Being Highly Skilled and a Refugee

Experiences of non-European physicians in Sweden

Katarina Mozetič
“The border exposes me to a gaze that does not see me as an individual but reads me as a type.”

(Khosravi, 2010: 76)
ABSTRACT

The thesis refines the analytical categories of ‘refugee’ and ‘highly skilled migrant’ by exploring the experiences of non-European medical doctors who came to Sweden as refugees. As a narrative research study, the thesis is based on seven in-depth semi-structured interviews with refugee doctors who live in Sweden. By employing Van Hear’s concept of mixed migration and the notions of human, social and cultural capital, the thesis accounts for the interconnectedness of research participants’ migratory and professional trajectories. The analysis of the complex criss-crossing of their doctor and refugee identities makes use of Brubaker and Cooper’s concepts of identification and categorization, and self-understanding and social location which are further developed by Jenkins’ theory on social identity and Anthias’ concept of translocational positionality. The thesis concludes that these individuals’ migratory trajectories cannot be ranked as either forced or voluntary, but have to be conceptualized in terms of mixed migratory movements. In the same vein, the thesis points to the processual nature of identity which is always partly self-constructed and partly determined by the external categorizations, and hence pleads against the essentialization of migrants’ identities, be it that of a ‘refugee’ or ‘highly skilled migrant’.

Keywords: physician, refugee, mixed migration, identity, Sweden
ACKNOWLEDGMENTS

I wish to express my sincere thanks to the interviewees for finding the time and the interest in speaking to me. This thesis would not be possible without my encounters with you. I cherish every single one of the stories you told me – they taught me a lot and I appreciate immensely the openness with which you shared them with me.

Another teacher who was indispensable for the creation of this thesis is my supervisor, Prof. Maja Povrzanović Frykman. She made me recognize the forest when all I could see was a maze of trees. She stocked me with essential readings and never forgot to add a few simply inspiring ones; she guided me through the ups and downs of my fieldwork and made me discern the crucial from the irrelevant. Most importantly, she was enthusiastic about the study from its very beginning and was a constant source of support and encouragement. As a young researcher, I could not have wished for a more profound teaching experience and better guidance - something I am immensely grateful for.

Furthermore, I would like to express my gratitude to Pernilla Hultberg from the University of Gothenburg for her keen interest in my thesis and her utmost kindness with which she shared her knowledge and views on the present licensing process concerning the non-EU doctors. I would also like to thank Brigitte Suter for the conversations that sparked the idea for this thesis as well as for her assistance along the way. This thesis would also not be possible without the help of numerous friends and acquaintances who enabled me to get in contact with medical doctors. In particular, thank you, Bengt Hällgren.

Last but not least, I thank my fellow students (you know who you are!) for the tiptoeing, yet crucial beginnings at our brainstorming seminars, for the shared gallons of tea, quiet co-presence and chatty lunch breaks during those endless library-days, and for your cheering up when spirits were low. Without you, this journey would have been much more solitary.
LIST OF ABBREVIATIONS

AT Residency in the medical field (*allmäntjänstgöring*)

CEFR Common European Framework of Reference for Languages

EEA European Economic Area

EU European Union

IMG International medical graduates

ID Identity document

ISIS The Islamic State of Iraq and Syria

NBHW The National Board of Health and Welfare (*Socialstyrelsen*)

NGO Non-governmental organization

OECD Organisation for Economic Co-operation and Development

OTD Overseas trained doctors

SFI Swedish for immigrants (*svenska för invandrare*)

ST specialisation in the medical field (*specialiseringstjänstgöring*)

Tisus exam Exam in Swedish for university studies
   (*test i svenska för universitets- och högskolestudier*)

TULE exam Medical exam for doctors qualified outside the EU/EEA and Switzerland
   (*tentamensgruppen för utländska läkares examination*)

UN United Nations

UNHCR United Nations High Commissioner for Refugees
TABLE OF CONTENTS

Abstract ......................................................................................................................... i
Acknowledgments ........................................................................................................ ii
List of abbreviations ..................................................................................................... iii
1. Introduction ............................................................................................................ 1
2. Aim and research questions .................................................................................... 3
   2.1. Delimitations .................................................................................................... 3
3. Clarifying terminology ........................................................................................... 4
   3.1. Refugees or asylum seekers? ........................................................................... 4
   3.2. Highly skilled migrants ................................................................................... 5
   3.3. Foreign medical doctors ................................................................................. 5
4. Academic relevance and contribution .................................................................... 7
   4.1. Review of relevant scientific literature .............................................................. 7
      4.1.1. Literature on refugees ............................................................................... 7
      4.1.2. Literature on highly skilled migrants ......................................................... 8
   4.2. Contribution of the thesis ............................................................................... 9
5. Background ............................................................................................................ 10
   5.1. Working as a doctor in Sweden ......................................................................... 10
      5.1.1. Obtaining the Swedish medical license ....................................................... 10
         5.1.1.1. Doctors from an EU/EEA member state or Switzerland ................. 10
         5.1.1.2. Doctors from outside of EU/EEA or Switzerland ............................... 10
      5.1.2. Comparison to other EU countries ............................................................. 11
6. Theoretical framework ........................................................................................... 13
   6.1. Mixed migration ............................................................................................... 13
      6.1.1. The role of choice and coercion ................................................................ 14
   6.2. Human, cultural and social capital ................................................................. 15
   6.3. Identity ............................................................................................................. 16
      6.3.1. Identification and categorization ................................................................. 16
      6.3.2. Self-understanding and social location ...................................................... 18
         6.3.2.1. Translocational positionality ............................................................... 18
7. Methodology, methods and material ..................................................................... 20
   7.1. Philosophical considerations .......................................................................... 20
   7.2. Research design .............................................................................................. 21
      7.2.1. Approach .................................................................................................. 21
      7.2.2. Material .................................................................................................... 21
         7.2.2.1. Sample ................................................................................................. 21
         7.2.2.2. Access ................................................................................................ 23
      7.2.3. Method ...................................................................................................... 24
         7.2.3.1. Semi-structured interviews ................................................................. 24
      7.2.4. Analysis .................................................................................................... 25
         7.2.4.1. Coding ................................................................................................. 25
7.2.4.2. Narrative analysis ................................................................. 26
7.3. Final methodological reflections .................................................. 27
7.3.1. Ethical considerations ............................................................ 27
7.3.2. My role as a researcher .......................................................... 29
7.3.3. Credibility, dependability and transferability ............................... 30
8. Findings ..................................................................................... 31
8.1. Introducing the interviewees ....................................................... 31
8.2. Narratives of leaving ................................................................. 32
  8.2.1. Reasons to leave, reasons to stay ............................................. 32
  8.2.2. Where to go to? .................................................................... 33
  8.2.3. On the way ........................................................................... 33
8.3. Being a refugee ......................................................................... 34
  8.3.1. Insecurity ............................................................................... 34
  8.3.2. Out of their own hands .......................................................... 35
  8.3.3. “We sit and…” ...................................................................... 35
  8.3.4. Being a refugee, being a foreigner .......................................... 36
8.4. Being a doctor .......................................................................... 37
  8.4.1. Motivation ............................................................................ 37
  8.4.2. Being a doctor ...................................................................... 38
  8.4.3. Professional reestablishment in Sweden ................................... 39
  8.4.4. Working as a doctor in Sweden .............................................. 40
  8.4.5. Gaining strength from profession ......................................... 41
9. Analysis ...................................................................................... 44
  9.1. The move ................................................................................. 44
    9.1.1. Walking on the terrain of choice and coercion .......................... 44
    9.1.2. Profession matters ............................................................. 45
  9.2. After the move ......................................................................... 46
    9.2.1. Professional career on rewind ............................................ 46
    9.2.2. Interplay between professional and migrant selves ............... 47
      9.2.2.1. Self-understanding: ‘provider’ versus ‘recipient’ .............. 48
      9.2.2.2. Identification and categorization: profession does not matter .... 48
      9.2.2.3. Translocational positionality: being a migrant and a doctor .... 49
10. Conclusion ................................................................................ 51
11. References ................................................................................ 54
12. Appendices .............................................................................. 65
  12.1. Appendix 1: Invitation to participate in the study ....................... 65
  12.2. Appendix 2: Interview guide .................................................. 66
13. Original Swedish excerpts ............................................................ 67
1. INTRODUCTION

This thesis takes its point of departure in the often one-dimensional portrayal of refugees as victims of conflicts who are dissociated from the intricate fabric of their personal, social and political histories. Moreover, as research on public discourses pertaining to refugees shows (see Bleasdale, 2008; Chouliaraki, 2012; K. Moore, 2012; Wright, 2000, but also, e.g., Agier, 2008: 8; Khosravi, 2010: 72-73, 111-113; Malkki, 1996; Peromingo, 2014: 76), refugees are seldom attributed capacities that would enable them to actively participate in and contribute to the societies they live in, but are rather seen as beneficiaries of host societies who pose a threat to the national welfare. On the other side of the wanted – unwanted spectrum (Faist, 2015) stand highly skilled migrants who are often portrayed in terms of their invaluable, even indispensible, contribution to the host societies (Chaloff & Lemaître, 2009: 10; Iredale, 2001; Mahroum, 2000: 23-24; Millard, 2005: 344-345).

In her article on Hutu refugees in Tanzania, the anthropologist Liisa Malkki (1996) depicts the discrepancy between refugees’ self-perceptions and humanitarian agencies’ habitual connection of refugeehood to poverty, victimhood and visible features of despair and violence. In order to break with such dehistoricization, which construes refugees as passive and speechless objects of humanitarianism, Malkki (1996: 390, 398) suggests we need to engage with ‘historicizing humanism’ that re-embeds refugees into their social, political and historical context. In order to do so, the author argues, we need to include refugees’ narratives and understandings of their own situations, roles and ‘complex loyalties’ (1996: 385).

Certainly, the ambition described by Malkki transcends the framework of this thesis, yet its direction is still worth taking. By delving into how high-skilled refugees perceive their own situation, the thesis seeks to document the narratives of people standing at the junction between welcomed and unwelcomed; desirable and undesirable migrants. More precisely, by exploring the experiences of non-EU² physicians who came to Sweden as refugees, the thesis highlights the entanglement of migratory and professional trajectories and selves, draws attention to the limitations of the established classifications, and pleads for their refinement.

The focus on physicians is grounded in the idea that refugee doctors³ clearly depict the contradictory social positions in which they find themselves. These individuals belong to the esteemed group of medical doctors, while they are simultaneously connected to the category and less favourable social imaginings of refugees (Salmonsson, 2014: 11).

---

¹ Also Swedish research supports these findings (see, e.g., Eastmond, 2011; Graham, 2002; Horsti, 2008a, 2008b).
² I am using the terms ‘non-EU’ and ‘non-European’ interchangeably since all interviewees originally come from the Asian continent.
³ The terms doctor and physician are employed as synonyms, as the term doctor refers to medical doctors.
Nowadays, there is nothing uncommon in being treated by a foreign physician within the Swedish medical system. The percentage of practicing physicians who were trained abroad grew steadily over the last couple of years and amounted to 24% in 2012 (Socialstyrelsen, 2011: 33; 2012: 20; 2013: 31, 35; 2014: 27; 2015: 23). The statistics furthermore coherently show that among those, two thirds received their education within the EU/EEA. The rest come from the countries outside of Europe, mainly Iraq and Russia, and migrated to Sweden mainly as refugees and family migrants (Socialstyrelsen, 2011: 32, 2012: 19-20, 2013: 31-35, 2014: 24, 26-27, 2015: 23).

The internationalisation of the Swedish medical sector is due, among other reasons, to the insufficient number of domestic doctors and the resulting recruitment of foreign professionals (Socialstyrelsen, 2014: 7, 44). According to the National Board of Health and Welfare (NBHW) (Socialstyrelsen, 2013: 51; 2014: 28), the majority of Swedish county councils (landsting) actively recruit foreign doctors and other medical professionals in order to decrease the shortage. Whereas recruitment has until now been limited to the EU, the need for physicians and the realisation that many of the refugees possess the much sought-after medical skills made some of the Swedish counties consider recruiting also among the refugees (see, e.g., Öst, 2014). If nothing else, this seems reasonable in light of the high admission numbers of refugees in Sweden. In 2013, Sweden received, in proportion to its population size, the highest number of asylum seekers and refugees among the OECD countries (for clarification of terms, see Section 3.1). And the numbers are increasing. In 2013, Sweden obtained 54 300 asylum applications in comparison to 43 900 applications in 2012, which was in turn an increase of 48% on the figure from 2011 (OECD, 2014: 13, 300).

With that said, the thesis is highly relevant for the Swedish context since it contributes to our understanding of refugees and foreign physicians, two groups of significant societal concern and importance. More generally, the pertinence of the thesis lies in its critical engagement with ‘modes of generalization and essentialization’ (Malkki, 1995: 510) of different migrant categories that are present in contemporary public discourses. In extricating the experiences of highly skilled refugees, the thesis, furthermore, offers a theoretical contribution since it refines the analytical categories of refugees and highly skilled migrants. As the French anthropologist Michel Agier (2008: 4) writes: “As against the ready-made ‘truths’ we are given to think, it is necessary rather to start from the social situations and experiences that are lived and shared, to trace the chain of lost causes buried in complex political histories.”

---
4 The numbers on foreign physicians in the quoted reports by NBHW (Socialstyrelsen, 2011; 2012; 2013; 2014; 2015) refer to those who were trained abroad (läkare med utländsk utbildning) which may also include Swedish nationals with foreign education. Despite this fact, I am using these statistics because they represent the official and closest approximation of the number of foreign physicians in Sweden.
2. AIM AND RESEARCH QUESTIONS

The overall purpose of the thesis is to contribute to the theoretical debate in migration studies by critically assessing and refining the analytical categories of ‘refugee’ and ‘highly skilled migrant’.

The thesis aims to explore the experiences of non-European physicians who came to Sweden as refugees, thereby accounting for their spatial and social movement, as well as their subjective perceptions of themselves.

Hence, the research questions that guide this thesis are:

- How do the refugee and professional trajectories of non-EU doctors affect each other?
- How do the refugee and professional identities of non-EU doctors influence each other?
- How can we theorize the combination of the two fields of research on refugees and highly skilled migrants?

2.1. DELIMITATIONS

This thesis focuses exclusively on physicians from non-EU countries who came to Sweden as refugees. I delimit the scope of the thesis to one profession (see Chapter 1) in order to tease out the profession-related considerations and factors that shape individuals’ experiences. The ambition of the thesis is, therefore, not to grasp the realities of the interviewed refugee doctors in their entirety, but in explicitly examining the nexus between their professional and refugee experiences. The focus on non-EU doctors is grounded – beside the fact that refugees come to Sweden from non-EU countries – in the distinct regulations pertaining to EU/EEA and non-EU physicians who intend to work in Sweden.

