The ‘Other’ Doctor

The ‘Other’ Doctor

Boundary work within the Swedish medical profession

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UNIVERSITET

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Abstract
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This thesis is about medical doctors with immigrant backgrounds who work in Sweden. Based on 15 qualitative interviews with medical doctors with immigrant backgrounds, this thesis explores the medical doctors' feeling of professional belonging and boundary work. This thesis focuses mainly on the doctors' experiences of being part of the Swedish medical profession while, at the same time, being regarded as 'different' from their Swedish medical counterparts. It starts off with the idea that medical doctors with immigrant backgrounds may have, or could be regarded as having, contradictory social positions. By virtue of being part of the Swedish medical profession, they belong to one of the most privileged groups in Swedish society. However, due to their immigrant background these doctors do not necessarily occupy a privileged position either within their profession or in society in general. This thesis shows that doctors with immigrant backgrounds feel that they are not perceived as full-fledged doctors, which seem related to how they are somewhat 'othered'. The results show that these doctors cope with being seen as different from doctor with non-immigrant backgrounds, by using the notion of 'migranthood' as a resource in negotiations in everyday work life but they also do what they can to overcome the boundaries of 'Swedishness'. Belonging should therefore be seen as having a formal and an informal side, as getting a Swedish license does not automatically mean that you feel belonging to, in this case, the Swedish medical profession. This seems to put doctors with immigrant backgrounds in a somewhat outsider within position, which seems having to do with boundaries between who is included in the 'us' and in the 'them'. Lastly, these findings indicate that sociologists need to expand the understanding of professional groups to also include boundary work within these groups. In order to do so, this thesis argues that sociological theory on professional groups could be combined with sociological theory about social positions as that is one way to understand the outsider-within position that these doctors (and presumably other skilled migrants) have to cope with.

Keywords: boundaries, boundary work, ethnicity, IMG, immigrant background, medical doctors, profession, negotiations, social constructionism, social position, sociology, qualitative methods

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To my family

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1. Introduction

This thesis is about medical doctors with immigrant backgrounds who work in Sweden. It is based on qualitative interviews with medical doctors and focuses mainly on the experiences that these medical doctors have of being part of the Swedish medical profession while at the same time being potentially regarded not only as 'immigrants' in this society but also as 'different' from their Swedish medical counterparts. The thesis finds its point of departure in the idea that medical doctors with immigrant backgrounds may have – or could be regarded as having – contradictory social positions. By virtue of being part of the Swedish medical profession, they belong to one of the most privileged groups in Swedish society (cf. Abbott 1988), but do not – because they have an immigrant background with all that it entails in this country[1] – necessarily occupy a privileged position either within their profession or in society in general (e.g. Bevelander, 2000; de Los Reyes & Kamali, 2005; de Los Reyes & Mulinari, 2005; Mattsson, 2001, 2004, 2005; Ålund, 2002). This is why the title of this thesis is 'The 'Other' Doctor'; a title that aims to reflect the somewhat 'in-between' position in which medical doctors with immigrant backgrounds can find themselves in.

One of the sociological problems that this thesis addresses is therefore the question of boundary work: how do medical doctors with immigrant backgrounds negotiate the professional boundaries that they encounter within the Swedish medical profession because of their foreign background or because they received their medical training in a country whose education is not automatically recognized by the medical profession of the country in which they now live?

It therefore seems important to point out that professions are organisations for practitioners within a certain occupation that control the licensing of all practitioners within this occupation (Tilly, 1998). Licensing processes are according to Tilly (1998), in other words, in place in order to exclude

[1] In a speech in mars 2014 the leader of the Swedish Democrats (a anti-immigration, anti-diversity party in the Swedish parliament (the whole speech in Swedish can be found on their homepage accessed 2014-03-21.) took medical doctors from abroad as an example of why Sweden should restrict labour migration. When he was asked about it he relates labour market problems to labour migration and stated that: "Take the deficit of doctors as an example. We have been forced to get doctors from abroad and the problems that come with them" (Dagens Nyheter 2014-03-16 pp12 my translation). This xenophobic and nationalistic discourse (introduced by SD) about 'immigrants' is also seen elsewhere in the Swedish society today and therefore probably affects the interviewed doctors everyday experiences.

"unorthodox, unworthy and unauthorized persons from practicing the occupation (and) in order to secure a monopoly over the distribution of the occupation's products to non-members" (p. 167). To this end it seems important to note (as will be discussed in more detail in Chapter 4) that the Swedish medical profession (through the Swedish medical association) has been 'successful' in controlling its outside boundaries. One example is the way in which the Swedish medical profession has controlled the number of enrolled students at Swedish medical schools[2]. This has prompted criticism from different sources that suggest that this association's control over the number of medical doctors that are trained is a way to protect medical doctors' status and high salaries[3]. Despite this, Sweden has experienced a rapid increase in the number of medical doctors that have received a Swedish license but who come from other countries[4]. Official statistics show that one in every five medical doctors working in Sweden in 2008 was trained outside Swedish borders[5]. I see this as a "salient contradiction of structures" (cf. Mills, (1959) 2000, p.11) since the Swedish medical profession, by controlling its boarder almost to efficiently now have to rely on doctors that are trained elsewhere in order to solve the shortage of doctors that exists especially in the rural parts of Sweden.

The idea for this thesis came from an observation I made when I was working with recruitment of medical doctors between the years of 2007 to 2009. In the course of that job, I observed situations where Swedish-born medical doctors were 'preferred' by my clients who were often managers in health care facilities all over Sweden. In other words, when there were two candidates with equal skills and experience applying for a certain position the Swedish-born candidate was often offered the job while the one with an immigrant background missed the opportunity for employment. The questions I pondered upon back then were: How do medical doctors with immigrant backgrounds experience these situations? And how can we, as sociolo-

[2] As stated in an article published in the Swedish Medical Journal (in Swedish: Läkartidningen) written by the then Chairman of the Swedish Medical Association, MD Marie Wedin. The title of the article was "More training places is not the solution" (in Swedish: "Fler utbildninsplatser är inte lösningen"). The article can be accessed through this link: http://www.lakartidningen.se/Aktuellt/Nyheter/2013/08/Marie-Wedin-ordforande-i-LakarforbundetFler-utbildningsplatser-ar-inte-losningen/, accessed 20140401.

[3] This was discussed in a public service TV program called Uppdrag granskning that audited Swedish authorities. In 2009 The Swedish Medical Association was audited in a program that was entitled "The Swedish Medical Association 'stopped' training" (In Swedish: "Läkarförbundet bromsade utbildning"). For more information on this program (which is also in Swedish) see the following link: http://www.svt.se/nyheter/sverige/lakarforbundet-bromsade-utbildning, accessed 20140401.

[4] According to unpublished data from the National Board of Health and Welfare (in Swedish: Socialstyrelsen) only three medical doctors from outside Sweden applied for a Swedish medical license in 1985. This can be contrasted with the number that did so in 2009 which was 845.

[5] According to the Swedish National Board of Health and Welfare's annual report NPS, 2010, p. 33.

gists, understand the fact that being regarded as 'different' by virtue of either one's non-Swedishness and 'immigrant' background or one's foreign-training seems to be a principle of organisation that can shape the experiences of medical doctors with immigrant backgrounds in Sweden? In short, my impression was, in other words, that medical doctors with immigrant backgrounds had an outsider-within-position in the Swedish medical profession; a position which I found sociologically interesting to explore. I wanted to know how these medical doctors talked about what being a doctor in Sweden meant for them, in order to see if their experiences deviated from what I had observed while working in the recruitment company.

Moreover, the idea for this thesis is also partly informed by observations made about the Swedish medical profession and the fact that this is a group that has undergone numerous changes over the past few decades (c.f. Carlhed, 2013). In Sweden, medical doctors have gone from being state officials to becoming team players. They have also gone from being provincial medical doctors who treated poor citizens in return for money from the king, to becoming responsible for providing health care to *all* members of this nation (Saltman & Bergman, 2005). As health care providers, medical doctors in Sweden have also become 'gatekeepers' to social insurance and sick leave benefits in recent years (cf. Clancy & Hillner, 1989; Reagan, 1987; and Weinstein, 2001). Something else worth noting is that this profession has also undergone changes not only in terms of the role that medical doctors now play within the health care system but also in terms of the backgrounds that these doctors have. The Swedish medical profession has gone from being a 'white' and male-dominated profession to becoming a much more gender- and ethnically-diverse profession (cf. Eriksson, 2003 as well as the statistics that are presented in Chapter 4). It was against all of these changes that I wondered how medical doctors with immigrant backgrounds navigated the Swedish medical profession.

With regard to the research gap that this thesis addresses it seems relevant to note – as will be discussed in Chapter 2 – that some aspects of the topic at hand have received more attention in international research than others. Numerous scholars have studied the re-establishing process of medical professionals with immigrant backgrounds[6] and their journey to earning a medical

[6]There are numerous ways in which one can refer to the group of medical doctors that this thesis focuses on. A look at the international literature on this group clearly suggests that the boundaries each country sets between its 'own' medical doctors and medical doctors with immigrant backgrounds can be based on different things. While North-American researchers use the term IMGs (international medical gratuates) to refer to these medical doctors, Australian and New Zealand researchers talk about OTD (overseas trained doctors). Sweden and other Scandinavian countries use the terms 'immigrant doctors' (in Swedish: invandrarläkare) and 'foreign doctors' (in Swedish: utländska läkare) synonymously. These different ways of referring to the medical doctors that this thesis focuses on are interesting since they suggest that the boundaries the Swedish medical profession draws regarding these doctors can be based on either background (i.e. where they come from) or training (i.e. where they received their medical training).

license (see e.g. Baer et al., 1998; Brown & Connell, 2004; Cooper, 2005; Han & Humphreys, 2005, 2006; Krahn et al., 2000; and Wong & Lohfeld, 2008). Thus, although this is not the case in Sweden (a matter that makes the thesis a contribution in itself), these angles of study were not deemed to be of particular interest. Most of the international literature examines the credentials, competency, demographic characteristics and distribution of medical doctors with immigrant backgrounds from a macro perspective (see, for example, Krahn et al. (2000) who show that medical doctors who have immigrated to Canada have to travel a longer path before gaining a license and that they work longer in lower positions than Canadian-born medical doctors). This thesis' focus is therefore a little different since attention is not primarily directed towards these issues but rather to how the interviewed medical doctors experience their social position when working as doctors in Sweden.

Something else worth noting is that this thesis engages with the literature on professional boundary work and problematizes it from the perspective that a focus on 'migranthood'[7] as a social position offers. As such, this thesis is interested not only in shedding light on the professional boundaries that medical doctors with immigrant backgrounds face but also – though not to the same extent – on the 'ethnic' boundary work with which they must grapple. This thesis' empirical focus (i.e. medical doctors with immigrant backgrounds in Sweden) therefore draws attention not only to the boundaries between 'us' (i.e. medical doctors) and 'them' (i.e. non-medical doctors) but also to the boundaries that the Swedish medical profession seems to operate from on the basis of 'ethnicity' (or non-Swedishness). As the chapter on theory (Chapter 3) will show, the literature on professional boundary work has focused mostly on boundaries *between* the medical professions and other occupational groups such as nurses, this thesis however, will shed light on boundaries that might exist also *within* the Swedish medical profession itself; a focus that have been peripheral in the literature on professional groups and which social position theory – I will argue – could help us explore.

With regard to 'ethnic' boundaries, it seems worth noting that Swedish scholars who work on international migration and ethnic relations issues have long argued that 'ethnicity' is not necessarily the most important category on the basis of which demarcations between 'us' and 'them' are made in Sweden. Ålund (2002) has, for example, argued that the dichotomy (Swede/immigrant) is more important than other potential dichotomies based on 'ethnicity' (such as Swede/ Finn or Swede/ Iranian to name a few). She argues therefore that the former has governed much of the understanding of difference in Sweden, which is why Swedish scholars often use the term 'migranthood' (my translation of the Swedish term 'invandrarskap') when

[7] This means that the term 'migranthood' is often used in contrast to the term Swedishness in Sweden. This term draws on the often taken for granted assumption that 'immigrants' deviate from the norm that 'Swedishness' is assumed to entail.

alluding to the social position at stake when discussing boundaries between Swedes and Non-Swedes (cf. Forssell, 2004; Göransson, 2005; Runfors, 2003; Schölin, 2010; Torres 2002, 2006, 2010).

In this respect, Trondman (2006) has argued that the reason why the term 'migranthood' is sometimes preferred by Swedish scholars is that the position of "immigrant, and not 'race' and 'ethnicity' is absolutely the predominant choice of term in Sweden" (p. 435). This clarification raises the question of whether all immigrants are regarded in the same manner in Sweden or not, and the answer of course is that they are not. In the Swedish professional debate on medical doctors with immigrant backgrounds, however, the terms 'immigrant'[8] or 'foreign'[9] medical doctors are often used interchangeably, while terms that allude specifically to ethnic background are seldom used. The terms 'immigrant' and 'foreign' are, in other words, often used when talking about medical doctors that have migrated from both the European Union or European Economic Area (EU/EEA), and medical doctors that have migrated from outside this area (or what the National Board of Health and Welfare calls a 'Third country' – in Swedish: Tredje land). In this thesis I therefore sometimes use the term 'medical doctors with immigrant backgrounds' to allude to both medical doctors born and/or trained outside Sweden, and medical doctors born in Sweden but who received their training outside Sweden. The reason I do this is that both the Swedish Medical Association and the National Board of Health and Welfare tend to use the term in this manner and it seems appropriate – at least at the beginning of the thesis - to use the term in a manner that matches the debates in this country.

Empirically speaking, however, this thesis focuses on medical doctors that are either non-Swedish born or non-Swedish trained (although most of the medical doctors interviewed have – as will be shown in the description of the sample offered in Chapter 5 as well as Table 2 – an immigrant background by virtue of where they come from and where they were trained). The reason for this is not only because it was not until 2010 that the National Board of Health and Welfare started to differentiate between medical doctors with a Swedish background and foreign-training, and medical doctors with an immigrant backgrounds and foreign training (a fact I will elaborate on in Chapter 4) but also because while working in the recruitment company mentioned earlier, I observed that it was the medical doctors who had neither a Swedish background nor Swedish training that faced the greatest challenges once they re-established themselves as medical doctors in this country. So, the medical doctors interviewed in this thesis represent the internal diversity that can be found among the group known as medical doctors with immigrant backgrounds in Sweden (with the exception of those medical doctors who are Swedish-born and have non-Swedish training and were, up until 2010, regarded as medical doctors with immigrant backgrounds in both the

[8] In Swedish: Invandrarläkare
[9] In Swedish: Utländska läkare

statistics and the debate). Being trained in another EU/EEA member state or being trained outside the EU/EEA is also an important distinction to make (even though this thesis focuses on the Swedish case, the impact of the European Economic Area borders is hard to ignore). This will be explained in more detail in Chapter 4, which is where the Swedish licensing process will be addressed. Here, I want to articulate that the thesis focuses on medical doctors with immigrant backgrounds, by which I mean those who have a non-Swedish background, non-Swedish training or who have both.

Another point that must be clarified from the start is that the medical doctors with immigrant backgrounds that this thesis focuses on are medical doctors that have come to Sweden mainly as refugees or for family reunification purposes. They are in other words, not labour migrants (in a legal sense). This must be kept in mind since medical doctors that emigrate for other reasons than professional ones face different challenges when they arrive. Labour migrants often have a professional context and network when they arrive in Sweden, but the medical doctors interviewed here lacked such connections. This means, that the majority of the medical doctors this thesis focuses on, are medical doctors that have faced numerous challenges in order to re-establish themselves within the Swedish medical profession. These medical doctors are not – for the most part – doctors from other European Union countries who receive automatic recognition for their medical training (i.e. medical doctors whose application for the Swedish license is more of a formality than the actual beginning of a long process). They are also not (with one exception) Swedish citizens who have studied in other European countries. Neither are they directly recruited by the county councils. So, the medical doctors the thesis focuses on could be regarded as immigrants in the sense this term is often used in both Swedish public debate and in the professional debate carried out by the Swedish Medical Association (see Chapter 4). Having stated the 'peculiarities' that this thesis has chosen to focus on it is now time to spell out the specific research questions that will be addressed.

1.1 Aim and research questions

This thesis aims to shed light on how the interviewed medical doctors perceive their position within the Swedish medical profession. The research questions to be addressed are: How do the interviewed doctors talk about belonging to the Swedish medical profession? What interactions do they talk about as important for that feeling of belonging? And what types of resources do they talk about using in order to feel that they belong to the Swedish medical profession?

The thesis explores, thereby, the dynamic interplay between professional boundary work and 'ethnic' boundary work by looking at what 'being a medical doctor' and 'having and immigrant background' mean to these doc-

tors' feeling of belonging within the Swedish medical profession. Therefore, the thesis treats both of these backgrounds as social positions that are theoretically profuse sources of information on professional boundary work.

1.2 Outline of the thesis

This thesis consists of nine chapters. Chapter 2 focuses on reviewing the international literature that has focused on medical doctors with immigrant backgrounds or medical doctors who have received their training abroad. This chapter aims to shed light on the research gap that this thesis addresses by drawing attention to the focus that previous research about medical doctors with immigrant backgrounds has had and the research questions that have yet to be addressed. The literature that will be reviewed in this chapter offers a broad outlook on the field, which means that some themes are more central to my analysis than others.

Chapter 3 introduces the conceptual and theoretical framework that informs the thesis. It is rooted in from sociological ideas about professional boundary work and the roles that professional groups play in society. This frame of reference is then combined with a social constructionist understanding of social position theory. The chapter will show that within the sociology of professions, the concept of boundaries has mostly been used as a way to theorise about how boundaries are constituted toward other professions. In this chapter I will suggest – as the empirical analysis aims to show – that adding a social constructionist lens to the study of professional boundary work makes it possible to see boundary-making processes within a profession. Important concepts in this chapter are *professional boundary work*, *'migranthood', assigned*, *asserted, thick,* and *thin social positions* and *construction site*.

Chapter 4 sheds light on the context in which the empirical data for this thesis was collected. This chapter offers insights into some of the structural obstacles that medical doctors with immigrant backgrounds face, since it presents what they have to do in order to get a Swedish medical license and what the regulations in place (i.e. the EU directive) mean for their re-establishment. This chapter also gives insights into the *Swedish Medical Association's* stand as far as boundary work is concerned. Moreover, this chapter sheds light into what could be perceived as the 'cultural' obstacles that these doctors face since it gives insight into the way in which cross-cultural medical interaction in Sweden has been regarded in the literature and what the *Swedish Journal of Medicine* has written about medical doctors with immigrant backgrounds in Sweden over the years. This means that this chapter draws on some of the research findings that previous research have shown to be important when studying the re-establishment process that medical doctors with immigrant backgrounds undergo.

Chapter 5 is devoted to the methodological point of departure of this thesis. It starts with presenting why a qualitative approach was chosen and goes on to present what I did to find my informants, who was included and why, how the data was collected and analysed and how trustworthiness and credibility was ensured. This chapter addresses also the ethical considerations and methodological limitations of this thesis.

Chapter 6, 7, and 8 are the empirical chapters. In Chapter 6, I analyse how the interviewed doctors talk about belonging to the Swedish medical profession in order to understand how the interviewed doctors perceive their social position but also how they perceive boundaries to feeling a sense of belonging within it. The focus of Chapter 7 lies on the interactions that the interviewed doctors mentioned when talking about belonging to the Swedish medical profession. This chapter also focuses on how the interviewed doctors talk about the social positions that they use in negotiating feelings of belonging within the Swedish medical profession in interactions with others. Chapter 8 focuses on the types of resources that the interviewed doctors talk about using in order to cope with a challenged feeling of belonging within the Swedish medical profession.

Chapter 9 is the concluding chapter. This chapter summarizes the findings of the three empirical chapters, and the contribution of the thesis to our understanding of professional boundary work. In this chapter I also make some further suggestions about how combining theory about professional boundary work with social position theory makes possible a social constructionist analysis of what it is to have a 'dual' social position; a dualism that many of the medical doctors interviewed in this study share.

2 Literature review

In this chapter, a review of the international literature[10] that has focused on immigrant medical doctors will be presented. As implied in the previous chapter, this chapter aims to synthesize the literature in this field in order both to shed light on the issues that need to be taken into account when studying the re-establishment process (and which I have taken into account in Chapter 4), and to find out what the literature suggests about social positions. This is important since research about medical doctors with immigrant backgrounds is conducted in various scientific fields (such as human resource management, public administration, medical sociology, professional sociology and international migration), and syntheses of previous research are seldom made.

This review begins with section 2.1, which presents the literature that focuses on the role that governments play regarding the opportunities (and obstacles) that medical doctors with immigrant backgrounds face when re-establishing in a new country. Section 2.2 presents the literature that focuses on the post-migration experiences of such doctors in different national settings, while 2.3 presents the literature that focuses on their perceived social positions. In the last section, 2.4, the literature that focuses on ethnocentrism and racism that medical doctors with immigrant backgrounds experience is presented since these issues were assumedly also relevant for the study at hand.

It seems worth noting that this review has not explicitly informed the analysis of the data but was performed in order to offer insight into the backdrop against which this thesis has been conducted. This means that some of the themes addressed in this chapter will not be explored empirically, while others had explicit relevance to the data collection phase. This review is therefore meant to give the reader insights into how the scientific

[10] The literature review has mainly – but not exclusively - been conducted using PubMed and Sociological Abstracts to identify scientific articles that report on studies of medical doctors with immigrant backgrounds. An initial search was conducted using relevant keywords including, 'immigrant doctors/physicians', 'overseas doctors/physicians', 'international medical graduates', 'foreign-born doctors/physicians', and 'foreign-trained medical doctors/physicians'. Publications that addressed pre- and post-migration experiences of immigrant medical doctors and structural premises in the receiving country were included. Bibliographies of included articles were then used to expand the search.

debate on medical doctors with immigrant backgrounds has been carried out (what research has focused on and what it has failed to address).

Having clarified how this review is to be regarded it seems relevant to state that the themes that have received the most attention in the international literature on medical doctors with immigrant backgrounds can be summarized as follows:

1. Research that focuses on the impact that government policy and regulation have on the re-establishment process that medical doctors with immigrant backgrounds undergo (i.e. Allsop et al., 2009; Anderson & Guo, 2009; Cooper, 2005; Groutsis, 2003; Iredale, 1999; and Raguhuram & Kofman, 2002).

2. Research on the impact that social positions (such as gender, age and ethnicity) have on these doctors' post-migration experiences in different countries and health systems (e.g. Ashton et al., 2003; Bernstein & Shuval, 1995; Betancourt et al., 2000, 2002, 2005; Bornat et al., 2008, 2009, 2011; Cooper et al., 2002; Cooper, 2005; Daimian, 1984; Drange & Vågan, 2013; Durey et al., 2008; Han & Humphrey, 2005, 2006; Harris, 2011; E.C. Hughes, 1945; D. Hughes, 1988; Laveist & Nuru-Leter, 2002; Lupton, 2012; Miller et al., 2011; Porter, 1993; Raghuram et al., 2009, 2010; Raghuram & Kofman, 2002; Saunders, 1985; Schouten & Meeuwesen, 2006; Shah & Ogden, 2006; and Shin & Chang, 1988).

3. Research on the moral and ethical issues such as brain drain and exploitation associated with the recruitment of medical doctors with immigrant backgrounds to different countries (e.g. Cooper, 2005; Cooper et al., 2002; Dovlo, 2005; Eckhert, 2002; Forcier et al., 2004; Iredale, 1999, 2001; Jourdey & Robson, 2010; Ronaghy et al., 1976; Scott et al., 2004; and Zurn et al., 2004).

This thesis aims specifically to contribute to the second academic discussion but as issues of migration regulations (i.e. labour and asylum-seeking regulations) are bound to affect the re-establishment process of medical doctors with immigrant backgrounds I will use the next section to address these issues first. The third theme is not addressed in this review since it was deemed to be the most peripheral to the task at hand; it is a theme that primarily focuses on the moral and ethical dilemmas associated with the brain drain that the import of medical doctors entails, and the doctors interviewed in this thesis are not medical doctors that have come as labour migrants.

2.1 Research on migration and integration of medical doctors with immigrant backgrounds

Research that has focused on migration policy and the integration of medical doctors with immigrant backgrounds suggests that their migration experiences are often related to federal government policy and its ways of promoting and controlling these professionals' mobility and migration. It is therefore important to mention even though it will not be in focus in this thesis (Chapter 4 discusses, however, the specifics of the Swedish case in these regards and is a chapter that has been inspired by the literature reviewed here). The role that governments play as far as the migration of care workers is concerned have been discussed, for example, by researchers such as Allsop et al. (2009), Andersson and Guo (2009), Cooper et al. (2002), and Cooper (2005) as well as Groutsis (2003). One important contribution to the research about medical doctors with immigrant backgrounds has been the connection between state policy and professional migration. The way policy promotes and controls the mobility of medical doctors with immigrant backgrounds is discussed by Clark et al. (2006), Cooper (2005), Groutsis (2003), Iredale (2001) and Jinks et al. (2000). Allsop et al. (2009) has studied the way in which federal government policies in four different countries (Canada, Finland, France and the UK) affect the mobility and migration of professionals. They conclude that compared to engineers and psychologists, medical doctors are more regulated in all four countries. Their study also shows that professional mobility is constrained not only by the welfare state but also by federal government policies in sectors such as health care and education. The accumulated knowledge that studies in this area have produced emphasizes the need for more research in different welfare states and comparisons between such states. Allsop et al. (2009) argues also that the link between colonized and colonizing countries has shaped the mobility patterns of medical doctors throughout history. There are, however, other patterns that affect medical doctors' mobility and migration, such as the European Economic Area Agreement (EEAA), which will be briefly alluded to in Chapter 4. Research about medical doctors with immigrant backgrounds is therefore a highly contextual matter.

Andersson and Gou (2009) show how state policy impacts the opportunities that medical doctors with immigrant backgrounds have once they arrive in a country. In their study they exemplify the connection between policy and opportunities by alluding to the way in which prior learning assessment and recognition (what they call *PLAR*) plays a role for immigrant professionals in Canada and Sweden. They conclude that *PLAR* has created a system of governing through (1) excluding practices[11] (this is similar to the procedural practices explored by Allsop et al. (2009) which were discussed ear-

[11] How these excluding practices can be understood in the case of Sweden will be discussed more in Chapter 6, 7, and 8.

lier in this section). Andersson and Guo (2009) argue therefore that *PLAR* is (2) a normalizing practice, which means that there is no room for diversity of experiences and competence within the *PLAR* model. Both excluding and normalizing practices in the assessment of skills of medical doctors with immigrant backgrounds act as dividing practices that separate medical doctors with immigrant backgrounds from medical doctors that lack such backgrounds. This is why these authors argue that understanding the *PLAR* model is one way to understand the social structures that shape 'we' and 'them' within the medical profession in different national contexts.

Hence, not only the federal policies and the system of governing affect the opportunities available for medical doctors with immigrant backgrounds; the medical profession as an institution and its power over migration is another perspective related to policy. In a study done by Groutsis (2003) within the Australian context, the authors demonstrate how much power the Australian medical profession has by showing the way in which they have influenced Australian immigration policy. They suggest that the monopoly that the medical profession has in that context made it possible for this group to restrict services in spite of demand, thus directly controlling how many labour migrants can enter Australia. In Sweden the medical profession have not been in direct control of labour migration and have not shown much interest in that aspect but that might have to do with that many of the doctors with medical training from other countries (especially those with training from outside the EU) do not come to Sweden as labour migrants but as refugees.

The research about how different states have organised the integration of medical doctors with immigrant backgrounds informs the way in which I look at the Swedish medical profession in Chapter 4. The licensing process in Sweden, for example, says a lot about the actual boundaries that medical doctors with immigrant backgrounds face in this country, as do the boundaries that the Swedish Medical Association debate has built on. This is why I have chosen to draw attention to this debate in section 4.6 and why I also opted to review the literature on cross-cultural interaction in Swedish health care. The latter gives us interesting insights into how 'culture', 'ethnicity' and 'migranthood' tend to be regarded within the Swedish medical profession.

2.2 Research on post-migration experiences of medical doctors with immigrant backgrounds: country perspectives

Important work on the experiences of medical doctors with immigrant backgrounds has been conducted with different country perspectives. One such country perspective is the Australian one (e.g. Durey et al., 2008; Han &

Humpherey, 2005, 2006; Harris, 2011; and Louis et al., 2010). This research shows that experiences differ between medical doctors that practice medicine in the countries in which they were trained and medical doctors with a foreign training that practice medicine. This research also shows that medical doctors with immigrant backgrounds report having less control over where and how they work than medical doctors trained within Australian borders. For example, Harris (2011) suggests that medical doctors with immigrant backgrounds in Australia are concerned that they lack influence over the organization in which they work. She calls this 'a moment of mismatch' which refers to the period in which medical doctors have left a context and thereby a way of 'being a doctor' and have not yet been socialized into the new context.

Durey et al. (2008) as well as Han and Humphrey (2005) suggest that medical doctors with immigrant backgrounds in Australia have to work in rural areas as a result of this mismatch. Both the geographical challenges (put forward by Durey et al., 2008) and the challenges of different organizational cultures (put forward by Harris (2011)) seem to impact medical doctors with immigrant backgrounds differently, depending on the context. It seems as if medical doctors with immigrant backgrounds in Australia are restricted in the choices they can make. The results from Durey et al. (2008) and Han & Humphrey (2005) suggest that medical doctors with immigrant backgrounds use different strategies when forced to practice in rural areas. According to the authors the strategies used depend on the level of 'acceptance' they feel from their rural environment (p. 239).

Politzer (1983) reports on similar findings in the United State and argues that medical doctors with immigrant backgrounds (or International Medical Graduates as they are called in the US) tend to serve populations in geographical areas that are neglected by doctors that have received their training in the United States. Baer et al. (1998) has therefore argued that medical doctors with immigrant backgrounds even help to reduce the rural physician shortages in the United States. They also address the need for more research on why medical doctors with immigrant backgrounds, who are compensating for physician shortages, are more common in some American states than others.

The research conducted in Australia and to some extent in the United States (e.g. Han & Humphrey, 2005, 2006; and Politzer, 1983) has focused on the geographical and institutional adaptation strategies from a doctor's perspective. Research conducted in Canada has a somewhat different approach since it tends to focus on the integration process (e.g. Andersson & Gou, 2009; Joudrey & Robson, 2010; Ngo & Este, 2006; and Wong & Lohfeld, 2008). For example Wong and Lohfeld (2008) criticise the *Prior Learning Assessments and Recognition* (PLAR discussed in the previous section) used in Canada. They argue that the journey from entry to adaptation can be understood as a three-phased process of adjustment. This process is characterized by (1) moving from loss, which includes loss of professional

identity and status as well as professional devaluation; through (2) disorientation, which they describe as 'feeling like aliens' towards peers and staff supervisors and which includes problems of understanding the expected roles and responsibilities; to (3) adaptation, by several coping strategies they use to adapt to their new situation. The result of their study implies that there is a way to 'complete transition' for the migrant doctor (Wong & Lohfeld 2008, p. 56).

This study is particularly relevant to this thesis and especially it's focus on feelings of belonging within the Swedish medical profession that the analysis will explore. As we will see in Chapters 6, 7, and 8 similar tendencies can be seen in the interviewed doctors' stories. In some regards one can therefore argue that this thesis takes off where Wong and Lohfeld (2008) end and focuses not so much on whether or not the interviewed doctors can be claimed to have completed their transition but rather on their experiences of feelings related to the process of belonging.

The PLAR model and the lack of recognition that it implies (Andersson & Gou, 2009) could be seen as one of the barriers to gaining a feeling of belonging within the Swedish medical profession that medical doctors with immigrant backgrounds can face. Challenges such as loss of social networks and discrimination, as exemplified by Ngo and Este (2006), could be seen as another example of situations where the feeling of belonging within the Swedish medical profession is hard to achieve. In a quantitative study conducted by Drange and Vågan (2013) focusing on the Norwegian medical professional context the researchers use the administrative registers for health personnel as a source of data in order to study internal stratifications within the Norwegian medical profession (encompassing all physicians educated between 1985 and 2002 who received authorisation in the period from 1992 through 2004). The authors suggest that medical doctors with immigrant backgrounds in Norway are to a significantly higher extent becoming specialists compared to the majority of medical doctors, but also that foreign-educated non-Western medical doctors have a significantly lower likelihood of specializing in surgery fields. In their study it seems that it is the non-Western background that is the social position that matters, and it could be understood to mean that medical doctors with immigrant backgrounds may have a hard time getting a job if they are not specialized. The exception from the overall equality may result from exclusionary practices previously identified in surgery, but it could also result from differences in motivation. These challenges are relevant to this study as they show that the process of becoming a doctor (see e.g. Shapiro, 1987) in a new context is a process of negotiation between being and becoming on the one hand and being 'inside' in some regards and 'outside'[12] in others on the other hand. This will all de-

[12] Being in an outside position in this context is a matter of being categorized by others as someone that does not really belong to that context. The concept of boundaries will be discussed in detail in Chapter 3 while Chapter 6 will address how the interviewed doctors talked about these issues.

pend on the structure of the specific context into which medical doctors migrate. One conclusion that can be drawn from this section is that research on medical doctors with immigrant backgrounds has shown that context plays a decisive role in how these medical doctors gain recognition. This is why Chapter 4 has the focus it has.

2.3 Research on social positions of medical doctors with immigrant backgrounds

The studies reviewed in this section are ones that have, in one way or another, focused on social positions. These are studies that highlight the importance of understanding how different social positions such as age, gender, and ethnicity impact the experiences of medical doctors with immigrant backgrounds. This type of research has been done primarily in the United States (e.g. Baer et al., 1998; Becker, 1961; Cheng & Yang, 1998; Drange & Vågan, 2013; Fernándes-Pena, 2012; Mullan et al., 1995; and Politzer, 1983) even if there is also some Australian research (see Durey et al., 2008; Han & Humphrey, 2005, 2006) that has drawn attention to relevant issues. The work of Becker et al. (1961) *Boys in White* where the researchers do a thorough job of documenting medical students' views on the process of becoming a medical doctor offers insightful knowledge about how ideas about what it takes to 'become' a doctor are shaped. This study showed, for example, that individual students' grades or other achievements played a less important role in medical students' ideas of what it took to become a doctor than the negotiations that took place between students. The title of the book reflects the North American medical profession at that time, but as the percentage of women entering medical school nowadays has overrun the percentage of men, and as medical doctors more than ever move from country to country, the issue of social positions within a professional group, I would argue, is still a highly important one. Post-colonial scholars have criticised the medical culture as maintaining traditional hierarchical social orders, and marginalize alternative perspectives (i.e. Carmack, 2006; Geist & Dreyer, 1993; and Waitzkin, 1991) and this thesis is therefore one way to critically investigate these issues.

Cheng and Yang (1998) show that medical doctors with immigrant backgrounds in the United States are unsatisfied with their careers. They suggest that there are certain 'domains of experience' that contribute to medical doctors' satisfaction. Included in the suggested domains is the stress of being regarded as an 'outsider'. Even though they do not analyse how the outsider position is constructed, their work suggests that 'being an outsider' seems to depend on the context. This will therefore be touched upon in Chapter 7 and 8. Fernández-Pena (2012) has another approach to studying the positions of medical doctors with immigrant backgrounds. He does this through review-

ing participants in a program designed to help medical doctors with immigrant backgrounds to enter the United States' medical profession. From qualitative interviews among medical doctors that have immigrated to the United States, he identified four themes that need to be considered when re-establishing oneself in the United States. The themes are: (1) English language proficiency, (2) lack of familiarity with the U.S. health professions and system, (3) time and economic issues and, (4) loss of professional identity. Fernández-Pena (2012) suggests that by addressing these themes, one could fill a gap in providing the American health system with "qualified, culturally-aware, experienced clinicians" that the current medical infrastructure is unable to meet (p. 442). Point four is particularly important to this thesis since it implies that there is a connection between professional identity and the negotiated social positions of medical doctors with immigrant backgrounds. Even though the study done by Fernández-Pena (2012) does not go into detail about what "loss of professional identity" (p. 442) is, his findings could be interpreted as related to loss of occupational status in relation to other social positions *within* the profession.

Even though social positions have been mentioned in some of the literature discussed so far it seems important to note that most studies do not actually focus on social positions. Therefore, the few studies that not only mention social positions but also analyse data on the basis of this notion will now be discussed in more detail since they are important for the aim of this thesis. I begin with the important work of Bernstein & Shuval (1995) where (following Daimian, 1984; Saunders, 1985; and Shin & Chang, 1988) they argue as follows:

> Age, sex and education have been found to be good predictors of occupational status persistence. (Bernstein & Shuval 1995, p. 809).

Their longitudinal research project (Shuval & Bernstein, 1995; and Shuval, 2000) – which uses both quantitative and qualitative methods – explores former Soviet Union physicians in Israel. Their studies imply that immigrant male medical doctors who came to Israel with high clinical and academic ranks were more successful in resuming their professional status in Israel compared to female medical doctors and medical doctors with lower levels of professional achievement. In their study they look at the social position of gender and age in order to see what effects these have on the time it takes to re-establish oneself as a doctor in Israel. They argue that being a woman and elderly have a negative effect in the first years after immigration, and that it takes longer for these doctors to re-establish themselves as doctors than for male and younger doctors.

Jounin and Wolff (2006) have also studied the notion of status in relation to social positions. In their study they analyse employment statistics and conduct qualitative interviews with medical doctors with immigrant backgrounds in France. The authors find that these doctors are somewhat 'second

class doctors' (since they are paid lower wages and have limited career prospects) and the only reason is that they are considered 'Non-French' (see Jounin & Wolff, 2006 and compare with Bornat et al., 2008, 2009, 2011; Raghuram et al., 2009, 2010; and Raghuram & Kofman, 2002 for the British context). Simones and Hurst (2006) also show how medical doctors with immigrant backgrounds in the UK had to undertake lower level tasks that could be related to both their 'non-UK backgrounds' which, the researchers claim, led to relative disadvantages in terms of location and career progression for this group of medical doctors (cf. Raghuram & Kofman, 2002). What these studies show is that medical doctors with immigrant backgrounds run the risk of experiencing a decline in status and that social positions (such as age, gender and ethnicity) mediate these risks in some settings, which might also have an effect on their feelings of belonging within the Swedish medical profession.

With respect to research on the status of immigrant medical doctors but coming from a more institutional perspective, it seems worth mentioning the study by Gray (1981). This study sheds historical light on the hierarchies of the National Health Service (NHS) in the UK. By looking at how the NHS describes medical doctors with immigrant backgrounds in public reports, Gray (1981) suggests that medical doctors with immigrant backgrounds in the UK are seen as "second class" doctors (p. 1189 and compare with Jounin & Wolff (2006) for the French context). She also concludes that this image, at the time of the study, shaped the notion among medical doctors and patients in Britain that medical doctors with immigrant backgrounds were less competent than British medical doctors. Other studies (e.g. Baer et al., 1998; Barnett, 1991; Bornat et al., 2008, 2009, and 2011; Iredale, 1999, 2001; Raghuram et al., 2002, 2009, and 2010; Raghuram & Kofman, 2000; Shuval, 2000) suggest that medical doctors with immigrant backgrounds lose their professional status when they have to take the jobs that medical doctors that come from the ethnic majority group in a country do not want. They work in rural areas, have low-status positions shunned by the locally trained doctor, and sometimes even have to re-establish themselves in other health professions considered lower in status than medicine. The essence of what this type of literature argues was summarized well by Shuval (2000) who states that:

> In their effort to retain their professional identity, these options (low-status positions) are in most cases accepted by immigrant doctors. As in other segments of the economy, there is a "dual labour market" in medicine –which creates a permanent structural need for immigrant physicians because locally trained doctors are unwilling to accept the least desirable jobs. (Shuval, 2000, p. 197).

In the quote above, Shuval argues that medical doctors with immigrant backgrounds can sometimes take on low-status jobs as a way to re-establish themselves as medical doctors. She argues that this is due to the segmenta-

tion of the medical doctors' labour market and that being regarded as 'immigrants' plays a role in this segmentation. Similar observations were made based on the interviews conducted for this thesis, and will be addressed in detail in the empirical chapters.

What Shuval (2000, p. 197) calls "an effort to retain professional identity" can be related to a study conducted by Remennick and Shakhar (2003) where they claim that there is a some kind of 'persistence' of professional identity even though one is not working in that profession. They argue this on the basis of a study they conducted among medical doctors with immigrant backgrounds in Israel who did not get a job in their profession. They therefore started working as physiotherapists instead. In their qualitative interview study among medical doctors with Russian backgrounds working as physiotherapists in Israel, the researchers interviewed the doctors about their professional identity. The results show that the doctors' professional identities were still vivid as in many ways they identified themselves as medical doctors and not as physiotherapists. This alludes to the importance of professional identity and how this identity persists.

Lupton (2012) argues, however, that much of the theorizing around the professional feeling of belonging is based on the idea that medicine has one static way of addressing inequalities; an idea she questions. In her book *Medicine as Culture: Illness, Disease, and the Body in Western Societies*, she unpacks the socially constructed evolution of medicine and reminds us that there are reasons why Western societies understand and enact health and medicine in a certain way. She urges us therefore to listen to the medical voices that have been previously silenced or lost. Her study calls out for studies that take into account people within the medical profession that might have different ideas of what the medical profession is all about, and she questions grand theories in the field of medicine that do not include these voices. The feeling of belonging, I would argue, is something that has not received much attention in studies about the medical profession, and this might be related to the fact that it has been treated as something that is automatically achieved through license. As we will see in this thesis' chapters this might not always be the case. In other words, if we want to understand what feelings of belonging there are within the Swedish medical profession, we need to understand what defines a doctor in this context. This is why social position theory has been chosen as one of the theoretical points of departure for this thesis (see Chapter 3).

2.4 Research on ethnocentrism and racism towards medical doctors with immigrant backgrounds

The issue of racism is a contested one, especially in research about privileged groups such as medical doctors but it is – as the literature reviewed so

far suggests – relevant to the post-migration experiences of medical doctors with immigrant backgrounds. This is why I will address this in a section of its own. Having said this, it is important to point out that there is an inherent difficulty in attempts to study discriminatory, ethnocentric and racist practices from an international point of view since official race and ethnic categories differ from country to country.

The most relevant contributions to the literature on medical doctors with immigrant backgrounds and 'ethnocentrism' have been conducted in the tradition of E.C. Hughes (1945). This research was done at a time in North American history when racial categories had legal status. E.C. Hughes (1945) introduced the theoretical concept of 'status dilemmas' (p. 353) and observed that being a black doctor, for example, was problematic because black medical doctors 'had' a status, in a sense, because they were medical doctors but lacked status at the same time because of the colour of their skin (racial or ethnic identity). This is, of course, a notion that this thesis explores though it does so on the basis of 'migranthood' rather than on the basis of 'race'.

D. Hughes identified, in other words, 'whiteness' as an assisting characteristic of high status occupations such as medicine very early on. D. Hughes (1988) followed in E.C. Hughes footsteps and conducted an ethnographic study of doctor-nurse interactions in a British hospital casualty unit. Many of the medical doctors he studied were recent immigrants to Britain from the Asian sub-continent and he noted that the geographic origin of the doctors significantly impacted the doctor-nurse relationship as the nurses' respect for the doctors was being eroded. In reference to D. Hughes' (1988) findings, Porter (1993) made participatory observations within an intensive care unit in Ireland, and found that medical doctors from ethnic minorities adopted different power strategies in order to maintain their status, especially in regard to nurses. One such strategy that Porter observed was related to a situation where medical doctors with immigrant backgrounds often asked nurses in the room to try to interpret the patient's x-ray. The nurses who were not used to this often failed to identity what was wrong with the x-ray. One of Porter's empirical examples arose in a situation when the x-ray showed a patient who had half a lung removed, which the nurses did not recognize. The strategy that the doctor used should, according to Porter, be understood as a deliberate strategy by a medical doctor with an immigrant background to prevent the nurse doubting his knowledge. Porter (1993) goes on to show that what seems to be an absence of racism can instead be understood as an instance of "backstage racism" (p. 601) such as talking behind the doctors' backs in in more 'informal' settings such as coffee breaks where professional status hierarchies are not maintained.

