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Relationships and reputation: Managing intercultural health communication issues

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Abstract

This study highlights the role of managers in workplace communication in a publicly funded health system in Aotearoa New Zealand, and positions issues surrounding intercultural communication in the system as a public relations dilemma. It also explores the significance of 'indirect' reputational effects, arguing that interpretations of managerial reciprocity and empathy demonstrate such effects, with consequent implications for the standing of the public health structure subsequent recruitment. In this research, trust and reputation were found to reside in networks, with managers seen as nodes of dysfunction: experience-based trust has its limits. While the paper identifies challenges, it also offers areas where indirect reputational risk could be mitigated through effective communication, especially by focusing on building trust through fostering collaborative and reciprocal relationships. In the New Zealand setting, nurturing intercultural workplace relationships and communication was found to result in improved outcomes.

Keywords

intercultural communication; risk and reputation; management communication; teamwork; registered nurses

Introduction

This paper positions internal communication issues in a publicly funded New Zealand (NZ) healthcare system as, collectively, a public relations (PR) quandary arising – in this study – largely from managers' difficulties in communicating with a culturally diverse nursing workforce. It is a PR dilemma because communication is integral to public relations work. Broadly, however, interpersonal communication is neglected in PR textbooks, and 'true communication skill requires more than just speaking, reading and writing. It involves those behaviours to influence the attitudes and behaviours of others' (Doorley, Garcia & Hauser, 2015, p.115, in Theunissen & Sissons, 2017, p. 194). The findings here support the importance of the 'personal influence model' of public relations, which focuses on practitioners using their

personal networks to solve organisational problems (Theunissen & Sissons, 2017, p.200). Influence may be constructive – or not – while exceptional interpersonal communication is an attribute of effective public relations practitioners (Theunissen & Sissons, 2017), outcomes of miscommunication have reputation effects which can influence cooperation (see Hermann et al., 2012).

Reputation is a central public relations concern. The Chartered Institute of Public Relations defines PR as 'the discipline which looks after reputation' (*About PR* – CIPR, n.d.). Reputation effects of miscommunication arise not only directly, through ineffective dyadic interactions, but also indirectly, by contributing to the development of a culture whose dysfunctional aspects help shape the system's standing, influencing trust amongst both present and potential stakeholders. There is a positive relationship between culture and reputation (Flatt & Kowalcyk, 2008). However, the linkage is not always traceable by way of a straight line: rather, it may be indirect. Some studies examine indirect reputation in both humans and animal relationships, investigating its role in decisions both species make to cooperate or not (e.g. Bueno-Garrera et al., 2020; Yoeli et al., 2013). This study makes an important contribution by applying the concept of indirect reputation to workplace communication dilemmas and their outcomes.

By 'indirect reputation effects', we mean those deriving from actions or omissions within the organisation – but which are not susceptible to straightforward cause-and-effect analysis. Such indirect effects could include staff responses to managerial communication behaviours, especially when the managers are engaging with a highly heterogeneous workforce. Negative responses, referencing issues such as ignorance of, or indifference to, language barriers, can flow into an ongoing trust deficit through a lack of reciprocity and empathy. The result is an unfavourable reputation for the health system and its leadership, resulting in an exceptionally high staff attrition rate, associated difficulties in recruitment, and an unstable employment environment characterised by unproductive 'them-and-us' attitudes.

We suggest that the notion of indirect reputation effects warrants further study, as it is under-developed in the extant literature, including that of public relations. Crisis and reputation scholars are familiar with studies of issues where causal attribution is relatively clear, such as criminal acts committed by organisational leaders or product failures and contaminations whose origins are quite easy to determine. In contrast, identifying indirect reputation effects may require using techniques such as detailed network analysis. Examining these effects becomes even more important when (as in NZ) they lead to costly human resource challenges. Drivers impacting the long-term reputational standing of organisations can affect healthcare providers, among other entities (Louisot, 2004, p.35).

This medical context is fraught with challenges as host nurses and foreign-trained colleagues negotiate their professional interactions. A contributing cause to such communicative difficulties lies not only in the rational, scientistic mindset which dominates health-related professions but also – and, arguably, increasingly – in culturally-defined understandings of appropriate clinical behaviour. Internationally, health workforces often blend staff from a variety of countries and cultures – employees who carry with them assumptions that frequently diverge from those of the host culture, including normative beliefs about how the healthcare system should function. These differences may extend to what 'counts' as communication itself and to various culturally mediated conceptions of what effective workplace interactions

look like in practice. These complexities impact the healthcare environment in NZ where all Registered Nurses (RNs) need to engage productively with an ever-more diverse cohort of foreign-trained migrant colleagues. Workplace interactions may have an indirect as well as a direct bearing on RNs' experiences, and subsequently, the reputation of healthcare organisations as employers of choice.