While qualitative methodology in general, and in-depth interviews in particular, is fully suited for the purpose and aim of this thesis, a delimitation lies in the number of interviews. The designated timeframe for this thesis and the recruitment difficulties presented in Section 7.2.2.2 allowed me to conduct eight interviews, of which this thesis employs seven. Furthermore, interviewing in a foreign language may additionally constrain the richness of the material. However, the 85 pages of transcriptions prove to provide rich narratives and a solid ground for analysis led by the research questions.
3. CLARIFYING TERMINOLOGY

3.1. REFUGEES OR ASYLUM SEEKERS?

Refugees and asylum seekers are usually classified within the group of forced migrants. In other words, refugee migration is propelled out of the need to escape conflict or persecution, not one’s own wish to follow economic or other incentives (Castles & Miller, 2009: 188; Serra Mingot & de Arimatéia da Cruz, 2013: 176-177). Though popular usage often tends to use the terms ‘refugee’ and ‘asylum seeker’ interchangeably, legally and politically there exist several important differences.

Refugees – also referred to as Convention refugees – encompass forced migrants who had to flee their home country for reasons recognized by the international refugee law (Castles & Miller, 2009: 188). As defined by the 1951 United Nations Convention Relating to the Status of Refugees, refugee status is assigned to a person who is living outside of their country of origin, was subjected to forced displacement and is now unable or unwilling to return to it due to a well-founded fear of persecution on the grounds of their ethnicity, race, religion, political opinion or membership in a certain social group (Agier, 2008: 7; Castles & Miller, 2009: 188; Castles et al., 2005: 11; UN General Assembly, 1951).

A specific group of refugees are the so-called resettled refugees who – by being selected by the UNHCR in cooperation with national governments of resettlement countries – are permitted to move from the country of their first asylum to countries that offer them long-term residence and protection (Castles & Miller, 2009: 189).

Asylum seekers, on the other hand, are individuals who migrated to another country in order to seek protection, but whose claims for asylum have not yet been assessed. Host countries offer various types of protection for asylum seekers: typically refugee status for those who fulfil the 1951 UN Convention criteria (UN General Assembly, 1951), temporary protection for war refugees and humanitarian protection for those who do not meet the 1951 Convention criteria, but might still be endangered if returning (Castles & Van Hear, 2005: 12; Serra Mingot & de Arimatéia da Cruz, 2013: 177).

If an asylum seeker is not assigned refugee status, Sweden recognizes two types of protection. Subsidiary protection (alternativt skyddsbehövande) is in accordance with EU regulations and may grant an individual residence permit if the person is at risk of being sentenced to death, subjected to torture or injured due to an armed conflict. Other protection (övrig skyddsbehövande) has no equivalent in international conventions or EU legislation and exists only in the Swedish Aliens Act. An asylum claimant can be assessed as in need of other
protection if the person cannot return to the home country due to an armed conflict, natural disaster, or a well-founded fear of being subjected to violence (Migrationsverket, 2015).

In this thesis, I use the term ‘refugee’ to refer to the interviewees, though some of them legally-speaking might have been granted asylum on the basis of another type of protection. As I focus not on the legal regulations that frame individuals’ admission to Sweden, but on the experiences of flight as well as the analytical and social category their entry to Sweden puts them in, strict differentiation between refugees and asylum seekers is not relevant in this thesis.

3.2. HIGHLY SKILLED MIGRANTS

In contrast to refugees, highly skilled migrants are consistently placed onto the opposite side of the voluntary – forced migration dyad (King, 2012a: 137). According to Iredale (2001: 8), highly skilled migrants possess a university degree and often have extensive professional experiences. As they usually move abroad in order to find more rewarding employment, highly skilled migrants are mainly categorised as a subdivision of labour migrants. In contrast to low-skilled labour migrants and due to their talent and human capital, highly skilled migrants (here also called migrant professionals) are seen as an important asset in fostering innovation and international competitiveness, and enjoy a relatively privileged position of being sought-after by companies and welcomed by national governments (Chaloff & Lemaître, 2009: 10; Mahroum, 2000: 23-24; Millard, 2005: 344-345).

Though the migration of professionals is not a new phenomenon, scholars observe that it represents an increasingly large and complex component of global migration flows (Iredale 2001: 8). This development can be explained, among others, by globalisation of labour markets and the growth of knowledge-based economy. Moreover, shortages in certain sectors make many national governments deem professional migration as a means of filling the labour force gaps (Iredale, 2001; Millard, 2005: 344).

All people interviewed for this study had, before moving to Sweden, finished their medical studies in their home country or another non-European country. Some of them also had experience working as doctors before leaving for Sweden. They are the refugees among the highly skilled migrants, a group that has not been investigated to a large degree (see Section 4.1.2).

3.3. FOREIGN MEDICAL DOCTORS

There exist numerous ways of distinguishing between ‘own’ medical doctors and those coming from abroad. For example, North American research differentiates between medical
doctors who were trained at home from those with foreign medical training by referring to the latter as IMGs (International Medical Graduates). Researchers from Australia and New Zealand use the term OTDs (Overseas Trained Doctors). Swedish terminology, on the other hand, is less straightforward. In Sweden, and many other Scandinavian countries for that matter, researchers write about immigrant and foreign doctors interchangeably (invandrarläkare and utländska läkare). The demarcating line can thus be drawn either according to person’s national background or their country of training (Salmonsson, 2014: 13). In this thesis, the term ‘non-EU doctors’ signifies both the national origin as well as the country in which the individuals’ obtained their medical training.
4. ACADEMIC RELEVANCE AND CONTRIBUTION

4.1. REVIEW OF RELEVANT SCIENTIFIC LITERATURE

4.1.1. Literature on refugees

Refugee studies usually delimit the group they are examining according to, e.g., how refugees entered the country (see, e.g., Deng & Marlowe, 2013 and Harkins, 2012 on resettled refugees) or according to their legal status (see, e.g., Khosravi, 2010 and Willen, 2007 on irregular migrants). Furthermore, many studies on refugees take up a national or ethnic lens, as, e.g., research done by Colic-Peisker (2003; 2005; 2008; Colic-Peisker & Walker, 2003) on Bosnians in Australia, Malkki (1996) on Hutu refugees from Burundi and Rwanda, or Topham Smallwood (2014) on Syrian refugees in Lebanon (for further examples, see, e.g., Al-Ali, Black & Koser, 2001; Collyer, 2005). Also religion (see, e.g., Casimiro, Hancock & Northcote, 2007; Palmer, 2009) and gender (see, e.g., Hajdukowski-Ahmed, Khanlou & Moussa, 2013; Smith, 2013) are often used as delimiting features when studying refugees. The optic in Swedish research is similar; see, e.g., Bevelander (2009) and Rönqvist (2009) on resettled refugees, and Povranović Frykman (2009; 2012) on Bosnians in Sweden. These delimitations are mostly well-founded as they enable the researcher to explore the reality or examine characteristics of a specific group, or a particular legal, political and socio-economic context in which it finds itself.

However, to the best of my knowledge, research on refugees rarely delimits the group according to individual’s professional background. Profession has so far not played a defining role in refugee studies, though it is touched upon when discussing topics like labour market performance, integration and identity construction. However, even when such studies include highly skilled refugees, they do so without focusing on them.

Some of the research done on refugees and their employment integration addresses topics of education-job mismatch, professional down-adjustment and occupational mobility (see, e.g., Colic-Peisker & Tilbury, 2003; Renaud, Piché & Godin, 2003). In Sweden, a number of quantitative studies on labour market performance of refugees have been conducted by Rooth and Ekberg (2005; 2006) and by Bevelander (2009; 2011; Bevelander & Lundh, 2007; Bevelander & Pendakur, 2014). An example of qualitative studies is Povranović Frykman's research (2009; 2012) on employment-related experiences of asylum claimants and resettled refugees from Bosnia-Herzegovina who came to Sweden in the early 1990s.
Next to employment integration, several articles on refugees deal with social inclusion and identity issues (see, e.g., Colic-Peisker & Walker, 2003; Colic-Peisker, 2005). Though these articles do address the highly skilled among the refugees, they are not the focal point. This also goes for the extensive body of literature that outlines the experiential dimensions of refugeehood (see, e.g., Agier, 2008; Khosravi, 2010; Malkki, 1996). Their work is essential to our understanding of what it means to be a refugee and highlights the multifaceted nature of the experience. Nevertheless, also this literature does not take up the profession-related aspect of it.

4.1.2. Literature on highly skilled migrants

As shown in Section 3.2, research on highly skilled migrants usually defines these as labour migrants, leaving out those who did not migrate voluntarily or out of purely economic reasons. Though exceptions do exist (e.g., Badawy, 2009; Liversage, 2005, 2009; Pethe, 2007), to the best of my knowledge, no study focuses explicitly on the experiences of highly skilled refugees.

The academic discussion about highly skilled migrants repeatedly positions these within the ‘race for talent’ framework taking place within the international knowledge-based economy. Such migrants are thereby talked of in terms of resources that may be gained by or drained out of countries; the point of the matter is that the countries need to attract them and facilitate their admission (Cerna, 2009; Mahroum, 2000; Shachar, 2006). Consequently, a substantial body of literature pertaining to highly skilled migrants is concerned with the national policies regulating the high-skilled flows (e.g., Badawy, 2009; Becker, Liebig & Sousa-Poza, 2008; Boyd, 2014; Burkert, Niebuhr & Wapler, 2008; Cerna, 2009; Kofman, 2014; Koslowski, 2014; Peixoto, 2001; Shachar, 2006).

At the same time, an indispensable amount of migration research on migrant professionals pays attention to individuals’ experiences abroad and perceptions of their situation (e.g., Beaverstock, 2005; Jones, 2013; Kōu, van Wissen, van Dijk & Bailey, 2015; Lan, 2011; Mulholland & Ryan, 2014; Ryan & Mulholland, 2014; Tseng, 2011). Thereby, the studies explore the reasons behind the migratory move(s) (e.g., Magnusson & Osanami Törngren, 2014; Mahroum, 2000) or are interested in the individuals’ labour market integration as well as their socio-cultural emplacement (e.g., Benson-Rea & Rawlinson, 2003; Liversage, 2005, 2009; Madziva, McGrath & Thondhlana, 2014; Magnusson, 2014; Plöger & Becker, 2015; Somerville & Walsworth, 2010).

Studies of mobile professionals are interested both in those who are subjected to intra-company transfers, as well as those who move independently. Thereby, managerial elites
(e.g., Andresen & Biemann, 2012; Beaverstock, 2005) and IT specialists (e.g., Khadria, 2001, 2004; Raghuram, 2004; Xiang, 2001) are of particular interest, but also mobile academics and researchers have received close attention, though especially concerning the role of mobility for their career development (e.g., Ackers, 2004, 2005; Millard, 2005; Morano-Foadi, 2005; Oliver, 2012; Richardson & Zikic, 2007; Richardson, 2009; Robertson, 2010).

There exist numerous studies that focus on subjective experiences of migrant physicians regarding, e.g., the process of obtaining medical license in the country of immigration (see, e.g., Han & Humphreys 2005, 2006; Shuval 2000; Wong & Lohfeld 2008). On the basis of life-history narratives with 70 physicians who emigrated from the former Soviet Union in the early nineties to Canada, Israel, and the United States, Shuval (2000), for instance, explores how migrant doctors professionally re-establish themselves in the new society. Other studies explore the experiences of already practicing international physicians (e.g., Bornat, Henry & Raghuram, 2009; Harris, 2011; Raghuram, Henry & Bornat, 2010).

In Sweden, there exists a handful of studies dealing with the licensing process of migrant physicians (see, e.g., Berleen Musoke, 2012; Wolanik Boström & Öhlander, 2011, 2012). Salmonsson (2014), moreover, explores migrant doctors’ feelings of belonging within the Swedish medical profession. Further studies pay attention to the intercultural aspect of the medical work, particularly the communication between doctors, patients and staff (e.g., Andersson, 2010; Berbyuk Lindstrom, 2008; Berbyuk, Allwood & Edebäck, 2005). However, none of these studies focuses exclusively on the doctors that came to Sweden as refugees and what their experiences of being a refugee look like. This thesis hence aims to complement the existing literature by exploring the experiences of refugee professionals.

4.2. CONTRIBUTION OF THE THESIS

The contribution of this thesis is twofold. Empirically, the thesis produces and explores new empirical material on refugee physicians. By drawing on semi-structured in-depth interviews, this study seeks to gain a deeper understanding of what it means to be highly skilled and a refugee at the same time. By taking a step towards closing the gap in the literature where no study so far has focused on the experiences of the highly skilled among the refugees, the thesis also offers a theoretical contribution. It aims to connect the research fields on refugees and migrant professionals and, in doing so, refines the analytical notions as well as our understandings of refugees and highly skilled migrants.
5. BACKGROUND

5.1. WORKING AS A DOCTOR IN SWEDEN

In Sweden, medical studies consist of five and a half years of basic medical training at a college or university. After obtaining the medical degree, the doctors are required to do one and a half years of residency (allmäntjänstgöring, or as it is called briefly: AT) after which they need to complete a written and oral exam. Once they pass these, they can obtain the license to practice medicine (läkarlegitimation). For those who want to specialize (specialiseringsjänstgöring – ST), additional five years of training are required (Berleen Musoke, 2012: 4).

In order to be able to work in Sweden as a doctor, one has to have the Swedish medical license, as well as possess the required Swedish language skills and knowledge of national medical legislation (Region Skåne, 2015).

5.1.1. Obtaining the Swedish medical license

Doctors who have obtained their medical license abroad are required to fulfil the following criteria in order to be able to practise medicine in Sweden:

5.1.1.1. Doctors from an EU/EEA member state or Switzerland

Doctors who received their medical education within the EU/EEA do not need to provide an official proof of Swedish language proficiency and are not required to complement their training. They turn directly to the National Board of Health and Welfare (NBHW, or, in Swedish, Socialstyrelsen) in order to formally recognize their professional qualifications (Berleen Musoke, 2012: 5; Hultberg, personal communication, 2015 – see details in Section 7.2.2.2).

5.1.1.2. Doctors from outside of EU/EEA or Switzerland

Doctors educated outside of an EU/EEA member state or Switzerland must complement their medical training in order to obtain the Swedish medical license.

In the first place, doctors’ previous medical training has to be assessed and approved. At this stage it is decided if a doctor needs to do the medical knowledge test (the so-called TULE exam, or, in Swedish tentamensgruppen för utländska läkares examination) and residency, or if the specialisation experiences suffice for embarking directly to the probation period (provtjänstgöring). In the second step, all doctors have to document their proficiency in Swedish language skills. In order to do so, they need to either 1) pass the third/ high school
level of the course Swedish as a second language (svenska som andraspråk); 2) gain 60 ETC points for their Swedish studies at a university; 3) pass the Tisus exam (test i svenska för universitets- och högskolestudier) which provides proof of eligibility for university studies taught in Swedish; or 4) pass a Swedish language exam on the C1 level according to the Common European Framework of Reference for Languages (CEFR). Alternatively, proven language proficiency of Danish or Norwegian on the same level is also accepted.

Afterwards, the path of specialists and non-specialized doctors diverges. Specialists with at least five years of medical practice must do a probation period of six months at one of the Swedish medical institutions. During this time, the specialist works under the supervision of the local head of the unit (verksamhetschefen) who provides a final assessment of doctor’s competences and suggests, if necessary, possible additional training.

