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**ENTRANCE TO AND ADVANCEMENT
WITHIN THE SWEDISH MEDICAL LABOUR
MARKET FOR PHYSICIANS WITH A
MEDICAL DEGREE FROM OUTSIDE THE
EUROPEAN UNION**

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Entrance to and advancement within the Swedish medical labour market for physicians with a medical degree from outside the European Union

THESIS FOR DOCTORAL DEGREE (Ph.D.)

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ABSTRACT

Background

Many physicians who migrate wish to continue practicing medicine in their destination country. However, they may meet barriers and obstacles that prolong the process of entering and advancing within the destination country's medical labour market. Migrant physicians' competences are needed, and if fully utilised, it will be beneficial for them, the patients, the medical workforce, and for society.

Aim

The aim was to explore the entrance to and the advancement within the Swedish medical labour market for physicians with a medical degree from outside of the EU/EEA.

Method

The study participants were mainly physicians who had enrolled in a complementary programme for physicians with a medical degree from outside the EU/EEA and Switzerland. Both qualitative and quantitative methods were used. Study I included semi-structured interviews with 24 physicians. Study II was a cross-sectional study that included questionnaire data from 283 respondents. Study III included test data from physicians with a medical degree from outside the EU/EEA who had taken a licensing exam 2013–2019 ($n = 564$), and 14 semi-structured interviews. Study IV included questionnaire data from 101 respondents, and four semi-structured interviews. Interview transcripts and questionnaire free-text answers were thematically analysed. For Study II, the statistical data were descriptively analysed. For Study III, linear and logistic regression analysis were used. In Study IV, descriptive and inferential statistical analyses were performed on the data. To understand and discuss how MPs enter and advance within the medical labour market in Sweden, Bourdieu's concepts of the social field, symbolic capital and doxa were used as a lens. As a complement to Bourdieu's theory, self-determination theory (SDT) was used.

Results

In Study I, several conceptions about working in rural and remote areas in Sweden were identified. These regarded the themes finding work, work content and tasks, and living. Conceptions about working in a certain type of area gave rise to conceptions about what it would be like to live in the same area. The participants' conceptions derived from their own and from others' experiences; and conceptions influenced study participants' motivation of where to work, negatively or positively.

In Study II, 88% of the respondents held a position as a physician when answering the questionnaire, but they were in varying stages of their careers from one another; as they also had begun the complementary programme at different times. The respondents had mainly found their first job after the programme via spontaneous job applications, during internships

or via friends or other programme participants. Barriers and facilitating aspects as well as the different strategies they used were explored. During their job-seeking process, the respondents reported experiencing discrimination or having their competences undervalued. To increase job prospects, the respondents had, for example, worked as assistant nurses or medical assistants before beginning the complementary programme. Respondents had developed their language by using different resources. Due to high labour market conditions, respondents had moved or changed specialty to increase job prospects.

Study III revealed that age was a predictor for succeeding on the licensing exam, and that the complementary programme seemed to reduce the negative age effect for participants aged 45 years or older. In the qualitative material, perceived influential aspects for succeeding or failing on the exam related to the two themes preparations and biographical aspects, and to the exam and exam situation.

Study IV explored aspects that influenced choices of employment and specialty, and found that the most important aspects related to choosing employment were the ability to combine work with family, and possibilities for developing competences. The majority of the respondents had specialised in general medicine, and women were more likely to specialise in general medicine than men. Influencers on the interviewees' motivation and choice to specialise in general medicine related to the themes of job opportunities, positive experiences from PHC, working conditions and family conditions.

Conclusions

Barriers and limiting circumstances may derive from the micro and meso levels, and influence on a micro level; however, individuals still have agency. They can influence their paths to the labour market and advance within it through certain strategies and/or facilitating aspects. Many barriers and facilitating aspects corresponded to one another and were two sides of the same proverbial coin. The social context and environment influenced the study participants' choices regarding where to work and in which specialty. Aspects relating to work life and private life collaborated to influence motivation and choices. As a group, these MPs could be interpreted as being hierarchically positioned lower in the Swedish medical field than physicians who trained in the country. However, on an individual level, this may not hold true, as the group is heterogeneous in terms of gender, ethnicity, country of origin, country for medical education, and age. Influential aspects on the macro, meso and micro levels may change over time.

PROLOGUE

In the 1980s, I watched the Indiana Jones films. Indiana was a researcher, and I thought that his job seemed very exciting. Of course, I had absolutely no clue what being a researcher meant in reality. Now, I know that it is not like in the Indiana Jones movies; however, even if I am not seeking the Holy Grail which he did in one of the films, I still find research exciting. Above all, I find it fun, developing and challenging. For me, doing research is like swimming in a deep ocean. There is always a risk of drowning – perhaps not in water, but in scientific papers. In the ocean of research, there are many islands – I swim toward one specific island, the one that holds my aim and research questions. However, it can be difficult to keep the right course since all the other islands may also attract, as they all have interesting topics to explore. It is also possible to stand on these other islands, staring over at my specific island from the different perspectives and angles they provide, twisting and turning forever.

Since I had a curiosity about humans and what happens between humans, my academic swim began in ethnology and proceeded in pedagogy, eventually leading to a university diploma in educational science, and a master's degree in ethnology. My educational background and interests later steered me toward the Evaluation unit at the Department of learning, informatics, management and ethics, Karolinska Institutet. There, I started the swim towards my island; I began narrowing my research focus when evaluating a complementary programme for physicians with a medical degree from outside the EU/EEA, and doing a follow-up of the participants. I went on to evaluate complementary programmes for nurses and dentists. I found I was interested in healthcare professionals who had migrated to Sweden and wished to continue to practice. I chose physicians as my study participants because of their long and complicated journeys to a Swedish medical license. I had developed contact with those responsible for the complementary programmes, helping me to get in contact with migrant physicians and providing valuable insight and support for my work.

On a personal note, my interest in migrants working in the healthcare sector also derived from having a mother who migrated to Sweden, and eventually became a nurse. For her, it took several years. It took me several years to become a research student. But there is a Swedish saying that I agree with: 'Shame on the one who gives up'. I think that many of my study participants would agree with this. I have seldom met individuals who were as driven, focused and determined as the migrant physicians who participated in my study. Their reasons for wanting to practice medicine in Sweden differed, but they wanted to do it as soon as possible. Why? They were physicians – they wanted to work, and specifically, work as physicians again. Some mentioned they wanted to support their families and be role models for their children. Not working in their vocation made some of them depressed, whereas others reported feeling inferior in social situations. However, obtaining a Swedish medical license can be a time-consuming and difficult process. There are barriers, but also facilitating aspects to establishment and to the Swedish medical license – my research interests lay in identifying these.

LIST OF SCIENTIFIC PAPERS

- I. **Sturesson L**, Öhlander M, Nilsson G, Stenfors T
Migrant physicians' conceptions of working in rural and remote areas in Sweden: A qualitative study.
PLoS ONE (2019) 14(1): e0210598.
- II. **Sturesson, L**, Öhlander, M, Nilsson, GH, Palmgren, PJ, Stenfors, T
Migrant physicians' entrance and advancement in the Swedish medical labour market: a cross-sectional study.
Human Resources for Health 17, 71 (2019). <https://doi.org/10.1186/s12960-019-0414-0>
- III. **Sturesson L**, Heiding A, Olsson D, Stenfors, T
'Did I pass the licensing exam?' aspects influencing migrant physicians' results: a mixed methods study.
BMJ Open 2020;10:e038670. doi:10.1136/bmjopen-2020-038670
- IV. **Sturesson, L**, Palmgren, PJ, Öhlander, M, Nilsson, GH, Stenfors, T
Migrant physicians' choice of employment and medical specialty: a mixed-method study comparing general medicine with other specialties
Submitted.

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LIST OF ABBREVIATIONS

ANOVA	Analysis of Variance
AT	Allmäntjänstgöring (referred to as mandatory medical internship/MMI)
CI	Cognitive Interview
CPP	Complementary programme for physicians with a medical degree from outside the EU/EEA and Switzerland
EEA	European Economic Area
EU	European Union
GP	General Practitioner
IMG	International Medical Graduate
MMI	Mandatory Medical Internship (referred to as Allmäntjänstgöring/AT in Swedish)
MP	Migrant Physician
PHC	Primary Healthcare
SDT	Self-Determination Theory
SPSS	Statistical Package for the Social Sciences

1 INTRODUCTION AND RATIONALE

Many physicians who have migrated want to practice their profession in the destination country (1), and thus, need to establish themselves in the medical labour market. It could be argued that establishment is important by many reasons; Access to and establishment in the labour market are indicators and important factors for integration (2, 3), and thus, for society as a whole. On an individual level, work (4, 5) and integration increase well-being (6) since they raise individuals' socio-economic status and reduce exclusion and mental ill-health (7); on the opposite side, to be unemployed can put someone in a vulnerable position (cf. (8)). Thus, the benefits of establishment in the medical labour market are important for society, the individual, and the medical labour market as the medical workforce increases. This can specifically be important when staff shortages of practising physicians are evident. The absence of practising physicians in rural and remote areas, for example, has become a challenge for many countries (9-18). This absence creates inequality in society based on where patients live, and in underserved areas, it endangers public health. There are also staff shortages in certain healthcare sectors and medical specialties, usually general medicine (family medicine), psychiatry and geriatrics (10-16, 19-23). After having been recertified, migrant physicians (MPs) can proceed to specialist training. Research has also shown that MPs may have lower levels of distress if they are in the specialisation phase rather than the recertification phase (24).

It can also be argued that the establishment of MPs in the labour market is important since the professional group at large should reflect diversity in society and the patient population (cf. (25)). MPs' diverse backgrounds and professional experiences can become assets for their colleagues and for patients. Reflecting the patient population may increase cross-cultural competence in the medical workforce (25), and in the longer run, it could increase minority group patients' compliance with their treatment (26) because compliance is suggested to increase if physicians are perceived as culturally competent (27). If MPs' competences are utilised, they could also develop the profession based on their diverse professional experiences. Thus, MPs' establishment in the medical labour market is important as it can result in positive effects for them and patients, and for society as MPs can contribute to a balanced healthcare system and support the welfare in society. Therefore, it is important to explore the entrance to and advancement within the medical labour market, especially since the route to practice as a physician in a destination country often is a complicated and time- and energy-consuming process (cf. (1)) that can be lined with difficulties and barriers at the individual (micro), organisational (meso) and societal (macro) levels. Structural dimensions that permeate all the different levels may also influence the entrance to and advancement in the medical labour market, with the risk that some may give up along the way. Barriers, obstacles and difficulties could restrict an individual's freedom of action, the possibility of exercising free choices, and undermine an individual's intrinsic motivation which may decrease well-being. Actions based on intrinsic motivation leads to higher well-being (28) and signifies individual sustainability in working life. Barriers and difficulties that MPs meet

need to be explored and identified to allow efforts to be made to overcome or minimise them. This can ensure that MPs stay in work, benefiting individual MPs, patients and society. For the same reason, aspects that make establishment easier ought to be explored and identified. Thus, there are many reasons why MPs should work in their new countries, and specifically, why they should work as physicians.

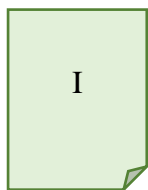
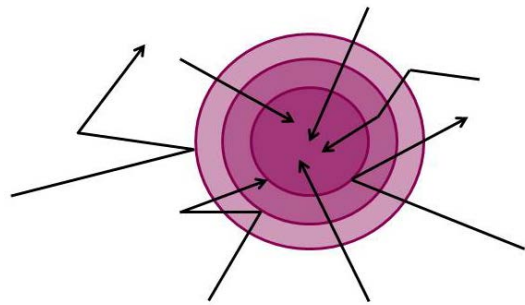
The focus in this thesis is on the entrance to and advancement within the medical labour market in Sweden for physicians with a medical degree from outside the European Union (EU)/European Economic Area (EEA) as they have other conditions than peers educated in Sweden and the EU/EEA (described in chapter 5). Research has been performed regarding MPs in Sweden (1, 29-34). However, while it has been indicated that it takes longer for MPs in general to obtain the Swedish medical licence to practise compared to peers educated within the country (35), less is known about how MPs with a medical degree from outside the EU/EEA enter the Swedish medical labour market and about their advancement within it.

The study aims are presented next (chapter 2). Then follows a background in which relevant current research is presented (chapter 3), and subsequently, a presentation of the theoretical perspectives that have influenced the design and the understanding of the findings (chapter 4). A description of the routes to the Swedish medical licence is presented in chapter 5. The methods and the material are presented next (chapter 6). The results of the studies are presented in chapter 7. In chapter 8, an overarching discussion is held based on the studies, previous research and the theoretical perspectives. Then follows a conclusion (chapter 9), and a summary in Swedish (chapter 10).

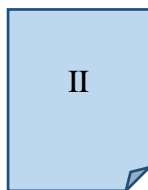
2 AIM

The overall aim of the thesis is to explore the entrance to and advancement within the Swedish medical labour market for physicians with a medical degree from outside of EU/EEA. This is done by exploring the following research question: Which barriers and facilitating aspects do physicians educated outside the EU/EEA

experience during their entrance to and advancement within the medical labour market? The research question is explored and analysed in four different studies with seven sub-aim, as presented below.



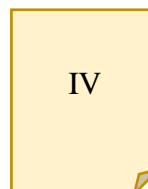
Study I concerns work in rural and remote areas. The study's aim is to explore non-established physicians' conceptions about working in rural and remote areas in Sweden.



Study II focusses on finding work in the medical labour market. The aims are as follows: (1) to explore how MPs enter into and advance within the medical labour market in Sweden, and (2) to identify perceived barriers and facilitating aspects for entrance into and advancement within the Swedish medical labour market.



Study III regards an exam in the licensing process. The aims are as follows: (1) to explore Complementary Programme for Physicians (CPP) participants' exam results in comparison to those from other MPs with a medical degree from outside the EU/EEA, and (2) to explore aspects that may influence the exam results of MPs undergoing the recertification process.



Study IV focusses on career advancement: employment and specialty choices with a focus on MPs specialising in general medicine (family medicine). The aims are as follows: (1) to explore aspects that influence MPs', with a medical degree from outside EU/EAA, choice of employment and medical specialty in Sweden and, (2) to identify any differences between general medicine and other specialties.

3 BACKGROUND

This section presents a background relating to the research question investigated and the study aims explored in this thesis. Also presented are some definitions of recurring terms.

Migrants and migration

We live in a global world. People cross national borders to find new places to settle down; an individual doing so is usually described as a migrant. Thus, a migrant is a person who changes residence—a person who moves from one place to another. The movement can be temporary or permanent. The term migrant is not universally legally defined (36), nor is how long a migrant is considered to be a migrant. There are different groups of migrants, such as work migrants, refugees and asylum seekers (36). Migrants are sometimes returners, while others have moved because of a partner. To migrate is an occurrence in life that has significant value (37, 38). The process of migration is often complicated and complex (39), and an individual can feel disoriented in the new country (40, 41). For many, it is a stressful situation that can last for years (24). Still, people move for various reasons.

Migrant physicians' reasons for moving and the flow of migration

Drivers of migration often emerge at different levels, representing the individual (micro), organisational (meso) and societal (macro) levels (42). Physicians' migration is said to be 'influenced by multifaceted aspects of experience including individual, environmental and political factors' (43) or 'personal factors and social and structural conditions' (39). Several aspects usually interact when deciding to migrate, and thus, it is difficult to identify only one specific reason (39). In the international literature on MPs, researchers sometimes use the categorisation of *push* and *pull* factors when categorising and discussing reasons for migration (39, 42-49). Push factors are more or less forceful and usually relate to negative living circumstances and problems in the country that is left, thus pushing the migrant away. Often, extensive migration from one country relates to the societal level and is influenced by political, economic and military aspects, as well as social transformation taking place (50). Pull factors usually concern aspects in the new country that encourage or attract the migrant; for instance, living conditions and opportunities may be perceived as better than those in the previous country. The push and pull categorisations were developed by a geographer during the 1960s (51); however, in current research about migration in general, these factors do not seem to be terms commonly used.

At an individual level, an area can be seen as able to provide circumstances to fulfil individuals' needs and offer opportunities for reaching their goals (cf. (52-54)). Hence, conceptions of an area can affect an individual's motivation and decision about migrating, as

well as where to move (cf. (30)). A country or an area can provide conditions that also become a driving force to stay in the place (52-54), and these reasons can be seen as *plant* factors (45).

As conditions in countries can change over time, so can the reasons for migrating and how the migration flow occurs. Regarding physicians' migration, the flow is usually directed towards Western countries, such as the United States, Canada, Australia and the United Kingdom (49). These countries have a medical workforce that consists of one-fifth to one-fourth of physicians educated abroad (48), which illustrates the large scale of internationally trained physicians (49). Research on physicians' migration often focusses on the issues of *brain gain* or *brain drain* (48), sometimes referred to as a medical carousel (49). When migrating, physicians take their competences with them to their new countries (brain gain), and at the same time, the country that is left behind loses the same competence (brain drain). The matter of physicians migrating is ambivalent. At an individual level, physicians should be able to move for whatever reason. However, if most of the physicians in a country leave, then the consequences for the inhabitants can be severe. Therefore, strategies for avoiding brain drain have been suggested (e.g. policy changes (49)), and it has been argued that countries gaining from other countries' loss should learn about the consequences of brain drain and independently train the number of physicians needed in the country (48).

Definitions of physicians that migrate

In some research, physicians educated abroad are defined as foreign-born physicians (55), foreign-trained physicians (56, 57), third-country doctors (48), foreign medical graduates (58, 59), overseas trained graduates (58) or international medical graduates (IMGs) (25, 41, 48, 58, 60, 61). IMG is probably the most common term. The definition may vary (56), but overall, an IMG is a graduate from a medical school outside of the country where they later intend to practice or do practice (25, 60). Other researchers use the term MP (62). An MP is also someone who completed their medical degree in one country but then practice in another country. In this thesis, the term MP is used. The term *physician* is used instead of *doctor*. A physician has completed a medical education. They can be referred to as a doctor, but a doctor is not always a physician.

Further, 'destination country' or 'new country' is used to label the country that the MPs have migrated to and where they wish to proceed to practice their profession within, even though the country per se does not have to be new to them or their final country.

The physician's profession

Physicians are well-educated and highly skilled (1, 29, 63) from years of university studies. The medical profession is regulated, and to be allowed to work as a physician; a professional licence is needed (64). To be an independent practising physician in Sweden, a Swedish medical licence is acquired. Physicians have a great responsibility; they examine, diagnose and treat patients. Some make the difference between life and death. To work in the profession is perceived as prestigious, and physicians can be seen as a privileged group in society (33). Research on professions, such as that of physicians, relates to such topics as expertise and having authority, status, what is counted as professional knowledge, relationship to science, the development of professions and professionalisation processes (65).

Accessing labour markets

As described, physicians have opportunities to practise all over the world, and the profession can be seen as transnational (66). Globalisation and international mobility have contributed to the arrival of physicians with medical degrees from other countries arriving in Sweden. Regarding migrants in general and their access to the labour market in their destination country, there are different stakeholders with diverse interests who use different strategies to restrict or open up to migrants' access (54). For example, a union may want to decrease the access to the labour market if the migrants are perceived as competing with the union members' interests, thus jobs (64). Employers could want to facilitate access to the labour market for migrants from low-salary countries as they then can keep down the wages (64). Access to the labour market is not always regulated only at a national level. In the EU/EEA, for example, there is a professional directive that regulates access to the labour market for citizens of the member states (48, 67). Based on legalisation and national borders, thus depending on citizenship and where a physician is educated, the conditions and routes to another country's medical labour market can differ (1, 31, 32, 67). However, as legislation may change, routes can differ over time.

Migrants that want to enter a new country's labour market may meet barriers, obstacles and difficulties that can be more or less challenging to overcome, depending on how big they are and depending on the individual. These can arise at an individual (micro), organisational (meso) or societal (macro) level, and in terms of overcoming them, there are aspects that can facilitate and make the entrance to the labour market easier. In the following sections, different identified barriers, obstacles and difficulties that MPs may experience in their entrance to and when advancing within a destination country's medical labour market are presented. Presented are also some identified aspects that may facilitate entrance and career advancement.

3.1 BARRIERS TO ENTERING AND ADVANCING WITHIN THE MEDICAL LABOUR MARKET

3.1.1 Information about the recertification process

Physicians educated in other countries often struggle with the complicated process of obtaining a licence to practice as physicians in the new country, referred to as a *recertification process*. For physicians with a medical degree from outside the EU/EEA and Switzerland, the process of becoming licensed in some EU/EEA countries may be time-consuming and complicated (68, 69). Often, several institutions can be involved (40, 48), and at the same time, MPs may lack knowledge on who to contact (60) and how to navigate in the recertification process (46). Information about the recertification process can be experienced as insufficient, fragmented, diverse, unclear and non-stringent (39, 48, 60, 69). The language used in the information regarding the recertification process can be too difficult to understand (39, 69). Insufficient language skills may also be a problem when participating in bridging programmes and courses (48).

3.1.2 Licencing exams

One barrier in the recertification process and for entering to and advancing in the medical labour market comprises the exams and assessments that MPs usually need to undertake. In many cases, the same exams apply for domestically educated peers (46). However, MPs' pass rate is usually lower (46, 69-73). For example in Australia, migrant surgeons have a pass rate of 48%, while peer surgeons educated in Australia and New Zealand have a pass rate of 70% (72). In Canada, physicians educated abroad also have a lower pass rate on their certification examination compared with domestically educated peers (46, 73). In the United Kingdom, the same pattern appears in a licensing examination (71). Sweden is no exception when exploring statistics about exams in the (re-)certification process. Physicians with a medical degree from outside the EU fail more often than physicians educated in Sweden do (70). The percentage of passed exams 2009–2015 was approximately 60% for non-EU educated physicians and 97% for physicians trained in Sweden (70). Exams conducted in 2016–2019 show similar percentages (74). Concerning the Swedish context, it is interesting to note that MPs have lower pass rates even if they previous to the exam have participated in a medical internship with a duration of 18–21 months, and previous to that may have worked in the Swedish healthcare sector.

Reasons mentioned for the lower pass rates are that MPs may lack the financial support and time to study (46); reasons can relate to inadequate ability to prepare or insufficient pre-information about the test (72), being located remotely (72). There are also possible difficulties with the language (70), for example, when the test is in a physician's additional

language and they need to translate questions, which could be a time-consuming process (71), or if they have insufficient communication skills (46). Other barriers mentioned are differences in education traditions (70) and training (46, 71), lack of familiarity with examination form (46, 72) or limited understanding of the feedback given (72). The test is also given and taken in a new healthcare context that differs from the ones to which the MPs are accustomed (67). Other reasons for lower pass rates include insufficient medical knowledge (70) and ‘problems with self-esteem and cultural competency’ (46). There are also concerns that examinations cost too much and that they are discriminatory (46) or unfair (69); the lower pass rates could thus also be discussed in light of research on test bias (75). Some explanations are comparable to the barriers identified in the research concerning difficulties that MPs may have when working as independent physicians, including for workplace integration (76), and this could be related to barriers derived from differences between contexts.

