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Culturally and Linguistically Diverse Nurses' Spoken Interaction Challenges in Finnish Hospitals: A Qualitative Descriptive Study

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Abstract

Background

Migration of nurses is focused on Finland and other high-income countries, strengthening the local healthcare workforce. Working in a second language can be challenging for culturally and linguistically diverse (CALD) nurses. Addressing the interaction challenges faced by CALD nurses is crucial for patient safety, workplace well-being, and nurse retention. However, little is known about CALD nurses' speaking and listening challenges from a micro-level perspective in a Finnish hospital context. Therefore, this study aimed to explore CALD nurses' spoken interaction challenges in Finnish hospitals.

Methods

A qualitative descriptive design was employed for this study. Semi-structured individual interviews were conducted from September 2024 to November 2025 with 12 CALD and 17 native nurses who worked in multiple Finnish university hospitals. The data were analysed using inductive content analysis.

Results

Two main categories and six subcategories emerged through the analysis. The main category of speaking challenges included subcategories of speaking competence challenges, challenging speaking tasks, and challenging speaking attitudes and experiences. The main category of listening challenges included subcategories of listening competence challenges, challenging listening tasks, and challenging listening attitudes and experiences.

Conclusions

CALD nurses faced spoken interaction challenges at linguistic, task-related, and attitudinal and experiential levels, demonstrating the complex interplay of multifaceted challenges. The findings showed the need to provide individual support and promote inclusion in workplace interactions. The findings inform the development of practices that enhance interactions, such as language mentoring, educational simulations, and diversity, equity, inclusion, and belonging policies.

Background

Healthcare in high-income countries is increasingly sustained by the expertise of nurses with migrant backgrounds [1]. Nurses with migrant backgrounds are often multilinguals who work in their second language [2]. Therefore, nurses with migrant backgrounds can be considered culturally and linguistically diverse (CALD) [3].

CALD nurses are professionals with valuable skills, such as language skills in multicultural patient encounters [2]. To enable CALD nurses to reach their full potential, specific attention must be focused on integration [4]. For example, destination countries should provide professional development support to migrant nurses [5]. Specifically, working in a second language can be demanding and require further workplace support [6]. Inadequate support can compromise patient safety, workplace wellbeing, and the attractiveness of nursing [3]. With respect to this, identifying interaction challenges faced by CALD nurses is crucial.

Hospitals are the workplaces of most nurses in high-income countries [1]. In hospitals, nursing is expected to be grounded in interactions that promote collaboration and safe working [7]. Workplace interactions in hospitals have distinct characteristics as they are dynamic and situated, involving different modalities and participants [8]. In diverse workplaces, interactions are also shaped by cultural and linguistic variations [7]. More notably, interactions are not dependent on individual contributions, as they are bidirectional [9]. Therefore, CALD nurses' interaction challenges should be explored with different interlocutors. Specifically, spoken interactions should be examined as they prevail in hospitals [8].

Spoken hospital interactions have been identified as challenging for some CALD nurses as they require adaptation to cultural norms in a second language [10]. However, previous studies have focused on English-speaking countries [10]. Consequently, the current knowledge emphasises English interactions and associated cultural influences while marginalising smaller linguistic groups. Therefore, this study was situated in the cultural and linguistic context of Finland. The topic is timely in Finland as solutions to the nursing shortage have been sought by intensifying the recruitment of international nurses and students [11].

In Finland, the right to practice as a nurse requires proficiency in Finnish or Swedish [12]. Most Finns speak Finnish as their first language [13]. Finland can be viewed as a low-context country where spoken interactions rely on the exact meanings conveyed by words rather than indirectness [14]. The approach towards CALD nurses' interactions is complex in Finland. The discussion raises concerns about the adequacy of language proficiency [15]. On the other hand, linguistic discrimination has been identified as a critical issue [16]. More significantly, challenges stem from structural barriers, such as the lack of workplace language learning practices [4]. For these reasons, knowledge about spoken interaction challenges faced by CALD nurses in Finland is critical.

Previous research on CALD nurses' spoken interaction challenges in Finland has focused on students [17] and integration-oriented approaches in various settings [18]. Therefore, little research has been conducted concerning micro-level interactions of practicing nurses in hospitals. Some CALD nurses have faced various spoken interaction challenges with patients, relatives, and healthcare professionals in a hospital due to cultural and linguistic disparities [6]. However, the previous evidence lacks the perspectives of native-speaking work community members. Furthermore, speaking and listening challenges have not been examined separately. This is justified because speaking and listening are

interconnected, yet separate functions [19]. Addressing this gap is essential for gaining a deeper understanding of the interaction challenges faced by CALD nurses. Therefore, this study aimed to explore CALD nurses' spoken interaction challenges in Finnish hospitals. The purpose was to describe the perceptions of CALD and native nurses concerning these challenges. The research question was: What speaking and listening challenges do CALD nurses face when interacting with patients, relatives, and healthcare professionals in Finnish hospitals?

Methods

Study design

A qualitative descriptive design [20] was employed to explore CALD nurses' spoken interaction challenges in Finnish hospitals as perceived by CALD and native nurses. A naturalistic paradigm was employed to gather information in participants' natural environment [21]. The data were collected with semi-structured individual interviews and analysed using inductive content analysis [22]. The study was reported using the Consolidated Criteria for Reporting Qualitative Research (COREQ) Checklist, provided in Additional File 1 [23].

