

CULTURAL DEMANDS ON SKILLED IMMIGRANTS, A DEVALUATION OF HUMAN CAPITAL

The case of immigrant physicians in Sweden

Abstract

The difficulties immigrant doctors encounter can be considered as an impediment to accessing skilful work, and are thus an indication of ethnic bias. Therefore the term “devaluation of human capital” is here used to analyze one case where schooling and/or licensure from other countries are less recognized. This study focuses on the case of immigrant doctors in Sweden and their difficulties in achieving similar status positions there as their Swedish counterparts. The study is based on a qualitative study of the Swedish medical journal over time and the aim was to broaden the understanding about how the skills of immigrant doctors are described in this context. Results show that, immigrant doctors in Sweden are constructed as assets when their language-skills are helpful in relation with immigrant patients. In this case the human capital of immigrant doctors is not devaluated, but often they are also considered as a threat to the ‘trustworthiness’ of the profession of doctors. *Cultural authorization* is a concept presented in this article that can help describing a profession’s way of re-evaluating immigrant professionals.

Keywords

Skilled immigration • social capital • physicians • devaluation • professional change

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1 Introduction

Physicians who have immigrated to Sweden are referred to as skilled immigrants, a term which designates immigrants who have either high education levels or specialized work experience from their home country. Physicians are one such skilled group and hence an important asset for welfare states such as Sweden. Following Bourdieu’s discussion on social and cultural capital (Bourdieu 1985), one could argue that high education and/or specialized work experience would increase an immigrant’s employability. But when reviewing the literature on migration research (i.e. Esses et al. 2003; Reitz 2007) we can see that immigrant’s qualifications are often devaluated. Reitz (2007) calls this phenomenon a *devaluation of human capital* and argues that it applies not only to skilled immigrants’ educational qualification, but also to their work experience. In an empirical study of skilled immigrants in Canada, Van Ngo & Este (2006) show that obtaining appropriate employment in one’s field is difficult, with a success rate ranging between 19 and 40 %. This article will examine and analyse if the Swedish context is also characterized by a process of devaluation, focusing on the case of immigrant physicians.

How an immigrants’ education level is considered in the Swedish context is a central theme here, but we also consider to what degree

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skilled immigrants are considered ‘real’ professionals. Sweetman (2004) states that a foreign-acquired education is almost always considered being of a lower quality than native-acquired. As shown by Van Ngo & Este (2006), immigrants with university degrees earn significantly less than their native-born counterparts. They also emphasize that female immigrants with advanced degrees show an additional earning disadvantage. As shown in international studies about migrant health care professionals (i.e. Bach 2007; Iredal 2001; Yeates 2004) there seems to be a similar devaluation of human capital in the case of physicians, but the Nordic context has not yet been studied to a sufficient extent. Therefore, this article will focus on the Swedish case in order to contribute to the understanding of skilled migration to these countries.

Our analysis of devaluation of skilled immigrants in the framework of human capital should not be understood as a hypothesis but rather as a point of departure. The aim is to explore and analyse perceptions of immigrant physicians through the lens of devaluation of human capital by exploring a sample of texts published in the *Swedish Journal of Medicine*¹ (SJM). The empirical case was chosen since this journal is one of many forums where physicians themselves specifically discuss the immigrant physicians as a group.

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1.1 The Swedish case: regulatory and legislative framework

In Sweden (as in most Nordic countries) county councils are responsible for the provision of health care services to the people, and overall recruitment of human health resources. One strategy used to fill the vacant physician positions has been to recruit from outside Swedish borders. Two regulatory domains intertwine: (1) immigration legislation and (2) professional regulations. In most cases immigrant physicians came to Sweden either as refugees/asylum seekers, or as labour immigrants. Yet non-European physicians are seldom considered labour immigrants. It was not until 2008 that physicians from outside the European Economic Area (EEA) could get a work permit. Therefore, most immigrant physicians in Sweden have come to Sweden as refugees or as labour migrants but then mostly from another European country. This divides the immigrant physician group in two groups: (1) the ones who come to Sweden from another European Union (EU) country and who receive a somewhat 'automatic' recognition of their license as stipulated in the 1993² physician act, and (2) the ones from outside the EU. Those in the second group have to pass written and oral medical exams in basic clinical subjects and a course on Swedish medical legislation before they can even apply for a Swedish Medical licence. This process can take up to 10 years and suggests that even though all physicians need to apply for a Swedish Medical license, the system values human capital on the basis of a physician's country of origin. Nevertheless, the number of Swedish medical license applicants from outside the EU is increasing³.