To explore these effects, we use qualitative interview data to investigate the management of interactions between host nation RNs and migrant RNs from diverse ethnicities in hospital clinical environments. The data comes from a study carried out between 2015-2016 to investigate intercultural influences on workplace communication, perceptions and practices of RNs working in culturally diverse healthcare teams. The emphasis in this article is the role of managerial communication and practice, which was found to have a significant bearing on the workplace experience not only of migrant but also of host nurses. While studies from a single cultural perspective offer value, often – as with much healthcare research – the voices of others are largely absent. This is a significant limitation, given that competent inter-professional communication underpins effective and safe teamwork (Graye, n.d.).

Background

Members of society rely heavily on quality health services, which are central to their overall wellbeing and health. The standard of these services is directly influenced by the availability of health professionals who are ultimately accountable to the public for reliable and appropriate care. However, in turn, healthcare organisations also depend on their reputation as employers in order to attract an international workforce to complement local hires. International staff are important because there are shortages of suitably qualified local health professionals. Therefore, reputation becomes salient in recruitment, just as reputation-building tactics are used by a rising number of companies to make themselves more attractive to prospective and current employees (Fombrun & van Riel, 2004).

All health providers operate in a competitive market for attracting international health professionals. Reputational capital (e.g., Cronin, 2016) plays a key role in health professionals' decisions as to where to work – and stay. Globally, nurses and other health professionals are a mobile population (Kingma, 2008; Pung & Goh, 2017). Throughout OECD countries there is a sustained shortage of RNs (Ono et al., 2013) with an estimated world shortage of over four million RNs worldwide (World Health Organisation, 2016). As Moloney, Gorman, Parsons, & Chueng (2018) argue, because RNs are the largest group of professional staff in healthcare, nursing shortages are of significant concern as they impact negatively on cost, patient care and staff morale. They also predict that the present ongoing shortage is compounded, as by 2035 over 50 percent of the current local RN workforce will have retired. However, not only do healthcare organisations need to recruit more RNs but also they must reduce high levels of attrition, which is also costly (Brown, 2018; Bulman, 2017). For example, in the aged care sector in NZ, in the prior 12 months, turnover rates for nurse/clinical managers and RNs were 15.6 percent and 37.8 percent respectively (McDougall, 2018): expensive and unsustainable long-term.

While reputation is an intangible asset for organisations to create a competitive advantage, including in recruiting staff, it also is important for retaining them (Winkler & Lukasik, 2019, p. 41). To be effective in these areas, management must be of a

quality consistent with the image portrayed: when expectations between the healthcare organisations and its nurses are disparate, the result is relational instability, as is the case in NZ and also in the UK (Maben, Latter, & MacLeod Clark, 2006). In both countries, nurses have taken strike action to signal their discontent and concern about unsafe staffing levels, lack of resources and inadequate pay (Jones, 2017; Roy, 2018; Triggle, 2016). Within the New Zealand nursing workforce, 25 percent of nurses qualified outside of New Zealand; and in the past decade these nurses have made up 50 percent of all new RN registrations (Nursing Council of New Zealand (NCNC), 2013). Recent analysis indicates that 55 percent of migrant nurses come from the Philippines and 20 percent from India (NCNZ, 2016). Host nurses are predominantly of European and British descent, with a small percentage of indigenous and Pacific nurses. (For a fuller discussion on the role of migrant nurses in the New Zealand context, see Jenkins & Huntington, 2015).

While communication can be a taken-for-granted 'good' in workplace settings, in healthcare, it takes on an added, critical dimension: with patient matters, misunderstanding can sometimes result literally in life or death. One reason is that, as Best, Hiatt and Norman (2008) note, actors within a system 'can share common goals but have different priorities and methods of inquiry' (p. 325). There is a need, they contend, to reconceptualize 'the role of communications as a central strategy in providing the 'glue' for connections between people and organisations' (p. 325). Given, therefore, that in healthcare, the stakes are high – and the differences to which the authors refer – this article explores the communicative aspects of a culturally diverse workplace using a NZ hospital clinical setting as a case study context.