While D. Hughes (1988) and E.C. Hughes (1945) state that the issue dealt with is status dilemmas, Porters (1993) takes a step further and claims that we need to perceive these 'dilemmas' as based on racism that is structural and that "can be seen as a tendency that is realised in certain circumstances

and unrealised in others" (p. 607). Hence, all three of them would probably agree that status is harder to achieve for medical doctors with immigrant backgrounds as they have to establish all over again in order to regain status in contrast to the domestic doctors[13]. Porter (1993) argues that the "status differentiation" (p. 603) observed by D. Hughes (1988) and later himself is not only limited to people that are not familiar with the British or Irish 'culture' but is also suffered also by second and third generation black British people. These early studies of racism in British medical settings and the strategies that medical doctors with non-white backgrounds use in these settings in order to preserve their status and respect of their co-workers become important for this thesis since the differentiations and strategies that E.C. Hughes, D. Hughes and Porter address are somewhat found in the stories of the medical doctors with immigrant backgrounds who were interviewed for this thesis. Their studies suggest that we need to keep probing how 'racialized' categories are negotiated along with professional status in medical settings. Their work suggests also that we need to further explore the underlying assumptions that shape boundaries today in different countries and institutional contexts. This is why this thesis is highly informed by their findings.

Huijskens et al. (2010) offers another example of how ethnic background and appearance shapes the notion of what a doctor is. In an interview-based study with medical doctors with immigrant backgrounds in the Netherlands, the barriers and facilitating factors that these medical doctors face in their professional careers were studied. In their study, the medical doctors with immigrant backgrounds from the Middle East reported being asked discriminatory questions during their job interviews related to their 'ethnic' and/or religious backgrounds (such as how often they needed to pray and if they had problems with attending female patients). These medical doctors also reported being discriminated against by doctors and nurses. The researchers concluded that the doctors' religious beliefs and foreign appearance led to discrimination and a hostile working climate. However, the same doctors reported that issues of discrimination were overcome after a while once they became more fluent in the Dutch language but also as they gained a better understanding of the Dutch medical system and the way in which medical team members were expected to work. This is interesting for this thesis as it suggests that 'becoming a doctor' is a process before and beyond licensing, and that notions of 'migranthood' can influence this process.

A similar result was drawn from a study conducted by Cooke et al. (2003). This study argues that racism is manifested in the UK medical system, and has consequences for the access to training and careers of medical doctors with immigrant backgrounds. The study was a part of the British

[13] This is one of the reasons why this thesis does not take for granted that the re-establishment process ends when a doctor with an immigrant background manages to get his/her license to practice medicine in Sweden.

Medical Association (BMA) cohort study of 1995 for medical graduates. In this survey medical graduates were asked for their views on the extent to which 'ethnicity' was impacting their career progression. Focus groups were also used to examine the issue in greater depth. Cooke and his colleagues concluded that within the UK health system there was still a widely held view that problems that medical doctors from an ethnic minority are facing are seen as individual problems that have to do with "not understanding English culture"(Cooke et al., 2003, p. 1). The structural problems are in this kind of discourse therefore neglected on the basis that 'they just do not know the language'. A similar way of explaining can be seen in the public and professional debate about medical doctors with immigrant backgrounds in Sweden, and will be discussed further in sections 4.5 and 4.6.

Disparities have also been shown to have an impact on the quality of care. Racial and ethnic disparities in health care can be seen as a quality problem as argued by Betancourt et al. (2000, 2002, 2005) (see also Anderson et al., 2003 for a review on the concept of cultural competent health care systems). In this literature much attention has been paid to the doctor-patient relationship (e.g. Ashton et al., 2003; Betancourt et al., 2005; Cooper et al., 2002; and Cooper, 2005; LaVeist & Nuru-Jeter, 2002; Meeuwesen et al., 2006; Miller et al., 2011; Roter & Hall, 2006; Schouten & Meeuwesen, 2006; Shah & Ogden, 2006). Schouten and Meeuwesen (2006) have reviewed the literature on intercultural medical communication in order to see how 'culture' and 'ethnicity' have been used within that field. They argue that 'culture'[14] and 'ethnicity' are often regarded as barriers to establishing an effective and satisfying doctor/patient relationship. Ethnic-minority patients are, in other words, often presented as having fewer possibilities to be recommended for certain treatments than white patients, which leads to ethnic and racial disparities in the use of health services (e.g. Betancourt et al., 2002; Harris et al., 1997; Johnson, et al. 2004; Schulman et al., 1999). Some research argues that this problem can be solved if the doctor and the patient have the same 'ethnic' backgrounds (e.g. Copper et al., 2005; and LaVeist & Nuru-Jeter, 2002).

Shah and Ogden (2006) conducted an experimental study in which patients got to look at pictures of medical doctors with different 'ethnic' backgrounds. The patients then had to report on which characteristics they *assigned* the different doctors on the basis of how they looked (p. 183). Results showed that the 'ethnicity' of the doctors impacted the patients' judgment of them, as did age and gender. A somewhat different result was found in a study conducted by Miller et al. (2011) who explored Kenyan patients' perspectives on the role of the doctor's 'ethnicity' by using both questioner and focus group interviews with patients. The results from this study showed that

[14] She avoids defining culture but argues that culture guides communicative behavior, and she also suggests that ethnicity should be seen as one element of culture (Schouten & Meeuwesen, 2006, p. 22)

patients did not want to consult medical doctors that had the same ethnic background as themselves due to concerns about confidentiality.

What can be added here is that in the literature on intercultural medical communication there seems to be a difference in 'who' is considered to have 'ethnicity' and 'culture'. In a literature review done by Schouten and Meeuwesen (2006), the authors analyse how these concepts have been discussed in research about the doctor/patient relationship. Even though their aim was not to answer the question of whether both parts of this affiliation are perceived as having 'ethnicity', I would suggest that this is an important question that should be raised in regard to studies about the doctor/patient relationship.

As many researchers before me have suggested (e.g. E. C. Hughes, 1945; D. Hughes, 1988; Porter, 1993; and to some extent Baer et al., 1998; Barnett, 1991; Iredale, 1999, 2001; and Shuval, 1995) discrimination seems to exist on the basis of gender (male and female), age (younger and older), class or status (economic and educational resources available) as well as 'ethnicity' and/or 'race' (where you were born/trained or how you look) within the medical profession. However, the interesting question to be studied here is not if this discrimination exists or not, but rather whether ideas about 'migranthood' (i.e. being categorised and regarded as an immigrant with all that this entails in Sweden) have any bearing on the way in which medical doctors with immigrant backgrounds talk about feelings of belonging within the Swedish medical profession.

3 Conceptual and theoretical framework

This thesis' conceptual and theoretical framework is based on two sociological traditions. As alluded to in the introduction, the thesis stems from sociological theories about professional boundary work and the role professional groups are said to play in society. This frame of reference is then combined with a social constructionist understanding of social position theory. This chapter has two aims. The first is to show that professional boundaries as a concept have mostly been used to theorise boundaries between one occupational group and another, and to argue that applying a social constructionist lens could allow us to see boundary work processes also within a profession (such as hierarchies and segmentation tendencies). The second aim is to present the conceptual and theoretical framework that will be used to analyse the empirical material that has been collected (and which is presented in Chapters 6, 7, and 8).

It is also worth noting that this thesis follows the work of Anthias (1998) who suggested that a conceptual framework should be seen not as a set of theories to be tested, but instead as a set of tools facilitating the ability to identify patterned social outcomes. In other words, the framework to be presented here should be seen as the "ontological space" (p. 510) that enables the recognition and analysis of notions of social categories (such as gender, 'ethnicity' and 'race') without limiting the recognition of differences and specificities. Having clarified this, it seems important to address why I chose to combine theories about professional boundary work with social position theory. The reason is that the combination makes it possible to locate someone´s position in an organisational setting. Lindemann (2007) suggests that by having a social position perspective one may identify a person's position within a social hierarchy (pp. 54-68). I would also add that all social positions are to be understood as a product of structural premises that have 'real' consequences beyond our notions of them. A doctor cannot be a doctor without knowing that he or she is one, and the position of being a doctor is therefore not only socially constructed but is also restricted by actual professional boundary work such as licencing. In this thesis it is the position of medical doctors with an immigrant background, and how they talk about belonging to the Swedish medical profession that I want to shed light upon.

Therefore, the framework of this thesis will combine social position theory with theories about professional boundaries. The professional perspective that will be used draws on the work of Abbott (1988), Brante (1988), Collins

(1990), Freidson (2001) Liljegren (2008) and Scuilli (2005). They all focus on the boundary between what constitutes a profession and what does not. The social position perspective that will also be used in this thesis draws on the work of Anthias (1998, 2002), Cornell and Hartmann (2004, 2007), Howard and Hollander (1997, 2000), and Lamont and Molnár (2002) and Anthias et al. (1993). The work of Howard and Hollander (1997, 2000) is important because these researchers emphasize the relationship between social actors and their environment. Cornell and Hartmann (2004, 2007) inform this thesis because they emphasize the notion of *construction sites* and elaborate on the notions of *assigned* and *asserted* as well as, *thick* and *thin* social positions. Lamont and Molnár (2002) are important because they put the emphasis on boundary work and status, while Anthias' work (1998, 2002) is relevant to the task at hand because she raises the issue of constructions in social positions through the notions of 'Otherness and Sameness'. The use of the notion of *'outsider within'* (Collins 1986, 1999) will be explored as a possible way to combine the professional and positional perspectives in order to analyse the interviewed doctors stories.

The thesis proposes that we need to explore how both the theories of professional boundaries and the theory of social positions have theorised the notion of boundaries. This is necessary in order to understand what is going on in the specific case that this thesis focuses on (i.e. medical doctors with immigrant backgrounds in the Swedish medical profession). As stated in Chapter 1, the Swedish medical profession has been successful in boundary work by controlling not only its boundaries with other occupational and professional groups but also by controlling how many new medical doctors are trained in Sweden. This raises questions about what is happening within this profession now that more and more medical doctors come from somewhere else.

3.1 What is professional boundary work?

In my view, the main contribution of theories about professional boundary work is that these theories explain what separates professional from other workers, and the reasons behind professional boundary work. These ideas have been theorised in different sociological traditions, and the typologies will be presented below.

Brante (1988) sees the development of theories about professions as a development that has entailed the construction of two dominant theory paradigms "Naivism" (before the 60s-70s) and "Cynism" *(on-going)* (p. 140). He argues that the early theorizing on professions began with Carr-Saunders and Wilson (1933) as well as with Parsons (1939). Parsons namely argues, "it seems evident that many of the most important features of our society are to a considerable extent dependent on the smooth functioning of the profession" (p. 457). He therefore introduces the idea that professions should be

seen as having a specific function in a system. The sociology of profession was therefore for a long time concerned with trying to define what was the function of a profession and what was not. This means that the functionalistic approach is concerned with the boundary work between the professional (system) and other occupations, but also with discovering what was at the 'core' of different professional groups.

Evetts (2003) draws on a somewhat different dual view than Brante (1988), focusing instead on what differs between those researchers who see professionalism as a value system and those who regard it as an ideology. She has also argued that there is a difference in approaches between Anglo-American researchers (who tend to focus on occupational closure and 'market shelters' (cf. Freidson 1982. pp. 39-54) and continental researchers who have been more concerned with occupational identity and career trajectories as well as professional training and expertise. Collins (1990) calls this contrast a difference in ideal types and claims that the Anglo-American ideal-type: "stresses the freedom of self-employed practitioners to control working conditions", whereas the continental ideal-type emphasizes "elite administrators possessing their office by virtue of academic credentials" (p. 15).

Sciulli (2005) takes this a step further when he claims that continental sociologists were never involved in trying to define a profession. He argues that continental researchers did not even have a word for profession and were instead drawing attention to broader social formation and occupational theories. He argues further that through approaching the 'profession' as a middle class (the so called *Bürgertum* approach) the continental research about professional groups was more closely connected to Weberian or Marxist class analyses of the occupational order, and stratification system in different societies than the Anglo-American, which stresses professionals' need for autonomy (p. 915).

Another way of understanding what Brante refers to as "nativism" (1988, p. 120), is offered by Evetts (2003) who refers to the same tradition as "professionalism as a value system" (p. 399). For Evetts, this tradition is mostly focused on defining the term 'profession' (and the 'core' of it) as well as a profession's function and consequences for a society. Both Brante (1988) and Evetts (2003) seem, in other words, to agree that there was a period in the sociology of professions in the 1970s where the functionalist (or nativist according to Brante) approach was questioned[15]. Researchers like Abbott (1988, 1995, 2001), Collins (1990), Freidson (1982, 2001) revised, in other words, the Sociology of Professions[16] and joined what we today refer to as the Neo-Weberian school (Evetts 2003, p. 410). These scholars' work contributed to the functionalistic approach's loss of popularity since professionals were now – in their frames of reference – regarded as experts who by

[15] This could be seen as related to the 'constructivist turn' in the understanding of social positions that is discussed later on in this chapter.

[16] Sciulli (2005) refer to this process as Anglo-American revisionism, which he argue we need to move beyond (p. 919).

strategic means (or boundary work) controlled certain services. In the *International Encyclopaedia of Social Behavioural Sciences,* Abbott (2001) defines any expert occupation 'that competes for jurisdiction' as a profession (p. 12167) and by doing that he re-directs the focus from the core value to the boundary that surrounds professional groups. Liljegren (2008) draws on Abbott but suggests that by focusing on boundaries, the researcher can study the boundary work, or in other words, the maintenance of boundaries that a specific occupational group upholds. He argues also:

> It is not the profession that comes first followed by the boundaries. Instead it is the opposite. (Liljegren, 2008, p. 21, my translation).

When we discuss boundaries it seems important to draw attention to Lamont and Molnár (2002) who have argued that professions originally emerged from a "demarcation problem" (p. 177), a problem that drew attention to boundary work between special and ordinary occupations, as well as between specializations within a profession (cf. Johannisson, 2004). The important thing here is therefore not what comes first (the profession or the boundaries) but instead that this way of looking at professions opened up the possibility to consider boundaries as things that demarcate who is outside and inside[17], and boundary work as what is done to maintain these boundaries. Let me use two studies to explain why we also need to consider professional boundary work within. The first example comes from a study conducted by Durey and his colleague (2008) where they show how normative control lies at the core of the Australian medical profession. These researchers draw on a study in which 49 medical doctors with immigrant backgrounds were interviewed in order to understand how they communicate and negotiate professional identity. The study concludes that these doctors' identity work is constrained by medical registration and geographic restrictions on practice, as they have to go and work in rural areas. The 'fluid' and responsive nature of professional identity emerged when these doctors had to move across cultural domains in order to re-work their identity as a team member (Durey et al. 2008, p. 517, cf. Scott, 2008; and Van Mannen & Stephen, 1984). Their results indicate that professional boundaries are not only something that separates one professional group from another but also reveal the group's internal hierarchies. The medical doctors in the study by Durey and his colleagues (2008) show that even though these doctors had a license to practice medicine, internal hierarchies restricted their possibilities.

There is another example I would like to mention in order to suggest that boundaries within are important even though research on professional boundary work has mostly focused on boundaries *between.* A study by Ap-

[17] I would like to emphasize that the functionalistic way of looking at professions as a function with a core value is not discharged through focusing on the boundaries, as boundaries also serve to 'protect' the core in some regards.

ker and Eggly (2004) shows how dominant ideas within the North American medical profession become particularly salient in medical doctors' socialization (which refers to the process in which new medical doctors become assimilated into a 'medical culture' 2004, p. 425). The authors exemplify this by observing morning briefings in a hospital and argue that gender determines who interacts with whom and who gets to give their opinion. They argue that notions about gender are intertwined with notions about the medical profession, which is why this profession is highly hierarchal. Both of these studies suggest – as I will be doing later on the basis of the analysis I have conducted – that the literature on professional boundary work needs to pay more attention to boundaries within professions and on how professional and positional hierarchies work together.

To this end it seems important to draw attention to the fact that many researchers have objected to the way in which grand theories have discussed professional boundary work (i.e. Riska, 2001). The objections have been mostly based on gender issues (e.g. Davies, 1996; Eriksson, 2003; Lindgren, 1992; Riska, 2001; Salahani & Coulter, 2009; Witz, 1990; and Wrede, 2008). Riska (2001), for example, criticizes the grand theories on professions because they do not consider the built-in gender contracts that exist in the societies they draw on. Witz (1990) argues, in turn, that the female professionalization project has been overlooked in the sociology of professions. She therefore presents a model of occupational closure strategies, which captures both the variety of strategies that characterize these projects and the gendered dimensions of these strategies (p. 675). This is relevant to the task at hand because she captures how social positions are intertwined with a variety of strategies within a professional group, which is one of the focuses of Chapter 8. Thus, without arguing that gender and 'ethnicity' share the same logic, Witz' work (1990) opens up the possibility of regarding 'ethnicity' as an important social position to consider when studying how medical doctors experience their situation as far as the feeling of belonging is concerned.

Another important notion that informs this thesis can be found in the work of Davies (1996), who argues that the key issue for consideration in the sociology of professions is not so much the exclusion of women from work that is defined as professional, but rather their routine inclusion in serving tasks and trivial support roles (p. 671). In this respect it seems interesting to draw attention to the work of Eriksson (2003) who shows – through ethnographic studies in different Swedish medical settings – that although 'gender does not matter', a 'gender-mix' is always considered good as far as the medical profession is concerned. She argues therefore that female medical doctors in the Swedish medical setting are described as exceptional medical doctors and at the same time are considered to be 'inadequate women' while male doctors embody the doctor's ideal of what she calls *läkarskap* (which translates into 'doctorhood') since they are perceived as 'genderless'. Even though she does not explain how female doctors negotiate their different

social positions she shows that the intersection of social positions is important to the study within the Swedish medical profession. I will therefore try to use 'the social position of medical doctor' as a way to talk about the feeling of belonging within the Swedish medical profession.

Wrede (2008) argues in a more theoretical piece that the recent theoretical turn in the sociology of professions has reframed professional knowledge as socially defined (p. 30). She refers to the persisting tension between changing governance and gendered hierarchies in health care and argues for new approaches through which professional expertise can be democratically represented in politics. Thus, one of the most important feminist contributions to the sociology of professional groups is that they have drawn attention to the fact that boundaries can be gendered (e.g. Hall, 2005; Lupton, 1994; May, 1999; Salhani & Coulter, 2009; Witz, 1990; and Wrede, 2008). Thus, although feminist contributions to the sociology of professions have not addressed ethnicity, there are some that have argued that a crucial problem in the sociology of professions is the inability to see gendered embodiment as interwoven with the history of colonialism (Connell, 2012). Connell proposes therefore that we need a relational approach to understanding gendered structures in health care, and argues:

> Gender continues to structure health services, but in ways increasingly intertwined with ethnic and international inequalities. (Connell, 2012, p. 7)

Besides Connell's (2012) allusion to the interplay that social positions can play in how we understand professions, there is also the work of Boudreau et al. (2011) who, in regard to the medical profession, has suggested that 'physicianship'[18] is the 'softer part' of medical education. It is this 'informal' part of professional belonging that this thesis focuses on (as will be explored in Chapters 7-9) and we will use the term 'social position of medical doctors' to refer to it. The empirical data analysed in this thesis draw attention to how the medical doctors interviewed in this study talk about belonging to the Swedish medical profession and how they negotiate boundaries they have experienced (and are experiencing) in the process of re-establishing themselves as medical doctors in this country.

3.2 Why do boundaries (within a profession) matter?

In the previous section I argued that the sociology of professions has primarily focused on boundaries between professions and not on boundaries within them; the boundaries between nurses and other occupations but not on the

[18] The term was first used by Bourdreu et al. (2004) to distinguish between the material and the symbolic sides of a profession. The term is used here to draw attention to the socially constructed side of professions.

boundaries related to internal hierarchies on the basis of where you are from. These internal hierarchies might not only influence the specialisation in which you are likely to find a job but also where in Sweden you are most likely to find employment. The framework presented in the previous section needs therefore to be combined with a framework that allows us to shed light on these internal boundaries. The medical doctors that were interviewed in this thesis were all medical doctors that had – formally at least (by virtue of having received their license to practice medicine in Sweden) – crossed the outside border of the Swedish medical profession. They belonged, in other words, to the Swedish medical profession in the formal sense of the word but the question is whether they regarded themselves as fully-fledged members of their profession and if they also felt that they belonged to the Swedish medical profession. This section will address the reasons why boundaries within are analytically important to consider.

Evetts (2003) – who does not focus on the boundaries within – has suggested that future research should explore what is happening with different professions now that globalization has led to some markets becoming increasingly international (p.1). This is one of the reasons why this thesis focuses on medical doctors with immigrant backgrounds. At the core of it is the interest in exploring what increased professional mobility can mean to the way in which a profession regards its members and distinguishes itself from others. Increased mobility among medical doctors means that more and more medical practitioners today are born in one country, are training in another, and can end up practicing medicine in a third country. When medical doctors re-locate in this manner they have to start over again, replacing lost networks and re-building their professional status in a new professional context (cf. Wong & Lohfeld, 2008). This process of re-establishment can be challenging for a variety of reasons (as suggested in the literature reviewed in Chapter 2) and therefore one questions that this thesis dwells on has to do with if gaining a feeling of belonging within the Swedish medical profession is a process that is more challenging than the mere crossing of the outside boundary through getting a Swedish medical license?

Johannisson (2004) – who is a Swedish researcher on the history of science – shows why it is important to look at boundary work in the Swedish medical profession. Through an analysis of the history of medical doctors' examination procedures from the 1800s to today, she argues that the Swedish medical profession has always been divided into two separate social orders: 'the practical' (e.g. family medicine) and 'the professional[19]' (e.g. neurosurgery). The practical ideal represents a world of masculine authority, patriarchal attitudes, social engagement and close patient relations (e.g. family medicine) that can be traced back to the nineteenth century. Later, this practical ideal was slowly replaced by the professional ideal (e.g. neuro-

[19] This is Johannisson's (2004) term and should not be confused with how the term 'profession' has been used in this thesis so far.

surgery) representing a world of rationally driven progress, distance to the patient, and expert knowledge (see chapter 3 in Johannisson 2004 and compare to Lamont & Molnár, 2002). Johannisson (2004) argues that this tension between two 'ideal types' of doctor comes back time after time, within the Swedish[20] medical profession, and suggests that the ways in which boundaries are drawn within this profession is an angle of study that deserves much more attention. According to Johannisson (2004), the white coat has, since the First World War, symbolized cleanness and modernity. She argues that the modern doctor's approach to the body is based on 'distance', which is why the stethoscope has become the potent symbol of medical authority in Sweden today. Related to this is an article in the Swedish Journal of Medicine[21], which argued that neurosurgery is assigned higher status while psychiatry and geriatrics are assigned low status. The work of Bornat et al. (2008, 2009) and Raghuram et al. (2002, 2009, 2010) is important here since they have shown that medical doctors with an immigrant background from South Asia were clustered in the speciality of geriatrics in the UK context.

Even though there are no statistics (at least to my knowledge) on what specialties medical doctors trained and/or born outside Sweden tend to choose, one can see that some of the medical doctors with immigrant backgrounds that were interviewed for this thesis were specialists in family medicine, anaesthesiology and geriatrics (some also had to change speciality as we will see in the empirical chapters). One can only speculate about the underlying mechanism for their choices but as there is (according to the National Board of Health and Welfare as we will see in chapter 4) a deficit of doctors especially in the rural parts of Sweden, it might be easier to re-establish oneself as a doctor in Sweden when choosing to work there or choosing what Johannisson (2004) would call a 'practical' specialty.

This segmenting tendency (or internal boundaries) within the medical profession has been studied in other countries besides the UK. There are also studies on this topic from Israel, the USA and Canada (e.g. Remennick & Shakhar, 2003; and Shuval, 2000) which we presented in Chapter 2 and which gave us a hint as to the challenges associated with being a medical doctor with training and/or born outside the country where you work. What is important here is therefore not the fact that specialization plays a role in the way in which boundaries are constructed within the medical profession, but rather that there may be other points of departure from which demarcations are made within medical professions in different contexts. The observations made while I was working in a recruitment company laid the foundations for the design of this thesis, as did the literature that was reviewed in Chapter 2. The empirical chapters will explore how the interviewed doctors

[21] The article is in Swedish and can be found online:
http://www.lakartidningen.se/includes/07printArticle.php?articleId=3614 accessed 20140401.

regard such boundaries, whether they experience them, and how they handle them.

In the coming sections I will present the social constructionist perspective on social positions as well as the other two perspectives (i.e. essentialism/primordialism and the structuralism/circumstantialism) from which this perspective draws. This will be done in order to complement the framework on boundaries that is offered by the sociology of professions since that framework – as already stated – has primarily focused on boundaries between professions and other occupational groups or between professional groups as opposed to boundaries within that have to do with other segmenting tendencies.

3.3 What are social positions?

Social positions and the boundaries within and between them is a part of what we sociologists regard as the social. In this thesis, the focus lies on the social positions that 'being' a doctor and having an 'immigrant' background can potentially entail in the Swedish medical profession. According to Howard and Hollander (1997): "one way to approach a social phenomenon is by looking at the relationship between social actors and their environment" (Howard & Hollander, 1997, p. 2). This statement could be understood as a way to define what sociologists do but also as an epistemological suggestion for what we need to look at when we practice sociology. Informed by this understanding, this thesis focuses on the relationship between the social actor (in this case, medical doctors with immigrant backgrounds) and their environment (in this case, the Swedish medical profession).

Of particular relevance to the way in which actors and environments interact is the process of social categorisation, which is the basis for understanding why and how social positions matter. In this respect it seems important to draw attention to Anthias (1998) who has argued that different treatments on the basis of labelling, and modes of exclusion that operate on this basis, (which is also the core of what she would call social division) are characteristics of modern formations (p. 503). In more practical terms – and using the words of Lindholm (2005) – this means that: "When we meet someone for the first time (in other words, if we have no prior information about a person) we tend to view him or her not as an individual, but as part of a social group e.g. as a woman or a man, child or grown-up, Swedish or immigrant and so on" (p. 395 my translation). Social categorization is therefore the process through which we take 'shortcuts' in order to handle the 'flood' of information that we are exposed to in everyday life. The classifications that are given meaning in a certain context can say something about socially constructed social positions. Thus, in the process of classification we not only draw conclusions about other people, we also make assumptions about ourselves and about our environment, which is why social construc-

tions should be seen as interactive, and why they are a sociologically interesting process.

Jenkins (2008a) suggests that social categorization is interactional and he distinguishes between internal and external definitions and between group identification and individual categorization. He argues that in order to understand the complexities of social categorization we need to recognize that the human world is constituted in and by, embodied individuals (Jenkins 2008a, chapter 4). Self-reflecting actions make the categorization process of people much more complex than when we categorize places, object or contexts. Social psychologists such as Tajfel et al. (1971) suggest therefore that when we categorize people as members of a group we draw a line between what we consider to be 'us', and what we regard as 'them'. Categorization can therefore be understood in terms of boundary work.

In the notion of 'social position' the subject is thus seen as someone who can actively 'assert' but also 'resist[22]' the social positions that are assigned to them through categorization. Social constructionists are sometimes criticized for neglecting this power dimension (assigned and asserted social positions will be discussed more in section 3.4). Therefore, I would like to propose that there seems to be an inequality in 'epistemic' access, which means that some people and groups have more power to assign a position to people than others, and that some positions cannot be asserted that easily (cf. durable inequality according to Tilly (1998). Jenkins (2008a) argues that within the varied processes of collective identification and categorization some people and collectives are in a strong position to construct their identities and resist the imposition of identification by others, while others are in a weaker position (Jenkins, 2008a, p. 130). This thesis will explore Jenkins' suggestion in the empirical chapters since the main purpose of the thesis is to examine the issue of feelings of belonging within the Swedish medical profession.

In other words, categorization is the social action that assigns people to certain social positions on the basis of dichotomies such as white/black and Swedish/immigrant. In this process of assigning someone a social position you also assert a social position yourself that is based either on similarities or differences to whomever you regard as 'the Other'. The social position of a medical doctor is also a type of categorization, yet it is not only socially constructed but also a consequence of successful boundary work on a more organisational level (i.e. the one entailed by getting a license). To this end it seems important to note that Gilroy (1993) has argued that in every for-

[22] Kemper (1974) argues that the idea of ascription was first introduced by Linton (1936), and further developed by Davis (1949). Kemper (1974) argues that in the functionalists' way of theorizing about ascriptions, only age and sex have received 'ascriptive' treatment. He argues, however, that race, ethnicity, birth place and "blood," (which all relate to kinship, either biological or associational), are also used as bases for ascription, though they have no categorical bearing on performance capacity in the division of labour (1974, p. 852). This thesis draws on this insight and uses Cornell and Hartman's writings about social positions in order to understand how boundaries can be re-constructed on the basis of the social position of 'migranthood'.

mation of a 'we' (created on the basis of similarities) there is also an excluding 'they' (on the basis of difference).

As alluded to in the introduction chapter, researchers in Sweden (e.g. de Los Reyes & Kamali, 2005; de los Reyes & Mulinari, 2005; and Göransson, 2005) have studied the structural barriers that people with immigrant backgrounds have to overcome in order to enter and advance in the organizational hierarchy of Swedish social institutions. Their research has convincingly shown that people with immigrant backgrounds have a harder time reaching high positions in Sweden. Therefore, in order to study social positions within a certain context (in this case, the Swedish medical profession) the researcher must always have (at least) two questions in mind: What possibilities do the individuals in this position have to negotiate the position that others assign them? What happens if people in a certain position do not feel that they are assigned to it? By keeping these questions in mind the researcher can always keep the power dimension present, and can critically analyse who (in a certain context) has the power to assign and resist assignments of others.

In the coming sections we will learn more about the three main understandings of what social positions are.

3.3.1 Primordialist understanding of social positions

Today most researchers would agree that in dealing with social positions we must make an analytical distinction between primordial and circumstantial explanations of different social positions. Primordial explanations are those, which assume that social positions and social identity are something 'natural' and non-changing. In this section I will present some ideas about what primordialism is and what it has meant for studies of social positions. This is because the social constructionist perspective that informs this thesis rests on the awareness that this way of understanding social positions has a bearing on how people categorize one another.

Primordialism is a philosophical term that can be traced back to Locke (1959). It is based on the idea that some characteristics of an object are essential. Primordial categorization is often based on the assumptions that people who share a certain 'culture' also have much in common and that there is an essential core in this commonality, which 'the scientist' should be able to find. Howard and Hollander (1997) – who are gender theorists – have argued that the primordial approach to gender that was prevalent among social psychologists (and social scientists more generally) in the first half of the 1900s somehow preserved a stable difference between the sexes. Thus, even though this approach to gender[23] has been highly criticized for decades, the way in which we understand gendered boundaries is to some extent consistent with primordialism. Howard and Hollander (1997) exemplify this

[23] Howard and Hollander (1997) exemplify this with gender but the same trend can be seen in research about 'ethnicity', which will be presented later.

with the common use of sex as a variable representing gender, and argue that in studies than conflate sex and gender, respondents are simply categorized as females or males, and any difference found between the two groups are labelled as "gender differences" (p. 27).

A similar primordialist understanding is found in studies about 'ethnicity' and health. Bradby (2003) shows that in studies about health outcomes, 'ethnicity' is still often treated in a similar way to gender. She calls this "researcher-assigned ethnicity" and argues that this way of understanding ethnicity neglects the complexity of someone's background and its relationship to distribution of economic resources and to racism (p. 8). When we base our understandings of ethnicity on primordialism we run the risk of disregarding other possible explanations for the marginalisation that is sometimes experienced by ethnic minorities or immigrant groups. Primordialist understanding can lead us also to reproduce stereotypical images of 'the Other', which can then be segmented (cf. Carter & Fenton, 2009). This thesis will therefore focus on understanding what hierarchies seem prominent within the Swedish medical profession. Howard and Hollander (1997) also mention that research on 'race' began with a deeply primordial set of assumptions. Characteristics were correlated with racial categories and assumed to be innate and irreversible. They give the example of studies done on the relationship between 'race' and intelligence. In order to avoid getting stuck in the discussion about 'race' I will instead focus on what primordial ideas about 'ethnicity' exist within the Swedish medical profession, and explore how they are negotiated.

It is clear that the strains of primordialist thinking are still present in much of the research done on the issues of social position and the results therefore neglect the complex character of social positions and their intersections. Research about doctor-patient interaction and social positions (and particularly ethnicity) tend to be treated as something that medical doctors need to learn about the patient so that they can behave accordingly (Ashton et al., 2003; Betancourt et al., 2005; Cooper et al., 2002; LaVeist & Nuru-Jeter, 2002; Miller et al., 2011; Schouten & Meeuwesen, 2006; and Shah & Ogden, 2006). In this kind of research, medical doctors are also often *assigned* a social position on the basis of the primordialist assumption that they are white, males and with 'hidden' ethnicity, while patients tend to be *assigned* problematic 'ethnicity' and 'culture'.

Assignments tend to be based on understandings of 'ethnicity' and immigrant backgrounds as something that people from minority populations have but that people from the majority population lack, and are therefore to be understood as the basis for assumptions about 'the Other'.

Culley (2006) explains how this works in an article about how the term 'ethnicity' has been used within nursing. She suggests that within this field of research, 'ethnicity' is treated in a traditional anthropological way that equates 'ethnicity' with 'culture' (p. 146). She builds on May (1999) who has argued that this primordial approach to ethnicity is rampant in nursing and is characterised by:

> The process by which particular groups come to be described in terms of fundamental, immutable characteristics, inherent within an individual or social group, which determine their nature and the manner in which that nature is expressed. (May, 1999, p. 34)

Hence, primordialist thinking about the 'Other' is very common in the health care literature, which is why research on cross-cultural interaction in Swedish medical settings will be presented in Chapter 4. In other words, a primordial understanding of social positions is based on the assumption that these positions are something that can never be taken away from people or something you can never get rid of yourself. This thesis does not approach the social positions it focuses on (i.e. being a doctor and having an immigrant background) in a primordial way. The empirical material collected shows, however, that the medical doctors that were interviewed in this thesis are constantly faced with primordial understandings of who they are which is why it seemed relevant to present the primordial understanding of social positions here. Having said this, there are also other ways in which social positions can be understood. These are the circumstantialist and the constructionist ways, and they also have a bearing on how the data collected will be analysed.

3.3.2 Circumstantialist and structuralist understandings of social positions

Howard and Hollander (1997) have stated that the focus of research about social positions shifted from biology to socialization in the 1960s as empirical investigations found that women and men were more similar than different in most social psychological dimensions. At that point in time, researchers started to consider the social processes and factors (other than biology that might account for the ethnic and gender differences that had been documented. Within social psychology the notion of 'learned behaviour' and the importance played by the environment gained ground. Social psychologists refer to this new paradigm as *circumstantialism* while sociologists more often use the term *structuralism* for a similar idea in research about social positions. It is perhaps worth noting that a similar period was identified in the sections about professional boundaries (cf. Davies, 1996; Eriksson, 2003; Riska, 2001; and Witz, 1990).

Structuralists explain different gendered behaviours. One such example could be that black women and white women do not have the same opportunities due to systematic or structural environmental mechanisms. They recognize also that it is possible to change gendered (and ethnified) behaviour if a society chooses to modify its' socialization practices. According to structuralists, individuals themselves can never change inequalities, as they are part of the structural circumstances given to them. It is therefore the representatives of the state (politicians and people in power) to make decisions

that promote and modify social practices. Otherwise, according to structuralists, we are not able to see beyond static social positions.

Thus, within the structuralist or circumstantialist approach, social positions are seen as something a person or a group has and the focus is on the circumstances that regulate these positions. It is therefore, in a structural understanding of 'ethnicity', the structural premises that set the possibilities for the positions people might be assigned that is important. As I see it, the biggest difference between structuralism and circumstantialism is that circumstantialism is more concerned with the issue of where, a social position is *assigned* and *asserted* within an institution or social structure, while structuralism is more concerned with how the structure actually controls the resources available to persons in different social positions.

Structuralists suggest therefore that 'ethnic' groups (and to some extent professionals groups) have been created through the structural conditions that have made available the resources and opportunities they have (see e.g. Yancey et al., 1976). Structuralists would therefore explain the fact that medical doctors with immigrant backgrounds tend to have less status by alluding to the way recruitment and introduction is carried out and how European Economic Area (EEA) regulations have constructed boundaries for this group. For example, a doctor trained in Iraq has a different path through the licensing process than a doctor from Poland. In Sweden (as will be shown in the next chapter), the system treats medical doctors who come from within the European Union differently from the medical doctors who come from outside the European Union Area. 'Migranthood' as social position can therefore be understood – in some cases at least – as structurally constrained and circumstantially affected. It is for this reason that I will suggest that in order to analyse both the formal boundaries that licensing entails, and the more symbolic ones that medical doctors with immigrant backgrounds may encounter (such as the different discourses on 'ethnicity' that may circulate about them in the debate within the medical profession; as alluded to in Chapter 3), we need to combine the primordialist, structuralist and circumstantialist understandings of social positions. In this respect, Cornell and Hartmann (2007) argue that:

> Groups may be influenced by circumstantial factors, including the claims that others make of them, but they also use the raw material of history, cultural practice and pre-existing identities to fashion their own distinctive notions of who they are. (Cornell & Hartmann, 2007, p. 81)

While structuralist research often treats 'ethnicity' (and professions) as something predetermined by the context a circumstantialist understanding of social positions is more about when (in what situation) a certain social position is being activated and about where in the structure this activation occurs. As shown in Chapter 2, research about medical doctors with immigrant backgrounds that focused on 'ethnicity' shifted to a more circumstantialist or

structuralist approach in the1990s (see e.g. Conzen et al., 1992; Denton & Walters, 1999; and Nagel, 1994 among others). This was also the time when 'ethnicity' started to be seen as a socially constructed, dynamic phenomenon, interwoven with class, age, gender and 'race' (see i.e. Anthias et al., 1993; Hall, 1996; Schierup & Ålund, 2011; Torres, 2010; Ålund, 2002; and Ålund & Schierup, 1991). As for example, expressed by Torres (2010), who has studied how ethnicity is constructed in an Swedish elder care setting, it is the circumstances that determine the given meaning of ethnicity, and that construct the 'migrant' as 'the Other'.

Circumstantialism has therefore contributed immensely to our understanding of 'ethnicity' (and to some extent to what it means to be a doctor). This thesis is about the opportunities (or lack of) that medical doctors with immigrant backgrounds experience having as far as a feeling of belonging within the Swedish medical profession is concerned. As such, the thesis aims to combine some of the notions on social positions that are offered by the primordialist and circumstantialist understandings presented so far. This is why the final approach to be presented – social constructionism (as Cornell & Hartmann (2007) defines it) – is the approach that this thesis will take.

3.3.3 Social constructionist understanding of social positions

Constructionism, a theory of knowledge argues that humans generate knowledge and meaning from interaction between experience and their ideas (see Berger & Luckmann, 1967 and Hacking, 1999). The postmodernist worldview has also had a great influence on social constructionism, but postmodernism sees the world as fragmentary, discontinuous and often chaotic, with no clear idea about the reality beyond the chaos. Culley (2006) suggests that Hall (1992) rejects the concept of a unified 'centred' human subject, which is a product of primordial discourses, which is why he suggests that we need to see identity as a part of the chaos (Culley, 2006, p. 148). Therefore, the notion of hybridity is used to draw attention to the numerous contradictory ways through which identities can be formed in postmodern times.

The constructionist approach shares therefore the circumstantialist idea of fluidity, which means that identities change in their nature and significance across time and situations. Therefore, in this case part of the meaning of 'construction' is that ethnicity (and being a doctor) is not rooted in nature in a primordialist/ essentialist manner, but can be regarded as a situational (or structural) product of particular events, relationships and processes (Cornell & Hartmann, 2007). In other words, the circumstances may tell us that we can constitute a group in a certain way but our identity is also a product of the claims we make. Both the circumstances and the claims we make may build on messages we receive from the world around us. We may start out with them, reject them, add to them, or refine them but they are always there even if we are aware of them or not. In this regard, neither the primordial nor

the structuralist approach to social positions is sufficient for analysing the way that different social positions are used in different situations. To do this, both *primordial assignment* of what someone might be, what characteristics one might have, and the positions that people assert for themselves need to be included, as well as the context in which this positioning is done.

Having a social constructionist understanding of social positions may also be understood as a combination of all three of the above mentioned perspectives of how knowledge is generated (see Cornell & Hartmann, 2007). Still, social constructionists admit that some positions may be primordially *assigned* to people and that this will impact their own possibility to control what positions they want to assert for themselves. Culley (2006, p. 147) for example argues that while there is always a degree of agency in every social interaction, context or external forces shape 'ethnic' boundaries. 'Ethnicity', according to Culley (2006, p. 148), is therefore context-dependent, as it has a different force in different context and she exemplifies this argument by showing how health discourses are involved in constructing ethnic categories and racialized identities[24].

This thesis is therefore informed by the social constructionist perspective (as presented by Cornell & Hartmann, 2007) and includes the notion of power structures that are always present in social interaction. The differentiation in power lies against this background in the choices we make when it comes to social positions within a certain social order. As put forward by Culley (2006):

> Identity choices are structured by a number of constraints and historical determinations, which leads us to a view of ethnicity, which stresses both agency and structure. (Culley, 2006, p. 149)

This means that all identities are not available to all individuals. The positions others think we have and the ones we see ourselves having may differ. One example of this can be found in Gray (1981) which was discussed earlier, where the British National Health Service (NHS) and especially the history and hierarchy of the NHS itself, was regarded as the main problem for the failure to integrate medical doctors with immigrant backgrounds into the British health care system. Gray's study not only included the experiences of the medical doctors themselves but also concluded that immigrant medical doctors were being denied access to good posts and found themselves clustered in low-status specialties such as geriatrics and psychiatry in non-teaching hospitals. Medical doctors' experiences of structural inequalities were explained in relation to 'racialized' structures within the NHS, and even though many doctors managed to overcome these structures their own strategies in doing so were not explored in this study. The works by Bornat

[24] She gives the examples of role of medicine in the constructing of 'scientific racism', which served to legitimate slavery in the nineteenth century and the racial policies of the Nazi state.

et al. (2008, 2009, 2011), Raghuram and Kofman (2002) as well as Raghuram et al. (2009, 2010) show also that these medical doctors can shape their own work environment in various ways, for example by choosing geriatrics as 'their' speciality. This research argues therefore that there are some pitfalls associated with focusing on the 'contributions' that these doctors make to an existing system, and urges us instead to focus on how medical doctors with immigrant backgrounds themselves actively constitute that system. By focusing on the medical doctors themselves, this thesis aims to shed light on the resources that these doctors use in order to overcome the structural barriers and primordial assumptions that are rampant within their profession. Studies that claim to be about social positions (such as Gray's) have tended to neglect the agency that medical doctors with immigrant background have.

To summarize, a social constructionist understanding of social positions includes an understanding of primordialism, structuralism and circumstantialism and of the way in which these perspectives could nourish an analysis of people's experiences of these positions, as argued by Cornell and Hartmann (2007):

> The constructionist understanding does not depart from the circumstantialist claims about fluidity and dynamism of 'ethnicity and race'[25], nor from the claims about the critical role that context plays in collective identification and action. It adds to those claims a creative component, rescuing ethnicity and race from the prison of circumstance. (Cornell & Hartmann, 2007, p. 83)

In the quote above the authors criticize research for being too focused on circumstances, and argue that although circumstances sometimes play a large role, it is important to note that they also sometimes do not matter at all. In this thesis, we approach being a doctor as a social position that needs to be both asserted and assigned in order for doctors to feel that they belong to the professional group in the country where they work. The licensing process is regarded as the way through which the doctors are formally seen to belong, but it does not necessarily mean that they are *assigned* the social position of medical doctor, which determines their possibility to *assert* this position. The social position that having an immigrant background can entail in Sweden is, however, different since it is a position that is often imposed on someone by others on the basis of their non-Swedishness. Being a medical doctor with an immigrant background means therefore that ones position as a medical doctor can be challenged, as we will see in the empirical chapters since the profession (in Sweden at least) has for years assumed that ethnic diversity is a given for patients but not for medical doctors. That is why a social constructionist lens is needed. What seems to be especially important here is the relationship between the position that is imposed by others (*as-*

[25] This could be argued for other social positions such as class, age and gender.

signed) and the position that a person claims for herself/himself *(asserted)*. This is why these concepts will be discussed in more in detail in the next section.