Study setting and participants

The study was conducted in adult somatic inpatient and high dependency units of multiple university hospitals, represented by one Finnish healthcare organisation. Participants were selected using purposive sampling to ensure a knowledgeable understanding of the phenomenon of interest [24]. Participants included CALD and native nurses. The inclusion criteria for CALD nurses were licensed practical or registered nurses with migrant backgrounds who used Finnish as a second language at their workplaces in hospitals. The inclusion criteria for native nurses were licensed practical or registered nurses who were native Finnish speakers, including nurse colleagues and managers, who regularly collaborated with CALD nurses. Nursing students were excluded.

Participants were recruited in accordance with the organisation's recruitment policies: study information sheets were sent via email to head nurses, who then distributed them to ward managers for further dissemination. JoK also disseminated information sheets through their project in face-to-face contacts. Those interested in the study contacted JeK via email, phone, or in person for further information.

Data collection

The data collection took place from September 2024 to November 2025. The data was collected with semi-structured individual interviews due to the sensitivity of the research topic. Before data collection, interview guides were developed for CALD and native nurses. The theoretical framework of the interview guide was based on Drew and Heritage's dimensions of institutional interaction [25]. These dimensions

were operationalised into the question areas of language and terminology of nursing, interactional tasks, interactional styles, interactional models and practices, and interactional roles manifested as asymmetries [10]. Questions concerned CALD nurses' spoken and written interactions with patients, relatives, and healthcare professionals at participants' current workplaces. Only spoken interactions were analysed in this study. The CALD nurses' interview guide was created in Finnish and English to support second-language users participating in the interview in the language they feel most comfortable using. The interview guide for native nurses was created in Finnish because they were native Finnish speakers. The purpose of the interview guides was to collect rich and similar types of data from all participants to answer the research question [24]. Interview guides are presented in Additional File 2. Additionally, demographic data were collected from the participants, including first language, professional title, nursing specialty of the work unit, work experience in the current work unit, and work experience in Finland and abroad. Work experience in the current work unit was not reported, as some participants worked simultaneously in multiple units.

Interviews were conducted by JeK, who identifies as female, is a native Finnish speaker with proficiency in English, and has previous experience conducting qualitative research. JeK is a registered nurse with clinical experience in somatic inpatient and high dependency units. JeK holds a Master of Health Sciences, is a PhD candidate, and works as a senior lecturer in a bilingual nursing degree program at a university of applied sciences in Finland.

Interviews were organised both face-to-face and online according to participants' preferences and the researcher's resources. The burden on the participating wards was avoided by facilitating interviews primarily outside of working hours. The interviews were conducted one-on-one in private, quiet locations, both at and outside the participants' workplaces. There were 19 face-to-face and 10 Zoom interviews. JeK was not in an employment relationship with the participating organisation, and the participants were not in a subordinate position to the researcher. The interview guides were piloted in the first interviews with CALD and native nurses. No amendments were made to the interview guides after pilot interviews, and pilot interview data were also included in the analysis.

Before the interview began, JeK introduced the study and herself, confirmed the participant's willingness to participate, and informed them of the option of not answering a question. In the interview guides, CALD nurses were conceptualised as nurses with migrant backgrounds and native nurses as native Finnish-speaking nurses in order to use everyday terms and facilitate the flow of the interview. These concepts were explained in detail to the interviewees what they meant in the study. CALD nurses were allowed to choose either Finnish or English as the interview language and provide clarifications in Finnish or English. Interview guides structured the interviews, allowing for rewording, reordering, and clarifying the questions based on participants' responses [23]. Probing questions were used to encourage participants to elaborate. Only speech was recorded during the interviews. Field notes were recorded after each interview, including contextual information and the researcher's reflections. Interviews lasted from 30 to 113 minutes ($\bar{x}$ = 56 minutes). The data consisted of 27 mainly Finnish interviews and two mainly English interviews. None of the participants dropped out of the study.

Data analysis

The data were analysed using qualitative inductive content analysis [22]. Inductive content analysis was preferred as a suitable method because there were no previous studies on the phenomenon of interest. The philosophical foundation of the analysis was based on social constructivism, which views individuals' experiences of reality as constructed through social interactions within an institutional context [26]. Therefore, the analysis was based on the meanings constructed by the participants and the researcher on the CALD nurses' spoken interaction challenges in a particular context. Interviews were transcribed word-for-word verbatim, including pauses and laughs. The data consisted of 803 pages in Microsoft Word, written in 12-point Times New Roman font, and 1.5 line spacing.

Inductive content analysis followed the phases of data reduction, grouping, and category formation [22]. Data analysis process and categorisation were conducted by JeK and reviewed by JoK and JMK [27]. Before the analysis, the unit of analysis was defined as a meaning, consisting of one or more sentences, that described CALD nurses' speaking and listening challenges relating to the interaction modality, interaction situation itself, the challenging features in interaction, or the participants involved. The data were read several times to become familiar with the content before coding.

In the reduction phase, the meaning units (n = 585) that answered the research question were identified in Microsoft Word documents using a comment function. The comment included the original expression, the participant's code number, the page number, the reduced original expression in a sentence form in its original language, and the open code. The analysis focused on the manifest content of the meanings. Next, the comment data were collected into a Microsoft Excel spreadsheet.