In this article, we will argue that indirect reputation effects can result from the interactions between RNs, managers and those they care for in the public health sector. Managers act as vital catalysts in developing the quality of relationships between healthcare organisations and healthcare professionals by fostering underlying trust through mutuality and reciprocity (Meyer & Smith, 2000). Employee identification with the goals of the organisation (May, Korczynski, & Frenkel, 2002) helps to establish a 'common-sense' way of understanding the world. Our data illustrate that, albeit inadvertently, managerial communication is acting as a catalyst for staff unrest and the high rates of staff attrition that pervade healthcare organisations both in NZ and internationally.

Literature Review

This study breaks fresh ground in an under-researched area, aligning with the emergence of the 'relationship paradigm' in public relations scholarship (Ki, Kim & Ledingham, 2015, p. xiii), which regards relationship management as a general theory of PR (Ledingham, 2003). Relationship management views 'mutually influential' relationships as the core of professional communication (Coombs & Holladay, 2010). On this basis, the absence of such relationships in a resource-constrained healthcare system presents public relations challenges and ***health system employees may be considered as internal publics – publics who make reputational assessments of an organisation that influence their behaviour.***

Reputation is based on what organisations do, say and achieve, making the concept largely perceptual and informational (de Quevedo-Puente, de la Fuente-Sabaté & Delgado-García, 2007). When public or direct reputation is founded on

information that is known to everyone, no individual has any particular information advantage over anyone else. However, when there is high information asymmetry, with little relevant data on which to base choice, individuals are more likely to trust credible indirect reputational information, shared through social and trusted professional networks to provide reliable information on performance issues or relational certainty.

It is the thickness and trustworthiness of information channelled through socially embedded networks that informs the concept of 'indirect' as opposed to direct or public reputation. Networks will emerge as a key factor under conditions of institutional and transactional uncertainty in interactions when individuals do not have specific personal experience of the organisation (Bachmann & Witteloostuijn, 2006). In such environments, trust is central to co-ordinate both expectations and interactions between individuals (Bachmann, 2001). Trust at the organisational level is a fundamental social quality that enables complex interaction such as the division of labor or the separation of performance and reward. The institutional framework of system or institutional trust coordinates actors' expectations and thus reduces uncertainty. At a personal level, trust based on previous transactions stabilizes interaction over time and embeds meaning, control, and solidarity into relationships under conditions of unpredictability. Once established, experience-based trust enables reciprocal and enduring transactions with trusted partners. As Kramer (2009) notes: 'We often rely on trusted third parties to verify the character or reliability of other people. These third parties, in effect, help us 'roll over' our positive expectations from one known and trusted party to another who is less known and trusted. In such situations, trust becomes, quite literally, transitive. Unfortunately, as … transitive trust can lull people into a false sense of security' (para. 16), with negative results when this trust is compromised by ineffective management practices.

Neves and Story (2013) showed that 'ethical leadership influences how employees view the organisation and determines their actions in the workplace'. They discussed how ethical leadership and reputation together resulted in 'combined indirect effects on organisational deviance' (p. 176). We therefore adopt the notion of indirect effects and reputation and apply it to the case of managers' communication behaviour in a health system workplace and the impact of this behaviour on the system's standing amongst stakeholders, with consequent ramifications for performance. We differentiate indirect reputation effects from the concept of networked reputation outlined by Glückner and Armbrüster in 2003. They suggested that in the management consulting market, experience-based trust and 'networked reputation' (p. 271) were the main drivers of competitiveness. According to these authors, networked reputation is different from both experience-based personal trust and from what they describe as public reputation. Public reputation 'segments the market into strata and competence areas'; networked reputation mediates reputation 'through business or private networks' (p. 271). While that mediation can occur through both formal and informal channels, our view of indirect reputation effects refers specifically to the impacts of social construction of reputation through an organisational grapevine – a communication vehicle which, as Delaney (2011, para. 3) points out, 'could lead to the detriment of an organisation's reputation as it may carry false and negative information and may lead to … hostility against superiors.' Flatt and Kowalcyk (2008, p. 13) found that corporate culture and reputation had both direct and indirect effects on corporate culture and reputation. Corporate culture is identified as a variable that can predict reputation (2008, p. 16). Flatt and

Kowalcyk comment that more research is needed to determine how indirect effects contribute towards a sustainable competitive advantage (2008, p. 27). We also suggest that given the paucity of scholarly literature on indirect reputation effects, more research is warranted.