On the other hand, doctors with no completed specialisation need to, firstly, pass the TULE exam which is organised twice a year by the Karolinska Institutet in Stockholm and is comparable to the Swedish medical exam. During the three-day exam, the doctors undergo one theoretical and two practical examinations. The doctors need to answer approximately 100 questions related to surgery, medicine, obstetrics and gynaecology, paediatrics and psychiatry. The practical examination consists of one surgical and one medical examination of a patient where the doctor diagnoses an illness and suggests a treatment. As an alternative to the TULE exam, the doctors can also take part in a supplementary course (kompletterande utbildning för läkare, tandläkare och sjuksköterskor från länder utanför EU) that takes place over two terms and is organised by the universities in Gothenburg or Linköping, or at the Karolinska Institutet in Stockholm. Afterwards, the doctors need to do residency for about 18 months. In the final step, all doctors need to pass a course on Swedish medical legislation and can then, finally, apply for the Swedish medical license. After the doctors receive the license, they can start their training as specialists which usually takes five years (Berleen Musoke, 2012: 5; Region Skåne, 2015; Socialstyrelsen, n.d.; Sveriges läkarförbund, 2013).

5.1.2. Comparison to other EU countries

Sweden is not the only country that has specific provisions for licensing of foreign physicians. Within the EU, licensing systems for foreign doctors have developed within specific national contexts. Apart from some basic similarities – in comparison to the EU doctors, the non-EU doctors are usually required to provide additional documentation and need to pass further examinations, as well as demonstrate competence in the official national language – the

---

1 I am using here the Swedish name since the institute refers to itself with its official Swedish name also in English texts and does not offer any official English translation.
precise pathway to obtaining the country’s medical license can vary significantly (Kovacs et al., 2014: 229, 232).  

All Nordic countries, for example, require language skills in order to practice medicine. As in Sweden, the neighbouring countries also differentiate between regulations for EU and non-EU doctors. Generally, the latter are required to do additional clinical and theoretical training, as well as to pass knowledge exams in order to obtain the national medical license. In Germany, on the other hand, the non-EU doctors have to pass lower language requirements. They obtain immediately temporary working permission for two years after which they take a knowledge test (Hultberg, personal communication, 2015; Kovacs et al., 2014: 235; Rowe & García-Barbero, 2005: 54, 56, 69, 93).

---

6 Many countries do not only distinguish between EU and non-EU nationals/qualifications, but have special agreements with particular countries that facilitate the transfer of qualifications and movement of physicians. The Nordic countries (Denmark, Iceland, Finland, Norway and Sweden) have, for instance, in 1965 signed the Nordic Agreement which acts as a basis for mutual recognition of medical qualifications (Kovacs et al., 2014: 230; Rowe & García-Barbero, 2005: 7).
6. THEORETICAL FRAMEWORK

To analyze the interconnectedness of migratory and professional trajectories of non-EU doctors who live in Sweden, I employ Nicholas Van Hear’s concept of mixed migration, as well as the notion of human capital and Pierre Bourdieu’s concepts of cultural and social capital. Whereas the notion of mixed migration aptly captures the role of professional considerations within the migratory move, I complement it with the notions of human, cultural and social capital in order to account for the effect of border-crossing for individuals’ careers.

To grasp the doctors’ self-understanding as well as social positioning, I make use of Rogers Brubaker and Frederick Cooper’s distinction between identification and categorization, and self-understanding and social location. I develop the two categories by using Richard Jenkins’ theory on social identity, and Floya Anthias’ work on social location, which she captures in the notion of translocational positionality. Whereas the concepts of self-understanding, identification and categorization will enable to me to map out a two-dimensional picture of individuals’ identifications, social location will transform the image into a multidimensional social space that takes into account not only the hierarchical positioning of the different locations, but also the spatial and temporal aspects.

The presented ‘conceptual eclecticism’ (de Haas, 2014: 11) is not just a loose assembly of random theories, but is firmly grounded in certain shared features. Of particular importance to this thesis is their ability to bridge the divide and simultaneously incorporate structures that frame people’s lives and the agency these same individuals possess within the given spaces (see, e.g., Jenkins, 2008: 46). All of the theoretical frameworks are hence able to reflect both the outer forces and individual choices, i.e. the interaction “between being an actor and being acted upon” (Jackson, 2013: 207).

What is more, the presented theoretical framework enables me to portray the multifaceted and complex nature of the processes guiding people’s lives while at the same time depicting the underlying regularities. As de Haas (2014: 13) points out: “Social theory formation is precisely about striking a delicate balance between the desire to acknowledge the intricate complexities and the richness of social life on the one hand and the scientific need to discern underlying regularities, patterns and trends on the other.”

6.1. MIXED MIGRATION

One of the denominators commonly used for classifying migrants and migratory flows is the motive that makes individuals leave their home country or country of residence in order to
move to another one. We know, for instance, of student migration, labour migrants, refugees and family migration. Thereby, a distinction is often drawn between forced and voluntary migrants, i.e. those who were compelled to move and those who chose to do so. Most distinctly, this dyad can be found in the international and national governance of migration flows, both on the policy level as well as in the organizational infrastructure supporting migrants (Van Hear et al., 2009: 4; Van Hear, 2011: 2; 2014). However, such a typology is only useful up to a point. It is worth noting that it represents an ideal type used mainly for analytical and political reasons, yet that it rarely reflects reality in all its multilayeredness (Castles & Van Hear, 2005: 11; de Haas, 2014: 21; King, 2012b: 8; Van Hear, 2011 and 2014).

The concept of mixed migration – which is primarily associated with the Oxford migration scholar Nicholas Van Hear (2011; 2014; Van Hear et al. 2009) – has been developed and used as an analytical tool to bridge this divide and to highlight the continuum between forced and voluntary migration. The concept aims to capture the complexity of migration dynamics: the blending of motivations that drive people into moving, as well as the mixing associated with other stages in the migration process. As Van Hear (2014: N/S) writes: “(D)ifferent kinds of migrants may make use of the same agents and brokers; they may travel with others in mixed migratory flows; motivations may change on route and after arrival; and people may find themselves in mixed communities during their journeys or at their destination.”

6.1.1. The role of choice and coercion

In order to challenge and resolve the problematic dyad of voluntary and forced migration, Van Hear (1998: 41; Van Hear et al., 2009: 2-3) suggests that we have to dissemble the migratory trajectory into five basic components: 1) outward movement from the place of origin or residence, 2) inward movement to the place of arrival, 3) return to the place of origin or residence, 4) further onward movement to some third place, and 5) non-movement, since all migration means also leaving somebody behind.

According to Van Hear (1998: 41-47; Van Hear et al., 2009: 3-5), each of these components involves elements of coercion and volition. The degrees of choice and compulsion are determined through the dialectic interplay between what is also known as agency and structure, i.e. the capacity of people to take action and the contextual conditions that frame it. This means that migration cannot be simply either voluntary or forced. On the contrary, migration should always be understood as being positioned somewhere on the axis between

---

7 As Van Hear (2009: 4) explains: “It might seem odd to include those who stay put in consideration of migration, but they are an essential element in a migration order: those who stay may support migrants abroad, especially in the period immediately after departure, or they may be supported by the migrant members of their communities, particularly after such members become established abroad.”
coercion and options. What is more, the disaggregation of movement into the above mentioned components reveals differences that happen along the migratory journey. As Van Hear et al. (2009: 4) point out:

Thus while outward movement may be forced, precipitated by persecution, conflict, war or some other life-threatening circumstance, inward or onward movement, including the choice or determination of the destination, may be shaped by economic, livelihood, betterment, or life-chance considerations. At some point then, forced migration may transmute into economic or livelihood migration, and it is this recognition that forms the basis for the discourse on ‘mixed migration’. [emphasis in the original]

6.2. HUMAN, CULTURAL AND SOCIAL CAPITAL

Pierre Bourdieu\(^8\) claims that within the different fields of social space – such as, e.g., the economic, academic and cultural field –, individuals and groups struggle for control over resources. Their position within these fields and the opportunities that are coupled to it depend upon the extent and the kind of the capital they possess (Bufton, 2004: 28). Thereby, Bourdieu does not use a narrow definition of capital associated with financial possession and monetary exchange, but uses the term in a broader sense (R. Moore, 2012: 98).

Bourdieu distinguishes between two main forms of capital: economic capital refers to one’s material resources, whereas symbolic capital is of non-material and non-instrumental nature. The symbolic capital consists of different sub-types, such as cultural capital which is embedded in world views, acquaintance with certain manners and dispositions, as well as linguistic propriety and cultural objects; and social capital which can be mobilized through social connections and group membership. It is important to note, however, that not all cultural and social capital functions as symbolic capital; the symbolic nature of capital is acquired through outer recognition, when it is accepted as legitimate to provide distinction and opportunities. Thereby, symbolic capital establishes hierarchies of discrimination within specific fields, where certain forms of capital are perceived as intrinsically superior to others, despite the fact that their hierarchical relations are purely arbitrary (Bourdieu & Wacquant, 2013: 295-297; Bufton, 2004: 28; R. Moore, 2012: 100-101; Reed-Danahay, 2005: 47). In Bourdieu’s words: “Any capital, whatever the form it assumes, exerts a symbolic violence as soon as it is recognized, that is, misrecognized in its truth as capital and imposes itself as an authority calling for recognition” (Bourdieu & Wacquant, 2013: 298-299).

Another capital that was not explicitly introduced by Bourdieu but has to be mentioned here is human capital. Human capital stands for an individual’s stock of knowledge and skills that

---

\(^8\) Although I am aware of the complexity and applicability of Bourdieu’s social theory, only his conceptualization of different forms of capital is used in this thesis.
are fundamental for an individual’s economic productivity. This type of capital is related to specific talents and competences, and can be acquired through education and work (Massey et al., 2008: 227; Renaud et al., 2003). The notion is used extensively when discussing migrants’ economic integration and is of crucial importance for the subject at hand.

The particular capitals are not evenly distributed between people. Whereas some may, for instance, possess a lot of economic and social capital, but have less human capital, others may have high amounts of human capital, but less so of social (Bufton, 2004: 28). Moreover, different forms of capital can be acquired, exchanged and converted into other types of capital (R. Moore, 2012: 99).

6.3. IDENTITY

Many authors claim that the term ‘identity’ has come to mean both too much and too little at the same time. It is being used to address too many elements all at once: its application ranges from, e.g., portraying individual’s core self to group identification processes. Concurrently, the concept often captures too little as it does not address the questions of identity production within specific contextual frameworks (see, e.g., Anthias, 2008: 7; Brubaker & Cooper, 2000: 6-8).

In order to avoid this trap and to understand, as Jenkins (2008: 5) puts it, the “multi-dimensional classification or mapping of the human world and our places in it,” I am interested in identity as conceptualised in two ways. I want to grasp individuals’ sense of who they are, while at the same time analyze their sense of the social location that they occupy (Anthias, 2008: 7). To analytically engage with the two facets, I follow Rogers Brubaker and Frederick Cooper's (2000) distinction between identification and categorization, and self-understanding and social location.

6.3.1. Identification and categorization

Speaking of identification shifts our attention away from the idea of identity as a static state of mind and being; as something that one has. Instead, the processual nature of the term emphasizes the importance of analyzing the dynamics of identity construction; of looking at what we do (Brubaker and Cooper, 2000: 14; Jenkins, 2008: 5). As Jenkins (2008: 17) points out: identity is not simply out there, instead it must always be established; it is a process of being and becoming.
The second major claim that Jenkins (2008: 46) makes about the processes of identification is that both individual as well as collective identifications follow one basic model of internal-external dialectics. In order to better understand this mechanism, we have to make a short detour into Jenkins’ (2000: 10; 2008: 39-48) understanding of the human world. Leaning on Erving Goffman and Anthony Giddens, Jenkins (2008: 39) distinguishes between three distinct orders of the world as constructed and experienced by humans: 1) the individual order consists of individual human beings and their perceptions of the world; 2) the interaction order is the world that is constituted in relationships between individuals; and 3) the institutional order is the world of organisation(s) and established ways of conduct.

When it comes to the individual order it is important to note that individual identification is always socially constructed, i.e. it emerges through the ongoing and simultaneous synthesis of self-identification (internal element) and definitions of oneself by the others (external element) (Jenkins, 2000: 7-8; 2008: 40). This dialectical game brings us to the interaction order: it is not enough to take into account what we think about ourselves, it is equally important to validate our self-understanding against what the others think of us. What is more, not only do we identify ourselves according to the internal-external dialectic logic, but we also identify others (Jenkins, 2008: 42). The institutional order, however, represents a vehicle of categorization which frames and shapes the identifications that occur on the other two levels, while being simultaneously influenced by them (Jenkins, 2008: 45).

This explains how identification and categorization are interconnected. According to Jenkins (2008: 8, 12), categorization is the external aspect of identification, i.e. the process when people categorize others. Yet, categorization does not need to be produced by a specific actor, as it can occur anonymously by means of, e.g., public discourses. While categorization takes place on all three levels of the human world, it is important to single out the categorization processes that occur on the institutional level – “the formalized, codified, objectified systems of categorization developed by powerful, authoritative institutions” (Brubaker & Cooper, 2000: 15). The modern state hence represents one of the most important agents of categorization since it has “the power to name, to identify, to categorize, to state what is what and who is who” (Brubaker & Cooper, 2000: 15). Yet, as pointed out above, even though the state may be powerful in its ability to construct and impose social categories on people and other non-state actors, the state is not the only producer of identifications and categories, and its categories may hence be contested (Brubaker & Cooper, 2000: 16).

9 Contrary to the common distinction between individual and collective identity, Jenkins (2008: 37-38) argues that these two are in many important ways very similar and tightly entangled with each other. Though their emphases might be different – the former emphasizing difference and the latter similarities –, they converge in their processual nature and in the mechanisms that lead to their existence.
6.3.2. Self-understanding and social location

 Whereas identification and categorization are active terms that denote the processes enacted by specific actors or through specific means, *self-understanding* is a dispositional term that designates one’s sense of who one is, where one is located in a particular social setting and thus how one is to act. In that way, self-understanding and social location are tightly connected with one another.

 Though self-identification is closely related to self-understanding, it is important to draw a clear distinction between the two. Self-identification is tied to an explicit discursive articulation, whereas self-understanding may be tacit. In relation to the process of identification (often affective), self-understanding is of a more cognitive nature and can only refer to one’s own understanding of who one is; it does not capture other people’s understandings (Brubaker & Cooper, 2000: 17-19).

 The dispositional character of these terms does not mean, however, that self-understanding and social location are unitary, never-changing entities. As shown by Floya Anthias’ understanding of social location, these positions do change according to different contexts and with time and space.

 6.3.2.1. Translocational positionality

 The concept of translocational positionality was developed by sociologist Floya Anthias (see, e.g., 2002; 2008 and 2012) and is particularly useful within the field of migration studies since it takes into account geographical moves as well as transnational spaces. The concept aims to capture people’s identity in terms of social locations. Similar to Jenkins, Anthias (2002: 502; 2008: 5, 7) rejects the idea of given identities and stresses the importance of understanding social locations as a dynamic practice that is dependent on context, and can hence involve shifts and contradictions.

