

Södertörn University | School of Life Sciences

Global Development C | Bachelor Thesis 15 ETCS | Spring Term 2012

Foreign Doctors and the Road to a Swedish Medical License

Experienced barriers of doctors from non- EU countries

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Sammanfattning

Denna C-uppsats i Global Utveckling har tittat på personliga erfarenheter av icke-europeiska läkare som har migrerat till Sverige för att ta reda på vad de har stött på under processen av att skaffa svensk läkarlegitimation och om det finns tecken på diskriminering. Sverige har brist på läkare, men har inte tillgripit ”brain drain”. Tvärtom är det svårt för icke-europeiska läkare att arbeta som läkare i Sverige.

En kvalitativ forskningsstrategi har använts och fem icke-europeiska arbetslösa läkare som försökte få svenska läkarlegitimationer samt en icke-europeisk läkare som arbetade intervjuades. Empiriska data från ett seminarium med svenska läkare som handlade om processen som utländska läkare måste gå igenom för att kunna arbeta i Sverige har också använts i denna C-uppsats.

Resultaten visade att läkare från icke-europeiska länder har strängare krav att uppfylla för att kunna arbeta som läkare i Sverige än läkare som kommer från europeiska länder. Systemet för att ta emot icke-europeiska läkare och validera deras kompetens var bristfällig. Processen var förvirrande, frustrerande och onödigt lång. Även om det inte fanns någon direkt diskriminering, så var europeiska läkare gynnade av systemet.

Nyckelord: medicinsk migration, postkolonial teori, Sverige

Abstract

This thesis in Global Development has looked at the personal experiences of non-European medical doctors that have migrated to Sweden to find out what they have encountered during the process of trying to obtain a Swedish medical license and if there are signs of discrimination. Sweden has a shortage of doctors, but has not resorted to brain drain. Contrary, it is difficult for non-European doctors to work as doctors in Sweden.

This thesis has used a qualitative research strategy and five non-European unemployed doctors that were trying to get Swedish medical licenses as well as one non-European doctor that was working, were interviewed. Empirical data from a seminar with Swedish doctors about the process that foreign doctors have to go through to be able to work in Sweden has also been used in this thesis.

The results showed that doctors from non-European countries have stricter requirements to fulfill in order to be able to practice medicine in Sweden than doctors coming from European countries. The system for accepting foreign doctors and validating their competence was flawed. The process was confusing, frustrating and unnecessarily long. Although there was no direct discrimination or prejudice, European doctors were favored by the system.

Keywords: medical migration, postcolonial theory, Sweden

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Introduction

This thesis studies the experiences of foreign doctors in Sweden as they go through the process of obtaining a Swedish medical license. The thesis explores the experiences of these doctors by drawing on postcolonial theory to explain the institutionalized treatment of the doctors, as well as, their reactions, reflections and feelings about the process.

Migration to Sweden

We live in a time that has been referred to as the age of transnational migration. What differentiates current migration from past is mobility, both voluntary mobility and the involuntary mobility that concerns refugees (Andersson b, 2010). In 2009, approximately 1.6 million people emigrated from a non-European country to a European Union (EU) member state (European Commission, 2011). Sweden today is a multicultural and multilingual country (Andersson a, 2010). This section is briefly going to look at how migration has changed in Sweden to see what effects this has had on migrants and the labor market.

After the Second World War, there was a shortage of manpower in Sweden and this resulted in large groups of people from neighboring countries migrating to Sweden (Andersson a, 2010). During the 1960s however, migration policies became stricter and migrants had to have their individual cases tried. Migrants that satisfied at least one of the following criteria: have a job offer, were Scandinavian, were refugees, or had family members in Sweden were however still allowed to migrate to Sweden without a trial (ibid). Because of the shift in policies, Sweden went from being a country with mostly labor migration to a country with mostly refugee migration (Andersson a, 2010; Ekberg, 2011).

Up until the middle of the 1970s, approximately 90 percent of all immigrants came from European countries, but during the 1980s, migration trends changed so that more than half of the immigrants came from countries outside Europe; mainly from Iran, Iraq and war-affected countries in East Africa (Andersson a, 2010).

Sweden has continued to have relatively open policies about accepting refugees and granting residence permits (Andersson b, 2010) and since the beginning of the new millennium, large

groups of immigrants have come from Iraq, Thailand, Iran, Afghanistan, China, Turkey, Bosnia-Herzegovina, Russia and the former Yugoslavia (Andersson a, 2010). At the end of 2009, approximately 20 percent of immigrants in Sweden were from Nordic countries, 36 percent from other European countries and 40 percent from countries outside Europe, such as countries in Africa, Asia and Latin America (Ekberg, 2011).

Refugees have different reasons for migrating. Whilst a labor migrant may have the choice to choose a destination country dependent on a number of factors, such as if he or she possesses the human capital suitable for the destination country and if the move will generate career development, a refugee does not have those choices (Rooth, 2005). Refugees have less opportunity to choose a destination country based on the transferability of their skills and if they will be able to acquire a job or build a career (ibid).

Along with the changes in migration trends, from labor-force migration to refugee migration, came changes in the Swedish society, whereby certain sectors of the labor market, especially the industrial sector, had to down-size which lead to a general decrease in job opportunities (Andersson a, 2010). During the 1980's problems with integration began to surface and the situation worsened during the 1990's when refugees were met with an unfavorable labor market and welfare cuts (Molina, 2006). Up to this day, people that migrate to Sweden no longer meet the same labor demand that used to be in place when Sweden needed the foreign workforce after the second world war. Today, immigrants have difficulties getting jobs (Andersson a, 2010). Even during the economic boom at the end of the 1990s, there were divisions between native Swedes and immigrants regarding career opportunities (Molina, 2006).

Most immigrants entering Sweden have relevant work experience from their home countries, but despite that, it is difficult for people of foreign origin to find jobs. It is especially difficult for foreigners to obtain jobs that correspond to the skills and knowledge that they possess (Andersson a, 2010). Even when taking education, gender and age at immigration into account, people born in Eastern Europe, Asia, Africa and Latin-America show a much higher level of unemployment (Molina, 2006). When immigrants do get jobs, their salaries are usually lower than that of native Swedes (Andersson a, 2010) .

For many foreigners, the first acquired occupation in Sweden has a lower status than the occupation in the home country (Rooth, 2005). Generally, the occupational socio-economic status amongst immigrants in Sweden is lower than for native born Swedes. Immigrants also fall behind native-born Swedes when it comes to career progression, even when they share the same educational level (ibid). Ethnic background, religion, age, gender, education, personality, social background and mastery of the Swedish language are factors that affect the success of an individual on the Swedish labor market (Andersson a, 2010). Even social competence has been said to have gained more importance when it comes to the chances of getting a job (Mattson, 2001). Social competence of course has cultural content. When educational backgrounds, work experience or the length of stay in Sweden cannot explain the lower position of immigrants on the labor market, questions about attitudes or regulations that give people from other countries less opportunities on the Swedish labor market arise (Molina, 2006). It has been claimed that discrimination affects immigrants applying for jobs in Sweden, especially people from overseas countries (Andersson a, 2010). Employers believe that hiring someone that is not competent in Swedish or familiar with Swedish cultural norms will lead to problems and additional costs (ibid).

The inequality in occupational status between immigrants and native Swedes is not only a problem for the people that are affected. There are more general impacts on society because of the unused human capital, skills and knowledge (Nilsson, 2009). In summary, it results in a dysfunctional and inefficient labor market.

The Different Roads to a Swedish Medical License

Large groups of immigrants in Sweden are unemployed and at the same time there is a lack of skilled workers in many different sectors such as the medical sector where there is a shortage of doctors (Andersson a, 2010). The reasons for the lack of health workers in Sweden are numerous, but these include that the number of newly examined doctors is relatively low when compared to the relatively high numbers of doctors retiring and that Swedish doctors choose to move abroad in search of better working conditions (Berbyuk, 2005). The shortage of health care workers leads to long patient waiting times and high workloads for health workers (Andersson a, 2010). According to a prognosis from 2009, Sweden will be missing 4,000 doctors in 2015 (The Swedish Medical Association, Sverige behöver fler läkare , 2009). One way to solve the problem

of the shortage of doctors in Sweden has been through hiring doctors from other countries within the EU (Andersson a, 2010). In 2006, 15 percent of the 32, 000 doctors with Swedish medical licenses were foreigners who were predominantly from the Nordic countries, the EU and Asia (García-Pérez et al., 2007).