3.1.3 Age and family

Another barrier to employment and advancement is age. MPs are often older than peers educated within the country (48, 60, 74) which is also described as a potential reason for lower pass rates on exams during the recertification process (77, 78). In the Netherlands, where MPs with a medical degree from outside the EU/EEA must participate in ordinary medical education before being re-licensed, they are 35 years old on average when starting the training (48). Age can also be a barrier for further career development, especially concerning finding specialty training positions (60). As MPs are often older, they may have children and partners they have responsibility for, which can make it more difficult to study (48). Many lack the financial conditions or support to be able to begin or proceed in the recertification process (46, 48, 60, 79). For example, some have to work while studying, which makes it difficult to devote their full time to studying for the exams they need to take (46). MPs may take survival jobs that can slow or even end their recertification process. Survival jobs may also lead to a change in their careers (39, 79). Career changes are ‘often explained by family responsibilities’ (79).

Such factors as having experienced trauma, missing a country and missing family and relatives who may still be living in the country of origin are also mentioned as difficulties that MPs need to deal with, and this can affect their ability in the recertification process and entering the labour market (60). Family members or the MPs could suffer severe health problems, making it difficult to participate in courses and bridging programmes (48). Having a family can also make it difficult to move to where the work is. Research also indicates that female MPs may need to step back in their careers due to giving birth or taking care of children (79).

3.1.4 Discrimination

Discrimination is a barrier to the labour market for migrants in general (80), and specifically, for individuals migrating to Western countries from non-Western countries (81-83). Research about discrimination in job-seeking processes and employment usually relates to ethnicity (82). In addition, highly skilled migrants like physicians may be or feel that they are discriminated against (30, 84). Having another ethnicity may be associated with having another religion or belief, or an appearance that could be perceived by others as foreign. Discrimination on these grounds has been highlighted in some research about MPs (48), while in other research, this has not been identified as common (60). In Sweden, discrimination due to ethnicity and religion is prohibited, and employers are obliged to counteract discrimination (85). The absence of discrimination findings may also depend on the difficulty of exploring and identifying discrimination. In the job-seeking process, MPs can also experience that their education and/or skills are devaluated (31, 32), and other devaluations of education and skills can become a barrier for MPs.

3.1.5 Differences between medical contexts

During the recertification process, and for entering and for advancing in the medical labour market, physicians often need to learn about a new medical context. Although most MPs most likely are successful in doing so, some may meet obstacles and have difficulties in the learning process. These obstacles and difficulties can emerge from differences in contexts, for example, between countries and workplaces. Subsequent sections present the differences between medical contexts that may become challenging for MPs' workplace integration as described in the literature. Barriers and/or differences are sometimes categorised as being cultural or non-cultural characteristics. Cultural characteristics relate to the interaction between people, while non-cultural characteristics are often related to medical education, the immigration process, language and the healthcare system (40, 76). In the following, a description of differences and any related difficulties is presented. The presentation is themed in culture, language, the healthcare system and the dimension of discrimination. After the presentation of the themes, different views on the process when MPs become part of a new medical context is described.

3.1.5.1 Culture

Many differences and barriers mentioned in research are related to culture and considered cultural characteristics (39, 60, 61, 76, 86). Culture is something that is created, transformed, challenged and protected in human action in interplay with structural conditions. Thus, cultural barriers or difficulties relate to human interaction (86). Usually, barriers and difficulties concern the relationship between males and females, the physician and the patient, the MP and the peers and the physician and other healthcare professionals (76, 87-90). In

addition, barriers and difficulties relate to how to work with and how to approach patients, colleagues and other professionals (39, 60, 61, 76, 86). For example, compared with non-Western working methods, Western methods focus on patient-centred care (76, 86), shared decision-making and separation of relatives in the treatment process (76). It can be difficult to include the patient in the treatment and exclude relatives, as well as to communicate with patients (60), for instance, ‘how to give patients bad news and how to handle the resulting emotions’ (91). One barrier mentioned is the loss of authority in the relationship and hierarchical differences (60). When it comes to team-based working methods, which are common in Western countries, difficulties can arise regarding ‘the distribution of tasks between nurses and doctors’ (61), and some might not be used to nurses being included in rounds (92). These other ways of working imply structural differences, for example, a less visible hierarchy and loss of status (87-90). There is a dominant culture in workplaces and in the profession, and the physician’s beliefs and values may differ from this (93). Parameters for how to work as professional and values and ideas about what is perceived as good healthcare may differ from what an MP is used to (cf. (93)). Moreover, there are social codes and informal norms embedded in culture that can be difficult to grasp, such as how one should talk to peers (cf. (90)) or dress (90). Barriers of cultural characteristics are often themed under culture in general, but some studies specify and theme these barriers under professional culture. In the literature, there are also differences in whether it is specified what in the (professional) culture that is a barrier. When unspecified, there are risks that a barrier or a milder friction concerning one part in the work will grow and affect the whole culture. Thus, a mountain is made out of a molehill.

3.1.5.2 *Language*

One difference between countries’ workplaces is the language used. Besides culture-related barriers, language is one of the most commonly mentioned barriers for MPs, and it is identified as a difficulty for workplace integration (39, 40, 42, 48, 61, 76, 86, 91, 94). Language barriers are about ‘problems with the use and understanding of common language, their own accent, the different dialects as well as the use of medical terminology and not only with the basic language use’ (76); MPs may ‘struggle with idioms, nuances, and vernacular terms’ (40), have difficulties in understanding abbreviations used by peers (91), and have difficulties in engaging in small talk with patients (91), but having an accent may also be a conversation starter (91). MPs, as well as peers educated within the country, need the language to communicate. However, it should be noted that knowing and sharing the same language does not imply that individuals can communicate with each other; rather, ‘[c]ommunication can be a challenge, even when the participants’ backgrounds do not differ very much. However, when communication is *intercultural* [...] it becomes more of a challenge’ (34). As Warwick (2014) puts it, ‘language itself is only a small part of communication, and the entirety of communication is intertwined with individual, and organisational, culture’ (91). Knowing the language is a first step for being able to

communicate. Language barriers may affect the communication between the MP and the patient, other colleagues and health professional staff (61), for example, when the MP must ‘describe non-medical abstract matters in a second language’ (86). Having insufficient language and verbal (as well as non-verbal) communication skills further reduces work satisfaction (Ballard et al., 2004, cited in (42)). However, MPs develop different strategies when their language skills may be perceived as lacking (91); For example to repeat information, change the way to talk, and make additional use of non-verbal communication (91).

3.1.5.3 *Healthcare systems*

As healthcare systems are country-specific and have various organisations, regulations and laws, a new healthcare system can be challenging to learn (40, 62). It can be difficult for MPs to orient themselves in the organisation (62). When to refer a patient and how to treat patients can vary between countries (e.g. when to give antibiotics). The names of different drugs may vary (92). Moreover, the resources being used may differ (92), and some MPs are not used to working with electronic records and find this challenging (92).

3.1.5.4 *The process of becoming part of a new medical context*

Since there are differences in contexts between countries and workplaces, MPs may need to learn about a new healthcare system, new methods and new ways to approach others. Thus, MPs could need to transfer their knowledge from one context to another (57). Knowledge transfer can be a smooth or difficult process (63). It can be seen as professional development and part of a physician’s lifelong learning. In some literature, the process of becoming a part of the new workplace is referred to as *adaptation* (40) or a *transition period* (92). During the first period of transition, Najeeb et al. (2018) identified the following different phases: ‘surviving the culture shock’, ‘learning specific differences between old and new working environments’ and ‘developing strategies for blending in’ (92). The process of adjustment has also been divided into the following phases: ‘moving from loss’, ‘disorientation’ and ‘adaption’ (95). Thus, parallels can be drawn to the process of acculturation. An *acculturation process* is suggested to occur when people from different cultures meet and adapt to each other, although to different extents (6). In this process, there may be changes on both an individual level (psychological) and a societal level, which may affect behaviour, values and well-being (6, 96). In the process of workplace integration, MPs may feel disoriented and disconnected (40) or isolated (40); they can experience unpleasant thoughts and feelings, such as stress (61), depression (62) and anxiety, which can affect ‘their learning attitudes, precepting behaviours, and clinical performance’ (86). This can influence their job satisfaction (62), while ‘language barriers may compromise their professional performance in treating native patients’ (67). Cultural and language barriers and difficulties can lead to misunderstandings, tensions and inefficiency in cooperation, which may lead to lower quality

of treatment and can negatively affect patient safety (61, 62, 94). Insufficient language skills have been associated with worse patient care (97, 98). Language barriers may become a great stressor (94). To overcome barriers, obstacles and difficulties that relate to workplace integration and their consequences, different coping strategies can be adopted. Strategies mentioned are silence or to avoid talking about difficulties/barriers (61), not asking questions just to avoid being seen as incompetent (91) or to 'change [the] mind set' (91). Experienced difficulties may lead to losing self-esteem (94). During the process of becoming part of the medical workforce and then when working, MP may be perceived as 'the other' (32). There are studies exploring MPs experiences of discriminatory behaviour towards them (92). This can be by colleagues (62, 92), patients (55, 97) or patients' relatives (55). Experiences of discrimination at workplaces and the implications of discrimination for MPs' workplace integration are seldom a prominent theme in research studies (40, 76), which may be because it is difficult to assess whether a specific behaviour should be deemed as unlawful discrimination or not. Discrimination is also contextual. It may neither be common (40). MPs may be too proud (29), or simply reluctant to talk about it (29, 76), or years may have passed and situations may have been forgotten if discrimination usually is experienced at the beginning of the career in the new country (76). Experiences of discrimination need to be investigated further (40).

The focus in some of the research literature found is on the MPs' needs of adjustment to the new healthcare context and not the other way around. Literature about cross-cultural interaction from a patient or a non-MP staff perspective sometimes postulates that there is a challenge (cf. (32)). The word *barrier* may connote an obstacle that is difficult or impossible to overcome, when in fact, it may characterise a milder cultural friction that can be overcome fairly easily (32, 90). Differences in contexts do not necessarily have to become a barrier, an obstacle or difficulty for MPs. Researchers have suggested that the process is about cultural fine-tuning and suggest that knowledge is translated into new knowledge (cf. (63)). However, re-learning can be challenging, and different aspects can become obstacles. One problem could be the very assumption that there will be a problem.

3.2 ASPECTS THAT CAN FACILITATE ENTRANCE TO AND ADVANCEMENT IN THE LABOUR MARKET

In this section, aspects that can facilitate MPs' entry and advancement in the labour markets in their new countries are presented.

3.2.1 Interventions and support

There are different interventions, such as bridging programmes and courses, to support the process for the physicians who want to enter another country's labour market (39-41, 48, 88, 99-101). Educational interventions can be voluntary or mandatory, they can last from hours to a day and up to several months, sometimes years (25, 41). MPs usually participate in these educational interventions during the recertification process as these often aim to meet the challenges that MPs could meet when working (46). The interventions can target MP graduates and/or postgraduates (25), comprising theory and/or practice. Thus, interventions may include internships (101), information about culture or the new country, training in language and communication skills and medical knowledge and guidelines (25). Other interventions are specific courses in language, either everyday language or medical terminology (60). Other courses identified as beneficial and appreciated by MPs include job-seeking courses (60). Courses may be face to face or web-based (41). In Sweden, there are different educational interventions and bridging programmes, such as 'Snabbspåret' ('fast track') and a CPP with a medical degree from outside the EU/EEA.

To have support by volunteers (60) or guidance by other MPs is another facilitating aspect (79). The latter is useful because other MPs have been through the recertification process and can share strategic information regarding informal and formal aspects (79). Exchange and sharing of information may be via social media, email or in person (40). MPs starting the process can be relieved if they can share their stress and anxiety with other physicians who have migrated; they have gone through the same process and know what it is all about (79). It has been suggested that 'sharing the medical profession and immigrant status is more important than the ethnic network itself. It means joining together with peer or mentors, both physicians and immigrants in this journey, which we might call initiatory' (79). On an individual level, characteristics that make it easier to enter the medical labour market are being flexible and persistent as a person (60).

As there are barriers to workplace integration, there are also initiatives and facilitating aspects and initiatives, or at least a need for them. MPs' expressed needs are initiatives specifically targeted to them. These could be online resources, having contact with supervisors during internships or with other persons involved in the educational intervention/bridging programme that one participates in (40) or MP peer mentors (92). Such educational interventions as bridging programmes and courses previously mentioned, are facilitators for

workplace integration, but also for finding employment (cf. (62)). As interventions should provide a safe environment (41), so should workplaces.

Having a spouse or other family born or raised in the destination country can be a facilitating aspect since they may know about the country's bureaucratic paths (60). Research has also shown that individuals who migrate because they have found a partner in the destination country learn the language quicker and 'to a higher level' than refugees do (48). Spouses or other family can also provide MPs with social support, which can be helpful for their careers (60, 79); they can also help take care of any children (79). Having financial support from family (60, 79), organisations (60) and funds (48) has also been shown to facilitate the recertification process and enter the medical labour market. Having previous experience of working as a physician is also perceived as an advantage (60).

3.2.2 Working in rural and remote areas

One facilitating aspect to decrease the time to the medical labour market is finding work in rural and remote areas since there are usually shortages of physicians working in these areas. The absence has become a challenge for many countries (9-18). For patient safety and patient opportunities to equal healthcare regardless of geographic location, it is important that physicians move to rural and remote areas and remain there. To solve the problem of the absence in certain areas, those physicians who are domestically educated and those educated abroad have been subjects of studies related to the geographical imbalance. Studies have identified factors influencing physicians' choices of where to work and identified challenges met when working in rural and remote areas to find strategies for recruitment, support and retention (10, 13, 15, 102). Challenges when working in these types of areas include decreased opportunities for professional development, less connection to certain healthcare facilities and specialties, and fewer opportunities for spouses and family (10). Strategies and interventions have been developed to solve the imbalance (15, 18, 89, 103), and these can be seen as ways of creating pull factors. In some countries, such as Canada, Australia and the United States, IMGs are assigned to work in rural and remote areas for a period, usually several years, due to staff shortages (104). This may explain why most general practitioners (GPs) working in rural and remote areas in Australia are MPs (32). Research has also aimed to find out where MPs work and whether they do, could or should fill recruitment gaps in rural and remote areas (cf. (102, 105)).

3.2.2.1 Geographical distribution of migrant physicians

The density of physicians in Sweden ranks fourth in Europe, and the percentage of physicians in Sweden related to the population has increased by 10% from 2009 to 2014. In 2014, there were 417 physicians for every 100 000 patients (102). However, there are regional differences in the availability of physicians in Sweden, with fewer physicians in rural and remote areas (18, 19). In the capital area, there are 476 physicians for every 100 000 habitants;

in the northern healthcare region, the corresponding figure is 399. The physician staff shortage in rural and remote areas has led to a market for consultant physicians (19). A system with consultant physicians can be seen to increase patient safety in areas where there is a lack of ordinary physicians (106); at the same time, it can be seen as endangering patient safety and negatively affecting the work environment since consultant physicians are temporarily placed, which means that it is more difficult to maintain continuity (106). No matter what approach is taken, consultant physicians increase the costs for counties in Sweden.

Migrants generally settle in urban areas in their new countries (44). Regarding where MPs settle, whether in urban or rural areas, the research shows various results, sometimes even when the same country is considered (102). Wenghofer et al. (2011) and Covell et al. (2016) suggested that internationally educated health professionals like physicians and nurses tend to work in urban areas (17, 39), and regarding MPs, the largest proportions can be found in urban areas; with the rurality increasing, the proportion of migrant physicians also decreases (17). However, research also suggests that MPs tend to work in areas with physician staff shortages, characterised by ‘below average physicians-to-population ratios’ ((107)), such as in small communities (59), rural areas (10, 107) and other unpopular regions (McClenahan and Yardumian cited in (107)). Furthermore, ‘[i]mmigrant clinicians are more likely to serve rural, low income populations; communities with high density of ethnic minorities and immigrants; and areas with primary care shortage’ (108). A majority of physicians working in rural and remote areas in Australia are also MPs, and there are limitations for MPs when it comes to their choices for where to work (32, 104). The differences regarding where MPs tend to work may be explained by Neiterman et al. (2017), who suggest that MPs are recruited to rural areas but then move to urban areas when they are fully certified (46).

When considering a move to a rural area, everyday life in the new location is a major concern (cf. (37)). Aspects of migration to rural areas have been explored using a life course perspective (37), and the complex concept of rurality has been analysed from the perspective of social representation (109). For retention in rural areas, aspects of personal matters and location characteristics are important (17). Parlier et al. (2018) identified five dimensions that described aspects contributing to the ‘development of a “rural physician identity”’— individual characteristics, residency, medical school, retention: rural medical practice, and retention: quality of rural life (15). Regarding domestically trained physicians, the strongest predictor for working as a physician in a rural area is having been raised in such an area (13, 15). However, for physicians educated abroad, this correlation is not significant, suggesting that other aspects affect their choice of where to work (15). To be educated in or originate from another country probably adds additional aspects that MPs may consider when thinking about moving to a rural area. This can relate to aspects like being the only one with a foreign appearance, being the only foreigner at work or in the area or living far from international airports, which makes it more complicated to visit family and friends abroad (110). Russo et al. (2012) showed that the region of origin could influence settlement patterns and whether

MPs settle in a rural area (102). Male foreign physicians over the age of 50 were more likely to work in rural areas in Portugal compared with other foreign physicians and domestically educated physicians (102). Gender have been identified as a predictor regarding attitudes for working in rural and remote areas (12), and for also working in such type of area (17). Regarding specialists in general and not specifically MPs, it has been indicated that several aspects are important in the decision to remain in the same region after specialty training. Aspects mentioned include salary, opportunities for competence development, working hours and the working climate, as well as their connection to the area (10). Thus, where a physician works geographically relates to different factors (15), and the area where they work is not just about the work in itself (cf. (30)). Decisions about where to work are also influenced by biographical aspects, internal motivation and conceptions of living and working in rural and remote areas (cf. (52, 105)).

3.2.3 Working in an underserved healthcare sector or medical specialty

Blain et al. (2017) suggested that filling gaps in underserved areas shortens the recertification process considerable (79). Underserved areas can relate to geographical location, as previously described, or the type of healthcare sector or medical specialty (32, 108). In the United States, as in Finland, it has been noted that physicians educated abroad more often work in primary healthcare (PHC), where there are also staff shortages (67, 69, 111). In Finland, this occurred even though MPs were more likely to be specialised in surgery (67). In the United States foreign medical graduates more often specialise in primary care specialties (59). In Norway, however, the likelihood of MPs specialising in surgery remains low (112), although MPs still become medical specialists more often than their domestically trained peers do (32). From the United Kingdom, it has been reported that MPs are more likely to work in less popular specialties, such as geriatrics and psychiatry (107, 113). Access to postgraduate medical training in Ireland for non-EU physicians is more difficult due to legislation, and having citizenship from certain countries does not qualify individuals for certain positions, such as those leading to specialisation; this impedes physicians' career advancement (107). However, for non-EU physicians with possibilities to specialise, they have more opportunities for career advancement in specialties with staff shortages (107). Specialties that suffer from staff shortages, such as general medicine (family medicine), psychiatry and geriatrics, are usually also ranked low when it comes to status (20, 21, 114, 115), as working in PHC can be (114). IMGs seem to fill staff shortage gaps in certain medical specialties and healthcare sectors, and at the same time, these shortages seem to be in specialties and healthcare sectors with low prestige (116). Further, research on domestically trained physicians' specialty choices shows that a variety of aspects influence these choices (21, 117-119). To undergo medical specialty training/postgraduate training to become a medical specialist can be seen as a career and/or professional advancement or progression. In Sweden, there were 286 specialists for every 100 000 inhabitants in 2014 (22). Of these, 22% ($n = 64$) were specialists in general medicine (family medicine), who usually work in PHC as GPs (22). There is a shortage of physicians in the medical specialties of general medicine, psychiatry and geriatrics in Sweden (18, 19, 21, 120).

4 THEORETICAL PERSPECTIVES

To understand and discuss how MPs enter and advance within the medical labour market in Sweden, Bourdieu's concepts of the social field, symbolic capital and doxa are used as a lens. As a complement to Bourdieu's theory, self-determination theory (SDT) is used. In the following, I outline these two theories, how they are used in the analysis and how they analytically emphasise different related aspects of MPs' experiences, motivations and choices when entering and advancing in the Swedish medical labour market.

4.1 THE CONCEPTS OF SOCIAL FIELD, SYMBOLIC CAPITAL AND DOXA

The sociologist Pierre Bourdieu's concepts of social field, symbolic capital and doxa (65, 90, 121) were used for the overall design of this thesis and for interpreting results. The concepts were used to gain further understanding of what may happen when individuals want to become a part of a professional context in another country and how structural circumstances can become barriers but also give rise to facilitating aspects. The concepts made it possible to analytically understand underlying mechanisms and/or structures on the macro and meso levels that influenced the micro/individual level.

A social field is a spatial metaphor (122) and can be defined as a limited system of relations between social positions (agents) with shared interests. In my thesis, I use the concept of the *medical field*. The medical field includes different kinds of medical professionals (but also allied healthcare professionals and allied healthcare aids (114)), whose positions are allocated based on negotiations about common interests, including characteristics of medical science, medical work or medical competence (66, 123). An agent can be involved in several fields (122). The social field is a part of a wider context that can be referred to as a social space (cf. (122)). Like a social field, a social space can be understood as a spatial metaphor (122). Bourdieu connects the concept of social space to physical space when relating it to the national state (122). However, it is not so much about geographical boundaries; rather, it is about the 'common sense ideas' about the world and the individual's place in the world that is nurtured 'by the state and [...] institutions (especially education)' (122). The medical field can be seen as a transnational field, and professionals have possibilities to practice in different countries (66, 124). However, the doxa between countries may differ, as well as the value of the forms of capital. An agent's symbolic capital may also differ depending on where the field in which they are active is situated.

Every social field has its *doxa*, which comprises what is taken for granted within the field, including rules, norms and values, as well as what is considered quality, and how to act (65). In the medical field, there is a medical language that the agents have to know to be able to communicate to peers; moreover, there is a 'right' way to communicate with patients, and there may be codes for how to act and how to dress (cf. (90)). The shared view is primarily reproduced by education institutions and healthcare facilities. Schools and universities are important in shaping the national identity (122) and reproducing what constitutes the state. In fact, for Bourdieu, 'a focus on education is key to understanding the relationship between the

state and national identity' (122). According to Bourdieu, the state both engages in control and service (122).

