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COMCAD Arbeitspapiere - Working Papers
General Editor: Thomas Faist
No. 110, 2012

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CENTER ON MIGRATION, CITIZENSHIP AND DEVELOPMENT

2012

Wolanik Boström, Katarzyna & Öhlander, Magnus: A troubled elite? Stories about migration and establishing professional-ism as a Polish doctor in Sweden, Bielefeld: COMCAD, 2012 (General Editor: Thomas Faist; Working Papers – Center on Migration, Citizenship and Development;110)

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Background and aim

Health care is a globalized labour market with an on-going transnational mobility among its practising professions (e.g. Connell 2008, Nolte, Dubois & McKee 2005). One way to label the global activities of health workers is to use a modified version of Pierre Bourdieu's (1988) concept "field". A field is defined as a social space related to joint interests, formed by shared norms, hierarchic positions and struggles over shared capital. We use the term "transnational medical field" to summarize the internationalized medical research, globalized labour market and possibilities for health professionals to practice medicine all over the world. The concept "transnational medical field" has parallels to Thomas Faist's concept "transnational circuits". These circuits are peer networks with "mutual obligations and expectations of the actors" (Faist 2000:195), where the social ties can vary in intensity. The medical field holds several parallel and overlapping "transnational professional circuits". This captures the fact that professions are the base of both mobility and cooperativeness. A physician can take part in the medical transnational professional circuit in different ways. He or she could be based in the country of origin and via temporarily mobility work on a transnational level. Another way is to migrate. Among the reasons for migration among health workers, better working conditions and wages and an increase in life quality are prevalent (e.g. Connell 2008, Nolte, Dubois & McKee 2005, Socialstyrelsen 2011) The medical transnational professional circuit is paralleled by national and local professional circuits. On the national level, there might be other kinds of peer networks and systems of cooperation. Just as the doctors' professions are characterized by knowledge and skills usable all over the world, there are cultural differences on both national and local levels regarding how health care is organized, ways of working and norms for social behaviour, e.g. how to perform properly in physician's role (Geest & Finkler 2004, Wolanik Boström & Öhlander 2011a, 2011b).

In this paper, we focus on the interplay between the transnational and national aspects of the doctor's profession (we use the terms "physician" and "doctor" interchangeably). More precisely, is our aim to analyse narratives of migrating Polish physicians with a transnational medical competence, telling about their experiences of establishing themselves as professionals in Sweden, both in national and local cultural contexts. The doctors currently live and

work in Sweden, but also have experiences from work in other Western countries. This group is a good example of the prevailing migration flow in Europe, from East to West, e.g. from Poland, Hungary, Lithuania etc. to Germany, UK or the Nordic countries. Sweden is increasingly dependent on physicians from abroad; 18% of doctors were educated in another country, and Polish doctor are one of the largest non-Scandinavian groups (Socialstyrelsen 2011). We will discuss in what ways the Polish doctors living and working in Sweden present themselves as an integrated part of the elite in the medical field, and in what ways they perceive the Eastern European origin as affecting their professional situation. In our analysis of the narratives, special attention is given to experiences of how they established themselves as doctors in the Swedish health care and as a part of a well-established Swedish elite. In which aspects do they present themselves as an integral part of the medical elite in Sweden and the West, and what are the more problematic or ambivalent aspects of establishing professionalism as a migrant from a former Eastern European country? The analysis is based on 20 extensive interviews with physicians currently living and working in different parts of Sweden and 4 interviews with doctors attending a preparatory course for migration to Sweden.

Motivating the move: in the shadow of the brain-drain debate

Most of our interviewees take good care to motivate *why* they moved to Sweden. There are stories about political obstacles in the 1980s, economic hardships as a state-employed doctor, or the sheer impossibility to combine work and a family life. Jarek says that his primary motif to move to Sweden was to get away from political entanglements, which were common in higher positions then. “And I thought, I am not going to deal with such things”. And Robert says that in the 1990-ies, “interpersonal connections” were imperative to get a decent job:

> It was impossible to find a job in the city where I lived; you had to have connections, incredible connections. Even though there was a free position where I wanted to work, I did not get it because t was supposed to *stay* free and wait for somebody.