The overall influx of immigrants in Sweden has played an important role in the availability of medical doctors in the country (The National Board of Health and Welfare d, 2012). A study showed that while Sweden has been hiring doctors from other EU countries, there are educated immigrant doctors in Sweden that fail to get the jobs that they are qualified for (Andersson a, 2010). Some immigrant doctors end up having to move to Denmark or Norway or get a lower status job that has nothing to do with their education, such as becoming taxi-drivers (ibid).

Doctors have a relatively transnational occupation, but health care systems vary between countries (Boström, 2011). Medical studies in Sweden consist of five and a half years of basic training at a university or college, which results in a medical degree (MD)¹. In order to obtain a license to practice as a doctor of medicine², an additional 18 months of medical internship³ is required as well as the satisfactory completion of a written and an oral exam. The medical internship supplements the basic training with practical experience and it is carried out under supervision (The Swedish Society of Medicine The Swedish Medical Association, 2010). It is the Swedish National Board of Health and Welfare⁴ that issues medical licenses (The National Board of Health and Welfare a, 2012). Once the medical license has been obtained, an additional five years of specialist training awaits (The Swedish Society of Medicine The Swedish Medical Association, 2010).

Foreign doctors who have received their medical licenses abroad have to fulfill certain criteria to qualify to become a Swedish doctor. Doctors coming from countries outside Europe have different requirements than doctors coming from an EU, European Economic Area (EEA) member state or Switzerland (The Swedish Medical Association, 2010).

¹ Läkarexamen
² Läkaregimitation
³ Allmäntjänstgöring (AT)
⁴ Socialstyrelsen

Requirements

Doctor from an EU/EEA member state or Switzerland

1. A completed application form, a formal recognition of professional qualifications based on the European Commission (EC) EU Single Market, along with other documents such as a certified copy of the diploma and an extract from the Swedish population register to be sent in to the National Board of Health and Welfare (The National Board of Health and Welfare b, n.d.).

Doctor from outside an EU/EEA member state or Switzerland

1. Assessment of foreign training
2. Certified knowledge of the Swedish language
3. a) Doctors without considerable medical experience either have to pass a medical knowledge test for foreign doctors called the TULE-test⁵ (The National Board of Health and Welfare e, n.d.) that consists of a theoretical and a practical part or do an 18 month internship with the concluding TULE-test at the end (The National Board of Health and Welfare c, n.d.) or take the one year course called *Supplementary education for professional status qualification for medical doctors, nurses and dentists with a degree from a country outside the EU/EEA/Switzerland* (supplementary course) that is offered at Karolinska Institutet, Sahlgrenska Akademin and Linköping Universitet (Gothenburg University, 2012).
b) Doctors that do have considerable medical experience need to pass a probationary service of six months within the relevant field of experience.
4. Pass a course on medical legislation
5. Completed application form admitted to the National Board of Health and Welfare after steps 1-4 have been completed (The National Board of Health and Welfare c, n.d.).

Statement of Problem

Typically, a Swedish immigrant has migrated as a refugee or through family connections. Generally, refugee immigrants have a harder time acquiring jobs that are at the same level of occupational status that they had in their home countries. For non-European doctors in Sweden, this is also the case. Regardless of the shortage of doctors in Sweden, the process for foreign

⁵ Tentamenskommittén för utländska läkares examination

doctors to obtain Swedish medical licenses is difficult to negotiate for foreign doctors from outside the EU.

This study on medical migration to Sweden is significant because of the recognized doctor shortage and the implications for an inefficient labor market. Researching about the experiences and difficulties that foreigners have when they are establishing themselves in the Swedish labor market can help create a foundation for successful integration (Andersson a, 2010). While discrimination is often cited as a reason for differences between immigrants and natives (ibid), little, if any research has been conducted on foreign doctors and their experience of immigration processes and entering the labor market in Sweden.

Research Objective

The objective of this thesis is to explore the personal experiences of foreign non-European medical doctors that have migrated to Sweden in order to find out what they have encountered during the process of trying to get a Swedish medical license and to help identify barriers faced by them in this transition.

Research Questions

1. How have foreign doctors from non-European countries experienced the process of trying to get a Swedish medical license?
2. How do foreign doctors from non-European countries feel about the requirements that they have to fulfill in order to get a Swedish medical license?
3. Do non-European doctors harbor feelings about being discriminated during the process of trying to get a Swedish medical license?

Delimitation

The experiences of doctors from North America, Australia and New Zealand have been excluded because this thesis is interested in the postcolonial experience of doctors from non-Western countries pursuing their profession.

The experiences that foreign doctors that are working in Sweden have about discrimination in the work place and if foreign doctors in Sweden are constituting to brain gain in their home count-

ries, has also been left out from this study because this thesis is interested in the process of obtaining a Swedish medical license.

Disposition

This introduction has presented the changes in migration to Sweden, the requirements for foreign doctors to receive a Swedish medical license, the Statement of Problem, Research Objective, Research Questions and Delimitations. The Theoretical Framework covers brain drain and brain gain in the review of past literature, postcolonial theory and a previous study about polish doctors in Sweden in order to seek similarities and dissimilarities with other studies. In the section titled Methodology, the approach, research strategy, method, methodological analysis of research findings and a critique about the limitations in this thesis are presented. The Findings are presented through quotes and descriptions of the informants experiences in the following section. The Analysis and Discussion section compares and contrasts the findings in this thesis with the theoretical framework and lastly, the Conclusion summarizes this thesis and answers the research questions.

Theoretical Framework

Review of Past Literature

A lot of the existing literature on the migration of doctors focuses on brain drain and brain gain. Brain Drain has been referred to as a phenomenon in which the educated elite in a country, migrate and settle in another country (Stephens, 2005) and it is an important part of current-day globalization (Docquier, 2011). Medical brain drain is the net flow of medical professionals from so-called developing countries to developed countries (Stephens, 2005). The migration of skilled professionals creates a net loss of human capital in so-called developing countries and a net gain in so-called developed countries (ibid). Studies on brain drain have highlighted the negative aspects that have to do with the outflow of skilled workers from the source countries and the benefits for the receiving country (Maria, 2009). This can exacerbate negative development prospects for already poor or unstable countries. Thus, the outflow of professionals has been said to threaten the national development of the source country in the long run (Jalowiecki, 2004). A lot of research has shown that professionals leave their countries of origin due to unsatisfactory professional and living conditions (ibid).

Opposite to brain drain, is brain gain which has been referred to as a phenomenon whereby countries actively work towards enticing professionals (ibid). Brain gain often constitutes deliberate attempts to attract professionals to a country (ibid). Countries that recruit professionals have a lot to gain from it. In an experiment based on the migration of health professionals to the United Kingdom (UK) it was found that even if foreign health workers remitted all of their salaries to their country of origin, the UK would still enjoy overall health and welfare gains (Rutten, 2009).

Early studies from the late 1960s on brain drain found that high-skilled emigrants often left assets in their home countries that were of benefit to low-skilled workers that stayed in the home country. The highly-skilled emigrants also sent home remittances. These sorts of actions were found to compensate for the brain drain and the losses that were affecting the low-income countries (Docquier, 2011). In the 1970s however, it was found that brain drain was leading to inequality because High-Income Countries (HICs) were becoming richer on behalf of Low-Income Countries (LICs) which were becoming poorer (ibid). In the 1990s, a different discussion came up that acknowledged both the losses for LICs and the gains that were being made (ibid). It was found that brain drain could be beneficial for LICs if countries are able to seize the benefits of having a skilled and educated Diaspora (ibid). Whether a country is benefitting or losing out on brain drain depends on the policies in both the country which is the source of the immigrant and receiving country (ibid).

Although there is an increasing mobility of health workers internationally and that discussions about medical migration have characteristically brought up brain drain from African and Asian countries. The case of Sweden takes a different form. Medical migration in Sweden has been mainly from countries within the EU and EEA (The National Board of Health and Welfare d, 2012).

Theory

Postcolonial theory is used to analyze the empirical data in this thesis. Different concepts such as superiority, inferiority, cultural differences, Eurocentrism and “the Other” are presented here.