Included in Bourdieu's concept of social field are the concept of symbolic capital and other different forms of capital—cultural, social or economic (21, 121, 123)—which can be seen as an agent's assets or resources. When forms of capital are recognised by the institutions and the agents that constitute the field, they are assigned a value. When the forms of capital are recognised and assigned a value within the field, this can be seen as symbolic capital. Thus, the symbolic value of capital is determined by the agents and institutions in a specific field. It positions the agents in relation to each other, hierarchically, in the field (123). Depending on the given social field, the different forms of capital are valued differently (122) and give the individuals various levels of credit within the field. The recognition of capital is made against the doxa, or the prevailing worldview in the specific field. However, rather than being static, a resource's symbolic value, and thus the agent's symbolic capital, can change over time (cf. (124)).

Cultural capital can be a degree from an institution, such as a university, or having competence that is appreciated in the specific field. It can be embodied, objectified or institutionalised (121), and it gives the agent a reputation. An agent might, for example, have the economic capital to buy a painting (the painting is in an objectified state) or a machine (also in an objectified state), but to appreciate or use these materialistic goods in a 'correct' manner, cultural embodied capital is needed. Thus, it is possible to transfer (buy and sell) goods, but it is not possible to transfer how they should be consumed (121). Cultural capital in its embodied form is often an outcome of a socialisation process, internalised and manifested in taste or how the agent behaves (121). Thus, it can be inherited or acquired, for example, through education (121, 123).

Social capital is anchored in social connections. These are based on kinship, friends or contacts and networks that have been shaped, for example, during education, such as a medical education. To be counted as social capital, it must be an asset. The network needs to benefit the agent that possesses it. For example, a friendship leading to employment is social capital (cf. (79)). Social capital cannot be materialistically stored like other forms of capital; for example, cultural capital can be transferred into a degree or a title (123), while economic capital may be stored in goods (121). Economic capital can be stored material or take the form of money (121). It can also give access to services (121) and can potentially provide access to the world and new experiences, for example, through travel.

Although the outlined theory analytically focusses on mechanisms and/or structures on the macro and meso levels that condition the individual's possibilities as barriers and facilitating aspects, the theory has limitations in explaining individual driving forces that influence how the MPs find their ways as professionals in the Swedish labour market. To further understand individual driving forces, SDT is helpful.

4.2 SELF-DETERMINATION THEORY

In this study, SDT is used to understand and frame how aspects related to the social context and the environment could influence MPs' motivation, but also their choices and strategies. SDT highlights motivation, thus, the individual's driving force, which was a recurring theme in the material. Essential for self-motivation is satisfaction of the three psychological needs—competence, relatedness and autonomy (28, 125). Fulfilment of these needs is required for psychological well-being. When an individual's motivation is intrinsic, behaviour stemming from the self is autonomous; the individual produces at their best and is at their best when it comes to, for example, learning (28). The social context and environment can enable or thwart intrinsic motivation (28, 125). What increases intrinsic motivation includes positive feedback and choice, as well as chances for self-direction; such elements increase individuals' feelings of autonomy (28). Factors that diminish intrinsic motivation include threats, deadlines, directives and pressure. Motivation can also be extrinsic. There are four types of extrinsic motivation that have different grades of autonomy (28). Behaviours that are extrinsically motivated can be performed to satisfy external demands or to satisfy ego and pride and have low grades of autonomy. External demands can also be valued and considered as important for the self and integrated or assimilated, and these have a higher grade of autonomy (28, 125). The different types of motivation have 'specifiable consequences for learning, performance, personal experience, and well-being' (28).

4.3 HOW THE THEORETICAL PERSPECTIVES ARE USED

The notions macro (societal), meso (organisational), and micro (individual) levels are used for an overall framing of the discussion. Bourdieu's concepts of the social field, symbolic capital and doxa can grasp and be used to discuss structural conditions derived at the macro and meso levels that may have consequences on the individual (micro) level. In this thesis, SDT is used to frame and discuss the micro level, and how circumstances on the macro and meso levels can influence the individuals' motivations, choices, freedom of actions, and strategies. Thus, SDT is used to frame how environment and social context may influence motivation (28, 125). The perspectives and the levels discussed in this thesis can be seen as different explanatory models that fit together like the different sides on a dice. To get the dice rolling, all the pieces must be in place.

5 THE SWEDISH CONTEXT: ROUTES TO OBTAINING A SWEDISH MEDICAL LICENCE

The description is based on the conditions applied when the study participants for this thesis began their route (described in 6.1 Study participants) to obtain the Swedish medical licence. The routes differ and depend on where the physician has had his/her medical education and degree, which may be

- A. in Sweden
- B. within the EU/EEA or
- C. outside the EU/EEA

The Swedish medical licence to practise is ‘a proof that the person who is working in a profession has the necessary skills and the required suitability’¹ (126). Therefore, the overall competence of every licensed physician should be equal.

A mandatory medical internship (MMI) is/was included in the re-/certification process for a part of the physicians, this depending on where they acquired their medical degree and which route taken. The MMI has a duration of 18–21 months, and can be seen as a second phase after a medical education. Physicians can apply for MMI twice a year, which offers four different start dates yearly. A special authorisation from the Swedish Board of Health and Welfare (SBHW) is a requirement during the MMI. The MMI is assessed with an exam that runs four times a year. If a physician fails the exam, he/she can redo it the next time that it runs. If the physician passes, he/she can apply for and obtain the Swedish medical licence from the SBHW.

The different routes to becoming a practising physician in Sweden are further described below.

- A. Physicians with a medical degree from Sweden

The Swedish medical programme is currently 5.5 years, and after its completion, the physicians need to apply for and complete the MMI², as well as passing the MMI exam.

- B. Physicians with a medical degree from the EU/EEA

EU citizens are allowed to practice as physicians in Sweden without a Swedish medical licence due to Directive 2013/55/EU, updating Directive 2005/36/EC. Before practising, EU-educated physicians need to have their qualifications recognised in Sweden and they need

¹ Own translation from the original Swedish.

² A new medical programme will be launched in 2021 with a duration of 6 years, including a 6-month internship that will replace the MMI.

permission to work. The SBHW is the authority that determines a physician's right to practice the profession (127).

EU/EEA-educated physicians are sometimes recruited to Sweden. Many of them have had Swedish language courses provided by the recruitment companies before their migration to Sweden. As workforce migrants in Sweden, many have work waiting for them upon arrival, and they usually do not need to apply for a position.

Swedish citizens have the possibility to participate in medical programmes in other EU/EEA countries. Some of them however return to Sweden for the MMI, and thus also undertake the MMI exam (74).

C. Physicians with a medical degree from outside the EU/EEA and Switzerland

Non-EU/EEA-educated physicians must obtain a Swedish medical licence to be able to practice their profession in Sweden independently and to have permanent positions as physicians. However, they can receive a special authorisation for temporary positions that employers apply for at the SBHW. Special authorisation is followed by restrictions as to how the physicians are allowed to work. For physicians with a medical degree from outside EU/EEA, there are three routes to obtain the Swedish licence to practice, as described below. To begin any of the routes, the physician must have formal qualifications in the Swedish language.

- Route 1. SBHW: In this route, the physician's education and skills are assessed. MPs must take a proficiency test and pass a course on Swedish laws and regulations.
After route 1, until 1 July 2016, MPs had to apply for and complete the MMI and pass the MMI exam. After this date, MPs instead have to find and complete 6 months of clinical training after passing the proficiency test.
- Route 2. CPP: With a duration of 10 months, this programme includes lectures and internships. This route will be further described.
After completion of the CPP, the MP has to apply for and complete the MMI and pass the MMI exam.
- Route 3. Swedish medical programme: The third route to a Swedish medical licence is to participate in the Swedish medical programme.
After having completed the programme, a physician need to apply for and complete the MMI and pass the MMI exam³.

³ However, when the new medical programme are launched, the MMI will be phased out and discontinued. Instead, a 6 months internship will be included in the medical programme.

There are possibilities to switch from one route to another to speed up the process. For example, an MP may have begun the CPP, and during the programme, also take the proficiency test. Having passed the proficiency test, the MP may drop the CPP and instead take route 1 via the SBHW. Trying to pass the proficiency test is common (101), most likely since this shortens the time to obtain the Swedish medical licence. However, MPs may also choose to complete the CPP even after they have passed the proficiency test.

Having completed route 2 or 3, as well as route 1 before 30 June 2016, the ideal was to have an MMI position since this is the final phase before the MMI exam, and the possibility to obtain the Swedish medical licence. However, since the number of MMIs is undersized and the competition high, many work as junior physicians (commonly referred to as junior doctors) for months or up to several years before the MMI. The time between having completed a route and before beginning the MMI is called ‘waiting time’. The physician may have a junior physician position (commonly referred to as a junior doctor position) after having failed the MMI test. When fully certified with the Swedish medical licence, the physician may apply for and start the specialty training (ST) with a duration of 5 years. When completed, the physician is a specialist. In Figure 1, the routes to the Swedish medical licence for physicians with a medical degree from outside EU/EEA, including the different phases and medical positions related to them practicing their profession, are described.

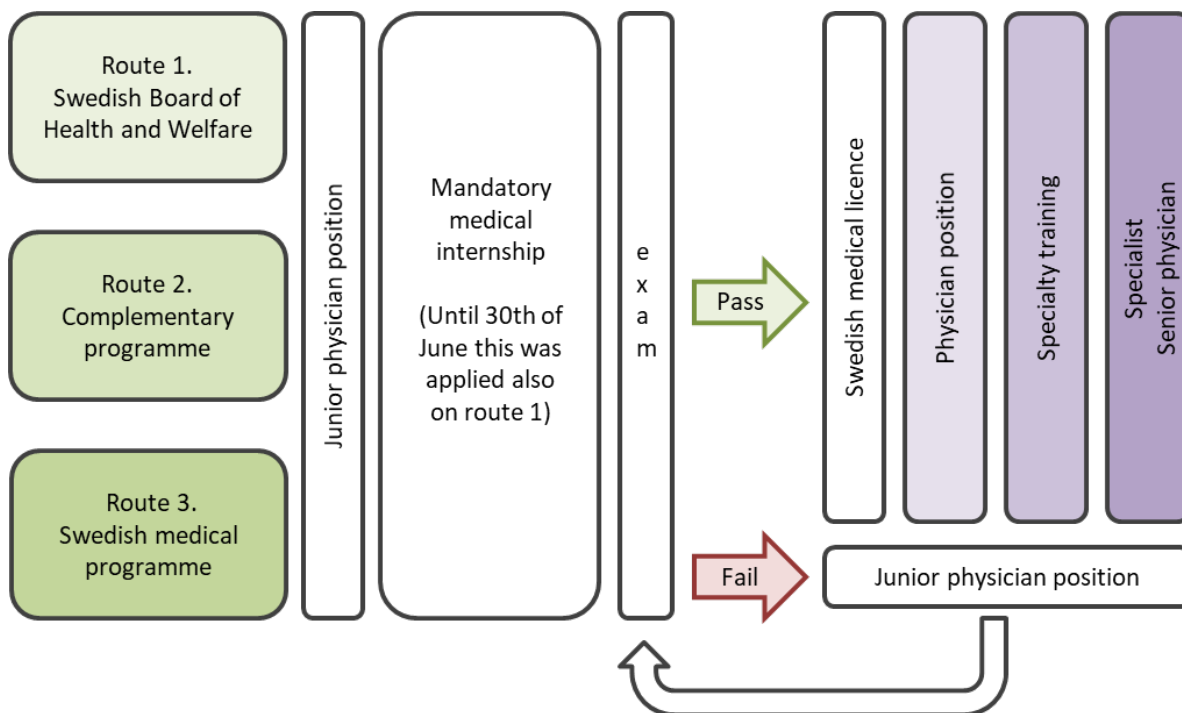


Figure 1. The routes to the Swedish medical licence for physicians with a medical degree from outside EU/EEA, including the different phases, and medical positions related to them practicing their profession.

The Complementary Program for Physicians (route 2)

This section provides further description of the CPP since the CPP participants were the subjects for this thesis, although participants from the first route were included in one of the studies (Study III). As described, the CPP is one of three routes for physicians with a medical degree from outside the EU/EEA to obtain the Swedish medical licence. The CPP is funded by the Swedish government and intends to utilise skills and increase integration in society throughout work. The programme started in 2009. Until 2017, it was offered at three universities in Sweden—Gothenburg University, Karolinska Institutet and Linköping University. The three universities together yearly received funding for admitting 65 physicians. From 2018, an expansion was made and two additional universities started to offer the programme (Lund University and Umeå University). Karolinska Institutet coordinates the CPP.

The CPP is regulated in the Ordinance on higher education bridging programmes to supplement foreign qualifications that states the target group and the aim of the programme: The education aims ‘at students who have completed a foreign higher education or another completed foreign postgraduate education corresponding to a degree under the Higher Education Act (1992:1434)’⁴, and to gain formal competence and knowledge to be able to practice, in Sweden, the profession relevant to the foreign education (128). The Higher Education Act (1992:1434) regulates higher education institutions (129).

The intended learning outcome of the CPP is that the participant must be able to show the knowledge and skills required for the medical profession, and after having been assessed by the SBHW, be able to apply for and access the MMI⁵. The overall intended learning outcome of the CPP is congruent with the overall aim for the Swedish medical programme(s)⁶. Thus, regardless of whether a physician have completed the CPP or a Swedish medical programme, physicians’ competence should be at the same level. As for the medical programmes in Sweden, the different universities providing the programme formulate curricula with intended learning outcomes that correspond to and are regulated in the Higher Education Ordinance (1993:100) (130). The detailed intended learning outcomes for the Swedish medical programme, which the CPP is aligned with, include that the student should be able to show knowledge about for example scientific methods, ethical principles, economy, the healthcare system, and relevant regulations (130). Further, the student should be able to ‘demonstrate in-depth ability to independently diagnose the most common medical conditions in patients and to treat them in collaboration with the patient’ (130). Some learning outcomes are related to the student’s cooperation with future peers and other healthcare professionals, for example,

⁴ Own translation.

⁵ Own translation from the CPP’s syllabuses. In Swedish: ”Efter slutförd utbildning skall studenten visa sådan kunskap och förmåga som krävs för läkaryrket och för att efter prövning av Socialstyrelsen kunna söka tillträde till allmäntjänstgöring (AT).”

⁶ More detailed learning goals for the Swedish medical programme can be found in the syllabuses. The intended learning goals are regulated in the Higher Educational Ordinance.

demonstrating the ability to work in teams, collaborate with other professional groups, report orally and in writing on measures and treatment outcomes with interested parties and document the outcomes under the relevant regulations (130). Physicians thus need to be able to communicate with peers, other professionals and patients and patients' relatives.

The applicant had to have finished their medical education and have a medical degree; have a decision from the SBHW stating that they could participate in route 1; and have formal qualifications in the Swedish language. Since there were more applicants than CPP positions, a selection of participants was made. The selection process was consistent for the three universities but hosted by respective universities. Every university had its own selection committee for the selection process. The selection process consisted of two steps. The first step included a merit evaluation of the applicants' previous education and working experience. Step 2 was an interview with applicants that had been selected in step 1. The interviews were held by two or three members of the selection committee. During the interview, the applicants' conditions for completing the programme and their future ability to work as a physician in Sweden were investigated and assessed by the selection committee. During the interview, the applicant also discussed a patient case that had been sent to them in advance. After the interviews, the committee did an overall assessment and ranking of the applicants.

The CPP had, and still has, a duration of 10 months, which included both theory and practice. Participants received different periods of internship, which were located within different types of health institutions and specialties. One of the internship periods was located in primary healthcare. The other two internship periods were usually completed in a university hospital, for example, in psychiatry, emergency, paediatrics, orthopaedics or gynaecology. In the lectures and seminars, medical theory and knowledge were included, as well as ethics and ethical values, how to work and communicate with colleagues and patients and other different culturally aspects and Swedish laws and regulations.

6 METHODS AND MATERIALS

In this chapter, the study participants are presented first, then follows a description of how the data were gathered, including how each study's participants were recruited. Next follows a presentation of how the data were analysed. In cases where one study or dataset informed another, this is also presented.

6.1 STUDY PARTICIPANTS

The study participants had a medical degree from outside the EU/EEA. They were recruited via the CPP (route 2), and had been admitted to the CPP 2009–2017. For Study III, MPs with a medical degree from outside EU/EEA who had participated in route 1 were also included as this route included the MMI until the 31 of June 2016. Thus, all study participants had started the process of acquiring a Swedish medical licence but were at different stages. Some were at the beginning of the CPP, others prior to or in the MMI phase and others had obtained the licence, of which some underwent ST and a few were specialised.

6.2 DATA COLLECTION

The aim was to explore the MPs' entrance to and advancement within the Swedish medical labour market. The aim and the included studies' different research questions guided the choice of methods and the types of data gathered. Both quantitative and qualitative methods were used, in some studies combined with a mixed methods approach. The methods used, the type of data these generated and which datasets that were included in each study are presented in Figure 2.

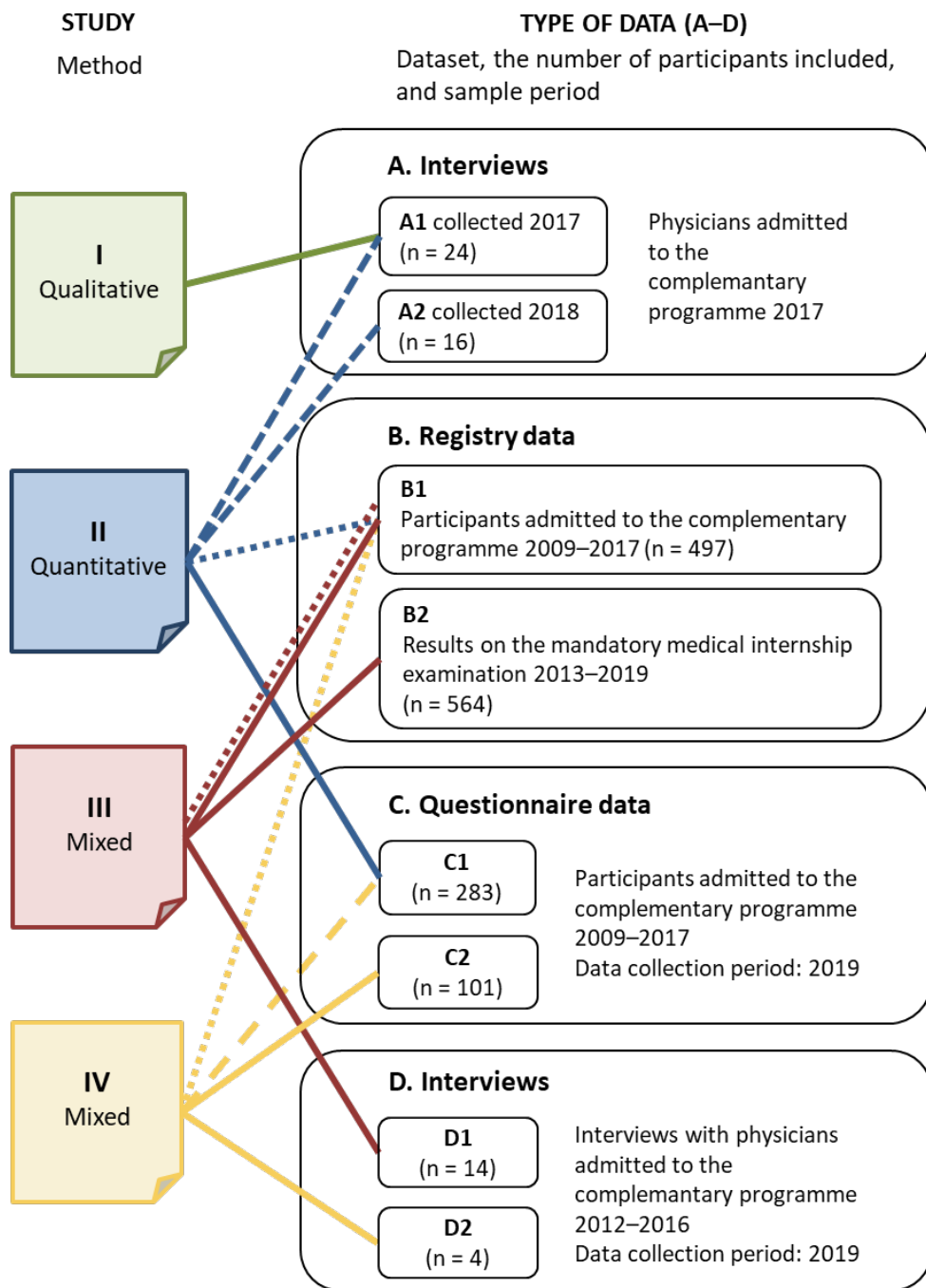


Figure 2. Overview of studies I–IV, the four types of data (A–D) and the eight datasets with their number of participants and sample period. Dashed lines indicate when a dataset or a study have informed another. Dotted lines indicates that the dataset were used to identify potential study participants.

6.2.1 A. Interview data

Dataset A1 was used as data for Study I. Datasets A1 and A2 were used in the development of the questionnaire that generated data C which was used for Study II and IV. Figure 3 presents the participants, the datasets and the related studies.

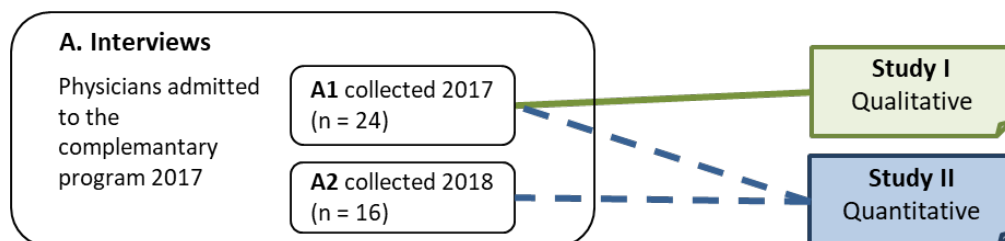


Figure 3. Dataset A: Interviews, dataset and related studies. The dashed lines indicate that the datasets were used to inform other studies.

The research project was presented to physicians admitted to the CPP during one of the admission years. Access was given by the three individuals responsible for the complementary programme at the three different universities, who invited the researcher to a scheduled occasion. Altogether, the study was presented for 62 physicians⁷. After the scheduled occasions, the CPP participants had the opportunity to register for the study. Altogether, 27 participants signed up to participate in the study. No selection was made even though the aim was to recruit only 15 respondents since there was a risk of study participants dropping out of the research study and/or the complementary programme. The study participants gave written consent to participate. Of the study participants, 3 MPs dropped out before the interview phase began, and 24 were interviewed once, during a first round of interviews. For the second round of interviews, 15 of the 24 participants volunteered to participate. Another MP from the same admission year as the others also volunteered to be interviewed during this period and was included in this round of interviews.

Before the interviews, an interview guide was developed. Between the interviews, the guide was refined. Interview guide themes during the data collection periods 2017 and 2018 are presented in Table 1.

⁷ 19 physicians at Gothenburg University, 22 at Karolinska Institutet, and 21 at Linköping University.

Table 1. Interview guide themes, sub-themes, and data collection period.