When Bogdan and Aneta, both specialized physicians, tell about their work-life in Poland in the beginning of the 2000, they do it with good humour, proud over the achievements but often laughing at the living conditions. Aneta was a tutor at a clinic “well, you earned enough to pay for the petrol to your car, the work was mostly for the social benefits”. As she wanted to have more contact with patients, she also worked some evenings a week at an emergency unit. Bogdan had completed his PhD and decided to work on “contracts”, getting paid for every patient, “to take responsibility for myself, pay for myself and to be my own master”. He ended up with lots of work places all over the city, with parallel contracts. Obviously, the in-

come was good, but the effort huge, the travels between the work places time consuming, and it was impossible to have any longer vacation. “It was fun for a while, but really scary if would last”. They both had too little time left for the family:

> Our children might say: “Well, Daddy is nice, but we don’t really know him” or “I want a life as an *ordinary* child! A life where mum picks you from school and gives you dinner and helps you with homework, instead of collecting us late at the child minder, just asking about homework and then: Goodnight!” And we were horrified that we were wearing our guts out, and the children did not appreciate it at all, so something was just *wrong* with the situation.

Some doctors tell about their admiration for the impressive images of Swedish health care, where they could develop and have decent working conditions. Eliza says that as a young doctor in Poland, she did not pay much attention to the economic aspects of health care. She liked her work and her colleagues, “the social contacts were great”. The hospital was functioning quite well, the equipment was not exquisite, but proper, the necessary medicines were available. But in relation to her level of education and in comparison with many other occupations in Poland, her wage at the hospital was “ridiculous”, though she seldom gave it a thought. It was just how things were. With her specialization, she could not easily take private patients to earn some more money. Her bank refused to give her a loan for a flat, because her income was considered too low. She and her husband relied heavily on their parents for all kind of help, including financial support.

> Eliza: Here [in Sweden] you can feel that your investment in this profession is *valued*, somewhere on a high level – even financially. In Poland, it was a little blue-eyed activity, you learned so much and you started to work and then you felt a little naïve – you could not help getting engaged, you could not let it go, and for such a wage it was…. embarrassing. (…) I thought that if I was a good doctor, then I should be able do live decently… but it was *not* possible to obtain in Poland at that time. It proved possible when I came here.

When she heard about the working conditions in Sweden, they seemed almost too good to be true. The recruitment company held an information meeting and the guests were some Polish doctors who already had worked in Sweden for some years. The following trip to Sweden also showed only good sides, as Eliza says “a demo-version of Sweden”, with well-organized and well-equipped medical care.

The fact that some of the interviewees put so much effort in motivating their migration may be understood through the prism of the brain-drain debate in Poland, about physicians and

other professionals who are looked-for in the West and enticed by better wages and living conditions. As ethnologist Oscar Pripp (2011) states, sometimes during an interview a person answers questions that had *not* been asked by the interviewer, but are so acute in the official debate that the person feels compelled to account for them. The "answer" is connected to what is said about his/her professional or ethnic group, and resisting those images. The physicians are naturally well aware of the recurring alarm reports in the Polish press, accusing the doctors of choosing the easy way out to the West, while Poland had born the costs of their long education and is facing shortages in specialist care. For example, in a series of articles in the Polish newspaper "Dziennik", there were suggestive titles as *Physicians, stay with us!* (Świerczyńska 2008), *Young doctors want to emigrate (*Klinger 2009) or *There is no one to anesthetize us in hospitals* (Weber 2008). In this light, it is not surprising that many of the Polish doctors feel compelled to show that they practically had no choice but to migrate. They are proud of their professional achievements in Poland but convey a message that as a part of a societal elite they should have been better paid, more appreciated and less overworked (cf Wolanik Boström 2005).

Migration: stories of success and struggles

In the interviews, the professional success is the implicit fond of evaluation. When the interviewees tell us about their professional trajectories, they implicitly evaluate their career and the ideal is to quickly establish themselves as excellent and hardworking physicians in the new country. For a variety of reasons, this was not always possible right from the start, though today they are all well-established professionals.

In the narratives, we found two recurring narrative patterns, stories of success and stories of struggles. In most of the interviews, there are both struggle and success stories. Some stories tell about epiphanies or turning points, e.g. when the physician's value has been proved beyond doubt in the new context. What, then, in the migration experience is told as unproblematic, and what is complicated?

An example of a success story is given by Robert, who is delighted with working conditions and a generous and open atmosphere among the colleagues – maybe, he says, because the clinic is a very international milieu, with migrant doctors from different parts of the world. Robert was recruited to the clinic and proved his value very soon by putting a right diagnose to a very diffuse case. His Swedish boss is great, supporting the younger colleagues and their further training.