In the grouping phase, open codes with the same meanings were combined. In total, 569 codes were formed. Next, codes representing similar meaning or phenomenon were grouped into six subcategories through an iterative process. In the grouping, the codes representing the perceptions of CALD and native nurses were separated, as well as challenges in speaking and listening. Within these, the codes were grouped separately based on the interlocutors in the interactions, i.e., patients, relatives, and healthcare professionals. Interlocutors who were not specified were grouped as unspecified interlocutors. Two main categories were formed by grouping subcategories based on similar content. Data saturation was reached as no new categories were identified [24]. An example of the coding and category formation is presented in Table 1.

Table 1
Example of a Qualitative Inductive Coding Process and Category Formation

Original Expression	Reduced Original Expression	Code[a]	Category	Main Category
”They [CALD nurses] need to use paraphrases quite a lot in their speech, as they use several Finnish words to explain what they mean. They don’t necessarily use phrases unless they can find them in English.” (Nurse colleague 04, p. 1)	Paraphrases, i.e., several Finnish words, are used quite a lot, but not Finnish phrases.	SPEAKING_NATIVE: Phrases are used less (unspecified interlocutor)	Speaking competence challenges	Speaking challenges
”Well, the task is, for example, to deliver medicines. And sometimes patients ask about these medicines, and sometimes not. Um, the most difficult part of this is when you need to answer questions about the current medicines.” (CALD nurse 07, p. 4)	It is difficult to answer the patient’s questions about medications.	SPEAKING_CALD: Answering the questions about medications (patient)	Challenging speaking tasks	Speaking challenges
”They [patients] can even see it that foreigner come to take care of them. … after I spend 5 minutes with them … Then, you will see that, that respect grow. How would they talking to you is totally different.” (CALD nurse 04, p. 25)	The patient had prejudices against the CALD nurse because the nurse was a foreigner but began to respect the nurse after talking with them.	SPEAKING_CALD: Prejudices based on foreign background (patient)	Challenging speaking attitudes and experiences	Speaking challenges
”In the doctor’s orders, there may be those terminologies that are challenging [to understand in speech].” (Nurse manager 01, p. 5)	In the doctor’s spoken order, there may be terminologies that are challenging to understand.	LISTENING_NATIVE: Terminologies in the doctor’s orders (healthcare professional)	Listening competence challenges	Listening challenges

[a]Includes information on the interaction challenge (SPEAKING = speaking or LISTENING = listening), name of the code, study participant (CALD = CALD nurse or NATIVE = native nurse), and interlocutor (patient, relative, healthcare professional, or unspecified interlocutor).

Original Expression	Reduced Original Expression	Code[a]	Category	Main Category
”Usually, when they [other nurses] give an oral report, they speak really quickly. Then you’re like, I didn’t get it, wait. When they speak there, you must write at the same time.” (CALD nurse 09, p. 9)	It is difficult to receive an oral report if the nurse speaks quickly and must write at the same time.	LISTENING_CALD: Receiving a report from a colleague in rapid speech while writing (healthcare professional)	Challenging listening tasks	Listening challenges
”Relatives might grab the person, and say ”hey, you”, and the person with a migrant background is deliberately confused, for that reason, not necessarily understand.” (Nurse colleague 08, p. 45)	Relatives may deliberately confuse the CALD nurse, causing them not to understand.	LISTENING_NATIVE: Deliberately making understanding difficult (relative)	Challenging listening attitudes and experiences	Listening challenges

[a]Includes information on the interaction challenge (SPEAKING = speaking or LISTENING = listening), name of the code, study participant (CALD = CALD nurse or NATIVE = native nurse), and interlocutor (patient, relative, healthcare professional, or unspecified interlocutor).

Ethical considerations

The study followed good research ethics in accordance with the Declaration of Helsinki [28] and Finnish guidelines on research integrity [29]. The study was conducted in Finland; therefore, ethics committee approval was not required for this study involving competent adult participants [30–31]. The research permit was obtained from the participating organisation before commencing the study. General Data Protection Regulation [32] and the university’s data protection guidelines were followed in the collection, processing, and storage of the data. Participants received a written information sheet and a data protection notice in Finnish or English before data collection. Written informed consent was obtained after participants were informed. Only the necessary personal data were collected from the participants, and special categories of personal data were not collected. The data was pseudonymised, and codes replaced participants’ identities: CALD nurse 01–12, nurse colleague 01–10, and nurse manager 01–07. The data were stored on a university’s secure password-protected network disk. The data were accessible and usable only by designated members of the research group, and will not be disclosed to outsiders. The data will be stored for 15 years after the research in the university’s secure network folder for the purpose of assessing the reliability of the results, and for possible subsequent compatible research. After this, all data and personal information will be securely destroyed.

Rigor and reflexivity

The assessment of the rigor was based on criteria of credibility, transferability, dependability, and confirmability [21]. Credibility was enhanced by creating a psychologically safe atmosphere during interviews. The researcher was an outsider to the organisation and did not express her opinions during interviews. Participants shared rich descriptions. Transferability was strengthened by conducting the study in similar hospital wards. Participant demographics and context were reported to assess the transferability of the findings. Dependability was supported by consistent documenting and reporting of the study process. The interview guides strengthened the traceability of the researcher's decisions. Confirmability was strengthened by recognising the impact of the researcher's characteristics and prior experiences on the study [33]. JeK, who conducted the interviews and analysis, had no experience of being a migrant. However, she had experience of being a second language user and learner in a Finnish multicultural workplace. Reflexivity was maintained through field notes, research group discussions, and personal journaling. Direct quotes from the participants were reported.