3.4 Assigned and asserted social positions

A social constructionist lens on social positions means that we need to regard social positions as *assigned*, *asserted*, interactive[26] and continuously changing. In doing so we might avoid the criticism raised against social constructionism that it does not consider power. The ways in which medical doctors interact and their feelings of belonging to their profession have long been an area of interest for medical education scholars. One can understand *assigned* social positions as identity markers imposed on someone by other people, and *asserted* social positions as identity markers that a person imposes on himself or herself. *Assigned* social positions might sometimes coincide with *asserted* social positions but in many situations this does not happen. As stated above, the possibility for objecting to or resisting social positions that are *assigned* to us is harder for some people than others. There is therefore a power struggle between those people that possess the ability to resist and are able to *assert* themselves with claims of other social positions than the ones *assigned* to them, and those people that cannot do this. There is also a power struggle between those that have the power to *assign* and those that do not have that power (cf. Kemper, 1974).

Cornell and Hartmann (2007) present a model for understanding the diverse ways in which social positions are constructed and negotiated. The model shows that a position such as ethnicity must be understood as consisting of different distinctions. According to these scholars, ethnicity constructions must be understood on a scale from more '*assigned*' to more '*asserted*' positions and also on a scale between '*thick*' (more comprehensive) and '*thin*' (less comprehensive). 'More *assigned'* positions are positions that are not self-made but imposed on people, while '*more asserted'* are instead those that a person or a group *assert* themselves. Variations in 'thick and 'thin' positions focus on the degree to which these positions organize the social lives of people. One wonders therefore how the social position of medical doctor is *assigned* to medical doctors with immigrant backgrounds, as they have not had their training in Sweden. One could assume that even though the interviewed doctors had a license and a job the more socially constructed side of what it means to be a doctor might be limited for them.

[26]I agree with Hacking when he regards social constructions as interactive because the social construction interacts with the people it concerns who can become aware of how they are classified and act on it. Consider the following point about 'women refugees': "A woman refugee may learn that she is a certain kind of person and act accordingly. Quarks do not learn that they are a certain kind of entity and act accordingly (Hacking 1999, p. 32).

Cornell and Hartmann (2007) suggest that the density of a social position (i.e. thick or thin) influences the social life while the '*more assigned'* or ' *more asserted'* positions focus on the relative importance of external and internal forces in the making and maintaining of both boundary and identity (p. 85). Thus, the concepts of *assigned* and *asserted* and *thick* and *thin social positions* will be used in this thesis as tools to understand the socially constructed side of the social position of medical doctor and 'migranthood' as a social position among a group of medical doctors with immigrant backgrounds in Sweden. Below I have tried to illustrate how the relationship between *assigned* and *asserted* positions and thick and thin positions as described by Cornell and Hartmann (2007) should be understood in this thesis. The social position of medical doctor and that of 'migranthood' as a social position could be understood in the light of *assigned* and *asserted* and *think and thin social positions*. It is important to note that they are different, as the social position of medical doctor is not only a social position that is *assigned* and/or *asserted* but also an actual position that is regulated through licensing. Therefore, not everybody can *assert* this position but if we understand the model as a way of understanding the socially constructed side of being a doctor (what we call the social position of medical doctor and what might be seen as conflated with notions about 'migranthood' in the case studied here) then, I would argue that it is possible to explore the social construction by studying how the interviewed doctors talk about feelings of belonging within the Swedish medical profession. It is important to note here that in a constructed group such as medical doctors with immigrant backgrounds, the diversity is vast. For example, being a doctor from the European Economic Area might mean you are assigned a slightly different social position than if you are a doctor from outside that area (as will be shown in Chapter 4). Therefore, it is necessary to understand the social position that having an immigrant background entails; a social position I hereby propose that could be called 'migranthood'. The idea is that this position could, theoretically speaking (but also empirically as the interviews will show), influences the way in which one's social position as a medical doctor, is experienced.

In order to exemplify the above in a more explicit manner, let us try to use the notions of *thick* and *thin,* and *assigned and asserted* social positions by applying them to the symbol of medical authority per excellence: the stethoscope. When we see a white male with a stethoscope in a medical setting we will probably assign that person the position of medical doctor, but what happens if the person with the stethoscope is black, female or both? Some people will still believe that this person is a doctor and assign the doctor the social position of medical doctor. In that case we could say that being a doctor in that context is a *thick* social position since it influences social life for this person to a large extent. Now, if the medical profession – as the research presented in Chapter 2 suggested – assumes the likelihood that a doctor will be white is greater than the chances that he or she will not be white, then medical doctors with a Caucasian background are more likely to be

assigned the social position of medical doctor without the stethoscope than medical doctors without this background are. The interviews conducted in this thesis suggest this is the case in Sweden. At least, this is the perception that most medical doctors with an immigrant background that I interviewed seemed to have.

Phrased differently, I could say that what this example illustrates is that some people can be 'stuck' in a certain position. Although they are considered to belong through licensing, I would argue that there are some medical doctors that have a harder time getting accepted as doctors and hence being *assigned* the social position of medical doctor. Therefore, the experienced *'thickness'* of the social position of medical doctor is probably very different between individuals in a group because they are also *assigned* 'migranthood' as a social position. As Cornell and Hartmann (2007) suggest:

> The diversity of identities within a single ethnic or racial group is important, for these are not the only identities, nor even necessarily the major identities that people carry. Some may take little note of ethnicity or even race, whether their own, or others. (Cornell & Hartmann, 2007, p. 87)

Gender, religion, class, occupation, cultural groups and other dimensions of social life can likewise offer bases for personal or collective positions, which will impact the possibilities we have to *assert* positions ourselves. If we go back to the stethoscope as a symbol that positions people, one could argue that the stethoscope can signal different things to different people depending on who carries it.

Thus, even if Cornell and Hartmann (2007) only talk about *assigned* and *asserted* 'ethnicity' in their model, I would argue that the model could be useful when trying to understand other positions such as the social position of medical doctor and 'migranthood' as a social position. To this effect they argue, for example, that:

> You can belong to a collection of people distinguished by its position in relationship of power and privilege and by cultural commonalities among its members without any substantive and cultural awareness that this position and culture (and the identity embedded in both) are primary factors organizing life and experience. (Cornell & Hartmann, 2007, p. 88)

To summarize, the social position of medical doctor and 'migranthood' as a social position can both be *asserted* and *assigned,* and the density (*thick/thin*) might differ depending on where you have emigrated from and/or what medical field you are specialized in. However, they also differ in that the social position of medical doctor is conditional upon you having a license, or in other words, you must belong in a formal way, while 'migranthood' as a social position can be *assigned* to anyone with certain attributes. Thus, I would argue that some medical doctors might have a harder

time being *assigned* the social position of medical doctor even if they have a Swedish medical license. In a similar manner, some medical doctors will have an easier time both being *assigned* and *asserting* the social position of medical doctor than others. The feeling of belonging to the Swedish medical profession is therefore assumed to be not only about receiving a license to practice medicine but also about getting *assigned* the social position of medical doctor, which for the interviewed doctors in this study might be conditional upon them also being *assigned* with 'migranthood' as a social position. That social position should be seen as a highly variable and contingent product of an on-going interaction between the circumstances groups encounter and the actions and conceptions of group members, but also the interaction between *asserted* and *assigned* and *thick* and *thin* social positions, and might also affect who is seen as part of the profession and who is not.

3.5 Construction sites

Cornell and Hartmann (2007) have argued that in order to understand how constructions about ethnicity are shaped (and I will argue that the same holds true for constructions about 'migranthood'), we need to study the *construction sites* where these constructions are formed. They describe these sites as:

> A place where social actors make claims, define one another, jockey for position, eliminate or initiate competition, exercise or pursue power and engage in other activities that encourage or discourage, create or transform, and reproduce or ignore identities. (Cornell & Hartmann, 2007, p. 170)

According to Cornell and Hartmann (2007), people never enter a group empty-handed or empty-headed but bring instead a great deal with them. Another thing that they focus on are *internal* and *external relationships,* which for the interviewed doctors are the networks and interactions that they have and the negotiations they have with other people at their workplace, as well as the *resources*, which for the interviewed doctors might be about the social status of being a doctor but also other more 'informal' belonging and characteristics that have to do with *symbolic repertoires* that groups have at their disposal and through which they can construct and communicate meaning.

Thus, through the notion of construction sites, Cornell and Hartmann (2007) give us a way to look at different 'spaces' where boundaries are established, rejected and cross; where some identities become more comprehensive or *thick* and some less or *thin* and where stratification between groups is established or challenged.

3.6 How to combine two sociological traditions?

So why do we need to combine the two theoretical traditions? As I see it, theories about professions and about social position are needed in order to understand how the interviewed doctors spoke about belonging. In other words, if you are a doctor born and trained in Sweden, it can be hard to understand the 'informal' feeling of belonging that exists within the Swedish medical profession. Both theoretical traditions, I argue, are also already closing in on each other around an idea about boundaries. For example, Abbott (1995) argues (in an article where he rethinks his own earlier work on the professional boundary work of social workers) that: "boundaries began to emerge between different kinds of people doing the same kinds of work…" (p. 557). Here he seems therefore to admit that there are rankings of people and tasks within a profession as everywhere else. In a somewhat similar way but from the other perspective Lamont and Molnár (2002) show that white workers associate black with poor and lack of work ethic, while black workers associate whites from the middle class with egoism. Similar tendencies – yet not as extreme – can be found in the interviewed medical doctors' stories as we will see in the empirical chapters where the interviewed doctors seem to feel that they are mistrusted by the majority of medical doctors and others because they are seen as 'immigrants'. I therefore argue that we cannot understand professional boundary work in this particular case without understanding the professional boundaries, as both existing around the Swedish medical profession (towards other occupational groups) and also the professional boundaries that exist within it. That is why we need both perspectives, and the two perspectives can be combined, I argue, if we assume that for doctors that were trained and born in Sweden the 'Swedish' is probably something unquestionable that you easily take for granted but if you were born and trained elsewhere presumably it is not. Thus, although licensing can be seen as a confirmation that someone is on the inside of a profession, the doctors with immigrant backgrounds that I have interviewed do not regard licensing as an automatic ticket to belonging. As we will see in the empirical chapters some of these doctors still feel that they are regarded as outsiders because of the fact that they have an immigrant background. It seems therefore useful to bring attention to Collins (1999) who uses the term "outsider-within" to:

> …describe social locations or border spaces occupied by groups of un-equal power(….) Thus, outsider-within identities are situational identities that are attached to specific histories of social injustice—they are not a decontextualized identity category divorced from historical social inequalities that can be assumed by anyone at will. (Collins, 1999, p. 86)

In this thesis, I use this term when I try to make sense of the fact that the medical doctors interviewed regard 'Swedishness' as a part of the profes-

sional and regard their immigrant backgrounds as something that makes them outsiders-within. By combining the two traditions that have been presented in this chapter (i.e. sociological theories about professional boundary work and social position theory) we hopefully stand a better chance of understanding the interviewed doctors' experience of what it is to belong, and what challenges the feeling of belonging within the Swedish medical profession. In other words, the term *outsider within* becomes important in order to understand the somewhat 'unfinished passage' or 'in-between state' they seem to find themselves in even though they have received their Swedish medical license.

As stated in the introduction, being a doctor means being part of a dominant group in the Swedish society. Being a member of the dominant group in a society means occupying the unspoken, taken-for-granted category against which all others is defined (Frankenberg, 1993; and McInotsh et al., 2007). Tilly (1998) argues that it is because professions managed to exclude "unworthy people" (p. 167) from practice that they became 'successful'. This is one example of why boundaries lie at the heart of professional boundary work. Thus, by focusing on these boundaries as well as the boundaries that these medical doctors face based on notions of 'migranthood', this thesis aims to see beyond the positions themselves and look at feelings of belonging within the Swedish medical profession from the 'migrant' medical doctors' perspective.

Looking at 'migranthood' as a social position and the social position of medical doctors through the perspective of boundaries allows us also to see that not all medical doctors have the same opportunities to belong to the Swedish medical profession. In the introduction to this chapter I suggested that the sociology of professions has, so far, been mostly concerned with *boundaries* between different professions and not so much with boundaries within professional groups. This is why Chapters 6-8 focus on how the interviewed talked about belonging within the Swedish medical profession.

In the introduction to this thesis I also posited that due to both the Swedish public debate on medical doctors with immigrant backgrounds and the debate as it has been carried out within the Swedish medical profession, 'migranthood' as a social position may entail boundary work within the profession in question. Some of the literature reviewed in Chapter 2 suggests that this is a proposition that make sense considering what research on medical doctors with immigrant backgrounds conducted in other countries has shown. It is against this backdrop that this chapter has proposed a theoretical/conceptual framework from which the experiences of medical doctors with immigrant backgrounds in the Swedish medical professional context can be studied.

The next chapter should therefore be seen as an important contribution that helps in understanding the context that the interviewed doctors are controlled by; the Swedish medical profession.

4 The context: Swedish medical profession

This main aim of this chapter is to enable the international reader to understand the context in which the interviewed doctors work. The idea is that it is against the backdrop of the Swedish medical professional context that we can make sense of the experiences of feelings of belonging (or lack thereof) within it that the interviewed doctors give voice to. Therefore, in this chapter I offer insight into the statistics that exist about medical doctors with immigrant backgrounds in Sweden and the limitations they have if we are to make sense of the Swedish medical professional context. The chapter also presents how the medical licensing process works in Sweden since the medical doctors this thesis focuses on are – for the most part – medical doctors that have had their training in a country that is not a member of the European Union. This chapter therefore also describes how Sweden's membership in the EU impacts some of the possibilities that medical doctors with immigrant backgrounds have to practice medicine in Sweden. Medical licensing and EU directives set some of the structural conditions under which the Swedish medical profession operate. These directives help shaping the 'formal' boundaries that some medical doctors with immigrant backgrounds face before they obtain Swedish licence. Thus, the first four sections of this chapter aim to give insight into what are the boundaries to 'formal belonging' to the Swedish medical profession.

Section 4.5 reviews the Swedish academic debate on cross-cultural interaction in medical settings because I believe this debate has implications for the underlying assumptions about 'migranthood' that seem to exist within the Swedish medical profession. Section 4.6 addresses, in turn, one part of the debate within the Swedish medical profession about medical doctors with immigrant backgrounds as it has been carried out in the Swedish Journal of Medicine[27] and adds to the understanding of the underlying assumptions about 'migranthood' that seem to exist within the Swedish medical profession. But before we consider those boundaries that the profession in question starts off with, let us see how the 'formal' process works.

[27] In Swedish: Läkartidningen

4.1 What can statistics tell us?

This section presents the statistics about medical doctors' immigrant backgrounds that are available in Sweden today in order to understand what the Swedish medical profession knows about the number of medical doctors that have such backgrounds. The ways in which the statistical categories used to describe these doctors have changed will also be discussed since this tells us something about the profession's understanding of 'migranthood' as a social position.

The statistics I will refer to in this section come from an annual assessment of the supply of health professionals in Sweden, which is a report compiled by the National Association of Health and Welfare[28] on behalf of the government. These annual reports are called *National Planning Support (NPS)*[29] and are written in order to assist policy makers who make human resource-related decisions, both on a national and a regional level.

In 2009 there were about 33,400 working medical doctors in Sweden. That is about one doctor per 277 inhabitants according to The Swedish Medical Association[30]. Between the years 2005 and 2009 a total of 6051 medical doctors immigrated to Sweden. Since then, the increase has been steady, as shown in Table 1. It is worth noting that before 2010 the statistics in these reports only showed rough indications of where these doctors were trained, which were sometimes based on the continent, and sometimes on region, where they were trained (which is what Table 1 shows). The statistics from 2010 – which I will allude to later but which I will not show table-wise since they are not particularly relevant to the task at hand – list instead the countries where the medical doctors in focus are trained, rather than the continent. This is interesting in itself since it means that the Swedish medical profession's debate on these medical doctors has had different statistical points of reference over the years.

A closer look at Table 1 shows that – in 2009 – most medical doctors with immigrant backgrounds had their training in one of the EU/EEA countries. The second largest group of medical doctors with immigrant backgrounds comprised medical doctors that had come from a "Third country" [31] followed by medical doctors that had been trained in another Nordic country.

[28] In Swedish: Socialstyrelsen
[29] In Swedish: Nationellt Planeringsstöd (NPS)
[30] In Swedish: Sveriges Läkarförbund
[31] 'Third country' is my own translation of the term used in public administration system for immigrants from outside the European Economic Area (EEA). In Swedish: tredje land.

Table 1. The actual number of medical doctors working in Sweden with foreign training from other counties, one year after approved authorization (incl. persons without government ID numbers), year 2005-2009[32]. (Socialstyrelsen 2010)

		2005	2006	2007	2008	2009
Nordic countries		220	235	294	275	255
EU25/EEA*		756	847	1057	1020	725
EU27/EEA**		788	887	1216	1096	799
Third country***		210	219	243	262	331
Of which						
	Asia and Oceania	104	101	117	112	157
	Other European countries	69	82	80	74	38
	Africa	16	3	12	6	9
	North and South America	3	7	4	4	5
	Unknown	8	17	14	55	103
Total		998	1106	1459	1358	1130

Worth noting is that in 2009 most medical doctors, that had their training in a third country, were doctors that had been trained in the Asia and Oceania regions. This seems to be the case in the other years that are accounted for in this table as well. Hence, I think it is safe to argue that there are probably more medical doctors in Sweden that have been trained in Iraq than there are doctors trained in New Zealand but that in the statistics the all fall under the same category.

The broad statistical continent/ region-based categories that were used for decades in Sweden (and the hidden country origin of medical doctors before 2010) to understand where the doctors that applied for a Swedish medical license came from led to intensive debates within the Swedish medical profession about who these medical doctors were on a more detailed level, as we will see in the sections that follow. This suggests that up until 2010, The National Board of Health and Welfare treated medical doctors with immigrant backgrounds in rather homogeneous ways. They were, in other words, mostly concerned about whether or not they were trained in Europe, while other variables were not deemed important.

In the report from 2011 (Socialstyrelsen, 2011) The National Board of Health and Welfare stated that most of the doctors that came to Sweden from outside the EU/EEA region were refugees or came for family reunification

[32] The year presented in this table, 2005-2009, is based on the NPS done in 2010. The years are therefore not something chosen by the writer but are the statistics that were available at the time this thesis was written.

reasons. It's easy to wonder if people fleeing from Syria today will show in these statistics in the future since many have higher education and some are likely medical doctors. Unfortunately, this will not be addressed in this thesis but I mention this because I think that research from a source country's perspective is needed in Sweden since, as suggested earlier, medical doctors with immigrant backgrounds in Sweden are a diverse group when it comes to where they were born and trained. The report from 2011 lists the country of origin of medical doctors with immigrant backgrounds and thus offers more insight into some of the assumptions that have been made about these doctors on the basis of statistics that up until 2010 said very little about their ethnic backgrounds. A look at the report from 2011 makes clear that Denmark was the country that trained the most Swedish 'foreign' doctors (n=812) from 2005 to 2009 (which is the period that is presented), followed by Germany (n=684), Greece (n=674), Poland (n=472), Hungary (n=454), Iraq(n=313) and Romania (n=284). Russia comes in as number 9 on the list (n=174). China trained a total of 60, and Iran trained a total of 36 Swedish medical doctors between those years (Socialstyrelsen 2011: 34[33]). Here, the homogeneous picture of medical doctors with immigrant backgrounds, which the reports up until 2010 contributed to, is challenged. In 2011 the report also separated Swedish-born medical doctors with foreign training from the category 'foreign trained medical doctors'. This change is understandable, as it was not until 2011 that the Swedish medical profession began to nuance the statistics and take into account not only in what continents and regions doctors with foreign training that got Swedish medical licenses came from but also their countries of origin.

According to the National Board of Health and Welfare (2011), about 1000 of the approximately 30 000 medical doctors that were working in Sweden in 2010 were born in Sweden, and had a Swedish medical license but had training outside the country. The report suggests that this number has increased for some years and will probably continue to do so in the coming years as more and more people born in Sweden choose to receive their medical training outside Sweden's borders. One of the reasons why place of birth suddenly became important in 2011 might be that 'Swedish-born' medical doctors were categorized as 'immigrants' in the statistics, which only noted where people were trained. Such an explanation would be indicative of the dichotomy that operates in Swedish society (as alluded to in the introduction; i.e. 'Swede' versus 'immigrant') and which underlies the Swedish medical profession's effort to have statistics that differentiate 'their own' from 'the rest'.

The way in which the vast emigration of Swedish medical students will affect the supply of medical doctors in the future is, according to the National Board of Health and Welfare, something that will need to be analysed

[33] It is worth commenting here that the same numbers were presented in the report from 2012 and no new report came out in 2013, and 2014 before this thesis was finished.

further. The report from 2011 (alluded to here) states however, that the statistics from 2002 clearly show that the number of licenses issued to persons with Swedish-born background and foreign education has increased over the past decade (Socialstyrelsen, 2011). In this regard it seems worth drawing attention to the fact that The National Board of Health and Welfare, does not keep track of where medical doctors with immigrant backgrounds (either by virtue of background or training) that have received a Swedish license to practice medicine are working. Neither do they know if they are in fact employed. The statistics they keep are statistics that focus on the 'formal' boundary (licensing) and not on what happens once this boundary is crossed. Therefore, the Swedish Association of Local Authorities and Regions[34] conducted a study focusing on whether foreign-trained medical doctors with Swedish medical licenses were actually working in Sweden. They concluded that 75 per cent of medical doctors with foreign training who obtained a Swedish license between 1994 and 2007 were working somewhere in Sweden. These numbers are not only interesting because they say something about the group of medical doctors we are interested in but also because they suggest that some medical doctors with the backgrounds in question do not end up practicing medicine in Sweden after they receive their Swedish license. To conclude, this section has shown that the way the National Board of Health and Welfare choose to categorise doctors with immigrant background in official statistics has set the parameters of what we know about this group. The fact that the National Board of Health and Welfare has chosen not to register more background variables for doctors that have applied for a Swedish medical license limits our knowledge about them.

4.2 Why the EU matters

The directives that the European Economic Area (EEA) set for the Swedish medical profession are relevant if we are to understand some of the 'formal' boundaries that are faced by those with a 'foreign training' who want to practice medicine in Sweden. The European Union physician directive makes a structural distinction between medical doctors that have immigrated from other EEA-countries and those that immigrate from outside this area. This section will therefore examine the 'Physician Directive' in order to understand some of the 'formal' boundaries that exist within the Swedish medical profession.

[34] in Swedish: Sveriges Kommuner och Landsting (SKL)

The formal recognition of medical doctors with immigrant backgrounds within the EU/EEA (and therefore also in Sweden) is regulated in the 'physician directive'[35]. Automatic recognition without charge applies when:

- The physician is a citizen of one of the member states,
- The diploma in question is a qualification from one of the member states,
- The training was done in one of the 52 specialties listed in the appendix of the directive (not included in this thesis) both for the country of origin and the target country.

This directive is a part of the common market act from 1992, which not only provides free movement of capital and goods, but also of people and services. The National Board of Health and Welfare stated that as a consequence of this directive, some EU/EEA-trained medical doctors had applied for a Swedish medical license but never actually worked here (Socialstyrelsen, 2012, p. 21).

Gerlinger and Schmucker (2007) analyse policy implementation in the EU and the effects that these policies have on migrant medical professionals. They write that since 1975 a number of directives have been adopted in order to govern the mutual recognition of licenses for medical doctors and other health professionals. They state that:

> The directives set a minimum standard that is binding for the member states, which in turn may raise the standards further within their sovereign territories. In addition, the directive includes regulation for the automatic recognition of occupations in the health sector. (Gerlinger & Shmucker, 2007, p. 185)

As stated in the quote, automatic recognition of a medical license makes it easier for medical professionals to move between member states while making it harder for medical professionals that come from countries that are not members of the EU/EEA. The directive could also be interpreted as dividing the group of medical doctors with immigrant backgrounds into 'EU-doctors' and 'non-EU doctors'; a division that brings with it quite unequal opportunities to gain recognition. In a study of professional mobility, Peixoto (2001) has shown that 'effective high skilled mobility' depends on the recognition of diplomas to enable entry to the labour market within the European Union.

The research reviewed in Chapter 2 suggests, however, that 'informal' belonging does not automatically come once one has managed to cross the 'formal' boundaries that a profession sets for itself (for insight into symbolic

[35] Council directive 93/16/EEC of April 1993 aimed to facilitate the free movement of medical doctors and the mutual recognition of their diploma, certificate or other evidence of formal qualifications. Official Journal of the European Communities 1993, L 165/1.

aspects of recognition see Bernstein & Taylor, 2005; Fraser, 2003; Hobson, 2007; and Valiente, 2003). Belonging, therefore, is not only about getting a Swedish medical licence; it also has a more socially constructed side to it since medical doctors with immigrant backgrounds need also to be 'informally recognised' in everyday practice if they are to feel that they belong.

Despite this, it is important to note that the 'Physicians Directive' can be understood as a type of boundary work that dictates that medical doctors with licenses from outside the EU/EEA will encounter greater difficulties in getting their medical licenses recognised than medical doctors from inside this area. This is also shown in a report called *Governmental Initiatives for Academics with Foreign Education*[36] conducted by the Swedish National Audit Office[37] in 2011. The auditors in the report are critical of the length of time it takes for medical doctors with immigrant backgrounds to get licensed in Sweden.

To conclude, the fact that Sweden is a member of the EU impacts the re-establishment process for medical doctors with immigrant backgrounds that want to work in Sweden. This process does not only differentiate 'Swedish doctor' from 'migrant doctors' but also differentiate between 'migrant doctors' from the EU and 'migrant doctors' from outside the EU. This will be explained in the next section.

4.3 How to get a Swedish Medical License

So what are the formal boundaries that medical doctors with immigrant backgrounds need to cross in order to re-establish themselves as medical doctors within the Swedish medical profession? The answer to this question is found in the licensing process, which is the most obvious formal boundary to belonging to the Swedish medical profession that medical doctors with immigrant backgrounds face. In order to explain how the process in question works I will now talk about the paths that two fictitious medical doctors with immigrant backgrounds would have to embark on depending on where they received their training.

Imagine you are a doctor and you want to work in Sweden and that you have a friend who is also a doctor applying for a Swedish license at the same time as you. Suppose you are from France and your friend is from Ghana. Both of you have to apply for a Swedish Medical license in order to enter the Swedish medical profession. The application has to include an application form, an extract from the Swedish Population Register[38], a certified copy of your medical diplomas (and one that states how long the training lasted). The application is then signed and sent to The National Board of Health and Wel-

[36] In Swedish: Statliga insatser för akademiker med utländsk utbildning
[37] In Swedish: Riksrevisionen
[38] In Swedish: Personbevis

fare. The next day, your two applications land on a government official's desk and this person assesses if your applications meet the knowledge requirements for a Swedish (and EU) license to practice. Your own French medical education grants you a Swedish license automatically, but your friend from Ghana needs to take further steps in order to get her license. The first step entails proving that she is fluent in the Swedish language. In your case your future employer is responsible for assessing your language skills. You friend goes for language training for some months and when finished she sends a document showing that she has passed to the government official at the National Board of Health and Welfare. After that, your friend has to pass a course in medical legislation, which aims to check that doctors of medicine in Sweden have knowledgeable about Swedish society. Because your friend is not yet specialised she also has to pass the so-called TULE[39] test. The test has two parts, one theoretical and one practical, and is taken over three days. Now, your friend is almost finished except for the internship of at least 18 months in different fields of practice, which she must find herself. This step is often time-consuming and something that the interviewed doctors talked about as one of the biggest challenges. Anyhow, she is fortunate and finds a place that will take her on. After about 18 months her supervisor (who is a medical doctor) assesses the new doctor's performance and sends a letter of recommendation to the government official at the board, and some months later she receives her Swedish license.

If your friend had already had her specialisation already she would have had to pass probationary service, which would have been six consecutive months within the relevant field of practice. The objective of this service, as described on The National Board of Health and Welfare's website, is to "assess your medical knowledge in relation to the knowledge needed to receive a Swedish license to practice, but also to assess your judgment, your way of relating to patients and your general aptitude as a doctor of medicine"[40]

As we can see from the described process, there are major differences between the procedures that medical doctors with immigrant backgrounds have to undergo in order to get a Swedish license. These procedures depend entirely on where these medical doctors have received their medical training. In this regard it seems important to note that 'public authorisation' of certain professions is, according to Tilly, a way to secure certain resources and it is often based on 'selective transmission' of knowledge to members of an in-group (1998, p. 169).

[39] TULE is the Swedish abbreviation for Tentamensgruppen för utländska läkares examination and stands for The Examination Group for Foreign Doctors (my translation).
[40] The licensing process can be found at the National Board of Health and welfare's website: http://www.socialstyrelsen.se/applicationforswedishlicencetopractiseothercountries/doctorofmedicine accessed 20140401.

4.4 The role of the Swedish Medical Association

This section describes how the issue of medical doctors with immigrant backgrounds has been discussed from a trade union perspective, starting with the Swedish Medical Association. *The Swedish Medical Association* (Sveriges Läkarförbund (SLF)) describes itself as a professional organization that works with advocacy to strengthen the doctor's position in health care and to improve the health care system in general[41], and 85 per cent of all medical doctors in Sweden are members of the association.

SLF is not only a professional organisation for medical doctors working in Sweden but also a trade union that has played an important part in deciding the 'formal' boundaries to belonging that the Swedish medical profession has set for itself. It is perhaps worth noting that the SLF has had problems getting medical doctors with immigrant background to become members[42]. In 2002 a new organisation called International Doctors in Sweden (In Swedish: *Internationella Läkare i Sverige; ILIS)* was established. The aim of ILIS was to support all medical doctors that had received their training outside the EU/EEA in getting their licenses recognised. ILIS from the start worked toward making this process less time-consuming. The organization ran its own courses for medical doctors with immigrant backgrounds on topics such as 'How to break the Swedish code" (In Swedish: Att knäcka den svenska koden), which were concerned with regulations, rules and cultural knowledge concerning working as a doctor in Sweden. ILIS was a separate organisation until 2010 when it was integrated into the Swedish Medical Association. According to a press release[43] from this association from May 2011, ILIS ceased its operations and the Swedish Medical Association has since been dealing with the issues that ILIS worked on.

Why ILIS was closed is something that we can only speculate about but it says something about how the Swedish Medical Association viewed migration-related trade union topics. Before 2011 questions related to medical doctors with immigrant backgrounds were deemed to demand special attention, but this is seemingly not the case anymore which means that ILIS was perhaps an example of the 'politics of presence' (cf. Phillis, 1995) as certain collective needs could be raised (such as better quality of language programs, effective licensing processes) by ILIS and this made medical doctors with immigrant backgrounds in Sweden a visible minority group within the Swedish medical profession. This association might have been closed because the Swedish Medical Association did not want to have a formal division of the professional group between those doctors that were considered

[41] For more information see: www.slf.se/Info-in-English/ accessed 20140401.

[42] As stated in an article in the Swedish Journal of Medicine called "It is harder to attract foreign medical doctors to the trade union" (In Swedish: Svårare att locka utländska läkare till facket) For full text see http://www.lakartidningen.se/engine.php?articleId=16440 accessed 20140401.

[43] For the press release see: www.slf.se/Aktuellt/ILIS-laggs-ner/ accessed 20140401.

'Swedish medical doctors' and those that were not. However, ILIS gave a voice to doctors with immigrant backgrounds in Sweden up until 2011 and became an important platform where these doctors could put specific demands on the Swedish Medical Association's agenda.

4.5 The role of the Swedish research debate on cross-cultural care

To understand the underlying assumptions that exist in this academic debate, this section reviews Swedish research that has focused on cross-cultural interaction where people with different 'ethnic' backgrounds meet. These assumptions give us insight into how 'ethnicity' and 'migranthood' as social positions are understood within the Swedish Medical profession, which is why I have opted to have a section about this. Alvesson and Sandberg (2011) state that debates such as this are important methodological resources if we want to critically study the underlying assumptions that might exist in a field (p. 252). In other words, this review aims to give some insight into what 'ethnicity' and 'migranthood' as social positions are assumed to mean for cross-cultural interactions in Swedish medical settings. The medical doctors interviewed are, after all, by virtue of their background, doctors that regularly engage in cross-cultural interaction in these settings, which is why it seems important to address what the Swedish academic debate on these interactions takes for granted.

It should be understood that the literature reviewed here[44] was often conducted with the aim of solving problems that medical staff might be facing when interacting with people that do not share their ethnic and cultural background. This is important to keep in mind since it says something about how 'migranthood' is understood within the Swedish medical profession. Having said this, it seems important to say a few words about how this section is organized. The literature was first divided into research that applies a patient perspective (e.g. Björk-Brämberg & Nyström, 2010; Bäärnhielm & Ekblad, 2000; Hjern et al., 2001; and Razavi et al., 2011) and research that applies a medical staff perspective (e.g. Berlin et al., 2008; Ekblad, et al., 2000; Hultsjö & Hjelm, 2005; Björn-Jarkman & Björn, 2004; Jirwe et al., 2009, 2010; Lundberg, 2000; Ozolins & Hjelm, 2003; Pergert et al., 2007,

[44] Different combinations of the following keywords were used in the literature search: *ethnic *encounters *interactions, Sweden *immigrant *ethnicity * health care *transcultural, *cross-cultural *intercultural. The search was done using PubMed, Medline and Sociological Abstracts and the bibliographies of the articles selected were also used to further broaden the search. The articles chosen are written in English or at least have an English abstract. The articles that only focus on health disparities between migrant and non-migrant patients or that explore differences in health or experience of health or ill-health in different immigrant groups were excluded, as they did not explore the encounter in itself.

2008). But, before reporting on the analysis I conducted on this research I would like to comment on two literature reviews written by Sundquist (2001) and Löfvander and Dyhr (2002) since these were the starting points for the review conducted here.

In the literature review conducted by Sundquist (2001) he focuses on the challenges that Swedish health care is facing due to increased ethnic diversity. He states that due to the rising proportion of people born abroad during the 1990s there is a need to study how these "different ethnic groups" use health care (p. 170). One year later, Löfvander and Dyhr (2002) reviewed the Scandinavian literature on what they call 'transcultural issues' in primary care and conclude that relatively few studies were found before 2001 and many of them were small, making it difficult to generalise the findings. They show that descriptive explorative studies suggest that there are problems in communication, behaviour, mental health, physiotherapy, and organisation of care among certain "ethnic minority groups". They state also that many transcultural studies in Sweden are case studies that have been conducted on minority patient groups or among certain professional groups. They suggest therefore that there is a need for studies using action research methods, since clinical transcultural care deals with complex illness patterns, including many emotional dilemmas. They also suggest that medical services need to be adjusted to the needs of the "culturally diverse" patients instead of the other way around. According to these researchers, increased understanding of the values that 'minority patients' uphold could contribute to an increase in successful health outcomes for these patients[45].

With Sundquist (2001) and Löfvander and Dyhr (2002) in mind we will now go further and explore the articles that regard the patient perspective. It seems worth noting, however, that these two articles take for granted that 'transcultural care' takes place when 'Swedish' staff care for 'foreign-born patients'. In other words, the possibility that the opposite may occur (i.e. that it is foreign-born medical doctors who care for Swedish patients) is not, taken into account in these studies.

4.5.1 Studies from the patient perspective

Many studies have applied a patient's perspective on 'migranthood' when discussing 'cross-cultural' interactions in Swedish medical encounters (e.g. Björk-Brämberg & Nyström, 2010; Bäärnhielm & Ekblad, 2000; Hjern et al., 2001; Löfvander, 2008; and Razavi et al., 2011). This means that these studies take for granted that the patient is the migrant while the doctor is not. These studies are characterised by the fact that they tend to dichotomize between 'Swedish' and 'immigrant' patients as opposite entities (e.g. Hjelm

[45] Phillips suggests in her book The Politics of Presence that one way of thinking of this is in terms of the asymmetry between exposing the problems of exclusion and identifying what inclusion brings about (1995, p. 53).

et al., 1999; Hjern, 2001; and Sundquist, 1993) as is customary in Swedish society (see introduction). This means that most of the literature reviewed here is constituted of research that focuses on 'migranthood' as different from the norm, which is, in this case, 'Swedishness' (e.g. Abrahamsson et al., 2009; Ahlberg et al., 2004; Berggren et al., 2006; and Svenberg et al., 2009). This is interesting to note since it suggests that – at least with regard to patients – 'migranthood' is expected to be the opposite of 'Swedishness'. That raises the question of what this may mean to the way in which the Swedish medical profession regard this social position if the focus would be on the doctor's background and not the patient's. In other words, it is about that not all people seem to be *assigned* 'migranthood' as a social position within this kind of research which says something about the context we are dealing with in this thesis.

The themes that these studies touch upon are vast. For example, some of the articles focus on the potential solutions to the challenges that are associated with cross-cultural interaction in medical settings (e.g. Akhavan & Karlsen, 2012; Berggren et al., 2006; Fatahi et al., 2005, 2008, 2010a, 2010b; Hadziabdic et al., 2009; Wiking et al., 2004; and Wiking et al., 2009) while others aim to explain why 'immigrants' consume more health care services than 'Swedes' (Hjelm et al., 1999; and Hjern et al., 2001). Most studies from a patient perspective tend to conflate 'ethnicity' and 'migrancy', and therefore compare Swedes with foreign-born people generally, instead of Swedes and a specific ethnic group (the exception to this 'rule' seem to be the studies that focus on one particular ethnic minority and the hardships they face in Swedish medical settings, (e.g. Ahlberg et al., 2004; Berggren et al., 2006; and Svenberg et al., 2009). In the literature in question we also find studies that have focused on the differences in power in medical encounters that take place between doctors and patients with immigrant backgrounds (e.g. Abrahamsson et al., 2009; Akhavan & Karlsen, 2012; Axén & Lindström, 2002; and Björk-Brämberg & Nyström, 2010). Thus, although most studies – with the exception of Razavi et al. (2011) – tend to take for granted that 'migranthood' is a problematic social position in regard to patients it is often taken for granted that this position is meaningful if we are to understand the challenges with which cross-cultural interaction in medical settings are associated. It is worth noting in this respect that, in this literature, patients are never assumed to be 'Swedes', so when cross-cultural interaction in Swedish medical settings is discussed from the perspective of patients it is always taken for granted that it is the patient that has the migrant background.

In the empirical chapters we will see that some of the medical doctors interviewed seem to assume that one of their potential contributions to the Swedish medical profession could be to offer this profession the 'cross-cultural' expertise that it lacks at present. Thus, the research reviewed here gives us insight into why some of the medical doctors interviewed seem to think that they – because of their immigrant backgrounds – are well

equipped to address the needs of patients with similar backgrounds. The idea is that Swedish-born medical doctors are assumed to lack this expertise because they do not understand the life of an immigrant – something that the non-Swedish-born doctors are assumed to understand.

4.5.2 Studies from the staff perspective

Most of the articles on cross-cultural interaction within Swedish medical settings that are from the staff perspective do so on the basis of nurses (e.g. Berlin et al., 2008; Björn-Jarkman & Björn, 2004; Ekblad et al., 2000; Hultsjö & Hjelm, 2005; Jirwe et al., 2009, 2010; Lundberg, 2000; Ozolins & Hjelm, 2003; Pergert et al., 2007, 2008). In these articles the focus often lies on the 'culture-appropriate/ culture-competence' skills that nurses need in order to handle 'immigrant patients'. Some suggested solutions to the problems are offered and these include better communication skills (e.g. Berlin et al., 2008; Berbyuk, 2008; Dellenborg et al., 2012; Ekblad et al., 2000; Englund & Rydström, 2012; Fatahi et al., 2005, 2008, 2010a, 2010b; Hultsjö & Hjelm, 2005; Jirwe et al., 2009, 2010; Nkulu et al., 2012; Pergert et al., 2008; and Wachtler et al., 2006) or the use of interpreters (Fatahi 2010a; and Ozolins & Hjerm, 2003). Some of these studies focus on the way in which 'culture' affects interaction in medical settings (e.g. Berlin et al. 2008; and Jirwe, 2009, 2010) while other studies focus specifically on the challenges that medical professionals face when interacting with 'non-Western immigrants' (e.g. Arborelius & Bremberg, 1991; Baksi, 1999; Dellenborg, et al., 2012; Ekbland, Marttilla & Emilsson, 2000; Englund & Rydström, 2012; Hjultsjö & Hjelm, 2005; Björn-Jarkman & Björn, 2004; Lukkarinen-Kvist, 2001; Nkulu et al., 2012; Ny et al., 2007; Nyampame 2008, Robertson et al., 2003; and Skott & Jakobsson, 2012). In these studies, the 'immigrant' is assumed to be more demanding and is therefore regarded as a challenge (e.g. Nkulu et al., 2012; and Pergert et al., 2007, 2008) because they exhibit 'unexpected behaviours' (e.g. Hultsjö & Hjelm, 2005). In this respect, it is worth noting that few studies on cross-cultural interaction focus on medical doctors with immigrant backgrounds (e.g. Berbyuk, 2008; and Wolanik Boström & Öhlander, 2011). It is also worth noting that some of the studies on cross-cultural interaction that have a staff perspective have shed light on how medical and nursing schools have been dealing with these issues (Fioretos, 2002; Johnsdotter, 2008; Hakimnia & Mizaoff, 2009; and Öhlander & Crozier, 2004).

Regardless of the angle that the studies reviewed here take, it is important to note that these studies assume – just like the studies from the patients' perspective did – that the social position that 'migranthood' entails is a challenge in medical settings (cf. Cuadra Björngren, 2007). Something else worth stressing is that the voices of medical doctors with immigrant backgrounds have been relatively silent in the Swedish academic debate on cross-cultural interaction. This research suggests, however, that the Swedish medi-

cal profession seem to take for granted that 'migranthood' is a challenge[46] that can only be addressed by employing certain skills. Against this backdrop it is perhaps understandable – as we will see in Chapters 6, 7 and 8 – why some of the interviewed doctors in this thesis regard their position as 'migrants' as an asset and think that the challenges associated with 'cross-cultural interaction' offer them a unique position from which they can contribute.

4.6 The role of the Swedish Journal of Medicine

The way medical doctors with immigrant backgrounds have been discussed within the Swedish medical profession offers also important contextual insight about the Swedish medical profession as such. Thus, in this section I will review how the Swedish Journal of Medicine has discussed medical doctors with immigrant backgrounds through the years. A few words about this journal are in order first. The journal is distributed to all members of the trade union: *Swedish Medical Association* (Läkarförbundet) which has about 45 000 members[47]. In my review of the professional debate I have focused on articles that contain the word *immigrant or the word *foreign. The articles I chose to review in order to obtain an insight into how the Swedish medical profession have been discussing medical doctors with immigrant backgrounds are articles written between 1997 and 2010. The reason I decided to start from 1997 is that this was an interesting year since (1) statistics from the National Board of Health and Welfare showed a large increase that year in formal authorization of medical doctors from other countries, and (2) around this time the Swedish Medical Association was arguing for a decrease in admissions to Swedish medical schools.

The discussion about 'immigrant' patients in the Swedish Journal of Medicine seems to draw some inspiration from the debate on 'cultural competence' and 'culturally appropriate care' alluded to in the previous section. I also want to note that when medical doctors with immigrant backgrounds are discussed, it is often in terms of the challenges they face when trying to learn about 'Swedish' culture. This suggests that medical doctors with immigrant backgrounds need not only a medical license but also a more informal type of 'cultural' licensing as well (cf. Salmonsson & Mella, 2013).

In an article published on May, 2011 with the title: *"It is not only the language that needs to be translated"* (my translation) two medical doctors

[46] Cuadra Björngren (2007) studied dental hygienists' way of talking about 'immigrant patients' and she suggests that if we want to pay attention to governmental processes we have to explore the scientific discourses' ability to produce normality and deviance. She suggests that an understanding of the deviant Other; the 'immigrant patient' should be seen as a manifestation of mutual dependence between social subordination (social class) and a discursively formation of deviance (p.106).

[47] See homepage: http://www.slf.se/Forbundet/, accessed 20140401.

