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# Cross-cultural adaptation in healthcare: examining expatriate doctors' strategies and challenges in Wales

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## Abstract

**Purpose** – This study examines the cross-cultural challenges experienced by expatriate doctors working within an National Health Service (NHS) Health Board in Wales, with particular attention to how they navigate adaptation in professional and social contexts.

**Design/methodology/approach** – The study adopts a qualitative research design based on semi-structured interviews with expatriate doctors employed at a Welsh NHS health board. Data were analysed thematically to explore participants' experiences of communication, relocation, workplace practices and organisational support during their adaptation process.

**Findings** – The findings indicate that expatriate doctors face persistent challenges related to language and communication nuances, relocation and social isolation, and adjustment to flatter professional hierarchies. Successful adaptation was facilitated by individual factors such as personality traits (notably extraversion and open-mindedness), access to social and familial networks, and prior exposure to the UK healthcare system. Participants consistently highlighted the absence of structured cross-cultural training as a barrier to smoother professional integration.

**Originality/value** – By focusing on self-initiated expatriate doctors in a Welsh healthcare context, the study extends existing research on cross-cultural adaptation in healthcare beyond commonly examined settings. It offers practical insights for improving onboarding, cross-cultural training and institutional support mechanisms, with implications for staff wellbeing, retention and patient care outcomes within the NHS.

**Keywords** Acculturation, Expatriate doctors, Healthcare, Cultural challenges, Integration, Wales

**Paper type** Research article

## Introduction

Acculturation, the cultural and psychological adjustment to a new environment, is particularly salient in healthcare, where patient care, communication and professional ethics are shaped by cultural nuance (Berry, 1997). Healthcare systems operate within context-specific expectations that influence clinical decisions and professional relationships. In the UK, where expatriate doctors form a critical workforce segment, understanding cross-cultural adaptation is essential to sustaining care quality.

Expatriate doctors encounter challenges in navigating hierarchies, adapting to local systems and meeting patient expectations grounded in host-country norms (Nolan and Liang, 2022). Previous research links culture shock, manifested through anxiety, confusion and disorientation, to diminished job performance, patient care and wellbeing (Guru *et al*., 2012; Nolan, 2023). The General Medical Council reports that 63% of newly registered doctors



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qualified abroad, with internationally trained doctors projected to represent 39% of the workforce by 2037 (Foster, 2023), underscoring the importance of examining cultural integration within the National Health Service (NHS).

This study explores the cross-cultural challenges facing expatriate doctors in a Welsh NHS health board, where Welsh and wider UK cultural dynamics intersect. Through qualitative interviews, it identifies key barriers, language, hierarchy and relocation-related isolation, and examines adaptation strategies involving social networks, personality traits and cross-cultural training. While some doctors achieve successful integration through personal and social resources, many continue to struggle due to limited institutional support.

The study offers practical recommendations for healthcare organisations to enhance onboarding, provide targeted cultural training and foster retention. Addressing these challenges can improve professional adjustment, patient care and organisational resilience.

## Literature review

Research on expatriate adaptation has progressed from linear culture shock models (Anderson, 1994) to dynamic, context-sensitive frameworks emphasising the interaction between individual dispositions and situational factors (Han *et al*., 2022). Adaptation is now understood as an iterative process influenced by personal traits, organisational support, and the cultural features of both host and home societies (Teng *et al*., 2024). This shift reflects a move from essentialist notions of culture to relational and experiential perspectives.

Communication is central to successful adaptation. Expatriate healthcare professionals often face linguistic and paralinguistic challenges that vary across cultures (Schumann *et al*., 2022). Such difficulties can compromise patient safety and professional relationships (Alotaibi *et al*., 2023). Cultural distance helps explain why individuals from high-context, collectivist cultures may struggle with the direct, low-context communication common in Western healthcare. In the UK, interactional norms shaped by low power distance and high individualism (Hofstede, 1980; Mannes *et al*., 2023) often intensify these gaps. Culturally competent communication training mitigates such risks, enhancing trust and care outcomes (Al-Yateem *et al*., 2023; Alkhamees and Alasqah, 2023).

Professional hierarchies pose further adaptation challenges. Doctors from hierarchical systems often experience tension when transitioning to the NHS's egalitarian team-based model (Rao-Nicholson *et al*., 2020). Hofstede's dimensions of power distance and uncertainty avoidance illuminate these tensions, which can generate role ambiguity and lower efficacy (Valenzuela *et al*., 2021; Mannes *et al*., 2023). Conversely, inclusive, learning-oriented cultures facilitate smoother adjustment (Hajro *et al*., 2019).