Results

Characteristics of participants

A total of 12 CALD and 17 native nurses participated in the study. Most participants worked in somatic inpatient wards. CALD nurses represented registered nurses (n = 9) and practical nurses (n = 3) from various linguistic backgrounds, as well as residence times and work experiences. Native nurses included nurse managers (n = 5), assistant ward managers (n = 2), and registered nurses (n = 10) with varying levels of work experience. Detailed participant demographics are reported in Table 2.

Table 2
Participant Demographics

Demographic Variable	CALD Nurses (N = 12)	Native Nurses (N = 17)
First Language	Indo-European language group (n = 6) Austronesian language group (n = 2) Niger-Congo language group (n = 2) Afro-Asiatic language group (n = 1) Uralic language group (n = 1)	Finnish (n = 17)
Professional Title	Registered nurse (n = 9) Practical nurse (n = 3)	Ward manager (n = 5) Assistant ward manager (n = 2) Registered nurse[a] (n = 10)
Work Unit	Somatic inpatient ward (n = 11) Somatic inpatient and high-dependency unit (n = 1)	Somatic inpatient ward (n = 14) Multiple somatic wards (n = 2) Somatic high-dependency unit (n = 1)
Time of Residence in Finland	6–10 years (n = 4) 11–15 years (n = 4) ≥ 21 years (n = 4)	N/A
Work Experience in Finland	0–2 years (n = 1)[b] 3–5 years (n = 1)[b] 6–10 years (n = 4)[b] 11–15 years (n = 3)[b] 16–20 years (n = 2)[b] ≥ 21 years (n = 1)[b]	0–2 years (n = 2)[c] 6–10 years (n = 1)[c] 11–15 years (n = 6)[c] 16–20 years (n = 1)[c] ≥ 21 years (n = 7)[c]

[a]A staff nurse and/or clinical nurse educator.

[b]Work experience in clinical nursing.

[c]Work experience in clinical nursing and/or nursing management.

Demographic Variable	CALD Nurses (N = 12)	Native Nurses (N = 17)
Work Experience Outside of Finland	None (n = 7)[b]	None (n = 16)[c]
	0–2 years (n = 2)[b]	0–2 years (n = 1)[c]
	3–5 years (n = 1)[b]	
	11–15 years (n = 2)[b]	

[a]A staff nurse and/or clinical nurse educator.

[b]Work experience in clinical nursing.

[c]Work experience in clinical nursing and/or nursing management.

CALD nurses' spoken interaction challenges

CALD nurses' spoken interaction challenges with unspecified interlocutors, patients, relatives, and healthcare professionals consist of two main categories: speaking challenges and listening challenges. The six subcategories were generated under the main categories. Table 3 summarises the challenges identified within categories.

Table 3
CALD Nurses' Spoken Interaction Challenges

Main Category and Subcategory	Interaction Challenge	Interlocutor in the Interaction Perceived by CALD Nurses[a]	Interlocutor in the Interaction Perceived by Native Nurses[a]
Speaking challenges	Professional language	U, P	U, P, H
Speaking competence challenges	Register shifts	U, P, R	U, P
	Grammar	U, P	U, P
	Pronunciation	U, P	U, P, H
	Expressions	U, P	U
	Socio-pragmatic language	H	-
	Linguistic variations	P, R, H	H
	Language proficiency	-	U, P, R, H
Speaking challenges	Phone calls	U, R, H	U, R, H
Challenging speaking tasks	New tasks	U	-
	Guidance	P	P
	Interviews	P	P
	Distressed encounters	P, R	P, R
	Discussing problems	P	-
	Questions	R	-
	Care procedures	H	-
	Reports	H	H
	Responsible roles	H	-
	Acute situations	-	H
	Describing a patient's condition	-	R
	Hospice care	-	R
	Doctors' rounds	-	H
		-	H
		-	H

[a]U = Unspecified interlocutor; P = Patient; R = Relative; H = Healthcare professional.

Main Category and Subcategory	Interaction Challenge	Interlocutor in the Interaction Perceived by CALD Nurses[a]	Interlocutor in the Interaction Perceived by Native Nurses[a]
	Consulting a doctor		
	Meetings		
Speaking challenges	Unsupportive attitudes	U, R	U
Challenging speaking attitudes and experiences	Dismissive attitudes	U, P	U, H
	Prejudiced attitudes	P, R	-
	Status-related experiences	U, P, H	H
	Experiences of incomprehension	-	P
	Experiences of mistrust	-	H
Listening challenges	Professional language	U	U, H
Listening competence challenges	Lay language	U, P	U, P, R, H
	Register shifts	U, H	-
	Linguistic variations	U, P, H	U, P, R, H
	Nonverbal interaction	H	-
Listening challenges	Phone calls	U, H	U, H
Challenging listening tasks	Medication management	P	-
	Doctors' rounds	H	-
	Reports	H	H
	Extensive tasks	-	U
	Distressed encounters	-	P
	Requests	-	H, P
	Instructions	-	H
	Orders	-	H
	Questions	-	H

[a]U = Unspecified interlocutor; P = Patient; R = Relative; H = Healthcare professional.

Main Category and Subcategory	Interaction Challenge	Interlocutor in the Interaction Perceived by CALD Nurses[a]	Interlocutor in the Interaction Perceived by Native Nurses[a]
Listening challenges	Prejudiced attitudes	P	U, H
Challenging listening attitudes and experiences	Unsupportive attitudes	-	U, R, H
	Experiences of mistrust	H	-
	Experiences of incomprehension	-	U, P, H

[a]U = Unspecified interlocutor; P = Patient; R = Relative; H = Healthcare professional.