Postcolonialism

The world that we live in today is characterized by an epistemology whereby superior and inferior relationships amongst the people in the world still exist. This way of thinking persists from colonial times (Molina, 2006) from where the power relations between the West and the rest of the world have its roots (Mc Eachrane et al., 2001). A postcolonial theoretical framework offers researchers that are trying to link contemporary ethnical segregation and marginalization of immigrants in Europe and the West to the power structures that were established during colonial times (Molina, 2006). Although Sweden never was a colonial power, Sweden has been shaped by Europe's colonial history and is still part of a situation where Europe appears as a global center from which knowledge and power originates from (Mc Eachrane et al., 2001). Postcolonial theory can help reveal how Sweden is a part of a complex situation that colonialism left behind (ibid).

Colonization can be defined as the occupation of territory and the exploitation of natural resources and manual labor. Historically, colonialism also involved intervening with political and cultural structures in the colony (Loomba, 2005). The term postcolonial is contested because "post" refers to coming after colonialism (ibid). A postcolonial Europe does not imply that Europe's imperial past is over; rather it implies that Europe has a scheme to hold onto its colonialist and imperialist position (Ponzanesi, 2011). In one way the whole world can be regarded as being postcolonial because colonialism no longer exists and people that have descended from people that were once colonized, live all over the world (Loomba, 2005). We still find countries that are independent but still economically or culturally dependent on another (ibid). People living in countries that have a colonial past also still face oppression that can be traced back to colonial times. Both former-colonizing and colonized countries have been imprinted by their colonial history (ibid). During colonialism, racist ideologists came to identify certain races that were better than others at certain things and certain traits that were typical for the different races. Colonialists saw white as superior to black (ibid). For example, there is a tendency to associate desirable phenomena such as science to "whiteness," instead of just viewing it as a phenomenon that developed in Europe during a certain era (Mc Eachrane et al., 2001). The distinctions made during colonialism still persist, migrants from former colonies are still subject to lower wages and fewer opportunities and there are still global inequalities although former colonization does not exist in the contemporary world (Loomba, 2005).

The belief that a colonial mentality exists in Sweden is often met with skepticism since Sweden did not have colonies such as the United Kingdom or the Netherlands had, but, colonialism was not only about occupying territory. Colonialism also incorporated an ideology that justified colonization by systematically constructing an image of the colonized people as inferior (de los Reyes, 2006). People were categorized into different races that were then ranked according to worthiness (ibid). The relationship between superior and inferior identities is central within post-colonial theory. The idea of “the Other” as the subordinated mirror image of the European is one example of how differentness is constructed. “The Others” are depicted as unconventional and backward, the opposite of how Europeans are defined (Sered, 1996). Europeans on the other hand are depicted with desirable traits (Loomba, 2005) as being innovative and dynamic (Gill, 2006).

Today, differences between Europeans and Africans are not traced to biological factors but to cultural factors (Loomba, 2005). It has been said that, racism without race exists and this is creating difficulties for people from different cultures to coincide (Ponzanesi, 2011). Within postcolonial theory there are discussions about cultural ranking whereby one’s own culture is normative and placed at the top. Cultural differences manifest between natives and immigrants through misunderstandings, lack of common social codes, and difficulties communicating with one another (Molina, 2006). Western Europe, North America, Australia and New Zealand are commonly grouped together as the Western culture. The rest of the world is perceived as non-European, non-Western, culturally different (Mattson, 2001) and culturally static (Gill, 2006). Discussions about cultural differences are mainly focused on emphasizing the otherness and deficiencies of non-Westerners (Mattson, 2001)

“Many people still hold onto the notion that Europe is not simply a continent, a mere geographical space ... but they want to see it as an ideal, the cradle of the Enlightenment and of scientific revolutions, and therefore of Western modernity and democracy” (Ponzanesi, 2011)

Eurocentrism is an extrospective discourse that explains European superiority and domination over its former colonies and the expansion of imperialism. Europism is a new introspective discourse that is characterized by Europe’s defensive position in wanting to create a homogenized Europe exclusive of foreign constituents. Europe’s defense has been described as a fortress that protects Europe from non-Western countries and this has manifested in the form of legal, eco-

conomic and political boundaries that close off Europe to immigrants and refugees (Ponzanesi, 2011).

How Postcolonial Theory Relates to Foreigners on the Swedish Labor Market

It is assumed that postcolonialism mostly concerns former colonies or the developing world. Postcolonial theory is seldom used to study modern day Europe (ibid) and therefore it is important to study Europe from a postcolonial perspective to see how the legacy of colonial history influences contemporary policies and experiences of those deemed as “the Others”.

It has been said that foreigners had no problems fitting into the Swedish labor market during the 1950s-1960s, a period that was characterized by industrial production. The problems started when more service-based jobs became available, in which the refugees were said to lack the necessary skills (Mattson, 2001). The view that foreigners did not possess the skills that were equal to the requirements of the modern labor market can be traced back to views of “the Others” and how their skills have been perceived taking into account generalized cultural assumptions (ibid). “The Others” have always been seen to be able to master simple jobs that require the use of manpower, hierarchical control and work done in isolation. As Mattson (Mattson, 2001) asserts, “the Others” could not handle jobs that required brains, independent work, responsibility and group work (ibid). People that come from countries that are culturally distant, such as countries in Africa and Latin America generally get described as having problems adjusting to new jobs whereas North Americans, Australians and Western-Europeans are not described with the same terms (ibid). This reinforces colonial prejudices that Europeans and non-Europeans are more or less suitable for the same types of jobs (ibid). Devaluation of foreigner’s professional skills is a common reason why foreigners have difficulties in finding jobs (ibid). If foreigners are described as being less competent, it becomes reasonable and legitimate to not employ people that come from non-Western countries (ibid).

The changes in the labor market that started to incorporate more elements of team work and communication have been claimed to make competence more culturally tinged than before. This means that both formal and informal skills are more difficult to transfer between cultures, and in turn, this means that no matter how highly educated a foreigner is, he or she will still lack the necessary competence because of the cultural difference and because they lack Sweden-specific skills. Notwithstanding that there are country specific skills that individuals possess because they

have been living in a certain country (Mattson, 2001). Sweden-specific skills are among others, mastering the Swedish language, being able to orient oneself in the Swedish society and having Swedish values concerning religion, gender roles and culture (ibid). The reasoning becomes a postcolonial issue when Sweden-specific skills are described in a stereotypical and general manner as those skills that Swedes are described to possess and that foreigners do not possess (ibid). Furthermore, when competence becomes strongly linked to culture, it becomes more difficult to be judged according to individual competence (ibid). It is reasonable to suppose that all immigrants will be lacking in Sweden-specific skills such as language, but if only non-Europeans are required to specifically meet standards and others not, this may indicate a form of discrimination and in turn a perpetuation of “othering”.

Similarities and Dissimilarities with Other Studies

In a study of polish doctors and their status role in Sweden that contained in-depth interviews with two female polish doctors, the language barrier was mentioned as a factor that lowered the status and credibility of foreign doctors. It was hard to gain authority when the Swedish language was not fully grasped. (Boström, 2011). Despite having the competence and skills, the two doctors experienced that foreign doctors had more difficulties than native-born Swedish doctors to obtain top posts or higher positions. If it came down to a choice between a Swedish doctor and a foreign doctor, the Swedish one would be chosen for the job (ibid). Regardless of the transnationality of the occupation of doctors, it was the lack of networks, connections, an understanding of Swedish social conventions and a cultural sensitivity towards power structures and relationships which were the weaknesses for foreign doctors in Sweden (ibid).

Another study showed that despite language barriers that foreign doctors’ experienced, the quality of the performed work was not negatively affected. The study showed that there were benefits of having a multilingual workforce at a hospital such as not having to use interpreters if members of the staff could understand or translate. Interpreters had to be booked, sometimes days in advance and not all of them are likely to be competent in the translation of medical terms (Andersson a, 2010). The study concluded that it would lead to financial savings if hospitals employed people with different ethnic backgrounds and languages to help with translation between doctors and patients (ibid).

Methodology

Epistemology in research addresses what is and what should be considered to be knowledge (Bryman, 2009). This thesis uses the epistemological approach called interpretivism, which assumes that individuals have their own knowledge about how they perceive the world (Levy, 2006) and helps the researcher understand the complexities of reality by taking into account the different realities and perspectives of the actors under study, as well as the involvement of the researcher (ibid). Positivist research on the other hand, strives towards obtaining objective knowledge (ibid). Interpretivism is an epistemological approach that builds upon understanding and interpreting phenomena (Bryman, 2009). In interpretative studies, the researcher studies how members of a social group interpret and understand their situation and the researcher also tries to understand the phenomena by placing it within a larger framework of interpretations and theories that have arisen in previous research studies (ibid). This thesis will use a postcolonial theoretical framework and the broader experience of labor migration to contextualize and analyze the findings. Although postcolonial theory will not give an explicit explanation of the findings in this study, some of the concepts will be drawn out and discussed in the analysis.