 The *translocational* part of the concept emphasizes two things. Firstly, the term highlights the multiplicity of social locations – “social spaces defined by boundaries on the one hand and hierarchies on the other hand” (Anthias, 2012: 108) – that we inhabit. Although Anthias uses the term social location especially in relation to ethnicity, gender and class, I consider it applicable also to migrant and professional positions. Both national and professional belongings are defined by boundaries and hierarchies: being a migrant means not being a native, which can be, on different occasions, both advantageous as well as disadvantageous. Also, being a physician means something else than being a nurse, for instance, and can be – due to its better financial position and higher social status – ranked higher. We thus need to
think of social locations in relation to each other, since they are interrelated and thus produced relationally. Thereby, social locations are not only relative to one another, but are also situational, temporal and subject to different meanings (Anthias, 2008: 15; 2012: 108).

Secondly, the term ‘translocational’ points to the idea that even though migratory movement might entail geographical dis- and relocation, it does not mean that we get dislocated in social terms. Anthias (2008: 15) emphasizes that our social locations are not only multiple, but that they span across temporal and spatial terrains. She gives an example: “To be dislocated at the level of nation is not necessarily a dislocation in other terms, if we find we still exist within the boundaries of our social class and our gender” (Anthias, 2008: 15). She does admit, however, that the movement will transform our social locations and the way we experience it.

The positionality part of the concept encompasses a reference both to social position (an outcome) and social positioning (a process), and thereby points to the intersection of structure and agency (Anthias, 2002: 501-502).

Taken together, the notion translocational positionality captures individuals’ position (structure) and positioning (agency) within the interplay of different social locations (such as ethnicity, gender, race etc.) that is relative to specific temporal and spatial contexts. To illustrate her point, Anthias (2012: 108) gives an example of a minority-background, working class husband and wife: the woman’s locations related to class, gender and ethnicity coherently put her in multiple subordinated positions, whereas the man may be in subordination, e.g., in relation to his employer, but be in a dominating position in relation to his wife.
7. METHODOLOGY, METHODS AND MATERIAL

7.1. PHILOSOPHICAL CONSIDERATIONS

Before delving into the presentation of the employed material and methods, I want to clarify my standing within the philosophical field. This is essential if I want to argue for the soundness of my research design and its suitability for the aims of this study. Taking a side in philosophical questions determines the scientific questions we deem important and answerable, as well as the methods we employ in order to address them. Furthermore, such positioning puts our undertaking into the broader frame of knowledge production. It enables us to realize what is the nature of the knowledge we are producing and what are its limitations (6 & Bellamy, 2012: 49-50; Rosenberg, 2012: 2-4).

This thesis is grounded in the philosophical perspective known as relativism. As opposed to realism, a relativistic stance does not assume the existence of an objective reality that prevails independently of our perceptions. Quite the opposite; relativism sees reality as something that exists only in relation to those who observe and act upon it. At a first glance, such an observation may seem irrelevant for the present research undertakings, yet our understanding of reality has crucial epistemological implications for the methodological design. It namely defines the nature of knowledge: what can be known and in what ways. Once the idea of an objective truth has been rejected, any pursuit of objective knowledge is futile. The only knowledge that can be acquired is hence of subjective nature, depending on the actors and their context (6 & Bellamy, 2012: 55-59).

This implies that social phenomena – as objects of social science’s inquiry – do not exist a priori, but occur only through people’s own definitions, beliefs and actions. In other words, these phenomena are socially constructed (Charmaz, 2006: 10; Rosenberg, 2012: 134-135). This has a twofold implication for my scientific undertakings. Firstly, there exists no reality about being a highly skilled refugee that is detached from individuals’ own meanings and perceptions. I myself as a researcher am furthermore a part of the world I study; I not only influence the data collection, but offer my own understanding of the meanings ascribed by the people themselves (see Section 7.3.2). As a researcher, I am hence engaged in the so-called double hermeneutics. Secondly, this constructivist stance assumes that my analytical endeavour with the social matter can offer merely an interpretation of the studied phenomenon. In other words, I can understand human action and social texture by giving meaning to it that claims no objectivity and offers no predictability (6 & Bellamy, 2012: 57-58, 232-233; Charmaz, 2006: 10; Rosenberg, 2012: 31, 118-119, 134-135).
7.2. RESEARCH DESIGN

7.2.1. Approach
What then can my research undertakings offer? Following John Creswell's (2007) distinction between five approaches to qualitative research, the present thesis is a narrative research study. By employing narrative analysis (see Section 7.2.4.2), the thesis gathers individuals’ recollections of events and interprets them within a suitable theoretical framework (Creswell, 2007: 54-56). The narrative approach is particularly useful for the purpose of the thesis since it provides a close-up of the experiential aspect of being a highly skilled refugee and illuminates the particularities of this little-explored state of existence (Bryman, 2012: 582; Creswell, 2007: 20; Flyvbjerg, 2006: 237; Squire et al., 2014: 74, 109-110). Moreover, by applying narrative analysis to the case study of non-European refugee doctors in Sweden, the thesis unravels, as Bent Flyvbjerg (2006: 238) phrases it, “apparently insignificant truth, which, when closely examined, would reveal itself to be pregnant with paradigms, metaphors, and general significance,” and advances the existing analytical categories of refugees and highly skilled migrants (Boje, 2010: 591). The strength of the narrative research is hence in the depth of the knowledge it produces, not its generalizability (Flyvbjerg, 2006: 241).

The gathered narratives are thus at the core of this study, and it is only on the basis of a careful engagement with the material that the suitable analytical framework can be selected. As Kathy Charmaz (2006: 3) puts it: “We begin by being open to what is happening.” Though this implies an inductive approach, the following description shows that the research approach was more of an iterative nature (Bryman, 2012: 26).

7.2.2. Material
I explored the experiences of highly skilled refugees using rich qualitative data that I collected through semi-structured interviews with non-EU doctors who came to Sweden as refugees.

7.2.2.1. Sample

The thesis is based on a purposive sample (Creswell, 2014: 189) of non-European doctors who came to Sweden as refugees. I conducted eight interviews, yet the thesis is based only on seven since one of the interviewees clarified during the interview that she came to Sweden as a marriage migrant. The sample consists of four Iraqi, two Syrian and one Malaysian doctor, three of them being female and four male. The interviewees were between 26 and 57 years.

---

This section refers to the sampling of participants (selection of interviewees that represent non-EU medical doctors who came to Sweden as refugees) and not sampling of the case (selection of the specific profession to represent the highly skilled). The delimitation to refugee doctors has been explained in Chapter 1.
old and had been in Sweden between one and 25 years. Three interviewees lived in Southern and two in Western Sweden, the sixth and seventh interviewees came from Eastern and northern Middle-Sweden respectively (Tillväxtverket, 2008). Four of them already worked as doctors, and three were still in the process of obtaining Swedish medical license. All of them studied in their home country or another non-EU country, and came to Sweden after they finished their studies. I met none of the interviewees before the interview.

The initial aim was to interview ten doctors with refugee background. Yet due to the recruitment difficulties (see Section 7.2.2.2), I was unable to conduct more than eight interviews in the given timeframe. However, the reoccurrence of certain narrative topics suggested that this sample size allowed me to reach an adequate level of data saturation (Bryman, 2012: 426; Onwuegbuzie & Collins, 2007: 289).

As for the sample composition, my initial intention was to focus only on Iraqi physicians who came to Sweden as refugees and were living in Skåne. Among the non-European doctors who obtained the Swedish medical license in the past decade, Iraqis represent the biggest group (Socialstyrelsen, 2014: 27). Furthermore, Iraqis are one of the largest refugee groups entering Sweden in the last ten years (Focus Migration, 2009: 16). By focusing merely on Iraqi doctors, I hoped to have a fairly consistent sample of people with the same national background, as well as similar migratory trajectory. The delimitation of my study sample to Skåne, on the other hand, was grounded in my wish to conduct the interviews in person – something that would be financially and temporally infeasible were I to travel across Sweden. Also, by talking to doctors living in the same geographical area and working for the same commune, I wanted to avoid possible regional differences.

However, at a very early stage of my recruitment process I realized that – regarding the faint response and the limited time at my disposal – I would be unable to find an adequate number of participants unless I opened up the sample to refugee doctors with other national backgrounds living throughout Sweden. A careful consideration of the significance of such a sampling alteration for the inferences of this study furthermore supported the justifiability of my decision. Since the purpose of the thesis is to tease out the association of refugee and career trajectories, and negotiations between individuals’ professional and refugee selves, the insistence to limit the study only to one national group seemed unwarranted and the broadening of the sample to other non-EU refugees justifiable. What is more, the material gathered through the interviews proved that although national background, time since migration, place of residence, and stage in professional career are important, the differences between these are insignificant for the conclusions of this research.
7.2.2.2. Access

In order to get in contact with possible interviewees, I used a number of strategies. First and foremost, I relied on my personal connections. This recruitment strategy has proven to be most effective since personal connections fostered trust and gave importance to my research. Secondly, I established contact with various institutions and projects that are involved in the licensing process for non-EU physicians. For instance, the project Nationell matchning of the Malmö employment agency forwarded my invitation for participation (see Appendix 1) to the non-EU doctors and the co-ordinator of the supplementary course at the University of Gothenburg, Pernilla Hultberg, was willing to provide me with extensive information on the licensing process.11 Thirdly, I made use of Facebook where I posted my invitation in various groups related to non-EU doctors, such as Irakiska läkarföreningen i Sverige and Arabiska läkare i Sverige. This has proven to be another good means of getting in contact with people who might be interested in participating. It was particularly important to get the approval and support of one of the founders of these groups – in research jargon also known as a gatekeeper (Bryman, 2012: 435; Miller & Bell, 2012: 61) – since the person further advertised and campaigned for the importance of participating in my study. Last but not least, I tried to establish contact with doctors through their workplaces. With the help of personal contacts as well as by visiting some of the hospitals and outpatient clinics myself, I brought attention to my study by leaving the invitation with the receptionists who then hung the posters in physicians’ lunch rooms and left the invitation in their pigeon-holes. After I established some contacts and conducted the first interviews, I used the snowball sampling technique (Bryman, 2012: 424) in order to get in contact with further interviewees.

Though I did not expect it to be easy to get in contact with research participants, the extreme tediousness of the process could not have been anticipated. Whereas I have been in contact with more than two dozen non-EU doctors, I was able to conduct only eight interviews so as to be able to complete this thesis in the given timeframe. I can merely speculate on the reasons for this difficult access, though the feedback from my interviewees and one direct declination support my interpretation. On the one hand, doctors are known for their heavy workload and scarcity of time, and to squeeze a one-hour interview into their busy schedules is certainly no small task. On the other hand, my research design established a number of barriers for participation, such as the fact that the interview was, ideally, to be recorded and to take place in English. Many of the interviewees excused themselves for their “stumbling”

11 For the past 15 years, Pernilla Hultberg has been involved in enabling non-EU doctors to obtain a Swedish medical license. She agreed to be interviewed in order to provide some background information on the development of the licensing framework and the rationale behind it.
English and occasionally reverted into Swedish. According to them, many of their colleagues would feel unable to do an interview in English since they no longer use it. My inability to conduct a complete interview in Swedish, together with my European background and specific scientific and professional position (student of social sciences) put me, therefore, in an outsider position with no links to the target group I was trying to reach. This lack of common ground made it extremely difficult to establish the minimum level of alliance and trust that is essential when conducting such personal interviews (Sherry, 2008). On top of that, the topics addressed in my research cannot be dismissed as not-sensitive (Hydén, 2008). The interviews asked about individuals’ journeys to Sweden, their experiences as refugees, and how they re-established themselves as doctors. These are private, past experiences which – as one of the interviewees commented – they often wish to forget completely.

7.2.3. Method

7.2.3.1. Semi-structured interviews

Out of the eight conducted interviews, four took place in person, whereas the rest were conducted over Skype. The interviews lasted between 54 and 94 minutes. Granted, there are several disadvantages connected to not being able to conduct interviews face-to-face (e.g., difficulties in establishing rapport and the inability to take into account interviewee’s body language), yet two of the Skype interviews were conducted with the camera on, which allowed for non-verbal interaction. There were also no technical difficulties that would impair the quality or interrupt the Skype interviews (Bryman, 2012: 667-668).

With the permission of the interviewees, all interviews were recorded and later transcribed. A digital recorder was used for face-to-face interviews, whereas the Skype interviews were recorded using a programme called Piezo. All of the interviews took place in English, except on one occasion when the interviewee switched to Swedish at the beginning of the interview. Though my active knowledge of Swedish is not good enough to conduct a whole interview in Swedish, my passive skills allowed me to understand not only the general meaning of the responses, but also the particularities and nuances which enabled me to ask (in English) specific follow-up questions. The part of the interview where the interviewee talked in Swedish was later translated into English.

The interview guide (see Appendix 2) consisted of questions pertaining to, on the one hand, the individual’s partial life-story concerning their job-related and migration trajectory, and, on the other hand, their subjective perceptions of how these two trajectories influenced each other and shaped them as doctors and refugees. The questions enabled me to map out the
individual’s geographical, professional and social coordinates, while, at the same time, allowed me to transform these spaces into subjective places of experiences and perceptions. When constructing the interview guide, I kept in mind my research questions as well as the semi-structured format of the interviews. Furthermore, I leaned on a number of secondary sources in order to tackle the possibly important overarching topics concerning doctors’ professional experiences and their experiences as refugees (e.g., Agier, 2008; Colic-Peisker & Walker, 2003; Colic-Peisker, 2005; Khosravi, 2010; Malkki, 1996; Shuval, 2000).

The semi-structured nature of the interviews suited perfectly to the purpose of my study. It allowed me to follow the topics I needed to address in order to answer my research questions, while giving me the flexibility to ask more specific follow-up questions. Most importantly, it opened up the field for the interviewees to express their stories and opinions, and to pursue the topics they deemed important (Bryman, 2012: 470-471).

The explorative in-depth interviews had traits of life-story and narrative interviews: the interviewees were invited to talk about professional experiences before and after coming to Sweden, as well as about their asylum-seeking process and the path of obtaining the Swedish medical license. At the same time, I encouraged the interviewees to talk at length about their personal experiences. By trying to capture individual perspectives (and not using the interviews to document external realities), I hoped to grasp the nuanced and positioned nature of these refugee-professionals’ perceptions, feelings, and understandings.

7.2.4. Analysis

7.2.4.1. Coding

Upon close reading, all transcripts were coded using Dedoose, a computer application for mixed methods research that was designed and developed by the academics from the University of California, Los Angeles. Dedoose is acclaimed for its integration of quantitative and qualitative data analysis tools. I used Dedoose to analyze my qualitative material, i.e. in order to code the transcripts of the interviews.

For the personal narratives to guide my analysis, I started off by sorting and synthesizing the obtained material through qualitative coding. By attaching labels to segments of data in order to represent what these segments are about, codes enabled me to define what is happening in the data and to make sense of it. In that way, the codes were not just about labelling, but much more about linking; they linked the data to an analytical idea, and lead from the idea to all the data pertaining it (Charmaz, 2006: 3, 44; Saldaña, 2009: 8).
Codes, as defined by Saldaña (2009: 3), are words or short phrases that assign essence-capturing attributes to specific portions of textual or other material. Descriptive codes summarize the primary topic of a section, whereas ‘in vivo’ codes are taken directly from the text and are put in quotation marks (Saldaña, 2009: 3). The steps in the coding process differentiate between initial and focused coding. During initial coding, the codes consist of ‘first impression’ codes and the aim is to remain open to all possible theoretical directions indicated by the data. Later on, focused coding is used to pinpoint and develop the most salient categories (Charmaz, 2006: 46; Saldaña, 2009: 4, 81).

