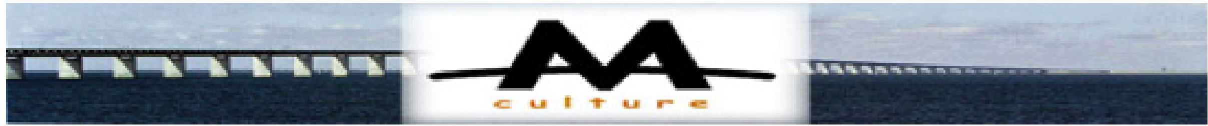

LUND UNIVERSITY

Packaging Swedish Health Care

Reciprocity, capital, identity and culture in an induction programme for foreign-trained doctors

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"In Scandinavian civilization, and in a good number of others, exchanges and contracts take place in the form of presents; in theory these are voluntary, in reality they are given and reciprocated obligatorily.“

- Marcel Mauss, 1990[1954]. *The gift*.

Abstract (English)

Packaging Swedish Health Care. Reciprocity, capital, identity and culture in an induction programme for foreign-trained doctors

Anna Franz

With a shortage of medical doctors, the functioning of the Swedish health care depends increasingly on recruitment of foreign-trained doctors (FTD). In order to facilitate the induction of FTD into the health care system, the Västra Götaland Region (VGR) in western Sweden offers a one-year induction programme, PLUS. The present research aims at examining dynamics in PLUS as an arena of meeting 'the other' and analyses how VGR packages and presents Swedish health care to foreign-trained doctors.

This research is a contribution to the discipline of Applied Cultural Analysis at Lund University in southern Sweden. It is based on three months of qualitative ethnographic fieldwork during PLUS using methods such as participant observation and semi-structured in-depth interviews. This study draws on Mauss' theory of the gift and Bourdieu's term of symbolic capital as well as the notions of identity and culture. Based on the concept of the gift, what is given, received and reciprocated in PLUS or refused to is the main theoretical question.

The results indicate that FTD perceive PLUS both as a gift by VGR but at times even as a hindrance to their career. They expect PLUS to add an external value such as a positive impact on their career, whereas managers and teachers rather highlight the internal value such as the programme's significance for participants' personal development. In terms of identity, PLUS creates a common 'we' whenever the participants are explicitely addressed as doctors. Whenever their identity as immigrants is addressed, it reinforces the gap between 'us' and 'them'. Participants often use culture to make sense of a challenging situation whereas managers rather seek technical explanations.

This thesis starts filling a knowledge gap as it is the first Swedish study and even the first applied cultural analysis of an FTD induction programme. The findings indicate areas of development for PLUS and will also benefit similar programmes in other regions or countries. Furthermore, it offers FTD a possibility of comparing and reflecting upon their experiences.

Keywords: Cultural Analysis; MACA; PLUS; foreign-trained doctors; IMG; international health personnel; qualitative methods; gift; migration; Sweden

Abstract (Deutsch)

Schwedisches Gesundheitwesen kompakt. Reziprozität, Kapital, Identität und Kultur in einem Einführungskurs für im Ausland ausgebildete Ärzte

Anna Franz

Das schwedische Gesundheitssystem ist zunehmend auf im Ausland ausgebildete Ärzte (*foreign-trained doctors*, FTD) angewiesen, um den bestehenden Ärztemangel auszugleichen. Um FTD besser in das Gesundheitssystem zu integrieren, bietet die Västra Götalandsregion (VGR) in Westschweden ein einjähriges Einführungsprogramm (PLUS) an. Die vorliegende Masterarbeit untersucht PLUS als eine Arena der Begegnung mit 'den Anderen' und analysiert, wie VGR das Schwedische Gesundheitssystem verpackt und für FTD präsentiert.

Diese Forschung entstand im Rahmen der Diszplin der Angewandten Kulturanalyse an der Universität Lund in Südschweden. Die Untersuchung basiert auf einer dreimonatigen qualitativen ethnografischen Feldforschung in PLUS mit Methoden der teilnehmenden Beobachtung sowie semi-strukturierten Tiefeninterviews. Die Analyse stützt sich auf Mauss' Gabentheorie, Bourdieus Kapitalbegriff sowie die Konzepte Kultur und Identität. Die theoretische Fragestellung basiert auf Mauss' Gabentheorie: Was wird in PLUS gegeben, empfangen und zurückgegeben – oder abgelehnt?

Die Forschung zeigt, dass die teilnehmenden Ärzte PLUS sowohl als eine Gabe von VGR als auch ein Hindernis für ihre Karriere wahrnehmen. Sie erwarten von PLUS eine externe Wertsteigerung – etwa durch bessere Karrierechancen – wohingegen Manager und Lehrer in PLUS eher den internen Wert des Programmes für die persönliche Entwicklung der Teilnehmer betonen. In Bezug auf Identität schafft PLUS ein gemeinsames 'Wir' wenn die Teilnehmer als Ärzte angesprochen werden. Wenn jedoch ihre Position als Einwanderer betont wird, vergrössert dies den gefühlten Abstand zwischen 'Uns' und 'Ihnen'. Teilnehmer nutzen häufig Kultur um erlebte Schwierigkeiten zu erklären, wohingegen Manager technische Erklärungen vorziehen.

Diese Arbeit schliesst eine Forschungslücke, da es die erste schwedische Studie sowie die erste angewandte Kulturanalyse eines Einführungsprogrammes für FTD ist. Die Ergebnisse zeigen Entwicklungspotenzial für PLUS auf und können auch ähnlichen

Programmen in anderen Ländern nützen. Des weiteren liegt hiermit eine Arbeit vor, die FTD die Möglichkeit gibt, ihre Erfahrungen zu vergleichen und darüber zu reflektieren.

Keywords: Kulturanalyse; MACA; PLUS; Auslandsausgebildete Ärzte; IMG; Internationales Pflegepersonal; Qualitative Methoden; Gabe; Migration; Schweden

Abstract (Svenska)

Att paketera svensk hälso- och sjukvård. Ömsesidighet, kapital, identitet och kultur i ett introduktionsprogram för utlandsutbildade läkare

Anna Franz

Utlandsutbildade läkare (*foreign-trained doctors*, FTD) har blivit en allt viktigare tillgång inom svensk hälso- och sjukvård och bidrar till att minska läkarbristen. För att underlätta för FTD att komma in i hälso- och sjukvårdssystemet erbjuder Västra Götalandsregionen (VGR) ett ettårig introduktionsprogram, PLUS. Denna masteruppsats undersöker PLUS som en arena för mötet med 'den andre' och analyserar hur VGR paketerar och presenterar svensk hälso- och sjukvård för FTD.

Föreliggande forskningen har skrivits inom masterprogrammet för tillämpad kulturanalys vid Lunds universitet (MACA). Undersökningen baserar sig på ett tre månader långt kvalitativt etnografiskt fältarbete med metoder som deltagande observation och semi-strukturerade djupintervjuer. Analysen använder sig av Mauss' teori om gåvan, Bourdieu's kapitalbegrepp samt begreppen kultur och identitet. Den huvudsakliga teoretiska frågeställningen bygger på Mauss' gåvoteori: Vad är det som ges, tas emot och ges tillbaka – eller avvisas – i PLUS?

Analysen visar att deltagarna ser PLUS som en gåva från VGR men också som ett hinder för karriären. De förväntar sig att PLUS ska ge möjlighet att utveckla sin karriär (ett extern värde) medan programadministratörer och lärare betonar de inre värde som finns i att deltagarna genom PLUS får möjlighet att växa som person och som läkare. När det gäller identitet så lyckas PLUS skapa ett gemensamt 'vi' när deltagarna tilltalas som läkare. När de å andra sidan tilltalas som invandrare vidgar sig avståndet mellan 'vi' och 'dem'. Deltagare använder sig ofta av kultur som förklaring för upplevda svårigheter medan programadministratörer hellre söker tekniska förklaringar.

Uppsatsen bidrar till forskningsfältet genom att vara den första svenska studien och första kulturanalysen av en introduktionskurs för FTD. Resultaten tyder på ett utvecklingspotential i PLUS och kan även bidra till utvecklingen av liknande program i andra landsting och länder. Dessutom ger arbetet FTD som grupp möjligheten att jämföra och reflektera över sina egna erfarenheter.

Keywords: Kulturanalys; MACA; PLUS; utlandsutbildade läkare; IMG; Internationell hälso-och sjukvårdspersonal; kvalitativa metoder; gåva; migration; Sverige.

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1 Introduction

It is around 8:30am on a Thursday morning and I enter the Nordic school of Public Health (NHV) in Göteborg to observe a lecture. Managers and lecturers gather in the little office on the ground floor of the historical building. They chit-chat about the weather, dying phone batteries, today's lectures and shortly complain about participants who arrive too late in class. Simultaneously, the first participants drop into the classroom a story above. They stand in a corner and chit-chat as well, sometimes in their mother tongue and often in Swedish. When the lecturer comes in at 9am, everyone picks a seat. Four participants who are somewhat older sit side by side, two others who are best friends as well. Some minutes into the lecture, the last participants stroll into the room. The lecturer talks about psychiatry and allows space for questions and discussions but they are scarse and questions are usually asked by the same few participants. Around 10:30am, all 15 participants and the lecturer go down to the entrance hall where they have *fika* (coffee break) with sandwiches, coffee and tea. The managers also mingle with participants and lecturers, offering an informal frame to ask questions or just talk. Participants from other programmes join, small groups emerge. Some participants mingle with others from a different programme, usually those who share a mother tongue. Some stand outside the building to smoke and have a bit of privacy. Then they return to the classroom. The lecture ends around lunchtime. Some participants go to a close-by restaurant to eat lunch, others stay in the classroom during the one-hour break. In the afternoon, there is *handledning* (mentoring). The group is split in two whith a mentor each and whereas one group stays in the big classroom the other leaves to a smaller meeting room where they have a discusion in an intimate atmosphere with the mentor. Some participants leave early in order to catch a bus, others stay until the mentoring ends around 4pm.

This description shows a day in PLUS – a *Program för Lärande och Utveckling i Svensk hälso- och sjukvård för utlandsutbildad personal* (programme for learning and development in Swedish health care for internationally trained personnel). Many readers will recognise the structure as it resembles other programmes – not much indicates that the inducton programme is desined for foreign-trained doctors only. The roles are well-known. Lecturers teach, managers organise and participants participate. If we take a closer look however, small differences and conflicts appear: Why do some participants show up late? Why do managers complain about it? Why are only some participants contributing with questions whereas others remain silent? In order to answer these questions, the reader needs to step beyond the description of an ordinary day and consider PLUS in terms of the gift

(Mauss, 1990[1954]). Mauss' obligations of giving, receiving and reciprocating shed light on dynamics such as consensus and agreement but even inequality and conflicts. The programme creates an arena of meeting 'the other' where Swedish managers and lecturers meet foreign-trained and in this case also foreign-born participants and vice versa.

The theory of the gift makes the reciprocity in the aforementioned scene visible: The teachers and managers give something to participants – in this case a programme with a certain structure. In turn, participants need to receive the structure in order to make it work. If they would not accept the time frame, they would refuse the gift and the structure would fail. This accounts for the occasional frustration expressed by managers and lecturers about participants who show up late. It is the act of refusing parts of the gift that upsets managers and lecturers. The reciprocity in this case consists in that most participants not only accept the time frames and breaks and show up, but actively fill in the structure and together with managers and teachers make the programme PLUS come into being.

1.1 Background

Sweden has long been aware of its rather low number of medical doctors per inhabitant. In recent years, changing demographics, a growing number of elderly patients and a high middle age among practicing medical doctors has increased this awareness. In order to maintain a high quality of health care, one of the main pillars of a welfare-state, Sweden has turned towards foreign-trained doctors[i] (FTD) to fill this shortage. This thesis is a cultural analysis of an induction course into Swedish health care offered for FTD in western Sweden.

Historically, Sweden was an emigration country until the 1930s when the number of immigrants for the first time exceeded the number of emigrants. Since then, Sweden is perceived as having generous immigration politics (Wiesbrock, 2011) but has even seen the rise of immigration-critical extreme-right voices (FN, 2015). Therefore, the increasing numbers of FTD is often a matter of debate, as they are highly desired by politicians and needed by society. At the same time, they are symptomatic of an immigration which is frowned upon by a growing number of citizens.

The flow of health workers, mostly from low- and low/middle income countries to richer countries intensified during the last decades (WHO, 2014) and raised questions of brain drain - "a situation in which many educated or professional people leave a particular place or profession and move to another one that gives them better pay or living conditions" (Merriam-Webster.com, 2015). Traditionally, health workers have migrated for better working

conditions and higher wages (Serour, 2009) but in the recent years these patterns have become more complex. These migration flows lead to a shortage of health personnel in eastern European countries which in turn is partly covered by migration from Asia and Africa. The most heavy shortage is experienced in Sub-Saharian Africa, a part of the world where health workers are needed the most (WHO, 2014). Another case is brain waste, a new term shaped around 2005 referring to the situation "when highly skilled immigrants are unable to secure employment that appropriately utilizes their education and skills" (WHO, 2014). For instance, not all foreign-trained doctors who receive a medical license get a job, and not all of those who do get a job end up staying with it.

Where lies the responsibility of the receiving country – in this case, Sweden? Sweden adopted WHO's Global Code of Practice on the International recruitment of Health Personnel (WHO, 2010) which provides ethical guidelines, such as in paragraph 4.6:

> All migrant health personnel should be offered *appropriate induction and orientation programmes* [emphasis added] that enable them to operate safely and effectively within the health system of the destination country.
> (WHO, 2010)

Even though medical knowledge is considered being transnationally valid, its national and local subcultures differ in practices, communication, laws and medical treatment. These differences are believed to be one of the reasons why many doctors drop out. In order to bridge these differences, the Västra Götaland Region (VGR) in western Sweden created PLUS. It is an attempt to improve integration of FTD into Swedish health care. PLUS is a voluntary one-year induction programme for FTD employed at a hospital or within *primärvåden* (primary health care). They work 3-4 days a week and participate in PLUS an additional 1-2 days.

The term FTD applies to three different groups. Firstly, there are doctors born and educated within the EU/EES[ii] who can generally move and work freely within the EU. This group grew rapidly during the last 20 years from 150 doctors who received their license in 1995 to around 1000 in 2011 (Agerberg, 2013a). In 2013, 50% of all licenses issued that year were issued to EU-educated doctors. A reason for this increase is that 12 new countries entered the EU between 2004-2007, which simplified the medical licence application process for students of these countries. Secondly, doctors educated in a country outside EU are called

tredjelandsläkare (third country doctors) and usually have a longer application process. From 1995 to 2013 their number varied in response to global crises between 100 to 300 per year. The third group are Swedes who chose to study medicine in another EU-country – mainly Poland, Romania and Denmark (Socialstyrelsen, 2015) and return after graduation. With 162 licenses issued in 2011, this is the smallest group, even though the number is growing. In 2013 around 3000 Swedish students were currently studying medicine in other EU countries (Socialstyrelsen, 2015).

PLUS partially follows this categorisation. After a common pilot programme, it was decided to separate three target groups: Firstly, EU-trained doctors employed as non-specialists in Sweden who are offered a language course, PLUS I. These are the doctors that this thesis is about. The second group are foreign-trained doctors employed as specialists, who also take a language course, PLUS III. Both PLUS I and PLUS III take a year to complete. The third group are Swedish citizens who studied medicine in other EU-countries, PLUS II and IV. As PLUS II and IV do not include a language course, these programmes are somewhat shorter. There is no programme aiming specifically at third-country doctors but they are not explicitely excluded either. However, at the time of my research, all doctors in PLUS I had been educated within EU.

Even though the research mainly focused on PLUS I, I had the possibility to meet the doctors from PLUS III and IV. From these meetings rose the idea of a hierarchy within PLUS, dominated by language skills and level of specialisation. The doctors in PLUS I were doubly vulnerable as they were both new to the language and to the profession or, if they had practiced before, they had less stable employments. Specialists were 'only' new to the country but stable and recognized in their profession. The Swedes who had studied outside Sweden were familiar with the language and only new to their position as doctor.[iii]

However, the term group is misleading, as the doctors in PLUS I are all individuals with different kinds of social backgrounds, some moving from a country in crisis, others moving out of curiosity or moving with the hope for better working conditions. They have different kinds of employment in Sweden, some in sequences of temporary internships, others proceeding through internship and residency on the way to becoming a specialist, some working in hospitals or *vårdcentraler* (community health centres) in large cities and others in rural areas. Some have worked decades in another country before they come to Sweden, others come directly from university. However, they are still perceived as a quite homogenous group of 'the other' by Swedish colleagues and media.

Previous cultural analytical research focused either on the integration of patients as 'the other' into Swedish health care or on the aspect of migration and its impact on foreign-trained doctors' professional identity. There is a knowledge gap concerning continuing medical education and induction programmes for FTD in Sweden. This thesis attempts to start filling this gap. The few studies that exist examine FTD programmes in Australia or Israel from a pedagogical perspective. Therefore my thesis even adds a new theoretical angle using cultural analysis. On an applied scale, the research will enable creators of PLUS and similar programmes to be aware of the programme's effects on reciprocity, capital and identity as well as its use of culture and give recommendations how the perceived gap between ”us” and ”them” within the programme and within the profession can be bridged.