Institutional support is a vital moderator of cross-cultural stressors (Takeuchi, 2010). Self-initiated expatriates, those relocating independently, are particularly vulnerable to misfit because of limited formal support (e.g. Doherty, 2013). Organisational interventions such as mentoring and pre-departure or cultural training enhance adaptation and retention (Gilles *et al*., 2008; Alshaibani *et al*., 2024). Yet in healthcare, such initiatives remain fragmented, leaving expatriate doctors to rely on informal networks (Abou Hashish and Alnajjar, 2025). Workplace social capital, especially bridging ties, buffers stress and promotes integration (Terry and Lê, 2014; Cramton and Hinds, 2014).

Individual factors, notably personality and psychological resources, also influence adaptation. Resilience, cultural empathy and open-mindedness foster effective adjustment (Van Oudenhoven *et al*., 2001; Han *et al*., 2022). Extraversion and emotional stability promote engagement, while cultural intelligence (CQ) integrates cognitive, motivational and behavioural adaptation components (Toumi and Su, 2025). In healthcare, these traits underpin collaboration, communication and stress management.

This study integrates Berry's (1997, 2013) acculturation framework and Hofstede's (1980) cultural dimensions theory to explain how expatriates negotiate cultural boundaries. Berry addresses how individuals balance heritage and host norms through assimilation, separation,

integration, or marginalisation, while Hofstede elucidates why mismatches in hierarchy and communication arise. Together, these perspectives link individual strategies (e.g. resilience, open-mindedness) with structural enablers (e.g. organisational support, cultural distance).

Despite extensive work on corporate expatriates (Sousa *et al.*, 2017), research on self-initiated expatriate doctors in Western healthcare remains limited. Existing studies focus mainly on nurses in Middle Eastern contexts (Dousin and Sulong, 2021; Hamze, 2020), neglecting culturally layered settings such as Wales. This study addresses this gap by examining how communication, hierarchy, support systems and personality jointly shape the acculturation of expatriate doctors in a Welsh NHS health board, contributing an integrated framework for understanding adaptation in healthcare contexts.

## Methodology and data analysis

### *Sample*

Purposive sampling was used to recruit expatriate doctors, a strategy suitable for studies targeting specific populations (Denzin and Lincoln, 1994). Recruitment was facilitated through a gatekeeper with authorised access to NHS doctors in the selected health board, who distributed invitation emails between 8 June and 3 July 2024. Although the target sample was 20–25, in line with Boddy's (2016) guidance that qualitative insights can emerge from as few as ten participants, 16 doctors ultimately participated. After the 16th interview, no new themes emerged, indicating data saturation and validating the final sample size.

Ethical Approval: This research was conducted in line with the UK Higher Education institutional ethical guidelines. Ethical Approval was granted by the University's Research Ethics Committee prior to any data collection taking place under the following reference number: PG/23/3368.

### *Analysis*

Thematic analysis (Terry *et al.*, 2017) was employed to identify patterns in participants' adaptation experiences. NVivo software supported systematic coding and theme management. A hybrid approach combined deductive coding, informed by existing theory, with inductive identification of emerging sub-themes, enabling categorisation into cross-cultural challenges and adaptation strategies.

Thematic analysis was preferred to narrative analysis due to its focus on commonalities and variations across participants (Gibbs, 2012). NVivo enhanced rigour through coding consistency and traceability. Our familiarity with the Welsh context enriched interpretation but also posed a potential bias, mitigated through reflexivity and adherence to established analytical procedures.

## Findings

Participants represented diverse nationalities, linguistic abilities and professional backgrounds, all influencing the nature of their cross-cultural challenges and adaptation strategies. Those from cultures more aligned with the UK reported fewer adjustment difficulties than those from culturally distant contexts. Variations in departmental training and support across the NHS health board also shaped participants' adaptation experiences.

Table 1 presents key demographic variables illustrating participant diversity. The findings are organised into two main categories, cross-cultural challenges and adaptation strategies, each comprising three core themes and associated sub-themes, as depicted in Figure 1.