Research Strategy

Qualitative and quantitative methods are usually described as opposites, despite that, a lot of research studies within the social sciences uses a mix of both qualitative and quantitative research methods (Bryman, 2009). In quantitative research, the aim is to quantify data, and the relation to theory is deductive, meaning that theories are to be tested. In qualitative research, the relation to theory is inductive, meaning that theories are to be generated and the aim instead is to place emphasis on words and the analysis of data (ibid). In this research, the aim has not been to test theory; rather the theory has informed the approach. While not taking a purely inductive approach, this research has tried to let the data speak by not overly predetermining theoretical categories.

Method

This thesis has used a qualitative research strategy. During this study on foreign medical doctors in Sweden, six informants that had migrated from countries outside of the EU/EEA were interviewed (Appendix 1) out of which five were unemployed and working towards getting Swedish medical licenses. The sample was narrowed down to only focus on non-European doctors from

Africa, Latin-America and Asia because these were supposedly having more difficulties than other foreign doctors in receiving their Swedish medical licenses. In total, 24 foreign doctors were initially asked via email to take part in the study.

Notes from a seminar that one of the informants was holding, which had 15 attending Swedish specialist doctors, have also been used as empirical data. Two of the interviews were conducted face to face, and four interviews were conducted via Skype because the informants did not live in Stockholm, one interview was done without a web camera. The purpose of conducting interviews is to produce knowledge (Brinkmann, 2009). Three of the informants lived in Gothenburg and the other lived in Ludvika. The two other interviews and the seminar were held in Stockholm. The spoken language was Swedish and the interviews lasted between 30-50 minutes each. Four informants in the interview were females and two were males. During the seminar there was an approximate even number of men and women.

Because of the researcher has no personal connections to foreign doctors, the first informant was found by searching the internet. The first informant invited the researcher to attend the seminar with the Swedish doctors and suggested that the researcher email Karolinska Institutet in Stockholm about the course that it offers in supplementary training for foreign medical doctors. A Swedish doctor involved, forwarded the researchers request to interview students to the course administrator who then sent out an email to the 19 students taking the course. Two of the students replied and agreed to be interviewed. Snow-ball sampling technique was also used, whereby a friend initiated the contact to a relative in Gothenburg that was a foreign doctor and who had got to know other foreign doctors through Swedish language courses that were in the same situation.

All of the interviews were recorded and transcribed. The recorded material amounted to approximately 4 hours and the transcribed material amounted to 42 pages.

The Methodological Analysis of Research Findings

In this thesis, the empirical results from the interviews are analyzed in conjunction with contrasting or similar statements from the informants, as well as by drawing examples from the theoretical framework that support, complement or diverge from the results of this study. By doing so, the analysis has been derived straight from the empirical data as well as being

constructed and framed by existing theories. Because analysis in qualitative research is central, this part describes how the empirical data of this thesis has been organized.

Systematically creating thematic categories from the collected empirical data is a tool used in qualitative research (Charmaz, 2003). In the findings section of this thesis, the empirical data has been divided under different themes that have been selected in consideration of the research problem and question as well as the specific issues raised by the informants themselves (Table 1) in order to place certain statements into thematic categories. Also common in qualitative research is that the researcher might during an interview become enlightened on a topic and thereafter adapt interview questions to explore the new topic (Charmaz, 2003). The research process was reflexive in that the interview guides (Appendix 2) were refined after every interview taking into account what was raised in previous interviews and was left open enough so additional topics could be raised by the informants themselves. This thesis aims at taking a more interpretative analytical approach wherein the respondents views and constructs of their reality and experiences, has formed the research. Certain qualitative research methods allow analysis to occur early on in this research process. Data collection and analysis has taken place simultaneously. Data has been collected, through that data a thematic category has emerged and that category has guided analysis and further data collection.

The transcribed material was not translated to Swedish; instead the categories and quotes were translated to English. This was done as accurately and carefully as possible.

Limitations

There are some limitations in this thesis such as the small range of informants which could affect the generalizability of the research findings. Furthermore, there were no interviews with representatives from the National Board of Health and Welfare or any other informants working with issues that have to do with medical licenses for foreigners which could lead to a less nuanced image of the situation since only one “side” is presented.

The snow-ball sampling method in this thesis depended on a friend to the researcher which may affect the reproducibility of this thesis. Another limitation is that the interviews were conducted in Swedish and the quotes have been translated to English which could affect the meaning of some words or phrases.

Findings

The informants in this thesis were between the ages 27-55 years old. All of the doctors that were interviewed had received their medical education and licenses to practice medicine in their home countries. One of the doctors had also been able to acquire a Spanish medical license, but was having difficulties getting it validated in Sweden. Only one of the doctors in this thesis was actually working as a doctor in Sweden. One informant was attending the supplementary course at Karolinska Institutet and the rest had passed all of their Swedish course exams but were unemployed. The doctors came from Egypt, India, Bolivia, Iraq and Russia and they all had at least one and a half years work experience from their home countries, one of the informants had worked for over 20 years as a doctor in her home country. Their length of duration in Sweden differed. The years spent in Sweden ranged from one year and nine months to 29 years.

These findings have been divided into six different themes that have been derived from the empirical data. Table 1 summarizes each thematic category.

Table 1

Theme	Explanation
Expectations	Expectations that the informants had on Sweden prior to moving.
The Swedish Language Barrier	Experiences from Swedish language courses and feelings about the language requirements for non-European doctors.
Lost in Bureaucracy	Experiences from the bureaucratic procedures that non-European doctors have to go through to obtain a Swedish medical license.
Taking Steps Back, Personally and Professionally	Experiences of coping with not being able to work as a doctor in Sweden.
It is not Discrimination, but...	Feelings of not quite prejudice or discrimination.
Professional Differences	Perceived professional differences between

Expectations

“Many of my Iraqi colleagues like it here, they have managed to go through this long road and they have fared well” (Informant 4, 2012)

Four of the interviewed doctors had emigrated because they had a partner living in Sweden. One informant had come to Sweden through a university exchange program in social medicine at Karolinska Institutet and another informant had fled the war in Iraq with her family. She explained,

“we were threatened and had to leave the country ... Iraq in 2006 was a disaster. The civil war between ... Shia-Sunni ... everyone was killing everyone ... all my colleagues and friends abroad were calling ... what are you still doing in Iraq? (Informant 4, 2012)

None of the informants had expected to have any difficulties trying to work as a doctor in Sweden. Rather, the expectations were high. One informant had heard about the medical school Karolinska Institutet while growing up.

Informant: “ I wanted to train as a pediatrician, and here in Sweden you can study that, and there are good schools ... Perhaps you remember a movie, a book that was called Dr. Islands (correction: The island of Dr. Moreau)?

No I have not seen it

Informant: It’s about doctors ... at Karolinska, and when I read the book I was maybe 13, 14, 15 and I thought, I’m moving to Sweden and I will go to medical school at Karolinska but unfortunately, that’s not how it worked out” (Informant 5, 2012).

The informant also talked about information technology as a reason for wanting to study and work as a doctor in Sweden.

“Why do we come here to Sweden, why do we move from our home countries to Sweden? I have a sister who is a doctor here and when I compared my skills with hers, she was always a step above me because she had very recent information that had only been published yesterday but I would have to wait another year to get the same information, but it does not mean that she was a better doctor than I. She just had better information” (Informant 5, 2012).

The Iraqi informant talked about how Sweden was a better alternative than living in a war zone because of peace.

“... I had heard that people here are equal and all can live in peace and freedom ... you respect each other ... the standard of living here is good ... I heard that you can live with integrity and have a good life here”
(Informant 4, 2012)

One informant had been aware of a shortage of doctors in Sweden, prior to leaving her home country.

“...before I came here, my husband made a little investigation and he told me that there is a shortage of doctors and they need a doctor so I came here and I thought oh I will start school...I'll go out and work but unfortunately it was not like that...” (Informant 3, 2012)

The informants in this thesis had expectations on Sweden prior to their move which were among other things to live in a peaceful country, access recent publications and be able to pursue their careers.