(Andrén-Sandberg & Gråberg) from a surgery unit discuss how immigration and especially 'cultural differences' led to challenges that their unit was not prepared for. They argue as follows:

> Our experience is that when our Swedish way of working is explained and combined with suitable ways of interaction one can connect with people from other cultural background than our own, but that this often demands several consultations with interpreters… and time. (Läkartidningen 2011 volym 108 nr 1948[49] my translation)

Thus, through the notion of 'cultural differences', 'migranthood' as a social position is constructed here as problematic and hard to overcome, as well as time-consuming. The 'cultural' context that the Swedish medical profession is coming from is, in this and other articles, assumed to be a context that is Swedish, and medical doctors with immigrant backgrounds are assumed to face difficulties in navigating this context since they are assumed to lack insight into the hidden codes that govern interaction within the Swedish medical profession. A similar notion can be found in the quote below. This quote comes from an article in which the opinion of one of the county councils is given a voice. In the article the head of the local medical doctors' organization in Örebro is interviewed about his experience of recruiting medical doctors from other countries. He states the following:

> They (read medical doctors with immigrant backgrounds) of course, have to have Swedish colleagues around in order to learn our medical culture, our way of investigating and treating patients. (Läkartidningen 2002 volym 99 nr 7[50])

In both examples above we see that the Swedish medical profession is assumed to share a 'cultural' 'we' that medical doctors with immigrant backgrounds – because they are perceived as 'the Other' – cannot easily navigate. Medical doctors with immigrant backgrounds need, in other words, to be taught the "Swedish" medical 'culture' in order to become a part of the 'we'. This might affect medical doctors with immigrant backgrounds' feeling of belonging within the Swedish medical profession as the notions of 'we' and 'them' (made explicit above) seem to shape the symbolic boundaries within

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[49] In Swedish: "Vår erfarenhet är att när vårt svenska arbetssätt förklaras och kombineras med rimliga tillmötesgåenden så kan man oftast få en mycket god vårdkontakt med människor med en annan kulturell bakgrund än vår egen, men att detta ofta kräver upprepade tolksamtal – och tid." for more information see full-text article in Swedish: http://www.lakartidningen.se/includes/07printArticle.php?articleId=16462, accessed 20140401.

[50] In Swedish: "De måste ju ha svenska kolleger omkring sig så att de kan lära sig vår medicinska kultur, vårt sätt att utreda och behandla patienter. For more info see full-text article in Swedish: http://ltarkiv.lakartidningen.se/artNo24217, accessed 20140401.

the Swedish medical profession. This is one of the reasons I deemed it necessary to begin the empirical part of this thesis (which starts with Chapter 6) by alluding to how the interviewed doctors talked about belonging to the Swedish medical profession.

In another quote from the journal in question 'cultural differences' are expressed as something positive. In an article from 1999 entitled: *The Medical Association helps immigrant colleagues to get a job*, the issue of what the profession can do for medical doctors with immigrant backgrounds in Sweden is addressed. In this article we find out that the Swedish Medical Association, along with the Swedish Society of Medicine, has a group to deal with the challenges that medical doctors with immigrant backgrounds are assumed to face, and that this group is called *The team for doctors with immigrant backgrounds* (AFIL: Swedish abbreviation). In that article Eva Asplund, the secretary of the team, states the following:

> The group (AFIL) see immigrant medical doctors as a super important resource in the multicultural society we have today and especially in the care of patients with immigrant backgrounds. (Läkartidningen 1999 vol 96 nr 25[51])

The way that institutions help shape the notion of 'the Other' (which is how the Swedish medical profession seems to regard medical doctors with immigrant backgrounds) has been discussed by several researchers, e.g. Bradby (2003, 2012), Culley (2006), Lukkarinen-Kvist (2001) and Ålund (2002). Even if these researchers do not discuss medical doctor their research is important to keep in mind since it sheds light on some of the experiences that the medical doctors interviewed for this thesis gave voice to that had to do with being 'othered'. Some of them seem very much aware that they were regarded as different from their colleagues, and their assumed difference challenges their feelings of belonging within the Swedish medical profession. In this regards it seems important to note that in the quote above we see that medical doctors with immigrant backgrounds are assumed to be able to become 'mediators' between the 'we' (the Swedish medical profession) and 'the Other' (in this case patients with immigrant backgrounds) (cf. Lukkarinen-Kvist, 2001). Regarding these medical doctors in this manner could lead to a process of 'peripherization' (see Shin & Chang, 1988) where medical doctors that emigrate from countries far away are automatically *assigned* 'migranthood' as a social position and can then – by virtue of their immigrant backgrounds (as the literature reviewed in the previous section showed) – be seen as better suited to care for patients with immigrant backgrounds.

[51] In Swedish: "...Gruppen ser de aktuella läkarna som en jätteresurs i det mångkulturella samhälle vi har idag i omhändertagandet av inte minst patienter med invandrarbakgrund." for more info see full-text article in Swedish: ltarkiv.lakartidningen.se/1999/temp/pda19725.pdf, accessed 20140401).

In another article we learn about a professional network initiated in order to address the issue of discrimination, which the article takes for granted affects medical doctors with immigrant backgrounds differently depending of where they come from. In this article a doctor who is one of the founders of the Association of International Doctors in Sweden (ILIS) is interviewed on the topic of discrimination. Heba Shemais says:

> Many of my colleagues from other countries feel discriminated against. They are not treated well but are met with negative attitudes. They do not feel respected by Swedish colleagues and other health care personnel. (Läkartidningen 2005 vol 102 nr 6[52])

The quote shows an articulated need for awareness of the structural discrimination that medical doctors with immigrant backgrounds are faced with. The journal also reports on the Swedish Medical Association's actions to solve this problem. And yet, in a report from the Swedish National Audit Office published in 2011 there is still criticism of the time it takes for medical doctors with immigrant backgrounds to get a Swedish medical license. The problem is therefore still a highly current one.

The examples above all show a concern in regard to the way in which medical doctors with immigrant backgrounds are discussed as deviating from the norm, which might affect their chances of feeling included in the Swedish medical profession. One possible way of understanding the phenomenon of professional inclusion (and exclusion) is found in Davies (1996), who introduces the ethnocentrism found in medical settings in the United States. By looking at the methods of inclusion from the professional group's perspective she suggests that professional inclusion could be understood as dressed up in gendered discourses, rooted in the core definition of professionalism, that are connected to a larger social and political context. Even if the United States has a quite different social and political context to Sweden, it seems noteworthy that Johannisson (2004) also claimed that the Swedish medical professional context has some ethnocentric characteristics. The constructed differences within the professional system are, according to Davies (1996), what makes the medical profession adopt a 'we' and a 'them' attitude. This theme will be further explored in Chapter 6.

Andolf is a historian studying the Swedish Medical professional's position in regard to medical doctors with immigrant backgrounds. In an article published in 1999[53] as part of a series in the Swedish Journal of Medicine

[52] In Swedish: "Många av mina utländska kolleger känner sig diskriminerade. De blir inte bra behandlade utan möts av negativa attityder. De känner ingen respekt från svenska kolleger och annan personal." For full-text in Swedish: ltarkiv.lakartidningen.se/artNo29762, accessed 20140401.

[53] In Swedish: "Läkarförbundets inställning till invandring av utländska läkare var således under hela 1940-talet synnerligen restriktiv". For fulltext in Swedish: http://ltarkiv.lakartidningen.se/artNo20326, accessed 20140401.

called *The Doctors and Spirit of Time 1930-1950 (my translation)*[54] he writes that the Swedish Medical Association in the 1940s was extremely sceptical towards medical doctors with immigrant backgrounds as they were seen as a 'threat' to medical doctors trained in Sweden. Even though this has changed over the years, the history of both structural and symbolic barriers within the Swedish medical profession might say something about internal hierarchies in everyday practice that is the focus of this thesis.

This chapter has therefore given insight into the context to which the interviewed doctor belong and will be used in order to contextualize the interviewed doctors' experiences that will be analysed in Chapter 6-8.

[54] In Swedish: Läkarna och Tidsandan 1930-1950. For full text in Swedish: http://ltarkiv.lakartidningen.se/serieL%E4karna+och+tidsandan+1930-1950, accessed 20140401.

5 Methodological points of departure

This chapter describes the empirical study that has been conducted for this thesis. It includes a section on the data collection, which describes the qualitative interviews conducted, and a section on what how I found doctors to interview, how they were interviewed, and how the analysis of the data was conducted. The chapter also presents what I did to assure the trustworthiness and credibility of the analysis, and the ethical considerations that were taken into account throughout the study.

5.1 Collecting data through qualitative interviews

Qualitative active interviewing is the data collection method used in this thesis, as I was interested in understanding what it is like to be positioned as a 'migrant' and a medical doctor at the same time. At the core of my interest is the fact that – as Chapter 4 showed – the Swedish medical profession is a professional group that has been very successful in boundary work in the past. As stated in the introduction, my interest lay in the boundaries that might be involved when a doctor comes from another country. Of particular interest was what happens once they obtain their license to practice medicine; i.e. once the first formal boundary to belonging has been crossed. I thought that the doctors' own experiences of boundary work within a professional group could be an interesting source of information. The medical doctors that became my informants were interviewed about their migration story and also about their everyday work lives and the 'identity work' that one could assume takes place when one moves from one country to another and tries to re-establish oneself in one's profession.

In Appendix 1 I present the interview guide that was used in order to make sure that I covered the aspects that the literature on this topic suggested was of importance. The questions were mainly directed towards the medical doctors' everyday work experience and were therefore also limited by that. Thus, I can only say something about the interviewed doctors' feelings of belonging to the Swedish medical profession as such. The interviews lasted from one to two hours and were conducted in different settings since the medical doctors were able to choose the location of the interview. Most of the interviews were conducted at the informant's work place. Consequently, the interview setting varied from offices to public places. The interviews

were recorded and later transcribed. In order for the sample to be as diverse as possible I interviewed medical doctors that worked at different hospitals, clinics, in urban and rural regions of Sweden.

5.2 Finding the informants

Sweden has had a poor track record in assessing the skills that immigrants have acquired prior to migrating to this country and this failure has led to the devaluation of human capital for this group of people (see e.g. Bevelander, 2000; and Bask, 2005). With that in mind, one of the sampling criteria I used when selecting medical doctors was that they should have experienced some kind of 'skill devaluation' in the sense of having experienced their medical skills being questioned. Another sampling criterion was that they should have (or have had) a job, a training position, internship or probation period themselves in the Swedish medical profession since I wanted them to be able to talk about feelings of belonging in relation to their everyday working life in Sweden. This means that I focused on medical doctors that had already gone through the licensing process and had some kind of employment. However, the kind of employment did not matter.

When I first started looking for potential informants, I contacted The National Board of Health and Welfare but found out that they do not keep track of where immigrant medical doctors (who have a Swedish medical license) work or if they are working at all. This meant that I needed to use different strategies in order to find potential informants. As a first step in finding people to interview, medical doctors from my former professional network (the recruitment company I mentioned in the introduction) were informed about the project and asked to participate. Secondly, human resource departments at hospitals as well as professional organizations such as international doctors in Sweden (see Chapter 4) were asked to help in contacting medical doctors that fulfilled the sampling criteria. When going through the human resource departments some of the medical doctors that were recommended had a somewhat different background to what I had in mind. Some recommended, for example, that I interview medical doctors that were trained in Spain but born in Chile, or medical doctors that were trained in Sweden but were born in another country such as Hungary. But as stated in the introduction and in Chapter 4, these were not the medical doctors I was interested in since my interest lay exclusively in medical doctors that could – on the basis of their background and their training – be assumed to have encountered the greatest challenges to gaining a feeling of belonging within the Swedish medical profession. As explained in Chapter 4, medical doctors with immigrant backgrounds that do not have training that makes them automatically eligible for a Swedish license can be expected to face greater challenges to feeling that they belong within the Swedish medical profession than doctors with the same backgrounds whose training allows them to get their license

through the EU physician directive. This thesis focuses primarily, though not exclusively, on medical doctors with immigrant backgrounds (i.e. with non-Swedish background and training) that had not migrated to Sweden primarily for work (with some exceptions that are discussed below).

A total of 15 interviews were conducted. The sample demographics are presented in Table 2. The sample was composed of three medical doctors that were born in Syria, three born in Iraq, two in Iran, two in Hungary, one in Cuba, one in Chile, one in Jordan, one in Somalia and one in Poland. Two of the medical doctors had all their training in Sweden (Juliana and Lajos), and three had their training in a country that when they came was a part of the EU (Masoud, Zilan and Tanja). One was trained in Spain before Sweden was a member of the EU (Marta), and one was trained in Romania before Romania was a member of the EU (Hamid). Therefore, ten of the interviewed doctors had, when they came to Sweden, had their training in countries that were non EU-members or came to Sweden before it joined the EU. The reason I included the medical doctors with Swedish and European training was that they made interesting contrasting cases in regard to feelings of belonging within the Swedish medical profession.

Gender-wise I interviewed eleven men and four women. Their ages ranged from 35 to 63 years. Some had been in Sweden a long time (since the 70s) and some had come quite recently (2011). Ten of them said they came for political asylum (one as an unaccompanied child) and three of these also said that they had come in order to be reunited with their families (one stated that was the primary reason). Two said they came because of love and two said that they came to work even though they were not labour migrants in a legal sense (Zilan for example had to leave Greece because there were no job opportunities there and Tanja came here because her sister lived in Sweden). Five were working in rural areas (Masoud, Mahid, Zilan, Hamid and Tanja) while the rest were working in urban areas in Sweden. Nine were specialized in fields including anaesthesiology, family medicine, geriatrics, orthopaedics, and ophthalmology while six were not yet specialised but had some kind of position (either training positions – probation position, AT or ST – or ordinary doctor positions when the interview was conducted. This information and more is displayed in Table 2.

5.3 Active interviewing

I started all interviews with some general information on what had prompted me to study the topic at hand. I did this in order to show my informants that I had some insight into their profession – because I had worked as a human resource manager in their field. Having providing this background information as to how the project came about I moved on to explain to the informants why the interviews needed to be tape-recorded and transcribed. I then asked the medical doctors that were to be interviewed for permission to

record the interviews and explained how I would handle their personal information (for more information on ethical consideration see section 5.7). It is relevant to note that this information was sent to the informants in advance by e-mail. The informants I met were, therefore, people that had already agreed to be interviewed.

According to Holstein and Gubrim (2011, p. 163) all interviews for the purpose of data collection are to be considered active. This way of looking at interviews derives from the social constructionist way of regarding knowledge production (i.e. Berger & Luckman, 1992 (1967); Blumer, 1969; and Garfinkel, 1984). As already stated, an interview guide was used but in order to focus on the experiences of the medical doctors, this guide served more as a checklist for the interview than as an interview guide in the strict sense of the term. This means that the medical doctors that were interviewed all had considerable freedom to talk about the themes that the guide covered and in the order they preferred. The interview often started by me asking the medical doctors if they could tell me something about their first job in Sweden, a question that allowed me to tap into their migration story in a relatively uncomplicated way. This strategy was successful and I got the impression that their post-migration experiences may have been harder to assess had I asked about them more explicitly. Throughout the interviews I asked my informants to explain the things I did not understand or aspects of their stories that I wanted them to elaborate on. For example, while the informants were giving their accounts of obtaining a Swedish licence I asked for clarifications and details when needed and, when they were telling stories from their daily work, I encouraged them to elaborate on why they thought different incidents they had experienced had happened.

Some medical doctors were very positive regarding the experiences they had had re-establishing themselves in Sweden and did not dwell much on difficulties. When this was the case, I was more focused on asking follow-up questions that could open up elaboration on their experiences (such as, “do you know if other medical doctors have had other experiences?” or “can you remember a situation that was not as easy?”). Through these follow-up questions the informants had the possibility to reflect on situations that might have been difficult, and often this led to a more complex reasoning about their social positions with regard to others in a similar situation.

Some of the informants were very critical of their workplaces and told detailed stories about certain situations where they felt misunderstood by managers and staff but also by migration officers and others outside the work place as well. In order to get into the next subject without neglecting the experience they were sharing with me at that moment, I used follow-up questions to redirect the informants (such as: “what did you do to get out of that situation?” or “what would you have done if that had happened today?”).

While the informants selected the location of the interviews, only one chose to have the interview outside the workplace. This interview was con-

ducted at a café close to the interviewee's workplace. Another interviewee chose to have the interview in the lobby of the hospital in which he worked. The reason they were given the possibility to choose the place for the interview was that it made it easier for them to participate. This strategy had its limitations as both the interview that was done in the hospital lobby and the one that was done at the café stand out as being less focused on the work place than the ones that were conducted at the work-place itself. These interviews had a more informal character, which is positive in some regards as they spoke more about their personal lives, but they were also interrupted, for example, by colleagues walking by or noise from other people at the café.

5.4 Analysing the interviews

Researchers need to sort all of the information they have collected into an understandable end product. One way of doing this is offered by Alvesson and Svedberg (2011, p. 252). They argue that problematizing is an interesting method to use in analysis since it allows researchers to develop typologies about the types of assumptions that can be problematized in existing theories (this is to some extent what I did in Chapter 3; in that chapter I problematized the existing theories about professional boundary work and argued that if we were to pay attention to 'ethnic' boundaries as well we may be able to gather information about boundaries within).

The analysis of the interview data that was done for this thesis can be seen as inspired by directed qualitative content analysis. Hsieh and Shannon (2005) suggest that there are three different kinds of content analysis and that the directed approach is more focused on further developing a theoretical framework (p. 1281). This approach is not as inductive as traditional content analysis, which is why I deemed it suitable for the task at hand. This thesis focuses thus on the underlying assumptions about 'being' a doctor and 'having' an immigrant background that are found in the interviewed doctors' stories. This is why, throughout the interviews, I asked follow-up questions intended to shed light on whether the informants felt that they belonged to the Swedish medical profession, the interactions that made them feel the way they did on the subject, as well as the resources they used in order to feel a sense of belonging. This line of questioning aimed to identify boundaries within the profession, which is the angle from which the conceptual and theoretical framework chosen for this thesis. Because barriers or challenges to belonging lay at the very core of my interest, I also paid particular attention to the assumptions about 'migranthood' that the medical doctors were sharing with me (either their own or the ones that others upheld and to which they made reference to when sharing their experiences with me).

Therefore, the first step of the analysis entailed categorizing all instances where belonging to the Swedish medical profession was talked about in the

interviews. This categorisation was done using Atlas-Ti. The transcripts were therefore read and re-read and the parts of the interview that alluded to the theme of feeling of belonging within the Swedish medical profession were highlighted.

The next step in the analysis entailed coding all highlighted passages using pre-determined codes (feelings of belonging, interaction, and resources used to gain the feeling of belonging). These codes were chosen because they had resonance with the conceptual and theoretical framework chosen. The feeling of belonging (the first code) to the Swedish medical profession was operationalized as how the medical doctors talked about belonging to the Swedish medical profession (or not), and the third step of the analysis entailed nuancing this code through the subcategories 'always', 'never' and 'sometimes' (see table 3, columns 1-3) depending on how the doctors spoke about feeling that they belonged within the Swedish medical profession. The second code (i.e. the one that focuses on how they talked about interactions, see table 3 column 7-9) came about as follows. First all instances of interactions were highlighted using Atlas-Ti and then all instances were subcategorized depending on who the interaction was with (i.e. if the interactions mentioned entailed interaction with other medical doctors, nurses and/or patients) (see table 3, column 7-9). The third code used focused on the resources that the medical doctors talked about employing in order to feel that they belonged within the Swedish medical profession. First, all instances of strategies were highlighted using Atlas-Ti, and then these instances were sub-categorized on the basis of the resources that were mentioned (columns 10-12 of Table 3 document the results from this step of the analysis).

Besides coding all of the nuances related to the three main codes that the analysis focused on, I also looked for eventual relationships between the findings in each of these codes and the demographics I had of the medical doctors interviewed. This is why Chapters 6, 7 and 8 present not only the findings in relation to the themes in focus but also the patterns observed in the conducted interviews. Thus, although notions about 'migranthood' are explored, these are tapped into throughout the themes that the interviews focused on most, i.e. feelings about belonging, interaction and resources.

In the third step of the analysis, I aimed to nuance this code further by analysing how the medical doctors interviewed talked about belonging to the Swedish medical profession; whether they saw it as something that was attainable, indifferent or unattainable (see table 3, columns 4-6). This was done in order to grasp whether the feeling of belonging within the Swedish medical profession that – by virtue of the frameworks I started from – I deemed important was indeed important to my informants as well. The idea was that belonging within the Swedish medical profession could (and maybe should) be only a formal matter (i.e. they had their license and were therefore already 'inside' the professional boundary) while many of the interviewed doctors seemed to regard it as also having an informal side to it,

which had to do with what happens after one is 'inside'. The analysis needed to take all of this into account, which is why I have paid close attention to the different ways in which the feeling of belonging within the Swedish medical profession was talked about. The particular reason for why I focused on trying to understand how the interviewed doctors spoke about belonging to the Swedish medical profession was that it seemed to be highly determined by the context. In Chapter 4 we learned that the debate within the Swedish Medical Association and the research on 'cross-cultural' medical interaction in Sweden tends to take for granted that 'migranthood' is a social position and that it is problematic and is often discussed in relation to patients with immigrant backgrounds. I would argue that under these circumstances, it is plausible that medical doctors with immigrant backgrounds can belong, formally speaking, to the Swedish medical profession (due to having their license to practice medicine in this country) without feeling that they truly and fully belong to their profession.

A few words about why I have chosen to describe what I do as, 'analysing talk' about feelings of belonging or boundaries is necessary since this is related to this thesis's ontological and epistemological stand. As I see, qualitative interviews can be regarded in different ways depending on the tradition from which one comes and/or whether or not one collects other data as well. Some qualitative researchers regard the information they collect through interviews as insights into how things 'are' while others regard them as insights into what people say about how they perceive things to be. In this thesis I regard the data I have collected as the latter. Had I also collected data ethnographically through observations, I may have regarded them differently but because I did not, I have opted to stay as true as possible to what my informants have conveyed. Therefore, I have chosen to refer to the analyses I have performed as analyses of their talk about belonging, boundaries, strategies, etc. The data collected allows me to analyse what the doctors said to me about belonging, for example, but I cannot know if what they have told me is a description of how things 'actually are'. Thus, by choosing to refer to what I have done as an analysis of talk about something, I wish to emphasise the something and not the talk itself.

The analysis presented in Chapters 6-9 is also somewhat informed by the work of Wong and Lohfeld (2008) who have argued that the feeling of belonging of medical doctors with immigrant backgrounds is challenged by the loss of professional identity and status when they leave behind the professional settings to which they have become accustomed. According to these scholars, medical doctors with immigrant backgrounds experience professional devaluation and disorientation when they leave behind the medical settings they know for new ones. This leaving behind can make these medical doctors "feel like aliens" in relation to their new peers and staff supervisors (p. 56). I decided to structure the empirical chapters accordingly; i.e. to first focus on how belonging within the Swedish medical profession is ex-

pressed by the doctor, and then move on to the interactions that the interviewed doctors mentioned when talking about belonging, which is the theme of Chapter 7, and to address the resources that these medical doctors talk about using to feel they belong within the Swedish medical profession in Chapter 8.

The work of Wong and Lohfeld (2008) has, in other words, been highly instrumental in the design of the analysis that was performed on the data collected for this thesis. Wong and Lohfeld's (2008) work suggest that there is a way to achieve 'complete transition' for the migrant doctor, which is why this thesis explores – albeit implicitly – if the medical doctors interviewed can be regarded as medical doctors that have completed the transition process in question, and if not, why not.

The need to look into whether the interviewed doctors talked about belonging to the Swedish medical profession is also inspired by Shuval, who claims that:

> Despite its on-going processes of segmentation into specialties and subspecialties, the profession of medicine provides its members with a shared identity through commonality in entry criteria and a long socialization process which includes both knowledge and practice skills that create a common culture. (Shuval, 2000, p. 192)

Shuval (2000) suggests that "commonality in entry criteria" and "long socialization" provide members of the medical profession with a shared identity, and she also shows in a study of Russian medical doctors who immigrated to Israel that the motivation to re-construct a professional identity is a powerful force among medical doctors with immigrant backgrounds (for more information on her study see Chapter 2). In other words the structure of the medical profession "creates a common culture" which forms the basis of a "shared identity" and that is why – together with the work of Wong and Lohfeld (2008) – my empirical interests began with the issue of the feeling of belonging, or 'informal' belonging as I also call it. All of these issues are related to what Anthias (1998) calls the 'construction of otherness and sameness' as well as Gilroy's notion (1993) that in every formation of a 'we' (created on the basis of similarities) there is also an excluding 'them' (on the basis of difference).

Even if the process of analysis may seem linear when described above, it is worth noting that it was nothing but. The process entailed countless rounds of reading and re-reading the interview transcripts as well as listening to the recorded interviews on numerous occasions at different stages of the analysis. During the course of the analysis I also read and re-read the literature on professional boundary work and social positions in order for the analysis to be as directed as possible (see previously mentioned directed content analysis). This means that the process of analysis entailed going back and forth

between theory and data, between writing and reading and between listening and coding[55] in a somewhat adductive way.

When describing the different steps I took as I analysed the data I referred to Table 3, and a few words seem necessary in order to explain why I chose to work with a data display. Data displays are often used in order to assist researchers in the analytical process (for more information on data displays see Cutcliffe & McKenna, 1999; Eisner, 1997; and Silverman, 2006). These displays allow researchers not only to pin down the results of each step of the analysis they conduct but also to make connections between individual stories and larger trends in the data. Using the data display allowed me, in other words, to get a birds-eye view of the data as I moved from one step of the analysis to the next, and offered me an opportunity to see when further analysis was needed since the idea was to move beyond the obvious (i.e. what was said) to the less so (i.e. how different angles of experience related to other angles mentioned). Thus, the data display that is Table 3 is used first to illustrate how each of the medical doctors interviewed talked about feelings of belonging and about challenges to that feeling in regard to 'migranthood' as a social position, and second to see patterns in the data which were shared by several of the medical doctors interviewed. Table 3 can therefore be regarded as part of the analysis. The interviews give us insight into how they regarded the boundaries that restrict or enable their feelings of belonging within the Swedish medical profession. The theme of interaction can be regarded as situations when professional boundary work took place (or not) while the theme on resources could be regarded as the assets that they talked about having and using in their everyday practice.

It is perhaps worth noting that finding ways of displaying qualitative data is not something new but has been a task of qualitative researchers since the 60s (Eisner, 1997, p. 4). In this thesis I have used a traditional data display in order to acknowledge the variety of ways in which I have coded the experiences that my informants shared with me. According to Eisner (1997, p. 7) finding ways to display data is about showing how the transformation of experience from the personal to the public can occur. To this end it seems important to state that the data display should not be regarded as a way to quantify the results, but rather as a way to get an overview of what the different medical doctors interviewed talked about and how different experiences relate to one another. It is also important to note that a data display does more than just displaying; it actually allows researchers to reduce complexity and achieve synthesis (cf. Asplund, 1968; and Strike & Possner, 1983, p. 346). Phrased differently, one could say that by displaying the data I was able to reduce the complexities associated with the issue of the feeling of belonging within the Swedish medical profession.

[55] Anecdotally it seems important to acknowledge that the first version of the data display I assembled as I coded and re-coded the collected data was 25 papers glued together, a reminder of the craftwork that underlies the process of analysis.

5.5 Trustworthiness and credibility

Analyses that are inspired by the social constructionist perspective take for granted that people's experiences are always contextually determined and that one of the main tasks a qualitative researcher faces is how to interpret the data in ways that stay true to the contexts that determined the data. The trustworthiness and credibility of an analysis is therefore at the forefront of qualitative researchers' quality control efforts. In the previous section I aimed to make the different steps of the analysis as transparent as I could. In this section I will explain – in more detail –what I did in order to avoid anecdotalism (cf. Silverman 2006, p. 20). Silverman describes anecdotalism as the writing or telling of short narratives concerning an interesting, amusing, or curious incident or event. To combat this, Silverman (2006) suggests different methods that researchers can use to systematize the research process[56]. In the process of analysis I relied primarily on two verification methods: deviant case analysis and tabulations. As already mentioned, I used data displays in the process of analysis in order to systematize the data and reach trustworthy interpretations. The use of data displays allowed me also to render visible the deviant cases that were found in the data and to compare these cases to the other patterns found. In addition, the analysis was reviewed on several occasions through peer-debriefing sessions and rival explanation analysis (cf. Lincoln & Guba, 1985) and de-briefer sessions. During the course of the analysis I had several de-briefing sessions with my supervisor. This means that I discussed not only how I have analysed the transcribed interviews but also how the data display could be constructed. I was also part of a peer-debriefing group with other fellow doctoral students in which we discussed alternative interpretations of the different analyses we were each conducting as part of our PhD projects.

Regarding the issue of credibility or in other words, the representativeness of this study, I will draw from some suggestions formulated by Cutcliffe and McKenna (1999) in relation to qualitative research in medical contexts. They argue that the most useful indicator of the credibility of qualitative health research studies is when practitioners regard the results as meaningful[57]. All through the data collection I talked to my informants about ideas that came up while transcribing. One could say that I tested my initial ideas about what is going on with my informants. Thus, instead of asking the informant to, for example, read the transcripts I instead talked with them about the themes that caught my attention during my fieldwork and while transcribing, and asked them if they thought my interpretations seemed fair. I also had one medical doctor (who has not one of the interviewees) that read the analytical chapters

[56] Creswell (1998) identifies eight verification procedures that qualitative researchers can use in order to verify analytical results (pp. 197-204).

[57] Creswell argues that instead of terms such as internal and external validity the qualitative researcher may employ term such as credibility, transferability, dependability, and confirmability (1998, p. 77)

as a way to see if the analysis would be comprehensible to someone in the field.

5.6 Methodological limitations and reflections

Sections on methodological limitations and/or reflections are meant to offer an opportunity to reflect on challenges faced during the process of data collection and analysis. In this section I would like to share some thoughts on some of the challenges I faced during the data collection phase. The first reflection is related to place and has to do with the challenges one faces when one allows the informants to pick the location for their interviews. To this end it seems important to draw attention to Elwood and Martin (2000) who argue that:

> The interview site itself embodies and constitutes multiple scales of spatial relations and meaning, which construct the power and positionality of participants in relation to the people, places, and interactions discussed in the interview. (Elwood & Martin 2000, p. 649)

One example that shows the importance of place comes from the interview that I held in the hospital lobby. During the interview, colleagues walking by greeted the informant. Although this did not seem to disturb the informant I cannot help but wonder if it did in fact distract or affect him. Of particular relevance here is, of course, whether or not he talked differently because of the fact that colleagues were there and their presence was obvious to him. Another example of how the importance of place could not be disregarded comes from an interview that was held in a doctor's office after the clinic was closed. In that interview the doctor commented on people walking outside, wondering who that might have been etc. These two examples show that the location of an interview, or micro-geography as Elwood and Martin (2000, p. 650) call it, is bound to have an effect on how informants talk about certain issues. Thus, although I cannot with certainty say that these locations biased what was said and how, it seems important to note that by allowing the informants to pick a location of their choice, I did open up the possibility of this type of bias. In contrast, the interviews that were conducted in conference rooms or other more 'neutral' places sometimes felt more formal. In these interviews, I felt that talk about experiences of differentiation and other less positive issues related to 'being' a doctor did not come as easily. Irrespective of the pros and cons that each of these different locations entailed it seems worth noting that – just as Elwood and Martin (2000, p. 654) state – informants position themselves differently with respect to the multiple roles and identities that structure their experience of different places.

Another matter that I would like to reflect on is the way I was perceived as a social science scholar in the interview situation. In some of the interviews I was made aware that the informant and I had very different views on what doing research entails. One such situation was when a doctor, instead of telling me about his experiences with interactions with nurses, just gave me a pile of articles that discussed the power relation between interns and nurses. It is worth noting here that he not only chose not to answer my question; he argued that it was better for me to read about how it is rather than have him tell me about his experience. The articles would, as I understood it, give me a story closer to some kind of truth. When this happened I did not see this as a problem but when I listened to the interview tape I could see that this was a way for him to resist talking about a topic that he probably thought had been discussed enough in other places. This incident says something about the way I was perceived by some of my informants. This way of taking the lead in the interview and suggesting that I read things instead of answering my questions is interesting from a methodological point of view and might be related to me being a social scientist in the medical field. Another example of this discrepancy in backgrounds can be found in some of the feedback I received before, during and after the interviews.

I was also often asked if I was a medical doctor myself, and I understood this to mean that the informants wanted to know if I was knowledgeable about their profession or not. In two of the interviews the roles of the interviewer and the interviewee shifted and the person I interviewed started asking questions about my profession and boundaries within academia. Thus, I think my position both as a social scientist but also as a woman with a Swedish appearance interviewing medical doctors with immigrant backgrounds, most certainly had some impact on the interview situation. At times (but not always) I think that these perceived positions were useful since some medical doctors seemed to feel that they needed to explain things in more detail in order for me to understand, and I was able to ask 'naïve' questions that a person with a similar professional background to theirs might have had a harder time asking.

Another matter that I somehow suspected to be a challenge was the risk that the informants would see me as a representing some kind of 'Swedishness'. I worried that some of them would be hesitant to talk about the more negative sides of the Swedish system and culture. That happened in one of my interviews in which a relatively young doctor from Iraq was talking about feeling like a stranger in the neighbourhood he was living, which was dominated by native Swedish middle class people. At some point in his reasoning about this he apologized for feeling like this. His reaction might be related to a fear of offending a person that he saw as representing Sweden and Swedishness. In order to handle this challenge, I used different strategies. Sometimes I used my experiences of having lived abroad as a way to relate to their migratory experiences, while at other times I used my background within the medical field as a way to move along in the interview. It is

hard to judge if and how these strategies affected the interviews but I tried to handle the situations I faced by reflecting on my role as a researcher, as a Swede and as woman after each interview.

A few words on the limitations of this study are also in order in a section such as this. These are related to the possibility of drawing generalizable conclusions from a limited number of interviews. The fact that the sample is small is perhaps counteracted by the fact that the sampling criterion is as diverse as it is (different countries of origin, different training backgrounds, different number of years in Sweden, different ages and different specializations) yet narrow in some senses (many were refugees and all except one was had a Swedish medical license). In addition, I hope it is the case that the high degree of data systematization I opted for allowed me to make interpretations that are valid enough even if only for the medical doctors interviewed. Thus, although the scope of generalization may seem limited, I would argue that the depth of the analysis offers opportunities for future research to further explore some of the findings that will be presented here. I also want to address the limitation that has to do with the questions I asked. As you can see in the interview guide (Appendix 1) I focused on asking about the interviewed doctors' workplace and their everyday work life, which limited my ability to draw conclusions about wider matters, for example Swedish health care in general. Therefore, this study and especially the empirical chapters are limited to analysing how the interviewed doctors talked about belonging to the Swedish medical profession, what challenged their feeling of belonging, and what they did in order to cope with that challenged feeling of belonging to the Swedish medical profession.

5.7 Ethical considerations

The study was approved by the Uppsala Regional Ethical Review Board (Regionala Etikprövningsnämnden 2010-05-18). The ethical considerations of this thesis are related to the issues discussed in the previous section. Interviewing people might be seen as 'violation' of a person's integrity. The informants might say something that they regret or would like to rephrase. In addition, the identity of the informants can be traced if their personal information is not treated with the outmost care. The informants were informed that all names of persons they talked about would be changed and that their work place would only be described and never referred to by its full name. Another important aspect of the ethical considerations concerned the informants' willingness to be a part of the study but also their ability to withdraw their participation at any time. To this end it seems important to mention that some of the individuals that were asked to be interviewed articulated the importance of this type of study. Many of them also commented on the need to have a voice in the on-going debate on integration issues in Swedish soci-

ety since they felt they could serve as a positive example in what they described as a pessimistic debate. Some also highlighted the need for studies that consider medical doctors' perspective on issues related to ethnicity and health. So all in all I feel confident that the medical doctors that agreed to be interviewed for this study felt genuinely engaged in the study and wanted to contribute to it. It is against this backdrop that I would argue that although some ethical issues had to be considered, the most ethically challenging aspects of the study have been handled in a satisfactory way.

6 Boundary awareness: Analysing talk about belonging to the Swedish medical profession

In this chapter the focus is on how the interviewed doctors talked about belonging to the Swedish medical profession. This is the first of three empirical chapters. The term 'awareness' will be used here to allude to the way in which the interviewed doctors talk about professional boundaries within the Swedish medical profession. It is the most empirically driven one out of the three and sets the scene for the other two. The empirical chapters should therefore be seen as accumulative since they build on each other to develop the argument that we need to look at professional boundary work within. In Chapter 3, I presented the work of Cornell and Hartmann (2007) who have argued that someone can belong to a group of without any substantive awareness of it (p. 88). That is why this first chapter aims to shed light on whether or not the interviewed doctors talked about belonging within the Swedish medical profession and in what way.

What became clear quite soon in the analysis was that when the interviewed doctors talked about belonging, one aspect of this belonging had to do with formal belonging in itself (getting a license) while another aspect had to do with feelings of belonging to the Swedish medical profession. The latter seemed more to be about persisting and being able to do the job without being seen as the 'Other', which indicated that belonging to the Swedish medical profession seemed more complex than one might think. This feeling of belonging I understood as a feeling of unity or cohesion, and this first empirical chapter focuses on how the interviewed doctors seemed to be aware of some kind of boundaries to that feeling of belonging within the Swedish medical profession. As already introduced in Chapter 5 but worth highlighting again, the transcribed data was analysed, looking for places in the interviews where the medical doctors talked about belonging within the Swedish medical profession but also where they did not, since silences might also say something about their awareness of the boundaries to the feeling of belonging within the Swedish medical profession.

It is now time to draw attention to the data display mentioned in Chapter 5 (Table 3). This chapter – as well as the other two empirical chapters that follow – will begin by drawing attention to Table 3 before going on to ex-

emplify and theorize[58] how the interviewed doctors were talking about belonging to the Swedish medical profession in relation to quotes from the interviews. Therefore, this chapter keeps quite close to the data, and the abstraction level (or the theorizing) increases in Chapters 7 and 8. This means that the analysis presented here will use the framework presented in Chapter 3 as well as the notion of the *outsider within* which was introduced in Chapter 4 in order to make interpretations of how the interviewed doctors talked about belonging to the Swedish medical profession. In regard to the construction site it is perhaps important to revisit the fact that Cornell and Hartmann (2007) define this as:

> A place where social actors make claims, define one another, jockey for position, eliminate or initiate competition, exercise or pursue power and engage in other activities that encourage or discourage, create or transform, and reproduce or ignore identities. (Cornell & Hartmann, 2007, p. 170)

In this chapter I will try to understand how the interviewed doctors with immigrant backgrounds 'make claims', and 'define one another' in relation to the Swedish medical profession since this is the site in focus. As stated at the beginning of Chapter 3 "Just what something is—an institution, a class, an ethnic group, a religious movement—depends on the meanings people give it and take from it" (Dennis & Martin, 2007, p. 292). I would also once again like to emphasise that belonging – in a more formal way– to the Swedish medical profession is gained through licensing. The analysis shows, however, that feeling a sense of belonging – in a more 'informal' way – seems to go beyond that, which is why I will focus on the 'informal' way in the coming empirical chapters.

6.1 Displaying the data: Feelings of belonging

As stated in Chapter 5, Table 3 should be understood as both a display of data but also as an abstraction of the interview material into theoretically informed themes. The data display gives us, in other words, an overview of whether or not the interviewed doctors talked about belonging within the Swedish medical profession (in column 1-3) and also when they did, how they talked about feelings of belonging (in column 4-6). This chapter focuses, in other words, on the first six columns of this data display. It is important to note here that feelings of belonging within the Swedish medical profession were in most cases something that the medical doctors talked about, yet often only occasionally (see column 1-3). Hence, when looking at previous research it became clear that a feeling that one belongs is often implicitly assumed to come with licensing; an assumption this thesis prob-

[58] This term is used in accordance with Swedberg (2012).

lematizes. In the transcribed interviews, belonging within the Swedish medical profession seemed more complex than just something you gained through a license, and therefore it needed to be investigated further. Belonging within the Swedish medical profession was often expressed when the interviewed doctors talked about themselves as individuals in connection to the Swedish medical profession as a group. This is interesting because it could be understood to mean that the feeling of belonging to the Swedish medical profession was talked about differently depending on what individual symbolic or material resources the interviewed doctors brought with them, and what they were given by the Swedish medical profession (as will be further analysed in Chapter 8).

As we saw earlier, in Chapter 2, Lupton (2012) argues that much of the theorizing around professional boundary work still seems to be based on the idea that medicine has one static way to belong which is why we will here listen to some of the medical voices that have been previously silenced or lost (cf. Carmack, 2006; Geist & Dreyer, 1993; Lupton, 2012; and Waitzkin, 1991). This was deemed important for this particular part of the study as it suggests that the feeling of belonging within the Swedish medical profession should not be perceived as something static but could instead be regarded as something that changes through negotiations with different groups and could be resource (economic, human and social)-dependent. Moreover, it also seems important to note that medical socialization research has been criticized for being non-contextual (cf. Harter & Krone, 2001; and Sharf, 1993) and therefore, approaching feelings of belonging with the presumption that medical doctors have had identical medical training is neither plausible these days nor relevant for the task at hand.

6.2 Theorizing boundary awareness

Considering both of the trains of reasoning referred to above it seems reasonable that the doctors in this study did not seem to have one unified way to belong to the Swedish medical profession (see column 1-6, Table 3). Instead, when they talked about belonging to the Swedish medical profession the belonging seemed to be conditional in some way. Thus, in the sections that follow I will explore in detail the different ways of talking about belonging to the Swedish medical profession that were expressed by the interviewed doctors.

If we take a look at the internal diversity in demographics (see table 1) of the interviewed doctors, it might be suggested that there are probably many more ways to belong to the Swedish medical profession, and the diversity in demographics might give a hint to some of these. Some seemed to talk about always feeling like they belong (See Juliana and Lajos in Table 3) while most of the interviewed doctors seemed to talk about feeling like they belonged sometimes or never, and some (see for example Mahid and Goran and Fadi in the same table) did not seem to care much about this feeling (see Hamid, Marta, Tanja and Saman). These people had quite different back-

grounds, which might tell us something about the differences in how they talked about belonging to the Swedish medical profession. They seemed to express that they had limited possibilities to be *assigned* the social position of medical doctor even though they were in fact working as medical doctors and belonged in a formal sense to the Swedish medical profession, which was something that I found worth looking into. But that feeling of belonging to the Swedish medical profession seemed only to be important under certain circumstances and to some of the interviewed doctors.

Therefore, this chapter focuses mainly on understanding the *assigned* social position of medical doctors and that of 'migranthood' that the interviewed doctors talked about as important for their feeling of belonging within the Swedish medical profession. It also focuses on trying to understand how the interviewed doctors perceived these social positions (*primordial* and/or *circumstantial*). I start here, as I believe that we need to know if the interviewed doctors' were *aware* of boundaries to feelings of belonging within the Swedish medical profession first in order to understand how these feelings are challenged (Chapter 7) and what the interviewed doctors did to negotiate the challenged feelings and the resources they talked about using to address these challenges (Chapter 8). All names of persons or towns in the following chapters have been changed in order not to be traceable to the individual medical doctors interviewed.

6.2.1 Talking about belonging to the Swedish medical profession

The first case I would like to draw attention to is the one that could be described as deviating from the rest of the interviews. It draws on two medical doctors that talked about belonging to the Swedish medical profession in an unproblematic manner. Thus, although their approach did not have much in common with the rest of the interviewed doctors, I have deemed it necessary to begin with these two cases since their take on things could perhaps be used as a contrast to the rest of the sample's take on this manner. Something else worth noting is that – as shown in Table 3 – Juliana and Lajos expressed a similar feeling of belonging within the Swedish medical profession all through their interviews, and I got the impression this had to do with the fact that they had received their medical training here. Hence, they both seemed to think that although they were not – ethnicity-wise – Swedish, they were fully-fledged members of the Swedish medical profession because they had received their training in Sweden and had only been socialized in that medical culture. They were also both white. Both of them seemed, in other words, to embody the social position of medical doctor having had their training in Sweden and being white. This combination seemed to grant them a feeling of belonging to the Swedish medical profession.