### *Theme 1: communication*

Communication difficulties emerged as a major cross-cultural challenge, particularly for participants whose first language was not English. These difficulties were often compounded by local dialects and the use of Welsh in the workplace. As Participant 5 noted, "The

**Table 1.** Participant demographic table

| Participant no. | Nationality | Gender | Hospital sector |
|---|---|---|---|
| 1 | Pakistan | Male | Breast surgery |
| 2 | Greece | Male | Breast and general surgery |
| 3 | Poland | Female | Emergency |
| 4 | Romania | Female | Emergency |
| 5 | Romania | Female | Anaesthetics |
| 6 | India | Male | Ophthalmology |
| 7 | Romania | Female | GP |
| 8 | South Africa | Female | GP |
| 9 | Sri Lanka | Male | Medical director |
| 10 | Nigeria | Male | GP |
| 11 | Egypt | Male | Anaesthetics |
| 12 | Egypt | Male | Anaesthetics |
| 13 | Bangladesh/USA | Female | Gynaecology |
| 14 | Egypt | Male | General surgery |
| 15 | Poland | Male | Anaesthetics |
| 16 | Lebanon | Male | Anaesthetics |

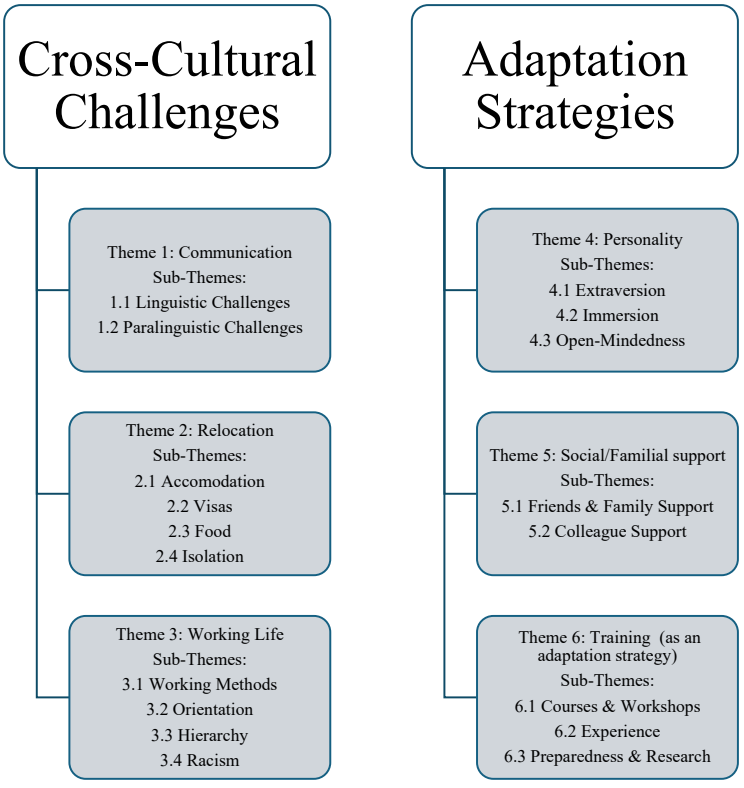


**Figure 1.** Themes and sub-themes

communication. It was a big problem." Similarly, Participant 10 reflected, "That was always at the back of my mind . . . they might not understand what I'm saying." Participant 14 added, "It took a lot of time for them to . . . work and communicate with people."

Three sub-themes were identified: linguistic challenges, paralinguistic challenges and tone.

*Sub-theme 1.1: linguistic challenges.* Participants frequently cited language barriers as a key obstacle. Operating in an unfamiliar linguistic environment, particularly within a professional context, heightened stress and misunderstanding. Participant 1 observed, "The language we study from the books or our medical books or the English book is different from the language spoken here."

Several participants also highlighted the challenges of using Welsh in professional settings. Participant 8 expressed frustration: "I got quite annoyed with colleagues speaking Welsh . . . it did irritate me that people speak Welsh at work when not everybody speaks Welsh . . . But in Bangor, the nursing staff often speak in Welsh amongst themselves or amongst Welsh speakers, and I just feel that's a bit awkward."

Similarly, Participant 9 described, "I have a problem with this Welsh Language and the slang the people communicate with me . . . Especially when we are communicating over the Teams or Zoom, it sometimes, it's difficult to understand the communication because of the language." These experiences reveal how language diversity within the workplace can unintentionally hinder collaboration and inclusivity.

*Sub-theme 1.2: paralinguistic challenges.* Beyond vocabulary, many participants struggled to interpret local expressions, humour and sarcasm. As Participant 6 noted, "The expressions can be sometimes not exactly the same way the locals express." Participant 11 echoed this sentiment: "I would say that I'm finding it quite challenging to make sense of everything the way I want to, you know on the level I would like to." Participant 12 added, "There's a difference between their understanding and your understanding."

Participant 15 elaborated on these difficulties: "I found differences in terms of accent pronunciations, general understanding of certain phrases, or the meaning of a certain things . . . So I found it's quite challenging culturally because you need to learn also the meaning of certain way people express themselves."

Similarly, Participant 13 explained how unfamiliar colloquialisms complicated patient interactions: "But when I come to this country, you know, especially with teenagers . . . I feel like that I need to know what they're thinking." Such communication gaps not only delayed adaptation but also affected clinical rapport.