The Swedish Language Barrier

The one informant that was working as a doctor explained that when she came to Sweden she was advised by the National Board of Health and Welfare that she could not work as a doctor because she could not speak Swedish. She started attending a Swedish for immigrants course⁶ (SFI) but quit after two days because she had been put in a class with Persian women that were illiterate in their own language. The informant then went on to learn Swedish on her own and later got admitted to the course Medical Swedish⁷ at Folkuniversitetet. After having lived for three months in Sweden, she claims that she could master Swedish. Her point was that she could not accept a “no, you cannot work as a doctor” instead she had to ask why was it not possible for her to work as a doctor, and the answer lay in the Swedish language barrier which she took on as a challenge. Swedish was her admission ticket to work as a doctor (Informant 1, 2012).

“I couldn't work as a doctor because I could not speak Swedish, so I went and learnt Swedish and came back. I said, look, now I can speak Swedish, so you see ... you have to analyze why am I being treated this way or why am I getting that answer” (Informant 1, 2012).

⁶ Svenska för invandrare

⁷ Sjukvårdssvenska

Most of the informants voiced their concern over the quality of the Swedish language classes. One informant that had passed all of his Swedish courses claimed that he could have learnt better Swedish on the streets (Informant 5, 2012). Another informant criticized the SFI course for being a waste of his time, he argued that the SFI course took too long to complete. According to him it was not efficient to study Swedish for two years; he required something more serious (Informant 2, 2012). One informant had been studying Swedish for three and a half years before receiving all the grades necessary to get accepted to the supplementary course and felt that she could have learnt Swedish in a shorter period but such courses were not offered in her city.

“... I have some colleagues that after 2 years... they were fully trained in everything from SFI, the Swedish language course b, and these are the scores that we are to have to register for the TULE test ... but for me it took three and a half years so I know it's just a waste of time” (Informant 4, 2012)

The fact that foreign doctors from EU countries do not have the same language requirements was brought up in most of the interviews.

“It is common to find non-Swedish doctors from the EU ... that cannot master Swedish well. They do not have to take a Swedish test, they do not have to do a knowledge test and that is dangerous for patients ... the policy is wrong, they should fix the system, and it's for their own good, not only for us” (Informant 2, 2012)

One informant elaborated about the difference between requirements for European doctors and non-European doctors.

“There is some sort of status symbol to have Swedish certification they need not do anything, they just need to send their medical certificate, and grades from Greece, and it will be converted to a Swedish medical license because there is an EU agreement” (Informant 1, 2012)

Another informant voiced frustration over after once having met with a doctor from Greece that had limited language skills in Swedish and English. To the informant, it was not comprehensible how a non-Swedish speaking doctor was working and he was not. Although having passed all of the Swedish language courses, he was still concerned about improving his Swedish. He said that Swedes often complained about “the damn foreign doctors that cannot speak Swedish,” He pointed out that it was important to show respect towards patients through mastering the language (Informant 5, 2012).

Lost in Bureaucracy

None of the doctors in this study had expected any complications before they moved to Sweden. One informant explained that it took a lot of patience to travel down the road to a Swedish Medical License (Informant 6, 2012).

“Before becoming a doctor in Sweden, you have to learn Swedish which takes 2 or 3 years, then you have to do an internship if you want to do your residency in Stockholm or around a big city, then you do residency for 2 years, so it’s at least 5 years to becoming a licensed doctor, when it only takes 6 years to become a doctor from the start. It is not a good process here. It is the most difficult and enduring process in the world.” (Informant 2, 2012)

The bureaucratic procedures for foreign non-European doctors were described as disorganized and confusing. The recognition of foreign doctors was according to one informant not handled in a Swedish manner and all of the informants discussed the difficulties in finding information on how to go about getting a Swedish medical license.

“When I came here, nobody knew what to do, we just acted, not randomly, but we just followed what was written on the computer, but no one had experience on what to do ...” (Informant 4, 2012)

The informants in this study had all had their share of being sent back and forth between different authorities such as the National Board of Health and Welfare and the Swedish Migration Board and between different officers working there. One informant had been waiting for the validation of his grades which was overdue and when he contacted the Board of National Health and Welfare he found out that his officer was no longer working there. He felt that they were not respecting his situation because his emails had been ignored and he also felt like he had been lied to because his application had not been processed in time (Informant 5, 2012).

Another informant described her situation,

“it was a disaster in the beginning, nobody knows, nobody knows, including employment services⁸ and it’s supposed to be their job, or I think it’s their job, they should know the way, know how to, what to do ... in the beginning I sent all my papers, the papers you get in fetters when you graduate from my home country, so when I sent it to the higher education authority⁹ and the National Board of Health and Welfare and they sent papers

⁸ Arbetsförmedlingen

⁹ Högskoleverket

that I have to do this TULE-knowledge test for all doctors who come from outside the EU and Switzerland, but this, it was wrong” (Informant 4, 2012)

All of the informants talked about inefficiencies in the system.

“The problem is that it takes so long to become a licensed physician, even though I know that I can work now ... I do not get an internship or anything, it takes about 3 years for me to become a licensed physician, and we forget everything in 3 years and, it is difficult, perhaps it would be easier if we can find internships or if the National Board of Health and Welfare can make the process quicker so that we can go out and work” (Informant 3, 2012)

Prior to immigrating the informants had not expected the difficulties that they have met in Sweden. It had been a disappointment for foreign doctors to be met by disorganization and obstacles while trying to restart their careers in a new country and professional environment. One informant thought that she would start working one year after moving to Sweden but now she described herself as depressed and not wanting to get out of bed in the mornings (Informant 4, 2012). Another doctor who has lived in Sweden for five and a half years said that he was tired and had lost almost all motivation (Informant 5, 2012).

“I thought I would start working from the first year or after two years ... I was very disappointed after half a year, after a year I became depressed, for 2 months, I could not get out of bed, I was so tired ... you realize that you’re getting older and also there are a lot of others with skills, many other doctors that come from all European countries ...” (Informant 4, 2012)

The road to a Swedish medical license was described as a struggle that the doctors had to go through on their own seeing as there were no authorities capable of helping them. Three informants had even been in touch with politicians. One informant mentioned,

“I’ve spoken to many people, including many politicians... but nobody can do anything ... we just talk talk, talk, until you feel that you’re just opening your mouth but it doesn’t pay off” (Informant 4, 2012)

The informant that had acquired a Spanish medical license, but still had difficulties in getting a Swedish license, described the situation compared to Spain

“Was it easier to get license in Spain?”

Informant: absolutely, no problem, they know that they need many doctors, just as all countries in Europe do. They said nothing, they just compared my records with my other personal documentation and looked at the difference between medical licenses in Spain and my home country,... the validation time was about 9-

10 months ... I have many friends who did exactly the same thing and their time was between 3 weeks to a year, so, I'm here almost 5 years, I have no response from the damn people who work at the National Board of Health and Welfare” (Informant 5, 2012)

The informant that had been working as a specialist for over 20 years wished that the process to get her medical license was more personally designed for her. She explained how difficult it was to study for the TULE-test that included five different sections, surgery, gynecology, obstetric, pediatrics, psychiatry and psychotherapy.

“I talked to the National Board of Health and Welfare and asked why they decided on TULE-test for me and I got no clear answer, I do not understand, he just said, you got the decision in 2010 and you have to do it this way.... The system in Russia is different, pediatricians study in a different faculty than doctors studying adult medicine so I cannot work as a pediatrician ... I have to repeat my knowledge of surgery that I studied 20 years ago... the Tule-test requires the answers short and precise but my Swedish is not so perfect ... the TULE-test does not show objectively how I as a physician” (Informant 6, 2012).

A slow process, not knowing where to turn to for guidance and losing motivation were some of the concerns that the informants had about the bureaucratic procedures for obtaining a Swedish medical license.

Taking Steps Back, Personally and Professionally

All of the informants who participated in the research presented in this thesis described themselves as coming from middle to high income backgrounds or families with academic traditions.