Such unblended success stories are rare; in most of the interviews – even describing success – there are elements of trials and tribulations. In an interview with a couple, Alina and Jedrek, both narrative patterns are occurring. They talk about their migration in the beginning of the 2000. They are both experienced specialists, Jedrek with a doctoral degree, while Alina according to him “did not want to defend her thesis", although they did a lot of research together. Alina had no plans to move to Sweden, even though Jedrek used to work in Sweden some months a year and she was happy for him and visited him there a couple of times. Then Jedrek was encouraged to apply for a leading position at the clinic and Alina thought “I will not hinder him, let him do as he wants, they will take a Swedish doctor anyway”. To her surprise, Jedrek actually got the job and wanted them to move to Sweden in just two month’s time. “It was a big shock for me”, says Alina. She used to have a leading position in a clinic in Poland, and in Sweden suddenly she was new, ”the last name on the employment’s list”.

> There were situations when nurses did not want to listen to me; they wanted a confirmation from someone else. It took me almost four years before I got established and strengthened my position, so *now* they want to work with me.

For Jedrek, the career was much smoother: he was already speaking the language, he had some professional reputation, and he had a good position. Today, he is a chief physician at the hospital, a medical director at his clinic and divides his time between research and clinical work.

Alina's experiences are an example of a returning element of struggle stories, narrating the process of deskilling and reskilling (e.g. McNeil-Walsh 2008). Deskilling can take many different forms; e.g. when a well-renown specialist suddenly finds him/herself reduced to a novice because of language problems or the existing formal hierarchies in the Swedish workplace. In some cases, the new doctors were paid significantly smaller wages than their Swedish colleagues. There are also several accounts on how the doctors were met with distrust and doubts about their competence that could be connected to their origin. Edyta wrote some major articles and could have done a PhD in Poland, but when she worked in England she noticed that East European theses did not get the same respect as Western ones. Even if there were no formal, explicit objections, there was an air of vague condescension. “Now in the EU everything is supposed to have the same value, but when I left Poland was not a member state and a couple of persons advised me not to do it.”

Another example comes from Boleslaw; he did not have any big problems to get work in Sweden, but he remembers some obstacles: “There were lots of small things, both positive

and negative. Being met with distrust, mostly in the beginning." For example, he got a lower wage and had some problems with getting a job at a recruitment company:

> I have sent my paper to different recruitment companies. They did not respond, even though my Swedish colleague encouraged me and gave me recommendations. I applied online and they did not respond. After a couple of days, I did it again, to the same company, but without letting them know I was Polish. Just "A specialist with a PhD, with long work experience". They answered the same day. So it was an interesting research.

But he says that he appreciates Sweden for giving everybody a chance to prove what he or she stands for. Every nation has stereotypes about other nations, Sweden respects Germany and the US while Poland is considered as "absolutely a Third World".

> But if you just after a short time prove that you really can something, then you get accepted. In Germany it is not so, I have friends who work in Germany and it is no fun. No matter how good you are, you are first of all a damn Pole, and then maybe a doctor who surprisingly enough manages. It is different in Sweden. First you are met with distrust, but then you get accepted.

Some persons tell that the whole span of their medical and organizational knowledge was neither respected nor asked for in the new setting – they were just supposed to do rudimentary tasks. Antoni says that he had an extensive experience of family medicine, which is a well-established specialisation in Poland, but in Sweden his skills were met with distrust, "as if I came from some obscure land", he says:

> The Swedish looked at us [Polish doctors] like: "Oh, some exotic doctors are coming and they will learn medicine *from us*!" They think *they* are the centre of Europe, while I think that we have much bigger experience in Poland. Of course they have a lot of positive things in the doctor's training here, but we have nothing to be ashamed of! When I discussed things with my Swedish colleague, it showed I was often right. You shouldn't generalize, but it is rather common that they have hard time acknowledging that somebody else may be right, at least in medicine, that there may be better systems, other conclusions.

Sometimes, Antoni gets tired of discussing, feeling that there is a kind of obstinacy on the colleagues, nurses etc. part – they just know better, even though the Poles have a four times bigger population that the Swedish, and thus much more people to practice medicine on.