1.2 Theoretical perceptions on social and cultural capital

Reitz (2007), among others, reports that the market value of immigrant qualifications is less than the market value of native-born (see also Fernandez-Kelly 1995). This can be described as 'human capital devaluation' and, as expressed by this author, the returns of human capital are less for immigrants. He argues that it is problematic not to notice a segmentation of the labour market, and that the segmentation should be understood in the context of intersectional inequalities related to class, sex and/or ethnicity. There is another segmentation dimension for immigrant physicians if they were trained in another EU country. This is somehow connected to Reitz's (2007) argument that segmentation of the labour market is connected to intersectional inequalities, but it is not necessarily the same thing. It places the immigrant physicians into a hierarchy where human capital devaluation is not equally distributed within a group belonging to the same profession.

According to the human capital perspective, professional qualifications should be sufficient for labour market integration, but in the case of immigrant physicians in Sweden this seems not to be the case. Human capital appears to be valued differently depending on where the physician comes from. In other words, ethnic factors seem to have an impact in the qualification process of becoming a physician in Sweden. In this context the term *cultural capital* is useful. As defined by Bourdieu & Passeron (1979) the concept aids in the analysis of cultural impact, especially on social classes. It refers primarily to the role played by the educational system with its ability to reproduce power and symbolic relationships between classes. As commented on by Lamont & Lareua (1988), cultural capital implies informal academic standards, which are also a basis for exclusion

from jobs, resources and high status groups. Or, as expressed by Van Ngo & Este (2006), another kind of human capital can be suggested that goes beyond educational investment or work experience. This human capital is somehow ethnocentric as it differs only on the basis of whether a physician immigrated or not. If human capital can be devaluated through migration we will need to analyse the case of immigrant physicians empirically.

It is important to note that the process of devaluation of human capital could also be seen as a type of *peripherization* (i.e. Shin & Chang 1988) leading to a segmented profession. According to Shuval (2000) people with immigrant backgrounds need to establish a sense of belonging in the new country, where the professional component is a crucial element. She suggests *five types of social functions of licensing* which are, 1) quality maintenance, 2) quantity control, 3) allocation of personnel, 4) expression of social values and 5) maintenance of professional elitism. In the context of this article the social function of licensing also have consequences related to physicians for whom it take several years to attain a license as they miss out on the social benefits of that same function. One could say that the profession controls the socialization of physicians through licensing, and the longer it takes to get it, the more difficult it is to become socialized within the profession. Licensing can then be seen as a means to maintain an elitist and monopolistic position compared to other professional groups but also within a certain profession, as human capital depends on the country in which professionals got their training (see also Ooka & Wellman 2006).

To that point, Shuval also comments (1985), "*Medicine is characterized by a long-standing tradition of elitism but its credibility requires periodic, visible mechanisms of reinforcement so that reference groups are strengthened in their belief that this tradition persists and is actively viable. Immigrant physicians requesting licensure may be perceived as a threat to quality practice; like an exclusive club, the medical profession uses licensing as a gate-keeping mechanism to control entry*".