One informant described,

“Actually I had a great economy in my country and that is why I think I miss having my own money here ... In Bolivia, I had a big house, but of course everyone has a big house in their home country but I had many things, jacuzzi, pool table and lots of things at home so it was very good.” (Informant 3, 2012)

All of the informants mentioned having good standards of living in their home country, and one informant also talked about the better opportunities in his home country where he could get a higher salary and where he had been offered a position as a chief at a hospital. He did not believe that he would get those opportunities in Sweden since he was “only a student.” He further explained his situation,

“you cannot work as a doctor before you have completed tests or the supplementary course, so you can do nothing really. Just be unemployed without money, without support, without a residence permit and try to go about it all by yourself” (Informant 2, 2012)

All of the informants were asked the question, Why they had chosen to become doctors in the first place? Their answers were quite similar. They had known since they were children what they wanted to do. Nonetheless, not being able to work as a doctor in Sweden had forced them to take other jobs that did not match their qualifications. Working at a place that did not make use of their competence and skills, where for example they were not allowed to medicate, was described by one informant as a waste of time and not helpful.

“I’ve tried as a personal assistant or staff in private nursing homes ... It is nothing, it’s not for me. It’s like high school students also work there. They do not need my expertise, I lose time if I work there and I cannot medicate, nothing, it is wasted time and expertise, it does not help” (Informant 2, 2012)

Another informant was not able to get a job because she was overqualified.

“I tried to find many jobs ... but I unfortunately got no job because they say ah but no, you’re a doctor ... you have to find a job or wait to become a doctor in Sweden... I applied as for a job as a personal assistant, as a nurse and as a nursing assistant I think five or six different types of work, I also applied as a waitress, but unfortunately they say no you are overqualified for the work, I did not get a job....”
(Informant 3, 2012)

She went on to describe her feelings of not being able to work,

“I get very sad that it takes so long because you know, all the time that you cannot work, you are forced to for instance, if you need money or anything, I have to go to my partner and say can you give me money, can you..., and it does not feel good because I know I can work I know I can do all things but unfortunately I just have to wait ... so it’s a bit hard” (Informant 3, 2012)

The same informant had volunteer experience from working with the Red Cross in her home country. She had been in touch with the Red Cross in Gothenburg to volunteer but they told her that she could not work for them. They told her, if you want to help it would be good if you donate 500 SEK or 300 SEK per month, but she went on and told them that she had no money, what she did have was skills and the will to help (Informant 3, 2012).

The informant who had been working as medical specialist for 20 years in her home country found it strange that she had to start all over again and do the internship that medical school students do immediately after graduation (Informant 6, 2012).

One doctor voiced that people expect doctors' to be headstrong and persistent but just because someone had studied medicine does not mean that they know how to do everything (Informant 1, 2012). She continued on to describe the many foreign doctors who were not strong enough to follow through the bumpy road towards getting a Swedish medical license. Some give up because they are not able to find a solution and get information about what to do (Informant 1, 2012). One doctor described himself as not being able to cope with all of the Swedish rules, he could not believe that at the end of it all, it would have taken him five years to get a Swedish medical license. If things did not get better he was prepared to move because there were other countries, such as Norway that had more attractive labor markets for foreign doctors (Informant 2, 2012). Another informant made a similar point,

“I would move to Spain, they need doctors, they will say, come, come here. We will thank you; we will pay you, not just Swedish kronor, but Euro, very good money, in Norway and Denmark as well. I do not understand Sweden ... all the people I meet on the street or on the bus ask all the time, we need more doctors, we need doctors, whilst another complains that we need doctors that speak Swedish” (Informant 5, 2012)

Although the discussion of moving was brought up in every interview, it was not an easy option, seeing as the informants had loved ones or families in Sweden, or because moving back to their home country was too dangerous. One of the informants said that she was just trying to remain patient (Informant 6, 2012).

Some of the informants had been in touch with the Swedish health system as patients. They voiced their thoughts on the perplexity of Sweden not having enough doctors.

“...In Sweden, it's good that you have insurance so you do not pay so much ... but unfortunately it's not that fast, you have to wait a lot when you go to the emergency, ... and they have only one doctor. . . they should have three to four physicians instead of one to solve all the problems and patients quickly. I talked to a doctor in the emergency of Sahlgrenska and he said there are not any more doctors to pay but we have the money. I said, but ... there are many foreign doctors. If you compare with my country, for example they have six different specialists in the emergency room and they solve problems in 30 minutes ... it is a big difference so I wish I could help Sweden ... (Informant 3, 2012)

“... I hear that Sweden still needs more doctors ... but at the same time, it's very difficult, very difficult...”
(Informant 4, 2012)

Not only did the informants talk about the supposed lack of doctors, but also a competence gap that they could fill. The advantages that foreign doctors have over Swedish doctors were brought up in every interview. Being bilingual was said to be an advantage, because not all patients can speak Swedish.

One informant had a personal encounter with health care in Sweden when the informant became ill. He said it took three and a half months for the doctor to determine the diagnosis. After his diagnosis in Sweden he travelled to his home country where the doctor was able to give the same diagnosis after half a minute (Informant 2, 2012). Another informant also had opinions about Swedish health care after a visit with his wife.

“I met a doctor in here at my health center, a girl who was an undergraduate doctor ... and we asked about my wife ... my wife is not feeling so good ... blablabla ... and this undergraduate doctor answered us, “oh, maybe you have a cold.” A cold for six months without symptoms without any signs, with nothing and I thought ... we are here in Sweden, Europe, they should know more about medicine right? ... I mean, not all people can become doctors ... and I thought to myself, if I compare this doctor with myself, when I was a student, I had much much much more knowledge and common sense ... so I think I can work here, no problem, I need no supplementation education, I only need to learn how the system works ... I would like to work a little ... with a supervisor, a person that can point out, this is how it works, you can't do that, but you have to do it like this...” (Informant 5, 2012)

Not only had the informants in this thesis taken steps back professionally since they were not able to work as doctors, they had also experienced personal setbacks that had to do with status. At the same time they all felt that they had something to offer Sweden.

It is not Discrimination, but...

All of the informants were asked if they had ever felt that they were being discriminated against in the process of trying to get a Swedish medical license. None of the doctors agreed to the term discrimination, their opinion was that the word was too strong and that it did not capture the essence of what was really going on. One informant described it as such,

“If you just look at the rules from the National Board of Health and Welfare, the rules are crazy, some think it is discrimination, but I do not know what the underlying thinking is” (Informant 2, 2012)

Another doctor asserted that foreign doctors from non-European countries are not discriminated against, but they are disadvantaged. The informant stressed that it was important that Sweden had medical license requirements for foreign doctors, because it was important that all practicing doctors had qualified medical skills. However, in discussing this issue she meant that Sweden was demanding more of non-European doctors than any other group (Informant 1, 2012).

Another informant had a similar opinion,

For almost two years I have stayed here and struggled with the Swedish language. Two years I've stayed out of work. It's pretty bad for doctors to not work for that long. It is not acceptable, I understand that the government must be sure that foreign doctors are well trained and can work as a doctor here; it's good, but I just want to say that the road needs to be a little easier. They could make it a bit more individual... It must be personal, not just be mechanic, go this way and if you are not specialized, go the other way. It is not good for Sweden (Informant 6, 2012).

One informant was concerned that foreign doctors were being treated as a homogenous group. He also felt that indirectly, Sweden doubted the quality of education in his home country,

“... the way of thinking here in Sweden is that we have the best skilled doctors, but it's not so. It is perhaps much better in other countries but they haven't checked... it's not black and white; it's not the doctors and the non-European doctors. That is the wrong idea... It's not just Sweden or the European countries that have good medical schools. If you come from ... India, it is great, really, a super good education” (Informant 2, 2012)

Another informant said,

“I understand that the system wants to be sure I have good skills, it is ok... but it's not so easy to become a doctor anywhere in the world, medical school is difficult all over world and I think we have many great doctors in my home country ... the equipment here in Sweden is much better, much better if you compare with my country, but we can think clinically, our surgeons can do everything with their hands , we don't have that much equipment , but here in Sweden it is perfect, the equipment here is fantastic” (Informant 6, 2012).

One informant described that a doctor coming from Romania would have a much easier time, getting grades validated and could get a specialist position at a hospital in no time, whilst a non-European doctor had to go back to being a student (Informant 2, 2012).

Professional Differences

All of the doctors were asked about medical education in their home countries. The informants had been trained as general practitioners in their home country, except one that had specialized in internal medicine (Informant 6, 2012). The findings show that medical school differs from Sweden and between the different informant's countries as well.