Let us start with Juliana, a general practitioner from Poland who came to Sweden in 1988 (for more demographics see table 2). She and Lajos were

the only ones in the sample that had their training in Sweden. Juliana came to Sweden because she met a man from here. She expressed feelings of belonging to the Swedish medical profession throughout the interview (see column 1, Table 3). In the quote below Juliana talks about how she felt when she came to Sweden and how this feeling has changed with time:

> Interviewer: Would you say you are different today?
>
> Juliana: Sure I am! Today I'm 55 and back then I was 20 and completely lost. I hope I am no longer lost (laughs) but sure I have another identity today. When I go to Poland to see my friends and cousins they do not care (read: if I'm a doctor). Some don't know I'm a doctor here (in Sweden) but here I'm a doctor…foreign or not…. Of course I have other identities among my friends and I might write poems… everybody has their way of categorizing others...When I go there (read: Poland) I belong with them in another way and it does not depend on which profession I chose. The only thing that irritates me is that here I'm Juliana from Poland and there I'm Juliana from Sweden.

In the quote Juliana elaborates on her feeling of 'ethnic' belonging (Polish and Swedish) together with a feeling of belonging to the Swedish medical profession. When Juliana was recruited for the study she said that she felt provoked by the research question and especially about the fact that the focus was on 'medical doctors with immigrant backgrounds'. This might be the reason why she felt the need to state "I am a doctor, foreign or not". Later in the quote she says, "I'm no longer lost but sure I have another identity today". Thus, she indicated that this feeling of belonging to the Swedish medical profession had not always been there but that being a doctor was something that could not be taken away from her and did not depend on what others thought nor was it dependent on whether or not she was in Sweden or in Poland.

Lajos who also received his training in Sweden, expressed similar ideas. Both of these informants seemed to feel that the social position of medical doctor had been *assigned* to them and that this position was not questioned. All through the interview they emphasised that the social position of medical doctor was somewhat separated from them as people and therefore could not be taken away from them. Juliana's *awareness* seemed to be connected to the fact that she also seemed convinced that professional belonging was universal. One could understand this through the model of Cornell and Hartmann (2007) by which her more *assigned* social position of medical doctor seemed to make 'migranthood' a social position that matters less (cf. 2.5 about the persisting professional identities in Shuval's (2000) work). In Poland, she said, people did not care and sometimes did not even know that she was a doctor but here, in Sweden, she was a doctor "foreign or not". She seemed confident in that she had been *assigned* the social position of medical doctor and therefore her feeling of belonging seemed, from what she said, to be non-negotiable. Juliana's talk about what it is to be a doctor can

be understood, as she seemed to feel that the social position of medical doctor had been *assigned* to her and that seemed to be enough for her to feel that she belonged to the Swedish medical profession. It is worth noting that Juliana also 'looked Swedish', which presumably had an impact on her possibilities to be *assigned* the social position of medical doctor and feel that she belonged within the Swedish medical profession, as we will see in coming quotes where she acknowledges her privileged position as a 'white' within the Swedish medical profession.

Her way of talking could be understood in light of the *circumstantial* perspective on *social positions* that was discussed in Chapter 3 as Juliana's feeling of belonging seemed connected to what she did (treating patients or writing poems) but also to the context in which she was located (Poland or Sweden). In Juliana's case she related her *social position* to the place she was. In Sweden she was a doctor "foreign or not" while in Poland they did not care as she had other identifiers with her friends there (such as writing poems).

Juliana's story can also be analysed in terms of her understanding of 'ethnicity' ('being Polish' or 'being Swedish') since she seemed to regard this background in equally relative terms. Juliana's social position in terms of 'ethnicity' seemed therefore – if we use the terminology introduced in Chapter 3 –more something that she talked about as being *assigned* with (sometimes she seemed also to *assert* her 'Polishness' while at other times she seemed to regard this social position as something she could choose). Something else worth noting is, however, that Juliana seemed to be *aware* of the fact that although she regarded her 'ethnic' background as something that was not that important, she knew that others treated this background in a *primordial* way. As she states: 'Here I am Juliana from Poland and there I am Juliana from Sweden'. In other words, Juliana's way of talking about her 'ethnic' background was interesting since she seemed *aware* of the *primordial* manner in which this background could be regarded but seemed also very much determined not to make it matter herself. Juliana's 'ethnicity' seemed therefore to be something that positioned her in both countries (Poland: which was where she came from, and Sweden which is where she now lives) while being a doctor seemed only to be something relevant in the Swedish context.

It is worth noting also that even though both Juliana and Lajos seemed to be quite secure in the way they talked about how the social position of medical doctor seemed more *assigned,* Juliana also seemed aware that there is a difference between 'being' European and white within the Swedish medical profession:

> Juliana: But, there are differences between foreigner and foreigner… it is a difference between us too…but one should not ignore that the difference exist. If you are a woman from Ethiopia and have a headscarf and such…they have different pre-conditions than if you are a European. When I came here I

> was also the 'little Polish girl', who you could pat on the butt... it was easier to be French. But that you know.

In this quote we see, in other words, that Juliana seems to be *aware* that there is some kind of 'ethnic' hierarchy in Sweden. Moreover, she draws attention to another type of 'Othering' process that she thought I should know about. She talks about the fact that within the Swedish medical profession there are ethnic demarcations that seem relevant when it comes to who is *assigned* the social position of medical doctor and who might not be, according to Juliana. As she seems to be suggesting 'not all immigrants are treated equal' and some of them who like herself are being seen as white seem more easily accepted by the profession than others. Therefore, Juliana voices, in a rather explicit manner, the view that although 'being' a doctor is conditioned by regulations that are pretty clear cut (one has a license to practice medicine or not), feeling like one belongs to the Swedish medical profession seems more complex and it seems to be conditioned by *assigned* 'migranthood' as a social position, and the way you look, according to Juliana. It seems that one can (depending on one's appearance and gender in this case), be seemingly 'inside' yet 'outside' at the same time (or as stated in previous chapters, some doctors with immigrant backgrounds are 'outsiders within'). "Being from Ethiopia" and "wearing a head scarf" seems to Juliana to be 'even' harder than being seen as the "little Polish girl" she is assumed to be. Thus, she seemed to regard 'migranthood' as a social position that is more *assigned* (than asserted) to people who have immigrant backgrounds, but more so to those that deviate from the norm by the way they look. The impression I got from interviewing Juliana was therefore that although she claimed that she had not experienced problems in feeling that she belonged to the Swedish medical profession due to her background, she was *aware* of the fact that she might 'appear Swedish' (which for her meant having a European background, being white and not wearing a head scarf) which had made it easier for her. She was, however, also *aware* – as her stereotypical statement about being 'the little Polish girl' suggests – that the Swedish medical profession takes for granted that 'Swedishness' is still the norm for most medical doctors. This is a norm she also seemed to deviate from but it does not seem to have affected her feeling of belonging within the Swedish medical profession.

I understand this 'appearing Swedish' as an indication that she was *aware* of the 'informal' boundaries to belonging within the Swedish medical profession that seem to be related to stereotypes such as being seen as 'the little Polish girl'. When she says 'but that you know' I understand that she is referring to this as something that is a well-known fact. However, it is also worth noting that she referred to these hierarchies as gendered, which is something she assumed that we, as women, share an understanding of. Thus, although these hierarchies could, at first glance, not to be of importance to her understanding of belonging to the Swedish medical profession, she relat-

ed the 'pat on the butt' as treatment she had to cope with as a female medical doctor from Poland.

Worth noting is also that Juliana got somewhat upset when I asked about this, even though she recognised – as the quotes I have shown above suggest – that being *assigned* the social position of medical doctor is harder for some (i.e. Ethiopian women) than others. My impression is therefore that Juliana thought that the Swedish medical profession and Swedish society in general (which I believe she thought I was representing) have a *primordial* definition of the social position of medical doctor that is connected to notions about 'Swedishness' (cf. the notions of 'white supremacy' in the work of hooks, 1995, pp. 184-195). Both Juliana and Lajos seemed, in other words, *aware* of the underlying assumptions about the 'Other' that shape the boundaries to the feeling of belonging within the Swedish medical profession, but she did not seem to see herself as being 'othered'. Juliana talked about the fact that 'ethnic' boundaries did not affect her but showed some ambivalence when she referred to 'the pat on the butt'. We could understand this to mean that she had been socialized into the Swedish medical profession and therefore also felt that the social position of medical doctor had been more *assigned* to her than to others.

In this section we consider the two medical doctors that were born in another country but had their medical training in Sweden. We could tentatively suggest that their social position of medical doctor seemed *assigned* to them, which might have something to do with the fact that they also seemed to feel that they belonged within the Swedish medical profession. They seemed *aware* that *primordial* understandings of 'migranthood' exist on the basis that you do not look Swedish, and even if Juliana seemed to have experienced some of these notions ('a pat on the butt') this did not seem to challenge her feeling of belonging within the Swedish medical profession. In other words, the *assigned* 'migranthood' social position seemed not to define these two interviewed medical doctors and this might be related to the fact that they also seemed to feel that the social position of medical doctor had been more *assigned* to them since they had their training in Sweden.

In the next section we will look at the ways in which the rest of the medical doctors talked about belonging within the Swedish medical profession. They seemed to talk about the social position of medical doctor as something that was less *assigned* to them and about the Swedish medical profession as something they belonged to (see table 3) but did not necessarily feel that they belonged to.

6.2.2 Talking about not belonging to the Swedish medical profession

If we go back to Tables 2 and 3 we can see another demographic pattern among the medical doctors (Amin, Masoud, Mahid and Goran) who did not talk about belonging to the Swedish medical profession. They also seemed somewhat *aware* that there are boundaries to the feeling of belonging within

the Swedish medical profession, but for them these boundaries also affected their own way of feeling that they belonged within the Swedish medical profession. What they said somehow contrasted to Juliana's (and Lajos) talk about belonging to the Swedish medical profession as they never talked about belonging to it during the interview (see column 2, Table 3) but instead talked about other unifying constellations (such as travel experiences or 'migranthood'). The social position of medical doctor is something that many of the interviewed doctors talked about but it seemed less *assigned* to them and they also seemed not to be able to feel that they belonged within the Swedish medical profession. Let us take a look at what I mean by that.

Mahid, is an unspecialized doctor who came from Somalia to Sweden as a refugee in 1984. He obtained his degree in Russia (for more background information, see table 2). At the time of the interview he was in Stockholm to do an internship. It is worth noticing that in the statistics he would be one of the people that left Sweden to get their medical degree somewhere else. Mahid says for example:

> Mahid: It isn't easy to get integrated into the group (read: Swedish medical doctors). There isn't any instant feeling of belonging with them… nothing else to unify us except the fact that we're doctors.

In this quote Mahid is talking about the professional unity that he feels is not enough for his feeling of belonging to it. He seems *aware* of the fact that there is a way to belong within the Swedish medical profession but he has not found it. This is something he comes back to in other parts of the interview as well. Mahid seemed to think that being a licensed medical doctor was not enough for him to gain a feeling of belonging within the Swedish medical profession since that feeling seemed conditioned by something else, beyond formal belonging such as licensing. He seemed to feel that the social position of medical doctor had not been *assigned* to him, which might say something about the fact that he did not feel that he belonged within the Swedish medical profession. Thus, for Mahid, the social position of medical doctor seemed more fragile and transient than it seemed to be for Juliana and Lajos, which might be related to the fact that he felt that the social position of doctor was not *assigned* to him.

It is worth noting, however, that even though he did not seem to feel that he belonged to the Swedish medical profession, he seemed to be *aware* of where the boundaries to this feeling of belonging are. This could be understood, as Mahid needed more than a license in order to feel that he belonged, which might indicate that belonging is complex for medical doctors that have not had their training in Sweden, and maybe especially those who deviate when it comes to appearance. It is perhaps worth noting that Juliana's and Mahid's backgrounds differed to some extent but still, Mahid had been in Sweden since he was young but had his training in Russia (and Ukraine) while Juliana came to Sweden in the 70s and had her training here. In the

following quote, Mahid continued to talk about what he thinks are boundaries to his feeling of belonging:

> Mahid: You want to… and they say: 'No, no thank you'... and what shall you do all that time… so we (here referring to doctors with immigrant backgrounds in general) started working…I worked at X hospital in Sweden as an assisting nurse during the summers… during my training in Russia. X hospital, Y-hospital, Z-hospital... to get an understanding of how things worked here in Sweden. In the fourth and fifth years I did that every summer.

In this quote Mahid talks about 'they' who say 'No, no thank you' to him and 'we' (or 'we in this case') as the group of medical doctors with immigrant backgrounds similar to his. He regards these medical doctors as doctors that are – as he himself seems to feel – outside trying to get in. During the interview with Mahid he often talked of a 'we' that he and other medical doctors with immigrant backgrounds consisted of. In other words, Mahid was one of the medical doctors interviewed that seemed to see belonging within the Swedish medical profession as unattainable due to the fact that he talked about not being *assigned* the social position of medical doctor. In Chapter 8 we will address the ways in which Mahid tried to cope with this challenged feeling of belonging.

Goran expressed a similar 'semi-included' position (i.e. as 'being' on the inside because of having had the license but still not 'being an insider' for reasons that were based on the Swedish medical profession's own boundaries[59]). A look at Table 2 will show that Goran is a specialist in ophthalmology, who was originally from Iraq and came to Sweden as a refugee in 1987. He also obtained his degree in Russia (for more information on his background see table 2). In the part of the interview I will quote here we were talking about his first time in Sweden. He refers to his first internship as something that was a turning point for him. I asked Goran if it was hard to get the internship, and he answers:

> Goran: Well… no one wants trouble, to be honest. Trouble… Someone has to write something after six months[60] and no one wants to do it. Today it might be somewhat different but…In Sweden they go through acquaintances…that's the way it is…

It is worth noting that Goran was one of the medical doctors that talked about his journey toward obtaining a Swedish medical license and the specialist license as being something that was very hard and laborious. He talked about getting his first internship through 'pure luck' and said it was an

[59] The term outsider within is according to Collins (1986): "All individuals who, while from social strata that provided them with the benefits of white male insiderism, have never felt comfortable with its taken-for-granted assumptions" (Collins, 1986, p. 29).
[60] "Write something" here means proving that he has the skills needed to do the job.

opportunity that took a long time to find. When he was talking about those times he seemed to realize that the people he came into contact with then (the people working in Swedish health care as he defined them) were instrumental to his journey but that they did not provide an adequate network to help him feel that he belonged within the Swedish medical profession. Goran also expressed some criticism of the fact that one needs to know the right people or have 'acquaintances' to re-establish oneself as a medical doctor in Sweden, and as I understand it, to feel one is *assigned* the social position of medical doctor. Here he was not referring to what it takes to get the Swedish license to practice medicine but rather to what is needed in order to find a place to work. Later in the interview he said that he had "no one" which I understood as a reference to the fact that if he had known someone with a similar migration background, he would have had somebody to share his experiences with. The way he described his situation seemed to suggest that he felt that some people could take short cuts to being *assigned* the social position of medical doctor (if they knew the right people, or had a network with similar experiences) while others, such as him, could not. The latter have no choice but to rely on formal belonging, which he seemed to be *aware* of, but this did not seem to give him the feeling that he belonged.

Thus, for Goran, the feeling of belonging within the Swedish medical profession seemed attainable but only if one had the 'right' connections, which can open up the opportunities one needs (since feeling belonging, in his case, seemed to be about the ability to navigate the system once one had obtained a license). To some extent it seemed that Goran regarded the Swedish medical profession as a system that considers the social position of medical doctor as something formal, while he described it as also being about something 'informal' (the license is one aspect but seemed not necessarily to affect one's feeling of belonging). The way in which Goran described his situation gave me the impression that he was one of those doctors that did not seem to think that he would ever achieve a feeling of belonging within the Swedish medical profession. In his mind the fact that getting his specialist license took so long and that the journey as far as internships were concerned had been so laborious seemed to him to be proof of the fact that he would never really feel that he belonged; a fact he seemed to have accepted. He went in and did his job and that was it, but there was an underlying sadness in his story that might be related to the fact that he did not feel that he belonged within the Swedish medical profession (I am not saying that there would not be other reasons behind it of course).

Goran did not talk about belonging to the Swedish medical profession even though he had his specialist license and a job at one of the major hospitals in the capital of Sweden. He seemed *aware* that there was some kind of feeling of belonging to the Swedish medical profession that he had not been able to find. In the quote above he starts by saying "someone has to write something" which is a reference to senior medical doctors that needed to give him the "drivers licence" to work as a doctor. The similarity between

Mahid's and Goran's talk about belonging to the Swedish medical profession was that they seemed to see the "insiderism" or this unity if you will, as something to strive for (as shown in the example of Goran above). Thus, although Mahid had just started his career (while Goran was about to retire) they both seemed to share the feeling that they were *outsiders within* (cf. Collins, 1986, 1999). Both of them perceived the Swedish license as just the first step in a quest to feel they belonged within the Swedish medical profession, but while Mahid was still determined to get there, Goran seemed to have given up, which might be because he had had such a hard time getting a job and also that he had been in Sweden much longer than Mahid, which might have made him somewhat more cynical. Both of these medical doctors seemed, in other words, to think (just as Juliana did) that the Swedish medical profession is not aware that belonging to it is not only about getting a license but also about achieving a feeling that one belongs. This 'informal' belonging seemed for many of the interviewed doctors to be conditioned by whether or not one was *assigned* the social position of medical doctor. Thus, although Goran's story was completely different to Juliana's, there was something that they shared, and that was the understanding that feelings of belonging within the Swedish medical profession are not something that is attained just because one has a Swedish license to practice medicine; there are other angles that play a role in whether you feel that you belong or not.

In the next quote Goran talks about a feeling of not being welcome, and connects this hardship to a general feeling of belonging to the Swedish medical profession that is hard to attain:

> Goran: It is as usual in Sweden… it takes time and you have to wait. You are not invited here or welcome here, you have to prove who you are, where you come from and why you are here.

This quote is interesting as Goran (like Masoud and Amin) came to Sweden as a political refugee. Being a refugee and not a labour migrant can mean that you have less, or as for Goran, no social ties in the country.

Formal social ties (cf. Weiss, 1974; and Wireman, 1984) but also peripheral or weak ties (cf. Fingerman, 2009) seem important for our feeling of belonging within a certain group and Goran seemed *aware* of this fact and regarded this as one of the reasons he had not managed to feel that he belonged within the Swedish medical profession. In Goran's talk about 'getting in' he says he was not "welcome". This suggests that he was *aware* that there are 'gatekeepers' whose attention you need if you are to have the possibility to feel that you belong, and this goes beyond getting the Swedish medical license. It is worth noting, however, that the way in which Goran talked about not belonging within the Swedish medical profession – although important to him – seemed to suggest that he did not feel he was *assigned* the social position of medical doctor even though he had a Swedish medical license and he had practiced medicine in this country for several

years. When he talked about his current situation he emphasised the hardships he was experiencing, as shown below:

> Goran: yes, very long time and hard… and still I'm not standing on my own two feet[61]… it is shaky…
>
> Interviewer: Do you know what will happen after this?
>
> Goran: Well, there are many jobs, no problem… many jobs… we will see… one thing at a time.
>
> Interviewer: When it comes to the fact that you were not born in Sweden, have you had experiences of encounters with patients and colleagues that reminded you of that fact…?
>
> Goran. Yes, maybe sometimes I have felt a bit… but I'm that kind of person that…I'll not surrender, not stop fighting and I'll never bend… but when someone is not nice…You have to use diplomatic ways.

All through the interview Goran seemed to be 'on guard' and he emphasised many times that "he will not surrender, not stop fighting". This could be understood as an indication that despite all that he had experienced while trying to get a job he wanted to feel that he had been *assigned* the social position of medical doctor. He seemed to see himself as David, fighting Goliath (hence the Swedish medical profession), and I could not help but get the impression that Goran would not easily be derailed from his goal of being *assigned* the social position of medical doctor even if he seemed to have accepted that the feeling of belonging within the Swedish medical profession was something he would not experience.

Masoud's way of talking about trying to belong to the Swedish medical profession was somewhat related to Goran's and Mahid's experiences as medical doctors that had received their training outside the EU. They seemed to share a feeling that they were not fully-fledged members of the profession and they seemed to be trying to figure out why this was. Masoud, another doctor I interviewed was an ophthalmologist specialist from Kurdistan in Syria. He came to Sweden in 2011 as a refugee but had received his degree in Syria (for further information on his background see table 2). When I met him he was about to change career path and become specialised in family medicine instead. Therefore, he was working as an intern at a primary health care clinic in northern Sweden. In the part of the interview below we talk about a special introduction that this particular health care clinic was offering to their new doctors. The clinic where Masoud was working had a focused on trying to attract medical doctors who had received their training

[61] In Swedish there is a saying: "Stå med två fötter på jorden" (Which is directly translated as: "To stand on my own two feet") which means that you are not depending on others.

outside Sweden as they believed that this would be a successful way to get medical doctors to the medium sized town in mid-Sweden where the clinic was located. Masoud was one of the recruited medical doctors, which is why I asked the following when I interviewed him:

> Interviewer: Earlier we talked about the introduction that H give his doctors here…What are your thoughts on the introduction you got here?
>
> Masoud: If there is a system for recruiting people from other countries you mean? Yes, there are many people that want to come here and they have much experience but from the beginning it is hard. It is very expensive[62] but if they (he means the medical profession) can offer them something they will come and they will do good things here.

Masoud's story shared some similarities with Goran's as they both talked about how the feelings of belonging within the Swedish medical profession seemed somewhat related to the struggles they had to go through in order get jobs. They were both ophthalmologists and they both talked about how they were *aware* that there were boundaries to the feeling of belonging within the Swedish medical profession. Masoud talked about 'them' when referring to the medical doctors that have not come to Sweden yet, and 'they' as the Swedish medical profession that he thought should help out more. In Masoud's case he seemed to feel that he had finally found a way to feel that he belonged within the Swedish medical profession but talked as if it could have been easier. Irrespective of this, he seemed to feel that the Swedish medical profession let him down in some ways and that there was some kind of 'informal' belonging or feeling of belonging that was hard for him to find.

Goran and Masoud also shared the notion that it was somehow up to them as individuals to fit in. When Masoud says: "that depends on the person" this can be related to when Goran says: "I am the kind of person…I will not surrender". Both of these medical doctors gave the impression that the feeling of belonging within the Swedish medical profession was something that some of the interviewed doctors struggle with and that some of them – due to their stubbornness, or because of luck in finding people that could "break the code" for them – would manage to achieve the feeling that they belonged while others would not. Both of these medical doctors seemed, in other words, to be just like the ones we have presented so far, operating under the assumption that the Swedish medical profession has a *primordial* understanding of 'migranthood' that seems somehow to be related to who is *assigned* the social position of medical doctor and who is not and that medical doctors with immigrant backgrounds can become accepted but not necessarily fully-fledged members. They seemed, therefore, to regard their chances of feeling that they belong as small due to the fact that they did not feel that

[62] Masoud often talked about how expensive it is in Sweden, especially in the beginning before you get a salary.

they were *assigned* the social position of medical doctor but that of 'migranthood'. They also seemed to think that they had to find their own way to gaining the feeling that they belonged within a group that did not to see them as fully-fledged members.

In the quote, Masoud is talking about some structural changes that he believes would have helped him and his wife to overcome the professional boundaries and hence become medical doctors faster. These changes would according to Masoud also make immigrant medical doctors less dependent on themselves. Later in the interview Masoud also talks about the fact that he gave up trying to become an ophthalmology specialist in Sweden even though that was his speciality, as he did not find a job. Masoud acted, (and in some regards also Goran and Mahid), in other words, on the basis of the *boundaries* that he seemed to be aware of.

Contrary to Goran – who decided to stick to his original speciality in ophthalmology even if it meant a longer and more laborious journey – Masoud decided to choose another "door" and opted to become a family physician since he seemed to see more possibilities in this speciality. Irrespective of what they did in order to try to feel that they belonged, it is clear that they both talked about the Swedish medical profession as a group that they did not feel they belonged to, and which one of them had given up trying to belong to. These medical doctors seemed to regard their *assigned* 'migranthood' as a social position, as something that impeded them from being able to feel that they belonged to the Swedish medical profession, but as we will see later, this is not the whole story.

Amin, a specialised orthopaedic from Iran that came to Sweden as a refugee in 1999 (for more information on Hamid see table 2) In the following quote Amin is describing a situation he experienced when he was a resident. He is citing the doctor who was his supervisor at the time. The supervisor is the one that decides the length of the internship period that a doctor with immigrant background has to complete. Here Amin explains why he thinks it took such a long time for him to pass his probation period:

> Amin (citing his supervisor): -"You are over qualified. Our specialists, they become specialists after five years and they do not know half of what you know. It is obvious …but the process works like that and you have to have patience and let it take time" (Amin stops citing the supervisor) … OK… we can let it take time.

This quote is interesting as it once again shows some kind of ambivalence towards the feeling of belonging within the Swedish medical profession. Amin seemed to accept, to some extent, that his supervisor had excluded him from the category "our specialists" but he seemed to some extent also to say that Amin could become a part of the team if he accepted the "rules of the game" (which in this case entailed him being patient). It is worth noting also that Amin stressed that his supervisor's reason for not letting him pass the

internship had to do with the fact that he was "over-qualified". Thus, even though he did not seem to think that he was, he seemed to be facing a supervisor that believed that was the reason the other medical doctors saw him as different Therefore, adapting to the Swedish medical profession – as a doctor with an immigrant background – seems to mean being *aware* of the boundaries or the ways in which one differentiates oneself from the norm (which in this case is dictated by what is seen as Swedish) and seems to be about learning how to wait for the *assignment* of the social position of medical doctor from others.

Amin continues:

> Amin: There aren't any big differences between specialist interns (Specialistjänstgörande in Swedish) and specialists in Sweden… both kinds of doctors do surgery and so on. I've adjusted to that… Then certain things happen… people see an over-qualified doctor as a threat. I started hearing that I was proud (think he means haughty)…because I had been working with well-known doctors all over the world… I have done hip prostheses and so on…but younger specialists saw me as a threat… which means that if I got my specialist license I would dominate them…

In this quote we can see that Amin seems to starts off expecting that the specialist interns would be equally qualified as the specialists and hence, that there would be no differences within the profession as they all do similar tasks, yet he then talked about that he has had a somewhat different experience since he felt that his colleagues regard him as a threat (see previous quote). My impression from this interview is that Amin was trying to make sense of how being "over-qualified" could be considered a problem. He seemed *aware* of the boundary but he did not seem to understand why he did not fit in on the basis of qualifications and why his colleagues thought he was bragging when he told them about what he did before he came to Sweden. There was an underlying scepticism in Amin's story, which could be understood as a way to keep a distance from the group that he had not yet attained a feeling of belonging to or a group that had not *assigned* him the social position of medical doctor. In the quote below we see how Amin makes sense of why he is being treated as he is:

> Amin: I'm an easy case to exploit. They force me to work as an intern for as long as they want because I can't get my specialist license until a head of a clinic feels sorry for me… it's like being in prison until someone says: It's enough….let him be free! So that's why I need man, a human being, first and then, a head of a clinic. A fair person and then a supervisor… I say this even if it's being recorded. The system is our destiny… us immigrant doctors who are highly skilled. It's a lottery.

In this quote we clearly see how ambivalent Amin feels about belonging to the Swedish medical profession and that he feels he was exploited by it.

Amin talked, however, about being 'lucky' to have obtained his license fairly quickly (cf. Goran's story) and that it was because his boss "felt sorry" for him. This can be understood as Amin had left the desire to feeling that he belonged within the Swedish medical profession behind, as he felt he was exploited by this profession. He was instead arguing that he needed individuals or as he put it "human beings", that could help him through the "lottery" of who gets to feel they belong to the Swedish medical profession and who do not. His way of reasoning clearly showed that some of the medical doctors interviewed did not really feel that the system was as straightforward as it appeared at first hand (see Chapter 4 for insight into how medical doctors with immigrant backgrounds get their licenses).

Amin's way of describing the Swedish medical profession was a very cynical one. His story is also an example of how the interviewed doctors often seemed to perceive what it was to belong to the Swedish medical profession and their position within it. The cynical attitude seemed to be a recurrent theme in all of the interviews except for those with the two people who had received their training in Sweden (i.e. Juliana and Lagos) and who hence been *assigned* the social position of medical doctor. Thus, some of the medical doctors interviewed seemed to be suggesting that the main investment they were asked to make when it came to feeling that they belonged was not necessarily – as I would have thought originally – to try to get a license to join the Swedish medical profession but rather to find a more 'informal' belonging in order to access the 'we' that could help them feel that they belonged within the Swedish medical profession without necessarily being *assigned* the social position of medical doctor.

One could argue that they often talked about the Swedish medical profession by referring to a notion of a 'we' but that this 'we' was still not something that they felt that they were fully included in, which indicates that belonging is far more complex than just having a license (or formally belonging). This might be related to the fact that the medical doctors interviewed in this study seemed to be what Collins would call *outsiders within* (1986, 1999). Collins (1986) suggests that the *outsider within* applies to:

> All individuals who, while from social strata that provided them with the benefits of white male insiderism, have never felt comfortable with its taken-for-granted assumptions. (Collins, 1986, p. 29).

Collins (1986) concept was used to talk about black feminists, and the concept reflects these women's special standpoint on the self, family, and society. Black feminists' unique experiences were argued to be connected to them being black, which made them outsiders as white feminists could not really relate to them. Yet they were feminists and therefore *within*. In many ways the medical doctors interviewed for this study also seemed to feel like *outsiders within* (cf. Collins, 1986, 1999) due because they had been *assigned* 'migranthood' as a social position but not (often) the social position of med-

ical doctor. They therefore seemed to feel that they were *within* in regard to formal belonging such as (licence and job), while their *assigned* 'migranthood' social position seemed somehow to position them as *outsiders*[63] due to the *primordial* connotations that they thought existed within the Swedish medical profession (see Chapter 4). It also seemed that some of the interviewed doctors tried to *assert* the social position of medical doctor but were not really succeeding, as it had not been *assigned* to them. Moreover, their feelings of belonging within the Swedish medical profession seemed to collide with the *boundaries within* that they were faced with; boundaries which seemed to be based on the *assigned* 'migranthood' position.

6.2.3 Talking about sometimes belonging to the Swedish medical profession

Returning to tables 2 and 3 this section focuses on the interviewed doctors, who talked about belonging within the Swedish medical profession sometimes (see column 3, Table 3) but not all the time. What they had in common was that they did not have much trouble getting the Swedish licence (it took between one to five years). It is worth noting from the start that this was the most common way of talking about belonging within the Swedish medical profession. Hence, just as was the case above – except, of course for Juliana and Lajos who never questioned that they were part of the Swedish medical profession– these were doctors that regarded the social position of medical doctor as not *assigned* to them but still believed that they could feel they belonged within the Swedish medical profession and sometimes did, but this feeling of belonging seemed unstable.

In order to nuance the way I understand the interviewed doctors' talk about belonging to the Swedish medical profession further the analysis brings attention to the ambivalences found among the doctors that were categorised as talking about feeling that they belonged *sometimes*. These ambivalences show that while some seem to regard the feeling of belonging as something (1) attainable (i.e. they were just not there yet), others talked about it as something they were (2) indifferent to (i.e. they did not see it as important to strive for), and some thought of it as something (3) unattainable (they wanted to belong within the Swedish medical profession but did not seem to know how they could). The latter was the case with Goran but he did not talk about himself in terms of belonging within the Swedish medical profession, which is why he was grouped with Amin, Masoud and Mahid in the previous section. Amin on the other hand did not talk much about belonging within the Swedish medical profession either but when he did it still seemed that it was attainable to him.

[63] Can also be related to Simmel's notion of 'The Stranger' as they had access through their medical license yet were considered to be outsiders due to their background.

The first doctor I would like to draw attention to is Joao, an anaesthesiologist from Cuba. He came to Sweden in the 90s as a political refugee (for further information on his background see table 2). When we met for the interview he was doing a probation period in anaesthesiology at a hospital in Stockholm. Although he was very enthusiastic about the job he had, he did talk about other medical doctors with immigrant backgrounds as medical doctors that were "competing" with him in order to feel that they belonged to this professional 'we':

> Joao: So, I came to my migration officer (In Swedish: handläggare) and said: - Please I guarantee that I will pass the test if you only give me the allowance! And I did. We were nine students and I was the only one who passed.

In the quote Joao is talking about a non-obligatorily course in Swedish (in Swedish: *Sjukvårdssvenska)* for health care personnel with immigrant backgrounds that he convinced his migration officer he needed. Earlier in the interview he expressed criticism toward the way that the system works in Sweden and the fact that medical doctors with immigrant backgrounds sometimes have to attend ordinary Swedish classes instead of being offered the kind of course he took, which he felt was more suitable for somebody who had as high an education level as he did. In the quote Joao is talking about one of the occasions when he felt that there was chance he would get the Swedish medical licence when passing the test.

He seemed, in other words, to be *aware* of the boundaries within the Swedish medical profession and that not everyone made it. As he explained how he managed to navigate the system he reflected on how many "aspiring medical doctors" were "left behind" and seemed to feel, at times, guilty that he was not one of them. The impression I got was therefore that Joao regarded the *outsider within position* (cf. Collins, 1986, 1999) as a transitional position, while the feeling of belonging to the Swedish medical profession (i.e. one that not only has the licence to practice medicine but is also accepted by his peers) suddenly seemed 'attainable' to him once he was able to get into the much coveted course in Swedish for health care personnel. Meeting the migration officer allowed him to join the course in question, and can therefore be seen as one of many circumstances that made Joao find a way forward in his career. This is somewhat related to what Chen et al. (2010, p. 947) argue (by referring to earlier research) that internationally trained medical doctors were less satisfied with their career than the doctors that were trained in the US and argued therefore that there are several ways to optimize the professional experience for this group of doctors especially when it comes to their education (p. 951).

Thus, although most of the doctors interviewed seemed to be operating under the assumption that they should be *assigned* the social position of medical doctor many seemed to feel that they were not. Some of these assumptions were related to 'migranthood' as a social position entails while

others – mostly those that the female doctors expressed – also alluded to the fact that there were *gendered.* The following quote is from Heba who was an anaesthesiologist even though she had yet to get her specialization in Sweden (at the time of the interview she was working as an intern at a large hospital outside Stockholm). Heba was from Syria and came to Sweden in 2006 for family reunification reasons (for more information on her background see table 2). In the quote below she is trying to explain why she thinks people treat her differently. She says:

> Heba: I can't answer hundred per cent but my feeling is that people relate everything to the fact that I am foreign…but that might not be true… In anaesthesiology there are as many women as men but it is known that it is harder for women than for men… for example…

Heba started off thinking that people treated her differently due to, as she understood it, her 'foreignness' but then she changed track and started talking about the fact that there were equal numbers of female and male doctors in her speciality, and finished by confirming that "it is" harder for women than for men. The most interesting thing about this quote is therefore that she seems to be *aware* of the boundaries of 'informal' belonging but also seems to connect it both to her *assigned* 'migranthood' as a social position and to the fact that she is a women, and while doing so she seems to be unable to separate these two positions in regard to why people treat her differently. Thus, Heba's talk about belonging to the Swedish medical profession seemed ambivalent as it seemed conditioned by both *assigned* 'migranthood' and *gender.* Therefore, we can understand her feeling of belonging as attainable but the social position of medical doctor, as harder still, since it has to be *assigned*. In the interview with Marta (for more background information see table 2) she talked about a group of female doctors with immigrant backgrounds that might have a better chance of feeling belonged to the Swedish medical profession than she had:

> Marta: It has changed within the medical profession here…. It's (ethnic diversity) starting to become very common in Sweden… and there are even patients with other backgrounds… but they can't pronounce the doctors' names, they don't have complaints… they just can't pronounce their names and neither can I because there are many Arabic doctors. We have had many interns that are second-generation immigrants and they are very skilled, unbelievably skilled girls who speak perfect Swedish and who are very interested and eager so it's going to be a big change…

In this quote Marta is talking about a change in the Swedish medical profession that has to do with what she refers to as some kind of group of female doctors with immigrant background, that she is somehow not a part of. Feeling belonging within the Swedish medical profession in Marta's story seemed therefore to be attainable (at least for the next generation of medical

doctors with immigrant backgrounds) and especially considering that they will no longer be in the minority in the future (since the number of medical doctors with immigrant backgrounds in Sweden is increasing). In this quote Marta also explains why the "second generation" migrants that are medical doctors might have an easier time than her generation had in being *assigned* the social position of medical doctor. She talks also about the fact that because they are "very skilled" and "speak perfect Swedish" they are, in her opinion, more likely to have fewer problems than she had in feeling that they belong within the Swedish medical profession.

All of the quotes presented in this section so far suggest, in short, that some of the interviewed doctors seemed to be reflecting on the complexity of belonging within Swedish medical profession where notions about '*ethnicity'*, 'migranthood' and *gender* seem to be based on *primordial* ideas (see also Chapter 3); something that the interviewed doctors with immigrant backgrounds seem to question.

Marta highlighted that there are many patients with backgrounds from other countries and therefore medical doctors with other 'ethnic' backgrounds like hers are also needed. Although she seemed to see herself as having a special role to play she still also talked about the fact that she had similar problems as the patients when it came to "pronouncing" some doctors "names", which somewhat puts into question the first statement that 'migranthood' matters. She argued that this was because they were "Arabic" and in that regard her Latin-American background did not help her. Statements like this remind us of the statement that Juliana made about Ethiopian female medical doctors as doctors that are bound to have a harder time feeling that they belong to the Swedish medical profession than a European female doctor would have. These statements suggest that Marta regarded the Swedish medical profession as a profession that operates on the basis of 'ethnic' hierarchies even though the primary demarcation it operates from seems – from the interviewed doctors perspective – to be one drawn between 'the Swedish us' and the 'migrant them'. However, Marta's statements suggest that she took for granted that the 'new generation' of medical doctors with immigrant backgrounds might have a better chance of feeling that they belonged to the Swedish medical profession.

It is also worth noting that in a previous quote from Marta, she seemed to want to close in on what distinguished her way of being 'Othered' from her male counterparts. During the interview Marta often wanted to highlight the structural problems that are embedded in the Swedish medical profession because of the *primordial* understandings about *gender* and 'migranthood' that the Swedish medical profession operates from. In the quote above she also connects feelings of professional belonging within the Swedish medical profession to the idea that the implications of 'migranthood' as a social position will 'wear off' as new generations of medical doctors with immigrant backgrounds enter the profession. Marta seemed therefore to regard the "second generation" of immigrants in this country as the first group to possibly

feel that they belonged to the Swedish medical profession. Thus, although Heba and to some extent Marta talked about belonging to the Swedish medical profession from a *gender* perspective, they seemed also to see that their 'ethnic' background was somewhat intertwined with that position. For Marta, as for Heba, it was not just about "being an immigrant" but also rather about different 'ethnicities' and about being a woman. Marta for example, seemed to see her Latin American background as a limitation to her possibilities to feeling that she belonged within the Swedish medical profession, as it did not help her, either with pronouncing 'Arabic' medical doctors names or being seen as 'Swedish'. Things seemed to be expected of her (such as the fact that she was assumed to be able to pronounce foreign names) and this expectation seemed to be put on her because she had an immigrant background. In other words one might argue that it seemed that she regarded the 'migranthood' position as something that was *assigned* to her but something she could not live up to. This *assigned* position – which she regarded as a position that entailed being the mediator between different 'ethnicities' (see Chapter 4) – did not fit her own way of positioning herself as a female doctor in a system based on masculinity. Through the "second generation girls" now entering the Swedish medical profession she seemed to see a possibility for this social order to change as they might be *assigned* other social positions and could maybe even be *assigned* the social position of medical doctor. The internal professional struggles on the basis of *gender* seemed for Marta to be intertwined with the struggles for a more diasporic, instead of nationalistic, view of the profession[64].

Hamid was a specialist in family medicine. He was from Iran and came to Sweden in the 90s as a refugee. He obtained his degree in Romania (for more information on Hamid's background see table 2). At the time of the interview he was running his own primary health care clinic. All through the interview he talked about how he had a mission to help medical doctors with immigrant backgrounds who were coming to Sweden. He seemed to think that this mission was his way of 'giving back' to both the Swedish medical profession and these doctors. This is interesting as it somehow relates to Schouten and Meeuwesen's (2006) review of the literature on 'cross-cultural' medical communication that was presented in Chapter 2. They argued that '*culture'* and '*ethnicity'* have often been cited as barriers to establishing effective and satisfying doctor patient relationships. Hamid talks about it as follows:

> Hamid: I believe that it's good that they (patients) meet people from their own background…It's like the Swedish patient who wants Swedish doc-

[64] The concept of a professional diaspora was introduced by Neiterman and Bourgeault (2011) and has to do with how professions today cannot be understood as part of one state but instead they have different professional stories that include different national contexts. The feeling of profession belonging seems therefore not limited by the national context but is shaped and reshaped in time and space.

> tors…I think people with an immigrant background want doctors that they can talk with …freely…I think that's an asset…but… then again… immigrants also like Swedish doctors and they don't always choose a doctor on the basis of language and that it's a bit unfair….

In the quote above Hamid talks about the fact that patients are best served by medical doctors that have similar backgrounds to them. If we think about this from a *construction site* perspective it seems that this idea builds on a *primordial* idea about 'ethnic'/immigrant background that we have seen exists within the Swedish medical profession (see Chapter 4). Hamid talked about the opportunities (and constraints), which medical doctors with immigrant backgrounds face when it comes to what is seen as the best for the patient. Yet at the end of the quote he changes track and talks about the fact that it is always better to have Swedish medical doctors, as patients with immigrant backgrounds also seem to prefer to see Swedish doctors. This makes little sense considering how he started the quote above but was an idea he returned to throughout the interview. In saying that Swedish patients want medical doctors with a Swedish background and patients with immigrant backgrounds want medical doctors with immigrant backgrounds but also medical doctors with Swedish background, he indicates that being *assigned* 'migranthood' as a social position is a challenge to being *assigned* the social position of medical doctor.

Yet, it seemed that Hamid regarded the *primordial* idea about 'migranthood' (that exists within the Swedish medical profession) as a social position that was not only *assigned* to him but also as a position that he could use for his own benefit by referring to patients with immigrant backgrounds. This is somewhat baffling but perhaps not surprising considering what we learned about the Swedish medical setting in Chapter 4. Hamid's statements make sense if we regard the taken for granted assumption that seems to exist within the Swedish medical profession about the fact that there is some kind of *primordial* bond between medical doctors with immigrant backgrounds and patients with immigrant backgrounds. Hamid seemed, in other words, to regard the 'migranthood' position as a possible asset that he could exploit instead of regarding these backgrounds as the challenge that the Swedish medical profession tends to see them as. Phrased differently, one could say that Hamid used 'his Otherness' and seemed to see this as giving him the possibility to feel that he belonged within the Swedish medical profession and therefore he seemed to think that other medical doctors with immigrant backgrounds should do the same. The fact that he had an economic incitement to argue that being *assigned* 'migranthood' as a social position could be something positive probably played a part in his line of reasoning but that is not really the most interesting thing here since I am not concerned with the reasons behind his reasoning but rather the underlying assumptions behind them. As I understand Hamid, he did not reason as he did simply because he was a manager, he was also using his own *assigned*

'migranthood' position to positioning himself within the Swedish medical profession.

In other words, Hamid's line of reasoning could be understood in terms of the framework presented in Chapter 3, and if we do this we could perhaps see that he was using his *assigned* 'migranthood' as a social position to make other medical doctors aware of the *primordial* ideas about 'migranthood' that are ever present in the Swedish medical profession. We can understand this as the underlying assumptions about 'migranthood' that the Swedish medical profession seems to be based on might also limit the interviewed doctors' feeling of belonging and their possibility to *assert* the social position of medical doctor.

Hopefully, this section has exemplified how, when the interviewed doctors talked about belonging within the Swedish medical profession, they also shared thoughts on their *awareness* of boundaries that shaped the feeling of belonging. That awareness seemed to be related to the fact that they were not *assigned* the social position of medical doctor. As was noted earlier, the talk about belonging to the Swedish medical profession seemed ambivalent, which is also shown in the quotes shown in this section where medical doctors talked about 'we', but that 'we' seemed often to be defined in different ways (sometimes it was the 'we' that belonging to the Swedish medical profession entails, and sometimes it was the 'we' that other medical doctors with immigrant backgrounds form). It is worth noting that I think it would be good to see these challenges to the feeling of belonging as inherent in our understanding of what a profession is and that belonging to the Swedish medical profession seems to have both a formal and 'informal' side to it. In this chapter, I have used some of the terms of the conceptual and theoretical framework presented in Chapter 3 (with a special focus on *assigned* social positions). 'Informal belonging' was a way to understand the interviewed doctors' description of belonging yet not necessarily feeling that they belonged within the Swedish medical profession, and their *awareness* of what it was that caused them (except Juliana and Lajos) not to be *assigned* the social position of medical doctor in the way that non-migrant medical doctors see seemed to be. We have seen that many of the medical doctors interviewed talked similarly about belonging to the Swedish medical profession as something that was highly *circumstantial,* and as indicated above, it seemed to depend on other social positions.