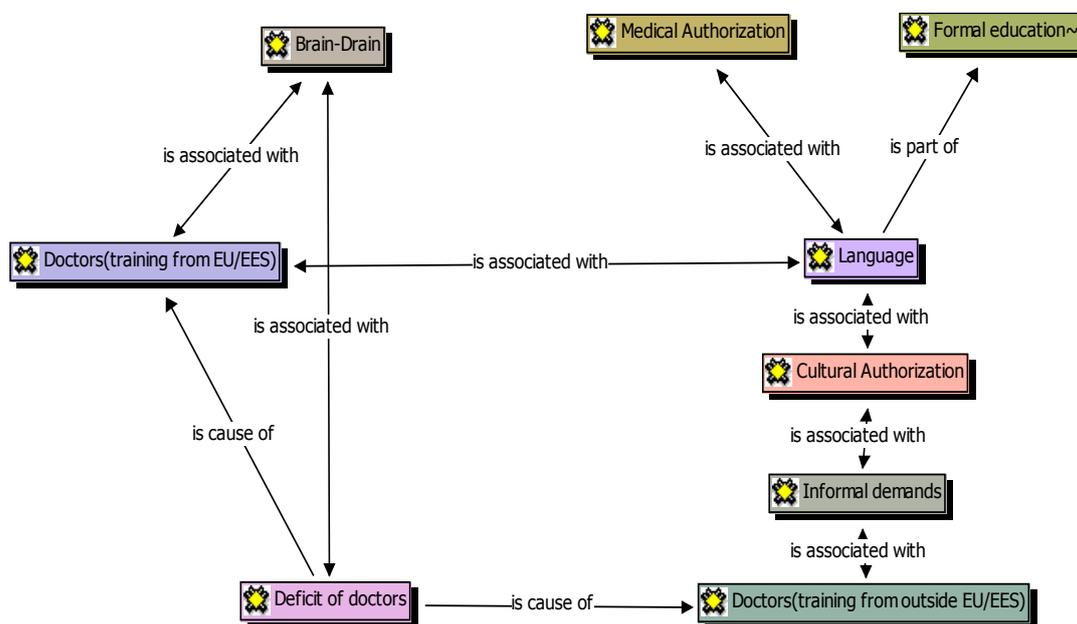
In this article we have chosen to explore how these gate-keeping mechanisms are connected to devaluation of human and cultural capital. We have done so by studying the perception of immigrant physician as expressed and transmitted by *Swedish Journal of Medicine* (SJM).

2 Method

The texts analysed were selected from SJM published online in Sweden between the years 1997 and 2010. SJM is the Swedish medical association's membership journal and its main readers are physicians with membership in the Swedish Medical Association. Therefore, it is an important forum when studying the perception of immigrant physicians from the profession's point of view.

1997 was chosen as the starting point because it was the period when the Swedish Medical Association started the debate on the lack of physicians in Sweden. A discussion then followed on issues surrounding immigrant physicians as a possible solution to that 'deficit'. The texts that have been analysed concern immigrant physicians as 1) a resource to handle, 2) as a moral issue to be considered, or 3) as a solution to the shortage of physicians in Sweden.

The selection of articles for analysis was done in two steps. The first selection contained all articles that included the words: 'immigrant', 'doctor', 'physician', 'foreign' and combinations of those words. The second step selected only articles where the discussion of physicians with immigrant backgrounds related to their role



Model 1: Preliminary network: Social constructions of “immigrant doctors” in professional health journalistic text.

as health care providers. This process insured that articles which covered health issues in the immigrant population were excluded from the study.

This study applies a Grounded Theory (Bryant & Charmaz 2007; Charmaz 2006) methodological approach. According to Charmaz, a researcher can never approach an area of research without some ideas of what it is he or she will look for. Researchers always have some micro-theory when approaching our empirical case. This does not mean that we had any kind of hypothesis to test as we started the analysis process. Instead we used our core concepts to define what we wanted to study and allowed other themes to emerge from the data. The texts are to be viewed as qualitative data used as a source of information to generate a theory about how the perception of human and cultural capital of immigrant physicians are constructed in the Swedish Medical Journal. As defined by Suddaby (2006), Grounded Theory is neither a deductive nor an inductive process, but an interpretative process. The focus should depend on the researcher’s interpretative analysis of the data, not on the testing of a hypothesis against the data (Lindgren 2011). He argues that the researcher collects data and analyses it in order to see patterns that suggest theoretical concepts and relations between them. It is not only the concept in itself but the relation between the codes that is important for a theoretical understanding. In this context, the texts were studied systematically in order to detect patterns on a textual level. Emergence is a central dimension in Grounded Theory. Through its use we will construct a theory about the perception of human and cultural capital in the case of immigrant physicians in Sweden through understanding what is happening in the selected texts.

