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GRADUATE SCHOOL OF ARTS AND SCIENCES

Dissertation

COST AND REWARDS OF PHYSICIAN MIGRATION:
COMPARING US AND SWEDISH MODELS

by

SELMA LINNEA HEDLUND

B.A., Lund University, 2013
M.A., Columbia University, 2015

Submitted in partial fulfillment of the

requirements for the degree of

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Approved by

First Reader

Nazli Kibria, Ph.D.
Associate Dean of the Faculty for the Social Sciences
Professor of Sociology

Second Reader

Deborah Carr, Ph.D.
Professor of Sociology

Third Reader

Joseph Harris, Ph.D.
Associate Professor of Sociology

Fourth Reader

John Stone, D.Phil.
Professor of Sociology

DEDICATION

I would like to dedicate this work to students everywhere who continued to pursue their PhDs during a disorienting and isolating pandemic, and to the healthcare staff that cared for patients around the world.

ACKNOWLEDGMENTS

I would like to express my sincere gratitude to my incredibly helpful and supportive committee. Thank you to Nazli Kibria, my advisor. You have been steadfast in your mentorship, responsiveness and willingness to guide me through the many winding steps of the dissertation process. I am grateful to Debby Carr, for your encouragement and careful reads of my very long drafts, and for being such a staunch supporter of your students' development and wellbeing. Joe Harris, thank you for seeing the potential of my work while also reminding me that life is more than your dissertation. Your unwavering encouragement and sense of humanity enriches this department immensely. Thank you, John Stone, for serving as my fourth reader. I appreciate your thoughtful feedback and kind support throughout this program. Thank you to Margaretha Stenmarker for helping me navigate the international component of this research, and for cheering me on. A special thanks to Sarah Miller for your warmth and compassion and to Lory Dance for inspiring me to become a sociologist and pursue graduate school in the US. It would not have happened without you.

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COST AND REWARDS OF PHYSICIAN MIGRATION:
COMPARING US AND SWEDISH MODELS

SELMA LINNEA HEDLUND

Boston University Graduate School of Arts and Sciences, 2023

Major Professor: Nazli Kibria, Associate Dean of the Faculty for the Social Sciences, Professor of Sociology

ABSTRACT

The fact that many OECD countries are reliant on international medical graduates (IMGs) to serve their most vulnerable has become even more apparent in the wake of Covid-19. This dissertation examines the role that nation brands play on the international physician labor market and how visa regimes and migration industries shape IMG pathways to Sweden versus US; two widely different societies where around a third of all doctors are IMGs. The US and Sweden represent two different approaches to addressing the same problem — solving a shortfall of healthcare providers, especially in rural areas populated by ethnic minorities and low-income families. While many Swedish regions actively attempts to facilitate the incorporation of IMGs through an intra-European physician recruitment industry, the US seem to rely on the attraction of its political economy and has done little to modify the substantial financial and visa-related obstacles that IMGs face. As a high-skilled immigrant group, immigrant physicians occupy a complex position of advantage and disadvantage; they are privileged in comparison to low-income migrant workers and unauthorized immigrants, yet face more barriers in comparison to domestic physicians, and are often informally sorted into less prestigious positions. This study centers the two largest immigrant physician groups in each country:

Indians in the US and Poles in Sweden. The experiences of these labor migrants are triangulated against a third IMG group that have undergone the asylum process in order to reach their host societies — Iraqis.

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LIST OF ABBREVIATIONS

AIC	American Immigration Council
AMA	American Medical Association
CME	Coordinated Market Economy
ECFMG	Educational Commission for Foreign Medical Graduates
EU/EEA	European Union/European Economic Area
IMG	International Medical Graduate
LME	Liberal Market Economy
NBHW	National Board of Health and Welfare (*Socialstyrelsen)*
OPT	Optional Practical Training
SIV	Special Immigrant Visa
SLF	Swedish Medical Association (*Sveriges Läkarförbund)*
USCIS	US Citizenship and Immigration Services
USMLE	United States Medical Licensing Examination