With a service-based organisational setting, typical of healthcare, much of the indirect reputation is founded on the antecedents and consequences occurring in interactions between individuals. Although healthcare reputations are founded on standards and quality of patient care (Lee & Scott, 2018), they are also arguably important in the perceived standard and quality of *staff* care, thus the role of managers is integral to healthcare organisations on many levels. For example, Magnet Hospitals in the USA are recognised as having reputations that attract and retain quality healthcare professionals (Aiken, Clarke & Sloane, 2002).

In the reputation literature, Fombrun suggests that credibility and trustworthiness represent the distinctiveness of an organisation and therefore its reputational advantage:

> *A company's reputation sits on the bedrock of its identity – the core values that shape its communications, its culture, and its decisions (1996, p. 268).*

However, in public healthcare environments the inherent complexity of communication is also heavily influenced by spiralling costs, which spurs managerialist demands for ever-greater efficiency (Bulman, 2017, May 14). The result is conflict between these imperatives and contemporaneous calls for well-managed, cohesive teams to consistently provide safe care (Ajeigbe, McNeese-Smith, Leach, & Phillips, 2013). In this resource-constrained climate, the outcome for host nurses has been increased workload and missed care as they struggle to manage seemingly incompatible stakeholder needs (Willis, Carryer, Harvey, Pearson, & Henderson, 2017). Their concerns illustrate the fact that the implications of a nursing shortage extend beyond staff to all those they care for (Squires, White, & Sermeus, 2016; Twigg, Duffield, Thompson, & Rapley, 2010) – patients whose treatment could be compromised by culturally-based misunderstandings arising from interactions with managers.

Rational, scientific decision-making dominates the health sector. As Maddox et al. (2017, p. e826) point out, '[c]linicians and patients must make decisions that integrate the continually evolving scientific evidence base with hundreds of individual data points …'. Such contextual considerations apply not only to patients but also to clinicians and the health professionals with whom they work. As Crum, Leibowitz and Verghese (2017, p. 1) state, 'medical diagnoses and treatments are never isolated from patient mindsets and social context … Rather than being incidental to treatment, these psychological and social elements play crucial roles in determining clinical outcomes.' Patient safety undoubtedly requires strict adherence to proven procedures for care, but the procedures in themselves are not enough if they are regarded as a form of 'box-ticking' to be followed without regard for relevant factors also present in the clinical environment. Willis (2015, p. 686) cites Dreyfus and Dreyfus' argument that 'those who are expert and proficient in different fields do not rely on rules. Indeed, insisting that rules should be followed can undermine understanding of what really counts in these situations'.

Pure scientific precision might, on this basis, neglect the shifting dynamics of interpersonal interactions in healthcare settings, especially among those directly

responsible for patient welfare. Any healthcare service relies upon well-functioning team communication, effective leadership and communication to maximize positive outcomes for both its health professionals and those they care for. Migrant nurses struggle on many levels to integrate into foreign environments, as illustrated in many studies (e. g., Goh & Lopez, 2016; Pung & Goh, 2017; Walani, 2015; Woodbridge & Bland, 2010). However, communication and relationship building must be a two-way process. While some studies examine the experience of migrant health professionals, very few investigate the reality facing host nurses, who must work hard to incorporate rapidly-increasing ethnic variety represented by both their colleagues and those they care for. As Best et al. (2008) comment, this:

> *… recognizes that relationships are shaped, embedded and organized through structures that mediate the types of interactions that occur among multiple agents with unique rhythms and dynamics, worldviews, priorities and processes, language, time scales, means of communication and expectations (p. 320).*

Within these relationships, however, there may be 'contrasting assumptions [framing] what is considered "evidence"" (Best et al., 2008, p.321). Drawing on Lomas (2005) and Lomas et al. (2005), they assert that:

> *… evidence itself is not all that drives decisions; decision-making is also influenced by 'colloquial' knowledge such as expert opinion, political judgment, habits and traditions, culture and political pressure (2008, p. 322).*

Healthcare, with its requirement for interdisciplinary collaboration, is the quintessential setting where communicating across cultures with the associated imprecision and fuzziness that can be involved in confronting cultural nuances does not sit easily within such a highly objective framework. For example, because culture is a kinship system that also defines rights and responsibilities of members, cultural values are sometimes incongruent with other worldviews. As Ledingham (2003, p. 193) argues, 'effective management' is central to the process of ensuring 'mutual understanding and benefit' to strengthen positive communicative relationships and encourage staff retention in a diverse healthcare sectors.