Another key dimension in Grounded Theory is coding, which means the identification of social processes in the data (Mella 2007), categorizing them with the aim of formulating a theory. All texts were coded in Atlas.Ti into more abstract categories. The codes were created by asking questions of the texts about structural, cultural and interactional characteristics. Through this process a theoretical context began to emerge.

This process of coding is the segmentation of the text in quotations and codes, based on analytical needs in order to understand the meaning that the texts have in latent forms, but the whole ought to be reconstructed, something that it is made by creating networks. In the selective/axial phase of working with Grounded Theory, relations between codes were established, creating temporary theories (networks) composed by codes and relations between codes (model 1). It is important to understand how textual descriptions are articulated as this is one social premise that immigrant physicians are facing in their professional re-establishment process.

3 Results and analysis

A network composed by codes and relations are first presented. The codes have emerged from the analyzed texts through asking questions such as: “What is happening in the texts?” Meaning is deconstructed into more theoretically informed codes that can then be related to other codes.

The network above consists of some key codes that connected to other related codes in the analysis where the relations between the codes are in focus. As expressed earlier, when working with Grounded Theory and Atlas.Ti the most important analytical task of the researcher is to establish relationships between categories in order to generate a theory. These relationships are grounded in preliminary theoretical assumptions that permit identification of structural, cultural and interactional dimensions in the texts. The assumptions become more specific according as the research process progresses. Central to the preliminary assumptions is the notion of human capital devaluation and segmentation of the skilled migration labour market (Goldstein & Horowitz 1977; Reitz 2007; Shuval 2000).

The network reveals that there are discursive differences in the text depending on an immigrant physician’s place of origin. Perceptions about physicians that have immigrated from the EU/EEA-countries are closer related to categories with economical

connotations (categories: Brain-Drain and Deficit of Doctors). The code Brain-Drain is also related to ethical dilemmas with that type of recruitment:

It is to give away the responsibility and it is highly immoral to let other countries take that responsibility for the provision of human resources to Swedish health care; Denmark, Poland and Hungary are at the top among the countries where Swedes go to educate themselves to become doctors.

Many doctors come from Poland, Greece (and Iraq) but there is also a global shortage of doctors and many move from poorer to richer countries.

The category *Brain-Drain* also shows the criticism that has been highlighted in the debate over colonial power structures that still exist where rich countries dominate. Worth noticing is that the Brain-Drain category, surprisingly, was not strongly related to physicians from outside the EU/EEA. *Brain-Drain* in other areas of research is often talked about in reference to high skilled migration from low income countries to high income countries, mostly from African and Southeast Asian countries to the US or Europe. In the case of this study the Brain-Drain is only presented in the European context.

Doctors immigrating from outside the EU/EEA-countries are more closely related to codes about formal and informal educational demands, language, medical and cultural authorization. The code *Informal Demands* consists of constructions about what latent difficulties an immigrant physician might have when working in Sweden, such as differences in customs, humour, and informal communication (in coffee breaks and other type of behaviour patterns that are not formally regulated but are present in these texts). Informal demand and cultural markers in the text often occur when language is discussed. It is statements such as: "...their formal ways make them come about as harsh". Here, there is a silence in respect to the effects that can be seen as informal demand on the physicians to become "less harsh" and therefore more 'Swedish'.