CHAPTER I: INTRODUCTION

This dissertation project examines the experiences of immigrants working as physicians in Sweden and the US along with an analysis of the institutions that govern their immigration and professional integration processes. It also assesses the role that nation branding plays in attracting large numbers of immigrant physicians to two such different political economies. As domestic physicians retire at a higher rate than those who are entering the profession, there is a growing shortage of doctors, especially in underserved areas where domestic physicians are reluctant to settle. My goal is to explore and compare the challenges and opportunities presented to international medical graduates (IMGs) in these two host countries relative to the structures created by institutions such as visa regimes, licensing institutions, recruitment companies, and other entities or agents that seek to gatekeep, broker or facilitate connections between immigrant physicians and potential employers. I broadly show that the US and Sweden represent two different approaches to addressing the same problem — a shortfall of medical providers. Sweden actively works to facilitate the immigration and integration of immigrant physicians (albeit predominately IMGs from other EU/EEA countries) through international recruitment, the US takes a laissez-faire approach, relying on its attraction as an immigrant destination and the ability of international medical graduates to individually negotiate the substantial financial and visa-related obstacles to practicing medicine in the US.

As a high-skilled immigrant group, foreign-born physicians in Sweden and the US occupy a complex position of advantage and disadvantage; they are privileged in comparison to low-income immigrants yet face more barriers in comparison to their native-born colleagues. Some forms of (dis)advantage will play out on organizational or interpersonal levels, while others may be related to immigration policy and legal status. In order to examine how particular immigrant communities have become established players and navigators of this field, the main focus of the project will be on two of the most prominent immigrant physician nationalities in each country: Indians in the US and Poles in Sweden. In addition, I will also examine the experiences of a group that straddles both countries: Iraqis. While Indian and Polish physicians can broadly be categorized as labor migrants, Iraqis will often have come to the US and Sweden as refugees, which will unveil how different modes of legal entry and immigration status impact the immigrant physician experience.

In addition to comparing the experiences of immigrant doctors in Sweden versus the US, this project will also examine how immigration policy and healthcare policy are entwined, and how the two political economies grapple with the fact that immigrant labor is critical to their healthcare delivery systems. Although the number and prominence of immigrant physicians are growing, we know little about their experiences of integration in the societies and communities in which they practice. This project fills gaps in the literature by analyzing policy and organizational effects in relation to the interpersonal and cultural dimensions of IMGs' experiences. I ask the following: How do the experiences of immigrant physicians differ across the Swedish and US context, given different sets of immigration policies and healthcare systems? What nation brands do the US versus Sweden represent on the international medical labor market? How do migration industries, visa regimes, and relicensing requirements in Sweden versus the US shape the experiences of their immigrant physicians? What strategies do immigrant physicians employ to overcome social, legal and financial strains throughout their integration process? Answers to these questions will not only provide important insights regarding the understudied topic of high-skilled immigrant integration, but also address the policy issue of how better to ensure that international medical graduates are able to successfully integrate and meet a critical labor shortage.

Immigrant Physicians in the US and Sweden: Brief Statistical Background

According to International Migration Outlook 2015, the number of immigrant healthcare professionals working in Organization for Economic Co-operation and Development (OECD) countries was 4,3 million people in 2014, representing a 60% increase since 2004. A substantial proportion of these migrant professionals come from India and China, although Eastern European countries such as Poland and Romania are also becoming significant senders within Europe due to the ease of inter-EU flows. In Sweden, 30% of all doctors and 14% of all nurses were immigrants (OECD 2015) and their numbers are likely to increase given the medical shortfall created by lower numbers of newly licensed domestic doctors in comparison to those going into retirement. In addition to this growing shortage of newly licensed physicians, more Swedish health care workers are seeking employment abroad (Norway, for example) where salaries are higher, taxes are lower, hours are fewer, and opportunities for professional development are more frequent (Berbyuk, Allwood and Edebäck 2005).

According to statistics from The National Board of Health and Welfare (Socialstyrelsen [NBHW]), 58% of the 2 378 physicians earning their license in Sweden in 2014 were trained abroad, figures that are consistent with the previous five years (Ollars 2015). Although these numbers may include native Swedes completing medical school at non-Swedish universities, the National Board of Health and Welfare continuously treats foreign training as a generally strong proxy for immigrant status (Ollars 2015). This assumption seems fair when considering the fact that Swedish medical students studying abroad for training are at a steady decrease, totaling at 2,807 out of 10,782 in 2017 (Ström 2018).