*Sub-theme 1.3: tone.* Several participants described how their tone or manner of speech was misinterpreted, leading to tension with patients or colleagues. Participant 10 reflected, "I didn't speak the way you expected me to speak, even though I felt I did all the right things . . . But because of the tone which I say this, it sounds and it comes across as if I'm shouting."

Participant 7 shared a similar experience regarding interactions with colleagues: "Yes, even now I still have this habit . . . People they found not nice."

Tone was also a source of difficulty when delivering sensitive news. As Participant 2 explained, "Because it's one thing how you break bad news to a Greek family and how you break bad news to a British family . . . It's a big cultural difference and how not to upset people . . . Here you may upset people, especially I mean you know how I speak loud and fast . . . sometimes people may think that I'm angry or aggressive and this is something which I'm trying to control all these years and I'm still trying."

*Theme 2: relocation*

Relocation emerged as a significant source of cross-cultural challenge beyond the immediate workplace context. Participants described difficulties associated with becoming expatriates and adapting to life in North Wales. Four sub-themes were identified: accommodation, visas, food and isolation.

*Sub-theme 2.1: accommodation.* Most participants initially lived in hospital accommodation at Ysbyty Glan Clwyd, Ysbyty Gwynedd or Wrexham Maelor. Experience varied, but many found the accommodation and related services inadequate.

Participant 13 described the difficulties vividly:

> It's a big challenge in it because I left my big house in Dallas and I stay in accommodation and that several times was horrible . . . I sent a picture how the water was dripping on my carpet. I got sick at night . . . And with the cold water, that's so horrible that time.

Several participants compared the accommodation to student housing and questioned its suitability for experienced professionals. Participant 15 commented, "As a specialist who came from Poland, it was more like a student accommodation suitable for people to just survive cheaply rather than proper accommodation." Similarly, Participant 3 said, "I came from my home country having my house, my apartment and coming here and you know, at the beginning, living like a student . . . so that's a bit frustrating."

Participant 5 echoed this dissatisfaction: "They haven't had any family accommodation, so it was just too small . . . It was very dirty . . . Not welcoming at all . . . It was very, very unpleasant."

Overall, many participants felt the accommodation's quality did not reflect their professional standing. However, others viewed it positively, noting its diversity and community value. Participant 2 said, "Living at the accommodation for three years, it's a multicultural accommodation . . . It's more likely that helped me to understand other cultures, including the British culture as well . . . So it was a good challenge."

*Sub-theme 2.2: visas.* Visa and work permit processes were another major challenge. Several participants reported stress, uncertainty and limited institutional support.

Participant 11 shared, "I got a visa refused . . . And that was quite frustrating to be honest because I'm a doctor coming to get an exam . . . refusing my visa was a really, really awful experience."

Participant 5 described similar difficulties: "And back then, we needed something called work permit, which we had to apply for . . . I do not remember all the detail but oh look like nobody kind of knew how it works."

Such experiences illustrate the administrative burden faced by expatriate doctors and the need for clearer institutional guidance during the relocation process.

*Sub-theme 2.3: food.* Differences in diet and food availability also affected participants' adaptation, particularly among those from cultures with specific dietary requirements. Participant 6 explained, "The dietary challenges were enormous because I come from South India and I am from a family where we are vegetarians."

Participant 10 expressed similar concerns: "So that in itself made me a little concerned, especially as regards to things like food, like adapt to change my meals or diets."

However, not all participants struggled. Participant 1 noted, "provided us with Halal food in the mess," suggesting that institutional accommodation of dietary preferences could ease adjustment.

*Sub-theme 2.4: isolation.* Isolation was a pervasive theme across the participants' accounts. Doctors from collectivist or family-oriented cultures described a loss of community and connection.

Participant 2 stated, "Coming still from European culture, there is a strong family culture . . . If you're feeling that you're alone, better leave because then it's dangerous when mistakes will happen."

Participant 4 similarly reflected, "East European we are kind of more friendly if I can say yeah, so much more open, you know, and we like to socialize more in the way, like with your friends, we are really close together." When asked whether they felt a lack of community within the health board, they responded, "In a way yes . . . I did not have too much interaction outside of work."

Participant 5 observed that "Quite often for speciality doctors, they are quite isolated. They're still quite isolated," while Participant 11 added, "I didn't expect to feel that alone I would say."

These reflections underline how relocation challenges extend beyond logistical hurdles to emotional and social wellbeing. The combination of unfamiliar accommodation, limited social opportunities and distance from family often leads to feelings of loneliness, affecting morale and adaptation.