Method

The research question which drove this research was: 'What are the key variables with the potential to influence organisational reputation?' The study used an exploratory approach involving qualitative feedback from semi-structured interviews (carried out by the second author) with 36 migrant nurses and 17 NZ registered nurses (NZRNs). After obtaining ethics approval from a university human ethics committee, a call for volunteers was made in the national nursing journal.

As the ethnicity of respondents was typical of the diverse national population, place of registration was the variable of interest. The NZ registered nurse participants included NZ Māori (2) NZ Pacific (2) and NZ European (13). The migrant RN sample included nurses who had first registered in the United Kingdom (8), China (5), the Philippines (11), India (9) and South Africa (3). Respondents' ages ranged from 21 to 60+ years and 46 were female, 7 were male. Years of practice as a RN ranged from 1 to 30 years, as did years practising as a RN in NZ. Participants were all currently employed in the health care service, working in 7 of the 20 District Health Boards, and responded to a call for volunteers from an advertisement placed in the national nursing magazine of *Kai Tiaki, Nursing NZ.*

The focus of the questionnaire was devised from the literature and related to communication experiences in the workplace. The interview questions were focused on eliciting detailed descriptions of nurses' experiences of learning how to adapt to the new workplace culture they were experiencing. Critical incidents (CIs) were used. A methodology developed by Flanagan (1954), it is appropriate for exploratory research as 'a set of procedures for collecting direct observations of human behaviour in such a way as to facilitate their potential usefulness in solving practical problems' (p. 327). It is particularly useful for providing insight into tasks that are complex and non-routine, which helped to generate insight into the type of occurrences that respondents saw as meaningful (Butterfield, Borgen, Amundson, & Maglio, 2005). Initially, the data were coded by each researcher, who independently reviewed transcripts to identify patterned responses, which were grouped into themes. Transcripts were then re-read and discussed to identify differences and decide on the final patterns. Thematic analysis demonstrated a number of challenges in the healthcare setting, as this initial coding was allocated to broader themes. One of the themes focused on RNs' experiences of their managers – the focus of this article. Thematic analysis served to explicate how members of the organisation constructed their own 'reality' in the workplace (Braun & Clarke, 2006). A secondary focus group with seven respondents, who previewed the identified themes, affirmed the findings.

Exemplar quotes will provide insight into the incidents that populated the data. Responses of RNs to the incidents demonstrate the potential of managerial communication to help address the current situation of flux. All of the quotes are anonymized to protect the identity of respondents. There is a corresponding identifier number for respondents (R+number), depending on where the RN had qualified, the variable of interest in this study, with captions of 'H' (host nurse) and 'M' (migrant nurse) throughout.

Results

The results illustrated that the role of managers was presented as central in creating an effective organisational environment to foster teamwork and cultural integration through enhanced understanding. However, respondents perceived that this outcome was largely not the case in their experience. There were negative interactions and outcomes from managers in three key areas, which undermined the reputation of the workplace. Conversely, there were also some incidents where respondents described positive outcomes from managers who did espouse empathic communication to engender trust and confidence in their staff – but most were not seen in this light.

Trust

Trust was key in both host and migrant nurses adapting to the ever-changing dynamics of the workplace. However, development of trust in workplace relationships was not always evident, as some reported that their managers were unwilling to address evidence of discrimination and racism. A host RN explained how she was caring for a family who were unhappy with the care. However, when she discussed the situation with her colleagues, she 'did not feel supported' (R05H). Similarly, a migrant RN described how her manager refused to acknowledge overt racism from colleagues. She explains:

> *Their behaviour was well known throughout the department and unfortunately nothing has been done about it (R47M).*

Developing trust is an interpersonal process. Leadership will directly influence the norms of performance and decision-making as well as the behaviour and intercommunication among workers, particularly if managers establish trust through recognition and commitment to encouraging staff. However, this was lacking. Unfortunately, on several occasions the manager's actions (or lack of them) appeared to lower trust between cultural groups. Nurses talked of feeling isolated and distressed at their managers' perceived lack of understanding and unwillingness to address issues that arose. For example, although likely unintentionally, the efforts of migrant nurses to integrate were undermined when they experienced management critique of their practice. One Filipino nurse reported,