There are no official accumulative statistics outlining the proportions of each IMG nationality in the Swedish physician workforce; the only data available (per request from NBHW) are yearly compilations over countries in which the applicants that have been approved for a Swedish medical license earned their medical diploma. These lists only include EU/EEA countries, with a collective category of "third country," referring to applicants with medical diplomas from non-EU/EEA states. While numbers can fluctuate significantly from year to year, some of the largest sender countries are Denmark, Poland, Romania, Hungary and Germany. While a clear majority is hard to discern, Polish physicians have received special attention in the media and Läkartidningen in particular, Sweden's main medical journal published by Svenska Läkarförbundet (Swedish Medical Association [SLF]), the national union and professional organization for medical doctors and students. An article from 2005 shows how the numbers of IMGs from Poland increased dramatically after the EU accession the previous year, placing them in a clear lead at 200 licenses issued in 2004 compared to Germany at 162, Denmark at 107 and Hungary at 74 (Gunnarsdotter 2005). It further states that the focus on and prevalence of Polish physicians is largely due to the targeted recruitment of physicians from Poland through international recruitment companies, forming a niche migratory relationship between Poland and Swedish county councils, which is also reproduced by "friend recruitment" in which Polish IMGs already in Sweden encourage their colleagues to migrate. While the explosive numbers of the mid 2000's have waned somewhat over the following decade, Poland have remained among one of the top sender countries. According to data requested from the NBHW, over 600 Polish physicians received a Swedish medical license between 2016 and 2021.

The US statistics on the prevalence of immigrant physicians resemble those of Sweden. According to the American Immigration Council's (AIC) special report from 2018, more than 247,000 physicians practicing in the US earned their medical degrees abroad, among which a vast majority are presumed foreign nationals (American Immigration Council 2018). This group constitutes about ¼ of all medical doctors currently working in the US. Indian IMGs have steadily held a strong majority among immigrant physicians at over 20% of the total IMG workforce, followed by physicians with diplomas from Pakistan, the Philippines, and Mexico, each holding under 10% (Young et al. 2021; also see McMahon 2004). The AIC report emphasizes how the US visa policy allows the government to send immigrant physicians to underserved and disadvantaged communities in exchange for a visa status that expedites the path to permanent status and citizenship. As a result, foreign-trained doctors are significantly more likely to serve in “healthcare deserts” frequently populated by Indigenous, Latinx and Black minorities, and people that are elderly, working class, or living in poverty.

Case Selections

The US versus Sweden

While the proportions of immigrant physicians in Sweden and the US are similar, it must be acknowledged that the social, cultural, legal and political makeup of these two societies are in many ways radically different. Rather than conceptualizing this study as a flat comparison of IMGs in Swedish versus US society, this research project will seek to compare how two opposite kinds of Western political economies approaches a similar problem — the shortfall of physicians — and the impact that these two different approaches have on immigrant physicians responding to this demand. According to the framework developed by political economists Peter A. Hall and David Soskice in *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage* (2001), Sweden represents a coordinated market economy (CME) while the US represents a liberal market economy (LME). More specifically, Sweden is a welfare state with a regulated market economy, and the US is a state founded on Laissez-Faire capitalism with relatively limited government intervention. I go into more theoretical depth with this comparison in Chapter 3, “Two Political Economies: Healthcare and Immigration Policy.”

With regards to healthcare delivery, the Swedish state model is based on universal healthcare while the US relies on a variety of distinct organizations and agencies, many of which are owned and operated for profit by the private sector. Although the US government covered over 60% of all health care spending in 2013 through programs including Medicare and Medcaid (Himmelstein and Woolhandler 2016), a significant portion of Americans are covered by private insurance or none at all. Furthermore, the US is a far more stratified society than Sweden, sustaining a wider wealth gap (Balestra and Tonkin 2018), income gap (Alvaredo et al. 2017) and gender inequality gap (Bohlen 2019).