In the interviews, there are reflections about how making a career and having influence is harder for an immigrant. Eliza used to work in hospital, when she was recruited to a health center in Sweden after a six months' language course. In her new job, an intensive daily communication with patients, nurses and secretaries was an absolute requirement, and the first months were frightfully stressing: "It was terrible, it was a hell!". She could ask her mentor or the nurses if she did not know some of the routines or Swedish expressions, but the work brought constantly new demands, and as she wanted to do a good job, she was tired to the bones.

> It was terribly frustrating! As a doctor, you must be an authority for the person coming to see you, and it is difficult being an authority if you cannot speak properly. Jesus, in Poland I was brilliant, the conversation just floated, I decided what I wanted to know and sorted it out if it were too many loose ends… and here I talked, well, just as well I could.

For an energetic and self-assured physician this shift from "brilliant" to just understandable was humiliating. It took some years to get quite confident with the new language. Even though she has often been praised for her language skills, she feels that the expectations on her are rising with every year. Sometimes, if a colleague corrects her in some nuance, she is thankful, but sometimes it gets on her nerves, if she knows that she was perfectly understandable and making an important medical point, while the colleagues just try to make her "totally Swedish". Especially older professors have hard time believing that somebody who does not speak "fine" still may be a clever and competent person.

> In the beginning you feel that you will *never* be trustworthy enough, as you won't be as eloquent and talk so fine [as the Swedish]… But later on, you have to find other system to secure your trustworthiness – OK, I don't talk so beautifully but I give *other* proofs of my competence. But still, you always have the feeling that in comparison with the Swedish colleagues, you don't have equal chances! When a friend of mine delivers a lecture it is a pure delight, and when I do it, it is much more rough.

Nevertheless, Eliza is very contented with all the benefits of work in Sweden: the good wage, the possibility to take a longer vacation, the concern for the employees' health and comfort. "You can just practice medicine and be a doctor and live quietly and safely and comfortably".

Despite the examples we have given of struggle stories, it is important to underline that all interviewed doctors are doing well in their professional careers in Sweden, and all interviews have elements of very positive descriptions of their life and work in Sweden. For example, Bogdan says that his working conditions in Sweden are in many respects a dream; as a spe-

cialist he has the luxury to give a patient his attention for an hour, to do everything thoroughly and with quality: “you can have a professional satisfaction, a job where you have contact with people to a realistic extent”.

Making professionalism culturally passable

In the migration process, the transfer of theoretical knowledge and hands-on skills are much easier than the more nationally and locally dependent work place customs and practices (c.f. Berthoin Antal 2000). Explorations, evaluations and discussions about cultural traits are a returning theme in both success and struggle stories. The doctors often have to make an effort to make themselves culturally “passable” as professionals. It takes time to learn how the hierarchies work, how to perform authority, what kinds of gendered expressions are proper etc. In our material, there are recurring stories about experienced cultural differences and a kind of cultural “friction” or rasping, when things are not as smooth as they should. The interviewees’ goal is not get assimilated to a Swedish work place culture, but rather understanding different cultural traits in order to be able to negotiate and modify working place cultures, in order to make the everyday cooperation better, without giving up too much of their own professional identity.

One sign of professionalism is the manner of speaking. To be able to express oneself in an elegant an precise way is perhaps a globally occurring signifier of middle class. But there are cultural variations in how to do this and how to manage the local language in the right way. While for some of the interviewed specialists language is not an issue – they are contended with the communication – some physicians, who have a lot of patient contact, dwell on the importance of “fine” language for establishing a professional authority. Ludwik tells us that you cannot function fully, neither as a professional nor as a colleague, if you cannot speak properly, so “you have to invest very much in language”. He has taken courses and got help from his employer, as everybody recognizes the importance of language “and not only for the job”. It has taken some years to speak fluently, “which doesn’t mean that I speak perfectly, but I understand what people say without having to concentrate so very much on the person talking”.

Mastering the language is also an aspect of performing socially. Some of the interviewed doctors describe that they are unaccustomed to the informal, social interaction at work. The hierarchies among different positions and occupational groups are not as easily visible in Swedish health care as they are in Poland. At the Swedish work places, everyone are addressing each other with first name and no titles. And you are expected to socialise and talk

to everyone, irrespective of position or titles. Language eloquence is also an aspect of gaining status and making way in the career. When Eliza talks to other foreign doctors in Sweden, they share a feeling that they do not have quite the same position as the Swedish colleagues. It has nothing to do with competence, which is often politely acknowledged. ”I think many foreign physicians feel that they are needed and appreciated for working here, but then it just takes a stop there”. The Swedes are often chosen to the higher position, which Eliza understands: “It takes more communicative competence, linguistic flow, knowledge about Swedish politics and conditions and relations, which not everybody has interest in.”