Data collection period	Theme	Sub-theme
2017	Background	Where the interviewee grew up. Where the interviewee participated in the medical programme and received his/her medical degree. Interviewee's experiences of working as a physician before migrating to Sweden. Reasons for migrating to Sweden. Living experiences in Sweden.
	Rural and remote areas	Conceptions about working in rural and remote areas in previous countries. Conceptions about working in rural and remote areas in Sweden. Career opportunities.
	Work experiences	Previous work experiences in the healthcare sector in Sweden. Differences and/or similarities between countries in the job duties of a physician. Essential earning or competency development to work as a physician in Sweden. Difficulties faced while working in Sweden.
2018	Career	Finding and receiving work in Sweden. Future career plans
	Follow-up from the first interview	Life changes. Experiences with the complementary programme. Difficulties during the complementary programme. Need for support.
	Professional development	Adjustments. Last year's professional development. Further learning and professional development that is needed to work as a physician in Sweden. Difficulties encountered working as a physician in Sweden.
	Future career	Job plans. Personal description of job seeking process. Career plans. Changes in career plans during the last year. Difficulties reaching career goals.

Most of the interviews took place in a neutral environment, such as in a library, lecture hall or conference room at the universities or in the hometowns of the study participants. In a few cases, the interviews were conducted in a café. During the second round of interviews, some interviews were conducted online with the help of a digital communication tool for practical reasons.

6.2.2 B. Registry data

Datasets B1 and B2 were used for statistical analysis in Study II. Dataset B1 was used to identify participants for Studies II, III and IV. Figure 4 presents the participants, the datasets and the related studies.

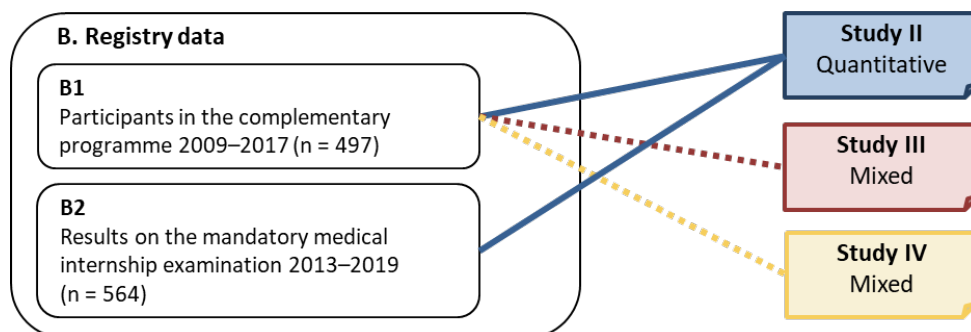


Figure 4. Registry data, the participants, the datasets and the related studies. The dotted lines indicates that the dataset were used to identify potential study participants.

Dataset B1, comprising registry data, was used to identify CPP participants and consisted of participant lists from 2009 to 2017. The lists included the MP's name, personal identification number and contact information. Lists of the CPP participants' study results, and thus, the number of credits taken, were also collected. The lists were provided by the admission offices and officers working with the CPP at the three universities, which provided the education during the current years. These were Gothenburg University, Karolinska Institutet and Linköping University. The different lists were merged into one Excel file that included all the information. All information has been kept on a protected server.

Dataset B2 consisted of lists of participants that had taken the MMI exam from 2013 until 2019 and their results on the exam. All exam participants with a medical degree from outside the EU/EEA were included in the dataset; thus, the dataset comprised not only CPP participants (route 2) but also those who had taken route 1 to the Swedish medical licence for practise. The dataset was collected from the MMI examination board.

6.2.3 C. Questionnaire data

The questionnaire data were used for Study II and Study IV. In an early stage, dataset C1 informed Study IV. Figure 5 presents the participants, the datasets and the related studies.

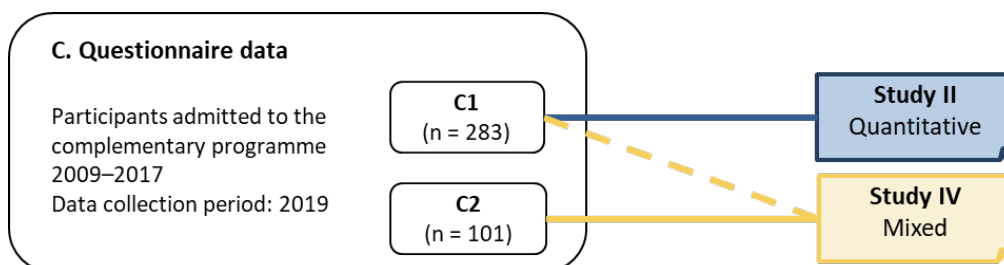


Figure 5. Questionnaire data, study participants, datasets and related studies. The dashed line indicate that the dataset were used to inform another studies.

The questionnaire data was gathered via a questionnaire developed by following a process consisting of seven steps, which Artino et al. outlined (131). The development of the questionnaire is presented in Table 2 (Table 2 is also presented in Sturesson et al. (132).

The content of the questionnaire was decided based on what had been identified in literature studies and the interviews (dataset A, Table 2, steps 1 and 2) as relevant to investigate further. The questionnaire hence developed deductively, but it was based on a previous iterative process from the analysis of datasets A1 and A2 and the literature review.

The questions were open-ended with no character limitations and close-ended with binary, nominal or ordinal response options. Depending on the participants' responses, different questions followed. Hence, all the respondents did not receive the exact same set of questions. The questions were in Swedish.

The questionnaire was self-administered and distributed digitally in February 2019. Respondents could answer the questionnaire until March 2019. The questionnaire was distributed to 497 MPs who had participated in the CPP between the first admission year 2009 and 2017. In the email to the CPP participants, information about the study and contact information to the project leader and researcher, written consent and a link to the questionnaire were included.

The response rate was 57% (n = 283). The internal non-response bias was less than 10% on each question. The number of respondents on each question varied since the physicians were at different stages in their careers, and thus, not every question was relevant for everyone.

Dataset C1 was used for Study II and included all 283 respondents. Questions included in the questionnaire used for Study II were divided into the following sections: participants' backgrounds and previous experiences, entrance to the labour market, experiences of discrimination and experience of having one's competence devalued, interventions and the MMI.

Dataset C2 was a subset and included 101 of the 283 respondents. Inclusion criteria were to have indicated having a position as a senior physician, a specialist or having a specialty training position. Applicable parts for Study IV concerned the following: participants' backgrounds and previous experiences; if the MPs had begun or completed specialist studies before their migration to Sweden, and if so, which specialty; if general medicine was a specialty in their education countries; if they were undertaking or had completed medical specialty training in Sweden, and if so, which one and if that was their first choice, and if not, perceived reasons for not having that specialty; perceptions of the different medical specialties' status in Sweden; aspects influences decisions on where to work.

Table 2. Development of the questionnaire.

Step	Procedure
1	Literature review When conducting the literature review, little empirical knowledge was identified regarding MPs' pathways into the labour market in Sweden.
2	Interviewing In a process parallel to the literature review, 24 participants from the CPP were interviewed at the beginning of the programme and after completing it ($n = 16$). Informal interviews with experts, such as recruitment staff, a physicians' trade union, researchers and responsible persons from the CPP, were also conducted ($n = 7$).
3	Synthesising Themes for further investigation were developed based on the literature review and interviews.
4	Item development The themes were described, and questions as well as response scales were developed and discussed continuously (133-135).
5	Feedback Questions were presented and critically discussed in different forums (e.g., research seminars) to obtain feedback on the themes, questions and wordings, as well as to streamline the questionnaire, fill any gaps and reduce redundant questions.
6	Cognitive interviews (CIs) The constructed questions and response scales were discussed during individual interviews with six physicians, who were migrants <i>not</i> educated in Sweden (except one). After the cognitive interviews, the questionnaire was further improved regarding wording, formulation and response alternatives.
7	Pilot test I) The questionnaire was constructed digitally with a survey tool and sent out for pretest to 23 individuals. In this pretest, 16 respondents provided feedback on the logic in the questionnaire, as well as on the questions and response alternatives. The respondents consisted of researchers, people responsible for or working with the CPP, and others with relevant expertise. The questionnaire was thereafter further improved. II) The questionnaire was sent out for a pilot test to 24 physicians working in Sweden who were at different stages in their careers; however, this did not include a sample from the MPs selected for participation in the study. Some of the respondents in the pilot study had their medical education in Sweden. Fifteen of the 24 responded in the pilot. In the pilot, the respondents answered the questionnaire, but they also had the opportunity to provide feedback on the questionnaire, questions and wording. The results and comments from the pilot were discussed during two research meetings with different participants, and the questionnaire was refined twice more before use.

6.2.4 D. Interview data

Dataset D1 was used as data for Study III. Dataset D2 were used for Study IV. Figure 6 presents the participants, the datasets and the related studies.

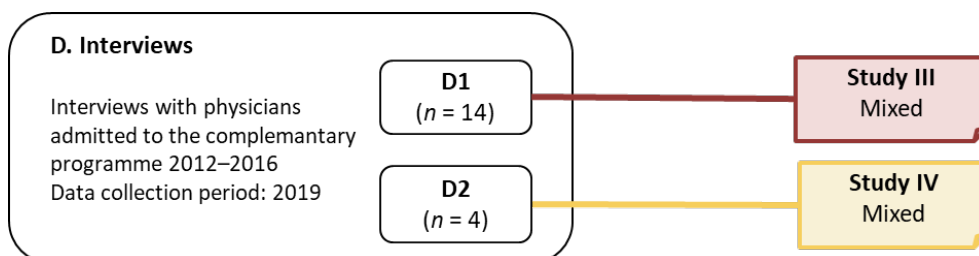


Figure 6. Dataset D: Interviews, dataset and related studies.

A semi-structured interview guide was developed and refined during the interview process. Table 3 specifies the interview guide themes, examples of subthemes, and in which study the theme were used. Every theme consisted of 3–10 introductory questions whereupon various follow-up questions were asked.

Table 3. Interview guide themes and examples of sub-themes.

Theme	Study III	Study IV
- Exemple of subtheme		
Background	Included	Included
- Country of origin, and growing up		
- Year for medical degree		
- Reasons for migration		
Work experiences as a physician	Included	Included
- Before migrating to Sweden		
- In Sweden		
- Current position/employment		
Differences in medical education between countries	Included	
Differences and similarities when working as a physician in Sweden in comparison to previous country	Included	
The mandatory medical internship	Included	
- About finding an internship position		
- Experiences during the internship		
- Reasons for lower pass rates that has been up for speculation (language skills, examination type, discrimination and that competences is not fully utilised under the internship).		
- The exam assessing the internship		
Specialty		Included
- Begun or completed specialty training in previous country		
- Begun or completed specialty training in Sweden		
- If general medicine was a specialty in their country for medical degree		
- Reasons for specialty choices		
- Status of specialties		

Study participants were recruited via an email sent to MPs that had participated in the CPP between 2012 and 2016 (n = 278). The email was sent in 2019 and included information about the study, such as the inclusion criteria. In total, 20 potential participants responded. However, one person did not fit the inclusion criteria, while five did not respond to the following emails. The 14 remaining participants were interviewed during 2019. Interviews were conducted face-to-face and some by phone.

For Study III, all 14 interviews were included. The interview guide questions relevant for this study mainly concerned the MMI period and the MMI examination. The interviewees were asked to describe their experiences of the MMI period and the MMI exam.

For Study IV, a subset of four interviews was included. Inclusion criteria were to be specialised in or to have a specialty training position in general medicine. The main theme for this study was 'Specialty'.

6.3 ANALYSIS

Depending on the type of data and the intended usage for it, different analysis methods and tools were used.

6.3.1 Interviews

Interviews were audio-recorded and transcribed verbatim. Transcripts were read in parallel during the data collection periods. This led partly to a refining of the interview guides and partly to a beginning of the analysis process, which was carried out in parallel. The analysis process, however, also continued after the all interviews were conducted. The interviews were thematically analysed and the steps used in analysing qualitative data were followed (136-138). First, the interviews were read and re-read for familiarisation. In the next round of reading, keywords were noted on a sheet. What was explicitly said—thus, the manifested content—was noted in one column. In another column, an interpretation of the manifest content was noted. The noted keywords (sometimes referred to as codes or meaning units in the separate studies) that related to the manifested content were grouped together in themes and sub-themes. Keywords and sub-themes were categorised in different ways during the analysis process to represent the material as much as possible but at the same time without the content overlapping too much. Themes and sub-themes were named and sometimes re-named during the analysis process. Keywords related to an interpretation of the manifest content were themed, and analysed in the light of theoretical perspectives to identify patterns and underlining mechanisms to discuss the results, thus, zooming out from the data. The theoretical perspectives used in the studies had already been established in some cases, but in other cases they were searched for to discuss the findings at a deeper level. The analysing processes were foremost inductive, and thus, data driven, although theoretical frameworks worked as a base. During the analysing processes, themes, sub-themes and interpretations were discussed between authors.

Differences in the analysing processes in the different studies existed, but mainly regarded the tools for sorting data. In Study I, the analysis was carried out across the dataset and as separate cases. The qualitative software program NVivo 11 was used for dataset A1. In NVivo 11, nodes and sub-nodes were created based on the keywords that had previously been identified and noted on a coding sheet. The material was read through again in NVivo, and the content was coded into nodes and sub-nodes. When nodes overlapped, they were merged. In Study III (dataset D1) and Study IV (dataset D2), regular paper sheets (also applicable for Study I, dataset A1) and spreadsheets in the software program Excel were used for notes and to sort the data. Post-It notes were also used to arrange and re-arrange sub-themes and the belongingness of keywords.

6.3.2 Registry data

Dataset B1 was analysed to identify potential study participants for the questionnaire and to describe the demographics of the study participants in Study II. Dataset B1 also was analysed to identify potential study participants for interviews for Study III and IV.

For Study III, datasets B1 and B2 were used. Dataset B1 was employed to separate the group of physicians who had participated in the CPP from physicians who had not participated in the CPP in dataset B2. The inclusion criterion for the CPP subgroup was to have acquired at least one-half of the credits awarded by the programme. Two subgroups were thus created—CPP participants and non-CPP participants. The registry data consisted of information about test score on the MMI exam, number of attempts, birth year, gender and country for medical degree. For statistical analyses, R 3.6.1 was used. The data were analysed using linear and logistic regression analysis. A linear regression model was used to assess the combined effects of potential predictors on the total score in percentages. The final model included age and CPP, where age was modelled using a restricted cubic spline function with a knot at 35 years of age and boundary knots at 26 and 58 years of age. The model also included an interaction between the subjects' age and the CPP. Age was categorised into the groups of under 30, 30–44 and 45 years and older; however, the CPP and an interaction between the two variables were included in the model. This model was further fitted with the use of a logistic regression model with the proportion of subjects failing the test on their first attempt as the outcome variable. Boxplots were also presented to illustrate this interaction descriptively.

6.3.3 Questionnaire data

The respondents' completed questionnaires were exported from the digital survey tool to Excel.

For Study II, questionnaire dataset C1 was used. The statistical analysis was descriptive and conducted on categorical data, which were then presented as frequencies and percentages. Respondents could further leave a comment related to the closed-ended questions. Comments related to the closed- and open-ended questions were thematically analysed (136). The responses were read through for familiarisation, and significant sentences and/or keywords were identified and noted; then, central concepts were deductively grouped into some pre-set themes that had been identified during the development of the questionnaire and asked explicitly about. The respondents' comments were also analysed inductively to identify other themes related to barriers and facilitative aspects (cf. (139, 140)). The findings were iteratively discussed between the authors to enhance credibility. The aim of this thematic content analysis of the free-text responses was to complement the quantitative results and to deepen the knowledge on the topic (cf. (140-142)).

For Study IV, questionnaire dataset C2 was used. Responses to open-ended questions were thematically analysed (136, 137). Descriptive and inferential statistical analyses were performed on the completed questionnaires, and SPSS was used for this. Regarding the descriptive analysis of the quantitative variables, means and standard deviations were calculated. Frequencies and percentages were generated for the categorical variables. The data distributions were assessed visually via boxplots and by contrasting potential discrepancies among the parameters of the central tendency, as well as by evaluating the skewness and kurtosis of the distributions and by employing Shapiro-Wilk tests. Parametric statistical tests were also performed to compare two independent subsamples. Differences between groups were calculated using an independent samples *t*-test, while a one-way between-groups ANOVA was used to examine differences between three or more groups. The *p*-values were adjusted for multiple comparisons via a Bonferroni correction of primary endpoints. The chi-square (χ^2) test was used to compare proportions between two or more independent groups and to investigate associations between two nominal-scale variables. The Pearson correlation coefficient was calculated to test the association between the variables. Probability values less than 0.05 were considered statistically significant for all statistical tests.

7 RESULTS

The MPs included in this study were a diverse group consisting of both females and males, with different countries of origin, countries of medical education and degree, and various ages. Some had worked for decades as physicians before migrating to Sweden and others had not practiced at all. Some were specialists, and others were not. Some had families and relatives in Sweden, and others had no one. They had settled in different types of areas, including urban regions and areas that were more or less rural and remote. Reasons for migrating to Sweden varied, and they related to career opportunities, better life opportunities, family and place of MPs' birth or growing up. Questionnaire respondents could indicate one or several reasons for migrating to Sweden. The three most common reasons for the respondents ($n = 277$) were leaving their current home country due to war or political uncertainty (30%), having met a partner living in Sweden (23%) and following a partner to Sweden (22%). Other reasons were to improve their life conditions (14%), that Sweden seemed to be a well-functioning country (11%), wanting to have the specialty training in Sweden (9%) and to have a better economy (8%). Wanting a challenge was another reason (8%). Other motives mentioned were to study at a master's (8%) or doctoral level (7%) or to do research (5%). Some MPs were born, raised or had lived in Sweden before and had that as a reason (7%), and others had parents, siblings or other relatives already living in the country (12%). One third of the respondents mentioned more than one reason for migration; hence, several reasons interacted in the decision. On average, the respondents had been in Sweden for 10.3 years when answering the questionnaire ($n = 274$).

7.1 STUDY I

The aim of Study I was to explore non-established MPs' conceptions about working in rural and remote areas in Sweden; this chapter presents the main results of the study. In the interviews, it became clear that what interviewees considered to be rural, remote and urban was relative, and they often contrasted the areas against each other.

Main results

Some of the interviewees had not yet determined their plans for their future careers as physicians in Sweden. Most of them intended to practice in urban areas, however; a temporary placement in a rural area was a possibility. Several conceptions within the situation of working as a physician in rural and remote areas in Sweden were identified, and themed as follows: finding work (table 4), work content and tasks (table 5), and living (table 6). Displayed in the tables are also the sub-themes.

Table 4. Conceptions about finding work in rural and remote areas.

Theme	Sub-theme	Comment
Finding work	Easier Few workplace options Higher salaries	<p>A concern about working in a rural and/or remote area were that the family would need to move to have more career options:</p> <p>'I have to move the whole family there...and...my child has to change school, something like that...for me bigger cities are...definitely better'</p>

Table 5. Conceptions about the work content and tasks in rural and remote areas.

Theme	Sub-theme	Comment
<p style="text-align: center;">Work content and tasks</p>	<p>Healthcare system</p> <ul style="list-style-type: none"> - Being the same all over Sweden - Have ability to access digital records, regardless of area 	
	<p>Type of healthcare facility</p> <ul style="list-style-type: none"> - Smaller hospitals and health centres that were associated with different duties and specialties 	
	<p>Duties</p> <ul style="list-style-type: none"> - The same if working at a health centre regardless of type of area 	
	<p>Specialty</p> <ul style="list-style-type: none"> - Become excellent in general practice 	
	<p>Resources</p> <ul style="list-style-type: none"> - Having internet and air ambulances available - Lacking for example magnetron x-ray equipment and computer tomography 	<p>A health centre in rural and remote Sweden was said to have 'loads of resources so you can do much more' in comparison to [mentions a country]'</p>
	<p>Patient population</p> <ul style="list-style-type: none"> - Homogeneous - Varying 	
	<p>Colleagues and other healthcare professionals</p> <ul style="list-style-type: none"> - Having few colleagues: working alone often, increased responsibility, independence, experience and knowledge 	<p>'It is more difficult to work in the countryside because you are more responsible there, because you are almost alone, there are not so many doctors. In big hospitals, there is always somebody you can ask...a consultant, other physicians, specialists'</p>
	<p>Development of knowledge and competence</p> <ul style="list-style-type: none"> - Develop broad knowledge and competence - Learning to only a certain level 	

Table 6. Conceptions of living in rural and remote areas in Sweden.

Theme	Sub-theme	Comment
Living	Geographical characteristics	
	- Quite	
	- Small	
	- Cold	
	- Dark	
	People living in rural and remote area	
	- Older	
	- Few	
	- Mainly Swedes	
	Could lead to:	
- Feeling lonely		
- Opportunities to develop knowledge of the Swedish culture		
Travelling		
- Expensive		<p>If I want to go to [European country] it is much cheaper here [urban area where the physician now lives] ... you need more time to travel from [a small town in a remote area] to [the capital of Sweden] and then via airplane to another ...'</p>
- Complicated		
Family		
- Difficult to find a partner		
- Decreased possibility to live close to children studying at university		
Social life		
- Less friends		
- Less places, such as restaurants, to socialise in		
Hobbies and leisure activities		
- Opportunities for nature related		
- Difficulties in exercising certain sports		
- Less opportunities to visit theatres, exhibitions and dine at restaurants		
Language skills		
- Difficult to understand the dialect		
- Unpleasant to be the only one with a dialect		

Conceptions about working in rural and remote areas gave rise to thoughts about how it would be to live in the same (type of) area. Conceptions about working and living in a rural and remote area were thus intertwined. Conceptions about working and living in rural and remote areas were contrasted with working and living in urban areas. Rural areas were often considered to have less to offer in comparison to urban areas, regarding both work life and private life. Further, the conceptions seemed to influence the study participants' motivation

about where to work. Their motivations were also influenced by biographical, professional and societal aspects. For example, one of the interviewee had children who were supposed to go to the university. This decreased this MP's motivation to work in a rural and remote area since the MP assumed that universities were located in urban areas, and living close to children was important, something that the interviewee stated as being part of their culture. Other MPs perceived that rural and remote areas suited them. A more detailed list of how examples of how conceptions seemed to influence interviewees' motivation, either positively or negatively, is presented in Table 7.

Table 7. How conceptions seemed influenced interviewees' motivation to work in rural and/or remote areas

Biographical, professional and societal aspects	Positively influenced motivation	Negatively influenced motivation
Background, and previous experience of rural and remote areas	Migration to Sweden because of a Swedish spouse living in a rural or remote area; having positive living and work experience in rural, remote or smaller urban areas in Sweden.	Raised and lived in cities with millions of inhabitants; once in Sweden, had more or less involuntarily experiences living in rural, remote and small urban areas, or no experiences of rural and remote areas in Sweden. Lacking work experience in rural and remote areas; those who only had experience living or working in larger urban areas in Sweden and in previous countries; those who had worked as specialists in larger urban areas.
Specialty	Wish to develop excellence in general practice.	Being specialists or had begun specialist training and wanted to pursue these specialities.
Age, marital status and family status	Moved so many times that moving again would not make a difference, especially those who were young and did not have a family.	Too old to move to a rural and remote area; have moved too many times already; living far from grown children (e.g. that were supposed to study at university).
Surroundings	Prefer quiet or small areas; have local friends; think people in rural areas are friendlier than those in cities; enjoy the surrounding nature.	Cold and dark climate; expensive and complicated to travel to visit family and friends abroad.
Presence of other physicians	Possibilities to obtain a mandatory medical internship position at a highly-ranked hospital located remotely (as per the national ranking system).	If staff shortages, thus absence of other physicians, i.e. if other physicians did not want to work in these areas, interviewee questioned why they should work there.