When it comes to racial inequality, the US collects and produces data with rigor while Sweden opposes the official production of racial categories in the census altogether. Although the American conceptualization of race does not map on to Swedish society, otherization and racialization of Muslims, Black Swedes and other non-ethnic (White) Swedes are tangible social and political processes (e.g., Agerström and Rooth 2009; McEachrane 2014; Khosravi 2012). More so than in the US, race relations and attitudes towards immigrants are inseparable in the Swedish context. As of 2014, about 20% of the Swedish population was of immigrant background, meaning that they are either born abroad (around 15%) or to immigrant parents (around 5%) (Fredlund-Blomst 2014).[1] These percentages precede the large recent influx of refugees associated with the Syrian civil war and recent statistics suggest that Sweden has surpassed the US in proportion of immigrants; in 2022, the estimated 1st generation immigrant population was over 2 million people — about 20% of the total population (SCB 2022). In comparison,

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[1] Children of immigrants making up 26% of the 70 million children under 18 living in the US (Zong, Batalova and Burrows 2019).

44.9 million immigrants were estimated to live in the US in 2019, comprising 13.7% of the total population (Esterline and Batalova 2022).

Unlike the US, the Swedish government tends to take an active role in the incorporation of immigrants — refugees and asylees in particular — and it is not uncommon for government agencies to be involved in people's lives for several years through different programs and forms of assistance, until an individual is deemed self-sufficient. Still, Sweden has historically not held the same ethnic or racial diversity as the US, which can make social integration more of a challenge, especially for non-Europeans. Much like the US, Sweden is experiencing significant struggles with segregation along ethnic lines, perpetuating socioeconomic gaps between ethnic and non-ethnic Swedes.

The Indian Case

Indian migration to the US increased dramatically with the US Immigration and Nationality Act of 1965, uprooting the national-origins quota system established in the 1920s and replacing it with an immigration policy based on skills and kinship ties, ultimately leading to a significant influx of immigrants from the Global South who had been barred under the previous system. This skill-based reform would profoundly facilitate the uptake of Indian nationals into the US labor market and society, who soon became one of the most competitive high-skilled immigrant groups in the country. With family sponsorship and work visas combined, India has in the last few decades become one of the largest sender countries to the US and people of Indian origin (both first and subsequent generation immigrant) are currently representing 1% of the national population (Chakravorty, Kapur and Singh 2016).

High-skilled Indian immigration is intimately connected to the H-1B Specialty Occupations visa. Typically associated with high educational achievement, professional performance and fluency in English, Indians have consistently held an unchallenged majority in the H1-B visa program for years, generally being issued around 70% of the yearly quota. In 2020 for example, 74.9% of all approved H-1B beneficiaries were Indian nationals, followed by Chinese nationals at a mere 12.1%. The following seven countries in the top ten held less than one percent each (US Citizenship and Immigration Services 2021:8). The visa category was enacted through the Immigration Act of 1990, making 65,000 visas available for application each year. Under the American Competitiveness and Workforce Improvement Act (ACIWA) from 1998, the number of H-1B visas was increased to 115,000 with the American Competitiveness in the Twenty-First Century Act (AC21). The expansion of the H-1B visa category would mark the most significant wave of Indian immigration in US history, paving the way for the so called "IT generation" along with Indians becoming the leading immigrant group in the medical profession (Chakravorty, Kapur and Singh 2016). While Indians have long dominated the H1-B category, competition for the coveted specialty occupation visa got steeper as the number of H-1Bs granted every year was reverted back to 65,000 in 2004 with the establishment of the H-1B Visa Reform Act (reserving an additional 20,000 visas for applicants with a US graduate degree).[2]

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[2] Universities and related nonprofit entities, nonprofit research organizations and government research organizations are not subject to the cap. In 2020, USCIS approved 426,710 H-1B petitions for entry

India has been deemed the largest exporter of IMGs in the world, predominately to English speaking receiving countries such as the US, the UK, Australia and Canada. However, despite becoming an extraordinary force to be reckoned with in the global market, India struggles with domestic problems such as health and economic disparities between urban and rural areas and an underfunded public health sector. This has caused a debate around brain drain, in which public health scholars see large scale high-skilled migration as detrimental to the health needs of the massive Indian population. Economists on the other hand tend to uphold research documenting the economic value that sender countries might accumulate from physician emigration. Many Indian policy makers tend to adopt this mindset, perceiving India's capacity to produce physicians for export as an asset for the homeland, arguing that domestic physician shortfalls as a result more of resource maldistribution than of actual shortages (Mullan 2006).