1.2 Shaping PLUS

The Västra Götaland Region (VGR) started the pilot programme PLUS in 2013. Prior to this, an induction was already going on at a smaller scale. Since the early 2000s, Nenad Stankovic, *överläkare* (senior doctor), who came to Sweden from Serbia, had offered the one-week-course *Att knäcka den svenska koden* (cracking the Swedish code) in order to make pursuing a career in Sweden "less painful" in the beginning (Stankovic, 2013). The target group was medical doctors who had received their education abroad – both Swedes who had studied abroad and doctors from other countries – and was part of their formation in becoming a specialist.

Given the raising number of FTD, the *Regionstyrelsen* (regional directorate) decided in 2011 to develop a one-year regional introductory pilot programme for international health personnel (Hagqvist, 2013). The programme was developed according to *vuxenpedagogik* (adult education), constructed around the idea that participants are no students but adults and only learn when they want to and when they see a direct benefit from the learned content in their daily work. What's more, the learner takes responsibility for her own learning. That is why there were no tests or other learning assessments planned in PLUS. An exception was made for a Swedish language test to assess if participants had reached the C1-level of European Comparison.

A training form called *grupphandledning* (group reflection) builds the theoretical spine of the programme. A mentor, usually a retired medical doctor, reflects with 6-8 participants half a day per week on topics such as difficult consultations with patients, challenges in daily work, ethical questions, leadership or diversity. During the programme

that I observed, they followed a book called *professionell utveckling inom läkaryrket* (professional development in the medical profession, Andersson et al., 2012).

The other learning situations consisted of a Swedish language course, lectures, *auskultation* (internship) and some days of contextualised learning situations. The language course targeted those who did not speak Swedish as a first language and took place every other week on a Wednesday. The teacher was experienced in teaching Swedish for health care professionals and included a great deal of cultural codes and experiences from her own experience of living abroad. Lectures covered clinical subjects such as insurance medicine, psychiatry or law and took place half a day once a week before or after mentoring. *Auskultation* is an internship where the participant practices several weeks in another clinic. PLUS also included days with contextualised learning situations. There, participants either trained consultations skills live in simulations with actors and dolls or discussed and received feedback about videotaped consultations from their workplace.

The pilot programme included all groups of FTD, both Swedish citizens who studied abroad and international doctors, specialists, interns and residents. The participants had to be employed full-time in VGR during the year that the programme took place and got a leave during the one respective two days per week to travel to Gothenburg where the programme was held. Those who did not have Swedish as a first language needed to speak Swedish on a B2 level (according to the European Grading Scale) as the programme was entirely held in Swedish. Due to the dimensions of VGR, participants travelled between 30 minutes up to 3 hours one way.

During the still ongoing pilot programme, the *Regionstyrelse* decided in 2013 to start three follow-up programmes in 2014 because of the high demand. The one target group – FTD – was split into three target groups, those with Swedish as a first language and two groups of those who were no native speakers. The latter was divided into doctors employed as specialists and those training to become one. This seemed necessary because participants in the pilot programme had expressed discontent with different levels of language proficiency within the same group and different workplace situations. The programme for participants with Swedish as a first language was shortened to six months.

1.3 Aim, research question and disposition

Applied cultural analysis aims at making taken-for-granted habits and routines visible, for instance in the form of expectations towards a programme such as PLUS. Routines and

behaviour often remain unconscious but are crucial for understanding how PLUS is perceived by FTD. It is a qualitative analysis based on observations and in-depth interviews conducted during a 3-month period in 2014.

The aim of the thesis is to examine dynamics in PLUS as an arena of meeting 'the other' and find out how VGR packages Swedish health care for foreign-trained doctors. In order to address this aim, I will draw on the theoretical concept of the gift (Mauss, 1990[1954]) in order to make a reciprocity visible. The second concept is symbolic capital (Bourdieu, 2011[1986]) which serves to describe underlying processes of changes in status within this reciprocity. The terms of identity and culture complete the theoretical frame and connect the aforementioned concepts to the experience of migration and cultural differences. The following research questions are derived from the theoretical concepts which will be further outlined in chapter 3:

- *The theory of the gift:* What is given, received and reciprocated? If PLUS is regarded as the gift, what is its perceived value?
- *Symbolic capital*: How does PLUS influence managers' and participants'[iv] symbolic capital?
- *Identity*: When does the programme create a common 'we', an in-group of doctors, and when does it rather emphasize differences within the profession of doctors, between 'us' and 'them'?
- *Culture*: What role do cultural differences play in PLUS?

In order to clarify, I would like to explain who I mean by 'us' and 'them' or 'the other'. During the fieldwork, I took a position in between FTD (participants of PLUS) and managers of PLUS as I had both an insider- and an outsiderposition. I was not a doctor, however I shared a background story of coming to Sweden with FTD and could relate to their experiences as my partner is also a foreign-trained doctor. I was no manager in PLUS, but shared an office space with one of them once a week and was taken to different kinds of meetings. This in-between-ness allowed me to switch between 'us' and 'them', depending who I was talking to and I aim to represent this kind of dialogue in the analysis. When taking the position of the managers, 'the others' generally refers to FTD. When taking the position of FTD, 'them' or 'the others' refers to managers in PLUS and occasionally also Swedish colleagues. However, at times, a common 'we' as doctors is created in the programme. Then,

'the other' would refer to other groups in society, such as patients, nurses – or the researcher.

The following chapter presents selected literature on foreign-trained doctors in Sweden and other countries and chapter 3 continues by explaining the theoretical tools used in analysis. Chapter 4 presents methodological reflections about how the study was carried out in the field and the analysis. In chapter 5 the results are presented and analysed. Finally the conclusion sums up the main findings, gives indication about the applicability of the study and delineates areas for further research.

2 FTD, Culture and Health Care in Academic Literature

In this chapter, the thesis is placed into the context of previous research on FTD. This is not meant to be an exhaustive review and I selected researchers that inspired me for my study. As there are only few cultural analysts and ethnologists who research FTD, I also included literature from the fields of sociology, intercultural communication and pedagogy.

2.1 Foreign-trained doctors

Wolanik Boström's and Öhlander's ethnological studies (2011a,b,c, 2012a,b) of Polish doctors in Sweden show that the doctors feel different. The authors use Bourdieu's notions of field, capital and disposition and find that cultural markers such as emotions, professionality, gender and status are articulated or performed in different ways in Poland and Sweden. They inspired me to look at pedagogy as a cultural marker which might rise or lower participants' or teachers' capital in each other's eyes. Wolanik Boström and Öhlander further highlight the role of the researcher, as sharing a language and background story (as Wolanik Boström did) influenced the interviews. I will reflect further on my role as a researcher in the chapter on fieldwork.

In her sociological study, Salmonsson (2014) analysed sociocultural boundaries within the profession of medical doctors. Her analysis shows that FTD feel different and that both normalizing and excluding practices manifest deviation from the norm. PLUS might be such an example of a "normalizing practice" but it is multi-layered – some parts are perceived as manifesting the deviation from the norm whereas others are rather creating a new including norm, as the analysis shows. According to Salmonsson, the identity as immigrant was perceived *thicker* than the *thinner* identity as a medical doctor, as the first one was automatically assigned by society whereas the second one had to be achieved (Salmonsson, 2014). Inspired by her study, I will include identity as a theoretical concept and analyse when PLUS emphasises participants' identity as doctor or as immigrants. As Salmonsson's analysis showed, a strategy to achieve belonging was to find *boundary openers* on the inside, usually a person that is 'at home' in both cultures and can explain the subtle codes. PLUS is thought to be a boundary opener on a regional level and sometimes manages to open boundaries, whereas it sometimes rather creates new ones.

Berbyuk Lindström (2004) discovered in her study on intercultural communication in a Swedish hospital that language proficiency mattered more to Swedish health personnel than

to immigrant health personnel. A lower language proficiency was easily mistaken for a lack of knowledge by Swedish colleagues. She examined the significance of language at the workplace. In an education programme such as PLUS which includes a language course, language obviously plays a more explicit role than at the workplace. However, there can be different layers of language and Berbyuk Lindström's research inspired me to include some reflections about the meaning of communication in PLUS.

In a report about Sweden as an intercultural workplace, Swedish health personnel was shown to often lack knowledge about the immigrant colleague's culture and background (Allwood et al., 2007). PLUS aims at introducting FTD into Swedish healthcare so the knowledge seems to flow mostly into one direction. Is there some space allowed for participants' individual cultural backgrounds and are they included as a source of knowledge in PLUS? Allwood et al. claimed the need for a course mixing language classes and professional lectures. Also, real patient case studies should be taken up and videotaped consultations should be used to give feedback. Additionally, the researchers suggest that a mentor who could bridge the cultural gap would help FTD to adjust. Allwood et al. draw the conclusions based on their study done at the workplace but did not have the opportunity to examine a programme. I can start to fill this gap as PLUS corresponds to their suggestions and the analysis will offer some first insights into the programme's significance for adjustment and integration. The researchers also see a lack of awareness for different communication styles because education focused on medical consultation only. Again, this was the case in a workplace setting – how is it in an education setting such as PLUS?

Medical studies from Canada about FTD (Wong & Lohfeld, 2008; Hall, Keely, Dojeiji, Byszewki & Marks, 2004) showed, similar to Allwood et al. (2007) that the doctors need communication skills, the opportunity to practice specific skills in contextualised training situations and there is also a need to create awareness in colleagues and staff about the specific challenges that FTD face.

Morrow, Rothwell, Burford and Illing (2013) ask in their cultural study if Hofstede's (2001) cultural dimensions can help explaining difficulties that FTD experience in the UK. Hofstede explored "differences in thinking and social action that exist among members of more than 50 modern nations" (Hofstede, 2001:xix) and based his research on quantitative data collected between 1968 and 1972 at the multinational company IBM. Morrow et al. find two dimensions to be especially helpful. One of them is uncertainty avoidance (UA), the degree to which the members of a culture "feel either uncomfortable or comfortable in

unstructured situations" (Hofstede, 2001:xix). UA is used as a tool in this thesis and proves helpful in explaining differences in perspectives on education.

Even though there is a number of articles about FTD, publications about training-programmes for foreign-trained doctors are sparse. Those that do exist take a pedagogical perspective and mainly use quantitative methods. A programme to support FTD in Australia mixed contextualised learning situations with online-tools and lectures (Wright et al., 2012). The researchers found that simulations of doctor-patient encounters were appreciated most among students but the skills aquired in the programme were not automatically applied in the workplace. The findings from PLUS replicate some of these results as doctors also valuated contextualised learning situations highest. Cohen Castel et al. (2011) studied a programme for FTD in Israel and highlighted that FTD felt more comfortable in their workplace and rated themselves being more competent doctors after completion of the programme – however, their actual work performance did not improve significantly. This is an interesting finding, however, due to ethical concerns when meeting patients during fieldwork, I did not have the possibility to conduct research at participants' workplace. Still, my analysis contributes to filling a research gap of Swedish research within the field of trainings for FTD.

In the literature about trainings for foreign-trained doctors, this thesis is the first cultural analysis to my knowledge. It breaks new ground by using ethnographic methods such as participant observation and is even introducing Mauss' theory of the gift as a new theoretical concept for analysis in this field.

2.2 Culture and health care in anthropology

In cultural analysis, anthropological and ethnological research on health care, culture is often treated as cultural differences between native doctors and immigrant patients (Fioretos, 2009; Fioretos, Hansson & Nilsson, 2013; Wachtler, 2006). In her analysis of culture, class and body at a *vårdcentral* (community health centre), Fioretos points out that Swedish norms and values are seen as "normal" and other forms to organize life as "deviant from the norm", even though they should be recognized as right and equal (Fioretos, 2009; Fioretos et al., 2013). In PLUS, both Swedes and non-Swedes are doctors but there might still be a normative discourse even though they belong to the same class. Fioretos' analysis also shows that today's health care in Sweden is marked by a postcolonialistic attitude where one group has the power to decide what is right – "the norm" – and what is recognized as knowledge (Fioretos et al., 2013). Is such a postcolonialistic attitude present in PLUS?

Concerning education of doctors, Wachtler (2006) found that Swedish medical students thought cultural topics to be of lower interest in education than purely medical ones (Wachtler, 2006). This hierarchical thinking is sometimes tangible in PLUS but culture is not often made explicit. So in order to investigate how participants and teachers position culture to medicine, the analysis will use culture as a theoretical starting point.

Torsten Risør's cultural analysis (2012) of junior doctors during their first year in practice found a gap in clinical decision making between theory and practice. Borrowing his idea of a gap between theory and practice will help to illuminate similar phenomena in PLUS and their impact on the perceived value of the programme.

3 Theoretical toolbox

Cultural analysts tend to see theories not as a fixed framework to sort the material, but more freely as a toolbox where certain tools highlight different aspects, add new perspectives and help us to ask questions (Ehn & Löfgren, 2012). I will adopt this liberal approach and combine theories from the disciplines of anthropology and psychology.

The term of the gift (Mauss, 1990[1954]) is connected to the idea of giving, receiving and reciprocating and will serve as leitmotif through the analysis. Using the gift as a tool makes an implicit 'social economy' around and within PLUS visible. By describing what one would understand by reciprocity, it measures the value given to programme.

The term symbolic capital (Bourdieu, 2011[1986]) continues this analysis of PLUS as a society with its own rules. It directly relates to value and here refers to personal development of participants and how this development is recognized by structures within the Swedish health care. By studying personal and professional identity as well as identity shifts in PLUS, the effect of such a programme on the individual becomes pronounced.

Finally, the concept of culture illuminates breaking points where taken-for-granted assumptions are not met. This chapter merges the aforementioned concepts into a new theoretical frame which will then be applied in chapter 5. The selected theories will be briefly introduced and discussed more in-depth when applied in the analysis.

3.1 Shaping relations: The gift

It was a quote from one of my informants that made me initially consider the theory of the gift as a tool for analysis. In this quote – which will be analysed in chapter 5.1 – a participant complains that she feels a pressure to be *thankful* for PLUS. In order to grasp what might stand behind this thankfulness, I borrow Mauss' theory of the gift which sheds light on different layers of reciprocity in PLUS. In the following I will shortly outline Mauss' theory of the gift.

Mauss analysed the ritual of the potlatch – a ritual of exchanging gifts practiced by the indigenous people of the pacific North-West Coast of Canada and the United States (Mauss, 1990[1954]). According to Mauss, there are three obligations related to the gift: The obligation to give, the obligation to receive and the obligation to reciprocate. Failing in one results in losing one's honour or *face.* In some occasions it might even "be tantamount to declaring war" (Mauss, 1990[1954]:13). In return, giving, receiving or reciprocating a gift

"serve[s] the purpose of buying peace" (Mauss, 1990[1954]:17). The gift is not given from one person to another but always from one group or "collectivity" to another.

Mauss has been critized for not defining his term of the gift (Testard, 1998). Furthermore, his study of so-called archaic societies might not fully apply to the Swedish society under study. However, the theory of the gift helps to make obligations – felt or real – visible. In this thesis, the term 'gift' refers to something that is given from someone to someone else or perceived as creating an obligation to receive and reciprocate. This someone does not have to be a real person, it can also be an imagined entity. The gift can take many different forms, be it an action, an education or a person, as we will see in analysis. It is linked to the term of negotiation, which is slightly more outspoken as it refers to giving away something one would have preferred to keep (Andersson, 2014). The theory of the gift will help to answer the first two research questions: What is given, received and reciprocated in PLUS? What does PLUS add?

Underlying PLUS is the idea of integration in the sense of including a group that has hence been 'outside' and actively inviting them into a new situation. The theory of the gift might highlight an expected reciprocity: Inviting 'the other' to be a part of this new situation, offering or giving PLUS might entail the obligation to come and to learn what is offered – receiving – in order to better 'fit in' the Swedish health care – reciprocate. Integration in PLUS is locally bound: to a specific western Swedish health care system. It would not help much if participants decided to work in another country than Sweden. Consequently, it will be of greatest value for those participants who aim at staying in Sweden – and specifically in the Västra Götalandsregion – for a long time.

3.2 Gaining importance: Capital

Bourdieu's theory of symbolic capital can also serve as a tool to analyse the meeting with 'the other' in PLUS. Bourdieu defines capital as "accumulated labor (...), a force inscribed in the objectivity of things so that everything is not equally possible or impossible." (Bourdieu, 2011[1986]:83). The structure of the distribution of capital represents the "immanent structure of the social world" – therefore an analysis of symbolic capital can illuminate those structures. Bourdieu developed his theory in France in a context of class society. The theory aimed at making the costs and gains of passing from one class to the other visible.

Bourdieu outlines three different forms of capital: economic capital which can be

directly converted into money; cultural capital which exists in the three forms of the embodied state "in the form of long-lasting dispositions of the mind and body", the objectified state "in the form of cultural goods" such as books or pictures and the institutionalised state such as education; and social capital as the social network that backs up the individual with its "collectivity-owned capital" (Bourdieu, 2011[1986]:88). Even though Bourdieu developed the theory in France in order to explain class mobility, it can even be a helpful tool when applied to other circumstances. In the context of PLUS, I understand economic capital as the economic position of FTD in society, usually measured through their wages. As cultural capital in PLUS, I understand the internal growth of participants in PLUS and accumulation of knowledge. Lastly, by social capital, I understand the quality of the network built for instance through meeting others in PLUS. According to Bourdieu, both cultural and social capital can under certain conditions be converted into economic capital. This requires an "effort of transformation". Symbolic capital cannot always be transferred from one culture to the other and might in this case suffer from unequal "exchange rates" (Boström & Öhlander, 2012b). Finally, the value of capital is linked to culture. In a context of migration, the notion of capital will add to the idea of the gift in specifying *what* is given as PLUS happens – cultural, social or economic capital? I will study how PLUS changes the capital of different actors – teachers, managers and participants. There is a profoundly felt tension among participants between cultural and social capital – which they acknowledge that they acquire through PLUS – and economic capital which some fear that they might lose through PLUS. Among managers and teachers, the economic perspective does not matter as much. For them, it is rather a question of cultural and social capital.

