management measures since there are not very many differences between native and migrant workers (interestingly, almost all of them interpreted the lack of difference as the absence of Muslim staff). In this regard, they argued that the only "ethnic conflicts"[20] that can possibly emerge have to do with patients' attitudes of rejection or distrust. However, such attitudes are usually seen as a consequence of patients' and their relatives' difficult conditions. Some may unload their anxiety and tension onto staff, arguing about everything. In such cases, offensive words may not only refer to a healthcare worker's origin, but also to his or her physical appearance or gender. Nevertheless, these were referred to as isolated cases without need for specific policies.

The low relevance of diversity management seems to be related in some cases to MHWs' integration concept, which ranges from assimilationism to the concept of mutual accommodation (or interculturalism – *interculturalidad* – according to the terminology of the current Spanish debate). The interviewees' views, for instance, ranged from statements such as "*I have to integrate myself, I have to integrate myself*" (migrant doctor private) and "*they have to accept us more readily*" (PRIVRLA2) to mixed positions such as "*My way of seeing the situation is that when you go to a country they have to accept you and you have to try to adapt yourself*" (PRIVRLA1). In this respect, it was observed that the more integration is perceived as a personal responsibility, the less they consider diversity management to be a relevant issue: "*I believe that it is not*

[20] Terms introduced by the interviewers.

necessary [to put into practice specific measures]. I believe that everyone can integrate perfectly, if he/she is willing to do so" (PRIVNEU2). And therefore such integration is the result of an effort to integrate and do the job well.

Notably, MHWs who arrived to Spain at a very young age stated that diversity management would strengthen differences. "*If we paid attention to how somebody works rather to where he comes from, then I think there would not be any integration problems*" (PRIVRA).

On the other hand, native staff members explained why diversity management measures are unnecessary, referring to the lack of racism in Spanish society: they said that racism was "before", during the dictatorship, whereas now Spain is a modern, open-minded society, where everyone can develop professionally irrespective of their origin. The only exception may be "*older people who grew up with this mentality [mentality developed during the dictatorship A/N] and who may discriminate at some point…*" (PRIVRS1).

> *Spain is diverse. What are they going to teach if you walk on the street and you see a multilingual city? Before it was London, now it is Madrid, we are all very used to it, if you go to pick up any child from school, you see a Chinese child, a little black child…I don't think anybody came to explain to us how to live together.*
>
> *I think that the Spanish mentality is very modern and very open to the entry of all types of people, wherever they come from, if they engage in their job, in doing what they have to do and in being good professionals, of course, because if you are a bad professional they will not like you. But as long as they are good professionals and good people, it does not matter where they come from. I have never seen discrimination, in any sense.* (PRIVRS1)

To sum up, both the positions of native and migrant interviewees consider integration to be an individual process based on professional competence, which does not need to be guided by specific policies. Once more, individual professional capacity outweighs ethnic diversity, which also influences the perception of which measures could improve MHWs' workplace integration.

3.5.3. Suggestions for improving workplace integration

Most of the MHWs interviewed argued that a better management of workplace integration would benefit from the improvement of administrative situations. The need to renew residence permits or to apply for residence permits after specialty training negatively affects the feeling of being integrated. There was also a (more concrete) demand by Latin American nursing assistants for advanced bridge training or credential recognition procedures to increase their chances of getting a nursing degree. Native staff suggest measures for foreign

newcomers such as an office or a guide to help them with housing, language or education matters upon their arrival in Spain.

The MHWs are generally not in favour of specific communication channels against discriminatory attitudes or of resolving conflicts between foreigners and natives because they believe they would not work. They argued that complaints against discrimination would be considered a sign of weakness, and may turn out to be counter-productive. They also added that narrow mentalities can only be changed if people travel and get to know other countries. Some even argued that it is impossible to change natives' prejudices or stereotypes.

In fact, both native and MHWs pointed to a lack of general measures (not necessarily focused on ethnicity) for resolving conflicts and improving workplace organisation.

In both hospitals, employees suggested that supervisors should play a more active role in this respect by distributing formal information about the responsibilities of each professional category as well as by playing a more central role in integration and conflict prevention issues.

> *Well, I think that yes, it would be good to resolve a conflict if it avoids escalation. […] I think that this would be more of a duty for supervisors, to talk with staff, to investigate and do a closer follow-up. Because sometimes they talk to staff if a conflict arises, but do not address the origin of the conflict, as they do not work with us, they sometimes simply form an opinion, and they see it from an external perspective. For this reason, it would be interesting if they got more to the heart of the problem.* (PRIVNAS)

Interviewees also highlighted the importance of the integration period for any healthcare worker coming from another hospital or service. They suggested extending the duration of this integration period for new personnel, giving newcomers the right to ask questions and voice doubts, and formalising the role of colleagues and supervisors.