Language, as a code, refers to texts where language as an issue itself is brought up. The code is textually important and analytically interesting. It connects the codes relating to economical and ethical aspects of immigrant physicians from EU/EEA countries to the codes relating to cultural, informal and educational demands that are closer related to doctors from outside the EU/EEA. Language is discussed in different contexts, sometimes as a problem with Swedish-speaking patients and colleagues, and sometimes as an asset in understanding Sweden's immigrant population. The need for both Swedish and other languages is important for both doctors immigrating from both inside and outside the EU/EEA. Medical Authorization is a code related to texts where different aspects of the authorization process are covered. It is related to more cultural aspects of the authorization process that are constructing the key code: Cultural Authorization.

Cultural authorization is a category based on coded texts that ascribes physicians with training outside Sweden in general, and more specifically outside the EU/EEA, with certain cultural markers. These markers have to do both with ideas about what is or is not Swedish culture is or is not Swedish *health care* culture. As shown in the network, the category is closely related to the subcategory *Informal demand* and to *Language*. On the other hand, *Medical Authorization* and *Formal education* are both related to the logical demand for proficiency in Swedish for physicians from outside the

EU/EEA. They need to demonstrate a command of the Swedish language before having their medical competence assessed. The code *Doctors from EU/EEA* is also related to the core category but not as close which can say something about the difference within the group of immigrant physicians and their relation to the profession.

The category *cultural authorization* consists of codes that in one way or the other have to do with the cultural connotations found in the text. The category evolved through quotations where immigrant doctors were constructed as having different cultures, as needing training in Swedish health care culture and as having a type of culture that differs from the patients. It does not only construct the idea of the immigrant doctors but it also constructs the patient in a normative way, which will be shown in the quotes below. This relates to ideas about what is 'the Swedish mentality' (Daun 1996) of doing things and what is different from that. It is a type of stigmatization process from the professional system towards the group of doctors with immigrant background in general and doctors from outside the EU/EEA in particular. Immigrant background seems to be connected to a perceived need for them to learn the type of cultural capital which doctors trained in Sweden are assume have innate. This may indicate that doctors with immigrant background not only need a medical authorization but also a more informal cultural authorization in order to become 'Swedish doctors'.

Here, we follow some code examples from the category *cultural authorization*:

Cultural differences and lack of knowledge about what is important in Sweden lead to that it can take several years before they pass the test.

Cultural differences are often constructed as static and difficult to overcome. Mattsson (2001), among others, have shown similar examples in the Swedish labour market context. She argues that this way of constructing immigrants, as lacking culturally specific skills, should be understood as a form of economic racism since it expresses culturally racist ideas, which legitimizes ethnic hierarchies in the labour market and the economy. The differences are also constructed as a causal reason for the time it takes for the doctor to get Swedish medical authorization. Differences between the health system culture and the culture of the individual doctors are constructed in a discriminatory way, in line with devaluation of the human capital of skilled immigrant doctors. They are perceived as lacking knowledge and which is then used to justify why doctors outside the EU do not get their Swedish medical license. The culture of the Swedish health system is seen as the norm, and an individual's lack of that cultural knowledge is construed as part of the reason for not passing the cultural 'initiation ritual' of the system. A similar description can be analyzed in the next example:

In addition to take a supplementary examination on their medical knowledge, they get to learn about Swedish health care culture, what rules and laws apply and how the health care sector work.

In both examples the discussion is about how the Swedish medical system is constructed as well as what immigrant doctors need to learn in order to be assimilated into the system's culture. The immigrant doctors are constructed as objects that are to be taught the "Swedish" culture in order to *become* a part of the health system. The citations above also show that "Swedish" cultural characteristics are assumed to be difficult to understand. Culture is here described as standing in the way of the structure of the authorization process,

as expressed in the quotation below. Surprisingly, cultural differences are also talked about as a positive factor as seen in the quotations below:

These doctors (immigrant background) take their time to talk with the patient and create a bridge between immigrants with the same background and Swedish health care.