3.3 Doctors and migrants: Identity

Psychological research has shown that an individual always possesses universal-, e.g. biological universal needs; shared-, e.g. learned and cultural behavior; and individual qualities such as personal traits (Hofstede, 2001). Research in immigrant psychology has shown that the behaviour, values and culture of individuals living in other – or in-between two or more – cultures cannot be explained by their home culture only (Matsumoto & Juang, 2013). Social constructivists (Alsmark, 1997) agree with psychologists that identity is something fluid, changing, depending on and shaped by the meeting with others and therefore influenced by the surrounding culture:

> Identities, which is a loose term that refers to perceived roles in life, aggregate role and life experiences, narratives, values, motives, and the conceptualisation and understanding of oneself, should be (…) more influenced by culture because these are in large part cultural constructions of the meaning and value of one's thoughts, feelings, and actions. (Matsumoto & Juang, 2013:273)

Psychologists and anthropologists have described immigrants who developed a bi- or multicultural identity, sometimes even transnational.[v] By moving to Sweden, doctors suddenly become immigrants. What happens to their professional identity? How and when does the programme manage to create a common 'we' and an 'in-group' identity of doctors and when does it rather emphasize differences between 'us' – FTD – and 'them' – Swedish doctors, here the managers and teachers of the programme? These are central questions in the identity part of analysis. Doctors moving to another country might give up parts of their previous identity and need to negotiate a new one. The analysis of identity seen through the lense of the gift will help to make the experience of gain or loss in migration visible.

3.4 Culture

Culture is a widely and broadly used term. In this chapter, I will discuss only two different aspects: Firstly, culture as a tool for cultural analysis and secondly, culture as a sharedness. Discussing the concept of culture and relating it to PLUS will help to answer the last research question: What role does culture play in the construction of the programme and how is it practiced?

3.4.1 Culture as a tool

In cultural analysis and anthropology, culture is understood as the habits and worldviews that one has learned indirectly under a longer period of social contact and that are then taken for granted (based on Ehn & Löfgren, 2012:9). As these habits are taken for granted, they usually go unnoticed. A way to study them is to find *brytpunkter* (breaking points), where everyday-life's trot is questioned and thereby our small habits are made visible (Ehn & Löfgren, 2012:30). As an outsider will usually become aware of many things that remain unnoticed for an insider, migration is a situation that generates breaking points. It questions one's own habits, makes one aware of the comparative nature of one's own identity (Mahalingam, 2013) and lets differences become visible (Wolanik Boström & Öhlander,

2012a). Immigrants can be said to take both a position of *folk anthropologists* and *informants* at the same time (Mahalingam, 2013) – because whilst discovering their own habits they equally discover the host culture's ones. Looking at PLUS through a cultural lense will tell us where its culture breaks with participants' expectations and in this way analysis shows where it differs from previously experienced learning situations.

The idea of breaking points relates to the differential concept of culture (Bauman, 1999). "Coming across cultural differences does not necessarily mean noticing them; and noticing them does not automatically imply conferring an equal existential status on contradicting ways of life" (Bauman, 1999:14). In other words, talking about cultural differences usually marks 'the other' as behaving wrong whereas oneself is seen as behaving normal and right. This judgement can be translated into symbolic capital as the same behaviour might be assigned a different capital by different persons. This happens for instance when participants criticize teachers' behaviour in PLUS as different from previous learning situations, whereas the same behaviour is highly valued by programme managers. Here the idea of reciprocity and the gift might involve telling 'the other' how to behave right in a certain situation. Receiving would mean to accept this advice and reciprocating to act accordingly. However, as both parties usually believe 'the other' to be wrong, there might be a tension as to who's turn it might be to give, receive or reciprocate.

3.4.2 Culture as sharedness

Culture is often associated with a sharedness. I used 'individuals' and 'cultures' as if they were the same thing – but how do these two concepts relate to each other? In a nutshell, scholars have adopted two positions towards culture: the idea that individuals constantly shape and thereby change culture, and the idea that culture somehow steers individuals and their behaviour. The latter is often used in cultural studies and psychology and frequently related to a geographical location or specific ethnic background.

As we constantly externalise meaning – the social manifestation of values, beliefs and expression of feelings – these meanings can and are interpreted by others (Hannerz, 1992). On one hand, people must therefore deal with others' interpretations of their externalised meanings – Hannerz calls it a distributive understanding of culture – but through their interpretations constantly shape social meanings and structures and shape thereby culture. Hannerz' term for this is interactionist understanding. He talks about the "cultural flow", emphasizing that culture is not just there: "As actors and networks of actors, they are

constantly inventing culture or maintaining it (...) A human being both possesses culture (...) and is possessed by culture, shaped by it and – to this degree – made somewhat robotlike by it" (Hannerz, 1992:17).

If we combine the perspectives of culture and the gift when looking at PLUS, the idea of a flow might imply that every participant adds his or her personal contribution to the flow of culture – giving – which might shape the programme itself – receiving – and might then make it easier for the individual to integrate and make optimal use of the content of the programme – reciprocating. Here, a friction between the individual's power to shape culture and a pressure to fit in, to 'join the flow' in the sense of accepting the structure is likely to occur.

Culture is often perceived as being shared by a group within certain borders. In culture studies, these borders are often seen in terms of national borders whereas anthropology rather looks for borders such as class, profession or ethnicity as independent from geographical borders.

The position that individuals are steered to a degree by national culture is for instance taken by Geert Hofstede (2001) who formulates his famous – and contested – metaphor of national culture as a "mental programming". He also describes culture as something that is learned during a period of *acculturation* (Hofstede, 2001; Matsumoto & Juang, 2013) and later becomes unconscious. Contrary to the metaphor of the flow, Hofstede defines culture as something stable in a country compared to other countries. Cultural change occurs approximately in the same pace as in neighboring cultures and therefore the difference between them is likely to remain the same – if no change comes from the outside through breakthroughs in technology, trade, conquest, economic or political dominance (for this concept known as cultural diffusionism see also Boas, 1940). Hofstede gathered quantitative data comparing 50 countries and 3 regions in the 1970s. From his data, he then constructed four – later five and now six – cultural dimensions that compare cultures according to certain characteristics. In each dimension, Hofstede's analysis assigns a specific score to each country, the so-called index. As previously mentioned, the concept of uncertainty avoidance – the degree to which the members of a culture "feel either uncomfortable or comfortable in unstructured situations" (Hofstede, 2001:xix) – is used in the analysis. The Uncertainty Avoidance Index (UAI) is 29 for Sweden, 65 for Germany and Lithuania, 86 for Spain and 100 for Greece, just to cite some (geert-hofstede.com, 2015). Sweden's low score means that Swedes may have a tendency to embrace uncertainty and ambiguity whereas countries such

as Germany tend to develop strategies to avoid uncertain or ambiguous situations. Do these strategies show as "breaking points" in PLUS? In which way do these country scores help in analysing the participants' and teachers' experiences?

These dimensions do not say much about a certain national culture *as such* but in *relation* to others. Therefore, Hofstede's cultural dimensions need to be understood as relative. The country scores simplify and generalize culture as something mainly existing within certain – here national – borders. However, migration blurs the borders of nations and therefore, an outside does not simply exist but is shaped and imagined as much as the inside. Still, in this quality of an imagined outside, it can help to highlight what people regard as inside. In the case of PLUS, the imagined inside is the Swedish health care system and a possible change might come from the outside in form of different medical practices.

The analysis also aims at illuminating how culture is understood and practiced during PLUS. In participants' narratives, a link between nation and culture or more specifically between ethnicity and culture is often present. As cited above, migrants take on a role as folk anthropologists and the concepts of nation and ethnicity offer a common tool of understanding cultural differences. Through these perspectives, they start forming a theory of the collective 'other' in order to make sense of frictions experienced in everyday life. It is only after understanding the collective difference that they can see differences *within the difference* such as individual, class or subcultural differences. From my own experience of living in different countries, I can often relate to country scores and dimensions. I cannot draw a clear line between these personal experiences and narratives that create or enforce stereotypes, but I believe that recounting personal experiences points to one's own cultural values and habits which are highlighted by comparison to the 'other' culture.

As mentioned before, Hannerz' metaphor of the cultural flow describes how individuals shape culture, whereas Hofstede's metaphor of "programming of the mind" describes individuals as being steered by it. I do not see these concepts as mutually exclusive – instead I believe that people do have an impact on their immediate culture but are also to a degree shaped by it, a position described for instance by Wagner (1981[1975]). Those two concepts make it possible to analyse different things: The idea of culture as "programming" may highlight a sharedness in thinking, acting and giving meaning to behaviour. Taking an approach of culture as a flow makes it in turn possible to analyse individual cultural learning processes.

3.5 Theoretical frame

The theory of the gift and especially its obligations of giving and receiving illuminate the economic character given to the programme by its actors. It connects the concepts of reciprocity, capital, identity and culture. The act of giving creates a bond between people, makes them *deal* with each other, with 'the other'. What is given, received and reciprocated in PLUS – or refused to – will be the main theoretical question. For instance, if PLUS is perceived as a gift given to participants it obliges them to give something back in return. The concept of capital provides us with the three categories economic, cultural and social to sort these actions of giving, receiveing and reciprocating. It also adds the idea that the act of giving does something to the receiver, namely gaining or losing capital. It makes the value of the gift visible. For instance, PLUS can increase cultural and social capital by creating a peer network and enable participants to better understand Swedish health care. If a gift turns out to create a higher debt – obligation to reciprocate – than it is perceived to be worth, resistance might be the outcome. Some participants think that PLUS is not as efficient as it might be and are reluctant to invest their time and effort in it. When it comes to identity, the act of migrating turns insiders into outsiders, makes them give up a part of their identity and forces them to negotiate a new one. The act of giving would consist in giving up a certain identity – in some cases the taken-for granted position as a natives – the act of receiving by the host country would consist in receiving the foreign-trained doctors and provide employment. Giving back would be to create a common 'we', a common identity of doctors through integration measures such as PLUS. Culture is related to identity through the notion of breaking points that are a part of this loss of identity. Breaking points offer – give – an awareness of what once was perceived as 'normality'. Accepting this normality as one out of many – receiving – can lead to adapting one's actions according to another normality – reciprocating. This applies to both 'others', FTD as well as managers and teachers.

4 Methodology and Fieldwork

Before entering the field, I was informed that doctors could be very busy and it might be difficult to establish an initial contact with them. My research time was limited as well: Contrary to a 'traditional' anthropologist who immerses herself in the host society for one or two years (Arnstberg, 1997), three months were scheduled for the applied research project, resembling more a "quick and dirty" ethnography done on an "in and out" basis (Czarniawska, 2007:12).

The three months included project design, fieldwork, analysis and presentation of applied results to the client. Moreover, the programme took place on Thursdays and every other Wednesday, so the time frame for observations was restricted to a maximum of two days a week. Due to this structure and the closeness of my home and the field (Ehn & Löfgren, 2012), the fieldwork had a 'hop on- hop off'-character. I could go there and come back home on the same day. So I did not immerse myself in another world but instead grasped pieces of my informants' lives in a certain period – the last three months of a one-year-programme – of a specific context – PLUS.

The limited time frame did not allow me to shadow them in other situations of their lives such as at work, during freetime, on their way to and from PLUS or at home after work except the small glimpses made during interviews. Therefore I cannot claim to having received a holistic picture of participants' lives in general. On the other hand, I got an in-depth impression of their situation in this specific time and context which still provides us with helpful insights, as analysis will show.

4.1 Finding informants

Finding informants for interviews was facilitated by the fact that the programme united fifteen representants of my target group. Participant observation during seven days – including the language course, mentoring and lectures – allowed me to get to know the participants and allowed them to getting to know me. Participant observation as a fieldwork method was on the one hand a practical opportunity to get in touch with participants, on the other hand it allowed me to experience the setting myself and, literally, do research in the participants' place. However, as I did not participate as a doctor but as a researcher, I still kept some distance and felt the need to understand the programme below its surface. That is why in-depth interviews were chosen as a second method for fieldworking. During PLUS in

classes, I observed an unequal distribution of speaking turns due to group dynamics. Therefore, individual interviews were identified as a more suitable method than focus groups in order to give each participant space to share his or her own experiences.

Of the participants in the programme, I selected 10 respondents in order to picture a variety of both initial and current geographical locations – participants from as many countries as possible who worked in different parts of the region; work environments – participants who worked within *primärvården* (primary health care – community health centres) and hospitals; work experience; age – respondents were aged 26-50+; and gender. Interviews were recorded and transcribed and notes were taken simultaneously for quicker access to the data.

The place[vi] and the time influenced the content of the interviews. Those who were held at the NHV were in general shorter. Three of them were conducted during lunch breaks in order not to prolonge participants' trip home, so the structure of the programme framed the structure of the interviews. Critical opinions were voiced more freely when the interviews took place outside NHV, but this might also have been due to participants' personal 'baggage'. Interviews took between 45 and 150 minutes.

In order to understand the programme from different angles, I conducted participant observation at *Regionkansliet* (the regional directorate) where some managers of PLUS worked on non-PLUS-days. Furthermore, in-depth interviews allowed me to get a better understanding of the structures behind PLUS. The 7 semi-structured interviews between 15 and 120 minutes were conducted with programme managers – including counsellors – and teachers – including mentors.[vii]

Finally, I was lucky to be invited to present the results of my study for the other programmes PLUS III for foreigned-trained specialists and PLUS IV for foreign-trained Swedish citizens which allowed me to compare the mood to PLUS I. PLUS II, the first programme with foreign-trained Swedish citizens, had finished by the time I held the lectures. Therefore, no observations with PLUS II are included in the thesis.

4.2 Guaranteeing anonymity

The participants came from Romania, Greece, Spain, Lithuania, Germany, Iran, Palestina, Hungary and Bulgaria. They had studied in Romania, Bulgaria, Lithuania, Italy, Spain or Germany. However, as the number of representants from each country was small, naming the cultural background in this thesis would make them identifiable. For this reason,

countries and ethnical background will not be used for analysis in order to protect anonymity and build trust. I 'sacrificed' the individual cultural background and often even age in order to gain trust and guarantee anonymity (Arnstberg, 1997:132). This limits the possible angles of analysis but also offers an opportunity in exploring culture beyond national stereotypes and pushes the researcher to find new ways of categorising. When including parts from the interviews in the analysis, I anonymised the names by assigning an English cover name to each respondent so that the cultural background would not be overly simple to reconstruct. Sometimes participants' gender has been changed. With these strategies, I also aim to focus on their identity as medical doctors in the setting of the induction programme instead of their identity as immigrants.

These difficulties in protecting identity relate to the kind of ethnography that creates them. Doing research in our time in 'our world' among 'ourselves' with informants who will be able to – and probably will – read the finalised end results lifts reflections about anonymity in the foreground (Arnstberg, 1997:146). This kind of ethnography takes away the distance that anthropologists who researched far-away cultures gained when returning home and writing it up. In such a research context, is it even possible to fully guarantee anonymity? What does this do to the material and finally to analysis? The effort to protect identities might in the end weaken analysis if it forces the researcher to take away all edges and specificities in the narratives just to make the interviewee unidentifiable. Also, the measures taken to protect anonymity might contribute to a perception of FTD as a homogenous group, as a singular 'the other', something that is not at all in line with my aims. In the worst case, it could even enforce stereotypes. Therefore, I have to strike a balance between protecting respondents' identity and protecting the singularity of narratives.

The same effort of guaranteeing anonymity applies to teachers and managers of the programme that I interviewed and observed during the fieldwork. Only around a dozen people worked with PLUS during the time of the research and they knew each other very well. In order to protect their anonymity, I chose to gather at least three persons under the same label whenever their exact position is not crucial for analysis. 'Managers' will include managers, coordinators and external consultants whereas the term 'teachers' will refer to teachers, lecturers and mentors. Managers, teachers and participants have been given the opportunity to read a draft of the manuscript and were invited to discuss the thesis. Even though some of them recognized themselves in the text, they agreed on keeping the narratives for analysis.

4.3 "Studying up" or studying "sideways"

I expected interviewing doctors to be a case of "studying up" (Nader, 1972), them being well-educated and used to be in control. When I came to the language class in PLUS on my first day of fieldwork I was still very aware of my new-ness in the field and did neither know where to sit nor what to say. Suddenly, John, an FTD, saw me. "Are you new?", he asked and gestured at the chair next to him. "Come, you can sit here." We talked and he realised I was nervous. "You don't need to be nervous, we are not Swedish.", he said and we laughed. I understood this in two ways: firstly, he knew what it meant to be new, not knowing unspoken routines or practices. Secondly, we shared a background as immigrants and this is why he and the others will be helping me. He practiced the "small personal gestures" that would make me feel welcome (Srivastava & Green 2004 cited in Allwood et al., 2007:118) such as pointing towards a chair that was empty and actively inviting me. The ambiance or *emoscape* (Ehn & Löfgren, 2012:63) was open, warm and welcoming. Here being new meant being one of them – or us? The shared backgrounds built a mutual ground for conversation and a trust credit as I later understood, which gave me access to some "backstage"-stories that they would not tell in class – the "frontstage" (Goffman, 1959). This belonging to the same community was even more pronounced by the fact that the language course used the same book as a Komvux-SAS course (Swedish as second language) that I had taken earlier this year. So instead of 'just' being an observer I was turned into a very participant observer in this situation and slipped into the role of a student, encouraged by the language teacher who treated me as one.