Conceptions derived from the interviewees' own as well as from others' experiences both from former countries and from Sweden. In a simple progression, their experiences influenced their conceptions, and their conceptions influenced their motivation regarding where they wished to work (Figure 7).

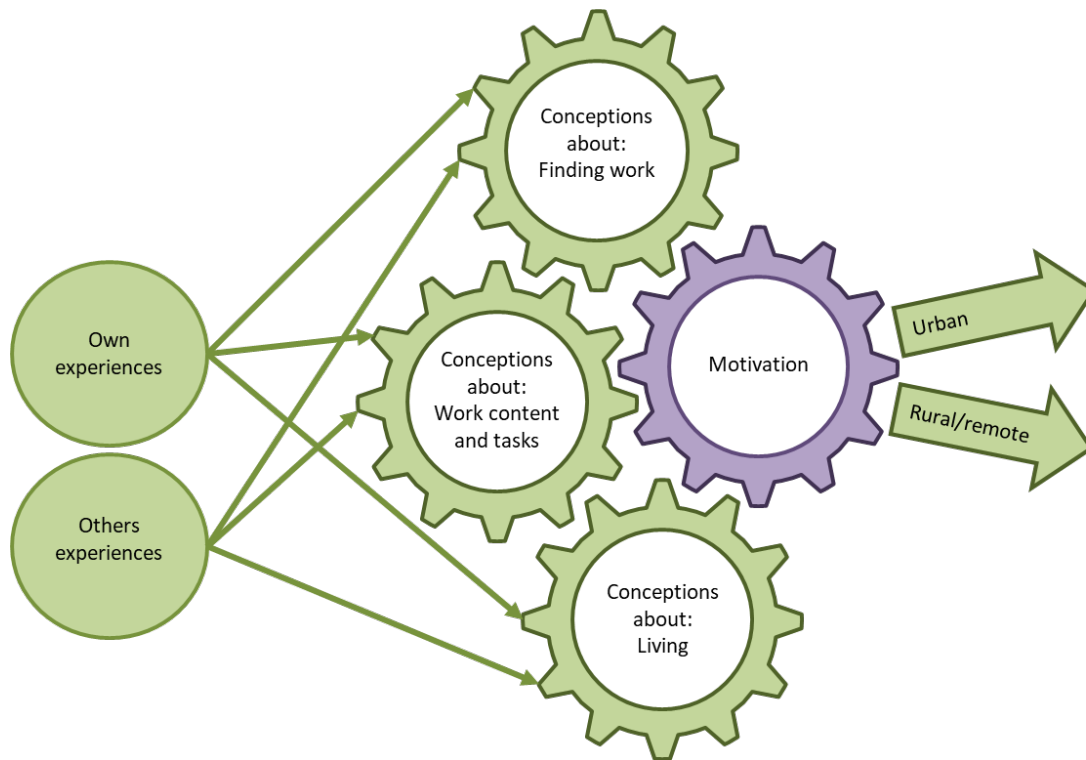


Figure 7. Aspects influencing interviewees' motivation regarding where to work.

7.2 STUDY II

The aims of Study II were (1) to explore how MPs enter into and advance within the medical labour market in Sweden and (2) to identify perceived barriers and facilitating aspects for entrance into and advancement within the Swedish medical labour market. Dataset C1 (questionnaire data) was used for this portion of the work.

Main results

The respondents represented 43 (n = 241) countries (including Sweden), and the number of countries where they received their medical education totalled 52 (n = 269). Prior to taking the CPP, 61% had worked in the Swedish healthcare sector as, for example, assistant nurses or medical assistants. The respondents had mainly found their first positions after the CPP via spontaneous job applications, during their CPP internship or via personal contacts. Most common was to have secured positions as junior physicians. The average time it took them to begin their MMIs was 16 months; this average was 20 months for those who began their MMIs in larger urban areas. Of all the respondents, 88% held a position as a physician in Sweden when answering the questionnaire.

The study identified barriers that the respondents had faced when entering and advancing within the Swedish medical labour market; it also identified facilitating aspects of this process and strategies that the respondents used for increasing their job opportunities. During the respondents' job-seeking processes, some of them reported that they experienced that their competences had been undervalued. Perceived reasons for why their competences were devalued related for example to having another country of origin or a medical degree from outside the EU/EAA. As one respondent wrote, 'They have said it straight out in the interview without knowing what knowledge I have. On several occasions, I heard prejudice about the country I was trained in'. Respondents also perceived that they had been disfavoured related to the grounds of discrimination, usually in relation to their ethnicity. The material also showed that MPs perceived themselves to have been disfavoured related to several reasons, 'Personally, I believe that foreign names and ages can affect the application. I experienced that'.

Having work experience and work references developed in the healthcare sector previous to taking the CPP, for example if working as nurse assistants, were perceived as facilitating. The respondents found that work in the healthcare sector was beneficial for developing their Swedish language skills, understanding new workplace routines and practices, demonstrating their skills and developing contacts and work references. The identified barriers and facilitating aspects regarding entering and advancing within the Swedish medical labour market often corresponded; Figure 8 illustrates this correspondence together with strategies that the respondents used for increasing their job opportunities. A more detailed table is included in Study II's corresponding article (132).

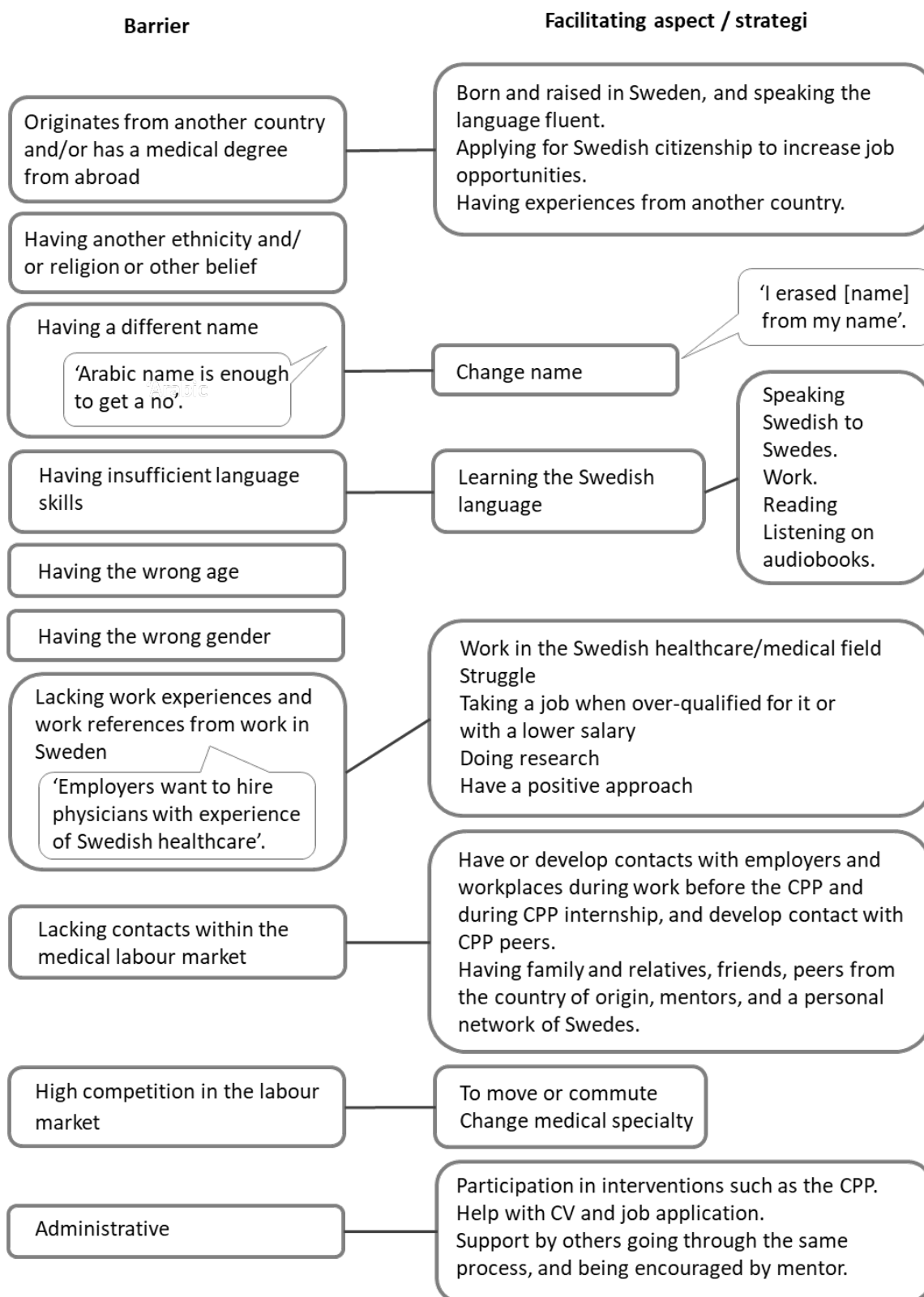


Figure 8. Barriers and facilitating aspects for entering and advancing within the medical labour market and strategies used.

7.3 STUDY III

Study III aimed to (1) explore CPP participants' exam results in comparison to those from other MPs with a medical degree from outside the EU/EEA and to (2) explore aspects that may influence the exam results of MPs undergoing the recertification process. Datasets B1, B2 and D1 were used for this study.

Main results

On average, the CPP participant group was marginally older than the non-CPP participant group (38 and 36 years, respectively). The CPP group had slightly more men and marginally lower test scores on their first attempt. Gender and geographical region were not significant predictors for failing on the first attempt; however, age and test score were strongly associated. Age seemed to be an important predictor for failing on the first exam attempt – specifically, older MPs failed more often on their first attempt than their younger MP peers. An interaction between age and CPP participation existed: 72% of the CPP participants aged 45 years or older failed on their first attempt, whereas the corresponding failure rate in the non-CPP group was 82%. Thus, participation in the CPP might reduce the negative effect of age on test scores for older exam participants. Figure 9 presents the themes and sub-themes identified during the analysis of dataset D1.

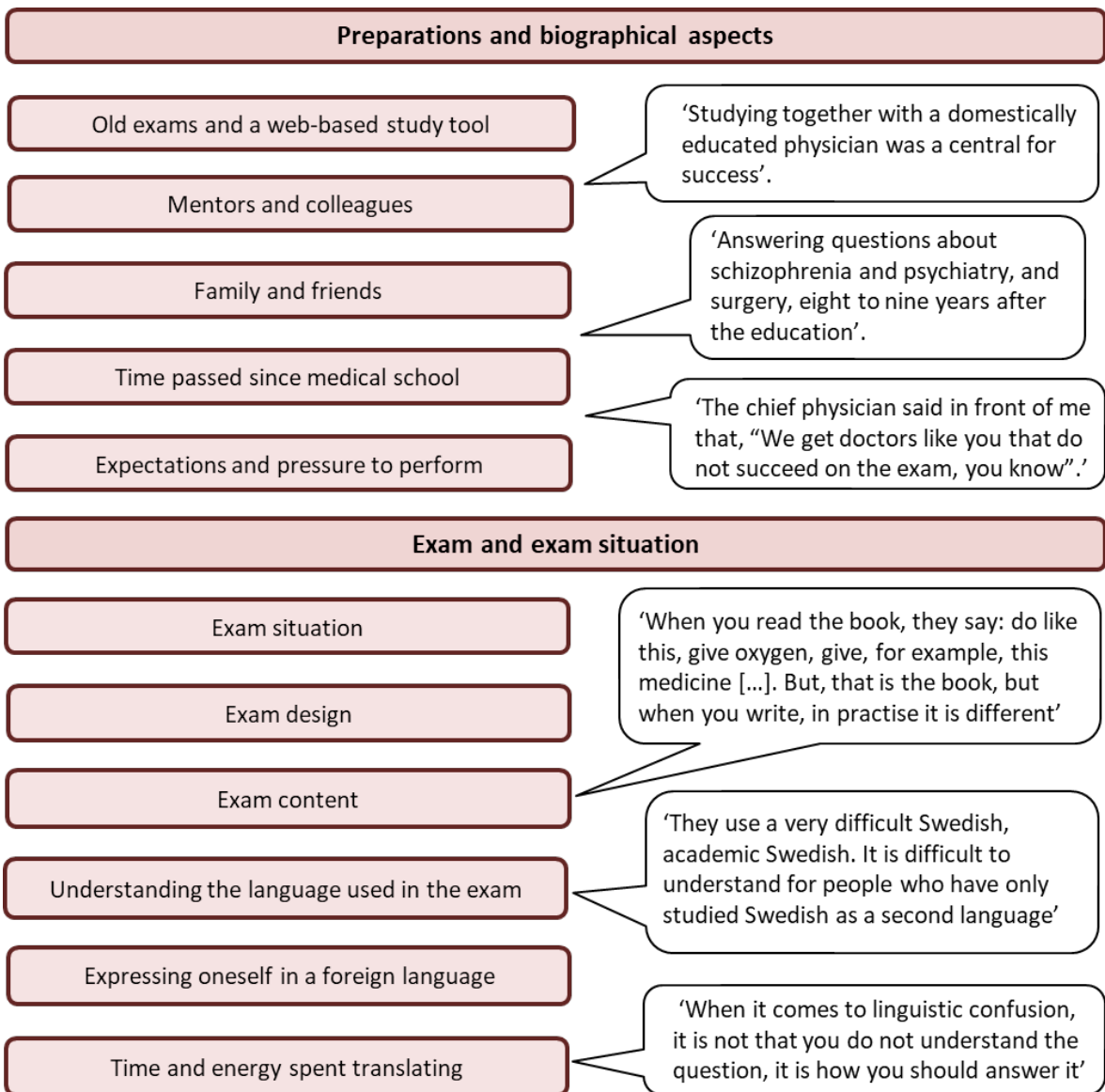


Figure 9. Qualitative results, themes and sub-themes.

7.4 STUDY IV

Study IV's aims were (1) to explore aspects that influence MPs', with a medical degree from outside EU/EAA, choice of employment and medical specialty in Sweden, and (2) to identify any differences between general medicine and other specialties. Datasets C2 and D2 were used for this work.

Main results

In the questionnaire, the respondents could value the importance of 34 aspects when choosing employment that related to work life and private life (5-point scale). The aspects that received a mean >3.0 are presented in Figure 10.

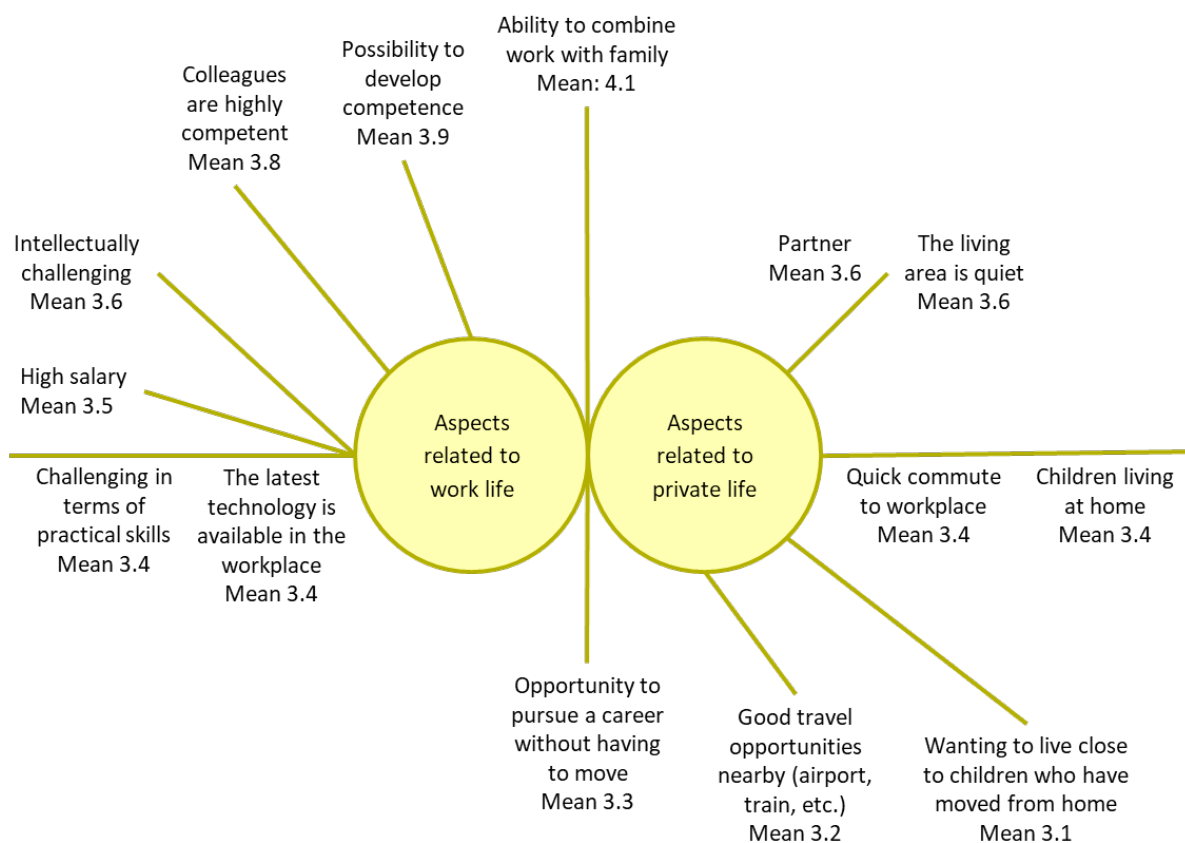


Figure 10. Aspects with the highest values (means) for MPs when choosing employment.

The two aspects valued the lowest in terms of choosing employment were 'close to a religious institution' (mean = 1.6) and 'ability to live near other people from my country of origin or education' (mean = 1.8).

Women scored significantly higher than men on four aspects:

- Close to theatres, museums and cinemas
($M = 2.84 \pm SD = 0.166$ vs $M = 2.10 \pm SD = 0.913$; $p = .000$)
- Quick commute to workplace
($M = 3.64 \pm SD = 0.106$ vs $M = 3.26 \pm SD = 0.964$; $p = .027$)
- Good travel opportunities nearby
($M = 3.47 \pm SD = 0.919$ vs $M = 3.02 \pm SD = 1.009$; $p = .025$)
- Easy to make new Swedish friends
($M = 3.05 \pm SD = 0.914$ vs $M = 2.56 \pm SD = 0.938$; $p = .012$)

Of all the respondents, 24% had not end up specialising in their first choice. Their perceived reasons for why this was related to labour market conditions and discrimination.

Regarding specialising in general medicine versus in other medical specialties, the following were found:

- There were no significant differences between the MPs in general medicine and the MPs in other specialties regarding if they were practising in their first choice specialty or not.
- A significant difference was found between choice of employment and the aspect 'Ability to have the same patients for a long period of time'; those working in general medicine scored higher than those in other specialties.
- Women were more likely to specialise in general medicine than men ($p = .017$, phi coefficient = .238).
- MPs with a medical degree from countries where general medicine was not a specialty were more likely to specialise in general medicine than MPs with medical degrees from countries where general medicine was a specialty: $X^2(1, n = 98) = 5.09$, $p = .024$, phi coefficient = .228.
- MPs who were training in or were specialised in general medicine considered their specialty to be of a lower status compared to how MPs in other specialties perceived the status of their specialty ($M = 1.82 \pm SD = 0.697$ vs $M = 2.15 \pm SD = 0.709$; $p = .028$).
- Regarding the variables of birth period, geographic region of origin or geographic region of medical education, no significant association was found between MPs in general medicine and MPs in other specialties.

The identified aspects that influenced the interviewees' choice to specialise in general medicine were themed as follows: job opportunities, positive experiences of PHC, working conditions and family conditions (Figure 11). The importance of an influential aspect could change over time.

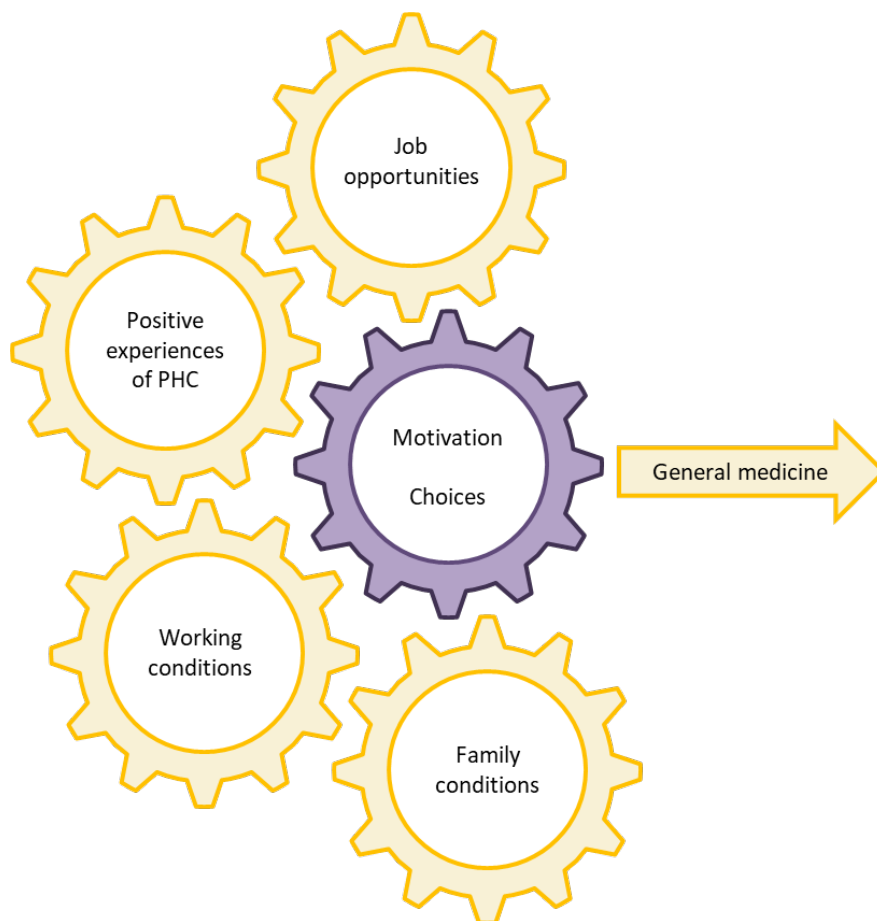


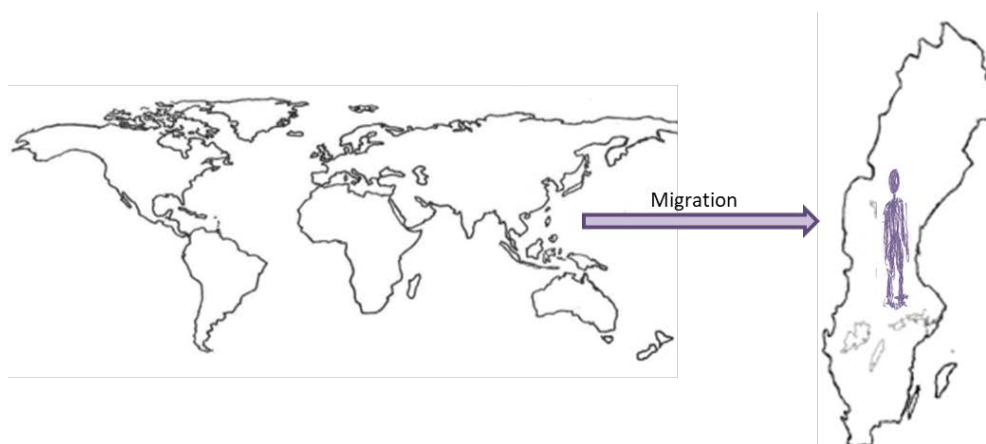
Figure 11. Identified aspects that influenced interviewees' choice to specialise in general medicine.