Several steps in the coding process were implemented in the analysis of my material. At the beginning, I conducted initial coding on the first four interviews. The codes included both descriptive (e.g., staying in contact with medicine, loss of drive, Swedish colleagues) and ‘in vivo’ codes (e.g., “receiver” of social benefits). At the second stage, I categorized the codes into families of related codes and thereby started to create thematic patterns. I then applied focused codes to the selected text sections in order to discern the reoccurring topics and possible analytical issues (e.g., agency, identity, immobility). This furthered my understanding of the gathered material and enabled me to direct my subsequent interviewing towards the discerning topics (Charmaz, 2006: 3, 42). Once I transcribed the subsequent interviews, I coded them in a similar manner.

7.2.4.2. Narrative analysis

In order to analyze my material, I made use of narrative analysis; an approach that is sensitive to the narratives that individuals recount when telling about themselves and when accounting for particular life events (Bryman, 2012: 582, 584). As elaborated in Section 7.2.1, there are several reasons why narrative analysis is particularly useful for my undertakings.

The first step of my narrative research involved material gathering which encompasses spoken narratives obtained through the interviews with non-EU medical doctors who came to Sweden as refugees. Even though my interviews were not truly life history interviews, they followed the professional and migration trajectories of the interviewees and hence tried to capture the interviewees’ accounts of events, and their connection to the wider context (Bryman, 2012: 584). Moreover, I encouraged the interviewees to recount stories by consciously choosing question formulations that elicited narratives (e.g., “Can you tell me what happened when...” or “[Is there a particular moment when...]”).

The second step of the analysis consisted of the scrutiny of the narrative material. This was done through coding (see Section 7.2.4.1) which categorized the material and thus facilitated
its interpretation (Squire et al., 2014: 7, 10). Though coding may fragment the material (Bryman, 2012: 578), I was wary not to tear the text sections out of their narrative flow and to keep the narrative context in mind when connecting the material to the theoretical framework. There are several approaches to narrative research: narrative researchers might be interested in the structures, contents or contexts of the narratives (Squire et al., 2014: 8-9). This study is mainly interested in the narrative content, i.e. themes and meanings that interviewees’ narratives convey. This should not be confused with thematic analysis, since narrative analysis, as Squire et al. (2014: 9) point out, does not just pick out themes from stories, but it rather focuses on those that develop across stories.

7.3. FINAL METHODOLOGICAL REFLECTIONS

7.3.1. Ethical considerations

When conducting research with people, engaging with the ethical considerations that such research raises is indispensable. Ethical guidelines have led me through my research process, all the way from the designing of the study, through the recruitment and the interview situations, to the material analysis and presentation. Thereby, the most important act was to apply these guidelines in specific real-life situations. In order to consolidate the normative with the hands-on aspects, constant reflexivity was required of me.

One of the most important things was to inform possible as well as actual participants about the aim of the study and what participation in it would encompass. Though the final outcome of the research might be slightly different from what the participants agreed upon (see, e.g., Miller & Bell, 2012 on “Consenting to what? Issues of Access, Gate-Keeping and ‘Informed’ Consent”), I created at the beginning of my research an invitation (see Appendix 1) which was distributed to potential participants. The invitation included information about what the study was about, who was invited to take part in it, and what participation entailed. The same information was repeated at the beginning of each interview. All interviewees agreed to participate in the study voluntarily and gave consent that the interview could be recorded as well as that the information could be used for the purposes of this thesis. I consequently stressed that all information exchanged throughout the interview was confidential and that the presented material will be anonymized. In doing so, I hope to warrant an adequate degree of privacy (for problems on guaranteeing complete privacy, see Bryman, 2012: 142). In this thesis, I am not using interviewees’ real names and am omitting information that might disclose their identity.
One other point has to be made when discussing the practices of recruiting research participants. The proliferation of studies that employ social media as a means of getting in touch with (possible) research participants opened up a whole new chapter in discussions concerning ethical codes of research conduct (see, e.g., Lunnay et al., 2015 and Klimek, 2015). One of the main troubles with using Facebook as a recruitment tool is the confusion of public and private roles. The roles of the researcher and the research participant become blurry, since – due to the private nature of the platform – Facebook possibly reveals stories that were not intended for the purposes of the study and shows sides of the individuals that might otherwise have remained covered (Lunnay et al. 2015: 5). I used Facebook as a means of getting in contact with possible research participants and as a communication tool when arranging the time of the interview. Being aware of the aforementioned difficulties, I posted the invitation only to the designated groups and did not go through people’s profiles to figure out their profession. In order to ease the communication with some of the physicians, we became friends on Facebook, yet I did not go through their profiles and I made use of the ‘Unfollow’ function in order to not see their posts on my timeline. I also changed my own privacy settings so that the research participants could see only parts of my Facebook identity.

Another important consideration when using Facebook as a recruitment tool is that of privacy. Although I explicitly encouraged interested participants to contact me directly, some of them demonstrated their readiness to participate by commenting directly under my post, making it visible to the whole community. Though this was their personal decision, it is noteworthy since it signals possible difficulties when trying to provide for participants’ anonymity.

Last but not least, by inviting the interviewees to talk about private experiences and personal perceptions, it was my responsibility to create an interviewing experience that would not harm the interviewees. By asking very general questions and letting the interviewees talk about what they found important, I hoped to act more as a listener than a questioner (Forsey, 2010; Hydén, 2008: 122). I did my best not to be intrusive, but instead “to move forward, with caution, humility and sensitivity” (Squire et al., 2014: 108). This was of utmost importance since the interviews touched upon sensitive topics (Hydén, 2008: 123-124) about leaving the home country, the journey to Sweden and the initial period in Sweden when their asylum application was processed. I take the fact that some of the interviewees thanked me at the end of the interview for being able to tell their stories and to express their opinions as a sign that the benefit of their recounting was not merely mine but also theirs (for more about the implicit exploitation of research undertakings, see, e.g., Plummer, 2001: 215-216).
7.3.2. My role as a researcher

In order to deliver the most reliable representation of this study’s findings, I need to take full account of not only the interviewees’ positions, but also mine (Pezalla, Pettigrew & Miller-Day, 2012). Thereby, I reflect on some of the most important stages in the research process. As mentioned earlier, the tediousness of the recruitment process might be in part ascribed to my outsider status. As Sherry (2008: 434) notes, insider/outsider status may affect greatly how a researcher enters the field. The issue of researcher’s status apropos that of participants’ plays, however, an important part also during the data collection and analysis (Dwyer & Buckle, 2009: 55). During the interviews themselves, my outsider position did not seem to represent an impediment for the interviewees as none of them expressed any concern about it. Nevertheless, whilst there was not much to be done regarding my national background, age or gender, my good passive-skills in Swedish allowed me to be flexible if the interviewee switched from English to Swedish, and I took special care to not appear ignorant towards topics concerning medical education, the practicing of medical profession in Sweden and the licensing process. Insomuch as this was a matter of showing respect for participants’ time- and energy-investment as well as of professional attitude, my acquaintance with the Swedish medical system proved to be important also because it brought me closer to them. Many of the interviewees showed great appreciation for my understanding of what they had to or still have to go through with regard to professional recognition.

During the interviews, I furthermore avoided leading questions (Bryman, 2012: 257). This was of particular importance when I conducted the final interviews and already knew how certain topics were addressed by the previous interviewees. However, my intermediate round of analysis helped me only to pinpoint which topics need to be addressed in the upcoming interviews, not how they should be addressed. I therefore continued with my strategy to start off by asking very general questions and then proceeded with clarification and more detailed questions (Creswell, 2014: 139-140). Furthermore, I bore in mind that my verbal and non-verbal reactions might influence interviewee’s answers. I hence tried to create and sustain a friendly rapport that was neither overtly supportive nor dismissive to any of the answers, stories or opinions expressed by the interviewees.

The interpretation of the narratives and the act of writing them up positions me as an ‘owner’ of other people’s stories and opinions (Gready, 2008: 138-139; Plummer, 2001: 216-217). It is with utter caution that I perform the balancing act between staying true to the narratives told by specific people and the analysis that makes me ‘comb’ through them, and ‘pick’ the excerpts that I use to construct a new whole presented in the following chapters.
7.3.3. Credibility, dependability and transferability

In order to assess the quality and trustworthiness of the given study, the following paragraphs reflect on the credibility, dependability and transferability\footnote{In comparison to the positivist tradition which mostly informs quantitative research and usually relies on the criteria of validity, reliability and generalizability to ensure quality of the research, this qualitative study – following the constructivist paradigm – employs this alternative set of criteria where dependability replaces reliability, credibility internal validity, and transferability external validity (Lincoln & Guba (1985) in Loh, 2013: 4; Seale, 1999: 34).} of its design and results (Lincoln & Guba (1985) in Loh, 2013: 4-5).

I hoped to achieve dependability of my research design by laying out all stages of the research process. Thereby, I not only provided an account of the applicability and consistency of the chosen methodological tools, but also dwelled upon the difficulties I encountered along the way, sketched my own reflections, and outlined some critical points. When presenting the results, I give accurate descriptions of interviewees’ narratives and include – if applicable – both English translations and the original Swedish transcript (6 & Bellamy, 2012: 261-262; Seale, 1999: 45).

In addition, the transparent display of all research steps bears witness to the legitimacy of the study’s conclusions and contributes to its credibility. In order to establish greater credibility, I furthermore made sure to double-check my understanding of what the interviewees were communicating, to provide thick descriptions of findings, and to bring my interpretations as close as possible to the interviewees’ original stories (6 & Bellamy, 2012: 233, 259-260; Creswell, 2007: 207-209; Seale, 1999: 44-45).

With regard to the transferability of the present study, i.e. the generalizability of the inferences about refugee doctors in Sweden (Bryman, 2012: 69-71; Creswell, 2014: 203-204; Seale, 1999: 45), the purpose is not to transfer the findings to other cases (as mentioned in Section 7.2.1). Instead, this thesis produces an in-depth understanding of the studied group and points to the (in)applicability of the existing analytical categories, thereby contributing to their refinement (Flyvbjerg, 2006: 228).
8. **FINDINGS**

8.1. **INTRODUCING THE INTERVIEWEES**

Before proceeding to the findings, I want to introduce the research participants. Here I am mentioning just the basic characteristics of the interviewees and do not go into detail, e.g., how exactly they came to Sweden or what their professional career looks like, since I will talk about that in more detail in the subsequent sections. All names and details that would allow recognition of the individuals are changed in order to protect the participants’ identity.

Fatin (late 30s) is a female doctor who comes from Iraq. She came to Sweden more than five years ago as a resettled refugee from another Middle Eastern country. She lives in a small town in central Sweden and is at the moment doing her specialization.

Hayder (around 40) is a male specialist from Iraq. He is now learning Swedish language in order to obtain the Swedish medical license. He lives alone in a town in southern Sweden.

Yi Hui (late 50s) is a female specialist who lives in middle Sweden together with her family. She comes from Malaysia and moved to Sweden 25 years ago together with her husband who is from a Middle Eastern country. Yi Hui, legally speaking, did not come to Sweden as a refugee, but rather as a family migrant. However, her migratory trajectory made her, as she claims, into a refugee which is why I am including her in the sample. Because the Middle Eastern country where her husband comes from was at war in the 80s, Yi Hui and her husband sought asylum in Sweden. For about a year they lived in different detention camps where she gave birth to their daughter, yet due to her Malaysian citizenship, they rejected their asylum application. Because of that, she decided to return to Malaysia and leave her husband and their daughter in Sweden. After she left, her husband got his asylum application approved which enabled her to reunite with them after living back in Malaysia for almost two years.

Noor (mid-40s) is a female doctor from Iraq who lives in a town in southern Sweden. She came to Sweden more than ten years ago and is currently pursuing her second specialization. She lives together with her family.

Rashid (early 30s) is a male doctor who came to Sweden more than five years ago. He is from Iraq and works as a specialist in a town in southern Sweden.

Khalid (late 20s) is a male Syrian doctor who lives in western Sweden. At the moment, he is finishing the Swedish language course in order to obtain the Swedish medical license.

Mohammed (early 30s) is a male doctor from Syria. He lives in a town in the west of Sweden and is studying for the TULE exam in order to be able to work as a doctor again.
8.2. NARRATIVES OF LEAVING

8.2.1. Reasons to leave, reasons to stay

Devastation of the country due to the war, the related deteriorating economic conditions and insecurity – all these were uttered by the interviewees as reasons for leaving their home countries. Rashid, for example, explained how his family’s home was destroyed:

One day the Americans came, so there was military and there was fighting between them, so they destroyed our houses, my father’s house and he was forced to flee. Everything was destroyed, everything that he built up in 30 years. Imagine that (...), you build up all this, a family and the house and everything, you have your job and then suddenly everything disappears.

The conflict was, however, not the only factor that shaped their decision to leave. Professional considerations, among others, also played an important role. Only Noor claimed that her career considerations acted as a push factor – “First of all, it was very bad salary, income … and also, I wanted to make my specialisation in a good place.” –, for many others, their profession was a reason to stay. For instance, after Rashid’s family left Iraq due to the war, he stayed behind in order to finish his medical studies. Or take the stories of Khalid and Hayder. After finishing his medical studies, Khalid decided to work in the field hospitals of the opposition that fought against Assad’s regime in Syria’s civil war. He lived under terrible conditions, faced death on several occasions and compromised his career:

I didn’t even have a bed to sleep on. So, in those two years, I slept in the emergency room on a bed that was one hour ago, unload a patient that… How to say... disinfect the bed. (...) There is many difficult moment. I can tell you I could see death in my eyes more than 10 times. Like that feeling you will die now. You will die now. You will die now. You will die now. You will die now. (...) In Syria, (...) after the medicine student studied 6 years, (...) they make specialisation in the hospital. That’s the first thing that I lost while I worked as a field doctor.13

Nevertheless, he stayed in order to help people:

Katarina: When you say that at the beginning you didn’t consider moving away – what made you stay?
Khalid: In Syria? The difficult situation of the people. (...) Because I feel I should help people, I should help those people.

His medical profession was also for Hayder one of the reasons to stay in Iraq – despite the war and job offers in other Middle Eastern countries: “I think that a lot of people, they need help. And we must, we don’t just leave them and say goodbye, as if they don’t matter.” In the end, however, it was precisely their profession that drove both Hayder and Khalid out of their home countries. In Iraq, Hayder was active in fighting for the improvement of patient rights,

13 The excerpts are not grammatically corrected.
because of which he was threatened and had to flee literally overnight. Also Khalid’s life was threatened due to his profession:

In the last six months in Syria I start working for [the name of an international NGO] (...) I worked with them like emergency doctor. And I didn’t think to travel to Sweden in that time. But ISIS started to be stronger and stronger and stronger and stronger there and they started to intervene in anything with doctors or nurses or people living there. (...) Like why am I working with those people that are coming from the Western, they are not good (...) They started to threaten us and kidnapping and they accused me that I am a client to the Western intelligence. So, I decided to leave Syria because if they will catch me, I am hundred percent sure they would kill me.