The Polish Case

Since the 19th century, Poland's role as a country of emigration has become more significant in the global system of migration. However, the wave following World War II was limited due to restrictive anti-emigration policies put in place by the communist regime, and it was not until the late 1980's that mass movements to the West began. Statistics from the Polish Central Statistics Office have estimated that over 353,000

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into the yearly lottery pool. Read more about recent petitions filed and approved in the report *Characteristics of H-1B Specialty Occupation Workers* (US Citizenship and Immigration Services 2021)

Polish citizens left their country between 1990 and 2005 with the intent to migrate permanently and in 2006, over 50,000 people took themselves out of the Polish permanent resident register — a figure that was double the number of emigrants in previous years (Kaczmarczyk 2010). Poland became a member of the EU in the 2004 expansion. The accession drastically facilitated large-scale migration by introducing free movement and work authorizations at a time when dissatisfaction with national tax policy was high and Polish unemployment was peaking at 21% (White 2011).

General explanations for Polish migration focus on economic and labor market conditions, but evidence also suggests that the post-accession wave is also partly motivated by an element of exploration — especially for younger expats. Polish politician and diplomat Danuta Hübner who served as EU commissioner between 2004 and 2009 observed that, "young people will treat migration to the West as an adventure and the opportunity to gain experience" (White 2011: 33), indicating an approach to migration that is not only based on necessity but also spontaneity, recreation and personal development. Financial situations improving for many educated Poles relative to other Eastern and Central EU countries also suggests that their migration could be driven by more than just wage arguments — social and cultural aspects may also play an important role, as well as the opportunities posed by particular labor markets. It follows that neoclassical economic migration theories cannot fully account for the complexity of more recent flows of Polish migration (Kaczmarczyk and Tyrowicz 2015).

Poland is one of the largest sender countries of intra-European migrants with around 2.7 million Polish nationals residing elsewhere in the European Economic Area

(EEA) (Eurostat 2019). Polish citizens also are the second largest group of foreign-born Europeans residing in Sweden; in 2021, over 95,000 Polish nationals were living in Sweden, second only to Sweden's close relation Finland at 136, 607 and well above former Yugoslavia[3] at 62,444 (Statista 2022). In addition, there are over 17,000 second generation Polish Swedes living in Sweden (SCB 2022). It follows that Poles constitute the largest presence of Central and Eastern Europeans in Sweden. When Poland joined the EU in 2004 along with the other A10[4] countries predominately from the former Soviet Union and Eastern Bloc, Sweden was one of the older EEA member states that did not adopt transitional provisions towards the new member states; instead, they opted for so called community rules that allowed for unrestricted labor mobility, immigration and employment from the new members. This policy laid the path to Sweden initially more open to Poles than to other European destinations, such as the UK (Boeri and Brücker 2005).

Although the Polish diaspora is prominent in Sweden and the other Nordic countries, it has traditionally been characterized less by high-skilled professions and more associated with the intra-European vocational job market and low-wage gig economy, including blue collar labor such as construction, manufacturing and trucking, as well as pink collar labor such as domestic cleaning and care work (e.g., Friberg 2010; Thörnquist 2013; Friberg et al. 2014; Thörnqvist and Bernhardsson 2015; Ryndyk 2020). However, a significant portion of more recent post-accession Polish migrants are also college graduates and academics, causing debates about brain overflow (high skilled professionals being unable to find jobs in Poland), brain drain (loss of human capital to the West), and brain gain (foreign markets positioning themselves to attract educated immigrants) (Kaczmarczyk and Okólski 2008; Kaczmarczyk 2010; Kaczmarczyk and Tyrowicz 2015). While these studies have often shown that economic crises and language barriers stifles an even larger mass exodus to non-English speaking European labor markets such as Sweden, some have predicted that the intra-EU mobility of health professionals is likely to increase (Gerlinger and Schmucker 2007). There is a shortage of physicians in Poland due to emigration to Sweden and other countries in the West became particularly palpable during the heights of the pandemic, placing a severe strain on Poland's Covid-19 response (Lundin 2020).