6.3 Concluding reflections

This chapter aimed to analyse the interviewed doctors' talk about their feeling of belonging within the Swedish medical profession. In this chapter so far (as well as in Table 3) we have seen, by analysing the talk about belonging, that belonging within the Swedish medical profession is dynamic, complex and conditioned not only by surrounding boundaries (such as licencing and getting a first job) but also by boundaries within (such as the hierarchies that gender and 'migranthood' seem to entail) and that the interviewed doc-

tors were aware of these boundaries, at least to a certain extent. As stated at the beginning, the interviewed doctors seemed to belong to the Swedish medical profession only through licensing, without necessarily feeling that they really belonged (with the exception of Juliana and Lajos). It also seemed that they did not feel that they had been *assigned* the social position of medical doctor but almost always 'migranthood' as a social position, which is important to note for coming chapters. When analysing talk about belonging within the Swedish medical profession there was also a 'them' to consider. The categories 'we' and 'them' seemed to be based on the hierarchy within the Swedish medical profession, where someone has the power to *assign* other people *social positions*. In other words, the feeling of belonging within the Swedish medical profession seemed to be talked about as something that most of the interviewed doctors saw as attainable, which seemed to be related to them having people around them that cared for them, or as something indifferent, which seemed either to be related to the fact that they had given up (as in the case of Goran) or to the fact that they had found a way to use their *outsider* position in some way (in the case of Hamid). It is worth noting also that Hamid's talk about belonging to the Swedish medical profession sometimes referred to the Swedish medical profession and sometimes the collective that medical doctors with immigrant backgrounds form. In other words, in his story there seemed to be two ways to feel belonging; to either become "as Swedish as you can" or to focus on patients with immigrant backgrounds.

When the doctors talked about belonging to the Swedish medical profession they were referring to formal belonging (in terms of licensing, internships and specializations), but also to a desire to feel that they belonged to the Swedish medical profession, which seemed to be about some kind of 'informal' belonging (which in this case meant feeling as if one had been accepted as a member of the Swedish medical profession). Thus, the interviewed doctors seemed to be *aware* of boundaries within the Swedish medical profession that position people on the basis of where they come from and/or where they have received their training.

To conclude, belonging to the Swedish medical profession for the interviewed doctors should be understood as complex, and even if the interviewed doctors belonged in a formal way, the feeling of belonging within the Swedish medical profession seemed somewhat challenged. The next chapter (Chapter 7) focuses therefore on the situations where the interviewed doctors expressed the view that other people in their everyday working life challenged their feeling of belonging to the Swedish medical profession. In Chapter 8 the types of resources they talked about using in order to cope with a challenged feeling of belonging within the Swedish medical profession will be in focus.

7 Boundary negotiations: Analysing talk about interactions with others

As we saw in the previous chapter, the interviewed doctors often seemed to feel somewhat different from the majority of medical doctors in the Swedish medical profession. This seemed to be related to the fact that they felt they were *assigned* 'migranthood' as a social position; a position they believed impeded them from feeling that they belonged. Belonging seemed, after all, to be related to being *assigned* the social position of medical doctor; a position few of them seemed to feel that they were automatically *assigned* even though they had their licence to practice medicine and did belong to the Swedish medical profession, at least formally.

As mentioned in the previous chapter, when the interviewed doctors talked about belonging they mentioned that sometimes other people challenged that feeling. This chapter focuses on these people. The term *negotiation* (cf. Eriksson, 2003, p. 266) is hereby used to allude to the way in which the doctors interviewed talked about professional boundaries within the Swedish medical profession as boundaries that could be negotiated in interaction between co-workers. The reason for studying how the interviewed doctors talked about other people is justified by Abbott (1997) when he defines the relational aspects of social life and the relationship between social life and social actors in the following way:

> One cannot understand social life without understanding the arrangements of particular social actors in particular social times and places." (Abbott, 1997, p. 1152)

Here I will argue that analysing talk about personal interactions is a interesting way to understand social life. The importance of analysing personal interaction is also found in Tilly (2005), who suggests that "personal interactions create and transform *social boundaries*, and accumulate to durable social ties" (p. 13). Another justification for focusing on how the interviewed doctors' talk about interaction with other people is found in Dennis and Martin (2007) who argue that in order to understand social structure, we have to analyse these types of institutional negotiations between people. Some of these interactions were introduced in Chapter 6 but here they will be further analysed with some of the conceptual tools presented in Chapter 3. As we saw in Chapter 6, most of the interviewed doctors did not seem to feel that

they had been *assigned* the social position of medical doctor. We also saw that it seemed they had been *assigned* 'migranthood' as a social position. In this chapter we will look closer at how the interviewed doctors talked about *asserting* 'migranthood' as a social position. We will also try to elaborate on whether the social position of medical doctor could also be seen as something that the interviewed doctors tried to *assert*, but we also add an interactional level by looking at how boundaries *between* and *within* the medical profession are *negotiated* together with others.

Hence, this chapter aims to explore the question: What interactions do the interviewed doctors talk about as important for their feeling of belonging in the Swedish medical profession? In addressing this question this chapter draws attention to the data briefly alluded to in Table 3, columns 7-9. We start with a brief look at the data display, with special attention paid to columns 7-9. From there, we will go into how the interviewed doctors talked about interactions with other medical doctors, patients, and nurses.

7.1 Displaying the data: Interactions[65]

The data display (Table 3) gives an overview of the people that the interviewed doctors mentioned as somewhat challenging or at least with whom they negotiated, their feeling of belonging to the Swedish medical profession (see column 7-9). In Table 3 you also find if the interviewed doctors talked about belonging to the Swedish medical profession and how (in column 1-6), which was discussed in Chapter 6 and what resources the interviewed doctors talked about using in coping with the challenged feeling of belonging within the Swedish medical profession (column 10-12), which Chapter 8 will focus on.

A look at columns 8 and 9 in the data display (Table 3) suggests that the interviewed doctors commonly referred to interactions involving patients and nurses when discussing how feeling of belonging to the Swedish medical profession, were negotiated. This is understandable, as nurses and patients seem to be in focus when feeling of belonging within the Swedish medical profession, was *negotiated* while other medical doctors are seemingly absent (column 7) in these *negotiations*. Other medical doctors were more talked about as people important in relation to the interviewed doctors' possibilities to get a certain job or position. It is worth noting (when going back to the transcribed interviews) also that when interactions with the nurse were mentioned it was often in relation to *negotiations* to decide who should do a certain task. This will be further explored in the coming sections.

[65] See Data Display: Table 3, column 7-9

7.2 Theorizing boundary negotiations

Cornell and Hartmann (2007) claim that in order for us to understand the perceived position of the group (in this case medical doctors with immigrant backgrounds) within a society (or in this case the Swedish medical profession) we need to enquire into the boundaries to feelings of belonging that separate group members from non-members. As we have seen in Chapter 6, the interviewed doctors seemed to be *aware* of that there are boundaries within the Swedish medical profession that affect their feeling of belonging within it. It was also clear that while they did not seem to feel that they had been *assigned* the social position of medical doctor, they felt they had been *assigned* 'migranthood' as a social position. As stated at the beginning of this thesis but worth highlighting again, belonging is here understood in terms of the 'formal' belonging that a medical doctor gets through licensing and also the feeling of belonging (which I call 'informal' belonging) that most of the interviewed doctors seemed to struggle with. In other words, belonging in terms of having a Swedish licence to practice medicine does not necessarily make a doctor with an immigrant background feel that they belong to the Swedish medical profession. Looking at what the interviewed doctors mentioned as challenging to their feelings of belonging to the Swedish medical profession is one way to get some further understanding about how the feeling of belonging needed to be *negotiated* (cf. Strauss, 1978). In order to understand the 'ambivalence' between formal belonging on the one hand and feelings of belonging ('informal' belonging) on the other hand, this chapter focuses on how the interviewed doctors talked about feelings of belonging as challenged and *negotiated* within the group of medical doctors, and between them and other professional groups such as nurses as well as patients. It is worth noting that it is only the interactions that the interviewed doctors talk about in their everyday work setting that are in focus here. Since this thesis is about medical doctors, we start off with how the interviewed doctors talked about interacting with other medical doctors (see column 7, Table 3) and then go on to look at how the interviewed doctors talked about interacting with patients and nurses.

7.2.1 Talking about interactions with other medical doctors

To give a short review of the interviewed doctors' stories, Amin, Marta, Mahid, Masoud and Petrus were the ones that talked about a feeling of belonging to the Swedish medical profession with reference to interactions they had with other medical doctors; the other did not. This finding came as a surprise to me since theories about *professional boundary work* (e.g. Abbott, 1998; Bonsteel, 1997; and Mizrahi, 1985) often claim that *professional socialisation* is the key process through which feelings of belonging to a profession are shaped. Therefore, it seemed surprising that the interviewed doctors in this study did not talk more often about other medical doctors in reference to feelings of belonging to the Swedish medical profession, or

when they did, other doctors seemed to challenge that feeling rather than nurtured it. This is important as we have seen, and will see again, that belonging in the sense of having a license did not seem to be enough to feel that one belonged, at least for some of the interviewed doctors. The fact that other medical doctors were relatively seldom mentioned when belonging was addressed (or that they were mostly talked about in relation to getting a job) might have something to do with the fact that most of the interviewed doctors had their training outside Sweden and therefore had little contact with other medical doctors within the Swedish medical professional context, except when trying to get a job. Anyhow, it is clear that feelings of belonging to the Swedish medical profession seemed more like a trajectory for the interviewed doctors where they tried to *assert* a social position of medical doctors (without having been *assigned* it) and where their *assigned* social position of 'migranthood' at times seemed to make it harder for them to feel that they belonged within the Swedish medical profession.

The few interactions with other medical doctors that the interviewed doctors mentioned were often related to stories of 'getting in', and of other doctors helping them 'open the door' but still this 'getting in' was not directly related to getting a license but instead to getting a job and keeping it. In other words, the interviewed doctors talked about other doctors as people that seemed to make belonging possible but who were not necessarily a part of shaping their own feeling of belonging.

Amin, a surgeon from Iran working in a private clinic in a relatively big town in Sweden (for more information about his background see table 2) talked about the fact that it was hard for him to find a junior position. In the following quote and he also talks about 'they' as the group that made it harder for him. I therefore asked him: "Who are they in that case?" and he said:

> Amin: The clinic director… or directors…and such. The clinic director is also an orthopaedic but he wasn't present in Skövde and we didn't have contact but it was another one that was head of medicine who I never spent time with and he had said: "Why is he in such a rush?...He should not hurry." I started to get sad because it took such a long time but then again I got used to the thought of it taking another six months to a year, or…more.

When talking about 'they', Amin means medical doctors in management positions. It is worth noting that he only talked about other medical doctors as people that had the power to decide about getting or keeping a job. His way of talking about orthopaedics as a group implies that he did not really see himself as someone that belonged in that group even though he had a license and that was his speciality. Other medical doctors in Amin's story therefore also seemed to challenge his feeling of belonging within the Swedish medical profession. It seemed that Amin somehow tried to clarify (in the quote above) that the director was also a fellow orthopaedic doctor and

this seemed important to how Amin made sense of the fact that it took him so long to get a position. He seemed to have been given the advice to "He should not hurry", and as the advice came from a doctor Amin did not *negotiate* with him. Amin's interaction with the doctor or supervisor can therefore be understood as *non-negotiable* from a professional perspective, or in other words, Amin seemed to feel that he had to do what he was told otherwise he might not be able to keep his position. He also referred to other medical doctors as people with a lot of power and people that could decide whether or not he got a job but who were seldom present. What is interesting to note is that he did not seem to have often met the person he mentioned, even though the doctor was Amin's supervisor.

Petrus, another specialist this time in geriatrics, who came from Syria to Sweden in 1998 (for more information about his background see table 2) referred to an interaction with a doctor about getting a junior position. He says:

> Petrus: The first question in the interview for AT (a type of junior position) is: "You are from another country… What are doctors normally like there?"…I said: "They are the ones who decide and wear ties and so on…and walk around the hospital like kings" (Laughter).

In the interaction that Petrus is talking about he mentioned a doctor that was interviewing him for the junior position. The interesting thing in the quote above as I see it, is that Petrus seemed to notice that his non-Swedish background was the first thing they asked about in the interview for the junior position he was applying for. Thus, he answered the question by, as I understand it, ironically explaining a notion of a social order where the medical doctors are *kings*. It seems to me that by showing that he knew that this preconception exists, he was trying to *negotiate* the *assigned* 'migranthood' position. He seemed even to joke about the stereotypes that he seemed to know lay behind the question that was asked. In other words, Petrus seemed to be quite secure in his formal belonging, which I understand as something that made it possible for him to joke about the stereotypes that come with being seen as an 'immigrant doctor'. The fact that Petrus cited the interviewer is interesting as it shows how Petrus reflected on the importance of these situations when it comes to being *assigned* 'migranthood' as a social position. He therefore seemed to cope with that position by playing with the primordial notion of 'migranthood' that the medical doctors who interviewed him seemed to have. Worth noting is that Petrus was one of the interviewed doctors that throughout the interview seemed to resist the notion that the Swedish medical profession has of 'migranthood' (as was shown in Chapter 4) but used humour in order to play with theses stereotypical ideas (as somewhat shown in the quote above when he refers to the stereotypical ideas that he faced about how doctors are in other countries). Tentatively speaking, Petrus who seemed to feel that belonging was possible (he talked about it as

attainable and had sometimes felt that he belonged) might therefore see a possibility of playing with the notions of 'migranthood' without it challenging his possibility of getting a job. The question that he was asked is interesting in itself since it shows that there are underlying assumptions within the Swedish medical profession about what a doctor in "his country" is assumed to be. This is related to what we saw in Chapter 4 where underlying assumptions about the immigrant as the 'Other' were seen to exist both in the Swedish academic literature and within the Swedish medical profession.

Masoud was a specialist in ophthalmology from Syrian Kurdistan. He had been in Sweden since 2007 and obtained his degree in Romania (for more information about his background see table 2). In the following quote Masoud is pointing to a situation where he did not get to keep his job, which made him change speciality:

> Masoud: I needed experience from an ophthalmology clinic and that was difficult. So I decided to change speciality…I was there (at an eye clinic) for three months and they thought I did not speak good Swedish so I had to go. I thought they were doing the wrong thing as they didn't have any doctors and … they lacked doctors and the waiting-list was long yet they decided to sacrifice a specialist, or a person with experience, instead of giving me some months in order for me to improve my Swedish, and that I think was wrong…It was not my fault but it was an error somewhere.

In Masoud's story from the ophthalmology clinic he seemed to express an underlying feeling of being betrayed by the professional group that he felt he belonged to. When he said, "yet they decided to sacrifice a specialist" I understand it to indicate he thought he was seen as a fully-fledged member through Swedish licensing and that this formal belonging would make him feel included in the Swedish medical profession as well. He seemed therefore someway surprised that he was still struggling with trying to feel that he belonged to the Swedish medical profession, and related that to the fact that "they" (the medical doctors already on the inside) did not let him keep his previous job because of his poor language skills. To him it seemed that the Swedish medical profession preferred having no doctors to doctors that needed additional training in Swedish. From the professional perspective one could argue that this is not the profession's (as a collective) responsibility but the employer's. However, Masoud seemed to think (and I would agree) that this should be the responsibility of the profession, as it seemed to affect (at least in Masoud's case) the feeling of belonging within the Swedish medical profession.

Masoud can be perceived as an example of the segmenting tendencies within the profession that have also been observed in contexts such as Israel, the United States and to some extent Canada (e.g. Bourgeault & Neiterman, 2012; Shuval, 2000; and Remennick & Shakhar, 2003) and that were more

thoroughly discussed in Chapter 2. Masoud seemed to feel that he somehow was 'forced' to change from ophthalmology in order to find a job and keep it, which for him seemed to be the most important way to feel that he belonged there. Thus, Masoud seemed to feel that other medical doctors in his speciality challenged his belonging within the Swedish medical profession and in the situation that he referred to, there seemed to be nothing he could do about this. His social position seemed, in other words, *non-negotiable* in relation to other medical doctors. He seemed to find this troublesome since he did not understand why 'formal' belonging was not enough to find a job. This could be the reason why he seemed to *assert* the social position of medical doctor by getting another speciality training in family medicine. In other words, his formal belonging as an ophthalmologist seemed (for Masoud) to be enough for him, yet as it was not sufficient to give him the feeling of belonging within the Swedish medical profession or for him to be *assigned* the social position of medical doctor, he decided to get another speciality. In other words, Masoud seemed to feel that 'migranthood' as a social position was being *assigned* to him all the time while the social position of medical doctor was not.

What he was describing in the previous quote is to some extent related to the PLAR-model. As a reminder from Chapter 2, Andersson and Guo (2009) argue that the way a system integrates a doctor is a normalizing practice. In the light of the data analysed here it seems that these scholars are right when they argue that there is no room for diversity of experiences and competence within the *PLAR*-model. According to that model the competences of medical doctors with immigrant backgrounds therefore only seem sufficient if they can be assimilated into the idea of what the term 'competence' stands for in Sweden. The experience that Masoud talked about above seemed therefore like a 'turning point' for Masoud as it led him to change his professional speciality in order not only to get a job but also to feel that he belonged to the Swedish medical professional. The feeling of belonging or 'informal' belonging within the Swedish medical profession therefore only seemed attainable for Masoud through the path of family medicine and especially through his junior position at Hamid's clinic. In other words, Masoud's feeling of belonging within the Swedish medical profession can be understood as somehow both situated and changing in relation to his surroundings. 'Migranthood' as the social position that he was *assigned* seemed somehow to *primordially* define him, while being *assigned* the social position of medical doctor seemed much more circumstantial.

The examples above hopefully give the idea of the negotiations related to feelings of belonging that the interviewed doctors talked about having with other medical doctors. Their 'informal' belonging within the Swedish medical profession seemed to be talked about as *non-negotiable* in interactions with other medical doctors and seemed to be related to *assigned* 'migranthood' as a social position and the lack of *assigned* social position of medical doctors. Using Collins'(1986) wordings on this particular case, it

seemed that the medical doctors interviewed saw other medical doctors as the "social strata" (p. 26) that could provide them with the benefits of 'insiderism' and through that, with a feeling of belonging within the Swedish medical profession. But as already recognised in earlier quotes the interviewed doctors seemed to see other medical doctors more as challenging their feeling of belonging, while *negotiations* about their *social position* seemed to be happening somewhere else.

Here is Mahid again, now talking about how he found someone to help him 'get in':

> Mahid: I saw on Bengt's CV that he'd been in Africa. He'd worked in Africa so I picked[66] him over the ones that hadn't been there.
>
> Interviewer: Why was that important?
>
> Mahid: There was belonging there… there's something… belonging. There were: Zimbabwe, South Africa, Zambia …there were something …he's going to understand me I thought…and then I wrote an e-mail…"Professor so and so"…and: "I'm a doctor and Swedish citizen and I need to get started in Sweden". He answered and said: "You're welcome and so on". It was positive. So I called him and we decided to meet when I was done in Ukraine. That was in 2008.

This quote is about ties and somehow also about trying to find 'informal' belonging with the doctor that could help him to get a job. It is worth noting that Mahid might have had quite good knowledge of the Swedish system as he came to Sweden without his parents when he was 17. Yet, or maybe, therefore, he had gone through Swedish medical doctors' CVs in order to find a way that he could connect with them in some way beyond the fact that they were medical doctors. Mahid seemed to have understood that social ties are important in Swedish society, and used that knowledge as a way to negotiate his way in. His aim, as I understand it, was to locate a way to find a job and a feeling of belonging within the Swedish medical profession. He seemed to have done this on the basis of the fact that the doctor had experiences of working in African countries. Mahid seemed to see this as an important step towards his getting a job. He also regarded this doctor's experience from Africa as something that might make their connection stronger, which might have affected the feeling of belonging within the Swedish medical profession he was striving for. Thus, although he seemed to feel no sense of belonging within the Swedish medical profession at that time (see earlier quote) the next quote shows that he had tried really hard, all the way from the beginning, to find that feeling.

[66] I understand "picked" (in Swedish: tog) to mean that he not only picked the CV but he was also showing me that he was in control here.

Mahid continued to talk about what it was that made him feel like a 'deviant' when I asked him to comment on what was the hardest thing about having immigrant background and being a doctor:

> Mahid: It's connected to the system and other doctors. It's that first time… and then, when they know you, it isn't a problem…. Then you belong and… but in the beginning, when no one knows you, it's not easy and if you had been Swedish, it would have been much easier.

Here we can see that according to Mahid, being *assigned* 'migranthood' as a social position always made it harder when it came to getting a job and keeping it but also when it came to feeling a sense of belonging with other medical doctors. It seemed that Mahid felt that if you were *assigned* 'migranthood', as a social position your chances of getting *assigned* the social position of medical doctor were diminished. Mahid seemed to experience that this *primordial* idea of what it is to be seen as the 'non-Swede' was like a boundary to his feeling of belonging within the Swedish medical profession and therefore also a boundary to his chances of being *assigned* the social position of medical doctor. In that way he seemed to aim to *negotiate* the 'informal' belonging within the Swedish medical profession, 'faster' than if he continued to be regarded as an outsider. Later on we will see that Mahid also used the *primordialist* assumption about 'migranthood' as a strategy when it came to certain patient groups.

To conclude, the interactions with other doctors seemed from the interviewed doctors' perspective to be about finding a job and keeping it, but when it came to a more 'informal' belonging other doctors were seemingly absent.

7.2.2 Talking about interactions with patients

As we saw in Chapter 4, 'cross-cultural' interactions between patients and doctors have been regarded as a challenge in Swedish research. It is therefore interesting to study how the interviewed doctors talked about interactions with patients. Interactions with patients were something that the interviewed doctors talked about quite a lot in the interviews but when they did, it was about situations where patients were suspicious about their knowledge and where the boundaries between the patient and the doctor were being negotiated. In professional theories about the doctor-patient relationship these sorts of situations are often talked about in terms of power inequalities. What we will see here though is that the *assigned* 'migranthood' position seemed to challenge or reduce this difference in power and seemed to be used by some patients for that purpose. How this was done will be exemplified by a story told by Zilan.

Zilan was a non-specialised doctor from Jordan, who came to Sweden in 2011 after obtaining his medical training in Greece (for more information on Zilan's background see table 2). Zilan was the first to exemplify the medical

doctors' talked about their interactions with patients and how this related to their feeling of belonging within the Swedish medical profession:

> Zilan: A patient came and asked: "Where're you from?"… and I said: "From Jordan". "Jordan? Where did you get you training?"…and when I said "Greece" she started laughing! I got irritated but maybe she was already irritated…not with me but in general because people come here from different countries and I think she had problems with people from abroad…foreign people. I think she had such an idea before.

In the quote above Zilan is talking about a situation where a patient had made fun of where he came from and where he was trained. He "got irritated", which could be understood to mean his feeling of belonging to the Swedish medical profession was challenged by the patient *assigning* him the 'migranthood' position. Zilan says that he "got irritated" but also says that the patient 'was already irritated' before seeing him. He seemed somehow to be able to ignore the patient's laughter by referring to the fact that she probably did not like "people from abroad" in general. Zilan seemed to explain the hostile comment from the patient as part of the patient's general problem with 'people from abroad'. Explaining the patient's reaction as generally xenophobic seemed to make the situation more understandable to Zilan but seemed to make him question his possibilities of belonging (informally) within the Swedish medical profession.

Heba was a non-specialised anaesthesiologist from Syria. She came to Sweden in 2006 and obtained her degree in Syria (for more information on her background see table 2). Here she is talking about a general suspicion of medical doctors with immigrant backgrounds from outside the EU:

> Heba: You've to be extra careful… As doctors from outside the EU…people are more doubtful about what we know.

Heba says that people are "doubtful" about the skills of doctors with immigrant backgrounds. "People" in this quote can be understood to indicate a more general suspicion from patients towards her skills, which makes her want to be "extra careful" in order not to be questioned by the patients, as this might challenge her feeling of belonging or even make her lose her job. Another interesting thing to note in this quote is that she is expressing a feeling of belonging towards other medical doctors from outside the EU. Heba seemed to feel she belonged to a group that had –according to her – a different premise than medical doctors in general (which might be related to 'migranthood' as a social position that she had been *assigned*). This relates to Shah and Ogden's (2006) experimental study where patients got to look at pictures of medical doctors with different 'ethnic appearances' (in their study: Asian and Caucasian). The patients then had to report on which characteristics they associated with Caucasian medical doctors and which they

associated with the Asian doctor. Results showed that the 'ethnicity' of the medical doctors impacted the patient's judgments of them, which Heba's story somewhat confirms.

Hamid, (who was presented earlier) a specialist in family medicine from Iran (for more background information see table 2) talks in the following quote about complaints and connect it to the interactions between medical doctors with immigrant backgrounds and patients:

> Hamid: One can't deny that this (having an immigrant background) is the case…Not with me though…I'm well-known…. everybody wants to come to me but they react to the ones that aren't well-known… Especially elderly patients if they don't understand, they get sad…that's a disadvantage but…well… after some time they get going and then there're no problems with elderly patients, but it's not without risk.

His pragmatic view was that what changes people's notion of 'strangers' is time, and yet he seemed to see that running a clinic where many of the medical doctors have immigrant backgrounds in an rural area with a relatively small population was not done "without a risk". The "change" that Hamid was talking about can also be related to Marta's story about the "second generation immigrants", who she said were in the best position to *negotiate* 'informal' belonging within the Swedish medical profession. It seemed that Hamid wished that the meaning of 'migranthood' was more *negotiated* within Swedish society, yet it also seemed that he was hesitant about whether this was possible. Hamid seemed to acknowledge that he was taking a risk when hiring medical doctors with immigrant backgrounds because of how they were perceived by patients, which again indicates that *assigned* 'migranthood' as a social position somehow challenges the feeling of belonging. He seemed to have an understanding of what it meant to have an 'immigrant background' within the Swedish medical profession and he also seemed to see himself as someone who was in a position to show to patients that even medical doctors with immigrant backgrounds that were not "well-known" were doctors. Hamid was somehow trying to *negotiate* the idea that 'migranthood' matters but was still acting within the parameters that he felt that the Swedish medical profession offered. This means that he took for granted that both patients and the profession saw 'migranthood' as a social position, that is *assigned* and *non-negotiable* which is why he seemed to try to work around that rather than against that. In other words, instead of resisting the *assigned* 'migranthood' as a social position, Hamid was finding ways to address the fact that some patients (and colleagues, even though this particular quote was not about that) need some time to adjust to having a doctor with an immigrant background.

This notion might be related back to how the Swedish Medical Association, the research community and the administrative system (as we saw in Chapter 4) have perceived 'migranthood' over the past few decades. It might

be related to the fact that the interviewed doctors (as they were not *assigned* the social position of medical doctor) were instead trying to find a place within the Swedish medical profession where *assigned* 'migranthood' as a social position, could be used as an asset. One such possibility seemed to be related to referring to shared experience of a certain country. (See Mahid's quote earlier) This will be further explored in Chapter 8. Even though, migration experience and language proficiencies are important if the Swedish medical profession is to address the needs of Sweden's diverse population, it seems worth noting that *negotiating* professional boundaries on the basis of these competences could backfire since this way of arguing might just fix the social *constructed* dichotomy of 'we' (Swedes) and 'them' (immigrants) that we are seeing not only within the Swedish medical profession but in society in general.

To conclude, it seems so far that when the interviewed doctors talked about other doctors in regard to belonging within the Swedish medical profession, what they said was connected to the challenges of getting a job and not so much to feelings of belonging as such. When they talked about interactions with patients it seemed that the challenges they experienced were about not letting their *assigned* 'migranthood' position get in the way of doing their job. In the next section we will analyse how the interviewed doctors talked about the *negotiations* they had with nurses, and it will hopefully become clear that it was with this group that we found the most poignant descriptions of *negotiations* around *assigned* 'migranthood' as a social position and feelings of belonging.

7.2.3 Talking about interaction with nurses

So how did the interviewed doctors talk about interactions with nurses when talking about belonging within the Swedish medical profession? Well, doctors in certain specialities (such as anaesthesiology like Heba, Saman and Fadi) seemed to work closely with nurses, and that fact might be one possible explanation for why they seemed to mention interactions with nurses quite often in relation to *negotiations* around 'informal' belonging.

Saman was a specialist in anaesthesiology from Iraq. He came to Sweden in 2008 and obtained his degree in Iraq (for more information on his background see table 2). In the quote below, Saman mentions an interaction with a nurse:

> Saman: When it comes to anaesthesiology there're many manoeuvres and areas and decisions where the tasks of the two groups overlap...that you have to take into account. The important thing is to act quickly. I sometimes do caring work (In Swedish: omvårdnadsinsatser) that actually is the responsibility of the nurse…speed…if you twiddle you thumbs and wait for the nurse to do everything it's no good. Or when you should do a task that can be done both by the anaesthesiology doctor and the anaesthesiology nurse for example… intubate…() then I usually let the nurse do it as they have already met them

> (the patient) and got a… They already feel cared for by the nurse so therefore I leave it to the nurse.

From this quote, Saman seems to *negotiate* the task that needs to be done in order to give the patient the best care, but who should do a certain task is not clear and it is something he talked about a lot. In Saman's story (which is similar to Fadi's, Heba's and Joao's) the ambivalence of who should do what is somewhat negotiated by focusing on what he thinks might be best for the patient. I understand that he knew what tasks needed to be done but that the boundary between him and the nurse did not seem to be that important.

In the quote Saman adopts a somewhat pragmatic way of looking at the tasks that he and the nurse need to do. Here we see that he was not at all talking about himself as 'an immigrant' and it seemed that it was in the interaction with the nurse that he seemed to be able to *assert* the social position of medical doctor, as 'migranthood' as a social position was not on the agenda.

Joao also mentioned interactions with nurses but for him different social position came in handy when *negotiating* who should do what. Joao was a specialist in anaesthesiology from Cuba. He came to Sweden in 1994 and obtained his degree in Cuba (for more information about his background see table 2). In the following quote he is talking about an interaction between him and a nurse at his work place:

> Joao: The other day I was asked a question at my new work place by an anaesthesiology nurse. It was about a young man that had been in a trauma. As part of the care routine he needed a KD catheter…for the pee…She asked me if she should do it or if I wanted to and I asked why she asked me that. She answered: "Well I'm a young woman and he's a young man! I answered: But he's Swedish! You were born in Sweden and it'll be easy. You have no prejudices. If the patient had been from another country I would have considered it. But she was Swedish! No, go on, I said!

It is hard to know where to start in this very interesting negotiation around who will do what and why. In the quote the nurse asks if Joao would consider a task that is normally done by nurses, which can be understood as a type of *negotiation* between two occupations (cf. Allen, 1997). This is a good example of a *negotiating* order as she refers to her two *asserted* positions: young and woman, while *assigning* the patient two positions: young and man. For the nurse it seemed that some tasks could be managed on the basis of *gender* and *age* while for Joao there were other *social positions* that were more important. Joao answered this question by referring to 'migranthood' as a social position, as this was something he seemed to think could be used in the negotiation and he also *assigned* the nurse and the patient with 'Swedishness', and somehow through that he 'won the *negotiation*. In this situation the division of tasks between nurse and doctor seemed *negotiated* and both the nurse and the doctor seemed to argue about what they thought was

best for the patient. The interesting thing here is what made Joao 'win' the *negotiation* by referring to the dichotomy 'Swede' vs. 'Immigrant'. The nurse and Joao seemed to use different 'embodied' resources in order to 'win' the negotiation but *asserting* 'migranthood' as a social position seemed to be the one that 'worked' in this situation. While Joao was clearly *negotiating* on the basis of the *assigned* 'migranthood' position in order to explain to the nurse why he was not the one that was most suitable for carrying out this procedure, the nurse *negotiated* instead on the basis of gender and age which were positions *assigned* to her. On the other hand, the nurse accepted Joao's argument that he would perform the task if the patient could assumedly be *assigned* 'migranthood' as a social position, which can be understood to mean that the *negotiation* would possibly continue in another situation in which the patient was also, like Joao, *assigned* the 'migranthood' position. In this example it is clear that different social positions were used in order to *negotiate* about who should do what, and Joao identified that it was the *asserted* 'migranthood' position that was the 'winning card' here. I think he told this story as a way to illustrate to me how he could sometimes use the *assigned* 'migranthood' position to his advantage. This will be further discussed in the next chapter.

It seemed that Joao and the nurse had different perceptions on which *assigned* social position was legitimate to use in these types of *negotiations*. I would argue that when dealing with a matter like that described in the quote from Saman about the interaction with the nurse over an intubation procedure, the focus is on what is the best option for the patient; yet in the case of Salman he seemed not to feel challenged in the same way as Joao. They were – in that situation – only negotiating the task, and this may have something to do with the fact that other *social positions* such as the social position of gender, 'migranthood' and *age* were left out of that negotiation but included in the *negotiation* between Joao and the nurse. This can be connected to what Bell (1975) stated in a book chapter on *Ethnicity and Social Change*:

> What I think is clear is that ethnicity, in this context[67], is best understood not as a primordial phenomenon in which deeply held identities have to re-emerge, but as a strategic choice by individuals, who, in other circumstances, would choose other group membership as a means of gaining power and privileges. (Bell, 1975, p. 171)

Thus, I am hereby suggesting that the *negotiation* described by Joao can be understood in the light of Bell (1975) as a choice to *assert* 'migranthood' as a social position in this particular situation but not necessarily in other situations. Joao can be said to have used the *primordial* understanding of *ethnicity* in a *circumstantial* way, so that it did not challenge his feeling of belonging. I believe that Joao acted based on the definition that was available to

[67] In this quote Bell refers to industrial societies as the context.

him within the Swedish medical profession ('migranthood' as something *primordial)* but that he could use it to his advantage when negotiating with the nurse on not doing a particular task. In the case of Joao, this can be understood to be an example of him using the *primordial* notion of 'migranthood' to his advantage; a notion we clearly show (see Chapter 4) to be very rampant in the Swedish medical professional debate and the academic literature on it. This does not necessarily mean that he shared that *primordial* understanding of '*ethnicity'* but it can be understood to mean that it was the only tool available to him in order to position himself within the Swedish medical profession.

Here I would like to draw attention to E.C. Hughes' work (1945) since he sees division of labour as based on who is to do the 'dirty work'. According to him, those with high professional power retain the more desirable work, delegating the less pleasant or stigmatising work to others with less power. When looking at Joao´s example from Hughes's (1945) perspective we can see that this *negotiation* was also about the division of labour. From the perspective of E.C. Hughes, Joao's *negotiations* with the nurse could be understood as a *negotiation* of who should do the 'dirty work'. But what this does not explain is why this particular task (inserting a KD catheter), which is 'normally' performed by a nurse, was *negotiated* this time. The interesting thing here is not that it was *negotiated* but rather the basis of the *social position* on which the negotiation took place. Both actors were *negotiating* about this, using different logics, and Joao seemed not to have anything against doing the 'dirty work' "if the patient had been from another country". Worth noting is that it seemed like Joao (in the position of being the doctor) was the one that had the possibility to choose when 'ethnicity' should matter as he said he would have considered it had the patient been from another county.

This could be understood to show that the interviewed doctors sometimes used the *assigned* 'migranthood' position in order to legitimise why they took on 'nurse work' so that neither their feeling of belonging nor the social position of medical doctor that they tried to *assert,* were challenged. As I understand this, the interviewed doctors that *negotiated* the professional boundary towards the nurse in order not to have to do 'nurse-work' seemed to use the *primordial* understanding of 'migranthood' in *circumstantial* ways. It is worth noting here that Cornell and Hartman (2007) also argue that by applying a social constructionist perspective we are able not only to look at what '*ethnicity'* is but also to "focus on the way ethnic and racial identities are built, rebuilt and sometimes dismantled over time" (p. 72). By doing this they argue, the interactions between circumstances and groups are placed at the centre while accepting the fundamental validity of *circumstantialism,* although at the same time there is an attempt to retain the key insights of *primordialism*. In both Joao's and Saman's examples they somehow seemed to want to attempt to negotiate the boundary between nurse and doctors on the basis of existing *primordial* ideas about what 'migranthood' as a social position seems to mean in medical encounters in Sweden. Joao seemed to

use *assigned* 'migranthood' as a social position to de-emphasise *gender* and *age* and he therefore seemed to win the *negotiation,* as we saw. The nurse seemed to do the opposite. Saman somehow seemed to use a pragmatic way of focusing on what needed to be done while Joao seemed to use his *assigned* 'migranthood' position in order not to have to insert a catheter or in other words, to avoid having to do a task that was 'normally' done by the nurse and not *negotiated*.

The interactions had somewhat similar outcomes and could be understood as examples of how feelings of belonging within the Swedish medical profession are *negotiated* using somewhat different 'tools'. One can only wonder if the nurse would *negotiate* like that if the patient were a Swedish male or if it is the notion of 'migranthood' that somewhat opens up the possibility of negotiating the task?

On the other hand these interactions did not always seem to be without complications. The next quote is from the interview with Heba (for more information on her background see table 2) where she talks about her relationship to the nurses:

> Heba: It isn't fun… I think the nurses are the hardest because they're not comfortable when they work with a new doctor. That's understandable. There're some that come and say: "Hi, my name's so and so… and I've worked with this and this long, what've you worked with?" Then you've to agree about what you've worked with before or say: "Well, I've done this before. I know what I'm doing" (..) but there're others that don't do that and instead just stand there and watch and then they talk behind you back, and that I think is wrong.

In Heba's example of a nurse-doctor interaction she talks about a feeling of not being trustworthy and says that this lack of trust is not always outspoken but hidden and therefore harder to relate to. She is also talking about herself as "new" which could be understood as a way to get around the issue of her being from another country. It could also be understood as a type of degradation of her former experience.

Thus, in the quotes presented here we see different types of *negotiations,* and the important thing here seems to be that the negotiations about *professional boundary work* between the doctors and nurses also seemed to become somewhat 'ethnified' and seemed to be talked about as a challenge to possibilities to *assert* the social position of medical doctor. In other words, these doctors seemed to use notions about '*ethnicity'* and maybe more so 'migranthood' when *negotiating* who was going to do what, and when. The *negotiations* that the interviewed doctors talked about having with nurses seemed in other words, somewhat based on other social positions where 'migranthood' as a social position (and gender) became more prominent

when discussing patients with immigrant backgrounds[68]. This development could be understood as an example of that migranthood' as a social position is regarded by the Swedish medical profession as something *primordial* and static while the doctors with immigrant backgrounds that were interviewed regarded this position as *negotiable* and dependent on the situation. In their descriptions of how they handled situations that challenged their feelings of belonging we saw that they regarded themselves in complex ways and tried to use other social positions available to them when trying to *assert* the social position of medical doctor. Thus, it seemed that the interviewed doctors who felt that they had managed to cope with the fact that they had been *assigned* 'migranthood' as a social position were also the ones that were more likely to talk about belonging to the Swedish medical profession as something attainable or indifferent.

7.3 Concluding reflections

In this chapter I have tried to analyse how the interviewed doctors talked about interactions with medical doctors, patients and nurses as important not only to get a job but also to keep a job. These interactions seemed to be related to their feeling of belonging within the Swedish medical profession and the situation in which this feeling seemed to be challenged by people around them. Moreover, this chapter has shown that feelings of belonging (or not) are often talked about in terms of *negotiations* with other people, where the *assigned* 'migranthood' position seems to play a role and where the lack of assignment of the social position of medical doctor seems to be ever present.

When the interviewed doctors talked about other medical doctors they talked often about the fact that these colleagues were instrumental in getting them a job and that *assigned* 'migranthood' as a social position was something they saw as a challenge to job finding. The interviewed doctors talked about patients and nurses more in relation to keeping a job (or persisting) and trying not to let the *assigned* 'migranthood' position get in their way of doing their job. When it came to nurses we also noted that the *assigned* 'migranthood' position was circumstantially used in *negotiations* regarding who should do different tasks. Thus, what we have seen in this chapter is that 'migranthood' as a social position seemed to matter in all of these interactions but in different ways. It is worth noting also that this position was often regarded as a challenge to both their feeling of belonging and their capacity to *assert* the social position of medical doctor, which most of them did not feel that they had been automatically *assigned*. The *assigned* 'migranthood' position seemed, however, not only to be a challenge. Some managed to turn it into an asset. Thus, by focusing on analysing how they talked about inter-

[68] One may wonder if this has something to do with the on-going academic debate alluded to in Chapter 4 about the patient with immigrant background as someone who is more demanding and in need of care that is somewhat customized to his or her ethnic background (i.e. C-M. Allwood, 2000, 2009). If so, this could be a possible explanation for why medical doctors with immigrant backgrounds see this patient group as a possible "area of expertise".

actions that challenged their feeling of belonging within the Swedish medical profession these empirical chapters have so far shown how the interviewed doctors experience the social positions themselves and have shown how the social positions were *negotiated* from the interviewed doctors' perspective.

Looking at 'migranthood' as a social position and at the social position of medical doctor through the perspective of professional boundary work within (through using a social position lens) has allowed us to see that not all of the interviewed doctors seemed to have the possibility of *negotiating* the social positions that had been *assigned* to them (such as 'migranthood') and even though some tried to *assert* the social position of medical doctor this seemed to be very hard. As posed in Chapter 3, the sociology of profession has, so far, been mainly concerned with *boundaries between* professions, and even if we have seen those negotiations in this chapter as well I find it interesting that there also seem to be *boundaries within* professions based on primordial ideas about 'migranthood'

Some interesting conclusions to be drawn from this chapter are therefore that there are boundaries within the profession that seem to be based on who is *assigned* 'migranthood' as a social position and with whom they negotiated this *assignment* in everyday practice. The perspectives on the Swedish medical profession that the interviewed doctors offered also point toward understandings of a professional 'we' (understandings related to the *assignment* of the social position of medical doctor which does not, according to the interviewed doctors, come automatically with 'formal belonging') and a migrant 'them' (based on where you come from and/or where you were trained and all of the assumptions that the professional 'we' makes when *assigning* 'migranthood' as a social position, to these doctors). In other words, the interviewed doctors expressed the view that the *assigned* social position of medical doctor is conditioned by the social position of *assigned* 'migranthood' *(and gender),* which is why having a Swedish license to practice medicine does not automatically prompt feelings of belonging.

In Chapters 6 and 7 we have seen, in other words, that the feeling of belonging within the Swedish medical profession seemed interwoven with ideas about 'migranthood' and *gender,* and as many of the interviewed doctors talked about belonging to the Swedish medical profession, it can therefore be perceived as something that doctors with immigrant backgrounds either consider unattainable or are indifferent to. The *assigned* 'migranthood' position seemed, however, for the most part, to matter. Hence, we have started to understand the interviewed doctors' perspective and how they talked about belonging within the Swedish medical profession as conditioned by the *assigned* 'migranthood' position.

By looking at how the interviewed doctors talked about interactions with medical doctors, patients and nurses we have also obtained some insight into how boundaries to feelings of belonging are *negotiated* by doctors with immigrant backgrounds who are formally part of the Swedish medical profes-

sion yet who do not feel that they belong. In handling the challenges to feelings of belonging that the interactions analyse here, we also saw that some of the interviewed doctors used *primordial* ideas about 'migranthood' as a social position entails in *circumstantial* and *negotiated* ways.

8 Re-constructing a feeling of belonging: Analysing talk about resources

This chapter focuses on the types of resources[69] that the interviewed doctors talked about using in order to *re-construct* some kind of 'informal' (or feeling of) belonging to the Swedish medical profession. The term re-construction is hereby used to allude to the interviewed doctors' negotiations within the frames of the informal boundaries that they perceived (as we saw in Chapter 7) while also bringing attention to the resources they talked about using in order to handle these boundaries. Worth noting is that when talking about belonging, the interviewed doctors mentioned different types of resources that they used in order to re-construct their challenged feeling of belonging; a feeling they felt (as shown in Chapter 6) was challenged because they had been automatically *assigned* the social position of 'migranthood' but not the social position of medical doctor. The analysis presented here is informed by the way Cornell and Hartmann (2007) argue that in order to understand how people make sense of the social positions they are *assigned* with within a group, we need to identify the resources they talk about as useful. This empirical chapter focuses therefore on these resources and aims to deepen our insight into what the interviewed doctors saw as possible resources when trying to cope the challenged feeling of belonging to the Swedish medical profession that they expressed. The chapter starts with a description of the results presented in the data display columns 10-12 in Table 3 and then goes on to analysing them in more detail.