When looking at the 'other' as the care-taker, it seems as if their caring characteristics are emphasized as well as their mediating role toward the immigrant patients. It becomes an ideal type (introduced by Weber) of where "the other" doctor takes care of "the other" and "we" takes care of "us". In the example above the immigrant doctors are described as a care-giver with special skills in caring and communication with patients with immigrant background. Lukkarinen-Kvist (2001) showed that perceptions about the 'others' caregivers in a primary health facility had the results that patients with immigrant background were assumed to be more demanding and unable to be on time. In the material of this study "the other" doctor as a caregiver is present but it also constructs "the other" patient as in need of special 'caring' treatment. In the example above 'the other' as a care-giver is given a positive connotation but is also assumed to be the solution to the immigrant as a care-taker.

They add a way of thinking that leads to a positive development, they question the efficiency of Swedish health care and public sector.

The use of definite modality (e.g., these doctors 'take their time', 'they add a way of thinking,' 'these doctors are a bridge') constructs the idea of the speaker as being sure of the truth in these statements. In this case it is the acting subject (a representative of the norm), who is speaking about the passive object (the immigrant doctor), and this direct modality shows the constructed power relationship between the two. In the example above the 'adding' is positive for the system but it still constructs a difference between the system as a norm, and doctors with immigrant background as something else.

Foreign doctors express themselves in shorter and more direct sentences and can therefore be taken for being harsh.

In this example 'the other' is constructed as being different from the norm as they are assumed to be more frank and is once again a way of constructing immigrants doctors as 'the other'.

Cultural Authorization: Some theoretical statements about devaluation of human capital in the case of immigrant doctors in Sweden.

The key code: 'Cultural Authorization' shows, through the examples above, that the cultural aspect of the medical authorization process in Sweden is perceived as a type of capital that differs between doctors depending on their place of origin. We see this as an example of what Mattsson (2001) calls 'racialized' assumptions about culture, nation and skills,' which she claims 'reproduces a spatial hierarchy of (dis)similarity'. Along with Mattsson (2001) the theory in this article indicates similar assumptions to what she has found in other part of the labour market, i.e. that non-western immigrants (in this case non-western immigrant doctors) have a self-evident place at the bottom of labour market hierarchies. The constructed need of 'cultural authorization' is seen to be of more importance when addressing doctors immigrating from outside the EU/EEA than when addressing doctors from other EU/EEA-countries

where economic perceptions are more central. Cultural Authorization can therefore be defined as the cultural demand applied from the profession on doctors from outside the EU/EEA, which is connected to a devaluation process of human capital. Even if this theoretical suggestion is highly contextual, it might be used to study the same group, and how they are perceived, in other Nordic contexts or other skilled immigrant groups. Cultural Authorization is not only a theoretical proposal of what skilled migrants are assumed to need in the case of doctors, but also show the differences within the group of immigrating doctors. Those from outside the EU/EEA not only have different structural premises than doctors from other EU-countries, but also symbolic ones as shown above.

This segmentation within the profession is summed up clearly in the quote below:

Sure, there are problems with doctors that do not work hard enough, but that is the case with Swedish doctors too. Many of my colleagues are born in and/or grew up in other countries. Some of them had 15 years of experience before they came to Sweden. They had to take the long way, while newly examined doctors from Spain or Poland only need to ask the national board of health and welfare for a Swedish license and they get to start working the next day.

As articulated above and in our theoretical considerations, there are structural differences in possibilities to become a doctor in Sweden for immigrant physicians on the basis on their origin, but Cultural Authorization can also be seen as an implied, 'acquired' way of understanding culture (Robbins 2005). This acquired culture might also be considered as being ethnocentric, when the immigrant physician is constructed in a dichotomy relationship to the normative "Swedish" physician.

Adding an ethnocentric character to cultural capital, implies a theoretical way of approaching different cultural markers that was found in the data, and at the same time to get further understanding of the concept of Cultural Authorization. It is supposed to emphasize the textual descriptions that mark the differences between doctors with Swedish background and doctors with immigrant background'.