In general, employees demanded more meetings within each service so as to know at all times what needs to be done, enabling them to work in a more organised and comfortable way:

> *I think that in each service we should have a meeting to decide a little how to do things, what to do in the case that…. I think it would be good in every service. Each service has a specific way of working and each service has its own staff. "Hence, if you perhaps had a meeting with your supervisor and she showed you how it works, how everything is organised, what has to be done in each case, what has to be done in a concrete case, you work more confidently, because you know how to organise yourself. You and everybody. You have a protocol and you know this would be good. Hence I think that there should be more meetings in this sense. Not only with foreigners. Staff meetings in general, about work, to work more comfortably and in a more relaxed manner, and to know, to have everything very well organised.* (PRIVNS1)

In the same vein, particularly MHWs in both hospitals asked for channels to present their ideas, like a "suggestions office", and to be involved in the definition of protocols:

> *[specific measures?] I do not know, they could include us in some type of protocol in things that….what occurs is that ours is a general field, things are done as the oldest members have done them, to say the oldest people have done them. And sometimes it is difficult to change these things even if you provide many reasons for it. Hence, I think that maybe they could… also include the staff, foreign and native, to see how things could be improved somehow, I don't think they do this very often here. (PRIVNLA)*

In any case, interviewees reiterated that these measures should be defined and applied at a very local level, within small units (e.g. small services or work teams) due to the hospital-specific organisation. They also mentioned the possibility to benefit from the knowledge of healthcare workers who trained elsewhere, who have a different type of experience or who are doing their second specialty training.

3.6. The transnational dimension

There is little information about foreign physicians' will to return or intention to move to other countries in search of better employment options. In this respect, the Ministry of Health is currently working on comprehensive statistics on the presence of foreign doctors in the private and public sector. There are two reasons for compiling these statistics. First, the intention is to gain greater knowledge of the dimension of this professional group in Spain so as to plan future professional needs better (and hence the offer of training slots). The second aim is to assess the mobility patterns of foreign doctors, i.e. whether they intend to remain in Spain after specialty training or return to their country of origin or another European country. As the high public official of the Ministry of Health explained:

> *The survey will also ask them about their future intentions. We are interested in knowing what these new specialists want to do for two reasons. We are interested in planning because if they all decide to leave in the medium term, this could create an offer problem, but also because Spain, as a member of the EU, has signed a good practices code* (MSSSI).

Despite certain preferences for circular migration patterns ("We consider specialty training as a form of circular migration"), the public official interviewed admitted that the Ministry of Health would principally not reject solutions that allow foreign doctors to remain in Spain if they wish to do so.

However, for most of the MHWs interviewed, returning to the country of origin is the less attractive option at present, although intentions may change according to the interviewee's position. Not surprisingly, physicians who are permanent staff members do not intend to return to their country of origin or to move to another

country. In contrast, some few resident doctors interviewed are considering the possibility of returning to their country of origin (at least in the short term). As the interviewees outlined, there are manifold reasons for not returning, such as the lower level of technology in their home country and low salaries, as well as family or personal reasons. However, interviewees were also aware that that they have a slim chance of finding a job in Spain due to the poor economic situation and their difficult access to a legal work permit. Such a dilemma was summarised effectively by one of the resident doctors interviewed.

> *Salaries there [in the country of origin] are lower, I am not talking about quantities, but about the equivalence between (national currency) and the euro, about your salary's purchasing power. To tell you the truth, I do the numbers and it would not be a good idea. Also from the emotional point of view; if you come here to improve to do things the right way. At the psychological level, it would be like going backwards. I think more about, at the moment of my training, moving to another European country, now that I have the nationality, the passport, and so on. Where my CV is more valued, taking advantage of the offer of having better prospects. What do I see now in Europe? Well, that the salary in Spain is one of the lowest; we do not expect many job opportunities to come up in the medical sector.* (PUBRLA1)

Consequently, most of the interviewees are looking at other countries such as Germany, the United Kingdom or even the Arab States to improve their employment prospects. Only one of the resident doctors interviewed referred to mobility as a form of lifestyle after having left one's home country:

> *Once you leave your country, I think we become nomads. Once you leave (your country of origin) to live in another country, well you already think about coming back, but [...] I will come back at the age of 60 or 70. But once you leave your country, you do not mind going wherever you want.* (PRIVRLA2)

Interestingly, none of the nurses or nursing assistants interviewed had any intention of returning to their country of origin, mostly due to the worse employment conditions. They saw no possibility for improving their professional situation in their country of origin and a couple of them would rather think about moving to another European country, if necessary. Returning to the country of origin was seen as something that may occur in the long term, maybe at the end of one's life.