*Theme 3: working life*

Working life represented the most common source of cross-cultural challenges for expatriate doctors in the studied NHS health board. Participants reported difficulties arising from differences in working methods, orientation and training, hierarchical structures, and, in some cases, experiences of racism.

*Sub-theme 3.1: working methods.* Several participants acknowledged positive aspects of the NHS's working practices, particularly its structure and inter-departmental communication.

However, most participants found the unfamiliar working methods challenging. One recurring issue concerned family involvement in patient care, which differed markedly from their home-country expectations. Participant 10 noted, "So definitely the aspect of family, managing family members of all the family of the patient as well and taking the social context of treatment.". Participant 2 added, "So that was more like challenges, which is to learn where you will involve the family regarding you know the progress of the patients . . . You may end up having serious problems."

Differences in professional duties also created adjustment difficulties. Some participants expressed frustration at being unable to perform routine tasks in their home systems. Participant 5 explained, "But we have to cannulate here in the UK Back home it was a nurse job . . . Took me a while to get confident and do it." Participant 3 commented, "Here, no, the fact that you are nurse doesn't mean you can give IV drugs. You can't do IV cannula and can't catheterise, so that was a bit like a shock." Participant 4 concluded, "You need to set this in your mind like OK, fine, whatever you've done before, you're not really doing anymore."

*Sub-theme 3.2: orientation and cultural training.* A prominent issue was the lack of comprehensive orientation or cultural training. Seventy-five percent of participants reported receiving no cross-cultural preparation.

Some departments, particularly specialist units such as breast surgery and gynaecology, provided limited cultural training, whereas more general departments, such as emergency medicine and general practice, offered none.

Participants described the orientation as brief and largely administrative. Participant 2 stated, "The induction was not so great because I didn't have a real induction." Participant 4 added, "Shadowing might not be the best thing for all of the doctors because some of them, they will just be there shadowing, not taking initiative for 2–3 weeks" Participant 6 recalled, "The orientation was hardly anything . . . The orientation was just like, you know, he took me with him and introduced me to everyone. And just showed me around the department and that's it."

The lack of structured induction left many expatriate doctors uncertain about both workplace expectations and broader cultural norms, reinforcing adjustment difficulties.

*Sub-theme 3.3: hierarchy.* Many participants described confusion adapting to the NHS's flatter organisational culture, contrasting sharply with the rigid hierarchies of their home countries. Participant 6 reflected, "That feeling of like, you know, being a boss back home in India and when you come here and you are part of a team and it was a little bit challenging."

Participant 9 explained how this affected patients' perceptions: "Usually Sri Lankan health system is actually pushed by the hierarchy system. It's very clear . . . There is no hierarchy system in the UK . . . the patient couldn't understand who treated them."

Participant 15 highlighted both benefits and frustrations: "I recognized the benefits of the system for the patients, and it also got some frustration . . . simple thing to achieve becomes a big struggle because there has to go the certain process. You don't see the end for quite some time . . . so I found it a bit different and also sometimes frustrating."

These accounts illustrate that while egalitarian team structures enhance collaboration, they can initially disorient doctors accustomed to clear authority lines.

*Sub-theme 3.4: racism.* Some participants also reported racially motivated challenges. Participant 3 described encountering prejudice: "You always find the people which don't like overseas, it's your country where they don't like any kinds of immigrants when they don't like women, women doctors."

Participant 13 offered a similar reflection: "Also, one of the things that I thought because of my skin colour and the language, it could be the possibility."

Although not universal, such experiences compound the difficulties of adapting to new professional and social environments.

*Theme 4: personality.* This study found that expatriate doctors in the studied NHS health board employed three key adaptation strategies: personality, social and familial support, and training. This section focuses on the first, how individual personality traits facilitate adaptation to professional and cultural life in Wales.

Participants consistently noted that their personalities shaped their ability to transition, adapt and acculturate. As Participant 15 reflected, "But I think my personality, generally speaking, helped me a lot." Similarly, Participant 3 added, "It's still good to have some training, but it's just probably my personality."

*Sub-theme 4.1: extraversion.* Extraversion, encompassing social confidence, optimism and help-seeking behaviour (Amirkhan *et al*., 1995), emerged as a particularly valuable trait. Participants emphasised that successful adaptation required proactively engaging with colleagues, asking questions and forming new connections.

Participant 10 illustrated this clearly: "Having the ability to go up to people and ask questions and socialize would definitely help." Participant 9 adopted a similar approach, stating, "I'm an extraverted character. So I usually try to make friendship or try to make people known to me . . . so it is one strategy."