Speaking challenges

The main category of speaking challenges describes perceptions of CALD nurses' speech production challenges. This main category consists of three subcategories: speaking competence challenges; challenging speaking tasks; and challenging speaking attitudes and experiences.

Speaking competence challenges

Speaking competence challenges describe CALD nurses' linguistic competence challenges in speech production. According to CALD nurses, new vocabulary and phrases with unspecified interlocutors, as well as word nuances with patients, were challenging in professional language. In register shifts, switching between speech nuances with unspecified interlocutors, and switching between professional and lay language with patients and relatives, posed challenges. Following Finnish grammar rules with unspecified interlocutors and patients was demanding. Pronouncing Finnish words and medical vocabulary with unspecified interlocutors, as well as pronouncing Finnish words with patients, posed challenges. Expressing oneself sometimes required assistance from other people and machine translators in conversations with unspecified interlocutors. The CALD nurse's sensitive nature, tiredness, or nervousness were barriers to expressing oneself with unspecified interlocutors. The word expressions sometimes required assistance from healthcare professionals in conversations with patients. Socio-pragmatic language challenges included discussing in-depth or non-work-related issues with colleagues and approaching a new colleague. Linguistic variations caused challenges in conversations with patients and relatives who did not speak Finnish, as well as with new colleagues who were not used to the CALD nurse's speech.

"I think of maybe if the word is not known, or it's not familiar, then it's difficult to use because I don't know it." (CALD nurse 02)

According to native nurses, vocabulary and phrases with unspecified interlocutors, patients, and healthcare professionals were challenging in professional language. In register shifts, switching to a polite tone with unspecified interlocutors, and switching to a patient-centred, relaxed, and polite tone, as

well as between professional and lay language with patients, posed challenges. Finnish grammar rules with unspecified interlocutors and similar Finnish words with patients were challenging. Pronouncing Finnish words with unspecified interlocutors, patients, and colleagues was demanding. Expressing oneself sometimes required assistance from other people, dictionaries, notes, mobile applications, and machine translators with unspecified interlocutors. The CALD nurse's quiet nature was identified as a barrier to expressing oneself with unspecified interlocutors. Linguistic variations posed challenges when two CALD nurses had different first languages, as well as when adapting to the fast speech of native colleagues. Low Finnish language proficiency hindered conversations with unspecified interlocutors, patients, and relatives, requiring support. Regarding language proficiency, challenges with unspecified interlocutors were identified when starting to work in an acute ward, when both clinical and language skills were limited, and when Finnish was not used outside of work. Low language proficiency and the CALD nurse's quiet nature were perceived as challenging with healthcare professionals, leading to misunderstandings and increased workload.

"In that case, Finnish language proficiency is insufficient, so, in my opinion, misunderstandings are a lot more likely to happen in a team." (Nurse manager 02)

Challenging speaking tasks

Challenging speaking tasks describe CALD nurses' difficulties with work tasks requiring speech production. According to CALD nurses, phone calls were challenging when interacting with unspecified interlocutors, unfamiliar relatives, and on-call doctors, specifically when responding to relatives' strange questions and reporting to colleagues and doctors. New tasks with unfamiliar interlocutors were challenging due to the new working environment and lack of orientation. Patient guidance and related questions on medication, discharge, and examinations, as well as interviews regarding their functional ability, nutritional status, and pain, posed challenges. Encountering distressed patients and discussing problems with them, as well as encountering distressed relatives and answering their difficult questions, was also challenging. Care procedures demonstrated challenges in terms of medication management when two-way interaction was disrupted with a colleague. Additionally, there were challenges in using accurate wound care product names with colleagues. There were reporting challenges with colleagues, including answering questions, discussing unknown patients, adopting reporting models, discussing patients' follow-up care, and using phrases. Challenges in responsible roles included leading professional meetings, giving oral presentations to healthcare professionals, educating colleagues, and collaborating with a multidisciplinary team.

"But yeah, it's pretty typical that always for foreigners that… Phones are always scary… Tools." (CALD nurse 03)

According to native nurses, limited language proficiency and the urgency of the situation posed challenges in phone calls with unspecified interlocutors, doctors, and relatives, requiring support from colleagues. Additionally, phone calls to people higher in the hierarchy were mentioned as challenging. Phone reports to colleagues were perceived as challenging due to limited language proficiency, the fast

pace of interaction, the need to provide a comprehensive report, and the lack of common reporting practices. Acute situations, such as resuscitation, were identified as challenging with healthcare professionals and required support from native-speaking colleagues. Patient guidance on procedures, medication, follow-up care, and the use of care equipment was identified as challenging. Guidance was challenging due to long duration, delivery of core information, verbalisation of own actions, unpredictable questions, limited language proficiency and vocabulary, patients' multimorbidities, and the lack of orientation. Interviewing patients during their admission and asking about pain was also perceived as challenging. Interviewing was challenging due to the limited language proficiency and talkative patients. Encountering distressed patients and relatives posed challenges, as well as adequately describing the patient's condition to relatives. In hospice care, speaking with relatives was challenging when delivering sad news, providing emotional support, and answering challenging questions. Reporting challenges arose with colleagues as reporting required concentration, included unexpected questions, could occur in acute situations, lacked common reporting practices, and required knowledge of the Finnish healthcare system. Following the ISBAR model when reporting to a doctor and being concise when reporting in multidisciplinary teams were also perceived as challenging. Doctors' rounds were challenging because they required asking for clarifications, were busy, and included challenging content. Doctors' consultations were challenging due to medication orders, concise speech under time pressure, and limited language proficiency. Participation in development groups and multidisciplinary meetings with healthcare professionals was also perceived as challenging.