8.2.2. Where to go to?
Professional considerations were one of the many factors influencing the geographical decision-making processes of the interviewees. Fatin, who was resettled together with her family, could express her preference to be resettled to Sweden since the waiting time was shorter than to be resettled to Canada or Australia, plus her personal connections living in Sweden told her that “it is good in Sweden, equality, humanity, it is good.” These were important factors also for those interviewees who travelled to Sweden independently. For them, social connections in the destination country along with the country’s asylum policy were important; smuggling expenses were also decisive.

However, professional considerations also played a role in this migratory screenplay. Yi Hui, for instance, decided together with her husband to seek asylum in Sweden since they could not stay in her husband’s war-ridden home country. They considered moving to Malaysia, but realized that labour market restrictions would disable her highly skilled husband to work there for seven years. Also Rashid first wanted to move to Dubai where his family was living since the war in Iraq broke out. Yet, a series of immigration restrictions and regulations concerning practicing medicine made it impossible for Rashid to settle there. After an attempt to settle and work in India, he asked for asylum in Sweden.

8.2.3. On the way
Not only mentally, but also geographically and time-wise, the journey to Sweden was not a straightforward one. Only Fatin was resettled to Sweden, the other interviewees travelled to Sweden independently. Most of the Iraqi doctors first lived in a neighbouring country before undertaking their travels to Sweden. Though work regulations made it extremely difficult for foreign doctors to work there, all of the interviewees tried to practice their profession – in order to earn their living, as well as to stay in contact with medicine. Noor explained: “I didn’t have pocket money, so it was a must to work. Then I also wanted to continue as a doctor. Because if I don’t work, I will forget a lot of clinical things.” In Yi Hui’s case,
working was not only means to an end, but it crucially shaped the temporal and mental dimensions of the period in-between. While she waited to be able to reunify with her family in Sweden, Yi Hui worked as a doctor in Malaysia—something that restricted her as well as gave her strength:

When I went back to Malaysia I had to apply for residence permit from the Swedish embassy and it took time. And also, (...) in Malaysia, when you get a job, you have to sign in your contract that you have to work for at least one year before you can cancel your contract. (...) So, it was very difficult for me (...) I could not meet my daughter. But whatever she needed, I could buy her from Malaysia and send for her. Because I knew that my husband at that time, he was studying language, he was still on some kind of social benefits and he was not having so much money. (...) The economical independence was good and also I could progress in my work, I learned because I was still a very junior doctor. So, it was important for my career and that helped me a lot.

8.3. BEING A REFUGEE

Instead of following the chronological succession of events, I present the narratives of arrival to and living in Sweden with the sections ‘being a refugee’ and ‘being a doctor’. Such a structure fits best to the way the interviewees talked about their journeys, re-emplacement and professional re-establishment in Sweden.

8.3.1. Insecurity

The topic of insecurity about how things will turn out featured prominently in the interviewees’ narratives. Though the interviewees tried to consider as many different factors as possible when deciding when, how and where to travel, the precise outcome of their efforts was uncertain. Fatin travelled from Iraq to the neighbouring country with her family without knowing what the next step would be, and even once they applied to be resettled to Sweden, they did not know if and when they might leave for Sweden. Insecurity also forced Hayder to leave behind his wife and children: “I don’t know what the future will be. So, I can’t risk them.”

Also the initial time in Sweden was, according to many, full of uncertainties – will they receive asylum and when? Where will they live? Will they be able to work as doctors? Rashid told: “Before we got the residence permit, we didn’t know what was going to happen. Anxiety maybe. We were scared. We didn’t know what will happen, everything was strange.”

Those who have lived in Sweden for some years now, and have in the meantime obtained their Swedish medical license, are happy that their situation and future are clear now. As Fatin said: “(W)hen one first came here, one has to see. One doesn’t know what one should do, how life will look like. But now, now I know what I want to be, how life is going to be. Economically, psychologically, everything is clear, one knows how it will be.”
8.3.2. Out of their own hands

The topic of insecurity is tightly connected to the feeling that the interviewees’ lives are not completely in their own hands. Their trajectories depended very much on legal regulations, and on the people and institutions they relied on along their path. When Rashid was smuggled together with his wife out of Iraq, he depended on the smugglers for everything:

It was tiresome. Most of all we didn’t know how it will be afterwards, do we manage to come to Sweden, will we land... We didn’t know, we didn’t agree [if it will be] Sweden or the Netherlands, I didn’t know I am in Sweden till I came here. (...) The food was bad, we didn’t get food or all the time we only got what they gave us. Sometimes there was no food for hours, nothing to drink. So, it was tiresome. Physically, it was tiresome (...) Mentally also I can say that it was difficult. We didn’t know what will happen. That was the most tiresome.iii

Despite the fact that she was resettled and that Fatin admitted that – compared to many other Iraqi doctors who came to Sweden on their own – her journey was “well-planned”, also Fatin’s final destination was out of her hands. Once she knew they would be resettled to Sweden, she had understood that they would be going to Stockholm. However, they ended up in a small town in central Sweden: “That was something we couldn’t influence, it was not our decision. After about one year, we knew we have had a choice if we have said, I don’t want to live here. So, they would have to find a place for us to live in Stockholm.”

Legal and other types of regulations furthermore framed the life-paths of the interviewees – let us just remember Yi Hui’s story about having to leave her husband and daughter in Sweden in order to be able to reunite with them after she had worked for long enough in Malaysia. Also Hayder could flee Iraq so abruptly only because he still had a valid visa for a neighbouring country that he had obtained earlier in order to attend a medical conference there.

The feeling that their life very much depended on regulations, outer circumstances and even luck continued to stay with the interviewees also during their initial time in Sweden, especially with regard to obtaining the residence permit as well as accommodation. All interviewees also stressed the feeling of powerlessness when talking about the process of obtaining the Swedish medical license (see Section 8.4.3).

8.3.3. “We sit and…”

Waiting was yet another reoccurring element of the narratives regarding interviewees’ journeys to Sweden and their initial time there. For many, their stay in the transit countries was very much about waiting. Take Fatin’s depiction of waiting to be resettled to Sweden: “We knew that Sweden is going to us, some refugees, but we didn’t know when. So, we sit in
[the name of the country], I try to work, it was very hard, very strong competition. (...) My husband was sitting at home with children and I went working.”
Also the narratives about the initial time in Sweden recount long periods of waiting and passivity. Khalid told how he waited for the decision concerning his asylum application:

And you cannot do anything in that waiting time. Just sit in those apartments of the Migration Board, or in a camp (...) I was so sad and depressed, to sit there just eating and sleeping without do anything. And I tried to get books from the library to study Swedish or do something. But I couldn’t. Also people living with me in the apartment, so, like, just people apply for asylum and do nothing. Just drinking and taking hash, so, it was so bad for me. It was so bad for me.

Hereby it is important to note that the expression “to sit (around)” had an explicitly negative connotation for the interviewees. Especially Rashid used it often and consequently in order to express something negative. When I asked him if he remembers a period in which he was not able to work as a doctor, he replied: “If you count that [initial] period [in Sweden]. But I had something to do. I was learning Swedish. I validated my grades and went to courses. So, I wasn’t like… I didn’t just sit at home and do nothing.”

8.3.4. Being a refugee, being a foreigner
The interviewees understood themselves as refugees in two ways. On the one hand, they knew they were refugees legally speaking, i.e. because they had applied for asylum in Sweden. On the other hand, they understood themselves as refugees because of particular life circumstances, i.e. the way they travelled to Sweden, their unfamiliarity with the language, their dependence on the Swedish system, and their experience of how others treated them. Fatin explained why she had felt as a refugee during her initial time in Sweden: “Because you come as a refugee. I know myself that I applied as a refugee. I don’t know language, language is very important. We go shopping and we speak in English. It didn’t feel like home.” Even if Yi Hui was, legally speaking, not a refugee, she claimed that her migratory trajectory (see Section 8.1) and life situation in Sweden made her into one:

Because when we were studying Swedish and studying for the exams, we were not financially secure, we were much financially dependent on the government to give us, to pay us the benefits and when we were waiting for our residence permit, I lived together with the refugees too. So, we were treated as refugees.

Rashid, however, who came to Sweden with the assistance of smugglers, applied for asylum and lived in a detention centre, refused to apply that term to himself:

When one says refugees, there is a big difference if one is in a refugee camp like all those from Syria who have no water, no medicine, they are tired, it rains on them, snows on them. Or a refugee here in Sweden who lives in an apartment, who can take a walk to ICA Maxi and buy himself food, cook at home, watch television, or google
on the internet. So, that is a good life. So, I cannot say that I felt like... The word refugee or asylum seeker, it means something bad, or worse than it was. I didn’t feel like this. (…) I always felt like a stranger.\(^v\)

And Rashid was not the only one who spoke of himself as a foreigner, also others did. Take Noor, for example:

But I think that we, foreigners, are always afraid, we are little bit sensitive, we are little bit… You know what is ömtålig [fragile]? We can be injured, insulted easily. Because we feel like we belong not to this place.

The interviewees talked of themselves as foreigners mostly in relation to the situations that happened after their asylum-application process was finished, i.e. once they could freely set foot in the Swedish public space. They felt like foreigners because of how they were treated in work-related and private situations (see Sections 8.4.3 till 8.4.5).

Thereby it is important to note that even though many had the feeling that they were treated as foreigners, they all expressed the same insecurity as to whether or not their interpretation of other people’s actions was correct. As the recollection from Hayder shows below, many were uncertain whether the Swedes always act in a certain way, or if it’s just towards them as foreigners:

(I)n the first month when I lived in Sweden, I go to a shop. I need to buy a telephone. So, I ask [imitating the conversation], I can’t talk Swedish, can we speak English, of course! I see one iPhone, so, please can you tell me some details. There is another man coming inside at the same time, I don’t know, but I think he is Swedish, blond, big blue eyes [laughing], yeah, that’s classical stereotype, and he leaves me and go to that person and starts to speak with him. I don’t know why he did that. But maybe he... (…) I don’t know if it’s personal to me, or if it’s normal. Just considerations.

8.4. BEING A DOCTOR

8.4.1. Motivation

When asked why they chose to become doctors, the interviewees gave two types of answers. On the one hand, being a medical doctor meant for many achieving a certain social status and occupational security in life. Rashid expressed this in the following story:

I liked [my father’s] profession. It felt that it had good, I don’t want to say high, but it has a good status. And concrete, safe future possibilities. My grandfather used to say, there are three people who will never become unemployed. The first are those who sell food – people will continue to eat. Then those who are doctors – people will continue to get ill. And the third are those who sell clothes for women [laughing].\(^vi\)

The advantages of social status were rarely coupled with the benefits of a high salary, since they, especially in Iraq, did not necessarily come hand in hand. It was only Yi Hui who observed that in Malaysia people decide to become doctors also because of the salary.
On the other hand, becoming a doctor meant for many working with people, helping them and improving their well-being. In Mohammed’ words:

I wanted to be a doctor (...) to help people who are sick in the hospital. It’s a great feeling when you help somebody to be free of pain, to be healthy again. It’s a great feeling. Nobody can feel this feeling if they are not doctors.

Also Hayder painted a vivid picture of what inspired him to become a doctor:

Because I think, at the same time it’s a job, I am working with human beings. With the body of human beings, with their souls. And that’s. I am like you. I feel happy when I listen to the stories of the others. Usually they are the story of suffering. Really. But at the same time, on the other side of the coin, it is human stories. Because it’s not only a patient when you become a doctor, the patient will not tell you only stories of their disease. No, at the same time he will tell you part of the story of his life.

For the doctors, the two groups of reasons were not necessarily opposing, but rather went hand in hand. What is more, in most of the cases the practice of medicine was already within the family and the interviewees were either encouraged or simply inspired by their parents, uncles or grandparents to enter this profession. Many did also not forget to mention their good school grades, which made their medical career paths seem even more predestined.

8.4.2. Being a doctor

The above section points also to how the interviewed doctors understood their societal role. In their role of helping people, the interviewees perceived themselves as ‘providers’ of care, as the ones giving something back to society, and juxtaposed this role to the one of a ‘recipient’ (of, e.g., social benefits). One of Hayder’s hopes for the future was as follows:

I hope I can continue in Sweden. (...) To work, and for myself, so that I can be producer, not just receiver. I feel I must produce something, so that I can work, I can pay taxes, I can help others and not just wait for someone to help me. Because that’s sort of a transformation between the roles. I am a receiver, but within some years, I think, I will become a producer in that society. Not just a producer as a doctor, but I can also give many ideas for the improvement of my surroundings.

Another aspect that featured prominently in the interviewees’ narratives is that medicine is a practical profession. On numerous occasions, the interviewees expressed their efforts to practice medicine – either during their transit stay or during their initial time in Sweden when they were still in the licensing process – in order to retain their medical skills and to stay in touch with the developments in the medical field. As Mohammed said: “I need to be in tune, to be in the hospital, to keep my information. Now and three months ago, I feel that I am not a doctor. (...) Because I am not using my knowledge at all.”

All of the interviewees expressed having had extreme difficulties when they were not able to work as doctors, especially during their initial time in Sweden. When asked how is it for him
8.4.3. Professional reestablishment in Sweden

The licensing topic featured prominently in the interviews. The interviewees were either still in the process of obtaining the Swedish medical license or already worked as doctors. They all had to pass diverse Swedish language courses, which usually took them about two years, then the TULE exam, and afterwards do their residency. Only Fatin enrolled in the supplementary course at the Karolinska Institutet in Stockholm and also Khalid will try to get a place there.

Once in Sweden, all interviewees wanted to continue practicing medicine. Their decision was based on their dedication to medicine, but also on the realization that they are unequipped to practice any other profession, except some low-skilled jobs in, e.g., food service or transportation sector.

Nevertheless, once they embarked on the process of obtaining the Swedish medical license, many of the interviewees felt extremely frustrated. They were riddled with doubts if they will ever be able to practice medicine again and lost all interest in doing so. As Noor recalled:

I was depressed. It was nothing to do. I couldn’t work, like anything. And that’s when I got the feeling that maybe I cannot be a doctor in Sweden anymore. Or anymore at all. I don’t know what can I say more, but I was really unsure.

This was due especially to the tediousness of the licensing process. On numerous occasions did the interviewees refer to the number of years they invested in being able to work in Sweden. Mohammed “saw black” when thinking of it:

I was suffering with the [SFI] school. Suffering and just seeing black in front of me. You put yourself in my situation. Like, you already study six years and worked one year and then left here and then one year doing nothing, just waiting, and then come to the school and then know from your teachers that you have to wait. Can you imagine that they tell me, you have to be in SFI 38 weeks, then you can go to higher level.

The frustration also arose from the feeling that much of it was a repetition of what they have already done. The interviewees felt that their previous medical skills and knowledge did not count. As Hayder told:

After two years of the working and the supervision, they will legitimate me just as a doctor. I am specialist. (...) I have been working as a doctor for 15 years. But when I contact the National Board, they say, no, that means nothing for us.