These accounts demonstrate how social initiative and confidence allowed expatriate doctors to overcome uncertainty and build professional rapport, supporting smoother adjustment to their new environment.

*Sub-theme 4.2: immersion.* Another adaptation strategy involved full immersion in the new work and cultural environment. Rather than employing formalised techniques, participants described gradual acclimatisation through daily engagement and persistence.

Participant 11 explained, "I think you just get used to it . . . It's not like you will do something extraordinary. So to navigate that just it comes with time."

Similarly, Participant 7 attributed their adaptation to personal determination rather than institutional support: "I think was more my own willing to carry on and try to adapt to the situation and to find my way in the system rather than . . . formal support."

Such reflections reveal that perseverance and self-directed engagement were key to navigating unfamiliar communication styles, systems and cultural expectations.

*Sub-theme 4.3: open-mindedness.* Open-mindedness also played a critical role in enabling expatriate doctors to understand and accept differences in medical practices and cultural norms. Maintaining flexibility and curiosity allowed participants to view challenges as learning opportunities rather than obstacles.

Participant 10 noted, "I've come from a different background and orientation, I'm able to appreciate why things should be done in the right way as we do here sometimes because you see good patient outcomes."

Similarly, Participant 16 reflected, "I adapted, I was becoming flexible, adapting everything that was the European culture there . . . I think the most what's the most important . . . Like how he can deal with it and how he's willing to be adaptable to things we face in life."

These accounts underscore the importance of adaptability and cultural openness in facilitating successful acculturation. Expatriate doctors who demonstrated curiosity and acceptance of new norms appeared better equipped to manage the complexities of working within the Welsh NHS health board.

*Theme 5: social/familial support.* Support from friends, family and colleagues emerged as a vital resource aiding expatriate doctors' adaptation within the Welsh NHS health board. Whether within the workplace or in their social lives, such support consistently helped participants navigate cross-cultural and logistical challenges. Two sub-themes were identified: friends and family support and colleague support.

*Sub-theme 5.1: friends and family support.* Most participants emphasised that emotional and practical support from friends or family significantly facilitated their adjustment. These networks were particularly useful in overcoming early relocation barriers, such as housing difficulties and cultural unfamiliarity.

Participant 14 described relying on friends to ease the transition:

> They helped us a lot with accommodation, with the, with the understanding the culture . . . Having friends to be honest is a very, very important step to get over all the difficulties in the country, especially if they are, you know, if they are British.

Others noted that family assistance allowed them to focus more effectively on their professional responsibilities. Participant 5 recalled, "I brought my dad at the beginning. I can't remember how many months but just to help with the girls."

Participant 10 highlighted how support from a friend and colleague was crucial to everyday adaptation:

> Without him being there it would have been a lot difficult for me . . . even basic things such as going out to shop . . . And that was a major thing, that sense of community . . . I think the sense of community ultimately is what would go a long way in helping people settle better.

These examples demonstrate that access to familiar social structures, whether through family presence or friendships, helped expatriate doctors mitigate loneliness, develop cultural understanding and maintain stability during transition.

*Sub-theme 5.2: colleague support.* Professional support within the health board was also central to adaptation. Colleagues often provided practical guidance and reassurance, easing the pressures of relocation and workplace integration.

Participant 5 described how colleagues helped them settle:

> Kind of an accommodation package with kind of basic information . . . where you can find things.

Support also extended to manage language challenges. Participant 6 explained, "Have a few staff members who are very proficient in Welsh . . . whenever we need any help we can ask them to just come and help us in translating."

Such collaborative environments enabled smoother communication and encouraged learning within multicultural teams. Participant 10 reflected on this positive atmosphere:

> It was very supportive . . . you were not put on that so much pressure while the same time you had people who understood things and who knew what was going on then that you were going to try and adapt.

These accounts show that professional collegiality and supportive departmental culture enhanced expatriate doctors' confidence and encouraged continuous adjustment.

*Theme 6: training (as an adaption strategy)*

Training emerged as a key adaptation strategy among expatriate doctors in the studied NHS health board. Participants highlighted that structured courses, prior experience and adequate preparation either supported or would have improved their adaptation. Three sub-themes were identified: courses and workshops, experience, and preparedness and research.

*Sub-theme 6.1: courses and workshops.* A minority of participants received formal cultural or language training upon joining the health board and found it beneficial. Participant 16 explained, "I think we have like mandatory training . . . Compliant for in the Welsh language, so you learn it and also about some cultural things where you can talk to the patient and to be adaptable to the place."