”In the patient guidance, I notice that, in my opinion, the vocabulary is, kind of, limited.” (Nurse colleague 01)

Challenging speaking attitudes and experiences

Challenging speaking attitudes and experiences describe negative attitudes and challenging experiences related to CALD nurses' speech production. According to CALD nurses, there were unsupportive attitudes, manifested as negativity of unspecified interlocutors and offensiveness of relatives towards non-native speech. Dismissive attitudes manifested as questioning of professional competence by unspecified interlocutors and patients due to non-native speech. Prejudiced attitudes manifested as patients' and relatives' prejudices towards speech due to a foreign background. Status-related experiences reflected hierarchies. There were experiences of being an outsider with unspecified interlocutors, as well as experiences of being inferior and professionally doubted by healthcare professionals due to non-native speech. Addressing supervisors and doctors by their first names in accordance with Finnish norms was also perceived as difficult at first. Additionally, patients who were doctors by profession, a dominating colleague, and speaking in a job interview were perceived as stressful due to their hierarchical nature.

”Well, some [relatives] might raise their voice or use kinds of words that are kinds of offensive. Like they could say… 'Don't you speak Finnish? Give it, give it to someone else! …The phone.'” (CALD nurse 01)

According to native nurses, there were unsupportive attitudes, manifested as unspecified interlocutors' requirements for perfect Finnish language proficiency. Dismissive attitudes manifested as unspecified interlocutors' and healthcare professionals' questioning of professional competence due to non-native speech. Experiences of incomprehension manifested in some patients' inability to understand a CALD nurse's speech. Mistrust was experienced among healthcare professionals due to very low language proficiency. Colleagues experienced mistrust when the new colleague did not ask for help and when they were not familiar with the new colleague's working habits. Status-related experiences reflected hierarchies. Speaking with healthcare professionals and a supervisor was reported to cause pressure in CALD nurses due to fear of critique. The pressure was thought to be due to accustomedness to higher workplace hierarchies than existed in Finland.

"If I ask them [CALD nurses] to come here, um… To talk. Usually, they are really terrified." (Nurse manager 05)

Listening challenges

The main category of listening challenges describes perceptions of CALD nurses' listening comprehension challenges. This main category consists of three subcategories: listening competence challenges; challenging listening tasks; and challenging listening attitudes and experiences.

Listening competence challenges

Listening competence challenges describe CALD nurses' linguistic competence challenges in listening comprehension. According to CALD nurses, the slang words and abbreviations of unspecified interlocutors posed challenges in professional language. In lay language, Finnish proverbs of unspecified interlocutors were demanding, as well as patients' vernacular speech, young patients' slang words, and older patients' old-fashioned words. In register shifts, unspecified interlocutors' voice tones were sometimes challenging to interpret, as well as colleagues' jokes. Linguistic variations, including dialects and fast speech of unspecified interlocutors, patients, and healthcare professionals, were challenging to understand. The lack of nonverbal interaction when colleagues' faces were invisible also challenged listening comprehension.

"If the patient speaks vernacular, I don't understand." (CALD nurse 12)

According to native nurses, the vocabulary and phrases of unspecified interlocutors, as well as the vocabulary, word nuances, and complex speaking style of healthcare professionals, posed challenges in professional language. In lay language, Finnish proverbs of unspecified interlocutors, word nuances of patients, slang speech of relatives, and vernacular speech of doctors were challenging to understand. Linguistic variations, including the dialects of unspecified interlocutors, patients, relatives, and healthcare professionals, the fast speech of healthcare professionals, and patients' different first languages, made interactions challenging.

”It can be challenging for a person with a migrant background if a Finn speaks a certain dialect.” (Nurse manager 03)

Challenging listening tasks

Challenging listening tasks describe CALD nurses’ difficulties in tasks requiring listening comprehension. According to CALD nurses, the lack of nonverbal cues posed challenges during phone calls with unspecified interlocutors. There was also a challenge in understanding a doctor’s medication order over the phone. In medication management, a patient’s description of their medications posed challenges and required support from native Finnish-speaking colleagues. Following multilateral conversations during doctors’ rounds was perceived as challenging. There were also challenges with colleagues’ reports due to unclear structure and the need for note-taking from rapid speech.

”Last week, I didn’t understand. It came to medication, and I didn’t understand. I tried, I tried, but it’s medication. And I told Finnish nurses, say hey, I think I didn’t understand.” (CALD nurse 12)

According to native nurses, the lack of nonverbal cues posed challenges in phone calls with unspecified interlocutors and colleagues when reporting. Additionally, doctors’ phone orders in acute situations posed challenges. Extensive tasks caused misunderstandings in specialised medical care with unspecified interlocutors at the beginning because language proficiency was still developing. Understanding distressed patients was also perceived as challenging. Requests included colleagues’ requests for medication administration and patients’ requests, requiring support from colleagues. Colleagues’ instructions on patient mobilisation, the use of personal protective equipment, patient admission and discharge, posed challenges. Doctors’ orders on patient care, medications, and examinations were also challenging. Specifically, orders given in acute situations, unusual orders, or doctors who were second-language users, complicated understanding. Doctors’ questions posed challenges when language proficiency was low, and when the doctor did not ensure understanding. Comprehensive reports and reports concerning patients from other specialties were challenging with colleagues.