Also during the Swedish language courses, the interviewees felt that their abilities and educational level were not recognized. They disapproved that they had to attend courses with people with lower education which slowed them down. Noor remembered her course:
So what if you are a doctor from your homeland? You don’t have a certificate here in Sweden. You know, even teachers in the Swedish language, they treat us as if we are kids. (...) I mean, me and other kind of people who is not highly educated or not educated at all, we sit in the same place, the same start of the language level. And that’s why… People who has high education, they could advance quickly. And that’s why I’ve been and my colleagues have been frustrated.

Thereby, the interviewees continuously underlined their disapproval of the existent regulations pertaining to the non-EU doctors by referring to the fact that Sweden is in need of doctors. They also rarely refrained from mentioning the lax regulations concerning the EU doctors (see Chapter 1) and the more reasonable rules that exist in other EU countries (see Section 5.1.2 which demonstrates this is only partly true).

The licensing regulations do not leave much leeway for the doctors (see Section 5.1.1.2), yet the interviewees tried to make as much out of the circumstances as possible. All interviewees did – often unpaid – internships lasting for several months while they were studying the Swedish language or preparing for the TULE exam. This increased their chances to excel in the test, improved their language skills, and enabled them to practice medicine and get to know the Swedish medical system. As Fatin said about her internship: “I was treated very well there, it was a very good time. I learned much about the language, about the health system.”

Also, some of the interviewees told of occasions when they challenged the regular process of the license acquisition. Rashid, for instance, explained how he was able to arrange with his social worker that he and his wife would not have to go to a regular Swedish language course in order to continue receiving social benefits. Instead of going to school every day, they would study at home and at the same time prepare for their TULE exam and do internships. As he said: “So, it is no waste of time, pang, pang, pang, pang [makes a hand gesture to show how fast it all went]. Systematically, orderly, we had a study plan.”

8.4.4. Working as a doctor in Sweden

When talking about their working experiences in Sweden, the interviewees expressed great satisfaction in being able to practice medicine again. Nevertheless, they felt that they remain in a disadvantaged position. In comparison to their Swedish colleagues, they felt that they had less job opportunities. When talking about their AT, ST and internship positions, the interviewees mentioned that, except when having connections, they had to be prepared to commute over great distances or even to move in order to find employment. Mohammed got his internship position through an acquaintance he met at a sports club. Yi Hui changed her
mind about her specialization because she would never be able to get a position as a
gynaecologist, a very popular specialization among Swedish medical students.
Though they would not speak of discrimination, the interviewees furthermore felt that they
had to work harder, and that they were treated differently compared to the Swedish
colleagues. Fatin felt that foreign doctors have to exert themselves twice as much because they “are under a microscope”:

For example, if my colleague does something wrong, that is from one to ten, no one
would notice it. But if I do something wrong, there will be two out of ten that will
notice it. It will be noticed because I am an immigrant or a foreign doctor. There is
prejudice. But at the same time, I don’t feel that I was discriminated in any way.
Furthermore, many felt that the knowledge they acquired before coming to Sweden did not
matter. Granted, previous experiences made them better physicians, but the fact that they had
to repeat a part of their medical training meant they had to work with, and for, considerably
younger and less experienced doctors. Noor (in her early 40s) recalled a recent event:

If I am sitting here and a Swedish doctor who is more... blond, sitting [points to the
chair next to her] and come another doctor from outside and want to talk to us with
some patient. They don’t talk to me, they talk to the Swedish girl, because always, oh,
she is foreigner, she don’t understand, maybe she is new, beginner. It has happened
actually yesterday! Meanwhile, my colleague, she is a very young physician. But no
matter, they look at her, talking with her, not with me.
Swedish not being their native language was, as Noor said, a further “handicap” and they also
felt disadvantaged because they were less aware of their rights and did not dare to demand
them. Yi Hui said: “I don’t dare to demand the same rights. Because there is also always a
fear that I might be punished if I demand too much.”

8.4.5. Gaining strength from profession

Though a lot of what has been outlined till now speaks of limitations and disappointments that
the interviewees have encountered during their Swedish career, it also became clear that
professional successes were not rare and that they meant the world to the interviewees. It was
with pride that they talked about obtained jobs and successfully-passed exams, and they spoke
with joy when they remembered how they helped a patient. Noor told how she felt about an
internship offer: “She asked me if I want to work, I was so happy! I worked for three months,
without any vacation, just working hard, then they gave me flowers! Oh, it was so... Flowers
aren’t a lot, but it just approved that I succeeded. That I did something that I want.”
It was, however, not only them that gained something out of their work. The interviewees
contributed to society not only through their daily work as medical practitioners, but also by
actively engaging with the societal system. Much of Khalid’s and Mohammed’s work during
Syria’s civil war cannot be detached from its political context and wider societal importance. Also Hayder was a high-ranking member of organizations that fought to improve patients’ rights. Fatin created together with another physician a social media group for other non-EU physicians which enables them to share information about the licensing process.

In addition, several of the interviewees claimed that they get treated differently if they mention their profession. Yi Hui said that “when I go anywhere and you introduce yourself, you are a doctor, people do respect you more.” More importantly, they feel that their profession lifts them out of their migrant role and enables them to occupy a more worthy social position. To substantiate this point, I present here a story by Rashid:

Well, there exists, generally speaking, that foreigners in this country are unemployed. You know that for sure. So, if one looks like me [points to his skin], then you’re of course a foreigner. (...) There was something some weeks ago. So, I went to the BMW store and I was looking at a car that costs about 300 000 [SEK]. So, I went to the salesman, can I test-drive this one. Aha, do you have a driver’s license? Yes, I have that, I showed my driver’s license. Aha. How were you thinking to pay for it, he asks me. I will pay 20 or 25 percent. And the rest I would pay in installments. Aha, is it settled with the bank? He didn’t do that with the others. I saw that, he had many customers, but he didn’t do that with them. If they wanted to test-drive, they got the keys immediately. They give the driver’s license, he looks at it, makes a copy and then they get the keys. Two minutes. But he made a frigging long examination with me. And then I got the keys to the car. I got annoyed and to be honest, I wanted to say to him, you, I earn per month as much as you earn in six months [his voice grows louder]. I can even pay in cash for this car immediately, so I have no problem to pay for it with my own money and buy even two BMWs. I got very annoyed, I didn’t say it, but I would have wanted to. I regret it every time I think of it. So, it’s like, sometimes one gets judged by skin, background. And it helps... Now I show, if they ask after my ID, then I show this ID [points to his doctor ID from Region Skåne]. It says there that I am a doctor. Like this it gets much smoother. I have noticed that it goes better. (...) I thought of replacing the driver’s license and instead show this ID [again pointing to his doctor’s ID], it says doctor on it so they know, and it says Region Skåne on it, so they know I have a job and that I work as a doctor when they read it. viii

Noor, however, took a different stance and predicted, perhaps rather resigned, that her foreignness will continue to be her defining characteristic:

But I had one occasion, I was a doctor, I was in XXX hospital with my friend, she was operated. So, she was in the hospital, in the operation department and I was in the restaurant eating lunch, like everybody eating lunch. And there comes an old man and he sits beside me and there are a lot of tables nearby. And he starts talking, oh, who are you, you are not Swedish, where are you from, I thought he is kind to talk to me. So, I said, I am from Iraq. Yes! You, you come to Sweden our money, just taking Swedish [social] benefits. And he starts shouting. And I am a doctor! So, I just leave my food and the restaurant, I was... Really, I want to cry, I want to shout, I just want to say I [stressing] am a doctor, but I thought it was silly to talk to him, he maybe addict or psychologically ill, I don’t know so. But whatever you are, even with that clothes
[points to her medical white coat], even if they say... You look foreigner, it’s another feeling actually. I don’t think it will get better, because it was like that the whole time.
9. Analysis

9.1. The Move

In order to address the first research question, i.e. to make sense of how interviewees’ migratory and professional trajectories shape each other, I find it useful to compartmentalize interviewees’ migratory moves into 1) outward movement (the decision to move), 2) inward movement (the choice of destination, the journey and arrival), and 3) onward movement (transit stay) (Van Hear, 1998: 41). With that in mind, the following inferences evolve from the narratives.

9.1.1. Walking on the terrain of choice and coercion

With reference to Van Hear (1998: 41-47; Van Hear et al., 2009: 2-5; elaborated in Section 6.1.1), it is apparent that the interviewees’ migratory trajectories were not shaped merely by the outer circumstances that forced the interviewees into action, but that they still made choices, even if within a narrow range of possibilities. In my material, the narratives of the decision to leave were simultaneously also the narratives of staying. Hayder and Khalid might have ultimately been forced to leave Iraq and Syria due to direct life-threats, but they had stayed in their countries for years despite the danger. That is, while the impulse to leave came from the external conflict-related circumstances, the decision if and when to react to it was still taken individually.

The same goes for the choice of destination. The interviewees ended up in Sweden as a result of an interplay between self-determined choices and factors that were not within their control. When deciding about their geographical moves, the interviewees contemplated a number of factors, such as which countries would offer them asylum, if they know anybody in a particular country, or how long they must wait in order to travel there. However, these choices were indeed bound by, e.g., financial resources, smuggling possibilities and the decisions made by the UNHCR.

Thereby it is important to bear in mind that the line between choice and compulsion was extremely thin and constantly shifting. One can gain a sense of this also through the narratives about the journey to Sweden, and especially about the transit stays. When Fatin and her family chose to move to Sweden, how free was their choice if their diminishing savings didn’t allow them to wait long enough to be resettled to Canada? To what extent was the decision to leave the country of transit their own, if Fatin and her husband had difficulties working there and providing for their family?
What is more, these spaces of compulsion and choice were further intersected by moments of complete powerlessness – some things were simply out of their hands. Fatin might have decided to be resettled to Sweden, but she could not decide about the precise place of residence in Sweden. This indicates that the time axis is crucial when considering individuals’ migratory trajectories: not only is the choice-coercion interplay to be seen in the specific migratory (outward, inward, onward) movement, its shifts can also be drawn across the whole migratory timeline. This points to the fact that while some stages of the migratory trajectory might be less of individuals’ own making, others still are. However, there is hardly any predictability involved, and the interplay between coercion and choice might look very different for different individuals.

9.1.2. Profession matters

“There were two people inside me. One say to me, stay, help these people, help your country in this difficult situation. And the other one, no, you should leave now, you should leave Syria now, you should not die now. So, that was like a war inside me, you can say.” (Khalid)

Whereas conflict-related forces undoubtedly affected the interviewees’ migratory movement, they were not the only ones: professional considerations played, among others, an important factor determining their migratory trajectories (Van Hear et al., 2009: 4; Van Hear, 2014). Most explicitly, their profession shaped individuals’ decisions to move, as well as their transit stays. Whereas Noor’s decision to leave Iraq was conflict-induced, it was also propelled by her wish to increase her career prospects. Impossible working conditions in the transit country made both Noor and Fatin decide to move on. On the other hand, Hayder and Khalid stayed in the war-ridden countries because their profession enabled them to help people. They left only once they were directly threatened – because of their activities as doctors. The choice of destination, on the other hand, was affected negatively by job considerations, i.e. the inability to practice their profession. For instance, Rashid reconsidered his chosen destination and searched for another place of settlement where he could work. The same affected Yi Hui, as her highly skilled husband would not have been permitted to work in Malaysia for seven years. As presented in the narratives, the means of travel were not directly dependent on the professional considerations.

In sum, interviewees’ narratives show that their moves were not simply forced upon them, but that they consisted of numerous decisions, which were sometimes more and sometimes less constrained by the outer circumstances. Their decisions were, furthermore, coloured not only by their safety but also by their professional concerns. In that sense, the movement of these
highly skilled refugees cannot be understood along the lines of a forced – voluntary migration dyad (King, 2012: 8-9; Van Hear, 2014: N/S). We can only make sense of it in terms of mixed migration (Van Hear, 2014); i.e. as a mixture between forced and voluntary movements, as an interplay between security and other considerations, including career.

9.2. AFTER THE MOVE

In the text so far, the category of inward movement comprised only the choice of the destination and the journey to it, but not the actual arrival. The fact that all interviewees (will) work as doctors in Sweden further complicates the refugee – highly skilled migrant dichotomy. According to Van Hear et al. (2009: 12), their practicing of medicine transmutes the interviewees from refugees into highly skilled migrants who bring along professional expertise and – regardless of the fact that they were not directly recruited for this purpose – help Sweden address its occupational gap in the health care sector (see Chapter 1).

However, the picture is more complicated than that. To label the interviewees simply as highly skilled migrants would, firstly, disregard the fact that, most probably, none of the interviewees would live in Sweden had their countries (or countries of their partners, as in Yi Hui’s case) not been in conflict. Secondly, it would ignore the effect that moving to Sweden had on the interviewees’ careers and their individual self-perceptions.

9.2.1. Professional career on rewind

How the move to Sweden affected interviewees’ professional trajectories can best be understood in terms of different capitals (Bourdieu & Wacquant, 2013: 295-297; Bufton, 2004: 28; Massey et al., 2008: 227; elaborated in Section 6.2) that the interviewees brought with them, and/or had to acquire in Sweden in order to practice medicine again.

The interviewees decided to continue working as doctors in Sweden because they were not prepared to give up a profession they felt dedicated to. At the same time, they were unwilling to cast away the investment they had made into their human capital in their home countries and trade it for low-skilled jobs that have lower symbolic capital and would, in the long run, pay off in lower economic capital.

None of the interviewees questioned directly the licensing process and hence they all implicitly recognized the need of converting their foreign human capital into the Swedish ‘currency’ and of obtaining the necessary cultural capital, i.e. the Swedish language and communication skills needed by physicians when interacting with their patients.

However, the interviewees were extremely critical of the duration of the process and its design that prevented them from practicing medicine for years. Firstly, the interviewees felt
that the way the licensing process was designed only partly recognized their human capital and hence devalued it. This resonated strongly in their stories, e.g., that they had to study again for the TULE exam and attend language courses together with less skilled migrants.

As a result, many of the interviewees suggested that the process should be shorter, more practically oriented, and that all steps should take into account their skills. According to them, such a process would be more beneficial also for the acquisition of the necessary cultural capital. Because of that, many interviewees alleviated the tediousness and impractical design of the process by gathering the necessary capitals on their own initiative, rather than waiting for the next step and accepting the given pathway. Through their internships in hospitals and outpatient clinics, the interviewees felt that they were able not only to improve their communication and language skills, but that they gained further insights into the workings of the Swedish medical system and acquired crucial cultural capital that good, practicing physicians need to have.

Last but not least, some of the interviewees found that the duration and difficulties related to their professional re-establishment were associated to individual’s social capital. The interviewees claimed that connections within the medical sector proved to be of great importance in order to obtain internship, AT, and ST positions. This could not only reduce the interviewees’ waiting-times to get the positions, but also prevent them from having to relocate or become long-distance commuters.

The migratory move slices into the interviewees’ professional trajectories by rendering their existing human, cultural and social capital less valuable than the required Swedish ones, thereby pointing to the symbolic violence that is exercised within the nationally bound medical system (Bourdieu & Wacquant, 2013: 298-299).