Learning the codes of clothing is another example of a cultural domain in which one has to make oneself culturally passable as a professional. Aneta gives an example of this:

> I have no longer the habit of wearing high heels! Before, when I worked at the university clinic in Poland, you had to wear high heels and a costume, it was standard – an elegant short skirt, high heels, a little cleavage, not like a uniform but more elegant. And here, my mentor corrected me... (…) She said “you know, it is how secretaries dresses, maybe not even them, and absolutely not a doctor". As a doctor you should not show your calves or knees, it is not proper. /.../ In the beginning, I had thought “why shall I act silly and change myself, they can dress as they want, but I am from Poland and I dress as I used to”. But after a while, when I received some glances and small comments…

Another physician, Bogdan, tells us in an interview that he and another male colleague were rather shocked at the poor Swedish standard of elegance at the hospital.

> A standard for us, it was a newly ironed shirt, a jacket and a tie. And when we both had come to Sweden, we received our doctors’ rocks, which were just roughly mangled by the laundry. (…) And the boss who met us had a crumpled working T-shirt with a text “Conty council!” on it, totally creased, and doctor’s rock with rolled up sleeves. I thought: What kind of boss is this? There is nothing wrong about him, he is a professor and all, but in this outfit!

Bogdan says with good humor that they probably looked terrified. After some time, he got used to being practical and “gave up” on tie and jacket - as there are marvelous jogging routes around the hospital, he is often taking a training tour in the morning, followed by a shower and change of clothes to a doctor’s rock. But his Polish colleague never gave up for as long as he worked at this hospital; “he kept on the fight” and wore a whole collection of ties and jackets. In the long run, his style was actually appreciated both by the staff and the patients, as he looked as a “mass media doctor”.

The examples above show a few of the threads in the cultural web of work-place cultures, how they are performed, reproduced, negotiated and challenged in everyday life. Culture is an ongoing process and being a highly skilled migrant is to take part in that process as a kind of explorer, as a layman ethnographer. The doctors examine and scrutinize cultural traits in order to manage them and to make themselves culturally passable as professionals. But, as already mentioned, this does not mean that they become "Swedish". They remain in the position as someone who is not quite native. When Eliza sums up her experience of migration, she sometimes feels old and tired:

> It weighs heavily to move from one country – where you feel easy-going, where you form the rules and conditions and have a certain identity and personality, where you don't have to strive to establish it, because you have comprised it since your birth – to a country where you have come as a complete person, but where you are *new*. I have changed from being a very energetic person to one who gives up and tries to find a niche of her own, a place where I feel safe. I have no longer the urge to strive for something and change things and lead something.

A troubled part of the Swedish medical elite

In this paper, we have analysed some experiences of migration and the process of establishing professionalism when migrating to Sweden. It is evident that Polish born doctors working in Sweden are an integrated part of the medical elite. However, there are large variations on the individual level. Some of the interviewed doctors describe their trajectory as a smooth and untroubled journey, moving from one local setting to another in the transnational medical field. They learned quickly the local cultural traits and geared into the working place subculture as well-established professionals. Other doctors narrate a much more rough and bouncy path, even if they were well established in Poland and in the transnational professional circuit. Moving to Sweden meant a temporary drawback, they had to start from a lower position and re-establish themselves as professionals. This is not uncommon among highly skilled migrants and described as the process of deskilling and reskilling (e.g. McNeil-Walsh 2008). While some physicians present themselves in a non-problematic manner there are others, who tell about a process of reskilling that went on for two years or more. Some even say that they never will become totally recognized as a full member of their profession in Sweden.