”For example, it has been said that there is an antibiotic infusion running in room seven. And after that, the medication will be stopped. But the nurse in question didn’t understand it anyway.” (Nurse colleague 09)

Challenging listening attitudes and experiences

Challenging listening attitudes and experiences describe negative attitudes and challenging experiences related to CALD nurses’ listening comprehension. According to CALD nurses, there were prejudiced attitudes, manifested as patients’ refusal of care because they felt that there would not be understanding. There were also experiences of mistrust, manifested as a CALD nurse’s feeling that healthcare professionals did not trust them due to the lack of understanding during orientation.

”The fear that the nurse doesn’t understand or can’t take care of them [the patient].” (CALD nurse 08)

According to native nurses, there were unsupportive attitudes, manifested as unspecified interlocutors', relatives', and healthcare professionals' inability to adapt interactions to be understandable. Prejudiced attitudes manifested as biases towards understanding from unspecified interlocutors and colleagues. Colleagues had prejudices about whether reports were understood. Unspecified interlocutors, patients, and healthcare professionals had experiences of not being understood, and this manifested in different forms. Experiences of incomprehension contributed to the patients' refusal of care and healthcare professionals' mistrust of professional competence. Healthcare professionals also experienced uncertainties about understanding. Colleagues had doubts that CALD nurses did not always dare to admit incomprehension to colleagues, requiring them to ensure understanding. Specifically, silence and insufficient orientation created uncertainties.

"With some of them [CALD nurses], you need to ensure whether they have understood." (Nurse colleague 06)

Discussion

This study aimed to explore CALD nurses' interaction challenges in Finnish hospitals. Speaking and listening challenges with unspecified interlocutors, patients, relatives, and healthcare professionals were described as perceived by CALD and native nurses.

The findings showed multifaceted speaking competence challenges. Both CALD and native nurses identified challenges in professional language, register shifts, grammar, pronunciation, expressions, and linguistic variations with different interlocutors. CALD nurses described socio-pragmatic language challenges, preventing them from deepening collegial relationships. These findings supported previous evidence on the relevance of socio-pragmatic competence, in addition to language proficiency, reflecting the complexity of speaking competence [34]. In contrast to CALD nurses, native nurses described limited language proficiency as part of speaking competence challenges. This may reflect native speakers' unfamiliarity with second-language speech and cultural differences [7]. From the perspective of CALD nurses, this may reflect their perceptions of language proficiency as part of identity, and therefore not easily identified as problematic [35]. On the other hand, native nurse participants did not clearly define what is meant by limited language proficiency. This highlights the need to explore the basis of language proficiency requirements further [34]. In summary, perceptions of speaking competence challenges were influenced by the person's status as a language user.

The findings revealed multiple challenging speaking tasks. Both CALD and native nurses identified challenges in patient guidance and interviews, distressed encounters with patients and relatives, as well as in phone calls and reports with different interlocutors. These tasks have also previously been described as challenging in a Finnish context [6]. Also, studies conducted in the United States have identified challenges in phone calls [36], patient guidance, and distressed encounters with patients and relatives [37]. This study supported previous evidence that interaction challenges extend beyond linguistic competence, such as in distressed encounters, where the interlocutor's emotional state

complicated interaction and required mastery of cultural nuances [37]. However, findings showed that the challenges in the tasks were sometimes ambiguous and perceived differently by CALD and native nurses. CALD nurses emphasised that the new work environment and unfamiliarity contributed to the challenges. Instead, native nurses emphasised the challenging content, rush, and the lack of language proficiency, common practices, and orientation. Therefore, challenging speaking tasks seemed to be linked to structural factors, such as orientation, which can be influenced by work community support [4, 6]. To conclude, external factors contributed to the challenges in speaking tasks, and they were easier to recognise as barriers than implicit internal factors.

The findings reflected exclusionary attitudes towards and experiences of CALD nurses' speaking. Attitudes and experiences were intertwined and, therefore, challenging to separate. Both CALD and native nurses identified unsupportive and dismissive attitudes, as well as status-related experiences, preventing CALD nurses from participating equally in interactions. As in previous studies conducted in Finland and Australia, proficiency in the dominant language was a gateway to credibility and trust [3, 38]. The findings also reflected rigid perceptions, such as the requirement for perfect language proficiency. Thus, a non-native speech seemed to be a characteristic that needed to be corrected, reflecting othering attitudes [39]. On the other hand, the speech of some CALD nurses was not understood, and CALD nurses felt discomfort with Finnish interaction culture, reflecting adaptation needs [35]. Overall, speaking challenges were related to limited inclusion as reflected through attitudes and experiences.

It was found that challenges in listening competence were multifaceted. Both CALD and native nurses identified challenges in professional language, lay language, and linguistic variations with different interlocutors. The challenges were related to linguistic specificities, such as understanding dialects. Therefore, the findings demonstrated the multifaceted elements of listening competence that require adjusting to the speaker, such as their vocabulary and tempo [19]. It is noteworthy that listening has been preferred as a demanding linguistic skill that requires active processing [19]. However, in this study, listening competence challenges were described less than those related to speaking. A possible explanation for this might be the difficulties in separating speaking and listening in spoken interaction. Therefore, listening competence challenges might have remained partially unrecognised.