8.1 Displaying the data: Resources

The data display (Table 3) gives an overview of the resources that the interviewed doctors talked about using in order to feel that they belonged to the Swedish medical profession (see columns 10-12). The table also shows if they talked about belonging and in what way (columns 1-6), which was in focus in Chapter 6 and how they talked about interactions related to the feeling of belonging (columns 7-9), which was in focus in Chapter 7. It might be useful to look back at all of these columns as the analysis of columns 10-12 is presented.

[69] Asset(s) and resource(s) are used interchangeably in this thesis.

Column 10 shows the interviewed doctors who talked about people as 'boundary-openers' not only in regard to finding a job but also in regard to feeling that they belonged within the Swedish medical profession. Column 11 shows the interviewed doctors who talked about being seen as 'Swedish' as a resource, while Column 12 shows the interviewed doctors who talked about focusing on patients with immigrant backgrounds as a resource to cope with their challenged feeling of belonging within the Swedish medical profession.

8.2 Theorizing Re-constructions

This chapter focuses on the types of resources that the interviewed doctors talked about using in order to overcome the challenged feeling of belonging within the Swedish medical profession. Resources are, as I see it, one way to explore their agency within the Swedish medical profession. This relates to what Wong and Lohfelds (2008) describe as the "process of adaptation" (p. 56) which in this particular study is related to the interviewed doctors' descriptions of resources they use in order to overcome their challenged feeling of belonging. Thus, the interviewed doctors' talk about belonging will be analysed in the light of the conceptual framework introduced in Chapter 3 with a focused interest on how 'migranthood' as a social position seemed also to be *asserted* in order to *re-construct* some kind of 'informal' belonging. The idea is that by focusing on the types of resources that the interviewed doctors talked about using in order to feel that they belonged within the Swedish medical profession we may get a deeper understanding of how and why 'migranthood' as a social position seemed to matter within the Swedish medical profession.

8.2.1 Talking about 'boundary-openers' as a resource

As shown in Table 3 (column 10) but also indicated in Chapters 6 and 7 it seems that 'getting inside' or feeling of belonging to the Swedish medical profession was conditioned by the resources that these doctors have at their disposal. These strategic resources were talked about by most interviewed medical doctors (except for Lajos and Juliana) but in different ways. One type of resource seemed to be 'boundary-openers' who could make the doctors aware of the more 'symbolic boundaries' they would face and how they should tackle them. This relates to the analysis in Chapter 7, but in that chapter the focus was on the people who actually challenged that feeling and not necessarily the resources they used in order to address these challenges.

Hamid the specialist in family medicine who came to Sweden from Iran in the 90s was also talking about the fact that he had developed a system for introducing other doctors with immigrant background who wanted a job in

Sweden. The system was based on his own experiences of being trained outside Sweden:

> Hamid: Well, I worked as a nurse in the beginning and at that time people were more helpful. Now there are doctors that never get in. But I have a system… It is my own 'farm' (in Swedish: odling)(laugh) that I use and yesterday for example the Swedish Public Employment Service (In Swedish: Arbetsförmedlingen) [70] called and said that they had one more but I can't handle another one even if I would like to. I have two (doctors with immigrant backgrounds) now that are ready and two that are in the process to be ready and I can't do one more… It is only me that is up for this.
>
> Interviewer: And they are with you all the time?
>
> Hamid: Yes, and there are a lot of questions and I have to be in control so it gets done correctly and …If they were too many I might lose that control… but it's a shame because there are many skilled doctors that are not being utilised and they don't know the language, but if they aren't able to work they will not learn. Mine have learnt in one year because they've learnt at work! If they are not at work they don't learn…one can see that the ones that have been here a year are doing well… but the others don't speak as good (Swedish) because they weren't here from the beginning.

In this quote, Hamid is talking about his role as a mentor for the medical doctors with immigrant backgrounds that he has recruited. He seems to see himself as a resource that other doctors can use to gain a feeling of belonging within the Swedish medical profession but it has not always been this way since he too had to find someone that he could learn from. When he says: "I worked as a nurse in the beginning and at that time people were more helpful" he somewhat compares different periods and when he says: "Now there are doctors that never get in" it could be understood to mean Hamid that feels he was lucky to arrive in Sweden when he did and now it is his time to help other medical doctors in similar situations with getting in as his own belonging is not critical any more yet other's are. In the quote above he seems to emphasise the importance of learning the Swedish language at work in order to cope with a challenged feeling of belonging and he states that he can see a difference between the medical doctors that came to his clinic straight away and the ones that have made a detour.

One needs to bear in mind that Hamid was an entrepreneur and sometimes his way of talking about his 'success' was a part of his role as a businessman, but that is not the whole story I would argue. He also talked about having a moral responsibility for helping medical doctors with immigrant

[70] Arbetsförmedlingen is the Swedish Public Employment Service. Their most important task is to bring together those who have a vacancy to fill and those who are looking for work. By creating meeting places for employers and jobseekers, they aim to, according to their home page, contribute to a well-functioning labor market. (For more information see ams.se)

backgrounds not only to get a job but also to find a way to feel that they belonged within the Swedish medical profession. Hamid talked about the medical doctors he trained as "his own cultivation". The fact that he used a metaphor from agriculture is interesting in itself as it suggests that Hamid believed that doctors with immigrant backgrounds need something more than just a license in order to belong within the Swedish medical profession. His use of "my own" to refer to the group of doctors working for might also be understood as he sees them as his 'creation' in some ways and that without him their belonging would be critical. I would also like to argue that this 'something more' might be to realise that the *assigned* 'migranthood' position can also be *asserted* in order to *re-construct* 'some kind of 'informal' belonging within the Swedish medical profession, as we will see later on. Therefore, it could be claimed that Hamid wanted to 'help' Masoud, Tanja and Zilan come to this realisation. He said also that he was the only one that was "up for this", which can be understood to mean that he was critical of the fact that there is no system in place for introducing doctors with immigrant backgrounds to the Swedish medical profession. It is worth noting also that Hamid arrived in Sweden in the late 90s and even though it seems from the quote that there was no system for helping people like him at that time[71] either, he seemed to see this re-establishing process as even harder nowadays, which is why he felt that he could be of help. Thus, although he seemed to be aware of the boundaries to feelings of belonging within the Swedish medical profession that doctors with similar backgrounds face, he was also keen to convey that these boundaries can be overcome if one find another kind of 'informal' belonging within it.

If we apply the social constructivist perspective to how Hamid spoke about himself as a resource that every doctor with an immigrant background needs in order to reach his or her full potential, we can see that he was trying to *re-construct* 'informal' belonging within the Swedish medical profession through "his cultivation" as a place where feelings of belonging could be nurtured. When he spoke about his business idea and his vision of what he had to do for doctors with immigrant backgrounds and for the Swedish medical profession we can see that he felt that 'informal' belonging could be *reconstructed* if these doctors used the *assigned* 'migranthood' position to their advantage. Hamid's own way of feeling that he belonged to the Swedish medical profession can therefore be understood against the backdrop that he can also mentors others (especially newcomers from abroad) by giving them the resources they need to get a job but also to fit in and therefore overcome the challenges that he assumes that doctors that are *assigned* with 'Swedishness' are not faced with. In other words, Hamid seemed to be trying to find a new 'niche' within the Swedish medical profession for doctors with

[71] The so-called Stockholm and Gothenburg Projects were launched in 1999 order to attend to unemployed or medical doctors working in other areas in Sweden, and even if Hamid was not a part of that it might have been a reform that made it easier for medical doctors with immigrant backgrounds to work as doctors.

immigrant backgrounds, but was not necessarily challenging the *primordial* notion of 'migranthood' as such. Hence the boundary to 'Swedishness' was somewhat still there but he gave then a tool to over come the boundary and feel at least as long as they worked at his clinic. When Hamid talked about his close relationship with the Swedish Public Employment Service (in Swedish: Arbetsförmedlingen), this could be understood as an example of the fact that he saw himself as a 'boundary-opener' not only to other doctors with immigrant background but through that he could also help the Swedish medical profession as a whole which, through his efforts, did not have to do the work of introducing doctors with immigrant doctors into the Swedish medical profession.

This could also be understood as a *de-stigmatisation strategy* (Lamont, 2009, p. 162) because he was trying to use the particular strengths of medical doctors with immigrant backgrounds to get them to feel like insides. He also seemed therefore to be *re-constructing* 'informal' belonging through making them feel that they belong (at least his clinic). If we understand the statement "It is only me that is up for it" as a way to criticise the way the Swedish medical profession handles the issue of medical doctors with immigrant backgrounds, we might get some help from Jenkins (2007) in understanding what is constructed here. Jenkins notes that '*ethnicity'* (and 'migranthood' I would argue) needs to be understood as something related to how much it matters in a particular context, which might be in line with how Hamid talks about it. Yet, here it seems not to be '*ethnicity'* that matters but instead 'migranthood'. Hence, Hamid's willingness to put time and money into training medical doctors with immigrant backgrounds could be understood as a type of strategy that seeks to get around the some of the 'informal' professional boundaries within the Swedish medical profession by giving the doctors with immigrant backgrounds a place where their backgrounds were seen as an asset. Throughout the interview Hamid was talking about how appreciated his clinic was and how much gratitude that was shown him when he started his clinic and recruited doctors to this rural town in Sweden where few medical doctors normally wanted to work. He seemed to have been able to *assert* the *assigned* 'migranthood' position and through that he had managed to become a resource for other doctors with immigrant backgrounds (that the Swedish medical profession has yet to 'discover'). Hamid seemed to argue, in other words, that because 'migranthood' *matters* in the Swedish medical profession, he would use it to his and others' advantage. We will come back to the interview with Hamid and the *asserted* 'migranthood' position later but before we do, we will look at how some of the other doctors talked about the importance of other people to their feeling of belonging to the Swedish medical profession.

Zilan, a non-specialised doctor from Jordan, came to Sweden in 2011 and obtained his medical training in Greece (for more information on Zilan's background see table 2). Zilan was working at Hamid's clinic and was one of the medical doctors that Hamid had taken on and trained (he had been in

Sweden 1 year when the interview was conducted). In this part of the interview we talk about how he learnt Swedish:

> Interviewer: So if you've been here for a year… did you do any language course like the Swedish for Health Care Workers or something?
>
> Zilan: No…we did it like this: I learnt Swedish by myself and with Folkuniversitetet[72] in Stockholm but I didn't do Swedish for Health Care Workers. I started here on September first with Hamid and he explained the Swedish system and the language and he explained System cross (a digital EMR-system) and we went to training and so on…. Two or three months we did that… we didn't do anything, just checked the system and he talked to us and so on.

In this quote Zilan is talking about Hamid's 'cultivation' from another perspective. When I ask if he went to the Swedish language course specially designed for people working in health care he says that he made another arrangement with Hamid and included this in his three preparation months at the clinic (cf. professional socialization Apker & Eggly, 2004; and Shuval, 2000). When we look back at other quotes from Zilan in Chapters 6 and 7 but also if we look at Table 3 we can see that his way of talking about belonging to the Swedish medical profession gives the impression that he regards the feeling of belonging as somewhat attainable (see column 4-6, Table 3). This sense of attainability might have something to do with the way he was introduced to the Swedish medical profession by Hamid. The feeling of belonging to the Swedish medical profession seemed for Zilan to be reachable because he could be of use in Hamid's clinic (which might not be the case elsewhere as expressed in Masoud's story in the next quote). Hamid did not expect that Zilan would know Swedish upon arrival but instead gave him a structured way to attain the skills he would need to practice medicine in Sweden. Cornell and Hartmann (2007) suggest that the process of a social construction is an interactive one and that identities are made by and during interaction between *circumstantial* or human *assignment*, on one hand, and *assertion*, on the other. Zilan seemed to think he was given the right tools to feel that he belonged as well as a way to cope with *assigned* 'migranthood' as a social position.

[72] Folkuniversitetet is a private school of higher education with links to local universities. According to their homepage they offer a wide range of adult education courses throughout Sweden and in several European countries. The organization consists of five regional offices attached to the Universities of Stockholm, Uppsala, Gothenburg, Lund and Umeå. Each region has a board of directors appointed by the local university. Through its links with the universities, Folkuniversitetet states that it can provide the general public, businesses and organizations with the best available knowledge drawn from current research. (www.folkuniversitetet.se/Om-Folkuniversitetet/In-English/About-Folkuniversitetet 2013-04-15 accessed 20140401)

The next quote is from Masoud, a doctor who made a 'detour' before getting a job at Hamid's clinic. Masoud, a specialist in ophthalmology from the Syrian parts of Kurdistan had been in Sweden since 2011 and obtained his degree in Romania (for more information about his background see table 2). In this part of the interview we talk about the people he thinks are important for his own feeling of belonging within the Swedish medical profession:

> Interviewer: Who were those important people for you?
>
> Masoud: People that have patience with other doctors and people that give the doctor a certain amount of reassurance about living in Sweden…They are very nice and very good and if there were more of those people then even more doctors would arrive here.
>
> Interviewer: Is it important to find a person that you can follow into the system?
>
> Masoud: Yes, very important. But there should be a structure for this. When you are on the inside it's easy.

One could assume that Masoud is referring to the process of licensing here but instead he is talking about 'informal' belonging as he already has his license and refers to his current situation. He was quoted in earlier chapters when talking about his experiences before coming to Hamid's clinic and the reasons behind changing his speciality to family medicine. For Masoud, the crucial things seemed not only to be getting the licence and a job, but also finding a work place within the Swedish medical profession where he felt that he was accepted and where he had a chance to feel that he belonged. He had his license but he seemed to lack a feeling of belonging within the Swedish medical profession due to earlier circumstances where he felt challenged by other doctors in his specialty. He was more focused on the importance of having people with 'patience' within the system that you can follow. Masoud and Zilan talked about Hamid as their resource in that regard. Masoud seemed to think that he was lucky to find him but he addressed the need to systemise and institutionalise this footstep-following process in order to attract and introduce medical doctors with immigrant backgrounds into the Swedish medical profession. Masoud seemed to think it was somewhat unfair that it was up to the individual doctor to find the appropriate resources.

We can again understand this in relation to Hamid's story since Hamid seemed to be the person that showed Masoud the way when he first arrived and seems to have been instrumental in Masoud gaining a feeling of belonging. Masoud did not seem to expect that 'migranthood' would *matter* within the Swedish medical profession but learnt the hard way that it did. Then he

found Hamid who showed him what he needed to do to progress from feeling (and to some extent being) like an *outsider* to feeling that he belonged to the Swedish medical profession despite the fact that some regarded him as such. It is worth noting that Masoud was one of the interviewed doctors that had chosen to change his specialisation (see table 2).

The next quote is from the interview with Tanja, a non-specialist doctor from Hungary. She came to Sweden in 2011 and obtained her training in Hungary (for more information about Tanja see table 2). She was also one of the medical doctors working at Hamid's clinic. In this part of the interview we talk about why she decided to go to Sweden:

> Interviewer: Would you say that you came here mostly because your sister was here or was it also because of your career?
>
> Tanja: Yes I knew that many doctors had come here earlier so we knew that Sweden was a possibility…it was only the language that was hard.
>
> Interviewer: How did you learn the language then?
>
> Tanja: I started a course in March in Hungary but then I didn't want to wait more so I just left to come here and I didn't understand anything but I got a job after three weeks!
>
> Interviewer: But then you had quite a slow start, no?
>
> Tanja: Yes, we went along with Hamid all the time and only with 'easy' patients who had colds and such…and we talked to patients so that we learnt the language.
>
> Interviewer: Is the introduction better here you think?
>
> Tanja: Yes, I have been at an interview in Stockholm too but they thought that I first needed more language, and then they didn't know… because I have done six years in Hungary but I was between AT (general residency) and ST (specialised residency) so they didn't know. I was more than AT but less than ST so they said: Give it more time and then we can talk again.

Like both Zilan and Masoud, Tanja also identifies Hamid as the person who was the source of her feeling of belonging within the Swedish medical profession. She mentions the fact that getting a job was quite easy for her and the starting point for her being able to feel that she belonged, but then she emphasises the uniqueness of Hamid's model as they "went along with him all the time". She seems to contrast her experience of where she is now to another experience in a recruitment situation in Stockholm where they saw her poor language skills as a challenge that they did not want to deal with. This could be understood by considering that more medical doctors want to

work in urban areas than rural areas, but I also think this says something about the fact that Tanja seemed to need someone that could show her how to feel that she belonged to the Swedish medical profession. We can also understand this as an example of how the *assigned* 'migranthood' position seemed to *matter* more in the urban environment, as the Stockholm recruiters did not want to give her a chance due to the fact that she did not know enough Swedish. One possible explanation for their attitude could be, of course, that competition was higher at urban clinics and hospitals, so the clinics or hospitals did not need to 'bother' as much about evaluating the competences of applicants from other countries. Thus, although we cannot explore this here, Tanja's story seems to show that place does play a role when it comes to feelings of belonging. The lack of medical doctors in rural parts of Sweden might open up possibilities for doctors with immigrant backgrounds to get a job faster. It is clear that she placed an emphasis on this particular clinic, and Hamid as a person had made it easier for her not only to get a job but also to cope with the challenged feeling of belonging to the Swedish medical profession that she originally experienced. Or in other words, the interviewed doctors talked about people that have been able to access the benefits of insiderism (such as Hamid) as people that had helped them opening informal 'doors' to the Swedish medical profession. These people were therefore important for the interviewed doctors because they seemed to embody the 'informal' key that the interviewed doctors needed in order to feel that they belonged ('informal' keys could be networks and knowledge about the underlying assumptions about 'migranthood' that exist within the Swedish medical profession).

Joao, a specialist in anaesthesiology from Cuba who came to Sweden in 1994, had obtained his degree in Cuba (for more information about his background see table 2). In this part of the interview we talk about what happened in a particular probation period where a person could not help him any more:

> Joao: It was outside their power to help me but he suggested two hospitals in Stockholm that possibly could take care of me. One was X but it was a more limited type of surgery, and he also mentioned Y. Y was a more general hospital and was ideal, even though it was further away, but it suited me and they would give me a good probation period so that they could assess if I was for real… So I quickly ran over there! It was eight o' clock and by ten I was the hospital. I hadn't any appointment and the manager said that he had a meeting but asked if I could wait, and so I did, and after one and a half hours we had a meeting. I didn't know about Swedish customs regarding interviews and such, and I was desperate. Then he asked me at the end of the interview: "When do you want to start?". I answered: "Now!" (laugh). He laughed very much: " No, we have to coordinate this." And he promised to get in touch in a week. So I got to start on 1st December 1998.

For Joao it seems that the meeting he is referring to and the doctor that helped him to get there, were of great importance to how he first experienced the Swedish medical profession. He emphasizes how fast he got to the hospital and how he waited there in order for this semi-formal encounter to lead to his first junior position. He talks a lot about his eagerness to get a job, and his luck in meeting the right people as his greatest assets. He is the doctor that in Chapter 7 negotiated with the nurse about who should do the catheter procedure. Joao used an 'individualistic discourse' and he seemed to see his 'success' in finding a way to belong within the Swedish medical profession as being dependent on him finding certain people that would help him tackle the challenged feeling of belonging that he was faced with. The people he talked about meeting could be understood as a resource that helped him to move from feeling like an outsider to getting a job, but also to finding a feeling that he belonged within the Swedish medical profession. Joao did not explicitly talk about this individualised process as a problem, as for example Masoud did in an earlier section, but he still talked about it as something that shaped his feeling of belonging even though he seemed to rely on himself first, with some help from other important doctors that was already on the inside.

The next quote is from an interview with Heba, the anaesthesiologist from Syria that came to Sweden in 2006 (for more information on her background see table 2). In this part of the interview we talked about what challenges her feeling of belonging within the Swedish medical profession:

> Heba: Yes there are many (medical doctors with immigrant backgrounds)… I don't know how many… but I know people that tried to get in the system and did the probation period but…uh…I don't know if they had an attitude or if there wasn't any chemistry between the supervisor or the manager, which affected that doctors… but as it's only individual assessment it's one person that makes the judgment and if you don't get along with that person you're out.
>
> Interviewer: That is something other doctors I have talked to also said; that it is important to find persons that support you…
>
> Heba: Yes, sometimes there're people that don't get along and it affects the Manager's judgement, and I've heard: "No, I'll not approve this only because she's nice". Do you understand? It's highly personalised, this. The assessment. Sometime you feel it's unjust. You know colleagues that weren't approved after the first six months and had to do it again.

In this quote Heba is talking about a problem that has to do with the fact that medical doctors with immigrant backgrounds are dependent on one person to assess the their skills, and that the assessment is based on what she refers to as "chemistry" between two people. She seems a little hesitant at first saying that there might be a risk of a personal bias in that assessment. She is

using an example of a doctor she knew where she suspected that a personal bias, or in other words the relationship between the doctor and his or her supervisor, affected the assessment and therefore the medical doctors in question's possibility of belonging. This can be understood as she was under the impression that finding the right people was crucial not only for getting a job but also for feeling that one belongs within the Swedish medical profession. This is similar to what the other medical doctors talked about in previous quotes. Even though Heba is not talking in terms of resources in this quote she indirectly seems to indicate that some doctors with immigrant backgrounds do not make it, which she seems to believe is because they did not find the right gate-openers from the beginning. She avoids saying that it is due to the doctors' immigrant background yet she is highlighting a problem that is connected only to medical doctors that are *assigned* 'migranthood' as a social position. For Hamid, Heba and Masoud and Zilan, the feeling of belonging within the Swedish medical profession seemed to be about finding the right 'boundary-openers' and they all seemed to feel that they were dependent on other doctors' judgement of them. Thus, finding the appropriate 'boundary-openers' (which is not something that is necessarily connected to the Swedish medical license but to figuring out who has 'embodied' the 'symbolic' resources that you need to access and understand in order to know how to navigate the profession), seems important for how you are able to *assert* the social position of medical doctor and feel that you belong within the Swedish medical profession.

Heba shared Hamid's and Masoud's and experiences that the process of getting in (in a more 'informal' sense of the word) is highly individualistic. It also implies that getting in depends on finding the right resources in order to *re-construct* some kind of 'informal' belonging within the Swedish medical profession that these doctors experienced. In a sense, some of the interviewed doctors referred to the boundaries to feeling that they belonged within the Swedish medical profession as boundaries that could be challenged if one was willing to *assert* the *assigned* 'migranthood' position or at least accept that this position would most likely be *assigned* to you by members of the Swedish medical profession and others you met while practicing medicine in this country. In doing this, some of them felt that they could *assert* the social position of medical doctor which most of them felt was not automatically *assigned* to doctors with immigrant backgrounds in this country. It seems therefore that the two social positions (medical doctor and migrant) were in a dynamic interplay (as indicated in the introduction). Some doctors with immigrant backgrounds seem to manage to feel that they belong if they have someone on the inside that could explain how these social positions are perceived and how they should address the fact that they may not always be assigned the position they feel the medical license should entail. Thus, although many of the interviewed doctors seemed hesitant to *assert* 'migranthood' as a social position (which seems to relate to the outcomes of *particularisation strategies* mentioned in previous chapters), there were

some that seemed to feel that much could be gained if they were to highlight the positive side of having an immigrant background.

As already shown, Hamid was one of the interviewed doctors that had had the most explicit agency when it comes to the *assertion* of 'migranthood' as a social position since he seemed to have shaped his own 'micro-order' (or "cultivation" as he called it) where he recruited doctors with immigrant backgrounds. Hamid was in a way compensating for the 'shortcomings' of the Swedish medical profession and had managed to make the doctors that were working at his clinic to feel that they belonged (at least locally). His introduction program seemed important as it also seemed to shape a feeling of belonging on a local level yet it was not sufficient since the doctors that were not lucky or had not managed to access the 'right' resources stood the risk of being stuck in an outsider position; not getting a job or losing the one they had with little possibility to feel a sense of belonging within the Swedish medical profession.

Hamid seemed to feel quite strongly about this structural problem and when I asked him what he suggested that newly arriving medical doctors should focus on he said:

> Hamid: They have to find someone who cares for them… I know that at the X-clinic here…nine out of twelve positions are vacant and there are competent doctors from abroad… then a woman who's a X specialist and has done surgery and so on calls me and wants to be here! She wants to be some place where they care. It's the same with Y. He came from there (the hospital) and he is a X specialist but they do not want to put in that much effort…. You have to know the language and know all the routines and such, otherwise they'll kick you out…. if they'd tried they could've perceived it as something long-term. But I am very happy…they're very skilled and nice so I'm happy.

As I understand Hamid he had found a way to somewhat 'strategically' use the notion of 'migranthood' that exists in the Swedish medical profession to his advantage by *asserting* it. Above he is talking about how he gets highly specialised doctors to call him even if their skills would be better used somewhere else. Hamid's feeling of belonging seemed therefore to be based on the fact that he had managed to feel that he has *asserted* the *assigned* 'migranthood' position and through that also the social position of medical doctor. He seemed to regard his strategy as one that others could follow, which is why he encouraged doctors with immigrant backgrounds to contact him in order to get a job and find a feeling of belonging. Thus, Hamid saw the advantages that come with being *assigned* 'migranthood' as a social position that the rest of the profession does not regard as an asset yet. Yet, when doing so he somewhat *re-construct* a notion based on a 'we' and a 'them', I would argue.

To conclude, it seemed that 'boundary-openers' were an important resource for many of the interviewed doctors' (all talked about this except Petrus, Marta and Fadi) not only in order to get a job and keep it but also in

order to feel that they belonged within the Swedish medical profession. For many of the interviewed doctors it seemed that not feeling a sense of belonging was partly based on the fact that they did not seem to want to *assert* the *assigned* 'migranthood' position (or at least accept that it had been *ascribed* to them). Many of the interviewed doctors talked about trying to find a person that was on the inside who cared, and that they had a connection with that went beyond formal belonging to the Swedish medical profession. There are several layers here where *primordial* ideas about 'migranthood' seem to be *assigned* to medical doctors from abroad and it seems that they have to *assert* this social position themselves if they are to use it as a resource or try to *re-construct* 'informal' belonging (at least locally).

This could be understood as an indication that the feeling of belonging to the Swedish medical profession is somewhat limited by the people that doctors with immigrant backgrounds happen to meet. They also seem to try to find commonalities in these peoples' backgrounds as a way to find a feeling of belonging with the majority to whom many of the interviewed doctors wanted to belong both formally and informally. All of the doctors interviewed talked about one or several of those persons and they also talked about the challenges that are faced by those who do not find such persons and the implications that this has for their feeling of belonging within the Swedish medical profession in the long term. I find this interesting, as the Swedish medical profession is known for its well-functioning socialization system and its restricted way to belong through licensing, yet the interviewed doctors seemed to talk more about important individuals than the Swedish medical profession as a collective when addressing issues of feelings of belonging within it.

8.2.2 Talking about 'Swedishness' as a resource

In this section we will continue to explore the types of resources that the interviewed doctors talked about as important in order to 'fit in' or to cope with a challenged feeling of belonging within the Swedish medical profession. The theme discussed here differs from the former one as it focuses on how the interviewed doctors talked about acting 'Swedish' or being seen as 'Swedish' doctors, as a resource in finding ways to cope with the challenged feeling of belonging (see column 11 in Table 3). This theme is about how the interviewed doctors put emphasis on how they learnt certain ways of acting 'Swedish'.

The first example is from Hamid who created an introduction program for medical doctors with immigrant backgrounds at his clinic. Even though he thought it had been successful he still seemed to think that the medical profession needed to do more in order make new medical doctors feel that they belong within the Swedish medical profession:

> Hamid: I have noticed that this system and Sweden wants to become better at getting doctors from abroad to work here… it plays a role in the economy too… the Swedish economy …as it costs a lot to train doctors …but I think there is a need for a system for this… like these doctors that arrive here but have had their training somewhere else…. So that they get a short AT (junior position)…like we do…four or five months intensive general residency. In order to learn the 'Swedish way'… I think that is a good idea.

In the quote above Hamid talks about the fact that he has understood that Sweden as a country wants to get better at attracting doctors from abroad; a piece of information he interprets as understandable since he seems to believe that there are financial benefits at stake. He is also addressing the issues with introduction which here is understood as formal and 'informal' ways to gaining the feeling of belonging and he concludes that it would be better with a more formalised way to teach doctors with immigrant backgrounds about "the Swedish way". It seemed that he believed that feelings of belonging within the Swedish medical profession were not only conditioned by *assigned* 'migranthood' as a social position (as we saw in the previous section) but also by the idea that there is some kind of 'Swedishness' that the medical doctors with immigrant backgrounds lacked and needed to learn in order to feel like fully-fledged members of the Swedish medical profession. 'Swedishness' as a resource seemed to be about 'fitting in' but also about what is the core of 'Swedishness' as well as its boundaries. This can be compared to Juliana's seemingly prominent feeling of belonging that was understood as something that could be related to the fact that she was trained in Sweden and therefore did not 'lack' this resource. She knew how to fit.

Hamid also suggested that a short period of work place based training might help doctors with immigrant backgrounds to cope with the challenged feeling of belonging within the Swedish medical profession. He also relates this to the economic benefits that Sweden, as a country, would gain if it were to help these doctors to "learn the Swedish way[73]". These ideas are present in many of the interviewed doctors' stories but what a 'Swedish way' means is very hard to grasp. The interviewed doctors talked about it as something they 'lacked' and needed to learn in order to cope with the perceived *outsider within* position or in other words, with the challenged feeling of belonging within the Swedish medical profession that most of them experience. In the quote Hamid relates back to his own work with the doctors with immigrant backgrounds that he recruits, trains and helps socialize. He seemed to want to point out that we need to structure a way for these medical doctors to cope with the challenged feeling of belonging, as they cannot *assert* the social position of medical doctor or be able to be *assigned* it if they do not feel that

[73] It is important to state here that the meaning of 'a Swedish way' is a social construction that has been internalised and not something that exists beyond people's notion of it, I would argue.

they have a shot at belonging. He seemed to think that "a Swedish way" is something that he could teach the doctors that he was training. Hamid seemed, in other words, not to challenge the Swedish medical profession's way of looking at how 'migranthood' *matters* but he seemed to claim to offer a 'model' of how to expand the range of people included in the term 'Swedish doctor' by educating them in the notion of a 'Swedish way'.

Petrus, the specialist in geriatrics from Syria who came to Sweden in 1998 (for more information about his background see table 2) talked about things he did in order to feel that he belonged during his first years in Sweden in the following way:

> Petrus: I worked with older people. A lot with Swedes and I… I always tried to learn how they… how Swedes think. I had a little book where I collected proverbs and then I tried to learn all the proverbs as they teach you about the culture. I had an older lady that I helped for three years with domestic work. So I came from the Folkuniversitet[74] every day… I worked every day…I'll tell you something about how it was during my training. I worked all the time… I came at 7 and I worked with the elderly from seven to ten… like a personal assistant… and then I came here to X and ate something…a hot dog or something…then I went to the lady and I helped her with food and Christmas decorations and we listened to Swedish music together, and I helped her with medicine and went with her to the hospital and such…and this…I tried early on to learn to understand Swedish culture and Swedish health care and mentality.

For Petrus the interactions with elderly people during his first years seemed of great importance for his possibility learn "how Swedes think". He talks about the fact that he "learned proverbs" as well as other informal activities such as "decorating for Christmas" and "listening to Swedish music", which he identifies as important parts of understanding 'Swedish culture'. Petrus talks a lot about learning 'Swedish culture' as an important resource for coping with his challenged feeling of belonging to the Swedish medical profession and it almost seems that the evenings when he worked with the elderly gave him much more than the actual training sessions he went to during the days.

Goran, the specialist in ophthalmology who came from Iraq to Sweden in 1987 (for more information on his background see table 2) talked about a strategy he used to access 'Swedishness' as a resource to feel that he belonged within the Swedish medical profession:

> Goran: I worked during the summers while I was studying in Sankt Petersburg but as a nurse or assisting nurse to get money and at the same time learn routines and rules here. It was an advantage for me to learn about the Swedish culture and I also got a foot in the door, which made it easier to get a

[74] see footnote 72.

> junior position. I could get it because I knew a lot about Swedish health care and such.

In the quote Goran says that he had an "advantage" as he had worked as a nurse assistant during the summers and had therefore been able to learn the "Swedish culture" that way. He seemed to see his job as a nurse assistant as an opportunity that taught him some of the formal and 'informal' rules and routines that guide the Swedish medical profession. He claims that the reason why he had an easier time to adjust in the junior position he had later on is related to this prior experience. Goran's story shares some similarities with Petrus', in the previous quote, but they seem to regard the positive aspects that came from using these resources in slightly different ways. It is worth noting that some of the interviewed doctors talked about people that could teach them 'Swedishness' as an important resource in order to feel that they belonged within the Swedish medical profession and in order to *assert* (or even maybe get *assigned*) the social position of medical doctor. Through learning 'how to be a Swede' from someone already on the inside it seems that some of the interviewed doctors were more successful than others in identifying the right strategies to do so. The idea of that one needs to learn 'how to be a Swede' becomes problematic as it might backfire since it somewhat *re-constructs* 'informal' belonging within the Swedish medical profession by referring to the *primordial* idea of what being 'Swedish' is as a part of what it is to work as a medical doctor in Sweden.

Heba, the anaesthesiologist from Syria (for more information on her background see table 2) talked about feeling that she felt she needed to be better than the doctors that were trained in Sweden but also that she needed in order to learn another way of being a doctor:

> Interviewer: Do you think they're afraid that you don't have the technical competence needed?
>
> Heba: Yes but also that we haven't seen some procedures before. If I do something…They say: "But that isn't how we do it in Sweden", "You just have to forget this" or, "You have to learn a different way"… and it's correct. One has to adapt….but that's why you get very careful… when we are at doctors' meetings for example it was always like…my supervisor always said that the others said that I didn't participate in the discussions. "You also have to say something, say what you think!"…but I didn't dare to say anything. I always think about what they will think: "What's she saying now? That's not the way we do it here!" Do you understand?

In Heba's case the formal encounters with other doctors are something that she talks about as not building her self-confidence. This seems to be associated with her being seen as someone who does not do things the way "we do it in Sweden". She talks about the fact that these encounters are based on a presumption about her knowledge and her skills due to the fact that she has

been trained somewhere else, and she is therefore questioned. Her strategy is therefore to be quiet. This can be understood as an example of how, in the formal encounters, there seemed to be a presumption of what she might know on the basis of where she was trained. In that situation her strategy was to keep her thoughts to herself as she seemed to believe that everything she said would be interpreted as coming from a social position that was different from the other medical doctors and seemingly often interpreted as different from 'the way we do it here' (cf. "the Swedish way" in Hamid's quite earlier). It is worth noting that this 'way of doing things' seems to be implicit and hard to grasp and not necessarily having to do with a certain medical procedure but about a way of being in order not to be seen as an 'outsider'. Hence, she seemed to experience that her attendance in these meetings was limited by the fact that she was trained somewhere else and had not therefore "learned how to do it in a Swedish way", which can be related to a *primordial* understanding of who is included in the 'we'. She seemed therefore to avoid sharing her knowledge as it might be interpreted wrongly (or in a 'non-Swedish way' I would argue), something that she see seemed to believe might put her in an even more 'peripheral' position than the one she was in when not saying anything.

Amin, the specialised orthopaedic doctor from Iran (for more information on his background see table 2) talked about some help he got with identifying a 'problem' that might have affected his feeling of belonging within the Swedish medical profession:

> Amin: So I started there… month by month… I only had one problem and he helped me with it. It wasn't a medically related problem: "Now I understand when they say over-qualified. The problems you have are cultural. You have to change cultural expressions from Iranian to Swedish!" (imitating the person that helped him). That's it. So I've learnt.
>
> Interviewer: What was it that you should do then?
>
> Amin: I should… what is it called…lay low… So I kept quiet until I was asked about something.

In this quote Amin talks about a similar resource to the one that Heba mentioned in an earlier quote; a resource that he has used in order to feel that he belongs to the Swedish medical profession. He talks about how he is "quiet" until "he is asked" in order not to act in a way that would make his *assigned* 'migranthood' position to stand out, or in other words not, to be regarded as "cultural expressions" that seems to have negative connotations. He talks about the fact that the only thing that he did wrong did not have to do with his medical skills but with wrong "cultural expressions". It could be argued that Amin, on the basis of how he tries to explain why he is silent nowadays, views his *assigned* 'migranthood' position as connected to how he acts,

which is then something he seems to need to control in order to keep his job. There is a resemblance in Amin's and Heba's stories as they both balance the line between speaking up and keeping quiet. As we saw in previous quotes the interviewed doctors seemed to experience that they had to "lay low" as a way not to deviate, which might have made it harder for them to feel that they belonged and could *assert* the social position of medical doctor.

Mahid, the unspecialised doctor who was born in Somalia and came to Sweden in 1984 (for more background information see table 2) reflected on the hardships he had experienced trying to find a way to feel like he belonged by asking me to imagine a fictive place outside the Swedish medical professional context:

> Mahid: Imagine that we were in Congo and Doctor X was there (Doctor X was a doctor with whom he talked about not having a feeling of belonging and she was 'Swedish'). She is a doctor and I am a doctor…but there we would be a team. Then she would come to me. Then she would also be outside. She also doesn't have this strong connection that she has with Doctor Y (Doctor Y was another doctor with whom he talked about not having a feeling of belonging and he was also 'Swedish'). It (their connection) is very strong. And Doctor Y would agree with them…it's like this but it isn't right.

Mahid makes a very interesting point when it comes to 'Swedishness' and what this notion does for his challenged feeling of belonging within the Swedish medical profession. By drawing on a fictive place outside the Swedish medical professional context I think he was trying to make me understand how being seen as the 'immigrant' challenged his feeling of belonging to the Swedish medical profession and his possibility of *asserting* the social position of medical doctor. In his fictive example he locates himself and two of his colleagues (who he sees as 'real' insiders) in another country context (Congo) where neither he nor Doctors X and Y belong. In doing this he seems to want to convey that it is the Swedish medical professional context that shapes his and her experiences, and he shows, through his example, that he seems to need to share the outsider position with his colleague in order for them to feel like equals. This can also be understood as an example that shows that his colleagues would, in another context, also be dependent on him due to the fact that 'Swedishness' in that other context would not be seen as an asset as it is within the Swedish medical profession. In the fictive case that he talks about, Doctor X and himself could be equals not only because they would both be outsiders but also because Doctor X would not have the somewhat *primordial* connection to Doctor Y. In what he says about belonging to the Swedish medical profession, he seeks to erase the symbolic boundary between those that he sees as 'Swedish' doctors and himself, and by illustrating a fictive situation outside the Swedish medical professional context he shows that the notion that 'Swedishness' matters is

context-dependent. As I understand Mahid's story he seemed to be trying to explain to me that there are some particularities inherent in the Swedish medical profession that affect doctors with immigrant backgrounds' possibilities to feel that they belong, and that these peculiarities are to some extent conditioned by or related to the notion of 'Swedishness'. This is similar to the case of Tanja where the *assigned* 'migranthood' position also shaped her feeling of belonging within the Swedish medical profession. Mahid seemed to try to take it one step further and argue that his experience of feeling like an *outsider* was dependent upon the fact that he could not access the needed resource of 'Swedishness'. In other words, being *assigned* 'migranthood' as a social position within the Swedish medical profession seemed to affect both Tanja's and Mahid's feeling of belonging but while Tanja and Juliana (due to the way they look) did not seem to struggle as much with 'Swedishness', Mahid seemed to do just that.

Hence, if we relate this to Amin in the previous quote he seemed instead to have encountered someone on the inside that 'understood' why his actions were interpreted the way they were, and he seemed to think that it was because he had "too much Iran" in his "cultural expressions". Seen from a *constructionist* perspective it seems that Amin and Mahid were trying to feel that they belonged within the Swedish medical profession through trying to *re-construct* 'informal' belonging within the Swedish medical profession and they seemed to do that by de-constructing the boundary to 'Swedishness' and challenging its very meaning, something that neither Hamid, Heba, Tanja nor Zilan seemed to do.

Fadi, the anaesthesiology specialist from Iraq who came to Sweden in 2008 (for more background see table 2), talked about a resource he used in order to feel that he belongs within the Swedish medical profession:

> Interviewer: You talked earlier about how you found it hard to get to know what you called 'Swedish' doctors…can you say something more about that?
>
> Fadi: I don't know but you know… there are… I don't know… obstacles… I don't know what it is… if it's from their or from my side… I try to break the ice between us and it's working…
>
> Interviewer: What do you do to break the ice?
>
> Fadi: Mmmm… go to happy hour…it's a tip. I'll give you that tip. It helps a lot. To do things outside… that make you get to tell you story outside this system and organisation. To get to know personalities and not only that you are doctors.

Fadi talks here about a strategy that works for him in order to access 'Swedishness' as a resource and come closer to feeling that he belongs within the Swedish medical profession. As I understand this, Fadi thought that attending happy hour would allow him to be deemed more 'Swedish' in the eyes of

his colleagues. He used the happy hour to *de-construct* the boundaries he seemed to feel existed between himself and the 'Swedish doctors' and that affected his feeling of belonging within the Swedish medical profession. Yet he also seemed to see some problems with this way of socialising as we can see later in the conversation when we talk about the fact that he and his wife might want to move to a smaller town. He gets back to the encounters during the happy hour and connects them to the notion of 'we' and 'them':

> Interviewer: It can be nice in a small town but are there any problems too do you think?
>
> Fadi: A, there's something that separates us more…like hierarchies…what can I say us Muslims… that Swedes would go to Happy Hour…drink alcohol…I drink actually but I only drink light beer and my wife's always on my back and says: "No that's not ok, you can't!". Aaa…but what can you do? It's hard if you don't drink here you can't belong in society…you meet in bars or where do you meet? Concerts?...If you are a strict Muslim you don't drink but if you are 'in between' then there are no real problems…
>
> Interviewer: Do you know other people that act the same?
>
> Fadi: Oh Yes! Some have become even more strict here…and some become like Swedes. They live like Swedes and I don't say it's bad. I want to do that and there are others that became more strict. Everything is 'No!' It's easier to say no to that than to wonder…

For Fadi it seems that attending happy hour is something he feels ambivalent about and something that makes him ponder upon what 'Swedishness' means and how and why it seems to matter. Fadi wants to balance both following the Muslim traditions and being seen as a 'Swede' while he also seems to see some challenges in feeling a sense of belonging to both 'groups'. In this reflection we can see his fluid understanding of what 'being a Muslim' in Sweden means. He is reasoning about drinking habits and the fact that 'Swedish' peoples' way of socialising around alcohol is something he needs to adapt to. He talks also about the fact that it is harder for those that are more "strict" than him. As I understand this he is using happy hour as a way to cope with the challenged feeling of belonging within Swedish medical profession even though his actions are questioned, for example by his wife who thinks that what he is doing is wrong.

When he talks about moving to a smaller town it seems that he sees an even smaller possibility to feel a sense of belonging within the community as he talks about the fact that there are "hierarchies" between different ethnic groups where 'Swedishness' to him is always a privileged position. Fadi seems to see these interactions as 'informal' yet as strategically crucial for his feeling of belonging within the Swedish medical profession. He even

seems willing to give up some of his other ideals in order to feel that he belongs within the Swedish medical profession.

Petrus, the geriatrician from Syria also addressed an 'informal' feeling of belonging within the Swedish medical profession that he had attained at his working place:

> Petrus: X-hospital is a very nice hospital… we feel like a family. I have worked here for eight years so you go around…you greet everybody… I come from a culture where I can't go around stiff like Swedes (laughter)… I have to greet, I have to talk, so I'm a little bit like Italians… I can't be stiff. I have to greet everybody and attack (laugh)…so it is nice…like a family.

In what Petrus says we can see that he seems to feel he is deviant because he is not as "stiff as Swedes". He says that he greets everybody and that he "can't go around being stiff" (which he regards as the norm) and he refers to his way of acting as similar to "Italians" (Petrus is the doctor that in an earlier quote talked about what he did to learn 'Swedish culture'). In doing this he seems to draw on a *primordial* stereotype of what it is to be 'Swedish' ("being stiff") and as somewhat opposite to his way of being, not "liking to talk" that is often mentioned as a characteristic of a "typical Swede". Petrus seems to draw on that stereotype and describes the hospital where he works as a place where he is accepted for the person he is, and not because he "acts Swedish".