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[3] People who immigrated to Sweden before the country was split.

[4] Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Slovakia and Slovenia.

The Iraqi Case

For decades, Iraq has struggled with disastrous conditions related to political and economic turmoil, persecutions, invasion and armed conflict. Followed by Afghans and Syrians, displaced Iraqis constitute the absolute largest diaspora in the world. In the aftermath of the Iran-Iraq war, the Gulf War and the subsequent rise of the Hussein government, at least 2 million Iraqis had left the country by the mid 1990's (Vanderbush 2014). A mass exodus followed after the US invasion in 2003 and as the Islamic State gained global international prominence in 2014 following the Sinjar massacre on Iraqi territory, the United Nations declared its highest-level emergency for the humanitarian crisis in Iraq.

Most refugees have relocated to other Middle Eastern countries (predominately Iran) and Europe, and to a lesser extent the US. Estimates from both 2008 and 2021 continue to show conservative figures of internationally displaced Iraqis at over 2 million (Sassoon 2008; Watson Institute for International and Public Affairs 2021).[5] Exact numbers are difficult to calculate; data provided by scholars, journalists and international organizations tend to be snapshots of the number of refugees and asylum seekers at a particular point in time rather than a full accounting of the total number of internationally displaced Iraqis. In addition, continuous emigration in combination with waves of return migration further complicates exact assessments (REACH 2017).

Iraqi refugees and asylum seekers have received special attention from the US Refugee Admissions Program (USRAP) and special Iraqi refugee processing was announced in February 2007. Together, DHS and DOS joined forces to increase the number of admitted Iraqis (US Citizenship and Immigration Services 2013). Arriving from a variety of countries apart from Iraq (predominately neighboring states in the Middle East), approximately 91,000 Iraqi individuals resettled in the US during the period of 2008–2013 (Center for Disease Control and Prevention 2021). Still, the US has received heavy critique for not accepting enough Iraqi refugees (Sassoon 2008).

Iraqis in Europe are mostly concentrated in Western European countries such as the UK, Germany and the Netherlands, but also Scandinavian countries such as Norway and Sweden. Following a steady influx spanning over decades, Iraqi nationals have constituted the largest non-European immigrant group in Sweden before getting surpassed by the rapidly growing numbers of Syrians in 2016. In 2021, over 146,700 Iraqis were living in Sweden, and over 60,700 Iraqi Swedes with Iraqi parents (SCB 2022). After Syria, Iraq is now the second biggest sender country to Sweden followed by Finland (which Iraq surpassed in 2019), Poland and Iran.

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[5] These statistics are excluding the internally displaced persons that have fluctuated between over one million to five million depending on return migration. Read more at UNrefugees.org (https://www.unrefugees.org/emergencies/iraq/).

Iraqi emigration to Sweden began in the mid 1970's and was long dominated by the Kurdish minority. In the 1980's, they were joined by Assyrians and after the Gulf War in 1991, Sweden started receiving Shīʿa asylum seekers fleeing Saddam's persecution. Before this wave, most Iraqi immigrants were college graduates and political activists (Sassoon 2008). Scholars argue that Sweden with its relatively small population (that has recently reached 10 million) has had one of the most generous refugee reception policies per capita, pointing out that Sweden opened its doors to the Iraqi exodus in ways that were largely unmatched in the whole of the Western world following the start of the 2003 Iraq war. The post-2005 wave saw refugees and asylum seekers that were affiliated with the regime or belonged to minorities such as Assyrians, Chaldeans and Mandeans. Many also came from educated middle class backgrounds (Sassoon 2008).