The "studying up" in my case went smoothly because I rather studied "sideways" as Czarniawska (2007) calls it. The shared identity as immigrants was *thicker* than their identity as a doctor or mine as a researcher (Salmonsson 2014). Afterwards, the language course turned out to be a beneficial entrance moment as their identity as medical doctors became more pronounced in other settings such as the mentoring or lectures, where I as a researcher would have been in a position of "studying up". But it also brought problems concerning my professionality as a researcher (Boström & Öhlander, 2011b) in an almost auto-ethnographic field: How much was it me, the immigrant, that was doing the research and how much was it me, the researcher, that happened to have the same background? Wolanik Boström and Öhlander observed that Wolanik Boström's interviews had a tendency to be longer and produce more generalisations – *Swedes* are like this – whereas Öhlander's interviews, who did not share the same background with participants, were shorter and more nuanced to a degree

– they acted like this in *x-hospital*. Did my interviews thus have a tendency to be *culturalised*? Participants might have been afraid that blaming culture for problems might have been taken as an offense by a Swedish researcher. But towards me as a German, blaming the Swedish culture for experienced difficulties was unproblematic as it did not present any offense. Indeed, culture or a different cultural background often served as an explanation for situations experienced as problematic in interviews with participants. However, it was not only Swedish culture but cultural differences in general that were described as challenging by participants.

4.4 Doing analysis and researcher subjectivity

Those days of fieldwork and interviews gave me access to a rich material consisting of field diary, interview records, transcriptions and official documents. An advantage of the semi-structured nature of the interviews was that the content was flexible and allowed for many individual perspectives. The rich material provided me with an in-depth impression of each foreign-trained doctor's, manager's or teacher's situation, background, worldviews and values. On the other hand, access to such a body meant having to select. I based the categorization of the material on an emic approach by selecting topics that seemed important to informants and especially FTD. In a second stage, the final selection of narratives was steered by theories. In short, I do not discuss all topics that were important to informants, but all topics discussed in this thesis were important to informants. The descriptive, empirical and exploratory approach that I take in the analysis allows to grasp feelings, moods and a specific situation but can only be generalised to a certain point as it is based on singular experiences.

Quotes cited in the text are translated from Swedish and edited for better readability. This always implies an interpretation by the researcher and includes the danger that changing the way and the language things were said in will also change the final meaning of it. On the other hand the translation further anonymises informants as the specific words they chose are exchanged for words in another language. Choosing a specific quote always implies an action by the reseracher. Therefore they might tell the reader as much about my own background as about the actual context (Risør, 2012). On a larger scale, all words in this text might be loaded with more subjective connotations of the reader(s) than I as a researcher can be fully aware of. Throughout the text, the author and readers should ask: What image is created by using certain words to describe situations and persons? Is it the author's or the reader's subjectivity that influences how a word is perceived in a given context?

5 Results and analysis

This chapter presents an analysis of the selected empirical material. Firstly, the theory of the gift will serve to show the relation between FTD, their superiors, VGR and PLUS. Secondly, PLUS will be analysed as an arena of meeting 'the other'. Thirdly, the different learning situations are looked at through the lenses of identity and culture. Last but not least the perspective is broadened and the analysis is placed in time and space and in a national and international context.

5.1 Giving and receiving – reciprocity or imbalance?

In the following, I will analyse the relation between FTD, their superiors (heads of practices or senior doctors), VGR and managers and teachers at PLUS through the lense of giving and receiving.

5.1.1 Being thankful – PLUS as a gift?

> What do I get that I can apply? But you get a lot. So they have this attitude, you should be thankful for this. And I don't like it. They should be thankful that I came to Sweden, studied their language and work within their health care system. They should be thankful, not us.
>
> (Mary, participant, October 17, 2014)

It was this quote by Mary that actually made me consider the theory of the gift in the first place after only a few weeks in the fieldwork process. People expect being *thanked* for a gift or a favor. Giving a gift is a way of putting someone else into the position to receive and reciprocate. If looking at the acronym PLUS, it means adding a value that is above zero and evokes giving something more than one would expect. What do we discover when we look at PLUS as a gift? Is there a plus in PLUS?

Mary's quote points at an imbalance between what is given and received. It also expresses a confusion about who's turn it is to give back. She uses the pronoun "they" to create a distance between herself and 'the others', here managers and teachers in PLUS. In Mary's eyes, the three stages of the gift are completed: She came to Sweden, gave them their workforce, they received her and now they reciprocate by giving PLUS. However, from the manager's and teachers' perspective, the triad of the gift has just started: They gave them PLUS and expect Mary to thankfully receive it. Yet, there is no outspoken reciprocity in

Mary's quote yet, but I will elaborate on this later on. Mary refuses to be thankful and thereby refuses the gift. According to Mauss as partly cited previously, (1990[1954]:13), "to refuse to give, to fail to invite, just as to refuse to accept, is tantamount to declaring war; it is to reject the bond of alliance and commonality." (p. 13) Even if Mary did not declare war to PLUS, she refuses to nourish the bond of mutual obligations that might lead to friendship between her and 'them'. Thus, if PLUS was a present, it would have failed its mission in this case: "The goal [of giving presents] is above all a moral one, the object being to foster friendly feelings between the two persons in question, and if the exercise failed to do so, everything has failed." (Mauss, 1990[1954]:19)

Mary's rejection could even be rooted in a fear to reciprocate: In case PLUS was seen as the start of the the triad of the gift, it would indeed be Mary's turn to give something back. But Mary is part of PLUS I, whose participants stand lower in the hierarchy of doctors compared to PLUS II or IV – who are Swedish and know how to navigate in society – and PLUS III – specialists recognized as such in their profession[viii]. As doctors under formation and persons from another country PLUS I-participants are neither fully recognized in their profession nor feeling at home in Sweden. This double vulnerability might make Mary especially suspicious of the gift. In her work at a charity organisation, anthropologist Mary Douglas observed that "the recipient does not like the giver, however cheerful he be" (Douglas, 1990, in Mauss, 1990[1954]). The participant Mary might simply be afraid of the *return costs*. What would it mean for her to be thankful? What more would 'they' demand in return?

Apparently, managers *told* Mary to be thankful. According to Mauss, one should not voice what one expects in return of a gift. By making it explicit, one breaks the honor of the other. Maybe this is what Mary actually rejects: that she is not given the opportunity to decide herself what would be an appropriate gift in return. Being thankful does not appear to be a suitable way of reciprocating for her. Mary rejects that she feels 'forced' into the role of being thankful, that the reciprocity is already decided upon in advance and she has to play that role in order to 'fit in' if she wants to protect the bond of the gift.

As Mary's quote shows, there is a tension that PLUS as a gift creates between VGR and participants. But PLUS might even be perceived as a gift from VGR to the community health centres and clinics in the region, as Ann's quote illustrates:

Ann: Do you know that the hospitals get a lot of money from the region?

Researcher: How do you mean?

Ann: [laughs a little] So for every PLUS-participant, the clinic gets a certain sum from VGR (...)

Researcher: Hm?

Ann: Which is a large sum compared to our salary. (...) But if it is like that, I don't understand why not more clinics send participants? (...)

Researcher: And what would it mean that the clinic gets money when you take PLUS?

Ann: That they can exploit those persons who don't want to go, force them.
(Ann, participant, October 28, 2014)

Ann's quote describes a second layer of gift giving in PLUS but this time, participants are not the receiver but the gift. In her narrative, VGR gives something to heads of practices and clinics: money. They receive it and give participants back. To Ann, the value of PLUS itself does not seem to justify the sending of participants as reciprocating. In her eyes, her own workforce is worth more than the programme. That is why she looks for something that would be given on top of PLUS to the heads of clinics or practices, something possessing enough value to make them send participants. For her, money could be that something and would explain her superior's behaviour (but the question of money will not be discussed here further).

In the same interview, Ann explained that she felt forced to take PLUS even though the programme was presented as 'voluntary'. In her case, voluntary just meant that she was selected for the programme and not all FTD in her clinic 'had' to go. It did not imply that she had the choice to say no. The voluntaryness applied rather to her superior who could select who to send to PLUS but not to Ann. This reminds of Mauss' introduction to *The Gift* (1990[1954]:3): "In [ancient] Scandinavian civilisation, and in a good number of others, exchanges and contracts take place in the form of presents; in theory these are voluntary, in reality they are given and reciprocated obligatorily“. This underlines that PLUS is not always a gift to participants but sometimes goes over participants' heads and is instead directed at their superiors.

An aim of PLUS is to finally increase retention when the participant perceives the

bond as strong enough to stay. But as long as participants perceive PLUS as creating and enforcing bonds between other actors and not with themselves, they will not be more likely to stay in the region. On an applied scale, if VGR aims to increase retention, it might be a good idea to focus more on the bond created between VGR and participants. Participants should be regarded as *customers* of the programme and treated as such. When they perceive the programme as being aimed at them, a gift for them, they will come up with suitable ways of giving back – instead of refusing to receive or to reciprocate because they feel forced into a role that they do not agree with.

In short, if we use Mauss' theory of the gift as a tool for analysis, the relational perspective becomes pronounced. VGR attempts through PLUS to create two bonds at a time: On the one hand, a stronger bond with participants so that they will eventually stay and work in the region, and on the other hand, a stronger bond with heads of practices and community health centres. At the time of the study, it seemed that the bond with heads of practices and community health centres was sometimes prioritized before the bond with participants. In this other layer of giving, the participants become the gift, reciprocated from their superiors to PLUS.

5.1.2 Changing things – PLUS as capital

For managers and teachers, PLUS can also be described in a way of stepping up or down, increasing or decreasing capital (Bourdieu, 2011[1986]). As Bengt, one of the managers explained, their hope when they started PLUS was to change

> (...) things on an individual level, that people work better and like it better, and maybe, a problem that we have with those doctors is that many disappear. They are recruited, come, and leave again after a very short time. There is an example where a dozen doctors had been recruited to an emergency unit and I think two are still there, the others disappeared because they did not succeed in adapting to the Swedish health care system. So using the recruitments in a more effective way. And another point is increased patient safety. When these doctors come and got their education from somewhere else, they need to learn hands-on things such as how do we handle antibiotics to limit antibiotic resistencies.
>
> (Bengt, manager, October 29, 2014)

In terms of capital, the manager would like to see the doctors' professional, cultural and social capital improved – that they work better and like it better – in order to improve retention. This would in turn increase social and economic capital for Västra Götaland as a

region because they can offer better health care services and spend less of their budget for recruitments. VGR competes with other Swedish regions about competency and highly-skilled individuals such as doctors. Increasing retention would in this case mean increasing economic capital as less money needs to be spent on recruitment. It would also increase VGR's cultural capital by having more doctors that understand the health care system. Finally, it would even increase social capital because its health care might work better than neighboring regions in terms of patient safety.

But this capital increases in the long term. In the short term, PLUS causes a loss of economic capital as it costs the region money to run the programme, provide location and pay lectures, teachers and managers. It also makes the heads of practices and clinics lose professional and economic capital as they pay a fee for an employee's place in the programme and lose a full-time working medical doctor 1-2 days a week.

Even though Bengt does not employ the term, it is also a question of integration which is in this case understood as "adapting to Swedish health care". In Bengt's reasoning, the doctors leave because they could not adapt to the Swedish system – not because the Swedish system did not adapt to them. Integration is seen as the doctors' responsibility – maybe as an obligation of reciprocating and a way of giving back? PLUS is seen as a tool to help participants adapt and to make them "like it better". The idea of adaptation also includes the notion of becoming alike and of joining in. PLUS can thus also be seen as a tool to combat social exclusion and segregation.

In Bengt's narrative, this adaptation is a question of hands-on issues such as antibiotic resistencies. Doing it the Swedish way aims at increasing patient safety which is a goal that every doctor would agree on. Patient safety implies that the doctor knows how to navigate the system and possesses the skills to do so.

On an individual level, PLUS even offers something else for the retired medical doctors that work as group mentors: a second career path.

> When a doctor (...) retires, we want to offer them a way of giving back. We thought, the last years as senior doctor or distriktsläkare (district doctor), you might do a bit of mentoring here and then it is okay that you might not have the energy to keep up the same fast pace with treating patients as you used to when you were younger. (...) As a way of coping and not having to get pensioned early.
>
> (Maja, manager, October 29, 2014)

Maja's quote points towards another layer of giving within PLUS. Retirement is not perceived as something desireable but as something that one should try to resist as long as possible. PLUS thus offers a transit period, a way of smoothing the change from a full-time job to a full-time retirement. Retiring means losing a part of one's economic capital, social capital – as one suddenly loses the social position of being a practicing doctor – and a part of one's identity. PLUS thus offers them a possibility to continue being a doctor without being a doctor in the sense of not working with patients. The mentors that were interviewed highly appreciated the possibility of having a meaningful task some days a week, so the mentoring was a way to increase social and economic capital for them. However, as will be shown later, being a doctor was not always the role they assigned themselves in PLUS.

5.1.3 Working too good or not good enough – PLUS as stigma?

How is the way of handling PLUS perceived by FTD and what meaning is given to it? "My friend did not go to PLUS. He was too good [*duktig*] at work", said Olivia, a participant. In turn, do superiors select those doctors for PLUS who do not perform well enough at the workplace? PLUS is promoted as a programme that *turns* participants into more able doctors. In conclusion, those who are already perceived as able doctors by superiors are not always sent to take PLUS – even though they might still profit from it and might not feel as able themselves. On the other hand, several doctors who feel that they are able to do good work might be perceived differently by their superiors and 'sent' to PLUS against their will (some participants call that "being forced"), which is the case for around half of the participants in PLUS I. For them, it meant exchanging the identity of an *able* doctor against being a doctor *under construction.* They are even stigmaticed twice: firstly, having a different education which is not as much 'worth' as a Swedish one, and secondly, being pointed out as those who do not perform 'well enough'.

In which way would PLUS benefit them *in the end?* "What do I get on paper?" was a question often taken up during interviews. They asked for a visible proof for their efforts – the inner development was not perceived to be *enough*. Participants might have learned a lot, but in which way was this competence recognized by superiors and authorities? How did superiors *use* PLUS? If a foreign-trained doctor who was employed as an intern was sent to PLUS, it often prolonged the time until she would get the ST-contract (*specialisttjänstgöring* – residency) and could start specialist education 'on paper', as in the case of Erin. She was promised an ST-contract after completing a language course, but afterwards her superior had

already registered her for PLUS and postponed the ST-contract, saying that she would get it after having completed PLUS. Erin had worked as ST in another city before taking on her current job, so this waiting for the ST-contract was like being evaluated 'down' by her superiors, being forced to step back instead of stepping forward and losing capital instead of gaining it. In exchange, she got to work closer to her family but still perceived this waiting time as too long. Participants sometimes experienced that PLUS was used as a tool by their superiors to keep their salary lower for another year in comparison to some colleagues' salary, who did not take PLUS. Even though they understood the inconvenience of their 1-2 days absence per week from work, it created a feeling of being treated unfairly.

Borrowing the term from Mol, we can regard PLUS as something *fluid* (Mol, 2010) that is defined and re-defined by the significance attributed to it by its users. Some superiors send participants that function less well at work, thus giving the programme a slight meaning of a stigma of not performing well enough or of sticking out in a negative way. Some superiors use PLUS as a tool in order to turn less well performing doctors into better ones. Others promise an ST-employment after completion of PLUS, the ST-employment taking on the form of a reward. On the way there, PLUS is turned into the last hindrance before 'deserving' ST-status. However, not all superiors use PLUS in this way. Some participants are already employed as ST. Some FTD participate because they wanted to and not because they were forced. Some are already perceived as performing well and in these cases, PLUS might actually be seen as a reward for performance. These multiple meanings given to PLUS might be a topic for further research.

5.1.4 Trust – Imagined relationships

Even though teachers and managers emphasized that "what is said in PLUS stays in PLUS", some participants doubted this. They feared that a manager or teacher might talk "behind their backs" with their superiours which might cost them their jobs, in case their performance in PLUS was not "good enough". There was also a rumour that some FTD had lost their job after completing the pilot programme, which participants understood as a direct consequence of PLUS and which nourished their fears. For many, the experience of being without a job was relatively fresh and some working conditions were perceived as unstable which made the option of losing the job seem possible. The fact that PLUS lacked tests or other performance control measures further nourished this fear. Participants could never be sure of how they were doing or wether or not they reached the learning goals set by the

programme because there were no checks except for the final language test. In terms of capital, some participants feared losing economic capital – the job – and thereby also losing social capital – their position as a medical doctor.

This doubt was especially expressed prior to a meeting in November 2014. The managers invited the heads of clinics and *vårdcentraler* (community health centres) in order to spread information about PLUS. As the meeting approached, participants asked frequently: What will they talk about? They asked me, as an 'insider' because I was allowed in certain meetings and shared some office space with a manager once a week. I was not able to give them an answer because whenever the managers talked about the meeting, they focused on practical questions such as the number of attendants. Some participants doubted that managers would only spread information about the programme and feared that they would comment on participants' performance instead.