> *I heard from our acting manager that our own facility manager had called us foreign nurses inexperienced behind our back. This brings down my confidence and self-esteem (R36M).*

Although migrant nurses reported that they felt their confidence was eroded by feelings that they were not treated as a valuable part of the team, this was not always the case. There was also evidence of some managers who worked on establishing a cooperative and personal environment to foster positive working relationships, which was valued by respondents. For example, managers did provide some migrant nurses with positive feedback on their initiative and actions. As one respondent, an Indian nurse noted;

> *I reported to the manager the next day… she appreciated my efficiency in tackling the situation smoothly (R46M).*

Even small gestures were meaningful. For example, as a male Filipino nurse related,

> *I believe that managers play a core role in addressing problems by asking new staff how they are getting on in the unit, every now and then (R50M).*

There is not only evidence that migrant nurses need to feel appreciated and have their professional status respected to engender feelings of success, there were also mutual benefits for host nurses in the same empathic environment which privileged the development of trust between RNs despite diverse beliefs. As one host nurse explained:

> *It is the challenge of blending cultures in one working environment that has positive outcomes for the patient (R15H)*

Empathic understanding

Although empathy is recognised as a key precursor to developing trust (Nadler, & Liviatan, 2006), this was not always evident in the data. For example, in one incident, a host RN wanted to report a significant intercultural issue involving a breach of privacy and said:

> *The manager replied, 'Don't' - it wasn't going to be listened to … I did what I could, but it was taken out of my hands – it was whitewashed.*

The respondent reiterated that not only was the manager not listening, but she wouldn't allow migrant nurses to come into her office (R12H). This may also help explain a consistent perception of migrant nurses that they had to work harder for

their colleagues' acceptance, while also dealing with the strangeness of a new culture, and at times, unfamiliar ways of doing things.

A lack of empathy culminated in stressful situations for respondents as they attempted to navigate their own way in the midst of the strange and unfamiliar. As a host nurse reflected, there was little time to interact and negotiate difference:

> *I cannot stress highly enough the personal cost to the current health environment when there are expectations, increasing expectations, but the same or diminishing resources (R41H).*

However, at the same time, managers can be distracted by 'constraints imposed by outside interests' (Grunig & Grunig, 1991, p. 259). In this case, they are constrained by the political interchange and the dominance of the neoliberal environment in which they work as they 'pursue and meet their goals' (p. 275).

Conversely, some nurse managers were aware of the benefits of investing time in developing understanding. For example, a hospice manager reported how aware she was of the need to take the requisite time for reflection so she could help develop team motivation and empathy through modelling behaviour. For example, she believed her responses had an active role to play in many of the situations she encountered, and explained,

> *At the same time for me there also has to be an element of self-questioning: is this relevant criticism, or how have I contributed to this happening? (R24H).*

The comments also included empathic responses from RNs who understood the need for empathy between nurses – not just for their patients:

> *It's that feeling of shame. Everyone feels disappointed or fed-up when they make a mistake, they know they shouldn't have (R09H).*

Reciprocity

Nurse managers recognised that establishing positive working relationships involved providing staff with leadership and opportunities to access helpful educational resources. As Allert and Chaterjee (1997) contend, building a vision of trust and enthusiasm is important, and listening and communicating are central to a positive organisational culture. Because of a lack of time, RNs did not always perceive that managers invested in their professional development and believed that their professional or personal wellbeing was not always an integral management priority. Misunderstanding was seen as a direct result of an intensive, pressured workplace which denied opportunities to invest in developing cultural insight with colleagues. The outcome was often dissatisfaction, producing indirect reputation effects. Some migrant nurses expressed a sense of isolation and lack of support. As one American nurse explained,

> *I had to re-invent myself and re-prove myself in lots of things (R42M).*

Although there were many examples of a lack of reciprocity, sometimes nurse managers did invest in host nurses, helping them to manage incidents in the workplace. As one host nurse reported,

> *So, managers who have good judgement and can support you see things through a different lens (R24H).*

RNs did recognise the value of learning together, reflected in the number who had sought advice from colleagues from other cultures about how to care for culturally diverse patients. In the words of one:

> *With effort put into them (migrant nurses) getting to interact with Kiwi [colloquial term for NZer] nurses to learn from each other … you come out with the whole being far better than the two halves that you've got at the moment (R41H).*

Another RN working in a supportive environment talked about her enjoyment of learning from her culturally diverse colleagues.