"Iraq is not like here ... once we graduated from medical school we were given our medical licenses directly, and we have been trained as general practitioners, but I've also done a two year residency as a family practitioner, but actually you have to read four years to become a specialist, I have read only two years and then we had to move from Iraq" (Informant 4, 2012)

"I did five years at university and one year as a resident. I was every day in hospitals for one year, the same as here, so I do not know why we have to do again" (Informant 3, 2012)

All of informants in this study talked about needing to learn more about health care in Sweden because they were aware that there were differences with their home country.

"I know there's a big difference between my home country (and Sweden) but there's actually not many differences between actual diseases and the treatments themselves. Perhaps we do not have the same medicine in Iraq that you get here in Sweden, but it's still the same, we are well educated, I promise you" (Informant 4, 2012).

Some of the doctors who participated in this thesis felt that they had a lot to offer Sweden. One thing that two of the informants talked about was that they had more clinical skills than Swedish doctors.

"I think I have a lot of advantages in the clinical part of medicine, you know, in my country we do not have many laboratories or there are many people who are poor and so and they cannot pay for a ... ecocardio doppler so we need to see patients and examine very carefully to know what happens to the patient" (Informant 3, 2012).

The other informant made the point that doctors were more experienced in his home country because, during any one working day doctors got to meet a larger amount of patients than doctors do in Sweden. He believed that with more patients came more knowledge and experience (Informant 2, 2012).

One of the foreign doctors in this thesis had also noticed that there were differences between the patient-doctor relationships when she compared her home country to Sweden.

“I’ve noticed, when it comes to patients ... patients in my country, I do not know, maybe because I left Iraq in 2006 and it’s different nowadays, but when I was there ... we did not have internet, it was impossible to buy cell phones, so it was difficult to get information, so patients in my country did not know much about diseases, just what the doctor told them and just what they got to hear from others ... but we did not have much time to just talk to patients, explain to them. Here in Sweden ... I think it is 70% that you speak with the patient and disclose what the disease is, what the differences between treatments are, what kind of side effects, medications ... surgery ... In my country, I feel sorry for the patient. The doctor or specialist ... they do not have that time, to just sit with patients and talk, for example, here, a patient can make an appointment to only talk to the doctor, in my country there are no such things. Unfortunately ... sometimes a gynecologist ... specialist, has to attend to four patients at the same time It is terrible” (Informant 4, 2012)

During the seminar with the Swedish doctors, some discussion topics concerning working with foreign doctors were brought up. One Swedish doctor mentioned that sometimes patients complained about foreign doctors. The complaints often involved the patients feeling marginalized and that the doctor did not listen to patients during treatment. The Swedish doctor said that in Sweden, communication between patient and doctor is important. Patients are usually involved in the process of treatment and are able to influence outcomes. The Swedish doctor had the feeling that this was unfamiliar to one foreign doctor that she worked with who was probably used to being more straight to the point, telling patients that “you have to do this”. The question raised during the seminar was how to criticize a foreign doctor who was used to doing things in a different way, but who was still very experienced and knowledgeable. Another doctor at the seminar then answered, “but how do foreign patients feel about Swedish doctors, maybe they do not consider us real doctors” (Seminar, 2012).

The informant that was working as a doctor in Sweden said that she had been lucky during her own process but that she knew of other foreign doctors that had worked hard at getting their Swedish medical license, and once they had received it, they had run into a number of obstacles in their new work places. One of the biggest problems was the lack of knowledge that foreign doctors had about the Swedish health system. She explained that the health system in Sweden is complicated because all hospitals work differently. There is one way of working at Karolinska Institutet. At Södersjukhuset they work in another way and at Huddinge Sjukhus things work differently. The problem arose from the fact that although it was hard to get a Swedish medical license, there was no systematic way of schooling foreign doctors into the Swedish system. Her

opinion was that the supplementary course was the best option for foreign doctors wanting to work in Sweden, but that there were too few places (Informant 1, 2012). Another informant had a similar opinion,

“...there is a shortage of places. Here in Gothenburg there are only 16 places per year and it's very much compared to all the people who want to study, maybe they ... have more places and it would be perfect for all I... last year I went three times to listen to how they work and it's a very good course” (Informant 3, 2012).

Since there were too few places, a lot of foreign doctors just studied for the TULE-test, but while doing that, they lost out on practical training (Informant 1, 2012). Besides, it was described as difficult to pass the TULE-test without ever having worked with health in Sweden, because during the practical test, the doctors could be required to perform a gynecological examination, which was described as difficult if you did not know the procedures in Sweden (Seminar, 2012). One informant thought that it would be good if foreign doctors could do an internship (Informant 1, 2012). One of the Swedish doctors at the seminar said that she sometimes received requests from foreign doctors to do an internship, but that the procedure on how to go about it was too complicated. She had turned to the National Board of Health and Welfare for answers, but without any luck (Seminar, 2012). The one informant that had managed to get a six month internship describes it as not being that easy, the Integration Unit¹⁰ had helped her a lot and during her intern she learnt about the Swedish society. She had been nervous at first, as to how she would be received, she describes it as such,

“What was the most difficult thing during your internship?”

Informant: it was actually my prejudices one could say, or that I was afraid. I was afraid of people's prejudices. I am a Muslim, I wear a veil... sometimes I think, How will people react? How will people respond to my knowledge, will they trust me? But it went great, it was not like that, everyone was kind. Sometimes I saw reflections in people's eyes but it went well, I could handle it and it was so interesting, such a wonderful time” (Informant 4, 2012)

Another informant had not been so lucky when trying to find an internship. The response he had got was who was going to pay him, but he meant that salary was not that important, he just wanted to learn (Informant 5, 2012).

¹⁰ Integrationsenheten

An informant was concerned that because foreign doctors were unable to practice medicine for an extended period that they would “forget” their medical skills. As the informant explained,

“This test, the TULE-test for foreign doctors. When I was doing my internship, 3 years earlier, in fact, I did not have that much ... language proficiency, and as I read previous tests, I could answer the questions... but nowadays, the tests are becoming more difficult ... and you feel that you are so far from the health system so you actually start to forget, you have to constantly read about, read, but if you have no motive or you just feel, that it is not leading to anything, then why should you read? But I hope this feeling goes away, I still struggle and I hope to get my Swedish medical license” (Informant 4, 2012).

Analysis and Discussion

On the road to getting a Swedish medical license foreign doctors are divided into two groups: European (EU) and non-European. The empirical data in this thesis suggest that there are stricter requirements that act as barriers for doctors from non-European countries to be able to practice medicine in Sweden. The barriers were said to be institutionalized formally and in practice through stipulated language requirements, validation of grades, a slow process, no clear guidelines, no authority to help and confusion over where to turn to. Barriers that European doctors were said to be unaffected by. The findings in this study show that the experiences of non-European doctors in Sweden are not so much related to brain drain, but rather a convoluted and inefficient process that hinders them from entering the Swedish labor market for doctors. Although Sweden does not actively recruit doctors or seek to brain gain at another country’s expense, doctors leaving their home countries can still result in a brain drain effect.

The requirements of having to learn Swedish, pass the courses and get the certification in order to get enrolled in the supplementary course or be eligible to do the TULE-test were considered additional demands imposed only on non-European doctors. European doctors were not required to comply with these requirements. Complaints were also made over the lack of individual evaluations of medical skills.

The doctors who participated in this thesis were experiencing feelings that were not quite prejudice. One informant had expected discrimination because of her veil prior to starting her internship, but had not come across discrimination. None of the doctors in this thesis agreed that they were being discriminated. Instead they blamed their struggles on the faulty and inefficient

Swedish system. Why there are different licensing requirements for non-European doctors was not clear. To get more insights here would entail studying EU migration policies and Swedish labor force migration policies more in-depth, which is outside the scope of this study. However the results in this thesis show that there are traces of differential treatment between European and non-European doctors which may well be defended by arguments about labor migration and movement within the EU's administrative zone. Arguably the differential treatment could also be the result of traces of subtle systematic discrimination embedded in policies and practices. Although empirical data from this thesis has found only inferred or indirect evidence for this, there are broader theoretical discussions about Europe (through EU institutions) building a fortress of legal, economic and political boundaries around itself, with the aim of blocking out unwanted subjects from outside countries (Ponzanesi, 2011). The theoretical framework on postcolonialism may offer hints as to why the situation with foreign doctors in Sweden is as it is. Postcolonial theory provides a frame for discussion of the empirical data rather than directly a definitive answer.