8 DISCUSSION

In this chapter, some overarching themes identified that influenced the entrance to and advancement within the Swedish medical labour market are discussed. The discussion begins at a societal level (macro), proceeds to an organisational level where individuals interact (meso) and then follows the individual level (micro). A structural dimension that permeated the different levels is also present. Levels and dimensions influenced each other and interacted, and hence, there will be some overlaps in the discussion. Then follows a meta-discussion that relates to the theoretical concepts of social field, symbolic capital, and doxa (presented in chapter 4). In this section, the concepts will be used to analyse how the different influential aspects are valued (as symbolic capital) and how this can benefit or slow down the path to the labour market.

8.1 ASPECTS ON THE SOCIETAL (MACRO) AND ORGANISATIONAL (MESO) LEVELS THAT INFLUENCE MPS' ENTRANCE TO AND ADVANCEMENT WITHIN THE MEDICAL LABOUR MARKET

At these levels, different barriers and facilitating aspects that influenced the study participants' entrance to and advancement within the Swedish medical labour market can be identified, and they are more or less out of the individual MPs' control, but still have an effect. This section that takes its departure from when a physician has arrived in Sweden and wants to proceed to practice the profession. The recertification process consists of many steps; this thesis focusses on some of them.



8.1.1 The recertification process

An aspect that influenced the entrance to the labour market for the study participants was that they had to undergo a recertification process as they had a medical degree from outside the EU/EEA. In Study II, it was found that respondents perceived the organisation and the information about the recertification process as insufficient. The results were in line with research stating that information can be experienced as insufficient and diverse, which then

translates into barriers (39, 48, 60, 69). Further, Study II respondents perceived that the different authorities involved in the recertification process did not cooperate to the needed extent, which may explain why the information was perceived as insufficient. Furthermore, as in other countries, several institutions are involved (40, 48). A recertification process can be complicated and resource consuming in terms of both time and effort (57, 68, 69) which might prevent quick and smooth access to the medical labour market. However, there are reasons for why MPs often need to undergo a recertification process, and these implicitly hence influence their establishment. Such reasons relate to national and union borders, patient safety and differences in healthcare contexts between countries. They are further discussed.

That an MP with a medical degree from outside the EU/EEA has specific conditions to be able to enter the medical labour market in Sweden is based on legislation related to national borders, or rather on a union border. In this case, the significant border is the one surrounding the countries in the EU/EEA which separates the countries within the union from the ones located outside. Physicians within the union border formally have easier access to each other's labour markets than physicians educated outside this border due to Directive 2005/36/EC on the recognition of professional qualifications (143). In Study II, the different condition, depending on the country for medical degree, was present and brought up by respondents, even if this was not this thesis' scope. However, my interpretation is that the different condition created such emotions as frustration and a feeling of injustice. With a geopolitical lens, national and/or union borders can be interpreted as metaphorically have become a border that values knowledge and decides how physicians can access the labour market based on where the medical degree was acquired (cf. (144)). Thus, by legislation, a state can create and reproduce the categorisation of 'the other' and control a physician's opportunities for entering the labour market (cf. (145)).

Another reason why MPs educated outside EU/EEA must undergo a recertification process and acquire a Swedish medical licence relate to patient safety. Since MPs need to participate in a formalised mandatory route, the underlying statement is that, to some extent, their knowledge and competence might differ from the knowledge and competence that peers educated in Sweden have acquired, and that it is important to confirm that the level of knowledge and competence are alike amongst physicians that practice in Sweden. An assumption of differences probably has its ground in that medical contexts between countries differ, as presented in chapter 3 Background; for example, there may be differences in healthcare systems (40, 62, 92); how to approach patients, peers and other colleagues (39, 60, 61, 76, 86-90); the language used (39, 40, 42, 48, 61, 76, 86, 91, 94); and some observed medical conditions. As differences may become challenging for MPs workplace integration, this could explain why MPs need to undergo a recertification process that includes mandatory routes, and why the entrance to and advancement within the labour market may become slow. The reasons presented; union border, patient safety, and differences in contexts, may give rise to barriers, obstacles and difficulties for the individual, influencing their career path.

8.1.2 Participation in an educational intervention/bridging programme

To participate in an educational intervention/bridging programme can facilitate the entrance to and advancement within the medical labour market. In Sweden, different educational interventions are given by different stakeholders. One is the CPP, a formal educational intervention, and another one is the MMI. As the CPP is one of three routes to the Swedish medical licence, it plays a crucial role in MPs' further careers as physicians in Sweden since it enables them to even have the opportunity to have further careers as physicians in Sweden. Study II participants also perceived the CPP to be helpful in their professional careers in Sweden. In Study III, a correlation between age, the CPP and passing the MMI exam on the first attempt was further identified; The CPP counteracted a negative age effect for participants being 45 years or older. However, the CPP is likely beneficial regardless of age, as others perhaps would not have a chance at all without it. As the CPP was perceived as useful for establishment on the labour market, study participants suggested that the number of spots should be increased (Study II). This was also done in 2018, just prior to the study.

An educational intervention/bridging programme can be interpreted as a resource for aligning MPs' knowledge and competence to a new medical labour market, integrating and socialising MPs to a new medical context and making them less 'culturally distanced'. During the CPP, the MPs should gain knowledge and prove to have knowledge and competence comparable to the knowledge and competence of physicians educated in Sweden and applicable in the Swedish medical context so that, at the end of the recertification process, they can work as independent physicians. Research has highlighted that a demand for specific educational requirements and a country-specific medical licence can suggest increased opportunities to control access to the labour market (Åmark, 1990, Parkin, 1979, and Torstendahl, 1997, referred to in (64)). Thus, to have mandatory routes and requirements for MPs to pass exams can be interpreted as a method to monitor the profession and monitor who and how many should be included in the medical labour market workforce. At the same time, the CPP provides an opportunity for MPs to continue their professional careers.

8.1.3 Finding a job in the 'new' medical labour market and advancing within it

In this section, barriers and facilitating aspects that influenced possibilities to get a job are presented. These influential aspects relate to high competition, contacts, discrimination and devaluation of competence.

8.1.3.1 High competition in the medical labour market

In Study II, to find an MMI position was perceived by the respondents as difficult because of too few positions and the too-high competition that followed. In Study IV, one reason given for not having specialised in MPs' first-choice specialty also related to too high competition. In Study I, it was shown that high competition as a result of too few MMI positions in certain geographical areas could influence some MPs' choices about where to work. As it was

perceived as easier to find work in rural and remote areas, some considered working in these types of areas, although sometimes only temporarily.

It was found in Study IV that more than half of the respondents had specialised in general medicine. In Sweden, general medicine is the largest specialty, and specialists in general medicine usually work as GPs. PHC usually suffers from staff shortages, in Sweden as well as in other Western countries (18, 21, 59, 67, 69, 120). The results could be in line with research that has suggested that MPs adjust their careers to job availability (67, 146), and thus, have a tendency to work in underserved areas. Underserved areas can relate to a type of sector, a certain specialty, but also to a geographical location (32, 104).

8.1.3.2 Work given based on contacts

To lack contacts can become a barrier to the medical labour market and for advancing, while to have contacts is a facilitating aspect. In Study II, it was found that MPs had found work via spontaneous job applications and being active in this by, for example, establishing personal contact. Many also found their first job after the CPP via contacts that they had developed during work before the CPP or during internships under the CPP. Work was also found via other CPP participants. The results from Study II are in line with previous research that suggests that participation in a bridging programme is a predictor for securing employment (147), and with research suggesting that having a network in Sweden is beneficial for securing jobs or for career advancement (1, 29, 148). To only have a small network has also been suggested to cause difficulties for MPs in Finland to find employment and to change job (57). Research has shown that migrants in general have more difficulties than non-migrants to find jobs via informal networks, but at the same time, to have an informal network can make it easier for migrants to find work (Behtoui, 2008, cited in (82)). In Study IV, the value of having a network was discussed in terms of specialty choices; research has suggested that a recruitment process for a specialty training position in Sweden can sometimes already begin during medical education (21), as it may do in Ireland (107). This could be disadvantageous for MPs who completed their undergraduate medical education abroad (107). If lacking contacts leading to employment, a facilitating aspect in the job-seeking process explored in Study II could be to receive help with CVs and personal letters. This was thought to be partly, highly or very highly valuable for increasing job opportunities by almost three-quarters of the respondents.

8.1.3.3 Discrimination

When individuals are hired due to networks, this excludes those who do not have a social network (82). In the worst case, this systematic excluding process could lead to discrimination (82). Discrimination is generally an aspect that influences the entrance to a labour market negatively for migrants, as was also described in the background (30, 80-84). In Study II, it was found that respondents perceived that they had been disfavoured in the job-seeking process for reasons related to the grounds of discrimination. Experiences of being exposed to discrimination foremost related to the discrimination ground of ethnicity, but there

were also examples when it related to several grounds, for example, being a certain age or being a woman. Thus, MP women can have other experiences of discrimination compared with MP men. The MP group is heterogeneous, and MPs from some parts of the world could be discriminated against to a larger extent than MPs from other regions (cf. (82)). Certain combinations, such as country of origin, age, gender and religion or other belief, may thus generate more difficult barriers (149). Discrimination, as well as a perceived discrimination, is suggested to affect the acculturation process negatively as it increases acculturation stress, which in turn decreases well-being (6, 96, 150). Discrimination may also lead to separation instead of integration (6). Separation, as well as marginalisation, is linked to weaker physical and psychological/mental health (6). Perceived experiences of discrimination were also one aspect found to indirectly influence some study participants' specialty choices (Study IV).

8.1.3.4 Devaluation of competence

Devaluation of competence can occur at the macro level based on legislation and at the meso level by employers during an MP's job seeking process (31, 32). In Study II, the results showed similar results, participants perceived that their competence had been valued lower than domestically trained peers, for example, based on having a degree from outside the EU/EEA or when considered to have insufficient language skills. Devaluation occurs if others perceive that migrants' education is of lower standard than a domestic education (cf. (82)) or when MPs are perceived to lack competence specifically needed in the Swedish medical labour market (82). Migrants are then thought of as being less qualified (82). Research has highlighted that devaluation also can occur at workplaces by peers and colleagues, which may reinforce this barrier in the job-seeking process (151). Due to differences in healthcare contexts—for example, when it comes to having patient-centred care and team-based working methods—and the barriers that may arise, research has shown that this has consequences for the physician's career in the new country (61, 87, 88). Skjeggstad et al. showed that perceptions of MPs' professional competences were intertwined with knowledge of the language and professional identity (94).

It could be difficult to identify reasons for not being offered a job and whether this is due to discrimination, devaluation of competence or other reasons. In the medical context, other aspects can be important to consider. For example, having insufficient language skills can be a reason for having MPs' competence devaluated, and this can be related to having another ethnicity. However, having insufficient language skills can have consequences for patient safety. Discrimination and devaluation of competence could further be unconscious, as discussed in Study II, where it was brought up that employers may not know about the CPP or may mistrust foreign competences, consciously or unconsciously (cf. (124)), just as employers do not always discriminate intentionally (152).

8.2 ASPECTS ON THE INDIVIDUAL (MICRO) LEVEL THAT INFLUENCE MPS' ENTRANCE TO AND ADVANCEMENT IN THE MEDICAL LABOUR MARKET

On an individual (micro) level, conditions derived from the macro and meso levels can become barriers, obstacles and difficulties of smaller or bigger proportions. Thus, what happens on the macro and meso levels influences the individual's entrance to and advancement within the labour market. For example, structural disadvantageous power systems, such as discrimination, may be on a meso level but have complications at the micro level, i.e. for the individual. However, even if aspects trickle down on the individual level, the individual is not completely blocked. Thus, although circumstances on meso and macro levels put up a given set of possibilities and may limit individuals and sets the scene for action, the MPs have agency. They can choose within the possibilities set up by the conditions on the macro and meso levels, and try to improve their chances of entering and advancing within the labour market in other ways. Thus, MPs can influence parts of the own path to the labour market and advance within it through certain strategies and/or via aspects perceived as facilitating. In Study II, many barriers and facilitating aspects corresponded and were found to be two sides of the same proverbial coin.

8.2.1 Working in the medical context

Lacking work experience, contacts and references in the Swedish medical context could become a barrier for entering and advancing within the medical labour market. Thus, working in the Swedish medical labour market was a facilitating aspect. In Study II, it was shown that to have been working in the Swedish healthcare or medical field prior to participation in the CPP and that internships during the CPP could lead to a job after the CPP. One interpretation of this is that, during their work and internships, the MPs not only developed their competence but also *proved* their competence, acquired references and developed contacts and language skills that were beneficial for establishment on the labour market. To have worked in Swedish healthcare before the CPP was also perceived to facilitate admission to the CPP. In Study III, having experienced conditions in life instead of just having read about them was perceived to influence the results on the MMI exam positively.

8.2.2 Development of language

The spoken language in a country is 'decided' on the macro and meso levels, but it influences the individual level. Previous research has identified language related issues as a common barrier in the recertification process, and thus, to other countries' medical labour markets (39, 48, 69), for succeeding on exams during a recertification process (46, 70, 71) and for workplace integration (39, 40, 42, 48, 61, 76, 86, 91, 94). Improving language skills thus helps 'foreign-born physicians' to integrate into working life' (55). Language-related issues were a recurring theme in the studies, even if to different extent. In Study II, for example, perceptions of having insufficient language skills were a barrier to the labour market for some respondents, and to have sufficient language skills was a facilitating aspect (Study II). Study III showed that language skills were perceived to influence results on the MMI licensing

exam. Language related considerations were brought up in Study I. For example, interviewees thought that it could be difficult to understand the local dialect if working in a rural or remote area. Possibilities to develop language skills were perceived as easier or more difficult in this type of area depending on interviewee (Study I). In Study IV, language skills had been one influencing aspect when an interviewee chose medical specialty.

Improving the language was a strategy used as it was perceived to increase job opportunities (Study II). Language skills were mainly improved by speaking, as well as reading and listening. Of the respondents in Study II who had positions as physicians, 50% perceived that speaking Swedish to Swedes was effective and had increased opportunities for finding work as a physician in Sweden. Being married to a Swede was also mentioned in Study II as improving the MP's language, as they spoke Swedish at home. Resources to develop the generic language thus included Swedes and Swedish-speaking spouses, but also language courses and audiobooks (Study II). Resources to develop a professional language included working in the healthcare sector and taking medical language courses. To develop knowledge in how to use the language needed for answering exam questions, MPs studied with domestically trained peers or used a web-based study tool. However, the results from Study III further show that there can be discrepancy between perceptions on what are considered sufficient or insufficient language skills, and this can be contextual: In Study III, it was shown that MPs had difficulties with the specific language used in the exam but not when working. In Study II, it was found that the level of language skills, for some respondents, was perceived as a reason for having competence devalued. Having sufficient language skills may open doors to more opportunities and choices, and the feeling of having autonomy can be increased (cf. (28, 125)). Speaking the same language as others may also increase the sense of belonging, which could connect to the human need for relatedness (cf. (28, 125)).

8.2.3 Individual motivation and use of strategies

One aspect that probably influenced the MPs' paths, entrance to and advancement within the Swedish labour market was their motivation to work as physicians in Sweden. My interpretation is that they were motivated to work. This was evident in that they had begun the recertification process. Respondents mentioned having struggled to enter and advance within the medical labour market, for example by working hard, at uncomfortable working hours, and taking jobs being over-qualified for (Study II). Having to struggle may be a consequence of barriers and circumstances emerged on the macro and meso levels, such as the condition to participate in a recertification process, experience competence being devalued and lacking a network that can lead to employment; Results congruent with other research (29). My interpretation is that without the motivation, they would not have proceeded. However, the reasons for why they wanted to work as physicians again could be intrinsically or extrinsically motivated, which could have distinct implications for well-being. Whatever reason, their will to work as independent physicians in Sweden could be seen as a goal, and to accomplish the goal, different strategies were used. Thus, my interpretation is that strategies were used as they were perceived to facilitate goal reaching.

Conditions derived from macro and meso levels could create barriers and limiting conditions during the MPs' path, and to use a metaphor, if they encountered a stone or a mountain on the way, they sometimes had to change direction and/or use different strategies to proceed. Strategies used could be to move, to change specialty, and to develop the language. Strategies were for example used to shorten the time to the Swedish medical licence. In Study I, it was shown that working in rural and remote areas was perceived to speed up the licensing process, and therefore, to move was considered as a possibility (Study I). This conception influenced motivation to work in a specific type of area positively. In Study II, it was shown that one-third of the respondents that had or had held an MMI position had moved for the sake of it. To move was thus a strategy used by some respondents as a consequence of high competition in the labour market (Study II), an element that could be interpreted as relating to the social context even if on the macro and meso levels, thus somewhat on an abstract level. Further, one-fifth of Study II respondents had as a strategy to increase job opportunities changed specialty. Usage of strategies to overcome barriers and/or uncontrollable conditions derived from the macro and meso levels could, with reference to SDT, be due to extrinsic rather than intrinsic motivation, something that could have a negative influence on well-being in the longer run (28, 125). However, MPs' motivation to reach their goal could fully originate from the self and be more important, and strategies used would then be worth the struggle even if the strategy is extrinsically motivated.

Participation in a recertification process, thus in a given condition, may be perceived differently by the participants in their endeavour for the Swedish medical licence, an external reward. If the process is perceived as forceful, participation may probably be extrinsically motivated, which could have a negative influence on well-being. If participation in the recertification process is perceived as a possibility, the participation may be intrinsically motivated, thus the motivation then stems from the self and a need for competence and competence development, MPs' well-being along the way will probably be better.

Barriers and conditions derived from the macro and meso levels, may undermine intrinsic motivation as they limit MPs' autonomy and possibilities to exercise free choices; this could influence their performance, development and well-being (cf. (28, 125)). For example, having limited possibilities to find employment and to change job could cause psychosocial job stress (57). Strategies and facilitating aspects could be interpreted as ways to enable future increased autonomy.

8.2.3.1 Elements in the close environment and social context that influence motivation and choices

According to SDT, the environment and social context influences individuals' motivation, and have implications for motivation (28, 125). Elements in, or conceptions about, the close environment and social context that seemed to influence the study participants' motivation were identified, as well as how elements in the environment and social context could influence choices and strategies used.

In Study I, it was found that conceptions of rural and remote areas influenced the study participants' motivation to work in such an area either positively or negatively, and many conceptions were related to the close environment and social context. Aspects that influenced their motivation to work in a specific area related to both work life and private life, and depended on, for example, life circumstances, interests and experiences. Conceptions identified about rural and remote areas that influenced their motivation to work in certain areas could be related to human needs (28, 125)—competence (i.e. having resources for competence development), relatedness (i.e. wanting to socialise, be close to family and travel abroad easily; being the only foreigner in a place; speaking the same language) and autonomy (i.e. possibilities to be self-sufficient sooner than later affect the choice between different workplaces). The conceptions of an area could further derive from own or others' experiences. The same shared conception could attract or not attract MPs.

In Study IV, it was found that the environment and the social context influenced motivation and choices when choosing employment and specialty. Further, conditions such as high competition on the labour market or discrimination could indirectly influence specialty choices as these conditions led to changes in direction. In this study, most respondents had specialised in general medicine; some had also changed specialty in Sweden to general medicine, which could be due to circumstances on the macro and meso levels that may limit choice. However, my interpretation was that they were not in their specialty more involuntarily than others as there were other elements in the environment and the social context on an individual level that influenced their motivation and their choices. However, to what degree a choice is free can be difficult to determine since external limiting conditions may be internalised by the individual just like extrinsic motivation can be fully accepted in the self and turned into intrinsic motivation, which then influences the choice, and the choices that follow may then be thought of as free. What influenced motivation and choice could be based on innate human needs, and/or changes of priorities along with changed life circumstances, as well as on limiting conditions on the macro and meso levels.

In Study I and Study II, it was found that positive experiences influenced motivation and choices. Developed positive experiences in a certain area (Study I) and in a certain healthcare sector (Study IV) could influence motivation and choices to proceed to work in that area and to specialise in a certain medical specialty. Regarding a certain type of area, research has further shown that rural and remote experience is a predictor for domestically trained physicians to retrain in these areas (13, 15). This probably also regards MPs as long as the experiences are positive, as my interpretation is that positive experiences increase intrinsic motivation for all individuals (28, 125). However, what is experienced as positive in a context and enables intrinsic motivation could differ on an individual level (28, 125).

In Study III, it was found that other conceptions and knowledge about the MP group's higher failure rate on the MMI exam could be stigmatising, which also influenced motivation positively or negatively and was perceived to influence exam results. Others' knowledge about the group's high failure rate became a stressor for some MPs on an individual level.

Other MPs became motivated and chose to study even harder, determined to succeed. A social context where individuals are stigmatised probably does not enable intrinsic motivation, which in the longer run could decrease well-being (28, 125). In contrast, a social context where others are encouraging and supportive may increase well-being, and others can become a part of creating a positive experience.

The physician can be interpreted as formally fully belonging to the Swedish medical labour market after having obtained the Swedish medical licence (32). The physician can also have a sense of belonging to the Swedish medical profession (32), the medical labour market and the medical workforce. Belongingness may occur when having the knowledge and competence needed, as well as when others perceive that the MPs have this competence. It is suggested that individuals need to belong to a group as this gives well-being (6). Relatedness is also an identified need for humans (28) and could explain the importance of becoming a part of the profession and a medical field, along with the struggle in doing so. In Study I, it was further showed that conceptions about the people living in an area and opportunities to socialise with others influenced motivation about where to work. Drawing a parallel to SDT, one interpretation is that Study I participants also wanted to be a part of a social context outside their professional/work life and that the environment and infrastructure could be thought of as providing or not providing opportunities for them to socialise to the extent they wanted to. This also influenced their willingness to work in different areas. It is important that the environment and the social context facilitate motivation. This can be done, for example, by offering optimal challenges, positive feedback, rewards (not extrinsic ones), choice, 'acknowledgement of feelings, and opportunities for self-direction' (28).