This reminds of an example with a different topic but a similar structure: the case of the electric company as described in Sunderland and Denny (2007:178). Consumers feared that electricity from microwaves and electric cables might cause diseases. The electric company provided statistics and numbers proving that they did not, but consumers' fears did not decrease. Sunderland and Denny's conclusion can equally be applied to PLUS: Apparently, the provided information "bypassed [participants'] beliefs about electric companies, beliefs framed by assumptions customers made about big business, monopolies, and the government, and crucially, about the assumed relationship between them." (Sunderland & Denny, 2007:178). What beliefs do participants express about the organisation behind PLUS, about a governmental organisation or the government in general?

The research shows that not all participants trust the programme managers which might have to do with their personal experience made with authorities and with Swedish 'honesty'. Participants come to Sweden with an image of Swedes being generally honest and trustworthy and processes being transparent and fair. This image is created by research such as the World Values Survey (Wave 7, 2010-2014) where the results present Swedes as having high confidence in government and think that "most people can be trusted". Sweden stands out as an especially trustworthy and trusted country in contrast to countries where PLUS-participants come from, such as Germany, Romania or Spain. In most other European countries, people report trusting the government and each other less than in Sweden. So a participant might move to Sweden with the expectation of meeting a trustworthy government and trustworthy people. However, this attitude might easily be shaken by personal negative

experiences during immigration: A participant reported that Swedish authorities forgot to send her medical licence which forced her to return to her home country before coming back to Sweden. In her story, 'forgot' bears quotation marks which underlines that she understood it as an unwillingness to receive her in Sweden and an action that made her feel unwelcome. Such experiences can create new mistrust towards the Swedish government which might spread to PLUS for instance in the case of the meeting with heads of clinics and community health centres, as PLUS might be perceived as a regional representation of the government. Do they *really* do what they say they do, is the underlying question. Or do they just say they are different from "our" government but *in reality* they are just the same? A respondent recounted his partner's difficulties of finding a job and concluded that the job-seeking process in Sweden is not as transparent as 'they' officially say and there are still many things that happen "behind our backs". Just that "at home, we know the rules" contrary to here in Sweden. This leads to a more pronounced feeling of otherness and enforces a felt difference between 'us' and 'them', a feeling that Swedes generally might trust people but only those who are like them. Not 'us' because 'we' are different.

5.1.5 Entrance or Exit?

PLUS is supposed to be a *vägen in* (entrance) to VGR, Swedish work culture and health care system, an 'entrance' to a routine. Certainly, it is an entrance into a social network, rising the social capital of participants – one of the few aspects that all agree on. Meeting others in a similar situation with similar experiences and problems meant being *the norm* for one day in the week, not 'the other', and allowed building a social network, as Mary illustrates: "It was so nice to meet my friends, they are my friends now, and we have a lot of fun together. We have interesting discussions and can talk about everything."

But on the level of cultural and economic capital, some participants were afraid that PLUS would rather be an exit than an entrance, more minus than 'plus', as we saw previously in the discussion on PLUS as a stigma (5.1.3).

An aspect of losing capital was the fact that PLUS, by the time the research was done, was not included in the traditional medical post-graduation education (internship or residency). It was not perceived as a natural or inevitable step on the way up in one's career. The registration sheet for PLUS contains a clause stating that PLUS takes precedence over other education. For participants, this meant that they were not supposed to take medical education courses for their specialist education during the time of PLUS. This was partly due

to the fact that the target group of this programme was in diverse employment situations and managers did not want to exclude participants with temporary internships by 'only' admitting ST-doctors (residents). But mainly it was due to demands from the workplace that the doctor should not be away more than one or two days a week. This created confusion in the beginning of the programme. Some participants thought that the learning situations from PLUS such as consultation training would directly count for their ST-education. When they found out that they did not, the perceived value of PLUS dropped significantly. It was perceived as "losing one year" or a "waste of time". Even though participants recognized that they learned a lot – internal value – they were doubting in which way PLUS would help them to advance in their career – external value. Here, the symbolic character of the capital becomes pronounced as the internal personal development is not at once convertable to cultural, social or later economic capital and reminds of the notion of *exchange rates* (Wolanik Boström & Öhlander, 2012b). They employ the term when comparing the value of cultural markers in Poland and Sweden. The way a cultural marker, for instance gender is performed in Poland might have a different connotation in Sweden. It might suffer from – or gain value through – an exchange rate. In the case of PLUS, the notion of exchange rate shall illustrate that a participant might have acquired a certain knowledge but is not always able to apply it or to make it recognised externally in everyday life.

Concerning the question of the 5 years, the managers of PLUS stressed that the ST-education was aim-led, not time-led. As soon as a doctor shows that she masters a certain task, it can be 'ticked off' from the requirements. Before, this was bound to a certain time – usually five years – but had been changed recently so that it now depended on competence and skills. However, the time '5 years' was still a measurement in the participants' heads and even in the heads of many education coordinators at the workplace. No matter how often managers and teachers explained the concept of aim-led education, the perception of PLUS as a "waste of one year" in practical career terms had not changed when I interviewed the participants – even though participants had understood it in theory. This misunderstanding is also based on mistrust, on a doubt from participants if "they do as they say they do" in PLUS and sometimes perceived as "playing with words". Especially during the time that PLUS was not yet fully established, recognized signs of FTD's progress and ensurance that the programme was an integrated part of their specialist education would have been important for trust-building. But the crucial part is *recognized:* These signs should be recognized by the relevant authorities – their bosses, "the system", potential future employers – in order to

validate the value of PLUS.

The perception of the programme varied from participant to participant. Peter for instance was satisfied with the programme: "I got information from the right person in the right time in the right place". For him, taking the programme raised his personal and cultural capital. Another participant expressed that he was sad that the programme would have to end because he appreciated the structure that the programme gave to the week. So, PLUS even added a capital per week. A week with PLUS would have a greater value than a week without. However, if PLUS eventually also increases participants' performance at work and finally improves the quality of care given to the patient are questions which remain for further research. Fieldwork requires ethical approval as soon as it involves contact with patients. As this is no common procedure for a master's thesis in Sweden, I could not conduct fieldwork at participants' workplaces. Therefore, these questions are here left for future researchers to explore.

In terms of capital (Bourdieu, 2011[1986]), the programme plays an important role in raising social capital by building a peer network. The participants recognized the learning effect of PLUS in general and gained cultural and social capital by being able to feel more comfortable at work and aquire better language skills. On the other hand, some were afraid of losing economic capital as the benefit for the career were not immediately visible. If we understand integration in terms of risen capital, we can conclude that it helped social and cultural integration but can improve its impact on economic integration.

5.2 Meeting 'the other'

In the following, I will point towards PLUS as an arena for meeting 'the other' – firstly, through words. Secondly, participants meet an 'other' pedagogy in PLUS that breaks with many of their previous experiences. Thirdly, the idea of a 'Swedish' health care is examined and the chapter ends with a case study of a discussion about integration.

5.2.1 A reality constructed by words?

How do managers and teachers talk about, perceive and negotiate between participants' identity as a doctor and identity as an immigrant? Everyone has to be employed in order to qualify for PLUS, so the identity as doctors is a condition for the programme. The managers considered this indeed: "We don't call it education, we call it a programme", Maja

says because it shall be different from university and more like the training days that doctors take at work. "We don't call them students, we call them participants", is in line with this professional approach. However, in practice, the programme still feels like school in many aspects such as the structure of the lectures, design of the classrooms and content of the language course. According to some participants, it is 'like' school. Some state that they enjoy PLUS *because* they liked going to school, others expect mentors and teachers to act *like* their teachers at university. This points towards a gap between desired and lived reality.

The managers, who themselves are medical doctors, make a point in calling the participants "our colleagues" and thereby formally recognize their identity as doctors. However, the underlying assumption – the mere condition of participating in the programme – is that these doctors are 'different' by their education, even though they are colleagues. The emphasis of the 'we' masks – but not erases – a profoundly felt distance between 'us' and 'them' and turns the programme into a platform of meeting 'the other'. Jens, one of the Swedish managers, wondered: "If we were to be as open-minded and accepting as we like to present ourselves, why is a programme such as PLUS needed? Who are we if foreign-trained doctors need a course to become 'like us'?" He regards PLUS critically as a normalizing practice, trying to align different norms and behaviours with accepted, perceived as normal ones. Normalizing, similar to excluding practices further reinforce the immigrant doctor's identity as being "different" (Salmonsson, 2014). Cultural differences are treated as a technical problem for performance, "as an obstacle to economic rationality and effectiveness. It then becomes a question of controlling or bypassing culture so that 'it' does not obstruct rational plans or intentions" (Alvesson, 2012: 9).

To summarise, there is sometimes a gap between talking and enacting. Even though managers emphasize that PLUS is not a school and participants are not students, the setting and the expected relation between participants and teachers remind of a school or university. Similarly, even though managers talk about FTD as "our colleagues", FTD often emphasize the difference between 'us' and 'them'. Calling them "colleagues" thereby challenges participants' trust in managers because their lived reality differs from the described one.

5.2.2 Pedagogy as culture

PLUS is supposed to be a place where professionals learn what they want and need. The programme is based on *vuxenpedagogik* (adult education) which is rooted in values such as self-efficacy, motivation and taking responsibility for one's learning. It is described as

modern, contrasted to methods seen as 'old-school' such as *korvstoppning* (learning-by-rote). PLUS is not meant to give the doctors a 'cookbook' about how to be a successful doctor in Sweden, instead it encourages reflections, reasoning, discussions and speaking one's mind. The managers thereby distance themselves – and the programme – from cultural training courses that offer 'cookbook' advices based on an incomplete view of what culture means and focusing on do's and don'ts. These trainings are widely used within business and highly criticized by academia as enforcing stereotypes. PLUS is supposed to be a more sophisticated, more technical and less stereotyping course.

The managers and teachers emphasise that the doctors are adults, professionals and not students. They do not make it a cultural question but instead juxtapose 'old school' and 'modern' pedagogy methods. By stressing this, they give the participants credit in form of cultural and social capital – acknowledging their education and position as medical doctors – and even express a respect for participants' status as adults. However, considering the idea that the norm is never named (Sunderland & Denny, 2007), emphasizing the identity of participants as 'grown ups' might even more point towards their identity as students in this educational setting. Similarly, it might point towards the experience of PLUS as school in line with the reflection in chapter 4 where participating in the language course made me immediately slip into the role of a student.

"Here I get direct answers", says Erin, who works at a community health centre, and compared with her workplace: "When I ask my colleagues, they are nice and explain a lot and talk for a long time. But I do not get the answer I need." This behaviour of talking around the answer has been described by Allwood et al. (2007) and Wolanik Boström and Öhlander (2011) as a 'typically Swedish' way of communicating. It manifests itself *in comparison to* another behaviour such as getting direct, short, easy-to-understand answers. However, those who give answers in PLUS are also Swedish, but might be more aware of differences in communication. Ideally, both participants and teachers might learn from each other to build a 'communication bridge'. Even though the answers given in PLUS might be direct, the teaching style was not: many participants expressed criticism about the 'easy-going' structure of PLUS, with no tests except a final language assessment and no pressure, as Victor, one of the younger doctors describes:

> If you have studied in other countries, there is a lot of pressure all the time. Here, they are nicer, but I feel it could be good with a little bit more pressure, then we would get more out of a one-year-course, because one year is a long time.
>
> (Victor, participant, November 27, 2014)

And his colleague Erin adds: "I believe that lectures could be a bit more 'orthodox', with ten minutes questions in the end, otherwise the lecturer does not have time for the rest of the presentation." This tackles a problem of group dynamics that occurs with interactive structure of lectures: some people may ask many questions so that the lecturer needs to reduce the content of the lecture. These expectations were rooted in the routine, in the culture of having a lecture that participants have learned to value and handle. They valued the possibility to express themselves but asked for a slightly tighter grip, a bit more pressure not to get lost. Some even requested tests to make sure that the content of lectures was learned and not just went in one ear and out the other.

The participants unconsciously placed the task of learning the content at the level of the programme. They expect to receive content from the teachers, who in turn expect participants to learn individually. Both parties expect the other to give in the first place, thus there is a confusion who's turn it is to recieve.

If a concern with the structure of the lectures was expressed, it became even more pronounced in mentoring. Participants were eager to explain and take up their own medical cases and expected the mentor as 'experienced doctor' to guide them and provide helpful tips. However, as this was something that Rikard, one of the mentors, did not feel comfortable doing, he often avoided giving clear guidance and rather sent the question back in a loop around the group. This strategy created frustration in some participants, as they perceived it as "going round and round and not leading anywhere", because the other FTD did not have more experience with similar patient cases and therefore could 'only' come with suggestions but no guidance.

This structure and preferences are on the one hand due to Rikard's background: During a meeting with managers and teachers, he explained that he saw his role not as a *doctor* but as a *mentor*. For him, it meant that Swedish language proficiency should be in the foreground, not medical knowledge. The language can then be used as a tool to discuss medical professionalism. This positioning was important to him, as he was a retired specialist and felt unsure whether or not he would be able to answer medical questions about general medicine, where most participants worked. He distanced medical knowledge from medical professionalism. According to him, the first one would be transnational and can be taught, whereas the latter one refers to the national enactments of the role of the doctor and has to be learned.

On the other hand, it is in line with the pedagogical perspective of PLUS – adult

education – which shall not be a course where "participants are fed with facts" but rather an open discussion. The frustration expressed by participants who experience this form of pedagogy is surprisingly consistent with Hofstede's (2001) findings. As mentioned previously, he developed among others the cultural dimension of uncertainty avoidance, defined as the degree to which the members of a culture "feel either uncomfortable or comfortable in unstructured situations" (Hofstede, 2001:xix) and developed an uncertainty avoidance index (UAI) by comparing countries with each other. He described differences concerning education in countries with low (such as Sweden) and higher (such as the countries where PLUS-participants came from) UAI:

> When uncertainty avoidance is relatively strong (such as in France or Germany), both students and teachers favor structured learning situations with precise objectives, detailed assignments, and strict timetables. They like situations in which there is one correct answer that they can find. They expect to be rewarded for accuracy. When uncertainty avoidance is weaker (such as in Britain or Sweden), both students and teachers despise structure. They like open-ended learning situations with vague objectives, broad assignments, and no timetables at all. The suggestion that there can be only one correct answer is taboo with them. (...) Students from high-UAI countries expect their teachers to be the experts who have all the answers. (...) Students in these countries will not, as a rule, voice intellectual disagreement with their teachers. (...) Intellectual disagreement in academic matters is interpreted as personal disloyalty. (Hofstede, 2001:162)

The quote mirrors firstly the participant's demand for clear answers and for the mentor as an expert who is expected to know 'the right answer' and secondly the mentor's partial refusal of this role. By refusing from meeting participant's expectations, the mentor 'forces' them to enter a new *acculturation process* (*kulturell läroprocess*, Ehn & Löfgren, 2012) by learning a new role of being a student. In this case, PLUS does not facilitate participants' everyday-life but complicates it in the beginning by adding this new *acculturation process* – additionally to living and working in Sweden now also being a participant in PLUS. As we saw above, the strategies that participants brought to the programme from previous experiences did not work here, as being a student in PLUS was different from being a student

at university or being a doctor at work. However, the loose structure of the programme also served as buffer at the same time, making the PLUS-day a day of relaxing for some, of stepping out of the stressing workplace. For others, even if the day itself was relaxing, it was also demanding with several hours travelling to and from the programme and having to catch up with administration the day after.

Migration makes cultural differences between countries visible (Wolanik Boström & Öhlander, 2011c). Especially cultural differences that surface in the pedagogy proved to be the key to some of the frustration described by many participants. They perceived the programme as going too slowly, not giving enough content and not putting enough pressure. Participants had simply different expectations of how a course was supposed to be, compared with managers' and teachers' approach. Many of these differing expectations can be accounted for by the cultural dimension of uncertainty avoidance (Hofstede, 2001).

5.2.3 Preparing for a 'Swedish' health care?

> In a course [not PLUS], I learned that you should always ask questions in Sweden when you are not sure about something. They said, you can never know everything, and Swedes get afraid if a doctor does not ask from time to time. So I started asking my boss about things, but he was from Germany and said, Why do you ask? Can you not look that up on your own? Look it up. So I looked things up but what you find in books is not always applicable to the situation.
>
> (Olivia, participant, November 01, 2014)

Olivia's example illustrates that there is no such thing as a 'Swedish' health care, as migration of health care professionals involves migration of practices. In PLUS, I also heard mentors and teachers emphasize the importance of asking questions by defining it as something accepted and expected. Is PLUS preparing the doctors for an imaginary 'Swedish workplace' or is it preparing them for reality? In this case, PLUS is not mirroring a Swedish health care system but actively *producing* one. This might be rooted in an "anxiety of incompleteness" when the "threat" of the minority, diverging from the imagined norm of health care practices, hinders the majority of being "complete" and might even serve to reduce "social uncertainty", a striving towards certainty (Appadurai, 2006). It is an attempt to achieve control over the *how* of medicine, order being at stake. The anxiety of incompleteness also appears in other parts of society as Sweden and Europe in general experience a rise of xenophobic ideas, politics and violence. This growing xenophobia might result in an

increasing fear of 'the other'.

Olivia attributed the doctor's behaviour to his cultural background. When I took up this story with some PLUS-managers, they exclaimed instead: "What a bad leader he was!" They did not see the boss' reaction as cultural but as a question of good or bad leadership. By turning it into leadership, it became negotiable and apparently rational, even though the idea of a 'good' leader is as much culturally constituted as the idea of asking questions and showing weaknesses.