This type of capital, as shown earlier, is constructed as being negative in certain situations but positive in others. In the relation to the patient, the doctor's Swedish language skills is seen as a problem, but in relation to the doctor's colleagues, immigrant doctors are seen as being a solution to his or her colleagues' difficulties in understanding the "culture" of patients with an immigrant background. This reshapes the idea that the immigrant doctor is best suited to take care of the immigrant patients, while the Swedish-born doctors are best suited to take care of the Swedish-born patients.

This discursive dimension might lead to a segmentation of the professional on the basis of whether you essentially *are* a doctor in Sweden or in the process of *becoming* one. The ethnocentric cultural capital marks the differences between what is 'acquired' (using Robbins' terminology) in the construction of a 'we' and what is constructed as 'natural' in the construction of 'the other'. Davies (2003) states that this should be understood as dressed up in gendered and ethnocentric discourses rooted in the core definition of professionalism connected to a larger social and political context.

The theoretical suggestion in this article, 'Cultural Authorization,' can therefore be a useful concept when explaining the tension between professional inclusion and ethnocentrism. The constructed ethnocentric differences within the professional system that divide the medical profession into a 'we' and a 'them' can, in Davies' way

of looking at it, be understood as a part of the reshaping of the foundation of the medical profession in Sweden in order to cope with the changes in the society as a whole.

4 Conclusive discussion

Human capital has traditionally been regarded as one of the key factors behind economic growth but not many studies have focused on its importance for immigrants' integration, specifically for skilled immigrants.

This study has discussed devaluation of human capital in relationship to immigrant physicians in Sweden and has developed theoretical assumptions about Cultural Authorization which can contribute to an understanding of internal differences between doctors from the EU/EEA and doctors from outside this area. Members of the latter group need not only medical licenses but a more informal *Cultural authorization* as well. Physicians with immigrant backgrounds are often perceived as a threat to the 'trustworthiness' of the profession.

In this article we have shown that there seems to be a devaluation of human capital which might lead to marginalization of immigrant specialists in the case of immigrant doctors in Sweden. An important dimension however is a simultaneous process in order to reevaluate human capital through an informal authorization process where doctors with immigrant background are seen as needing to be culturally competent.

The devaluation of human capital has also an ethnocentric characteristic, especially when presenting immigrant doctors as a group. An ethnocentric norm of the professional group, which divides the profession of doctors in a 'we' and a 'them,' appears. This reshapes the landscape in which all doctors act. This constructed cultural demand becomes a matter of social stratification when these doctors are viewed as some kind of 'second class' professional.

Human capital theory suggests that individuals and society derive economic benefits from investments in people. Education consistently emerges as the prime human capital investment, but in the case of immigrant doctors the qualifications are considerably *devaluated* in relation to the qualifications of native-born doctors, segmenting the profession on the basis of origins, in favor of the Swedish-born.

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It seems that from a professional perspective it is not sufficient for immigrant doctors from outside EU/EEA to have an educational level corresponding to Swedish doctors. They need to show that they are able to manage Swedish cultural codes in the health context as well.

This article has drawn on the context of the immigrant physicians and the medical profession's way of authorizing their skills by reference to cultural markers. This group is described as having to work harder to advance in the hierarchy of the medical system, but at the same time is considered a part of the solution to the deficit of doctors in Sweden today and in the future.

Immigrant doctors are, moreover, far from the center of the professional landscape. This might lead to the creation of 'second class' doctors in the Sweden's welfare state, dividing the professional group of medical doctors in two where the Swedish-born doctor is assumed to be taking care of the Swedish patient, and the non-Swedish doctor is to be seen taking care of the non-Swedish patient.

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Notes

1. Our own translation of the Swedish title: *Läkartidningen*.
2. Directive 93/16/EEC of 5 April 1993 http://europa.eu/legislation_summaries/other/l23021_en.htm
3. i.e. the numbers of physicians from outside Sweden applying for Swedish medical Authorization was 3 in 1985 and 845 in 2009 (National Board of Health and Welfare, 2010).

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