Findings indicated multiple challenging listening tasks. Both CALD and native nurses identified phone calls with unspecified interlocutors and healthcare professionals, and reports with healthcare professionals, as challenging. CALD nurses have previously identified these, specifically phone calls, as challenging in a Finnish context [6]. In this study, native nurses recognised patients' and healthcare professionals' requests, as well as healthcare professionals' instructions, orders, and questions, as challenging. These listening tasks serve as a means of information flow and, therefore, indicate challenges in two-way interaction, as noted also in the previous literature [8] and in this study when discussing medication management with a colleague. The findings also indicated that understanding was affected by several factors, such as a colleague's rapid speech. Adverse listening conditions have been found to complicate the listening tasks of second-language speakers [40]. Thus, challenges were not necessarily related to the tasks themselves but to distractions and the lack of two-way interaction.

The findings revealed exclusionary attitudes towards and experiences of CALD nurses' listening. Attitudes and experiences were intertwined, making them challenging to separate. Both CALD and native nurses described prejudiced attitudes towards the CALD nurses' understanding. Prejudices may reflect native speakers' tendency to assume that second-language speakers have a lower linguistic comprehension [41]. Native nurses also described unsupportive attitudes towards CALD nurses' understanding. This reinforces the idea that native speakers tend to focus on interactions in a native-language-centric manner, rather than supporting second-language interaction [42]. Furthermore, the experiences of CALD nurses reflected mistrust towards them, and those of native nurses reflected suspicions of incomprehension. This is problematic, as concerns about understanding have demonstrated to increase a sense of vulnerability among CALD nurses and limit adaptation to the work community [38]. In line with speaking, listening challenges were related to limited inclusion as reflected through attitudes and experiences.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, there were limitations related to the participants. There were fewer CALD nurse participants (N = 12) than native nurse participants (N = 17), which may emphasise native nurses' perceptions. Although this study examined challenging interactions, it does not indicate that all CALD nurses have challenges. Furthermore, the challenges can significantly vary among individuals. Second, there were limitations related to data collection. It is possible that interaction challenges were not openly discussed due to the sensitivity of the topic. Additionally, none of the CALD nurses was able to speak their native language during interviews, which may limit the nuances of their responses. It is also possible that theory-informed interview guides over-directed data collection, leaving completely open perspectives unattained. Third, there were limitations related to data analysis. Responses were in Finnish and English, which may affect the interpretations of the data. Fourth, there were limitations related to the transferability of findings. The data were collected from one Finnish tertiary care organisation's somatic inpatient and high dependency units. Therefore, findings may not be transferable to all Finnish organisations, healthcare levels, nursing settings, and countries.

Implications for future research

Future research should employ mixed-methods designs to broaden understanding of complex interaction challenges. For example, observational studies can be used to observe interactions and quantify challenges in challenging tasks such as reporting. Surveys can be used to examine the associations between factors that complicate interactions, such as the lack of common reporting practices, and interaction challenges. Interaction challenges were situation-specific. Therefore, studies focusing on different contexts, such as psychiatric nursing, are warranted. Future research should also study different perspectives and modalities of interactions. Patients and relatives should be included as participants to meet the needs of healthcare service users. Additionally, implicit factors intertwined in interactions, as reflected in this study through attitudes and experiences, should be examined. These

studies could focus on language ideologies to reveal, for example, how perceptions of limited language proficiency are determined. Studies on written interactions are also needed. Overall, research on interaction challenges provides a robust foundation for interventions aimed at enhancing interactions.

Implications for practice and policy

In practice, CALD nurses' individual needs in language learning and the work community's ability to support them should be recognised. Therefore, the findings inform the development of practices, such as language mentoring, that enhance the interaction skills of CALD and native nurses. Findings on the challenging tasks inform nursing education in the development of simulations for challenging interactions. At the policy level, organisations and policy-makers should be aware of negative attitudes and challenging experiences related to interactions. Therefore, the findings inform the development of diversity, equity, inclusion, and belonging (DEIB) policies, for example, for respectful discussions of interaction challenges.

Conclusions

CALD nurses faced multifaceted speaking and listening challenges that manifested at the linguistic, task-related, and attitudinal and experiential levels. The findings showed that CALD and native nurses' perceptions of the challenges and the factors related to them differed. Additionally, the findings highlighted the need for better cultural and linguistic inclusion. Overall, challenges demonstrated the complex interplay of linguistic challenges, tasks, and related attitudes and experiences. Future studies should broaden the understanding of interaction challenges and related factors. Identified challenges reflected individual support needs in language learning and interaction dynamics. This study informs practice and policy by supporting the development of practices that enhance interactions, such as language mentoring, simulations, and DEIB policies.

Abbreviations

CALD
Culturally and Linguistically Diverse
COREQ
Consolidated Criteria for Reporting Qualitative Research
DEIB
Diversity, Equity, Inclusion, Belonging

Declarations

Ethics approval and consent to participate

The study was conducted in accordance with the Declaration of Helsinki. Ethics committee approval was not required for this study involving competent adult participants in accordance with Finland's research

ethics legislation. The research permit was obtained from the participating organisation. All participants received written information about the study and provided written informed consent before participation.

Consent for publication

Not applicable.

Availability of data and materials

The datasets (interview transcripts) generated and analysed during the current study are not publicly available due to confidentiality to protect participants' privacy in accordance with the European General Data Protection Regulation and ethical considerations. De-identified participant quotations are included in the manuscript.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

JeK: conceptualisation; methodology; formal analysis; investigation; data curation; writing – original draft; writing – review and editing; visualisation; funding acquisition. JoK: conceptualisation; methodology; writing – review and editing; project administration; supervision. JMK: conceptualisation; methodology; writing – review and editing; supervision. All authors read and approved the final manuscript.

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