The complaints that the Swedish doctor at the seminar had received from patients about that foreign doctors were too domineering, is an example of how cultural differences are made between Swedish doctors and foreign doctors. Here Swedish doctors were described as considerate to the patients' thoughts, and foreign doctors were depicted as inconsiderate. Statements like this group together a number of people from different cultural backgrounds and generalizes about negative norms. Foreign doctors from both European and non-European countries were treated as homogenous groups and individual competence was not taken into account. According to postcolonial theory, foreigners' skills and competence can get grouped together as one cultural entity and this can affect the culture that is perceived as most distant, in a negative way. Foreign cultures also get labeled as being static and backward which does not let foreign cultures to be seen as being progressive. In this case, non-Western cultures get a lower ranking because the Western culture is dominantly normative. The informants in this study felt that work experience from their home country did not matter during the process of trying to get a Swedish medical license. Feelings of frustration over this matter came forth in all interviews. The one informant that had over 20 years work experience as a specialist in Russia had received a decision from the National Board of Health and Welfare stating that she had to do an internship in Sweden, something that she described as being suitable for young doctors. The theoretical framework on

postcolonial theory suggests that the devaluation of skills that foreigners have can be traced back to colonial times in descriptions of “the Other”. By undermining the competence of “the Other”, or claiming that “the Other” could only handle simple tasks, it became justifiable to exclude “the Other” from certain positions.

Postcolonial theory explains that Europe is superior to Africa, Latin America and Asia because the former was once a colonizer and the latter were once colonies and that the power relations still exist. These viewpoints are not only shared by those in inferior positions but also by the ones in power. The postcolonial theoretical framework in this thesis suggests that Europe has an imperative to continue to depict itself as a center for science, knowledge and power. One way of maintaining this position may be by projecting the Western world as superior to the rest of the world. In this case, the medical labor market in Sweden becomes desirable. Having a Swedish medical license was described by one informant as being a status symbol for European doctors that could possess a license without having to move to Sweden. Modern medical equipment, information technology and peace were traits that the informants associated with Sweden. These traits offer Sweden an attractiveness that succumb particular conditions that the doctors dealt with in their home countries. However, none of the informants expressed ever feeling inferior or having inferior experiences. Instead it was mentioned that doctors in the home country could do the same things as doctors in Sweden, and that just because doctors in Sweden had more recent information, it did not make them better doctors. The doctors in this thesis also had views that European doctors were not always the most suitable candidates because they had not been required to learn Swedish and therefore did not master the language. Rather the informants in this thesis had interpreted feelings of distrust from Sweden about the quality of their education. The inferior complex was projected on them through the procedure of getting a Swedish medical license because they felt that Sweden doubted the competence that they had acquired in their home countries. The informants noted that medical school differed from their home country but reassured that that did not make it less good. The doctors in this thesis came from middle-high income socioeconomic classes which could explain why they ranked their competence highly or even above Swedish doctors’. In fact, the informants mentioned advantages that they had over Swedish doctors such as being bilingual and having more clinical skills. The disadvantages that the informants mentioned had to do with Sweden-specific skills such as that they were lacking knowledge of how the Swedish medical system worked, but they believed that they would learn

those skills if only they got to work practically or do an internship. Their disadvantages were not perceived as static, but as obstacles that they could overcome.

Being persistent and headstrong was described as personality traits that have been imposed on doctors. It is what is expected from a person that has gone to medical school and chosen the path of medicine. The informants in this study discussed how the process they were going through was a frustrating struggle and how it left them feeling sad and disillusioned. The socioeconomic backgrounds of the informants and because the informants rated their competence and skills highly could explain why they had not yet given up; even after five years in Sweden for example one informant was still focusing on perfecting his Swedish language and trying to get a Swedish medical license. They also mentioned that medical knowledge needs to be practiced, so it is not forgotten. Although they were studying for the TULE-test, the doctors felt that they were forgetting how to practically work with medicine. They were being confined to studying Swedish at a relatively basic level that did not correspond to their previous high level of education.

Although the informants were not strictly labor migrants, they had still had expectations on practicing their profession as doctors in Sweden. The expectations that the informants had on the Swedish health care system prior to migrating can be described as a type of counter-“Othering” since the informants valued and looked forward to the positive aspects of what Sweden had to offer. Instead they were met with professional disappointments and the reality of an inefficient system of validating foreign grades that was described as being done in a non Swedish manner, Swedish doctors that could not diagnose simple symptoms and a high patient to doctor ratio. The informants mentioned their wasted competence and how they could help Sweden resolve its lack of doctors’ problem. Instead they experienced regression both in terms of status and occupation, by being reduced to becoming students, unemployed, not being able to medicate when working with elderly people, and some not even being able to get a job as a waitress.

Conclusion

This thesis has looked at how non-European doctors have experienced the process of trying to get a Swedish medical license, how they feel about the requirements that they have to fulfill and if they have ever felt discriminated in the process.

The six doctors that were interviewed for this thesis had different reasons for migrating to Sweden that were not linked to brain drain but rather to general mobility and migration trends in Sweden.

It was found that foreign doctors from non-European countries had to fulfill more requirements than doctors from European countries in order to get a Swedish medical license to be able to practice medicine and work as doctors in Sweden. The informants in this study were disfavored and the road to getting a Swedish medical license was experienced as confusing, long, unfair and frustrating but it was not described as being discriminatory or prejudiced. Underlying reasons for the differential treatment between European and non-European doctors have been traced back to postcolonial discourses on cultural differences, Eurocentrism and “the Other”. Postcolonial theory could not fully explain the situation of foreign doctors in Sweden.

Through a postcolonial lens, Sweden, Europe and the West have medical systems that are superior to non-Western countries; therefore it becomes legitimate to question the skills of doctors coming from overseas countries. The informants in this thesis however showed no signs of inferiority. Rather they believed they had a lot to give to Swedish health care and that they had advantages over Swedish doctors. They saw some of the requirements that they had to fulfill as unnecessary. Learning Sweden-specific skills about such as the Swedish language and gaining more knowledge about the Swedish medical system were important, whereas certain medical knowledge requirements were not because they had already finished medical school and worked as general practitioners in their home countries. One informant had even worked as a specialist for over 20 years in her home country.

This thesis has found that the way that non-European doctors are treated during the process of getting a Swedish medical license is not direct discrimination, but the system is designed in a way that creates a number of obstacles for non-European doctors to enter the labor market.

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Appendix 1 Informants

	Age	Country of Origin	Home Town	Time spent in Sweden
Informant 1	55	Egypt	Stockholm	29 years
Informant 2	34	India	Stockholm	6 years
Informant 3	27	Bolivia	Gothenburg	1 year and 9 months
Informant 4	36	Iraq	Ludvika	4,5 years
Informant 5	35	Bolivia	Gothenburg	5 years
Informant 6	46	Russia	Gothenburg	2 years
Seminar	15 Swedish specialists attended the seminar for Swedish Specialists about Foreign Doctors and the Road to a Swedish Medical License			

Appendix 2 Interview Questions

1. Country of origin?
2. In what country did you receive your education?
3. In which field of medicine are you trained?
4. What year did you move to Sweden?
5. Did you have a medical degree when you came to Sweden?
6. Had you already done a medical internship before you left your home country?
7. Have you ever worked as a doctor in your home country?
8. How far have you come in Sweden? For example, do you have a Swedish medical license; are you practicing medicine, taking a Swedish language course?
9. What do you think is the biggest obstacle for foreign doctors in Sweden? How does it make you feel?
10. How do you feel about learning Swedish? Are you having problems tackling the Swedish language?
11. How do you feel about the organization concerning foreign doctors? Has it been easy to understand what to do? To who have you turned to ask for, guidance, instruction or advice?
12. How do you feel that the professional expectations of you as a doctor are?
13. Can you tell me a little bit more about the supplementary course for foreign doctors? Do you think medical school is different between Sweden and your country? Have you gained anything from studying medicine in Sweden? How do you feel that Sweden could gain from your knowledge and experience?
14. Why did you decide to become a doctor?
15. Why did you choose to migrate to Sweden?
16. What had you heard before you moved to Sweden?
17. Have you had any opportunity to work here in Sweden, if so, what was the job? How did you feel about that?
18. Do you have an understanding of the health care system in Sweden?
19. What are do you think are the biggest differences, even operationally between working in Sweden and in your home country?