The paradox and the most interesting thing here, I think, is that he did not seem to embody the way he acted but instead he related this way to another European country, which might be more accepted than the country he originated from. The, seemingly forced (he calls it 'attacks'), one-to-one 'informal' encounters in hallways still seemed to be important for his feeling of belonging to his work place. There was a similarity between Petrus and for example Hamid that seemed to be related to they seemed to have *asserted* 'migranthood' as a social position. It seemed that they had no problem being regarded as different because they had already accepted that 'migranthood' was associated with being different from the norm. Amin, Heba and Mahid for example, were still struggling with a dual positionality where *assigned* 'migranthood' was a challenge to their feelings of belonging to the Swedish medical profession; something that did not seem to bother Petrus and Hamid.

Learning 'Swedishness' seemed to be seen as a resource for some of the interviewed doctors when trying to feel that they belonged within the Swedish medical profession and even though some did not try to embody that 'Swedishness' they could at least use the knowledge of what it was in order to cope with challenges to feelings of belonging. *Asserting* 'migranthood' as a social position seemed by some to be seen as a possible way to *assert* the social position of medical doctor instead of trying to act 'Swedish', I would argue. This will be further explored in the next section where we will see how the interviewed doctors talked about patients with immigrant back-

grounds as a resource that could be used in order to cope with the challenged feeling of belonging. In the quote below, Mahid, who was a unspecialised doctor born in Somalia, (for more information on Mahid see table 2) talks about his own initiative in trying to shape his way of feeling a sense of belonging within the Swedish medical profession by using belonging to a specific geographic area in Sweden:

> Interviewer: So you try to find common factors?
>
> Mahid: Yes, if someone is a Jämte (a name for a person from a region in Sweden called Jämtland) we would be linked because we have a connection. But with time it was better because I'm outgoing. It's me…I have to take the initiative so I go around knocking on doors. I ask about things I already know to feel belonging. In the beginning it was hard… it relates to nurses as well… it's hard to get accepted. They don't know you, and also I don't look like them… that makes me appear foreign. But in the end it was good. I found someone that was a Jämte.

By referring to the fact that he is a "Jämte", he somewhat de-emphasises his *assigned* 'migranthood' position in what seems to be an attempt to allocate 'Swedishness' as a resource to fitting in. It seemed, as we can see in the quote above, that Mahid tried to find commonalities in colleagues' backgrounds that were based on the idea of belonging as something connected to kingship. When Mahid draws the picture of how he walks around knocking doors to find someone that he can connect with, he contrasts this with another example from another thing that he seems to identify as unifying; being from a special part of Sweden. The region of Jämtland is known for is tight cultural bonds and it is where he went to as an unaccompanied youth in the 90s. I understand Mahid's story as an example of someone who is trying to use where he used to live (rather than where he comes from originally) as a resource to feel that he belongs. Having lived in a particular place in Sweden can be understood as something that Mahid regarded as a resource in his quest to *re-construct* 'informal' belonging within the Swedish medical profession. In doing so, he is also, in some ways trying to de-construct the boundaries to 'Swedishness'.

To conclude, for the interviewed doctors, finding ways to 'informally' belong, and coping with a challenged feeling of belonging within the Swedish medical profession seemed to be about using certain resources they had at their disposal. The resources that the interviewed doctors mentioned were 'boundary-openers', being seen as 'Swedish' doctors, and (as we will see in the next section) patients with immigrant backgrounds. It seemed that coping with challenges to feelings of belonging was related to coping with *assigned* 'migranthood' as a social position. While some of the interviewed doctor talked about using more formal resources to cope, others tried to find 'informal' belonging even outside work as a way to belong within the Swedish medical profession. It is worth noting also that *primordial* ideas about 'Swe-

dishness' seemed to be a challenge that they somehow (and often in quite individual ways) needed to tackle.

8.2.3 Talking about taking care of patients with immigrant backgrounds as a resource

In this section we will focus on another type of resource that the interviewed doctors talked about using in order to tackle the challenged feeling of belonging within the Swedish medical profession. Even if learning Swedish seemed to be something that all medical doctors talked about as important it was seemingly instrumental for getting a job, as you will see in the quotes below. When I asked about language skills they often started by saying that learning Swedish was important and hard, yet quite soon they started talking about other languages they knew and the importance of those languages when treating patients with immigrant backgrounds. I understood this as an example of the fact that they regarded being able to treat these patients as something that made them feel 'useful' within the Swedish medical profession. Thus by taking on the role of 'mediators' between patients with immigrant backgrounds and the Swedish medical profession, these doctors seem to regard these patients as potential resources in their quest to gain the feeling of belonging to the Swedish medical profession that they long for.

Hence, there was something interesting in how they used and actively promoted their knowledge of other languages as a way to say that they were better at caring for patients with similar migration experiences, and sometimes also with similar 'ethnic' backgrounds as themselves. It is worth noting that this probably has something to do with the underlying assumptions that seem to exist within the Swedish medical profession that patients with immigrant backgrounds are more problematic (as was shown in Chapter 4).

We start off with a quote from Hamid again. Below he is talking about the importance of other languages in his privately run health care clinic:

> Hamid: Many immigrant groups come here because they can speak. We speak Persian, Turkish, Arabic, Romania, Greek and all staff know many languages… English and German everybody knows but those are not languages that immigrants need…
>
> Interviewer: So maybe you lose one group and win another?
>
> Hamid: We should have had a Somali doctor. Then we would score high. There was one candidate but he did his training in Sweden. I hope to recruit him later.
>
> Interviewer: Do you think it's good or are there problems with this thing that patients want the same ethnicity?

> Hamid: I think it's good that they meet people from their own background… it's like Swedish patients want Swedish doctors…

In the quote above, Hamid is talking about the medical doctors working at his primary health care clinic and he seems to highlight their importance by referring to the languages they speak and the 'ethnicity' they have. Hamid's story seems focused around the increased ('ethnic') diversity within the group of patients that he seems to have noticed and which is also highlighted in Swedish medical research literature (see Chapter 4). A more ('ethnically') diverse Swedish medical profession seems for Hamid to be a demand from the patients. As we have stated earlier, Hamid was the entrepreneurial doctor who used their *assigned* 'migranthood' position to his own (and other doctors') benefit by *asserting* it. Thus, the patients' freedom of choice together with him being *assigned* 'migranthood' as a social position seemed to open up the possibility for his own clinic to take care of patients that the Swedish medical profession saw as problematic.

In the interview with Mahid (for more background information see table 2) he said that many immigrants from Somali came to the clinic and asked for him. I asked about status in relation to those patients' wishes:

> Interviewer: Do you think that your status changes when patients with Somali backgrounds come, asking to see you?

> Mahid: I don't know… but the Somali people want to see me. Before they come they say: "We want the Somali doctor"…they don't want anyone else. They also speak Somali languages and I understand them. They get more respect from me. If she goes to a Swedish doctor he won't know whom she is. I know what background she has.

> Interviewer: But then culture plays a role? But you said that culture did not play a role when you met Swedish patients. Can you expand on that?

> Mahid: It's only medical when it comes to Swedish patients because I speak Swedish and know Swedish culture. Then there are no barriers from the beginning…only the first impression…"Oh who is this now"…for example, with a Swedish patient… I always use all three names, which no one else does, and when I listen to her then I include her in the decision. "Thank you", she says. "My neighbours said you were good and that is true. So her neighbour had said: "The black one. He is nice" (laugh).

> Interviewer: But does it not feel a bit weird…still?

> Mahid: But I deal with it in a positive manner with respect and that is very important. Somalis trust me more than other doctors.

When I first read this quote I felt it had to do with status. I understood it as a story about people that only wanted to see Mahid for a consultation. Yet, the more I read this quote and reflected upon the rest of this interview, the more I realized that this was a story about how he, in those moments, seemed to feel a belonging within the Swedish medical profession that seemed to make up for all the feeling of belonging he lacked in other situations. In the quote, he starts talking about the fact that there are patients with a Somali background that want to come to him, and goes on talking about a patient with a Swedish background that refers to him as "the black one". By doing that he seems not only to say that he is important for treating other "Somali patients" but also that "Swedish patients" accept him 'even though' they see him as "the black one". I therefore understand Mahid's story as a story about how treating patients with immigrant backgrounds (and managing to be accepted by patients with Swedish backgrounds) can lead these doctors to feel that they are needed (or accepted) within the Swedish medical profession if only because their patients do not see a problem with their backgrounds. Mahid also talks about patients with the same background as patients that have more trust in him, and by contrasting that to the example of the "Swedish" patients he shows how he has a special role to play within the Swedish medical profession even though he might always be seen as "the black one".

Yet, by regarding patients with immigrant backgrounds as a resource, he was in fact – albeit inadvertently – contributing to the notion that 'migranthood' matters and that this is a social position that doctors with immigrant backgrounds need to *assert*. By failing to resist the idea that 'migranthood' matters, he was *constructing* his own niche within the Swedish medical profession using *primordial* ideas about *'migranthood'* that are already there. This could be understood as a type of *particularization strategy* (Wimmer, 2008, p. 1029) whereas Mahid seemed, at times, to look for positive aspects of being an outsider, instead of trying to become an insider, and through that it seemed that he developed another way of feeling a sense of belonging.

Masoud, the specialist in ophthalmology that was working for Hamid(for more background information see table 2) talked about the advantage of knowing many languages:

> Masoud: It's the language. It's most important… I think that if there was a person or a company that could supervise the doctors in learning Swedish…I don't know how long it would take but that depends on the person… but if you could offer some minimum…necessary…many more would come here. For me… I've done a lot to be able to stay here…after that thing with the X clinic I stayed here some months without a job and that was tough. My wife doesn't have a job either … she's also a doctor but she has a hard time due to her psychological situation... I can't give advice to others but it depends on the person and the situation… but you have to sacrifice a lot yes… and it's not easy to come and start over. That's not easy.

> Interviewer: Is it easier to work at a primary health clinic, as there are so many different people that come here?
>
> Masoud: Yes, that's true…I know Arabic, Romanian, Kurdish so yes I know languages and it helps a lot and is an advantage for me …and the clinic.

In this quote Masoud is talking about his disadvantage of having trouble learning Swedish, but also about his advantage in that he speaks several other languages, and he seems to see this as an asset in the primary health care clinic where he is now working. Once again he seems to use patients with immigrant backgrounds as a way to claim that he is needed even though he has a hard time learning Swedish.

Petrus, the geriatrician from Syria (for more information on his background see table 2), talked similarly about his knowledge of language being an asset to him and to the place where he worked:

> Petrus: I live nearby and have small kids and it's very close and I can benefit from the fact that I've three languages. Apart from Swedish I speak Arabic and Syrian and yes, it makes it easier. Yes my world is larger here than if I went to a very advanced hospital. I feel they need me more here with the language and such…. I feel more important here.

Petrus' way of talking about the importance of knowing other languages when working in Sweden can be understood as a resource to cope with his challenged feeling of belonging within the Swedish medical profession but also as a resource he uses when *asserting* the social position of medical doctor he is striving for. Petrus talked about the hospital where he worked, as a place where his language skills were seen as a resource but it seems that is not the case in other hospitals. His hospital is located in a town with a high ethnic diversity, which probably has something to do with Petrus' feeling of belonging to that particular hospital. In the next quote he talked more about how he used his language skills:

> Petrus: So when I say that others need to adapt themselves to Swedish care we must also help them to understand how Swedish care is. When I behave in a certain way towards a patient that comes from my culture… from Syria… I explain why. When I see that someone is unsure… I give him a minute and explain why… because maybe I'll meet him somewhere or my brother or my sister will somewhere so I think it's an asset.

In this quote Petrus is talking about being almost like a mentor to the patients with immigrant background that he meets. He seems to see himself as helping them to understand "Swedish care". I understand this as a type of resource that he used in order to cope with his challenged feeling of belonging within the Swedish medical profession. Languages seemed for Petrus to be tools he used to strategically draw on the idea that exists in the field that

patients with immigrant backgrounds are more problematic. He seemed to use the underlying assumption that was available to him in this context, which was that 'migranthood' was problematic and he could be there to take care of that 'problem', but he seemed to use it in a *circumstantial* way. This says something about how strong and durable the *primordial* idea of 'migranthood' within the Swedish medical profession actually is. The interviewed doctors talked about how difficult they thought it was to constantly have to deal with these *primordial* ideas about what differentiates 'immigrants' from 'Swedes'.

8.3 Concluding analytical reflections

This chapter has focused on analysing how the interviewed doctors talked about the types of resources they used in order to cope with a challenged feeling of belonging to the Swedish medical profession. In doing so we have seen how a challenged feeling of belonging is tackled and how boundaries to 'Swedishness' (and 'migranthood') can be *de-constructed* in some regards through the *re-construction* of 'informal' professional belonging. The idea that 'migranthood' *matters* was not often questioned by the interviewed doctors, which might be related to the fact that they also saw that *asserting* 'migranthood' as a social position could help them not only feel that they belonged but also to *assert* the social position of medical doctor that they felt they had not been automatically *assigned* despite having a Swedish license to practice medicine.

For example, when Hamid talked about the fact that he had started a clinic and trained other doctors with immigrant backgrounds he seemed to have done this not only because he wanted to give doctors with these backgrounds a job but also because he wanted to help them (and to some extent himself) to *assert* the 'migranthood' position (or at least accept that that social position was *assigned* to them), to teach them about 'Swedishness', and to show them that they were useful because they could take care of patients with immigrant backgrounds. It seemed that the interviewed doctors either had to (in order to feel that they belonged within the Swedish medical profession) be *assigned* the social position of medical doctor from the beginning (as Juliana and Lajos seemed to have felt had happened to them) or *assert* the *assigned* 'migranthood' position, somewhere along the way, and through that *assert* the social position of medical doctor that they had not been *assigned* automatically.

Petrus highlighted language skills as a resource when it came to taking care of patients with immigrant backgrounds. This seemed to be connected to what he said about the sense of belonging being somewhat attainable and perhaps therefore to the fact that because he had been *assigned* 'migranthood' as a social position, he needed to find ways to make that work to his advantage. Mahid, who seemed to be in the midst of trying different

strategies, talked about belonging as something unattainable and seemed instead to be trying to find a way to be seen as a 'Swede'. On other occasions he seemed to *assert* his *assigned* 'migranthood' position. This was the case when he talked about treating patients with immigrant backgrounds as something he was particularly good at. All of these types of resources that the interviewed doctors talked about seemed to help them cope and act according to the professional boundaries within the Swedish medical profession that they regarded as real.

What was clear was that the interviewed doctors seemed to try to adapt to the assumptions made about them. In other words, the doctors interviewed in this study who *asserted* the *assigned* social position of 'migranthood', seemed to be able to use it to their own benefit. They also seemed to cope with the challenged feeling of belonging to the Swedish medical profession that they had experienced because the social position of medical doctor had not been automatically *assigned* to them. It is worth noting that acting on the *primordial* notion of 'migranthood' (as I see it) should not be understood as something that the interviewed doctors were doing because they wanted or chose to but rather because it was the one way that they could cope with the challenged feeling of belonging within the Swedish medical profession. And since this seemed to be necessary, in order to manage to *assert* the social position of medical doctor, it is perhaps not surprising that most of the doctors interviewed handled the lack of feeling of belonging that they experienced in certain ways. This suggests that the Swedish medical profession needs to rethink the presumptions that is made about doctors with immigrant backgrounds; presumptions that might underline 'migranthood' as a social position that these doctors felt was automatically *assigned* to them. The profession also needs to understand that for doctors with immigrant backgrounds to have a fair shot at belonging (the 'informal' way), they need to be treated as if they are doctors first and not 'immigrants' first, which is how most of the interviewed doctors seemed to think they were regarded. This is related to the study by Hansen (2005) on charter schools where he shows how 'ethnicity' is a *practical task* that serves as a conceptual basis for showing not only how notions of 'ethnicity' 'weave' in and out of social interaction but also what participants do with 'ethnicity' once it is an undeniable matter of record.

In conclusion, the knowledge gained so far attests to the fact that the *assigned* 'migranthood' position seemed to be *asserted* by some of the interviewed doctors because it already mattered within the Swedish medical profession. They maybe did this in order to *re-construct* 'informal' belonging within the Swedish medical profession. The interviewed doctors showed a *circumstantial* understanding of 'migranthood' yet they used what they believed to be the profession's *primordial* understanding in order to emphasise the particular and the positive sides of being trained and/or born outside Sweden. It is worth highlighting that the resources they talked about using seemed to be somewhat intertwined with the position they had at the time of

the interview and should not be considered as stable over time. Therefore, what is important is that we understand what knowledge we have gained in Chapters 6, 7 and, 8 and see what this knowledge does for how we understand the interviewed doctors' position within the Swedish medical profession. Chapter 9 aims therefore to highlight some contributions that this thesis hopefully has made to sociological thinking about professional boundary work, which is the theoretical framework of choice in this project. The empirical results presented so far have suggested that the combination of the *assigned* and *asserted* sides of 'migranthood' as a social position, and the social position of medical doctor, give us an insight into the dynamic interplay between the two. It also give us and insight of the kind of professional boundary work that research in this area has neglected, namely boundaries within professions as opposed to boundaries between professions that have gotten much attention so far.

9 Some concluding remarks

This thesis sheds light on how medical doctors with immigrant backgrounds perceive their social position within the Swedish medical profession. The thesis also contributes to the sociological understanding of how doctors with immigrant backgrounds make sense of the social position of 'migranthood' to which they feel they are *assigned*. The ways in which this social position is *negotiated* in different situations have also been in focus, as well as the strategies used in order to feel belonging to the Swedish medical profession. A re-cap of the main points that were made throughout the chapters is in order before I summarize the contributions of this thesis in more detail.

The thesis started off by introducing the sociological phenomenon of enquiry and the reasons why it was considered necessary to explore how doctors with immigrant backgrounds regard their social position(s) within the Swedish medical profession. On the basis of the abridged insight given on the profession and the situation of immigrants in Sweden I set out to answer three research questions: How do the interviewed doctors talk about belonging to the Swedish medical profession? What interactions do they talk about as important for that feeling of belonging? And what types of resources do they talk about using in order to feel that they belong to the Swedish medical profession?

In Chapter 2 I reviewed the international literature on immigrant doctors and established that most of the research about this group has focused on the impact that government policy and regulation have on their re-establishment process, the impact that social positions (such as gender, age and ethnicity) have on these doctors' post-migration experiences, and the moral and ethical issues associated with the recruitment of doctors with immigrant backgrounds. On the basis of this review, I argued that there were some research gaps in the literature that needed to be addressed. One of them had to do with the ways in which doctors with immigrant backgrounds regard their position within the medical professions to which they formally belong.

In Chapter 3 I presented the two theoretical frameworks I deemed would be fruitful for the kind of study I proposed to conduct, and argued that combining sociological theories about professions with social position theory could potentially help sociologists to shed light on how immigrant doctors (and hopefully other skilled/professional immigrant groups) regard their situation as *outsiders within*. Using this theoretical framework I analysed the

stories of the interviewed medical doctors in the empirical chapters (Chapters 6-8). However, before I did this I regarded it necessary to contextualize (Chapter 4) the setting to be studied – the Swedish medical profession. I did this by providing information about the number of Swedish licenses that have been given to doctors with training in other countries, the role that EU legislation plays in the setting to be studied, the licensing process, and the role that the Swedish Medical Association has played in the way that doctors with immigrant backgrounds have been talked about within the Swedish medical profession. In addition, this chapter offered insight into the research debate on 'migranthood' within this setting in order to give the reader insight into the way in which this social position tends to be regarded in health care research in Sweden. Thus, Chapter 4 also gave insight into some of the underlying assumptions that exist about doctors with immigrant backgrounds in the setting in which the data was collected. Chapter 5 focuses on the methodological points of departure for the empirical study that was conducted.

As already stated, Chapters 6-8 present the results of the analysis conducted. These chapters were organized in accordance with the three research questions that the thesis addresses. The first question – How do the interviewed doctors spoke about belonging to the Swedish medical profession? – was analysed in Chapter 6. The analysis shows that the interviewed doctors talked about belonging as something that they did not automatically feel just by getting their Swedish license to practice medicine. I analysed how they expressed not feeling that they were *assigned* the social position of medical doctor even if they were formally entitled to this position and understood this as their re-establishment process went beyond licensing. Something worth noting was that the interviewed doctors with Swedish medical training (Juliana and Lajos) seemed to be aware of the fact that 'formal' belonging was not enough, while the doctors who had received training somewhere else did not seem to be as aware of this fact. The latter seemed to have assumed that getting a Swedish license would be enough to feel that they belonged. The analysis conducted also suggests that there was a difference in feelings of belonging, depending on where in the country one worked. The doctors that I interviewed who were working in the more rural parts of Sweden seemed to have their own ways of achieving the feeling of belonging they were looking for.

The analysis presented in Chapter 6 showed also that the interviewed doctors talked about feelings of belonging to the Swedish medical profession in different ways and that these seemed to be related to the individual, symbolic and/or material resources that they brought with them. It is worth noting in this respect that although time in Sweden and time spent practicing seemed important in some ways, these were not regarded to be resources in of themselves. Mahid, for example, who had been in Sweden since he was a child, had a hard time feeling that he belonged to the Swedish medical profession. In that chapter I suggest that part of the reason for this might be that Mahid

received his medical training in Ukraine and Russia but also that his 'non-Swedishness' in terms of appearance may play a role when it comes to feelings of belonging. This relates to the title of the thesis, *The 'Other' Doctor,* which was chosen in reference to the fact that most of the interviewed doctors seemed to feel that they had not been *assigned* the social position of medical doctor that is automatically *assigned* to medical doctors with a non-immigrant background, which made them feel as if they were somewhat 'othered' despite the fact that they had a Swedish medical license and were therefore – at least formally – a part of the Swedish medical profession. It is worth also noting that the *assigned* social position of 'migranthood'– if *asserted* by the doctors themselves – was also used by the doctors themselves in order to create the feeling of belonging on a more local level (see for example Hamids clinic). This also seems to have to do with that they felt useful for the Swedish medical profession. The analysis shows, in other words, that the interviewed doctors that *assert* the *assigned* social position of 'migranthood' seem also to be able to *assert* the social position of medical doctor more easily. Thus, by accepting rather than resisting the *assignment*, some of the interviewed seemed to be able to turn the outsider position to their own benefit and create their own niche within the Swedish medical profession.

The second research question that this thesis set out to address – What interactions do they talk about as important for that feeling of belonging? – was addressed in Chapter 7. The analysis shows that the interviewed doctors felt that the social position of 'migranthood' was *assigned* particularly to them in interactions with doctors, nurses and patients. Thus, in this chapter I discussed in more detail the fact that, according to the doctors with immigrant backgrounds that I interviewed, belonging to the Swedish medical profession seemed to have one 'formal' and one 'informal' side to it. It is worth noting that the 'formal' side had to do with licensing and finding a job and that, although important, this was not at the core of what the interviewed doctors said about belonging to the Swedish medical profession. Belonging was instead more often talked about as something 'informal'. One possible explanation for this seems to be that these doctors did not feel that they had been automatically *assigned* the social position of medical doctor (as doctors trained in Sweden were) even though they had a Swedish license to practice medicine. That is to say, that they had to re-establish not only formally but also informally –something the doctors trained in Sweden did not do. Another explanation was that they regarded the professional 'we' as something that included notions of 'Swedishness', and the boundaries to this notion of 'Swedishness' were considered hard to overcome. Against this backdrop, Chapter 7 focused on the negotiations that the interviewed doctors spoke about when explaining what the boundaries in question meant for the division of labour at work. The doctors with immigrant backgrounds interviewed talked about the fact that they sometimes tried to negotiate what the bounda-

ries between 'Swedes' and 'immigrants', and between 'us' and 'them' meant in terms of the expectations they create for what doctors with their backgrounds should do in different situations.

The third question that this thesis addressed – what types of resources do they talk about using in order to feel that they belong to the Swedish medical profession? – was at the core of the analysis presented in Chapter 8. This chapter focused on the fact that some of the interviewed doctors felt they could *re-construct* their challenged feeling of belonging. The interviewed doctors spoke about different types of resources they used in order to accomplish this. One resource entailed finding people 'on the inside' – who I called 'boundary-openers' – who could help them to understand how to achieve 'informal' belonging. Another resource they spoke about entailed focusing on treating patients with immigrant backgrounds, since such work offered them a niche within the Swedish medical profession. The analysis in Chapter 8 focused, in other words, not so much on how doctors with immigrant backgrounds claim to feel, as far as belonging was concerned, but rather on what they claim to do in order to address the fact that they found it hard to acquire a feeling of belonging.

In the empirical chapters I argued that it is more fruitful to understand the *re-construction* of belonging as something that does not change the boundaries to professional belonging in itself but rather as something that allows doctors with immigrant backgrounds to handle these boundaries in a constructive manner. By finding someone to open doors one can feel more inside than before, and by doing that one might also find it easier to *assign* oneself the social position of doctor (for the time being). The analysis suggested that professional boundaries were not challenged on a structural level even though the interviewed doctors' perception of them seemed to become more easily coped for when they tried to find ways to address the fact that they did not always feel that they belonged to the Swedish medical profession. Thus, the 'informal' belonging that the interviewed doctors talked about seems somewhat circumstantially *re-constructed* at times since the primordial ideas about who was perceived to be the 'Other' did not seem to be easily dismantled. As such, some of the interviewed doctors' strategies seem to entail carving out a space of their own. This relates to the idea that Cornell and Hartmann (2007) stress: that people never enter groups empty-handed or empty-headed but bring a great deal of resources with them. The findings suggest that some doctors with immigrant backgrounds used the *primordial assignment* of 'migranthood' as a social position in *circumstantial* ways.

In addition to answering the research questions, this study has also contributed to our understanding of the ways in which professional boundaries work in some additional regards. As stated in the introduction, the idea for this thesis came from an observation I made when working for a recruitment company between the years of 2007 to 2009. There I observed situations

where Swedish-born medical doctors were 'preferred' by my clients (who were often managers in health care facilities all over Sweden). Even though this thesis did not focus on health care managers' perspectives, it can at least be argued that the interviewed doctors seemed to experience similar things. They often talked about the fact that being 'Swedish' is an advantage within the Swedish medical profession, and this is one of the reasons they think that they – because of their non-Swedish backgrounds – cannot always feel that they belong. It is therefore worth noting that even if I moved beyond the original focus – which was the re-establishment process of medical doctors in Sweden – the interviews did address this process since they clearly suggested that the process is far more complicated than just getting the Swedish license to practice medicine and then finding and keeping a job. The feelings of belonging to the Swedish medical profession that most of the interviewed doctors seemed to long for did not seem to come automatically to them even once these typical re-establishment steps had been taken. Medical doctors with immigrant backgrounds (in contrast to their peers) need to re-establish not only formally but also informally which seem to have an affect on their perceived status within the Swedish medical profession.

It is worth noting that this thesis makes some contribution to another question that I pondered upon when I first started to conceive this thesis: how could we understand the fact that being regarded as 'different' by virtue of either one's non-Swedishness and 'immigrant' background or one's foreign-training could be a principle of organisation that can shape the experiences of medical doctors with immigrant backgrounds in Sweden. As a comment, it seems important to point out that the experiences that the interviewed doctors talked about with me (not being trusted, having to work in rural places, and worrying about keeping the job they finally got to name a few) were all experiences that could be understood against the backdrop that ethnocentrism offers. This is a point that has been made by other researchers in other national contexts (see Chapter 2). The doctors that I interviewed perceived their 'non-Swedishness' as part of the reason why they did not feel automatically *assigned* the position of medical doctor in this setting. They seemed to regard 'Swedishness' as an intrinsic part of the Swedish medical profession and thought therefore that their challenged feeling of belonging could be explained by the fact that they were not Swedish. Thus, because 'Swedishness' and 'migranthood' were thought to be opposites, these doctors did not seem to think that they could be automatically *assigned* the position of medical doctors. The way they saw it, they had been *assigned* the social position of 'migranthood' and as such they could not also be *assigned* the social position of medical doctor. This process therefore seemed to become a principle of organisation that circumstantially shaped the experiences of doctors with immigrant backgrounds to some extent.

It is also worth noting that the 'ethnic' hierarchy that some of the interviewed doctors gave voice to as characteristic of the Swedish medical pro-

fession seemed also to be based upon the way they looked. Juliana, was probably the one that was the most outspoken about the fact that an Ethiopian doctor would find it harder to feel that he/she belongs than she would because Juliana was white and, as such, was more 'Swedish-like' than the Ethiopian doctor could ever be, according to Juliana. Mahid also talked about this when he explained that it would be easier for him to be a doctor in Congo than it is for him to feel that he belongs to the Swedish medical profession. In many of the interviewed doctors' stories one could therefore see that there were often some other 'immigrant medical doctors' that were described as having suffered worse experiences than those the doctors were sharing with me. Stating exactly what 'Swedishness', 'the Swedish way' or 'Swedish culture' entailed was hard but the notion of 'Swedishness' as what sets the norm was repeatedly present in the interviews. This could have something to do with the point made in Chapter 2 (about the international literature on intercultural medical communication) and in Chapter 4 (about Swedish research on cross-cultural care) as there seemed to be the 'migrant' that was considered to have 'ethnicity' and 'culture'. This could be another principle of organisation that at times also shape doctors with immigrant backgrounds' experiences.

Following on this, I would like to draw attention to Shuval (2000) who argued that there seemed to be a "dual labour market" (p. 197) in the medical profession where doctors with immigrant backgrounds tend to get the jobs that locally trained doctors do not want. This thesis could be said to have taken her argument one step further. If we take doctors with immigrant backgrounds' experiences as an indication of how things work in the Swedish medical field, we may not only be dealing with a "dual" labour market but also a 'hierarchical' one (on the basis of where you were trained and who is *assigned* the social position of 'migranthood'). As we have seen in the empirical chapters, the interviewed doctors often expressed not only that it was easier to get a job if you were 'Swedish' but also that the more 'Swedish' you seemed to be, the greater your chance of getting a job and keeping it would be. In this respect it must also be mentioned that the interviewed doctors also drew attention to the patients that locally trained doctors saw as problematic, i.e. those with immigrant backgrounds, and they claimed that focusing on them gave them a niche within the profession.

I therefore would like to dwell a little more on the boundaries to 'Swedishness'. This seems to be one possible mechanism behind what the medical doctors with immigrant backgrounds interviewed here, at length and in detail, talked about as the 'informal' side of belonging (the side they seemed to associate with the feeling of belonging). Also the way in which the doctors talked about the interactions that challenged their feeling of belonging suggests the fact that the interactions with other medical doctors were mostly talked about as challenging their feeling of belonging as far as job-seeking was concerned, and it seems that medical doctors with immigrant back-

grounds needed to find a 'boundary-opener' in order to get around the boundaries to 'Swedishness' as these seem somewhat intertwined with the professional boundaries.

Also, I would like to draw attention to the concept of the construction site (as defined by Cornell & Hartmann, 2007), which was introduced in Chapter 3. It is a concept I used in order to keep the boundary work within the Swedish medical profession (as I did in Chapter 4) in focus. To recall, Cornell and Hartmann (2007, p. 170) describe a construction site as a place where social actors make claims, define one another, jockey for position, and eliminate or initiate competition. In Chapters 6-8 we clearly saw that the interviewed doctors did all of this: they had to claim their place within the Swedish medical profession even though they had a Swedish license and belonged in the 'formal' sense, and they had to 'jockey' for a fully-fledged membership (including informal belonging) using not only other doctors but also patients and nurses in those negotiations. Although this thesis has only peripherally used the concept of the construction site, I can clearly see that this is a useful concept if one wants to understand how people handle the constructions of boundaries they face.

It is also worth noting that this concept relates to the theoretical concept of *thick* and *thin* identity (concepts which I used only occasionally in the analysis). The data suggests, however, that the doctors that *assert* 'migranthood' as a social position (instead of resisting it) seem to be the ones that experience that being seen as a migrant mattered, while those that do not think it mattered (who could perhaps be regarded as people that had a *thin* migrant identity) seem to be those that had a harder time accepting that they are *assigned* this social position. The social position of medical doctor seemed, however for the most part to be regarded as *thin* for doctors with immigrant backgrounds, at least relative to 'migranthood' as a social position that was *assigned* to the interviewed doctors all the time and affected their everyday interactions. Thus, although these conclusions about *thick* and *thin* social positions should be understood as highly tentative I believe that ethnographic studies may be able to elucidate how these positions play out in everyday interactions.

I would also like to comment on that some of the interviewed doctors spoke about that they were better able to care for patients with immigrant backgrounds because the language skills or of the fact that they shared similar migration experiences. The fact that the same group of patients was constructed in the literature and within the Swedish medical professional debate as 'problematic', and as a group that needed specific resources (as we saw in Chapter 4), seems not to be a coincidence but more a principle of organisation. Doctors with immigrant backgrounds seem, to some degree, to regard this as an opportunity since it offered them their own niche within the Swedish medical profession. Thus, this principle of organisation seems to leave doctor with immigrant backgrounds with one option, which is to use their *assigned* 'migranthood' position as an asset.

It is also important to note that it seems to be 'migranthood' as a social position together with (at least sometimes) the social position of '*ethnicity'* that position medical doctors with immigrant backgrounds within the Swedish medical profession. Together with the understanding of how the interviewed doctors with immigrant backgrounds acted within the Swedish medical profession, all of these findings suggest that doctors with immigrant backgrounds are in fact trying to *re-construct* 'informal' belonging within the Swedish medical profession. Therefore, 'migranthood' as a social position, in this case, seemed to be *primordially assigned* to doctors with immigrant backgrounds but could also be *circumstantially* used by the doctors themselves. Thus, the combination of the theory of professional boundaries and social position theory allows sociologists to understand what happens when the two social positions (i.e. 'migranthood' as a social position and the social position of medical doctor) are being negotiated in a certain context.

As this thesis applies a social constructionist perspective to the topic it seems reasonable to explicitly address what was actually constructed here. The thesis use Cornell and Hartmann's (2007) ideas about social constructionism and argue that social constructions about ethnicity (and as I have argued throughout – also migranthood) need to be understood as comprising both the *primordial* ideas that underlie them as well as the circumstances that bring attention to them. The analysis presented in Chapters 6-8 clearly shows that this is the case. Most of the interviewed doctors talked about having to handle the *primordial* ideas about what being a migrant and a non-Swede means. They did so *circumstantially* but seemed to be 'forced' to do it since they felt that they were *assigned* the social position of 'migranthood'. In this respect it seems worth noting that the doctors that had been trained in Sweden (Juliana and Lajos) seemed to resist this *assignment,* while the doctors that had been trained outside of Sweden had a harder time resisting this *assignment,* and therefore sometimes opted to turn the *assignment* into an advantage.

On a different note it is important to address one of the implicit questions that a thesis always raises: would I have made the same decisions I made along the way as far as the study design is concerned? The answer to that question is that if I had known what I know today I would have tried to interview doctors with training in other EU countries as well in order to enable a more comparative analytical approach. I would have also included questions related to the Swedish health care system in the interview guide in order to draw conclusion about how people's agency relate to the structural premises on a system level, and not only on a professional group level. Ethnographic fieldwork is also something that would have added some useful information about how these doctors interact with others. Ethnographic material – although most likely difficult to collect – probably would have given me the opportunity to see the interviewed doctors' everyday settings and how they 'navigate' them in a much more hands-on manner. Overall, there

are some different methodological choices I could have made along the way that probably would have contributed to the material this thesis builds upon and would have strengthened the result of the thesis, however the methodological approaches were undermined with this priori knowledge.

In short, the main contribution to the sociology of professions that this thesis has made is the notion of *professional boundary work within,* and the fact that the combination of theoretical frameworks used allowed me to analyse the Swedish medical profession and the notion of belonging from doctors with immigrant backgrounds' perspectives and to get an understanding of their perceived *outside within* position. In this thesis, the *boundaries within* that were explored had to do with the interplay between the *assignment* and *assertion* of two different social positions (i.e. the position of medical doctor and the position of migrant) and with the resistance and negotiation that these social positions gave voice to. One important thing that we have learnt is that in a privileged and highly restricted professional group such as the Swedish medical profession, the feeling of belonging among doctors with immigrant backgrounds seem to be conditioned by the *assignment of* 'migranthood' as a social position. The interviewed doctors talked about having Swedish medical training and being 'Swedish-like' (which meant either being fair-skinned like Swedes or acting the 'Swedish' way or both) as things that could allow them to move from the *outsider within* position they felt they had (since they did not feel they had been automatically *assigned* the social position of medical doctor) to an *outsider within*, with a chance to become an insider. Thus, having an immigrant background and being *assigned* the social position of 'migranthood' were deemed to be obstacles that doctors with immigrant backgrounds had to overcome if they were to feel they belonged to the Swedish medical profession. The *outsider within* position might therefore also be regarded as having to do with this *assigned* social position of 'migranthood' (as they already have their Swedish medical license) and somewhat affect their possibility to achieve the same 'status' as their Swedish trained peers.

The findings suggest, in other words, that professional boundary work might not be very different from other boundaries between 'we' and 'them' in society in general, and I would argue that it is because the Swedish medical profession seems to operate from an underlying latent assumption of 'Swedishness' that is based on a narrow and *primordial* idea of who can be included in the professional 'we', that doctors with immigrant backgrounds seem to feel like 'The Other' in comparison to non-immigrant doctors. This *primordial*, narrow and at times even racialized way of defining what it is to be 'Swedish' seems to be – as stated in the introduction chapter to this thesis – ever present in their everyday lives as medical doctors (cf. Hertzberg, 2003; Lundström, 2007; and Mattsson, 2005). This thesis therefore argues that if sociologists want to study and understand a profession we need to consider not only the boundaries between it and other professions but also

the boundaries that shape people's experiences *within* it. Some of the experiences that the doctors interviewed gave voice to remind us of research about racism in Sweden, as well as testimonies from 'non-white Swedish' people[75] who suggest that having a Swedish passport does not necessarily mean that you are regarded as 'Swedish'. I would suggest that the way of looking at professional boundary work as established in this thesis, opens up the possibility for the sociology of professions to elucidate discriminatory social orders within as well as between different professional groups. The boundaries *within* that my work has elucidated may – from the perspective of medical doctors with immigrant backgrounds – divide the medical profession along 'ethnic' lines and lead to a hierachization within it.

[75] See for example the speech (in Swedish) from a famous music artist called Timbuktu. He argues that the color of your skin matters in Sweden today, even if you have a Swedish passport and was born in Sweden. See his speech in Swedish at: http://www.svt.se/kultur/musik/har-far-timbuktu-priset-i-riksdagen (accessed 20140401).

Table 2 (Sample display): This table shows personal and professional background data of the doctors interviewed. All names have been changed.

Name	Sex	Age	Place of birth	Education country	Year of arrival	Years practicing in Sweden[76]	Years it took to get his/her degree recognised	Reason for migrating	Current work position	Career changes	Sees Sweden as his/her future	Is positive about the future	Thinks that Sweden needs a better system for integrating IMGs
Masoud	Man	55	Kurdistan (Syria)	Romania	2007	1 year	5 year	Family reunion	Junior doctor** in family medicine (primary health care)	From ophthalmology to family doctor	yes (or EU)	ambivalent	yes
Mahid	Man	38	Somalia	Russia and Ukraine	1984	1 year (came to Sweden when he was 17.	3 years	Political refugee	Junior doctor** in family medicine (primary health care)		yes	yes	yes
Zilan	Man	36	Jordan	Greece (EU-scholarship)	2011	1 year	1 year	Labour migration	Junior doctor* in family medicine (primary health care)		yes	yes	no
Petrus	Man	58	Syria	Syria	1998	10 years	5 years	Political refugee	Specialist doctor in geriatrics (hospital)	Emergency doctor to geriatrician	yes	yes	yes
Juliana	Woman	60	Poland	Sweden	1988	10 years	not relevant	Love migration	Specialist in occupational health		yes or Poland	yes	no
Goran	Man	63	Turkmenistan (Iraq)	Russia	1987	16 years	10 years	Political refugee	Specialised in ophthalmology (hospital)	was asked to change from ophthalmology but didn't	yes	no	yes

Continue next page

[76] The table was finalised in 2013 and therefore that is the year of reference here

Hamid	Man	62	Iran	Roma-nia	ca 1990	18 years	5 year	Love migrant	Specialised in family medi-cine (private clinic)		yes	yes	no
Heba	Woman	36	Syria	Syria	2006	4 years	3 years	Political refu-gee/famil y reunifi-cation	Junior doc-tors** in anaesthesiology (hospital)		yes	yes	no
Amin	Man	57	Iran	Iran	1999	4 years	10 years	Political refugee	Specialised in orthopaedics (private clinic)		yes	no	yes
Joao	Man	45	Cuba	Cuba	1994	14 years	5 years	Political refugee	Specialised in anaesthesiology (hospital)		yes	yes	yes
Marta	Woman	56	Chile	Spain	1975	37 years	1 year	Political refugee	Specialised in geriatrics (hospital)	from surgeon to geriatrician	yes	yes	ambivalent
Tanja	Woman	35	Hunga-ry	Hunga-ry	2011	1 year	1 year	Labour migration	Junior doctor* in family medicine (private clinic)		yes	yes	ambivalent
Lajos	Man	60	Hunga-ry	Sweden	1978	About 30 years	not relevant	Political refugee	Specialised in geriatrics (hospital)		yes	yes	ambivalent
Saman	Man	38	Iraq	Iraq	2008	2 years	3 year	Political refugee /family reunifica-tion	Specialised in anaesthesiology (hospital)		yes	yes	no
Fadi	Man	37	Iraq	Iraq	2008	2 years	no license	Political refugee /family reunifica-tion	Probationary placement*** in anaesthesi-ology		yes	yes	ambivalent

* In Swedish: AT-läkare

** In Swedish ST-läkare

*** In Swedish Provtjänstgöring

Table 3 (Data display): This table displays the themes related to the how the interviewed doctors talked about professional boundary awareness, recognition and re-construction (the themes are analysed in chapter 6-8) within the Swedish medical profession. The X indicates that the themes were found in that interview.

	Boundary awareness						Boundary negotiation			Re-constructing belonging		
	Talking about a feeling of belonging to the Swedish medical profession:			Talking about this belonging as:			When the feeling of belonging (or not) to the Swedish medical profession is talked about as challenged, it is in relation to:			When the feeling of belonging (or not) to the Swedish medical profession is talked about it is related to the following resources:		
	1.Always	2.Never	3.Sometimes	4.Attainable	5. Indifferent	6. Unattainable	7. Doctors	8. Patients	9. Nurses	10. Boundary-openers	11. Being seen as 'Swedish doctors'	12. Patients with immigrant backgrounds
Masoud		X				X	X	X	X	X	X	X
Mahid		X				X				X	X	X
Zilan			X	X			X	X		X	X	X
Petrus			X	X			X	X	X		X	X
Juliana	X			X				X	X	X	X	
Goran		X				X					X	
Hamid			X		X			X	X	X	X	X
Heba			X	X				X	X	X	X	
Amin		X		X			X	X	X	X	X	X
Joao			X	X					X	X	X	
Marta			X		X		X	X	X		X	
Tanja			X		X			X	X	X	X	X
Lajos	X		X	X				X	X	X	X	X
Saman			X		X			X	X	X	X	
Fadi			X			X					X	

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Appendix 1: Interview guide

Can you tell me about your first job in Sweden?
(Kan du berätta om ditt första jobb i Sverige?)

Can you tell me something about who you are?
(Kan du berätta vem du är?)

Can you tell me about your background?
(Kan du berätta om din bakgrund?)

-Where were you born?
-Where did you get your training?
-Why did you decide to leave?

Can you tell me about the licensing process?
(Kan du berätta om legitimationsprocessen?)

Can you tell me about your work place?
(Kan du berätta om din arbetsplats?)

- Doctors
- Nurses
- Your boss

Can you tell me about situations that have been hard for you, and how you moved on?
(Kan du berätta om svåra situationer och hur du tog dig ur dem?)

Can you tell me about something that is different about working as a doctor here in Sweden compared to other places?
(Kan du berätta om någonting som är annorlunda med att jobba i Sverige jämfört med andra ställen?)