9.2.2. Interplay between professional and migrant selves

After discussing the interconnectedness of migratory and professional trajectories, this section turns to the second research question and accounts for interviewees’ self-perceptions. By making use of Brubaker and Cooper’s (2000) distinction between identification and categorization, and self-understanding and social location, which are further developed by Jenkins’ (2008) theory on social identity and Anthias’ (2008, 2012) notion of translocational positionality (see Section 6.3), the following paragraphs interpret how the interviewees understood themselves and the social locations they occupy.
9.2.2.1. Self-understanding: ‘provider’ versus ‘recipient’

The interviewees’ narratives show that being a doctor incorporates two important aspects. On the one hand, the interviewees see it as a matter of practice: being a medical doctor means giving diagnoses, curing diseases, fixing problems and saving lives - it is not about “sitting around”. While this points to a particular kind of self-understanding, it also hints at an important aspect of the identification process (Brubaker & Cooper, 2000: 17). Though the interviewees identified themselves with their profession, their professional identity was deeply shaken when they could not practise medicine. On the other hand, though the interviewees see medicine as a profession that gives economic security and steady employment, it is also understood as a means of helping people. Taken together, the two aspects indicate that the interviewees understand themselves as ‘providers’. Being a physician entails for them active contribution to patients’ and thus also wider societal well-being. Concurrently, the interviewees had a hard time identifying themselves with the often constrained and inactive role of a refugee, i.e. a ‘recipient’ of social benefits; a person who “sits around” while waiting to get the asylum application approved.

9.2.2.2. Identification and categorization: profession does not matter

The interviewees identified themselves as refugees only in relation to their entry to Sweden and the particular circumstances that framed their life during the initial time in Sweden. When talking about the time after the asylum procedure, they referred to themselves as foreigners or, occasionally, migrants. Thereby, they were not shy in using expressions such as “we, foreigners”; something they never used in relation to the term refugee.

As suggested by Jenkins (2008: 40-48), these self-identification processes can only be understood when taking into account how the interviewees were categorized on the institutional level. On that level, the interviewees were categorized as refugees, while at the same time being placed within the larger category of immigrants. The interviewees understood themselves as refugees because the legal framework labelled them as such and at the same time made them into refugees. The very formal category that is used in political and bureaucratic contexts placed the interviewees within a certain frame of regulations and thus imposed upon them a lifestyle which shaped them into refugees (e.g., waiting for the approval of their asylum application while living in a detention centre, reliance on social benefits). Refugee identity emerged mainly through the external processes that defined them as such, whereas migrant identity stemmed also from the interviewees’ own self-perceptions. Rashid’s remark about refugees on pages 36-37 hints to a possible explanation. By associating
themselves as ‘being placed’ into the refugee identity rather than essentially ‘having it’, the interviewees disputed any possession of, often negative, characteristics that are attached to the refugee category by means of public discourses (see Chapter 1). Instead, the interviewees saw themselves as foreigners; a term which carries far less drastic and charged images of desolation, yet still reflects the disadvantaged social location (see next Section) in which they found themselves.

However, the interviewees were also categorized as immigrants on the institutional level pertaining to their professional reestablishment. The licensing regulations group physicians according to their country of education, differentiating between those trained in Sweden, within the EU, and those who obtained their medical qualifications outside of the EU (see Section 5.1). When it comes to the Swedish language courses, the interviewees were obviously categorized according to their immigrant background, yet no further categorization took place according to their educational or professional background.

As for their professional identity, during the initial time in Sweden, the interviewees’ professional identification took place mainly through their self-identification as doctors and their own drive to embark on and continue along the path that will establish them as doctors also on an institutional level. The institutional guidelines for non-EU doctors in Sweden indeed framed this process, but the actual design of the process impeded, rather than supported the interviewees’ professional identification.

9.2.2.3. Translocational positionality: being a migrant and a doctor

Through migration, the interviewees’ social location as a native changed into that of a migrant. The geographical relocation from their home countries did not dislocate the interviewees in terms of their profession, but changed it (Anthias, 2008: 15). Whereas the preceding sections show how the migratory move affected the professional pathways and identity, this section accounts for the positionality of the interviewees once they acquired the Swedish medical license and were thus placed within the institutional category of doctors.

Depending on the context, the intersection of their social locations as migrants and doctors put the interviewees in sometimes dominant, and sometimes subordinate positions (Anthias, 2012: 108). Once the interviewees started working as doctors, they felt they were in a disadvantaged position compared to the Swedish doctors. Not only did they de facto occupy the same or, even, lower positions than their much younger and less experienced Swedish colleagues, more importantly, it was through their daily workplace interactions with that the interviewees occupied a disadvantaged position within the otherwise privileged social
location of physicians. Thereby, the interviewees’ self-identification with being foreign was further reinforced by the external identification of the interviewees as immigrants (Jenkins, 2008: 42); something that was perceived largely as inhibiting. They understood that being a migrant puts them in a disadvantaged social location in comparison to Swedes and – due to their looks – sometimes even in comparison to EU and some other migrants.

On the other hand, outside of their professional context, the interviewees felt that their profession could sometimes put them in an advantaged social position. Expressing, or even just being aware of their professional affiliation not only made their position more advantageous, it sometimes even made it superior to their counterpart (recall, e.g., Rashid’s encounter with the car dealer).
10. CONCLUSION

The thesis accounted for the experiences of doctors who came to Sweden as refugees. By juxtaposing their migratory and professional experiences, this thesis aimed to offer a yet untaken perspective on these migrants’ trajectories and their self-perceptions. Thereby, the following conclusion can be extricated from the documented narratives and their analysis.

The interviewees’ migratory trajectories cannot be ranked alongside the simplistic dyad of forced and voluntary migration (King, 2012b: 8-9; Van Hear, 2014), but should rather be conceptualized in terms of mixed migratory movements, where professional considerations comprise one of the factors that shape an individual’s move. In the same manner, interviewees’ professional trajectories cannot be thought of without also acknowledging the contours which the act of migration imposed upon them. Whereas geographical relocation did not render it impossible for the interviewees to pursue their medical profession, it certainly took the wind out of their careers. Though the process of obtaining the Swedish medical license allows for an institutional framing of the conversion of non-EU doctors’ medical expertise, both the duration and design of the process concurrently devalues them as professionals.

Much as the interviewees’ migratory and professional trajectories intertwine, so do their self-perceptions. In a way, interviewees’ understanding of what it means to be a doctor and what it means to be a refugee can be seen as contrasting. For them, being a physician entails not only possessing a medical license, but actually practising medicine. Their profession is positively loaded and seen as a source of strength. It means providing for oneself, while at the same time actively contributing to society. Being a refugee is, on the other hand, burdened with negativity. It is therefore a term with which they reluctantly relate to themselves; instead, it is a label that is appointed to them. They rather perceive themselves as foreigners, which still captures the inhibiting elements of their existence. Thereby, the migrant and professional selves are in a constant interplay with each other and shape the interviewees’ existence and self-perceptions. Whereas their profession may increase their social position, the external labelling of the interviewees as immigrants and refugees rattles their doctor-identity. This is not only the case during the licensing process; their migrant identity gives even the licensed physicians the feeling that they occupy a somewhat outsider-position within the medical field.

Yet every answered question begs two more. Indeed, this thesis touches upon a number of subjects that would deserve deeper investigation. The engagement and length with which the interviewees talked about the Swedish licensing process proves that the topic deserves a whole separate thesis. The given thesis could also be expanded by incorporating an analysis
of media, political and other public representations of refugees, and the highly-skilled among them. Likewise, given more time and resources, it would be worthwhile to conceptualize a broader project that would map not only the experiences of refugee doctors but also of, e.g., the (still) immobile doctors, as well as refugees who refrained from obtaining the Swedish medical license.

With that said, these findings should not be seen as grist for sceptics within the migration-asylum nexus debate. Migration scholars have increasingly pointed to the reality of mixed migration and the perspective was adopted by the policy world under the term migration-asylum nexus. Within the policy arena of the migrant-receiving countries of the Global North, however, the recognition of the mixed nature of migration flows merely added fuel to the concerns about the abuses of the asylum system and perpetuated the agenda of fighting irregular migration, controlling the borders and identifying unfounded asylum claims (Crisp, 2008: 2; Van Hear et al., 2009: 6-10). This tendency of policy regimes to classify migrants according to a single motivation – let it be flight, job, studies or family reunification – should, however, not disregard the complexity of migratory movements and, as so often, interpret it as evidence of deceit. Instead, it should take up the challenge and tailor the policies so as to be conducive to this intricate reality (Castles & Van Hear, 2005: 11; Long, 2015; Van Hear, 2011: 2, 2014).

In the same vein as the thesis outlines how migratory trajectories slip their ‘descriptive typologies’ (Anderson & Keith, 2014: N/S), it also argues against the essentialization of migrants’ identity. By accounting for individuals’ self-understandings and how these are influenced by different types of interactions, the thesis emphasizes the social and irredeemably processual nature of identity formation (Rajaram, 2002: 262-263). As Malkki (1992: 37) puts it: “(I)dentity is always mobile and processual, partly self-construction, partly categorization by others, partly a condition, a status, a label, a weapon, a shield, a fund of memories, et cetera. It is a creolized aggregate composed through bricolage.” This, I think, - and herein is encapsulated the answer to the third research question – is the invaluable heuristic contribution of the chosen conceptual frameworks, which permit one to make sense of highly complex processes without losing sight of their agents and objects, as well as the contexts in which they take place and interact.

All in all, the thesis refines our understanding of highly skilled migrants and refugees, and “contains an important caution against over-generalization” (Mcbride et al., 2014: 1). Whereas the terms might have analytical usefulness as a legal or descriptive rubric, they should not be employed as labels for a particular type of person. Instead, they should
accommodate a diversity of individuals, along with their multifaceted histories and contextuality (Malkki, 1995: 496; Rajaram, 2002: 263). It is only in this way that we can move away from often one-sided depictions of welcomed and un-welcomed migrants (Faist, 2015), and acknowledge the value which each individual possesses. Though the present example of immigrant physicians who help to fill the Swedish labour gap may seem to make this point just a bit too neatly, it does so only at the first sight. The extensive exploration of these individuals’ experiences in fact shows the numerous struggles they encounter. And their experiences should, in all their complexity, represent a step towards more differential conceptualizations.

Remember the phone shop episode recounted by Hayder and his uncertainty as to whether the salesman treated him in a certain way because he was foreign, or simply because this was his attitude to all customers. As he explained to me, he always tries to refrain from making a quick judgement; he rather tries to understand “the big picture.”
11. REFERENCES


12. APPENDICES

12.1. APPENDIX 1: INVITATION TO PARTICIPATE IN THE STUDY

INVITATION TO PARTICIPATE IN A RESEARCH STUDY

BEING HIGHLY SKILLED AND A REFUGEE

Experiences of non-EU Doctors Working in Sweden

My name is Katarina Mozetic and I am a Master’s student of International Migration and Ethnic Relations at Malmö University. I am currently writing my MA thesis on non-EU doctors working in Sweden and would kindly like to invite you to participate in my study.

My research project explores the experiences of non-EU doctors who came to Sweden as refugees/ asylum-seekers and who are now working here. I am interested in your experiences as doctors in Sweden, how do you perceive the process of obtaining Swedish medical license and how did you experience the asylum-seeking process.

ARE YOU INTERESTED IN PARTICIPATING IN THE STUDY?

The participation would entail one interview of app. one hour. The interview would be conducted in English and take place when and where it is most convenient for you (possible also over Skype). If possible, I would like to audio record the interview. Please note that all information obtained through the interview will be treated confidentially and that you can withdraw from the study at any time.

If you’d like to participate or have any further questions, you can write me an e-mail (xxxx) or give me a call (xxx). You are also more than welcome to forward this message to your colleagues who might be interested in participating in the study. Thank you very much!

Best regards,
Katarina Mozetic
12.2. APPENDIX 2: INTERVIEW GUIDE

INTRODUCTION
Can you tell me a bit about yourself? (age, country of origin, professional status, family status)

PROFESSIONAL EXPERIENCES
Please tell me about your professional experiences in your home country.

LEAVING
Can you tell me about the circumstances when you decided to leave your home country?

MOVING TO SWEDEN
Can you tell me how did you end up in Sweden?
Can you describe your initial time in Sweden?

PROFESSIONAL REESTABLISHMENT
Please tell me about the process you went through in order to work as a doctor in Sweden.
- Did you want to continue working as a doctor in Sweden, of did you consider working as something else?
- What are, in your opinion, the good/ bad sides of the licensing process?
- How did you obtain your AT and internship positions?

WORKING IN SWEDEN
Can you tell me a bit about your current position?
- How did you obtain your current position?
- Can you tell me about your relationship with your colleagues?

BEING A DOCTOR
Why did you become a doctor in the first place?
What does it mean for you to be a doctor?
Were there periods when you were not able to work as a doctor?
Did you ever experience that people treated you differently once they knew you are a doctor?
Were there occasions when your medical knowledge and experience from your home country did/didn’t matter in Sweden?
Do you feel that your move to Sweden affected your career and you as a doctor?
Do you feel that you can be a doctor to your full potential here in Sweden?

BEING A REFUGEE
Did you ever think of yourself as a refugee?
Did you ever experience being treated as a refugee?

FUTURE
What are your hopes for the future?
13. **Original Swedish Excerpts**

i “På ett dygn kommer amerikanerna, så var där militär och det var bråk mellan dem, så har de förstört våra hus, mitt pappas hus och han var tvungen att flytta. Allting var förstört, allt som han har byggt i trettio år. Tänk på (...) att du bygger upp det här, familj och huset och allting, du har ditt yrke och sedan plötsligt försvinner allting.”

ii “Innan vi fick uppehållstillstånd, så vi visste inte vad kommer att hända. Anxiety kanske. Vi var ängsliga. Vi visste inte hur det kommer att gå till, allting var konstigt.”

iii “Det var jobbigt. Framför allt, vi visste inte hur det kommer att bli sedan, kommer vi att klara oss att komma till Sverige, kommer vi hamna... Vi visste inte, vi var inte överens om Sverige eller Holland, jag visste inte att jag är i Sverige tills jag kom hit. (...) Det var dålig mat, vi fick inte mat, vi fick bara det som de gav oss alltid. Man kunde skippa mat i flera timmar, skippa drickor. Så det var jobbigt. Rent fysisk var det jobbigt (...) Mentally kan jag säga också, det var difficult. Vi visste inte vad det är som kommer att hända. Det var det som var jobbigast.”


v “När man säger refugees, det skiljer sig väldig mycket om man är på en flyktningscamp som alla de från Syrien med ingen vatten, inga medicin, trötta, det regnar på dem. Eller refugee som här i Sverige som bor i en lägenhet, kan ta en promenad till ICA Maxi och köpa sig mat, titta på TV eller googla på nätet. Så, det är ett bra liv. Så, jag kan inte säga att jag känt mig... Ordet refugee eller asylsökande, det betyder någonting dåligt, eller sämre än vad det var. Det har jag inte känt mig. (...) Jag kände mig alltid som främling.”


vii “Så det är inget slöseri med tid, pang, pang, pang [makes a hand gesture to show how fast it all went]. Systematiskt, ordentligt, vi hade haft en plan för läsa och plagga.”


67