5.2.4 What is integration?

After completing the internship, I was offered to present my results to PLUS IV, Swedish doctors who had studied abroad and returned to Sweden to work. I was also supposed to talk about how it is to come to a new culture. The participants in this group had experienced how it was to live in another country during their studies, and many also remembered how it was to come to Sweden because many had immigrated to Sweden during their childhood.

Rikard the mentor also participated in the lecture and asked how long it would take until someone was completely assimilated? After how many generations would nothing be left from the "home culture"? One of the participants countered: "But Rikard, assimilation is outdated. We don't talk about assimilation anymore." Rikard reacted by telling a story about Swedish emigrants in the US who, according to him, had "nothing Swedish" left in their culture.

This situation tells us that in the mentor's world, assimilation is the goal of integration, getting as much alike the 'prototype' of the new culture as possible. He sees it as a process determined by time and generations – if we wait long enough, this person/ this group will assimilate. This was a position adopted in Swedish politics in the 70s and 80s (Ehn, et al., 1993) and supported by scholars of that time but the concept itself stems from the beginning of the 20th century (Mahalingam, 2013). "Assimilation was expected to be a one-way process that would also be natural and evolutionary" (Mahalingam, 2013:4) and an immigrant could be culturally – adopting habits, clothes, values and cultural markers of the host culture; or structurally – "taken up and encorporated" in the host society's politics, education and politics – assimilated. However, assimilation proved to be an imperfect concept to explain the process that immigrants undergo, as many did not fully assimilate but developed bi- or transcultural identities instead, involving more than one nation, more than one culture and more than one

set of values (Mahalingam, 2013).

If we look at integration through the lense of the gift, we see that it moved towards a certain reciprocity: Whereas in the beginning, the receiving country saw the act of receiving immigrants as the gift, and the obligation to reciprocate was adaptation, it is more balanced nowadays and reminds more of a negotiation: Both parties have to give away something that they had preferred to keep – the country has to give up the control of an imagined uniformity, a national culture, whereas the immigrant has to give up some habits but can keep others. The notion of negotiation highlights what is given *in order to* get. It completes the concept of the gift as a negotiation does not pretend to be free – the notion of getting something back is always present. In the situation described in PLUS, Rikard's question threatened to pose a new obligation on the participant, namely having to become even more 'Swedish'. The participant rejects this idea by highlighting that there is no such obligation anymore: He has already given back *enough*.

5.3 PLUS – Packaging means splitting up?

PLUS is a way of packaging Swedish health care into a one-year programme. It needs to split up the 'whole' of Swedish health care into smaller parts which can be treated separately. In the following part, I will take a closer look at the different learning situations within PLUS. The leading question is how culture is enacted and practiced. The concepts of capital and gift will help to analyse the observations.

Managers often use stories of how different behaviour rooted in culture creates problems at work to illustrate the importance of PLUS for the workplace. Still, when looking at the schedule for lectures, there are topics such as leadership, assurance medicine, psychiatry, law, medicinal products or patient-centreed care. Not once can the word 'culture' be found in the schedule nor in flyers used to promote PLUS. Sweden has been described as a country that sees it as taboo to talk about culture and seeks answers instead in individual qualities or technical aspects (Ehn et al., 1993). This negating attitude towards culture is illustrated by the following quote from Mark, one of the managers:

> Something we took up that is very important are medicinal products, for instance. Someone from Gothenburg University came and talked [about it]. Also patient safety, infection control, even if you have worked as a medical doctor for a long time things change, and infection control in Greece or Romania is totally different from how it is in Sweden, so it is very, very important.
>
> (Mark, manager, September 29, 2014)

Mark focuses on facts, things that 'simply are like this' and emphasizes that it is "very important" to know about them. Here, he links knowledge to time and space: The longer you work the more you know, is the underlying hypothesis that Mark counters with referring to the need of continuing medical education, because "things change".

Also, space or here geographical location matters, which is presented as a matter of fact and nothing cultural or negotiable. Differences are just to be accepted. This structure of turning cultural patterns and behaviours into rational and negotiable topics by renaming them surfaces more than once.

PLUS is packaged as a rational, research-based "best practice", similar to the observations made in the Swedish Kindergarten, where immigrant's adaptation to Sweden was not presented primarily as a cultural withdrawal from their own ethnic origin and background, but rather as a *technical* matter of welfare, laws, rights and obligations and acceptable living conditions (Ehn et al., 1993: 251). In a multiethnic society, potential cultural tensions about how one should live and think can vent themselves when the majority's culture becomes the same as 'satisfaction of essential needs'. Minority cultures, in contrast, are turned into fixed ideas to take into account and maybe even show interest in (Ehn et al., 1993: 251).

The focus of the lectures lies on medical 'facts', however, the awareness of culture and cultural codes is present in the minds of the managers of the programme, as Maja explains:

> This [cultural codes] was the main theme of Nenad's course [the 1-week-course that served as a base for PLUS]. And we have this as a main thought in PLUS as well, I think that the language teacher takes up many things in the language classes. And the mentors discuss it a lot as well, like if I say this or that to a nurse it may go wrong and then they discuss it.
>
> (Maja, manager, October 29, 2014)

So Maja links culture to language and communication and places it outside the 'pure medical' knowledge, consistent with the attitude that Wachtler's (2006) found with medical students even though, in PLUS, it is the managers and not the students who adapt this attitude.

In short, culture as such is described as one of the main pillars of the programmes, namely how cultural codes and practices differ between Sweden and other countries. In practice, these cultural codes are not always part of the programme.

5.3.1 Language course

The language classes were accepted by participants as a matter of course. It was also obvious for teachers that language had to be a central part of the programme, as colleagues see limited linguistic understanding as a major problem (Berbyuk Lindström, 2004). The required language proficiency for doctors had been successively risen over the past years. Why? If patients have the right to get consultation in their mother tongue, why can doctors not also give consultations in their mother tongue? What would be a situation when a doctor is allowed an interpreter?

In PLUS, Kristina, the language teacher took up many 'cultural codes'. During a lesson I observed, she treated the chapter *typiskt svenskt* (typically Swedish) of *Språkporten* (Åström, 2012), the course book. The texts described for instance observations and interpretations of Swedish girls making eye contact and smiling to strangers out of friendliness, not attraction; values such as *lagom* which means not too much not too little; *jantelagen* – do not think that you are better than others; and traditions such as celebrating midsummer. At some point, Kristina explained how one can give an order in Sweden:

> *Kristina: When a colleague asks 'kan du ta det här (could you take that)', it's most of the time not a question, but an order and means that you better do quickly what he said.*
> *John: [laughs] Really? Oh! I should have known that earlier! I always say, 'No, I don't have time now, I will do that later'.* (A. Franz, edited fieldnotes, Language course PLUS I on September 17, 2014)

This narrative illuminates that not only language but the interpretation of language is culturally constituted. The question "*Kan du ta det här*?" (could you take this/do this) is not naturally recognizable as an order. It has to be interpreted as such and depends on learned codes such as what it means to be friendly. In linguistical terms, this rather indirect communication style is also a way to mask hierarchy as it frames the order as a question or suggestion. It puts the decision seemingly in John's hands which he had misunderstood as actually having the power to decide.

Kristina had a long experience of living in other countries and shared many of her thoughts and experiences with the participants. When I interviewed her, she told me about how it was to live abroad, being the stranger and the white. She is not afraid of giving simple

and hands-on advices where she can and because of her cultural experience, participants accept her advices at once and with a laughter. Before the summer holidays, she taught the participants how to hug "the Swedish way", not too long, not too short, not too tight, not too loose. And certainly no "Spanish kiss on the cheek". The managers like this cultural story of the hugging-lesson and tell it often, always making the audience laugh in surprise that something so basic can become so important.

During the language class that I observed and participated in, I sensed that I easily slipped into the identity of a student. But during the afternoon that day, a change occured. The doctors moved to the computer room where they were supposed to work individually with online-tasks of a distance-course while Kristina would call them out one by one to give feedback on a written text from the previous week.

The distance course consisted of writing several official documents that they were confronted with everyday – *remisser och brev* (referral letters). The ambiance changed. The doctors started working on their tasks, individually and all in their own speed. I sat next to Julian who said that he enjoyed these hands-on tasks, even though in practice the medical secretaries wrote the referral letters and he only dictated them. Whenever he did not know the right terms or what medicine to recommend, he searched in some online-databases with a routine and professionality that told me that he was used to do this from work. In this computer room, the professional identity got pronounced. Suddenly the focus shifted from *foreign-trained* to *medical doctors*.

To summarise, the language teacher drew from her own rich experience from living abroad, gave examples and explained the 'Swedish culture' to participants. Her examples of how 'Swedes do it' were accepted in class. Culture was often seen and treated as understanding communication codes, which was highly valued by FTD as it allowed them to grasp and understand their everyday-life better. In terms of identity, both the identity as an immigrant or rather as a student and the one as a medical doctor was addressed – the first by using the same coursebook as a other Swedish language-course, the second one in the distance course when training to write referral letters.

5.3.2 Mentoring

Maja, the manager, said that mentors talk a lot about cultural codes – how was it in practice? As described previously, Rikard did not see his role as a doctor but as a mentor and described his main goal as improving FTD's language proficiency, "making them talk

Swedish" and discuss and improve soft skills in being a doctor. Where is culture in this context? What did Rikard understand as culture? The following is an edited excerpt from my fieldnotes from a day in mentoring:

> *Rikard tells about his weekend. He went to a musical about Swedish emigrants who left the country with the hope for a better life in the US and said that it made him think about the participants. The ambiance becomes weird. He says that the musical was written by one of the former members of the pop-group ABBA and asks, do you know ABBA? Of course! Replies a participant. Everyone knows ABBA!* (A. Franz, field notes, November 06, 2014)

What happened here? Telling the story, Rikard also expressed indirectly how he sees the participants: as emigrants/immigrants who are in Sweden in order to get a better life. Not as doctors in the first place.

By asking if they know ABBA, he shows an awareness that music that "everyone knows" in one society might be bound to geographical or national borders – however, the participant rejects this border by saying "everyone knows ABBA". Whereas the mentor is aware of possible borders, the participant highlights and demands the absence of them. The mentor's story assigns an identity as immigrants to the participants, whereas the participant's reaction rejects this identity and repositions them as belonging to the all-including group "everyone".

But culture is also enacted in another way, similar to the language course, as communication:

> *One day in mentoring, Lisa complained about the quality and quantity of mentoring at her workplace as doctors in internship and residency have a right to a certain number of hours mentoring at their workplace. She asked what she should say during the upcoming meeting with her superior. Here Rikard became very specific and advised her not to say that 'you don't get any mentoring at all', because this sounded negative and would put the superior into a defensive position. Instead, it would be better to say that 'you would like to increase the time of mentoring in the future' as this sounded more positive.* (A. Franz, field notes, November 06, 2014*)*

As we see, where Rikard feels capable, he gives hands-on advices. The first approach – saying directly that you do not get any mentoring at all – expresses a more direct communication style, whereas the second one expresses the same thought in a more indirect way. The first one is also en amplification of emotion – frustration in this case – whereas the second one is downplaying it. It is even a way of *saving face*, not directly confronting the other with an obvious oversight or even breaking the rules framed by the employment contract. This situation prevents a potential offense and reminds of a description of Swedes as "conflict-avoidant" (Daun, 1989). Even in this case, it was not a question of culture but framed as a question of communication: how to complain 'nicely' and positively without offending the other.

This practical communication advice rises Lisa's cultural capital: If she remembers and applies the advice and the superior understands the clues and receives her complaint, she will be able to ask for more mentoring in a way perceived as nice, non-offensive and respectful – in return, if she fails to do so, she might be perceived as rude and the superior might become reluctant to adjust the time of mentoring.

However, what is perceived as 'nice' varies between cultures and it might not always be as important to be 'nice' as in Sweden. By employing seemingly universal categories such as positive or nice, the cultural context is masked. Furthermore, framing the advice as positive marks other ways of complaining as negative or rude. In terms of negotiation, Lisa gets a hands-on advice but might sacrifice the feeling of having made her point as this might have required a more direct complaint.

In the sessions of mentoring that I observed, culture was a topic seldom directly addressed, but cultural values where often announced as ethical instead. Whenever a mentor tried to force a discussion about ethics for instance about homosexuality or transgenders, asking FTD to share their opinions or cultural values with the group and enable a discussion, few people spoke up. When FTD said something, it was in line with 'good Swedish reasoning' such as 'everyone has the same values' and 'homosexuality is a human right'. There were hardly any diverging opinions expressed so discussion in general went very slow. However, as soon as it was linked to solving a patient case, discussion exploded. This reminds again of Hofstede's (2001) high uncertainty avoidance, where disagreeing with a teacher might be interpreted as disloyalty and therefore participants' choice of not discussing might thus simply be a sign of respect. It also underlines how cautious participants are to not actively position themselves as 'others'.

In general, participants expected from mentors to be doctors in the first hand. Language was nothing explicitely focused on during sessions but rather used as a basic means of communication, even though the mentor mentions that it is important to "make everyone talk Swedish". Participants emphasized the uniting link between them and the mentor through emphasizing and appealing to Rikard's 'doctor identity'. Participants strove after creating a 'we', a common identity as doctors, in order to feel belonging. But as soon as the mentor focused more on culture or ethics, he emphasized his own *Swedishness* and emphasized the participants *otherness*. In those moments, some participants refuse to accept Rikard's advices and even refuse to give back and participate. On an applied scale, focusing deliberately on the medical cases during mentoring would allow participants and mentors to align and put emphasis on their common background instead of striking differences. This was the position and task that participants demanded. On a structural scale, feedback on medical performance was supposed to be given by the individual personal workplace mentor, but as Lisa's case showed, the quality and quantity of mentoring differed.

5.3.3 Lectures

One Thursday in October. I observe a lecture with Karin, an experienced psychiatrist. She asks the participants which disease they mainly associate with neuropsychiatry. After some minutes, she gathers the responses of the participants, who mention for instance bipolar disorders or schizophrenia. Then Karin explains that two of the main diseases usually associated with neuropsychiatry in Sweden are ADHD and autism.
(A. Franz, field notes, October 23rd, 2015)

The participants' examples from the country where they worked before serve to show the bredth of possible interpretations and practices within a single discipline. The swedish way of defining the discipline is then placed against this tableau of 'other' possible interpretations. The choices made in the Swedish health care system were not presented as one of possible alternatives but as a fact, as a 'here we do it like this'. How does it feel if a pattern of reasoning resulting in a flow of practices, that might have been learned over years of working as a doctor, suddenly does not 'work' anymore? Does the *technicality* facilitate to change behaviour?

> Sometimes it feels as if they want to teach us ethics and moral principles that they are maybe not the most appropriate (*bäst lämpad*) persons to do, as Swedes, I mean. They might not be the most ethical and moral society that ever existed. There were some courses where one got a bit upset, because one felt a bit like a child, you got told off. (...) They had these kind of questions and [pause] I like everything [pause] that contributes to making this culture and this person unique, I'm always interested in how things work but I don't try to change them. And not, why do you drink tea with sugar or without sugar? I just think it's interesting to take sugar. But they try to change that, indirectly. They say, well, *we* do not take sugar in our tea. (...) But I'm talking about medical things right now.
> (Ann, participant, October 28, 2014)

Ann uses a metaphor to describe and illustrate how she sometimes feels in the course. I interviewed her prior to the observed lecture, so it is no direct comment about the scene described above. Ann felt *threatened* in her own way of doing things, she felt *told off*. What she wished for was not only receiving information about how things are done 'here' but also a genuine interest for her background and an acceptance for her doing things differently. Sweden presents both a promise of a better life and a threat of her identity (Ehn et al., 1993). Even though she also criticizes her home country for the working conditions, it is also a symbol for home, warmth and friends. She felt that those positive feelings relating to her home country lacked both a place and space in PLUS, only the better sides of Sweden being emphasized as for instance expressed in the wish that someone would show genuine interest in *why* she was doing as she does.

Apparently, being told to do differently threatens her identity as a doctor, emphasizes her identity as an immigrant and causes resistance. She questions the ability of the lecturers to tell her "what to do" in their identity of "Swedes" – the content is *culturalised*. Her reasoning seems to be based on an assumption in line with what Ehn and Löfgren (2012) define as culture, a set of habits and values that usually go *unnoticed;* those who usually do not notice these habits – here, Swedes – might in fact not be the best to explain them to non-Swedes. She would be more willing to accept advice from someone who has made the journey herself, someone who discovered and de-coded 'health care' in Sweden coming from the outside. She perceived an in-group identity of immigrants or people having lived abroad as opposed to the group of 'Swedes'. However, this culturalising could also be due to my identity as a researcher and 'fellow immigrant' which might have influenced the content of the interview.

Even if managers preferred not to talk about culture and turn it into technical questions instead, FTD still used culture as an explanation for many things. Ignoring or

downplaying culture as a reason thus limited understanding of FTD's reasoning and sense-making of everyday-life. Ann also criticized this attitude as superior, as in "might not be the most ethical or moral society that exists", an attempt to *change* her values, her inner belief of right and wrong or moral and immoral.

From the side of teachers and managers, there is at times limited understanding for ways of doing things differently – in Sweden. "You cannot go around in Sweden and treat patients as you might do in Romania or Greece" is a sentence that I encountered in different situations. Things just work differently here. The notion of 'here' is presented as normality and different from practices in other parts of the world. Of course, health care *is* in some way different from health care in Romania, Germany and Greece, this being one of the reasons why some of the doctors wanted to work in Sweden. But it is presented as an absolute fact, ignoring that by employing doctors from Greece or Romania, some of the practices might enter Sweden, as health care is nothing ever stable but influenced by individual practices and routines. This is consistent with Hofstede's (2001) theory that cultural change comes from the outside, here through migration of practices. As I pointed out before, PLUS is trying to shape a future ideal Swedish health care, reducing the multiplicity of practices that exist today.