However, most participants did not receive such training and believed it would have eased their transition. Participant 14 suggested, "They have to arrange some sort of package or even course for the newcomers to get them more used to the community and health system and everything . . . the inductions should be tailored more to be suitable for the coming overseas doctors."

Several participants also proposed that cultural awareness training should be extended to local staff to enhance mutual understanding. Participant 10 observed, "The other doctors who work here, who are probably native Welsh or English doctors who also could attend those sorts of events or have that same knowledge, it will help them approach foreign doctors better." Participant 7 agreed, "So the local staff should get trained in understanding foreign cultures."

These reflections underline a shared view that well-designed cross-cultural training, addressing both expatriates and local staff, would strengthen integration and collaboration across multicultural teams.

*Sub-theme 6.2: experience.* Prior experience in similar environments was another key factor supporting successful adaptation. Doctors who had trained or worked in English-speaking contexts before relocation found communication and procedural adaptation easier. Participant 16 commented, "Also I didn't find a big challenge that it was a communication skills because I did my medical school in English."

Participant 6 explained how cultural values shaped their practice positively: "I would say cultural differences aided in doing my job effectively because . . . in terms of giving respect to your patients and giving respect to the elderly . . . that's our culture . . . and I find it's very transferable here."

These accounts suggest that drawing upon prior cross-cultural experiences and culturally grounded values can facilitate smoother professional and interpersonal adjustment.

*Sub-theme 6.3: preparedness and research.* Preparedness, through language proficiency, cultural research and psychological readiness, also emerged as a crucial determinant of adaptation success. Participants who invested time in understanding local customs, systems and communication norms reported fewer difficulties. Participant 14 noted, "So I think being good in a language will be very helpful in understanding the community." Participant 15 echoed this, "I learned English since I was a teenager, so I had a really good background . . . and I had well developed language skills."

Conversely, those who did not prepare adequately faced early obstacles. Participant 5 admitted, "I didn't really prepare and it was difficult to be fair."

These insights highlight that proactive preparation, linguistically, culturally and practically, plays a vital role in easing the transition and supporting long-term adjustment.

Collectively, the findings illustrate that structured cultural training, transferable experience and personal preparedness form an interconnected framework supporting expatriate doctors' adaptation. Participants consistently emphasised the value of pre-arrival and on-the-job training for both international and domestic staff. Personality traits, social support and institutional readiness complement these factors, shaping how expatriate doctors navigate challenges related to communication, relocation and professional integration.

## Discussion and implications

This study reaffirms the considerable cross-cultural challenges confronting expatriate doctors (Collinson *et al*., 2020) within the examined NHS health board. Communication barriers, including language nuances, tone and colloquial expressions, proved particularly problematic, echoing Hamze (2020) and Schumann *et al*. (2022). Misinterpretation of informal language highlights the risk of clinical miscommunication in high-stakes settings.

Relocation challenges such as inadequate accommodation, visa complications, social isolation and unfamiliar dietary customs intensified transition stress. These results extend Guru *et al.*'s (2012) work on culture shock by illustrating how poor accommodation and isolation disproportionately affect doctors from collectivist societies such as Egypt and Romania, where family networks are central. Hofstede's (2024) individualism–collectivism dimension explains why such doctors may feel heightened isolation within the UK's individualistic environment.

Professional challenges included divergent work practices, flatter hierarchies and experiences of racism. Doctors from high power-distance cultures struggled with the NHS's egalitarian structure, consistent with Mannes *et al*. (2023). Insufficient cultural training further exacerbated these difficulties, underscoring the need for structured organisational support (Guru *et al*., 2012). Beyond confirming classical acculturation models, this study contributes by revealing how these challenges manifest uniquely within the Welsh cultural and institutional context.

*Adaptation strategies*

Personality traits, particularly extraversion, resilience and open-mindedness, were crucial for successful adjustment, reinforcing prior research (Van Oudenhoven *et al*., 2001; Gilles *et al*., 2008). Proactive engagement with colleagues and local communities enhanced adaptation, supporting Terry and Lê's (2014) emphasis on social capital. Peer and familial networks provided vital emotional and professional assistance, helping expatriates internalise cultural and procedural norms. Prior UK exposure and cross-cultural training facilitated smoother integration (Gilles *et al*., 2008). Participants expressed strong demand for structured programmes aligned with workplace practices and cultural expectations. This supports Doherty *et al*.'s (2024) call for adaptive planning and institutionalised learning as key enablers of expatriate adjustment.

*Practical implications*

The findings of this study offer actionable recommendations to enhance the adaptation of expatriate doctors within the studied NHS health board. These context-specific measures extend existing research by proposing implementable, culturally informed solutions within the NHS framework.