In summary, aspects of the environment and in the social context that influenced the study participants' motivation to act and make specific choices were identified in the studies. Different elements in the environment and social context, also comprising own and others' experiences as well as conceptions, influenced study participants' motivation, and could in turn influence their choices. When considering where to work (Studies I), in which specialty (Study IV), or when choosing employment (Study IV), aspects related to both private life and work life were identified as important. To shorten the time to the Swedish medical licence or to a specialty training position seemed important to the study participants, and many strategies were used or considered for this. What motivates an individual to do specific choices can probably change over time, as individuals have new experiences, and as priorities might change due to changed family conditions; the latter shown in Study IV. With further reference to SDT, it could be suggested that they had a need for competence, relatedness and autonomy (28, 125), and that this influenced their motivation and choices.

8.2.4 Development and use of competence

Development of knowledge and competence seemed important on an individual level throughout the career, as was being surrounded by resources enabling this. This also influenced MPs' motivation and choices. In Study I, it was shown that possibilities to develop competence influenced motivation about where to work geographically. Resources to develop competence included the type of patients in an area and the complicity of the cases, the number of colleagues and their competence, and the proximity to research and advanced equipment. In Study III, different learning resources influenced the results on the MMI exam positively, including studying with nationally trained physicians, looking at old exams and using a web-based study tool. In addition, the CPP can be seen as a tool for competence development at an individual level. In Study IV, aspects related to competence scored high when MPs in specialty training and MP specialists were asked what was important when choosing employment.

That competence was a prominent theme may be explained by several factors. For example, the need for competence is an identified innate human need (28, 125). Development of competence, professional development and lifelong learning are also inherent components of the medical profession (cf. (63)). For these reasons, one can assume that aspects related to competence would also be important for domestically trained peers. Since the study participants had begun the CPP, one can also assume that they wanted to use their competence. However, as discussed previously, devaluation of competence and discrimination could narrow MPs' possibilities to make use of their competence to the fullest. Based on conditions on the macro and meso levels that were discussed in previous sections, the MPs need to develop their knowledge and competence to become a part of the medical labour market, which they can do via, for example, the CPP, as well as via the MMI and perhaps throughout their professional lives.

8.2.5 Time

An overall theme was time. It can be assumed that barriers slow down the licensing processes and increase the time for MPs to reach the medical labour market and to advance within it. However, it is impossible to know how long it should take to accomplish this. Optimal timelines can be created in theory, but as there are circumstances at the macro, meso and micro levels that influence the MPs' paths, timelines may appear unrealistic. The group of MPs is also heterogeneous and consists of diverse individuals. Comparisons between different groups, however, can be made for estimations, and patterns can be highlighted.

Study II showed that the study participants had longer waiting times until they received an MMI position, and it has been indicated in a previous report that it takes a longer period to obtain the Swedish medical licence for MPs (35). In Study IV, it was speculated about whether a time consuming recertification process influenced the study participants to specialise in a medical specialty suffering of staff shortage since this could decrease the time to receive a specialty position. To change path and use strategies perceived as facilitative

could give a push forward and decrease the time to the labour market and to advance within it. Some barriers, facilitating aspects and strategies identified related to time, and time can indirectly influence the entrance to and advancement within the medical labour market. Time can become a barrier in some cases. Conceptions of what would speed up the recertification process motivated participants to consider and use different strategies, for example, moving to another area (Studies I and II). In Study IV, it was shown that influential aspects and their importance could change over time. For example, having children led to changed priorities and new experiences to changes in motivation and attitudes.

Another factor related to time is age. MPs are often older than their nationally trained peers (48, 60). In Studies II and IV, it was found that respondents had experienced being discriminated against, which sometimes occurred on the grounds of age. Age could also be a pretext for discriminatory action and used as an excuse. In Study III, an association between the success rate, age and participation in the CPP was identified. Age has also been described as a predictor of failure/success in other research (77, 78). Age group showed in Study III to benefit from the CPP were MPs being 45 years or older, which can relate to the extent of practice they have had or how much time has passed since they had practiced. Competence may stagnate if it is not used. Passed time since graduation was a theme identified in the interviews that was perceived to have influenced the performance on the MMI exams (Study III). However, years since graduation was not a significant predictor when age had been included in the linear regression model (Study III).

It is suggested that the longer an individual stays in a vulnerable position, such as being unemployed, the more negative implications for health arise (cf. (8)). Therefore, it could be argued that it is important to shorten the time to the medical labour market. However, this must not interfere with patient safety. To avoid losing any time, it could be argued that the information in the recertification process must be sufficient, streamlined and provided at an early stage of arrival. This is specifically important in that MPs may not know who to contact (60) or how to navigate in the recertification process (46).

8.3 THE SOCIAL FIELD, SYMBOLIC CAPITAL AND THE NOTION OF DOXA

In the previous sections, MPs' paths into the Swedish labour market were analysed in terms of facilitating aspects and barriers. These analyses showed that these aspects work on the macro, meso and micro levels, and to some extent, they could be managed and transformed by the individual; however, in some cases, there are aspects out of the individual's control. Below, I analyse the facilitating aspects and barriers in terms of Bourdieu's concepts of the social field, symbolic capital and the notion of doxa. With this analysis, it can be shown whether and how different aspects that influence the MPs' path into the work life in Sweden interact in a specific context, the Swedish medical field.

Here, the medical field is understood as a social field, and it is limited to one country. With this perspective, MPs can be seen as migrating to the Swedish medical field from another country's medical field (Figure 12)

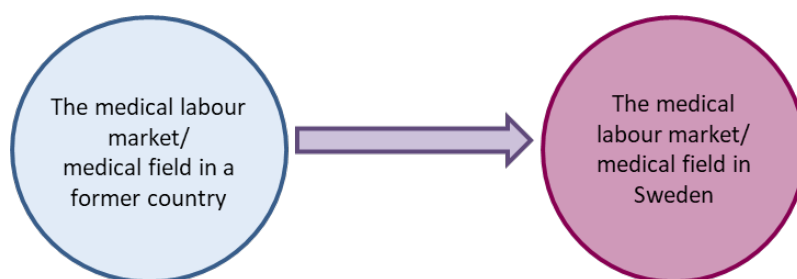


Figure 12. Moving from the medical labour market in one country to another.

8.3.1 Moving from the medical field in one country to another

To enter Sweden's medical field, the MPs' cultural capital (medical degree, knowledge and competence and work experiences) must be recognised. Thus, their medical degrees must be acknowledged formally. However, to practice the profession independently, they must also develop their cultural capital, which is possible via the CPP. A demand for specific educational requirements implies that the MPs' cultural capital is valued differently. When cultural capital is transferred between medical fields, this can lead to devaluation of capital (cf. (31, 124)), which displays the discrepancy between the symbolic value of cultural capital depending on where the agent is and where the asset/capital was achieved. Thus, depending on where a medical degree is acquired, cultural and social capital may not be valued equally.

The CPP can be interpreted as a resource for developing the MPs' cultural capital and merging it with nation field specific cultural capital. One interpretation is that the accumulated nation field specific cultural capital (a degree from the CPP, additional knowledge and competence) together with cultural capital from previous countries also could be understood as migration-specific cultural capital (124). Developing migration-specific cultural capital, which includes nation field specific competence, and having this

acknowledged could be interpreted as increasing the agent's symbolic capital and making it possible for MPs to enter the Swedish medical field (Figure 13).

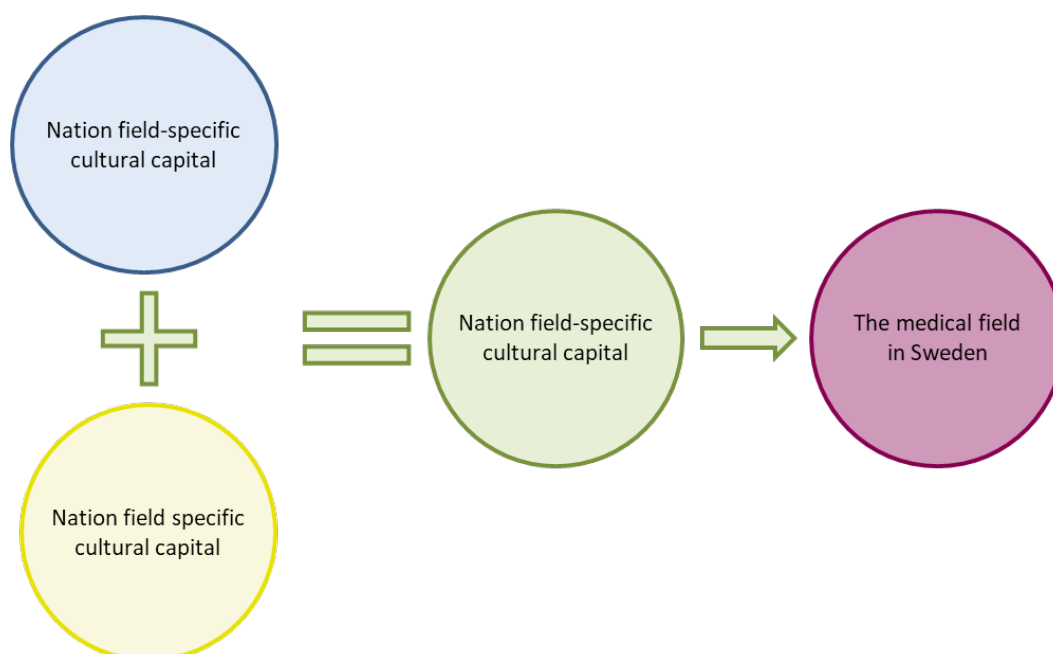


Figure 13. Interpretation of migration specific cultural capital.

8.3.2 Participation in an educational intervention/bridging programme

Via the CPP, MPs develop their cultural capital with field-specific knowledge and competence. The CPP socialises the MPs into the profession as how it is considered to be practiced within the Swedish medical field, for example, how physicians are supposed to work within the medical field, including diagnosing and which treatment methods to use, how to communicate with patients and peers, ideas of what characterises a good physician and the social codes. The nation field specific knowledge taught constitutes the medical field's discourse, or doxa, and the agents are supposed to transform their knowledge into practice, showing that they have acquired the nation field specific competence. Thus, the CPP reproduces the medical field's doxa, in which the Swedish, or Western, views are hegemonic and seen as the right way to work (cf. (153)). Thus, the development of cultural capital (knowledge and competence) should thus be towards the nation-field-specific competence, and accordingly, to the doxa. Failing to develop or submit to the knowledge acknowledged as 'right' and being unable to put the knowledge into practice within the Swedish medical field could potentially end the MP's career as a future independent physician.

Knowledge and competence can be interpreted as (cultural) capital and seen as a commodification, a product to be sold at the market (154). Before entering the labour market in Sweden, the MPs' knowledge can to some extent be seen as an ex-commodification. If the knowledge cannot be changed or streamlined, then it is better that the knowledge is not used

at all (cf. (154)). When obtaining ‘new’ knowledge or making some knowledge dominant, other knowledge is suggested to be pushed aside and marginalised (cf. (155)). One interpretation based on this is that, to avoid being marginalised in the medical field as a physician, the MP has to marginalise some knowledge. However, knowledge must not be marginalised; rather, it can be integrated. Knowledge can also be transferred—translated, twisted and tuned to fit into a new medical field (cf. (63, 156)). This knowledge transfer may be more or less difficult (cf. (63, 156)).

To submit to and reproduce a doxa is probably important in terms of becoming part of a medical field and being seen as a professional. If aware of social codes, for example, the physician can choose to blend in or not (cf. (90)). However, doxa imbues the field and is seldom questioned. In this manner, a doxa can be compared to a research field’s paradigm. With this comparison, other ways of thinking and other working methods may become anomalies that shake the paradigm, disturbing the hegemonic worldview and quietness experienced by others, who may feel their competence is being questioned. Hence, anomalies should socialise into the field, submitting to the paradigm as it is ‘right’ and the only option. Individuals who share the hegemonic view may suppress anomalies’ competence even if it could be useful in the field. However, more anomalies in a field can lead to a paradigm shift. A hegemonic view can be seen as superior; in this case, it might even be drawn back in time to imperialism and the rise of a Eurocentric worldview (cf. (31, 153)). When thinking of doxa, socialisation and professional development, one can draw parallels to the thought of history as development and implicit understanding that it represents progress (153). Society, which can be compared to an infant, is simple and primitive in the first stages, but it then develops to be more civilised and rational (153).

Regarding the medical field, there may exist an openness for other views as the field is characterised by knowledge, the development thereof and proven experience. However, the other views perhaps need to be expressed by agents that have become a part of the field and who have had their cultural capital recognised, reaching a higher position in the field. It may also be that, for the MPs, the socialisation process into the other medical field leads to reflexivity (cf. (63, 156)), in which they may more or less consciously decide that other ways are the ‘right’ ways.

To control that the MPs have acquired accurate nation-field-specific knowledge and competence, there are formalised exams during their recertification process, including the CPP and a later exam assessing the MMI. Thus, the state provides the agents with a service and at the same time controls them (cf. (122)). The MMI exam can be interpreted as a final station of control before obtaining the Swedish medical licence. Perceptions about aspects influencing the results were explored in Study III. Using Bourdieu’s concepts as a lens, it could be interpreted that the result displayed that MPs can have difficulties showing that they have developed nation field specific knowledge even if they perceive themselves to have this knowledge; this can be due to insufficient knowledge about another field specific skill—knowing how to express themselves on the exam. Thus, they need knowledge about the

language used in the country, but at the same time, they need to know the field specific language. Even more specifically, they need to know the language used in the exams to be able to show that they have acquired and possess field specific knowledge, which can be about, for example, medical conditions and treatments. Thus, an interpretation is that knowledge in the language can both be nation specific and field specific, and a physician needs both types of knowledge to prove their competence (cultural capital). Thus, there are different layers to the subject of language. The MP can use different resources to develop nation and field specific knowledge of language, which was discussed on the micro (individual) level.

8.3.3 Finding a job in the medical field and advancing within it

To enter the medical field, MPs must develop their cultural capital (education, degree and work-life experience). To enter the field, the MPs' cultural capital must also be acknowledged by employers. If an MP is judged to lack nation-specific cultural capital, this may lead to devaluation of agents' capital and discriminatory behaviour towards the agent (82). During their job-seeking processes, MPs perceived that they had their competence valued lower in comparison to domestically trained peers. One interpretation is that cultural capital acquired within the country is valued higher; thus, a domestically trained physician has more symbolic capital, something also suggested in previous research (31). MPs also perceived themselves to be met by discriminating acting.

In Study II, it was also shown that another form of capital had a role in becoming part of the medical field—social capital. When developing cultural capital, such as during the CPP or during work before the CPP, MPs could also develop their social capital, as shown in Study II. Thus, it was possible to gain more cultural capital via social capital, and vice versa. Included in this social capital was other MPs from the CPP and domestically trained peers (Study II). Thus, the interpretation is that there was a parallel development of different forms of capital when working or participating in the CPP.

A physician develops nation field specific cultural capital when working; however, the interpretation was not that the cultural capital gained in a former medical field is exchanged for the other medical field's cultural capital. Rather, a transformation of capital takes place, or an integration of different medical fields' cultural capital. It should be kept in mind that significant parts of the medical knowledge about the human body and its organs, tissues and systems are universal and not bound to national borders, thus the knowledge about human physiology and anatomy is much the same, and this knowledge is thus transnational. What may differ is how knowledge is expressed and used in practice. Thus, a physician do not only develop nation specific knowledge during a medical education or when practicing, and that is also probably why the profession can be seen as transnational (cf. (66). Development of competence further continues throughout their professional life.

Economic capital has an influence on the entrance to the medical field; as research has suggested, lacking financial resources is a barrier (46, 48, 60, 79) that may hinder the entrance if the agent gets caught in survival jobs (39, 79). However, in the studies, economic capital was not a prominent theme even though having a high salary was valued relatively high by study participants when choosing employment (Study IV). Although, the interpretation is that economic capital is less relevant; thus, it does not give much symbolic capital when being positioned in the medical field in Sweden. However, economic capital can be of importance in other fields to which the agent belongs.

8.3.4 Hierarchies in the medical field and the agents' position

Every field has hierarchies (114). The hierarchy of medical specialties has been analysed and discussed using Bourdieu's concepts as a lens (21, 114). Surgical specialties are usually seen as prestigious and perceived to have high status (21, 114). The perceived status levels of general medicine (family medicine), geriatrics and psychiatry are usually low. Further, general medicine is not a speciality in all countries. In Study IV, MPs specialising in general medicine valued their specialty lower in comparison with MPs in other medical specialties. An interpretation is that medical specialties in Sweden are hierarchically ordered, and respondents active in general medicine perceive themselves to be positioned lower than physicians in other medical specialties. As previous international research has suggested that medical specialties are ranked, with for example surgery positioned high and general medicine (family medicine) positioned lower, this may suggest that some ideas within the medical field, such as the hierarchy of medical specialties, may be transnational to some extent, and thus, not bound to national borders (cf. (114)).

Regarding the overall healthcare field, it has been suggested that healthcare workers who have a low position in the medical field have a greater tendency to be employed in PHC (114). In several countries, such as the United States, United Kingdom, Ireland and Finland, MPs are more likely to work as GPs and in PHC (67, 69, 107, 111). In Sweden, specialists in general medicine usually work as GPs in PHC, a sector that tends to suffer from staff shortages like psychiatry and geriatrics (18, 20, 21, 114, 115). In Study IV, it was shown that a majority of the study participants had specialised in general medicine, and a tendency of them filling staff shortages in a specialty and sector with less status seemed to occur. This may suggest a pattern that could be due to structural circumstances. However, in Study IV, the interpretation was that the MPs who specialised in general medicine did not do this more involuntarily than others, which can be explained by aspects presented in section 8.2.4. Some structural circumstances may be internalised and accepted, and MPs may become resigned to their position. However, others may be intrinsically motivated to specialise in general medicine from the beginning.

In Study II, the interpretation was that the group of MPs in the Swedish medical field had lower status than their domestically educated peers did, and this even if the MPs had

increased their nation specific capital and their cultural capital with participation in the CPP. Therefore, one interpretation is that MPs as a group may have a lower position in the medical field than domestically trained physicians. However, on an individual level, this may not be true since the group of MPs was diverse, and other aspects, such as gender and ethnicity, influence the individual's position in the medical field (114, 124). In Study IV, it was further shown that women were more likely to specialise in general medicine than men were, which could suggest that women may have a lower position in the medical field. Each agent's position in the field is based on different aspects, which could be understood as individual variations in intersections of gender, ethnicity and perhaps age, while the different variations frame the agents' conditions and possibilities for changing their position in the field (cf. (124)).

In Study I, it was shown that rural and remote areas were associated with healthcare centres and smaller hospitals, and urban areas were associated with larger hospitals and university hospitals with increased possibilities for, for example, competence development and specific resources related to technology, and more complicated patient cases. There may thus also exist a hierarchy related to geographic location, and this may be based on the type of healthcare facilities that are located in an area (cf. (114)). Further, rural and remote areas often suffer from staff shortages, and in some countries, MPs tend to fill these, sometimes because they have to.

Any imbalance may produce, maintain or reproduce differences in the statuses, thereby reinforcing other types of negative differences, such as devaluation of competence based on country of origin or education. Another negative consequence when labour gaps are filled by a certain group can be an imbalanced professional community, which, in the medical context, may create a segmentation in the medical field based on geographic region for medical education, geographic region for origin or gender.

Using Bourdieu's concepts as a lens, it could be suggested that the agents struggle over their positions in the medical field. When agents struggle over their positions in a field and for the agents to be able to shift position, some capital is valued highly, and therefore, important to expand, such as cultural capital. To increase social capital (network, contacts) may also be beneficial in the medical field. Different strategies used can be seen as resources for changing position in the field. Thus, an agent's position in the field is not static, but to shift position can be more or less difficult. Literarily, some study participants had struggled by working hard (Study II); a struggle that can be seen as a consequence of having cultural capital devalued, and lacking social capital (cf. (29)). To have a high position may be less important for some. Priorities in life may change, and the value of having a certain position in the field may decrease. Further, MPs have transferred from one medical field to another. Migrating is a major life event, and the reasons for it can be traumatic. To then struggle over positions in another country's medical field may not be important to everyone as there is more to life than work.

8.4 METHODOLOGICAL CONSIDERATIONS AND REFLEXIVITY

To increase the quality of any research project, some strategies can be applied during the research process and in how the process is described. For research based on qualitative methods, four aspects are important for gaining trustworthiness—credibility, dependability, transferability, confirmability and reflexivity. In quantitative research, the congruent aspects are internal validity, reliability, external validity (generalisation) and objectivity (157, 158).

Credibility refers to accuracy, that what was to be studied was indeed studied. To accomplish credibility, the researcher can include triangulation (50), describe limitations (117) and clarify the analytical process. Dependability regards the ‘extent to which findings are consistent in relation to the context in which they were generated’ (158); thus, it relates to whether another researcher could repeat the method. However, worth noticing is that the same results can never be found (117). Dependability can be reached by describing the research process and the steps taken. Transferability regards whether the findings can be transferred to other contexts and can be accomplished via, for example, descriptions of the study design (159). Confirmability refers to the researcher’s neutrality; the findings should reflect the studied phenomena and not the researcher (158). This can be reached by thick descriptions and reflexivity (159). To accomplish trustworthiness in this study, triangulation of methods and researchers were used, and the study design and the research process have been described.

8.4.1 Sample

Physicians from the CPP were chosen as a study sample because the group is limited and accessible. However, other MPs participated in route 1, and some were included in one of the studies. A study with a sample of physicians who had not been admitted to the CPP or those being in the early stages of the recertification process would perhaps have generated other results. The study participants had though once been in the early stage. Most of the study participants had been admitted to the CPP; thus, they had been assessed by a selection committee regarding their future ability to work as a physician in Sweden. The study participants may therefore have been likely to succeed in their endeavour to the Swedish medical labour market.

To contact study participants for Studies II, III and IV, email addresses were used, but some emails bounced as eligible study participants had perhaps changed their email addresses. If there was a possibility to contact them via a text message, this was done. CPP participants who did not find themselves as successful might not have wanted to participate in the study.

The study participant group was heterogeneous. The number of countries represented was about 50. They were also of different ages, with or without families, and they had migrated to Sweden for different reasons. Since the group was highly diverse, it may be difficult to draw conclusions on an individual level. However, zooming out and up to the organisational and societal levels, and adding a structural dimension, patterns of aspects that influenced the entrance to and advancement within the medical field could be identified.