On the other hand, adaptation to a new environment would be facilitated when one knows what one should adapt to (Mahalingam, 2013). And in order to "act otherwise" means being able to intervene in the world (Giddens, 1984). By telling the participants how one would be supposed to act (think, behave), the teachers gave the participants the chance to "act otherwise" and "intervene in the world". They offer them the possibility of choice. PLUS displays the structure of Swedish health care and getting to know this structure can be both constraining and enabling (Giddens, 1984). Ann's example illustrates the constrains of this structure, but she might also discover and value the enabling nature of it later – this is what managers hope for when they say that even though participants might be critical towards the programme as it happens, they might recognize its value at a later stage.

To summarise, in lectures, cultural differences are occasionally used to paint a multicoloured background in contrast to the Swedish customs. Otherwise, they focus on clinical practice which again is a cultural practice, just not explicitely named as such. Framing the Swedish practice as the 'normal' way runs the risk of making some participants feel patronised when they experience that their expertise is questioned.

What does the analysis tell us about the role of doctors in the workplace? They are surrounded by a system of invisible rules, which are attempted to be made more visible

through PLUS. The programme is therefore in a way following a tradition of 'packaging culture' or packaging Swedish healthcare' by translating the unspoken rules and practices into tangible topics and pressing it into the specific form of a programme in a certain time and situation. The form of the programme puts immigrant doctors in a position to be "told what to do", how to improve efficiency at work. The analysis shows a hierarchy of knowledge, reminding of colonialist thinking when Europeans could decide which knowledge was regarded valuable (Fioretos et al., 2013). If we turn the question around, would doctors from Sweden receive a 1-year-education programme when going abroad or would they rather take their knowledge with them and tell the "natives" what to do – in a context of *Médecins sans Frontières*, for instance? The local Swedish knowledge and practice is treated as having the highest status, other knowledge and practices ranked below it on different levels. As we see with Finnish and Dutch doctors taking part in the 'Swedish' programme, their knowledge and practice is apparently rated as not as 'divergent' as those with an education from Romania or Spain – so they are allowed to participate in a shorter course together with Swedish citizens who studied abroad). Again, this hierarchy of knowledge is closely related to language and how fast people from different countries can learn Swedish – and to a perceived cultural closeness of Dutchmen or Finns with Swedes. This 'cultural closeness' is consistent with findings of comparative cultural studies (Hofstede, 2001) where the Netherlands, Finland, Denmark, Norway and Sweden are often clustered together.

5.3.4 Other moments

PLUS even included *auskultation* (4 weeks internship in another clinic or community health centre) which I did not include in analysis as I could not observe doctors in their workplace. Additionally, a few days of consultation-training were scheduled where a doctor-patient-encounter was simulated in a workplace-like setting. As I was not able to observe any of those, I cannot include them in my further analysis. However, the interviews with participants indicated that these were the moments that they appreciated most – probably because their identity as doctors was most pronounced in these work-like situations.

5.4 Outlook

In the following, I will lift the analytical gaze from the specific programme PLUS I and take a look around. The perspective is broadened and the analysis is placed in time and space and in a national and international context.

5.4.1 PLUS in time and space

The analysis focused on EU-educated medical doctors employed as non-specialists who are believed to need more education in Swedish. What about the other groups, PLUS III, EU-educated medical doctors employed as specialists; and PLUS IV, Swedish citizens who studied in other EU-countries? How much is my analysis anchored in time and social space with PLUS I being the first programme after the pilot group? Presenting and discussing the results of the applied research to those other groups allowed me to get a quick glance at the ambiance or *emoscape* (Ehn & Löfgren, 2012: 63).

In PLUS III, specialists expressed less worries about PLUS' influence on their future career – logically, as they had already reached the 'top', being specialists, recognized as such by the system and safely employed. Some expressed a feeling of PLUS as a welcomed opportunity to learn. Once one is employed as a specialist in Sweden, there is no education comparable to internship or residency training. Therefore, it did not feel like "losing one year" for them, as there was nothing left to win. Also, specialists were slightly older and most of them had family and children who had moved with them to Sweden and could offer support at home. Taking up the influence that age has on psychological troubles during a move (Mahalingam, 2013), they probably did not feel as threatened neither in their personal nor in their professional identity.

In PLUS IV, the programme with Swedish citizens who had studied in EU and moved back to Sweden to work – and two Dutch and a Finnish doctor who also were part of the group – the mood was also different. As we saw previously in the discussion about assimilation, a participant criticized the mentors' statement. The discussion about the goal of integration went freely. This differed from the carefully expressed and framed opinions in the mentor-groups of PLUS I. Participants in PLUS IV did criticize their mentor openly. They were not afraid of negative consequences as they believed that there would not be any, because they had been *acculturated* into a system where voicing critique in a constructive way was seen as desirable. Even though they could at times perceive the programme as "going slowly", they appreciated the possibility to learn. A majority had also come to the programme voluntarily. This shows in which way the analysis is rooted in time: When the Swedish students started the programme, many of them had already talked to colleagues or friends who had been to PLUS and could tell them what to expect. Also, being the fifth group, they were already greeted by a routine[ix]. Additionally, they occupied a different position in social space and did not feel as 'alienated' as the participants of PLUS I. Most of

them came back to the country where they had grown up, which meant that they were also familiar with the *vuxenpedagogik* teaching style in PLUS.

As I did not have the opportunity to interview them individually, both group pressure and social desirability are likely to have influenced the impression I got. However, the different moods that lead to an impression of hierarchy were tangible. Swedish language proficiency assigned a higher hierarchy to participants than less language proficiency. Also, specialists were perceived to stand higher than non-specialists. On top of the hierarchy are Swedish-trained non-specialists and Swedish-trained specialists but they are not included in PLUS. Further research of those groups would be desirable as their different hierarchy is likely to influence their perception of PLUS. Third-country doctors are also not included in the research. In order to prevent brain waste in this group, further research should examine their experiences.

5.4.2 Why doctors?

Initially, PLUS was destined for other groups in society as well such as dentists or nurses. However, only doctors can sign up for it until today. What is special about doctors?

As national statistic reports show, the shortage of nurses is less pronounced than doctors and the percentage of foreign-trained personnel is lower. 22.8% of doctors are foreign-trained compared to 8,9% of nurses (WHO, 2014). This is on the one hand due to the high education and complex tasks that nurses take over in Sweden so that emigration of Swedish nurses to other European countries is easy in terms of education but immigration is harder. Furthermore, the number of nurses graduating per year fills more or less the general need (Socialstyrelsen, 2015).

The number of foreign-trained dentists is with 10% also much smaller than doctors – 6% outside EU and 4% within EU (Socialstyrelsen, 2015). Therefore, offering the training opportunity to doctors in the first place might have been a matter of numbers, having an easier time of recruiting the sufficient number of participants for the pilot and later the following programmes. Moreover, the managers were also medical doctors whith a personal network which made it easier to recruit colleagues as teachers and reach out to participants.

Furthermore, health care together with education is one of the pillars of the Swedish welfare state, doctors being the symbols and representatives of this sector towards patients. In this role, they are indirectly a sign for a well-functioning – or failing – state. They hold a higher symbolic value than dentists and nurses. Maybe, this is a reason why an "anxiety of

incompleteness" and an uncertainty towards a multiplicity of practices of doctors becomes especially pronounced, resulting in the attempt to align practices in order to create a better Swedish health care.

5.4.3 PLUS as a local practice in an international context

On a local level, PLUS presents a competitive advantage for VGR compared to other regions, trying to get a head start in the competition about skilled doctors in a situation of shortage. Moreover, if the programme increases retention in the long run, it would offer an economic advantage as less money needs to be spent on recruitemement.

In a national context where Swedish and international media describe Sweden as a country that struggles to integrate highly skilled immigrants (Arrius & Edström, 2015; Coen, Faller & Sussebach, 2014), PLUS is an important step showing that 'we are actually doing something'. With reports on increasing segregation (Hübinette, Hörnfeldt, Farahani & Rosales, 2012; Örstadius, 2015), PLUS is also an attempt to create a communication platform and build a bridge across this gap, encouraging meeting 'the other'. On a European level, Appadurai (2006) mentions the "two Europes" existing next to each other: the multiculturalist and the "anxious xenophobic". PLUS includes something of both: It is on the one hand an embrace of multiculturalism, an attempt to receive international doctors with open arms and smoothen the entrance procedure for them. At the same time, it is also a manifestation of, even though I would not call it xenophobia – Appadurai refers to violence and this is definitely not the case here – a fear of and frowning upon different practices.

On a global level, PLUS is a way of taking responsibility in the brain drain and brain waste debate, offering continuing medical education for FTD so that they will live happier, work better and last longer and be able to use their brain fully and as soon as possible. However, it does not target those 'wasted brains' of doctors who end up in lower-skilled professions, as the requirement for taking the programme is being employed as a medical doctor. This is taking advantage of the doctors who are already there and avoid actively recruiting and encouraging brain drain. However, some doctors are reported quitting work after a short time because of a burnout and in this case would 'go to waste'. If PLUS succeeds in smoothening their entrance to Swedish health care it might actually prevent these cases of brain waste.

6 Conclusion

In order to summarise the findings, it is time to return to the research question as stated in the introduction.

- *The theory of the gift:* What is given, received and reciprocated? If PLUS is regarded as the gift, what is its perceived value?

In terms of mutual obligations, PLUS might be a double gift: Firstly, from the region to its health care, in return receiving participants. Secondly, from the region to its doctors, in return enabling them to use the Swedish system more efficiently. Thus, there is both an altruistic and an economic interest. On a national level, PLUS presents a competitive advantage for VGR compared to other regions as it facilitates 'using' the resource of highly-skilled doctors from the European labor market who are already employed in Sweden. It allows VGR to spend less money on recruitment if retention is increased. Ultimately, it aims at improving the quality of health care.

The cultural analysis shows that the perceived value of such a programme differs between managers and participants. Whereas managers value the content itself – *internal value* – participants stress the importance of signs that prove the content's value for their future career – *external value*. FTD especially appreciate training that emphasizes their professional identity as doctors but also seek communication advices in their identity of a *foreign-trained* doctor.

- *Symbolic capital:* How does PLUS influence managers' and participants'i symbolic capital?

For participants, the act of shaping togetherness is central in the experience of PLUS. In terms of capital, PLUS played a crucial role in raising social capital by connecting participants to a peer network and also raised their cultural capital by education. However, in this group during the time of the study, it did not help to increase short-term economic capital as some participants were payed less than peers who did not take the programme.

PLUS actually adds a plus in symbolic capital for Sweden on the European and even global labor market. In times when national resources do not cover the needs, making better use of FTD is a possible strategy even though it comes with responsibility for global challenges such as brain drain and brain waste. Ensuring appropriate induction for FTD who work already within the country is one way of taking responsibility in this debate.

- *Identity:* When does the programme create a common 'we', an in-group of doctors, and

when does it rather emphasize differences within the profession of doctors, between 'us' and 'them'?

In PLUS, some learning situations emphasised FTD's identity as doctors whereas other emphasised their identity as immigrants. In general, FTD are more eager to learn when their identity as a doctor is addressed. The programme creates a common 'we' whenever the participants are explicitely addressed as doctors – whenever their identity as immigrants is addressed, it reinforces the gap between 'us' and 'them'. An exception is the language course, which does address the participants in their identity of immigrants. However, because the language teacher also positions herself as a former immigrant, it still creates a common 'we'.

- *Culture:* What role do cultural differences play in PLUS?

Participants learned through their experience of migration to culturalise their surroundings. Culture often serves as an explication for experienced challenges. This differs from the approach of managers who prefer other explanations when trying to solve problematic situations, framing it as a question of for instance leadership instead. Culture is perceived by managers as an inhibitor to performance which PLUS shall eliminate. Even though culture is described as a pillar in the construction of the programme, it is not always outspoken in practice. Instead, medical practice is framed as a *technical* question of differences in laws, insurances and medicinal products. An exception is the language course where the teacher, who herself has an experience of living abroad, includes many hands-on advices which are welcomed by FTD.

Additionally, creating such a programme means creating a new acculturation process, participants being unfamiliar with the *vuxenpedagogisk* pedagogy used and at times interprete it as time-consuming. In general, FTD see the responsibility for their learning in teachers, whereas teachers and managers see the responsibility for the learning in participants.

Furthermore, the analysis can even offer a first glimpse of PLUS' significance for adjustment and integration. Integration can take different forms. If we understand it in terms of risen capital, we can conclude that it helped social and cultural integration but can improve its impact on economic integration. Integration in terms of a stronger bond between VGR and participants has a potential to be improved. Integration as becoming included in a group is partially fulfilled, as PLUS creates a common group of FTD. Often, it even includes FTD into a common 'we' of doctors but here is also a potential for development. To a degree, PLUS might work as an *enabling* boundary opener as an arena where participants can openly ask questions and receive direct answers. In other aspects, it might rather be a 'normalizing'

practice which is perceived as patronising by some participants. This perceived constraint results sometimes in reactions of resistance.

All in all, PLUS is an important first step towards integration and equality of FTD in Sweden. The following part will delineate some next steps for improving PLUS but it needs to be mentioned that the programme has already undergone several changes since the end of the fieldwork and is constantly developing.

6.1 Applicability – Giving back

With the concept of the gift in mind, the informants and my internship provider gave me something – the possibilitity to conduct the study. But what do I give back? (Arnstberg, 1997:134). Since the fieldwork was conducted as an applied internship for VGR, I hopefully contributed with an analysis and recommendations in a presentation and a report that were handed over in December 2014. Their aim was to provide insights into the participants' perspective on PLUS. This thesis contributes with further reflections.

For some FTD, the mere situation of an interview and being able to reflect about their experiences was a welcomed opportunity. Moreover, I hope that this thesis opens a dialogue between participants and programme managers. Furthermore it starts to illustrate how PLUS might be connected to its network and society by providing a glimpse at the larger picture through the perspective of the gift. The findings from the analysis indicate areas for further development of PLUS. PLUS might:

- emphasize the common background even more – here: being doctors; not only in words but in practice
- direct the programme more at participants and less at *vårdcentraler* (community health centres) and clinics. This would create a stronger bond between participants and VGR and could increase retention in the long run
- include more teachers who either are foreign-trained doctors or have experience from living abroad in order to increase credibility and build trust especially in the early stages of the programme
- integrate the programme into a renowed education and communicate recognized signs of it for instance in the form of reports, grades or learning opportunities serving as stepstones for specialist education – this will also build initial trust
- give even more hands-on communication advices which would allow participants to understand the meaning *behind* the words

- allow space for participants' attachment to home or their home country and include and respect it
- take a *culturized* approach from time to time. Even if managers would rather frame misunderstandings as technical questions, FTD often use culture as an explanation. Taking culture into account more often would allow managers and teachers to better grasp FTD's way of reasoning and sense-making of everydaylife. It will even create an awareness of oneself as cultural even if one does not believe culture to be an issue.

Taking into account these recommendations will enable PLUS to gain value in participants' eyes. In turn, this will increase participants' learning motivation and will ultimately lead to a greater impact of the content of PLUS on participants' performance and effectivity. This may eventually improve quality of health care.

6.2 Indications for further research

Firstly, there is a need for further research within PLUS: As there have been several changes within the programme since the time of study, a cultural analysis comparing a similar group of doctors at a later time would be justified. Also, the programmes for foreign-trained Swedish doctors as well as specialists should be studied, for instance conducting in-depth interviews. Opening up to a larger perspective and include heads of practices and clinics as informants might make the multiple meanings given to PLUS by the broader network even more visible and allow for a plurality of interpretations.

Secondly, the impact of PLUS should be studied more in-depth. In order to grasp changes that occured after completion of the programme, former participants could be part of a follow-up study. Shadowing doctors at the workplace might be a way to include colleagues' and patients' perspective and give in-depth insights of the impact of PLUS on performance of FTD. In order to grasp changes and processes, it would be beneficial to conduct a longitudal study and follow selected FTD from the time before PLUS until some time after PLUS.

Thirdly, there is a need for further research about those who are not present in PLUS – third country doctors, Swedish-trained doctors as well as FTD that do not take PLUS. Studying those who do not participate might offer deeper insights into what it means to participate. As cultural analysis allowed to grasp individual reasoning as well as point to larger patterns and hierarchy, it is a suitable perspective for upcoming research.

6.3 Significance

Previous research about trainings for FTD was dominated by medical and pedagogical perspectives. This thesis is to my knowledge the first cultural analysis in this field. It breaks new ground by using ethnographic methods such as participant observation, and it is even introducing Mauss' theory of the gift as a new theoretical concept for analysis of FTD training programmes.

The discipline of cultural analysis provides helpful insights for those involved in PLUS as well as managers and teachers of similar programmes in other countries. Moreover the research benefits FTD as it offers an opportunity to compare with and reflect upon their own experiences. Cultural analysis makes individual reasoning visible and provides the reader with insights about the Why behind the How, for instance why participants and managers perceive the programme as they do. The theoretical lenses of the gift and of symbolic capital make socioeconomic structures within the programme visible. Many industrialised countries today are in a similar situation as Sweden with a retirement wave about to come and a growing need for migrant doctors or other migrant workforce groups. They face the challenge to bridge the perceived gap betweem 'us' and 'them' within the profession of medical doctors or even within an induction programme such as PLUS. Taking into account the notions of culture and identity, the research creates an awareness of the dynamics within such a programme and of the ongoing negotiation of identity between being a *foreign-trained* doctor and being a foreign-trained *doctor*. Taken together, these concepts provide first indications of the impact of PLUS on integration of FTD.