> *We had some fantastic conversations about 'so if this happened in your home country how would it be? (R02H).*

These efforts of mutuality and reciprocity provided 'shared solutions to common problems' (Ledingham, 2003, p. 188) and were greatly valued by host nurses who had the opportunity to establish a relationship of mutuality with their colleagues.

Commitment to working through the difficulties was evident throughout both groups. As a Filipino nurse commented, on his need to familiarise himself with his new cultural milieu:

> *Because it was my job, I had to really do something about it – rather than getting anxious every day I have to actually learn the culture. I have to know them and how to blend with them and then in that way I think I take one day at a time (R31M).*

Amid this milieu of goodwill, managers did attempt to foster reciprocal relationships as they struggled with multiple demands from both above and below, also experiencing their own barriers to effective practice, primarily from interpersonal issues and conflict. As one commented:

> *Sometimes I feel like I'm just managing personalities and egos (R41H).*

The mix of the interpersonal, intergroup and interprofessional was overlaid with the challenges of the care-rationed environment. Another manager stated:

> *Guiding principles are needed to influence the workplace activity and interaction between nurses to meet their needs and those of the organisation (R35H).*

RNs and their managers recognized that the world was becoming increasingly one of difference and wanted to find a way of incorporating those contrasts into their practice.

Discussion

The findings from this study indicate that workplace communication is subject to interpretations of managerial reciprocity and empathy to develop foundational trust, which has the potential to enhance both team effectiveness and efficiency. The conclusions not only pose dilemmas for nurses themselves but also, and especially, for those who manage healthcare practitioners while coping with change and attempting to create stability out of flux.

We identify three areas of potential for indirect reputational risk to be ameliorated through effective communication. First, managers can help foster retention of RNs through focusing on the centrality of collaborative and reciprocal working relationships to develop trust and confidence in colleagues. Both host and migrant nurses navigated their environment in the search for information and seeking help in understanding and establish positive working relationships in their increasingly

diverse work settings. As Zaharna (2016) argues, '[c]ultural assumptions about this basic concept [relationships] may vary significantly, and yet escape scholars' awareness' (p. 190). It may also escape both managers' and practitioners' awareness: culture remains 'below the threshold of conscious awareness because it involves taken-for-granted assumptions about how one should perceive, think, act, and feel' (Kreitner & Kinicki, 2007, p. 100). This suggests that there is potential for managers to benefit from the willingness of many host nurses to engage with change and participate in initiatives to help foster collaborative working relationships. However, managerial support is central to attaining high performance team-related practice and communication, which in turn, results in quality patient care.

Second, the examples above also illustrate nurses' sense of breaches of trust when managers did not appear either able or willing to facilitate collegial relationships, nor to address the links between communication breakdowns and poor staffing. In turn, this undercut confidence in their leadership as relationships floundered. Making the links between individual attitudes, perceptions and behaviour requires an environment of empathic openness to facilitate any positive outcomes. On the other hand, in the midst of teamwork issues, demands for efficiency and professional hierarchies, managers were having to focus on reactive responses to the many imposts on them. This left little room, time or resources to develop mutual trust and agreement on guiding principles to manage the workplace to meet the needs of both staff and the organisation. Any healthcare service relies upon well-functioning team communication, effective leadership and communication to maximize positive outcomes for both its health professionals and those they care for. A 'willingness to negotiate, collaborate and mediate solutions to issues of concern' (Bruning & Ledingham, 1999, p. 160) will depend on reciprocity and trust, both key aspects of leadership and relationships. However, in this case, as managers were coping with systemic barriers, migrant RNs were 'reading' managers' responses as dismissive and lacking in empathy for their 'newness'. The outcome was feelings of being unsettled when migrant nurses had typically made an enormous investment in the transition to another country.