8.4.2 Reflexivity

In the following, I will present some aspects that may have influenced the knowledge production of the research; this is done to be self-reflexive and critical of my own role as a researcher, the research process and the outcome (cf. (160)). Reflexivity has been identified as ‘a major strategy for quality control in qualitative research’ (161). However, I believe that reflexivity is needed regardless of method and type of data (quantitative or qualitative) used, and I do not believe that it is possible to ‘suspend our participation in the world we study’ (157). My purpose is to be transparent and upfront so that the reader can reflect critically about the results.

As I live in the world, I have presumptions about it (153, 157, 161). For example, my upbringing, where I have spent my life, the society I live in, my class, gender and age, people I have met, my educational background and acquired theoretical lenses have formed my principles, ideals and beliefs about the world. My positionality in the world has influenced my research and knowledge production in different ways (cf. (162)), from the formulation of the aim and research questions to the design of the studies, including choosing methods and scientific theories, to the interpretation and analysis of the data and the discussion of the results. My belief is that no one is objective, value-free and independent from the world (cf. (162)), and neither am I.

I stand with my feet in two research fields. One foot is standing in the medical research field, where the positivistic view of knowledge is hegemonic. My other foot stands in the field of humanities, with a constructivist and hermeneutic perspective on knowledge production. The different research fields have a different view on knowledge and how knowledge can be collected (cf. (50, 153-155, 157)); therefore, it may not be surprising that I use mixed methods. However, my humanistic foot is more firmly rooted. Thus, I have a rather reflexive approach to knowledge and look upon knowledge as contextual and constructed (50, 157), but still something empirical given the methodology it is based on.

Influencing my aim and research questions is that I am at a medical university, where the outcome of the research should have implications and lead to the improvement of health. I look at knowledge as something that should be used (cf. (154)). This includes both the knowledge gained from my research and the knowledge (competence) of the physicians. This permeates my research aim and questions. I argue that it is important that knowledge is used in the labour market (cf. (154)), and for society. Knowledge can in that sense be seen as being transformed into a commodification—a product that should come to use for political and economic reasons; otherwise, it is a waste of knowledge and the time and money spent on gaining the knowledge (cf. (154)). When not working, knowledge can be seen as an ex-commodification. I argue that knowledge should be used for the patients, and undeniably for the sake of the MPs, to increase well-being. Hence, I also perceive that it is beneficial for the individual to use their knowledge and work in their profession, and this increases the individual’s well-being.

8.4.3 Considerations about the methods used

Every method is open to problems, with different advantages and disadvantages. Advantages with a questionnaire are that a researcher can include many eligible respondents, a questionnaire disseminated via email is easy and cheap, reminders can be sent automatically only to those who have not answered, the data are easily exported to such software and analytical tools as SPSS and the analytical process is relatively short. Disadvantages are a long developing phase; the risk of including too many questions, which decreases the response rate; risk of being perceived as harassing if too many reminders are sent; and the shallowness of the data compared with the in-depth data obtained from interviews. Interviews can generate in-depth data; unexpected topics can emerge during an interview, and questions can be explained if not understood. However, the analytical process is time-consuming and study samples are relatively small compared with those involving questionnaire respondents. Both interviews and questionnaires can be individually adjusted depending on the answers. Triangulation, in the sense of using different methods (mixed methods), is advantageous. Questionnaire data and interviews may complement each other. Results from a questionnaire can be further explored in depth via interviews, while interviews can generate themes that can be further explored in a questionnaire, for example, exploring how commonly and how often something occurs. Aspects that may have influenced the data collection are presented in the following.

8.4.3.1 The relationship between the researcher and those being researched

The researcher and those being researched have characteristics (such as class, 'race', age and gender), similarities and differences that position the interviewer and the one being interviewed in a hierarchical relationship to each other and creates a power relation in between (cf. (154, 163, 164)). The power relation, and thus, characteristics, similarities and differences, influences the interview situation and the knowledge gathered. For example, class, 'race', gender and age carry 'hierarchical loadings of their own' (165). The research interview is also a social encounter that constitutes different categories and reproduces hierarchies (163). Physicians could be seen as an elite profession (cf. (166)). Conti (2007) brings up methodological issues related to interviewing an elite when it comes to power relations, such as accessing the field, authority in the interview situation and 'problems related to language, style and cultural capital', which can influence the knowledge gained (166). A researcher should be aware that there always exists a power relation between the researcher and those researched as this influences the interviews and the knowledge produced in different ways (cf. (166, 167)).

Depending on how much the researcher shares the background, belongs to the same group or has similar identities with the individual or the group being researched, the researcher can be an 'insider' or an 'outsider' (160-163). Both positions have advantages and disadvantages and may open some doors but close others (160, 162). These different positions can influence an interview (162). I did not share the study participants' backgrounds in the sense of being a physician or having migrated from one country to another. In that sense, I was not an insider.

However, we were all well-educated, even if the discipline differed. As the group was heterogeneous, some study participants probably had more similarities to me than to other study participants within the same group. To some, I was perhaps more of an insider than I was to others. I could relate to some through our similar family situation, gender, age, and/or cultural background. These aspects sometimes influenced my approach to them and perhaps their approach to me in what they told me and which follow-up questions I asked. During interviews, I sometimes brought up my non-Swedish background. This was perhaps done to create similarity to approach them (cf. (164)) and even out some gap between us, show an understanding of their situation and gain trust (cf. (162)). When they found out that I was not a physician, they sometimes explained certain issues in more to me, which probably enriched my data, and being an outsider was then advantageous (cf. (162)). My position may have varied during the same interview depending on the topics brought up; the position of being an insider or an outsider may shift during the interview, and the researcher can be both (163).

In the material, aspects related to race and ethnicity were present. My approach to race and ethnicity is much like how I look on knowledge, that this is something constructed and contextual: '[K]nowledge about "race" and ethnicity has been unstable and context specific, rather than universal and timeless', and race and ethnicity can be seen as something one becomes and belongs to rather than being born to, something dynamic (168). With a constructivist approach, an individual becomes racialised, and the racial identity is 'a product of situated conduct' (163). As in how I look upon knowledge, that ethnicity is 'constructed' is not the same being invented and untrue. On the contrary, race and ethnicity are created by people as a categorisation system that has had real dramatic and sometimes devastating consequences.

8.4.3.2 *The language used*

The language used in the interviews and in the questionnaire was Swedish. For most of the study participants, Swedish was not their mother tongue, which may have influenced the data if questions were not understood fully. In an interview, a dialect and nuances in the language can make the understanding more difficult (cf. (166)). However, the study participants had formal qualifications in Swedish and my interpretation is that they were skilled in the Swedish language. In cases where questions were misinterpreted, interviewees said, 'I do not understand' or 'What do you mean?'. I then repeated the question, tried to clarify, returned to the subject from another direction or just dropped the question to avoid causing any unpleasant feelings. Sometimes, I dropped a question when I was not able to explain it.

When a questionnaire is not administered in a respondent's language, this may affect reliability. There is a risk that questions will be interpreted in another way than intended, as in interviews. However, I had to trust their language skills due to their formal qualifications in the Swedish language and as many of them had worked in the healthcare sector previous to the CPP and as most of them, when answering the questionnaire, worked in Sweden as physicians. Because it was a questionnaire, they had the chance to read a question several times or not answer it. Before disseminating the questionnaire, the questions were discussed,

for example, with newly arrived physicians and pilot tested. The aim was to make the questionnaire language as clear and straightforward as possible.

8.4.3.3 The physical environment and the social context

The surrounding physical environment and the social context influence interview situations and the situation when a respondent answers a questionnaire. For example, during an interview, a study participant and I were interrupted by students who had booked the room we were using as the time had run out. We had to find another place and then navigate ourselves back into the interview. Also influential were others who were not in our physical surroundings but just a phone call away. Even if we were behind closed doors, people tried to contact us by phone. When respondents answered the questionnaire, they may have done this in a context where they could be interrupted or were in a hurry. However, the respondents could answer at any time and take the time needed. To what extent the physical surroundings and the social context affected the quality of the gathered data are difficult to know.

8.4.4 Exploring discrimination

One can experience oneself being discriminated against, but this does not necessarily mean that one has been discriminated as defined by law. Perceptions and experiences of discrimination are difficult and complex to explore (29), but it is still important as research suggests that perceived discrimination has effects on behaviour and well-being (96). Usually, the existence and extent of discrimination are measured by using different statistical methods (82). In qualitative research about MPs' experiences of discrimination, there are possibilities to highlight how discriminative acting from employers is expressed, for example, during job interviews and in the questions being asked (60), and how this is experienced by MPs. Questions related to perceived experiences of discrimination and aspects related to devaluation of competence was included in the questionnaire since these issues had been identified in a literature review and was brought up during interviews. Doing research about study participants who are selected based on having a medical degree from outside the EU/EEA often also have a country of origin located outside the borders of the EU/EEA which may make ethnicity and race an inevitable companion, and with this, discrimination may follow.

8.4.5 Ethical considerations

Ethical issues have been a constant companion during the research project. Ethical issues were considered on an overall level, as well as concrete and practical ones. Ethical considerations have been about technicalities and practicalities, as well as about how to navigate issues that fall outside the law's arms; where there is no right and wrong, positions must be weighed against each other and everything is a little more abstract and fuzzy. For the decisions taken, I have relied on a research ethics course, in laws and policies, and on my own, my supervisor's and my mentor's reflections and good judgement. In this chapter, precautions regarding technicalities and practicalities are presented first, followed by concerns and considerations that need more reflection.

Technical and practical precautions were considered and taken. For example, an ethical permit for the study existed, and the consent templates were sent to the legal counsel at Karolinska Institutet for review. Legal counsel was also sought about where in the questionnaire the consent should be stated. The General Data Protection Regulation has been considered (169). The data server where the collected data were stored required two steps of authorisation. This was done for the following reasons: to keep the project with the law and protect the study participants, the research project and the researcher (thus myself).

Some ethical considerations fell outside technicalities and practicalities. Laws may provide some guidance, but this is not complete. Sometimes, there is no right or wrong. Instead, there are different positions that must be weighed against each other as things can be fuzzy and abstract, with neither sharp edges nor form, like clouds. Some ethical considerations have hovered like dark clouds in the sky—visible, but without being able to be touched. Even within the cloud, it would be difficult to grasp it. If it were a rainy cloud, the drops would fall on the study participants, on me, on the research project and on KI. Some considerations were about how to balance different interests. Were there questions that should not have been asked since they might be uncomfortable, could be used politically or could pinpoint a group? If questions are not asked, there can be no answers, they cannot do any harm and eyes can be kept close. On the other hand, they cannot do any good either. In this vein, I came to think of an old motive in Japanese art in the beginning of my doctoral studies—three monkeys next to each other, one covering its eyes, one its ears and the third its mouth. It illustrates the saying, ‘see no evil, hear no evil and speak no evil’. I related this to my project, and I was the monkey.



The group of study participants is an identifiable cohort on an overall level. They have participated in a government-financed educational intervention in state universities falling under the laws of public access. A specific group within the group, for example, women, men, people of a certain age or individuals from a specific country of origin, could be identified if some investigations were chosen. Results could be used to include groups, as well as to exclude and judge groups on an overall level, without considering individual

variations. For example, results could reveal that men of a certain age had lower pass rates on the MMI test, which could potentially lead to increased difficulties in receiving an MMI position, or alternatively, more support. To minimise exposure of individuals, the quantitative data were categorised, for example, in terms of geographical world regions instead of countries, and instead of year of birth, longer periods were used. Any statistical analyses were performed and presented anonymously on an aggregated level. The qualitative data and presentation, such as quotations, were also anonymised so they would not be traceable to an individual.

The study participants were selected based on having a medical degree from outside the EU/EEA. When I did research on them, they were separated from domestically educated peers based on where they had acquired their medical degrees. Thus, they were singled out, and a line was drawn between them and other physicians. Hence, I contributed to a reproduction of MPs as a separate group within the medical profession, perhaps also as a group with specific challenges. The study participants were labelled 'MPs'. This labelling might produce or reproduce differences within the medical workforce group, which in theory ought to be considered as a united and equal group. Any consequences of categorisations should be reflected on (168). Reproducing an existing categorisation may be stigmatising on a group level and on an individual level, for example, when meeting peers and patients. When there is a categorisation of 'the other', there is also an opposing categorisation of the norm that 'the other' is compared against. Here, the norm becomes the physicians educated in Sweden. Thus, it must be kept in mind that 'the other' is a discursive intervention that does not exist ontologically (144). However, since physicians with a medical degree from outside the EU/EEA have other conditions when entering the medical labour market, the judgement was that it was important to conduct research based on this categorisation, but at the same time, be critically aware that pinpointing a group as different may also produce and reproduce a group as 'the others' (cf. (153, 168)).

In the literature, MPs are often treated as a homogeneous group even if the group is heterogeneous. One way to dissolve 'the others' and the homogeneous approach is to consider the group just as heterogeneous as it actually is. For me, and even if I might have clumped the MPs together in the first stage, it was always important to see the group as diverse and acknowledge the heterogeneity when possible. The study participants were of different ages, had been born and raised in different countries and had migrated to Sweden for various reasons; moreover, both men and women were included. Some had families and others did not. Some similarities they shared were having a medical degree from outside the EU/EEA, having applied and been admitted to the complementary programme and volunteering for this study.

9 CONCLUSION

Most of the respondents that have participated in the CPP had established themselves in the medical labour market and then also advanced within it. During the CPP, the participants developed competence, they had possibilities to prove their competence and many developed contacts that were beneficial for establishment.

Age was an important predictor for failing on the first attempt on the MMI exam, but the CPP seemed to counteract failing on the MMI exam for CPP participants aged 45 years or over.

MPs may face barriers and limiting circumstances that slows down their entrance to the labour market and then for advancing within it. However, the MPs used strategies and resources that were perceived as facilitative in order to receive work and to speed up the licencing process. Barriers/limiting circumstances and facilitating aspects were often two sides of the same proverbial coin. Thus, if the language was perceived as a barrier, then to have sufficient language skills was a facilitating aspect and to develop the language was a strategy, and for developing the language, different resources were used.

Most study participants had specialised in general medicine, and women were more likely to specialise in general medicine than men were.

The social context and environment (including other individuals), influenced the study participants' choices regarding where to work and in which specialty. Aspects relating to work life and private life together collaborated to influence motivation and choices.

To decrease the time to establishment, pursuing the Swedish medical licence and a specialty training position is probably easier if one chooses an underserved area (as in a geographical location, sector or specialty). However, whether this is a good strategy is another matter. In some countries, MPs are assigned to fill staff shortages in some geographical areas (103). However, to force any physician to work in an area is not a sustainable solution; following SDT, this may have a negative effect on well-being (cf. (103)). These might also create inequality in the workforce.

The macro, meso and micro levels interacts and meet in the Swedish medical field. Conditions at the macro and meso levels shapes barriers and facilitating aspects. At an individual level, MPs are thus surrounded by factors that are shaped at levels that lies beyond their control. At the same time, they are agents with the ability to change, to some extent, the facilitating and impeding aspects that condition their entrance to and advancement within the medical field and the working life in Sweden. They can change their conditions by, for example, participating in a course, choose a specialisation where there is staff shortages or improve their Swedish language skills. By doing this, they can sell their skills in a way that lands better within the Swedish context. Both facilitating aspects and barriers can be understood as conditioning their path into and advancement in working life, this since the aspects that are beneficial cannot be opted out of; If they want a job, they must 'use' facilitative strategies and resources to overcome the barriers.

9.1 IMPLICATIONS FOR FURTHER RESEARCH

Further investigation about the association between failure rate, age and CPP would provide in-depth information about reasons for failing and in what ways the CPP counteracts this effect. Most of the specialist respondents had specialised in general medicine; thus, they were working in a specialty where communicating with patients are important elements. At the same time, language is one difference between contexts, and in research a common mentioned barrier for MPs when practising in a destination country. What long-term consequences this has for patient safety and the MPs' opportunities to practice their profession to the full should be studied further, perhaps including patients with different backgrounds. Studies can further explore how knowledge and competence of specialist MPs who had changed specialty could be utilised and the possibilities to enrich general medicine and the PHC with additional expertise and knowledge. Also explored may be how this enrichment can relieve other specialist areas, even if only to a small scale. With the enrichment, the specialty will perhaps also develop if this is not already the case, into further ramifications based on various special skills. Future empirical studies could explore implications on specialty choice if living in rural and remote areas or in urban areas and where they want to be situated because some specialties are limited to larger hospitals that usually are located in larger cities. This could also be compared with domestically trained peers.

9.2 IMPLICATIONS FOR PRACTICE

The information about a recertification process must be standardised, thorough and clear. To design educational interventions and make them work, individual and organisational factors need to be considered, as well as the interaction of these factors. Interventions may to some extent need to be targeted to suit the individuals who have different experiences.

Interventions may involve a supportive learning environment, offering support from peers and supervisors both during the intervention and when it has ended. Interventions aimed at supporting MPs in their recertification process and future careers may include how to write job applications, peer mentors that have been through the same process and peer mentors with a medical degree from Sweden. A healthcare facility and/or a geographical area that wants to attract physicians may involve peers to create positive experiences and invest in opportunities and resources for competence development. Both work life and private life although matter when choosing where to work. Regarding private life, aspects that attract probably differ on the individual level. To have the possibility to socialise with others can be important. Targeting physicians might be a strategy, but to target specifically MPs may create an imbalance in the medical field.

10 SAMMANFATTNING PÅ SVENSKA

Läkare som är utbildade utanför EU/EES kan i Sverige påbörja en process för att få svensk läkarlegitimation. Detta för att så småningom självständigt kunna fortsätta utöva sin profession även i Sverige. Dock kan vägen till den svenska läkarlegitimationen och arbetsmarknaden vara lång och kantad av hinder och upplevda svårigheter, så kan även vara fallet när det gäller fortsatt avancemang.

Syftet med denna avhandling var att undersöka läkarnas etablering och avancemang på den svenska arbetsmarknaden, med fokus på hinder och möjliggörande aspekter.

Studien innehåller fyra delstudier. Både kvalitativa och kvantitativa metoder användes, i två av delstudierna kombinerades metoderna. Studiedeltagare var främst läkare som hade anmält sig till en kompletterande utbildning för läkare med läkarexamen utanför EU/EES och Schweiz. I en av delstudierna ingick även ytterligare läkare med läkarexamen utanför EU/EES och Schweiz. Studie I inkluderade semi-strukturerade intervjuer med 24 läkare. Studie II var en tvärsnittsstudie som inkluderade enkätdata från 283 respondenter. Studie III inkluderade provdata från läkare med en medicinsk examen utanför EU/EES som deltog i AT-provet 2013–2019 (n = 564) samt semi-strukturerade intervjuer med 14 läkare. Studie IV inkluderade enkätdata från 101 respondenter samt fyra semistrukturerade intervjuer. Intervjuerna transkriberades. Innehållet i intervjutranskriptionerna och fritextsvar i enkäten analyserades tematiskt. Kvantitativ data analyserades deskriptivt i Studie II och IV, för Studie IV genomfördes även inferentiella statistiska analyser. För att analysera kvantitativ data för Studie III användes linjär och logistisk regressionsanalys. För att förstå och diskutera hur läkarna etablerar sig på och avancerar inom den medicinska arbetsmarknaden i Sverige användes ett ramverk baserat på Bourdieus teorier rörande socialt fält, symboliskt kapital och doxa. Som ett komplement användes Self-determination theory.

Inom ramen för Studie I identifierades flera föreställningar om att arbeta som läkare på landsbygden i Sverige. De identifierade temana berörde dels att hitta arbete och arbetets innehåll och uppgifter, men också föreställningar om hur det är att bo på landsbygden. Föreställningar om att arbeta i en viss typ av område gav således upphov även till uppfattningar om hur det skulle vara att bo i samma område. Föreställningarna grundade sig på egna och andras erfarenheter. Föreställningarna verkade påverka studiedeltagarnas motivation positivt eller negativt när det gällde att arbeta på landsbygden.

Studie II visade att 88 % av respondenterna hade en läkartjänst, när de besvarade enkäten. De var dock i olika skeden i karriären vilket kan bero på att de började den kompletterande utbildningen vid olika tidpunkter. Respondenterna hade främst hittat sitt första jobb efter utbildningen via spontana jobbansökningar, under utbildningens praktikplatser, via vänner eller via andra utbildningsdeltagare. Hinder, underlättande aspekter och använda strategier för att öka möjligheterna till en effektiv etablering och avancemang undersöktes: Några respondenter indikerade att de hade upplevt diskriminering och devalvering av sin kompetens. För att öka arbetsutsikterna hade respondenterna till exempel arbetat som

vårdbiträden eller läkarassistenter innan den kompletterande utbildningen. Med hjälp av olika resurser hade respondenterna utvecklat sina svenska språkkunskaper. Respondenter hade också flyttat för att få en tjänst eller bytt medicinsk specialitet.

Studie III visade att ålder var en prediktor för att lyckas på AT-provet, där äldre provdeltagare misslyckades på första försöket i högre grad än yngre provdeltagare. Den kompletterande utbildningen tycktes dock minska den negativa ålderseffekten för deltagare som var 45 år eller äldre. I det kvalitativa materialet identifierades aspekter som upplevdes påverka resultatet på provet, dessa relaterade till temana förberedelser och biografiska aspekter samt till själva tentamen och tentamenssituationen.

I Studie IV undersöktes aspekter som påverkade valet av tjänst och specialitet. De viktigaste aspekterna för val av tjänst relaterade till att kunna kombinera arbete med familj samt möjligheter att utveckla kompetenser. Majoriteten av respondenterna hade specialiserat sig inom allmänmedicin. Kvinnor var mer benägna att specialisera sig i allmänmedicin än män. Intervjupersonernas val att specialisera sig i allmänmedicin relaterade till jobbmöjligheter, positiva erfarenheter, arbetsförhållanden och familjevillkor.

Hinder och begränsande omständigheter som kan härledas till makro- och mesonivåerna kan få konsekvenser på mikronivå, alltså för individen. Läkarna har dock fortfarande handlingsutrymme. De kan påverka sina vägar till arbetsmarknaden och sitt fortsatta avancemang genom underlättande aspekter och genom att använda sig av vissa strategier. Många av de hinder och underlättande aspekter som identifierades i studien korresponderade. När det gällde studiedeltagarnas motivation och val rörande exempelvis vart någonstans de ville arbeta och inom vilken specialitet hade den sociala kontexten och miljön påverkan. Aspekter som relaterade både till arbetslivet och privatlivet interagerade när det gällde deras motivation, vilja och val. Utifrån det teoretiska ramverket som användes för att diskutera studieresultaten kan det tolkas som att denna läkargrupp som helhet är hierarkiskt lägre positionerade inom det svenska medicinska fältet i jämförelse med läkare som är utbildade i Sverige, men på individnivå kan det dock finnas variationer i positioneringen eftersom den undersökta läkargruppen är heterogen när det gäller ålder, kön, etnicitet, födelse-land, uppväxtland och land för läkarexamen.

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