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invandrare/

Interviews

In the following, only the interviews with the 13 informants who are mentioned in the text are listed – the remaining 4 interviews are not listed.

01- Interview with Mark (September 29, 2014). *Performed, transcribed and archived by Anna Franz.*

02- Interview with Kristina (October 07, 2014). *Performed, transcribed and archived by Anna Franz.*

03- Interview with Mary (October 17, 2014). *Performed, transcribed and archived by Anna Franz.*

04- Interview with Peter (October 22, 2014). *Performed, transcribed and archived by Anna Franz.*

05- Interview with Ann (October 28, 2014). *Performed, transcribed and archived by Anna Franz.*

06- Interview with John (October 29, 2014). *Performed, transcribed and archived by Anna Franz.*

07- Interview with Maja & Bengt (October 29, 2014). *Performed, transcribed and archived by Anna Franz.*

08- Interview with Olivia (November 01, 2014). *Performed, transcribed and archived by Anna Franz.*

09- Interview with Lisa (November 06, 2014). *Performed, transcribed and archived by Anna Franz.*

10- Interview with Julian (November 06, 2014). *Performed, transcribed and archived by Anna Franz.*

11- Interview with Erin (November 20, 2014). *Performed, transcribed and archived by Anna Franz.*

12- Interview with Rikard (November 27, 2014). *Performed, transcribed and archived by Anna Franz.*

13- Interview with Victor (November 27, 2014). *Performed, transcribed and archived by Anna Franz.*

i In Sweden, the term *utländska läkare* (foreign doctors) was used to describe medical doctors who received their education abroad. Nowadays, *utlandsutbildade läkare* (foreign-trained doctors, FTD) became more common in order to be more accurate, as an increasing number of Swedish citizens study medicine abroad. I will use the term foreign-trained doctor (FTD) and not the term IMG, international medical graduate, which is often used in Literature from North America. I find it misleading because I understand the term 'graduate' as 'having (recently) graduated from another university'. However, many of the doctors in my study have already practiced in another country, this is why I prefer the term 'foreign-trained doctors' which includes the professional experience. The term medical doctors or doctors will be used, not the US term physician.

ii EES: Iceand, Liechtenstein, Norway; EU: Belgium, Bulgaria, Cyprus, Denmark, Estonia, Finland, France, Greece, Ireland, Italia, Croatia, Latvia, Lithuania, Luxemburg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Great Britain, Sweden, Czech Republic, Germany, Hungary, Austria.

iii See Appendix III for an illustration of this hierarchy.

iv I will sometimes call FTD 'participants' instead, in contrast to 'managers'and 'teachers' in order to explain their functions in PLUS.

v Here referring to the concept of diasporic citizenship. Today, technology offers the possibility to feel belonging to a community through video chat or online discussion foums, despite geographical distance.

vi For the place of the interviews with participants see Appendix I. See appendix II for the interview guide.

vii For the place of the interviews with managers and teachers see Appendix I.

viii See again Appendix III for an illustration of the hierarchy of doctors.

ix As a programme manager said: PLUS is alive. It changes constantly. From the time the study ended until the time this thesis is published, several changes have been made. Among others, an FTD has been employed as programme manager and teacher. Therefore, a follow-up study would be desirable in order to compare.

Appendices

Appendix I.

Figure I. Interviews with PLUS I-participants. Number and place.

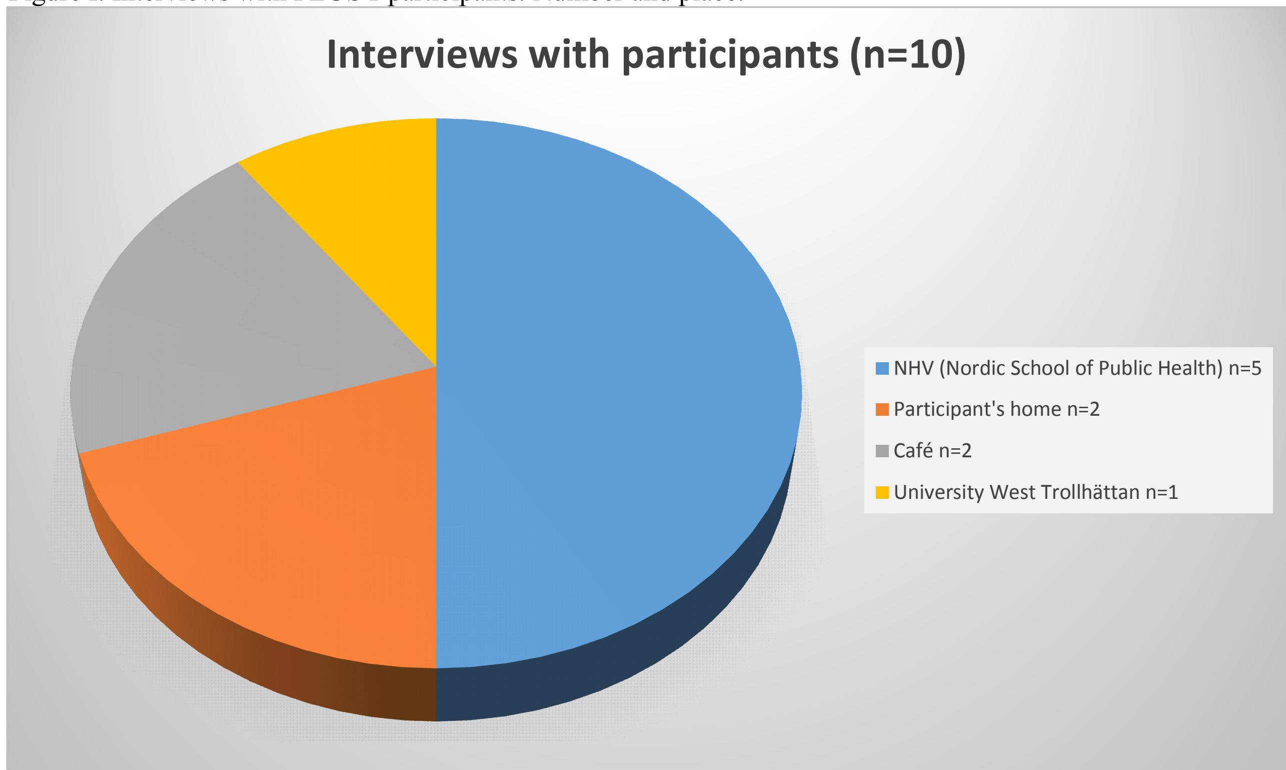
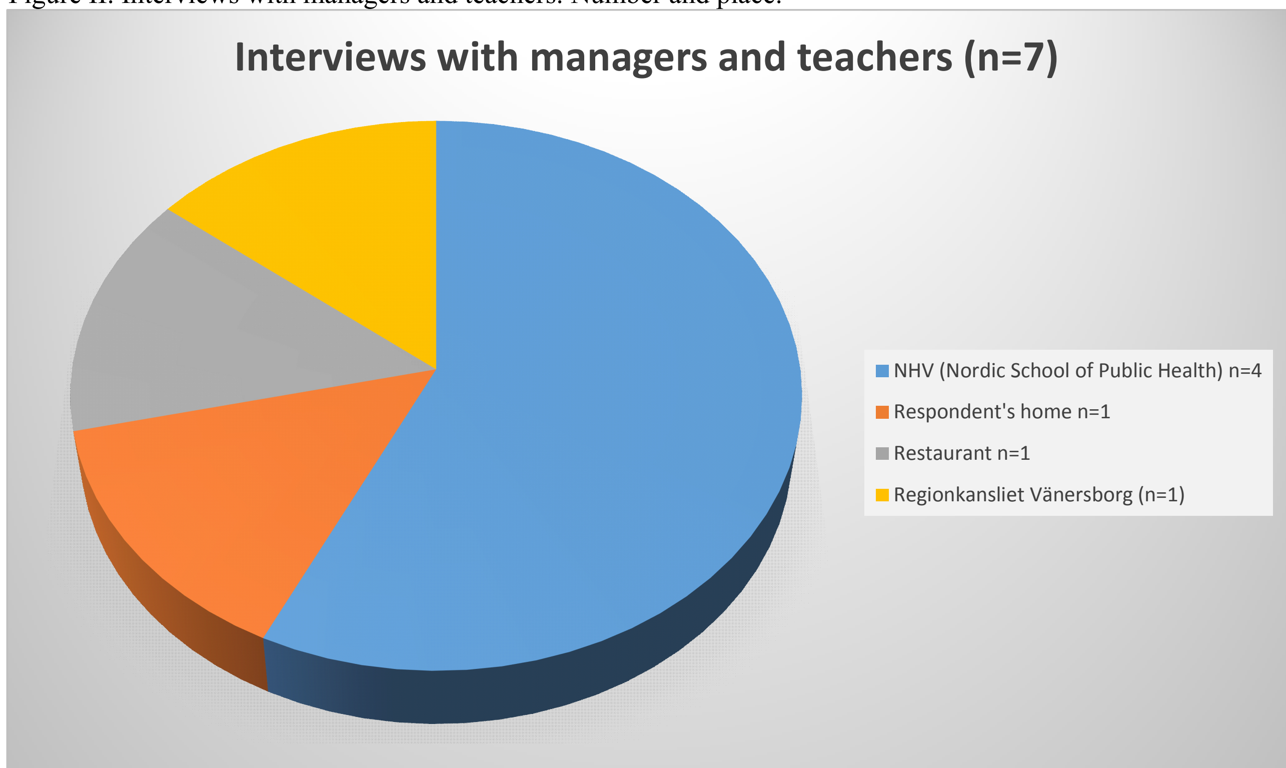


Figure II. Interviews with managers and teachers. Number and place.



Appendix II.

Figure III.A Interview-guide.

Interview guide

Jag presenterar mig

Frågor om intervjun?

Berätta lite om dig

Varifrån? Var studerat?

Varför Sverige`? När Sverige? Rekrytering?

Med vem?

PLUS

Jämfört med jobb

Bäst? Sämst?

Förändringar?

Vad tar du med hem?

Förväntningar

Vad har **förändrats** under tiden?

Plats?

Varför finns PLUS?

Hopp & rädsla

Fanns det något liknande som PLUS där du jobbade innan?

Hur tillvaratas din k**ompetens** i PLUS? (på arbetsplatsen/ på PLUS?)

Vilken roll har PLUS för dig?

Värderingar i livet?

Vilken **roll spelar jobbet**?

Familjen? Fritid? Vänner?

VG-Region?

Stannar/ lämnar?

Hur lång tid j**obbat innan** PLUS?

Erfarenhet i sjukvården

”första dagen”?

Kollegor: medvetna om din erfarenhet?

Fritid? Hobbies? Vänner?

Individualism?

Läkarroll i Sverige och i ditt hemland?

Mötet med patienten

AHAupplevelser?

Tips för nya läkare? Ville vetat innan du kom?

Identitet:

känner sig som ”ett barn”?/

en ny person i ett nytt land?

Visa status/respekt? Emotioner?

AT/ST?

Papper, Skatteverket?

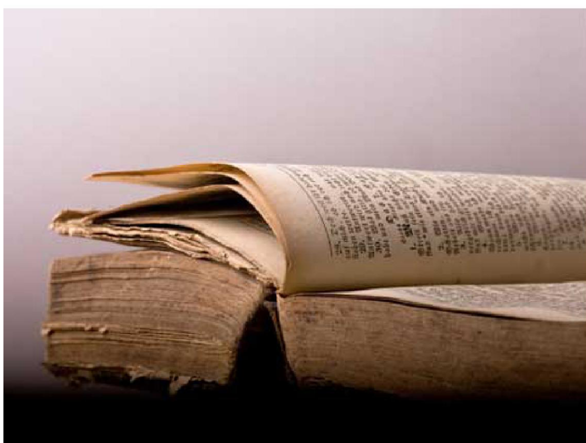
ta semester: vem frågar du?

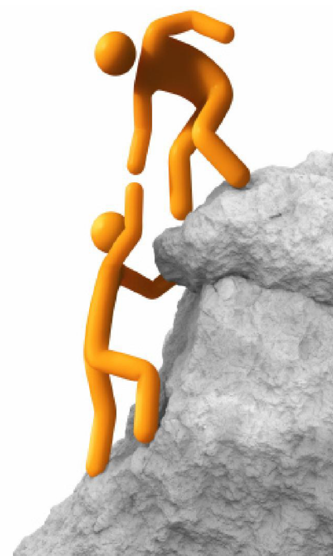
Migrationsverket & personnummer: vem frågar du?

Barn ska gå på Dagis: Vem frågar du?

Figure IIIB. Interview guide. PLUS is like...

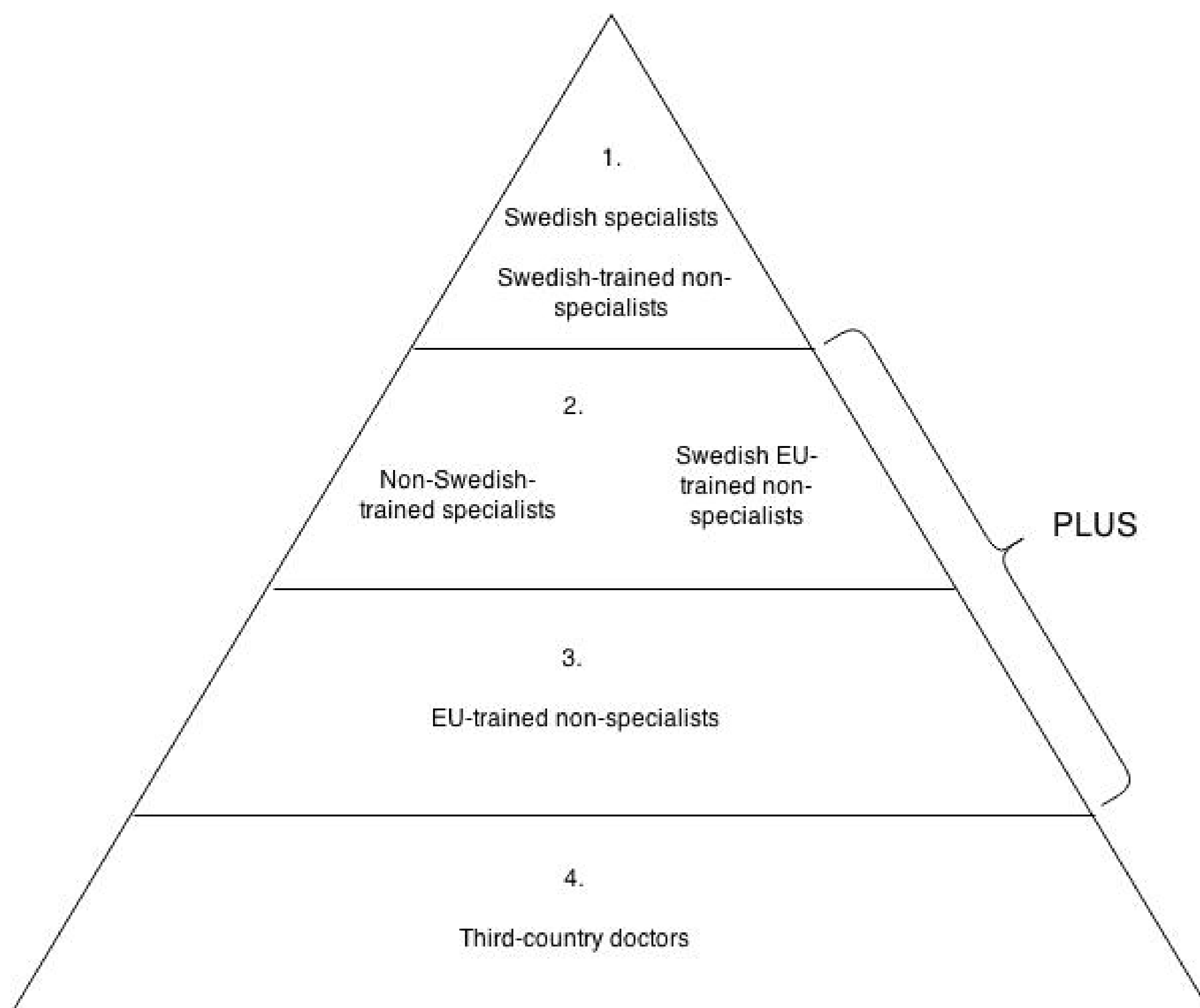
Plus är som...





Appendix III

Figure IV. Hierarchy of doctors; Level up: Language; Swedish education, specialisation; Level down: No language, no Swedish education, no specialisation, no EU/EES-Education



Note: I chose to place third-country doctors in the bottom of the triangle, even though some might enter at 2nd level if they receive their specialist license. However, many might be placed at the bottom of the hierarchy as a 4th group as they face numerous structural, cultural and social challenges until they are allowed to work as a doctor. It is a group that is absent in many aspects: They are absent from this study, they are absent in PLUS and not talked about, as the participants in PLUS I who came from a country outside EU/EES had studied within EU. A condition for PLUS is to be employed as a doctor which is often already one of the biggest challenges for third-country doctors. They might be more often victim to brain waste than the doctors in PLUS. They are the ones who might need a programme such as PLUS the most in order to understand and successfully enter the Swedish health care system.