Accommodation emerged as a key source of dissatisfaction, with several participants perceiving their housing as inadequate relative to their professional standing. The NHS health board should introduce a more personalised allocation process that considers cultural background and social preferences. Grouping expatriates from collectivist cultures could foster mutual support, reduce isolation and ease cultural transition. While this approach risks reinforcing segregation, the intent is purely social rather than professional; integration within the workplace remains paramount. Comprehensive welcome packages offering information about local services, transport and daily living in North Wales would further ease relocation. Such measures can reduce initial adjustment stress and promote smoother integration.

A critical gap identified in this study is the absence of structured cross-cultural training. Expatriate doctors expressed the need for programmes addressing specific linguistic, professional and hierarchical challenges. The NHS health board should develop modular, tailored training based on doctors' cultural backgrounds and previous experiences. Sessions should focus on communication nuances, such as tone, local idioms and indirect speech, as well as professional hierarchies and team collaboration. Interactive workshops, role-playing exercises and case-based learning relevant to healthcare practice could improve cultural readiness. The incorporation of virtual reality (VR) simulations presents a particularly innovative approach. VR technology allows expatriate doctors to practise challenging communication and hierarchy-related scenarios in a controlled, immersive setting. Research indicates that VR promotes empathy and confidence among healthcare professionals

(Halbig *et al*., 2022; Saab *et al*., 2022), making it a promising tool for experiential cross-cultural learning.

Adapting to the NHS's flatter, team-oriented structure was a recurrent challenge. To mitigate this, the NHS health board should implement regular peer-to-peer exchange sessions, enabling expatriate and local doctors to discuss hierarchy, communication and teamwork expectations. Such initiatives would build mutual understanding and reduce misinterpretations arising from cultural differences. Encouraging participation in team-building and interdisciplinary workshops would also foster collaboration and inclusivity, helping expatriate doctors integrate more fully into workplace culture.

Institutionalising cross-cultural competence within ongoing Continuing Professional Development (CPD) programmes would ensure sustained learning for both expatriate and local staff. Modules on CQ, conflict resolution and professional etiquette could enhance collaboration and patient care. Embedding such content within regular CPD schedules would help normalise intercultural dialogue and continuous improvement.

Formalising social networks is essential for reducing isolation. The health board should organise regular social events, mentorship schemes and professional networking opportunities tailored for expatriate doctors. Structured peer engagement fosters belonging, supports wellbeing and encourages knowledge sharing within multicultural teams.

Doctors who proactively researched UK healthcare practices and local culture before relocation experienced smoother transitions. To facilitate this, the NHS health board could establish an online resource hub providing pre-arrival information on North Wales, NHS structures and cultural norms. Such resources would allow expatriates to familiarise themselves with the local context and prepare for common professional and social challenges.

### *Theoretical implications*

Hofstede's (1980) cultural dimensions provided a valuable foundation for interpreting these experiences, yet this research extends the framework by revealing challenges unique to the Welsh NHS context, challenges that exceed traditional expectations of cultural dimensions theory. In doing so, it introduces a geographically and institutionally specific perspective on expatriate adaptation rarely addressed in prior scholarship.

Existing research on expatriate healthcare professionals has predominantly focused on non-doctor roles in Middle Eastern settings (Dousin and Sulong, 2021; Hamze, 2020; Al-Yateem *et al*., 2023; Alkhamees and Alasqah, 2023; Alshaibani *et al*., 2024). In contrast, this study foregrounds the intersection of Welsh culture, language and healthcare institutional norms as distinctive factors shaping adaptation, positioning the Welsh language as an underexplored source of cross-cultural complexity within the NHS.

Furthermore, the study reveals culturally contingent adaptation mechanisms: expatriate doctors in Wales often rely on family presence for successful acculturation, differing from counterparts in Saudi Arabia, who use digital platforms to maintain familial ties (Yusuf *et al*., 2021). Collectively, these insights refine theoretical understandings of expatriate adaptation by integrating cultural, institutional and linguistic dimensions within a UK healthcare context.

## Conclusion

This study offers valuable insights into the cross-cultural challenges and adaptation strategies of expatriate doctors within a Welsh NHS health board. It identifies communication barriers, relocation difficulties and professional adjustments, particularly around language, work practices and limited cultural training, as key obstacles to integration. Personal traits such as extraversion and open-mindedness, together with social and familial support, were found to facilitate successful adaptation.

Practically, the study advocates tailored cross-cultural training, enhanced accommodation provision, and structured social and professional support systems to improve integration and

retention. Overall, the research highlights that effective adaptation depends on both institutional initiatives and individual preparedness, contributing to more cohesive healthcare teams and improved patient care across the NHS.

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