Third, we expect staff to exhibit cognitive and affective empathic responses during communication with patients (Batt-Rawden, Chisolm, Anton, & Flickinger, 2013; Kaplan-Liss et al., 2018), so why not with colleagues? Empathy has been recognised as a key component of communication competence in the healthcare sector (Bennett, 2013; Gibson & Zhong, 2005). It has been linked to sharing concern for the other's welfare on both a cognitive and an emotional level and can aid decision-making through an increased awareness of self and others (Baker, 2017). Increased empathy has the potential to reduce intolerance and conflict (Wang et al., 2003). Conversely, a lack of empathy can lead to hostility towards 'other' groups (Stephan & Finlay, 1999), through a deficient awareness of values as a perceptual lens to view the world. In this research, empathy was a positive tool in facilitating positive workplace relationships. However, as cultural values influence decision-making and expressions of empathy, there may be obstacles to empathizing with other cultures in diverse workplaces. Although reputation is based on visibility, it also relates to how individuals evaluate the information they have. However, this process is situated within varying cultural worldviews.

Finally, some of the barriers relate to the fact that healthcare organisations' political, social and institutional contexts are unerringly influential. There is increasing pressure to perform in environments not conducive to employee wellbeing

(Montgomery, Todorova, Baban, & Panagopoulou, 2013) because of constant demands for change and increasing efficiency. There are many benefits from understanding cultural difference and how to build confidence in team-based decision making (Oetzel, McDermott, Torres, & Sanchez, 2011). However, managers in turn need support and resources to enable them to achieve positive outcomes. It is evident that a focus on efficiency can be counterproductive as signalled in the data.

Some limitations are associated with this study. This research is limited to a sample of RNs in one geographical location; therefore, generalisability may be limited. There may have been social desirability bias inherent in the interview process. However, the data clearly illustrated the desire of RNs for an environment that provides the time and space to learn and develop positive working relationships among culturally diverse RNs.

Conclusion

In this research, trust and reputation resided in networks – and managers were nodes of dysfunction because experience-based trust has its limits. It evolves only slowly and its maintenance demands commitment and energy. Without this, both host and migrant nurses experienced isolation, vulnerability and uncertainty with scant means of navigating their workplace challenges to develop trust within their networks. The resulting high attrition rates are very costly and in a competitive environment create future issues for recruitment.

This matters, because healthcare is not an optional service and supply and demand pressures mean that providing services will rely on attracting quality migrant staff. Most likely, everyone will depend on medical assistance at some time, increasingly so in the context of the aging of the baby boom cohort. Populations require exponentially increasing access to healthcare services as they age. At the same time, this experienced nursing cohort is leaving the health sector in large numbers, and there is a heavy reliance on migrant nurses to fill gaps. However, that same reliance is shared internationally, so making the sector more attractive through a positive reputation to prospective employees is key to a sustainable healthcare service.

The findings from this research attest to how nurturing intercultural workplace relationships and communication resulted in improved outcomes for RNs in a NZ setting. Thus, it suggests that if managers enhance their communication practice, the organisation would obtain value from RNs' commitment to participate in initiatives to help foster collaborative working environments. However, the findings show that navigating interpersonal and organisational influences in a multicultural environment can be daunting. Thus, when confronting other culturally defined cognitive maps for understanding the world, a potential disconnect creates dilemmas in practice and outcomes that in turn impacts indirectly on reputation.

Such findings are more than merely academic: in culturally diverse healthcare environments, recruitment and retention of adequate numbers of RNs is being compromised by miscommunication. The relational perspective advocated here has the potential to benefit not only the organisation itself, but also its internal publics: first, those nurses who are acculturating into a foreign environment, second, those who are learning to integrate their worldview with 'others' in their own familiar culture

and ultimately those they care for. The findings show that managers' communication is a catalyst in bridging differences between diverse ethnicities. However, prioritising productivity can come at the cost of communication effectiveness, especially in a system where significant numbers of migrant nurses work alongside local staff. The outcome is that when culturally diverse teams are having ongoing difficulties working together, the risk to patient safety is ever-present. A sustainable health service relies on a stable workforce, and managers' skills, willingness and support are a catalyst in providing a mutually acceptable working environment in a rapidly evolving culturally diverse workplace. A high rate of staff attrition serves no master well. Unfavourable staff experiences make for reputational impact, both directly and indirectly, on the ability to recruit RNs from a diminishing pool. As Theunissen and Sissons (2017, p. 1) note, '[a]t the core of all public relations activities are interpersonal relationships and consequently interpersonal communication'. Failure in this area is costly for everyone. Hard-pressed healthcare system managers would benefit from the reminder this study provides of the importance of their communication behaviour not only on day-to-day interactions but also the longer-term impacts on the system's standing.

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Table 1: A managerial pathway for effective communication and decision-making