The process of being culturally passable as a doctor is strongly connected not only to the medical competence, but also to the ability to perform the social class and gender in a proper way. The Polish doctors in Sweden may have to change some of their embodied dispositions, e.g. to behave, dress and talk in a correct and refined manner. It may be difficult to master a foreign language or a new dress-code. in such a way that it is possible to speak elegant and well-articulated. Another part of this capital is education. Even though talking about "a Polish symbolic and cultural capital" is a generalization one could say that there is a Polish capital that is exchangeable in Sweden, but has variations in exchange rates. In general Polish elites have a traditional capital based on classical education and refinement (Wolanik Boström 2005).An hypothesis is that this is not the case in Sweden. Swedish upper middle class, including physicians, have this classic refinement, but it becoming less important. Further, classic education is always connected to the nation and nation building activities (e.g. literature canons and the cultural heritage of a country). This means that a capital consisting of a Polish classic education could have a bad exchange rate in Sweden. In addition, the exchange rate of Polish symbolic and cultural capital could be affected by the often negative stereotypes about Poles and Poland that some of the interviews doctors told about in the interviews. The stereotypes should be understood in a larger context that includes the Swedish debated on "the Polish plumber" (Zaremba 2006) and the historical residues of the stereotypes on "Eastern communist Europe" and "The East European".

Even though the group "Polish doctors" is a well-established part of the medical elite in Sweden, they still may be, as we suggests, best described as a troubled elite. Iris Marion Young explains in her essay "Five Faces of Oppression" (Young 1990) how a (social) group and an individual can at the same time be both privileged and oppressed. Even though the concept of "oppression" is too strong in relation to such a privileged group as Polish doctors in Sweden, Young's discussion is relevant for our analysis. Oppression is a question of power relations and the exercise of power. It is a structural phenomenon, a result of many individuals' actions, with a variety of different motives and often with no outspoken intention of oppression or discrimination of any kind. The exercise of power takes many forms, Young discusses exploitation, marginalization, powerlessness, cultural imperialism and violence. Different groups are exposed to different combinations of these types of oppression. To understand how an individual can be both under-privileged and privileged, oppression has to be described as a group phenomenon. A social group is constituted by how it differs from other groups, expressed in e.g. culture and identity. Examples of factors that constitute groups are class, ethnicity, gender and sexuality. An individual is a member of several groups at the same time, and can be a part of both an under-privileged and a privileged group. Young's (1990) concept bears strong resemblance to intersectionality, that is how different combina-

tions of group belongings put an individual in a specific position in the hierarchic system of social categories, in the web of power relations.

A Polish doctor working in Sweden is constituted by, among other categorizing principles, gender, class and ethnicity. As a member of the upper middle class he or she has a well-paid, high status job – which the interviewees really appreciate. As Polish, he or she may get a lower salary or be (at least initially) less respected than the Swedish colleagues, an experience stated in some of the interviews. As Poles, the doctors become a part of the pseudo-ethnic group of "immigrants" ("invandrare") who in Sweden are constantly the subject of mainly negative and problem-focusing descriptions (e.g. Pripp 2002, Öhlander 2004). In addition, the Poles are surrounded by the remains of stereotypes about "communist Eastern Europe", again something that some of the doctors experienced. This is what can make their symbolic and cultural capital less valued in Sweden and make their native-born colleagues not fully trust their competence. In several interviews, (initial) problems with working together with Swedish nurses are mentioned, especially by women doctors. This could, as a suggestion, be explained by the combination of class (a higher position compared to the nurses), ethnicity (a potentially lower position in the ethnical hierarchy), gender (female gender is not the best raw material to construct a doctors authority), culture (differences in how to conduct authority) and local circumstances at a specific hospital. The fact that a doctor has to struggle to get accepted is because several persons' actions were *made possible* by the societal structure of power relations.

On the levels of nations, we can speak of exploitation in the sense that Poland educates skilled workers, while other countries benefit from it. Poles working in Sweden constitute an ethnic group subjected – to a different degree – to cultural imperialism. "To experience cultural imperialism means to experience how the dominant meanings of a society render the particular perspective of one's own group invisible at the same time as they stereotype one's group and mark it out as the Other" (Young 1990, pp 58-59). The dominant ethnic majority becomes the norm and its culture is universalized. Polish craftsmen working in Sweden and other European countries are evidently subjected to cultural imperialism and in addition, less paid (Zaremba 2006). By force of their ethnicity, Polish doctors in Sweden can be exposed to cultural imperialism and exploitation, but they may also present strategies of resistance and negotiation. As highly skilled migrants, they are a part of a respected societal elite in the upper middle class, where ethnicity and "being immigrant" become less important (cf Karlsson 2008). The Polish doctors working in Sweden are thus far from powerless; they have the prerequisites to take the sting out of cultural imperialism and exploitation. Still, there is the possibility of meeting prejudices and the effort to meet cultural expectations in the Swedish

context – and that is why we choose to describe them as a troubled elite, or as an elite with a conditioned existence in the Swedish context.

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