> *There are things that never change...roots are roots. Hence, you would always like to die where you were born. And if not, somebody should take you there. I, at least, tell my colleagues here, if I had to die today, incinerate me, buy a vase in the Chinese shop and send me back by ship. On the contrary, I come here and I pull your hair I would not let you work...then, under such a threat, who would not do that for me? (laughing)".* (PRIVNALA)

Despite the impressionist evidence provided by interviewees in this study, physicians' and nurses' mobility paths or intentions are undoubtedly embedded in a complex mix of factors made up of personal reasons, the legal situation and structural factors such as employment opportunities, which go far beyond the "circular migration" option often desired by public officials.

Conclusion

Neither the Health ministry policy agenda nor the HR departments of the hospitals interviewed mentioned diversity management as an instrument for workplace cohesion. The lack of diversity management policies at the institutional level certainly reflects the secondary role that integration policies played at both state (autonomic) and federal level for many years in Spain (Cebolla-Boado and Finotelli 2015). The lack of interest in integration measures at the hospital level should not come as a surprise either, considering the low rate of foreign health care professionals in Spanish hospitals. In such a case, integration is usually perceived as a spontaneous process and conflict resolution something that can be achieved 'on the fly'.

Despite the scarce relevance of diversity management policies for policy makers and in hospitals, our case studies reveal that there are no particularly remarkable difficulties with respect to the integration of health care professionals. The level of socialisation, for instance, seems to be very high in the public hospital due to the large presence of resident doctors sharing the same life course in the same location. Coexistence difficulties are more nuanced, particularly affecting Latin Americans, whose groups form the majority of opinions collected in this study. In this respect, interviewees mentioned that the way Latin Americans speak Spanish may be an object of criticism. As was seen, the question here does not regard the level of knowledge of the Spanish language, but much more the question about different varieties of Spanish and their use in daily working life. In contrast, the issue of religious diversity is almost completely absent in the interviewees' reports.

The perception of labour market integration in administrative terms seems to be more problematic. As was seen, the majority of the interviewees believe that the current legislation prevents the full labour market integration of health care professionals due to the precariousness of the contracts offered and the existing barriers to permanent employment, such as possession of Spanish or EU nationality. Another important aspect concerns foreign credentials recognition as, especially in the case of nurses, down-skilling as a consequence of the difficulties regarding foreign credentials recognition represents a source of dissatisfaction for many nursing assistants and a barrier to full labour market integration.

However, and despite the above-mentioned difficulties, it can be stated that ethnic diversity does not seem to seriously affect the workplace integration of health care professionals in the public or private hospital. In fact, workplace integration is not perceived as a cultural problem to the extent that health care professionals adapt

to the way of working and establishing relationships in each hospital. Yet, professional rather than cultural assimilation is required.

In this respect, it is important to note that health care professions have strict professional, behaviour and dress codes, as was observed in the interviews, and that there are other more important types of differences than ethnic differences. In particular, interviews revealed that the hierarchy among health care professionals within the hospital fosters employment relationships, where the difference between professional categories is more important than ethnic diversity. Furthermore, the same hospital's stated mission "where we are all working for the patients' well-being, in which we all go towards the same objective together", contributed to favourable conditions against discrimination. Eventually, and as some nurses in the private hospital highlighted, the need to work together very closely for many hours undoubtedly represents an incentive to soften conflicts and find a meeting point.

To sum, it is no exaggeration to state that the two case studies provide an optimistic view about the workplace integration of health care professionals, despite the absence of *any* measure of workplace integration. Notwithstanding this, such a result should not stop us from reflecting on the need for such measures at the institutional and hospital level. Yet, there may be a need to pass from a generalised laissez-faire optimistic attitude to a more proactive integration approach. In fact, we cannot exclude the fact that the prominence assigned to professional codes may have overshadowed possible cases of discrimination. In addition, it should be reminded that if relationships between colleagues do not seem to be affected by questions of ethnic diversity, this does not seem to apply to the physician-patient relationship. As was seen, xenophobic attitudes and coexistence problems were observed in specific cases of the doctor-patient relationship. In this respect, it is important to note that the ministry's and hospitals' action protocols take into account the cultural and linguistic diversity of immigrant patients to only a very small extent. It is therefore not surprising that the same occurred with the diversity of health care professionals. In addition, it would be advisable to consider establishing better internal communication channels in hospitals in order to prevent conflict situations. Finally, interviews revealed that, in contrast to institutional representatives' expectations, most interviewees do not aim to return to their country of origin. In this respect, it would be advisable to think about creating stabilisation channels of health care professionals based on the assessment of their professional qualifications. This would extract maximum benefit from the sector's human capital, avoiding the instrumental use of other stabilisation channels such as naturalisation.

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ANNEX: Coding for the interviews:

Hospital

PUB	Public
PRIV	Private

Professional category

HR	Human Resourses
D	Doctor
R	Resident doctor
N	Nurse
NA	Nurse assistant
T	Technician

Origin

S	Spain
EU	European Union
LA	Latin America
A	Asia
AF	Africa

Interviewees with the same characteristics (hospital, category and origin) have been distinguished by a number after the corresponding interview-code.