High skilled Iraqi migrants and refugees are relatively understudied, but the Iraqi physician emigration is well documented and contributed to the devastating brain drain that Iraq has continuously suffered due to escalating violence. Not only are Iraqi health facilities saddled with the overwhelming task of treating war injured patients; medical staff have also become a target for threats, assault, kidnappings, and killings (Lafta et al. 2021). A 2006 Brookings Institution study, cited by an International Federation of the

Red Cross and Red Crescent Societies report on Iraq, estimated that approximately 2,000 doctors had been murdered and 250 kidnapped. At the end of 2006, more than half of Iraq's 34,000 doctors had fled the country, according to reports confirmed by the Iraqi Ministry of Health (Zarocostas 2007). While Sweden does not keep records of country of origin for licensed IMGs outside of the EU/EEA area, several hundreds of Iraqi physicians are believed to have settled in Sweden (Sassoon 2008). Neither do exact statistics exist in the US, but Iraqi Doctors in the USA (IDUSA) estimates that there are around 5,000 Iraqi physicians in the US.[6]

Medical Licensing in Host Countries

US Medical Licensing

For IMGs moving to the US, the first step towards a US medical license is to hold a diploma from a medical school that is recognized by the Educational Commission for Foreign Medical Graduates (ECFMG) and obtain ECFMG certification. In previous years, this entailed taking the United States Medical Licensing Exams (USMLE) Steps 1 and 2 CK (clinical knowledge) and CS (clinical skills) before starting residency. Candidates typically take the USMLE Step 3 exam after completing at least one postgraduate training year in a US-accredited graduate medical education program, i.e., residency and fellowship training.

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[6] Numbers requested from IDUSA.

While the USMLE steps 1 and 2 Clinical Knowledge (CK) are both computer-based exams available at designated locations worldwide, the Step 2 Clinical Skills (CS) was an interactive test of applied skills and needed to be completed at designated exam centers in US In conjunction with Covid-19, USMLE Step 2 (CS) was suspended in March 2020, pending reconsideration. On January 26, 2021, The Federation of State Medical Boards (FSMB) and National Board of Medical Examiners (NBME), co-sponsors of the USMLE, made the announcement that the work to relaunch a modified form USMLE Step 2 (CS) had been discontinued due to rapidly evolving medical education and changes in other standardized exams, deciding that the test component would be altogether cancelled.[7] Instead, computer-based simulations in USMLE Step 3 would come to supplement medical students' education in place of Step 2 (CS).[8]

Not only are IMGs required to pay the steep fees associated with the first two USMLE exams (which can reach well over $2,000,[9] not including any travel expenses or J-1 visa sponsorship fees) they are also compelled to achieve very high scores in order to compete with domestic doctors when applying for their desired residency positions. In order to be matched into residency, IMGs are in need of either shadow or hands-on US clinical experience (USCE) and recommendation letters from American colleagues, which one would get by completing a clerkship, observership, externship, research elective, or through obtaining a job in the US healthcare system (as a physician assistant, nurse, EMT, or medical assistant). Some of these USCE options may yield income or scholarships, while others come at a personal cost for the IMG, along with living expenses for the duration of the program.[10]

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[7] Read full announcement of the discontinuation of Step 2 CS at USMLE.org (https://www.usmle.org/work-relaunch-usmle-step-2-cs-discontinued)

[8] Read more about recent changes to the USMLEs at USMLE.org (https://www.usmle.org/usmle-policy-updates-following-step-2-cs-discontinuation)

[9] Taking the exams outside of the US is associated with surcharges, which ultimately makes the USMLEs generally more expensive for IMGs than for US medical graduates. Read more at ECFMG.org (https://www.ecfmg.org/fees/usmle-surcharge.html). Also visit ECFMG.org to see a breakdown of the fees and costs related to the USMLEs (https://www.ecfmg.org/news/2021/12/23/fee-increases-for-2022/)

Step 1	**Step 2**	**Step 3**	**Step 4**	**Step 5**	**Step 6**	**Step 7**
ECFMG education eligibility	Pass USMLE clinical knowledge and clinical skills exams (Step 1, 2 CK, 2 CS)	Apply for ECFMG certification (including verification of diploma and transcripts)	Obtain US clinical experience	Match with and complete a residency program	Pass USMLE exam Step 3	Apply for license to practice medicine from State Medical Board

Table 1. US Medical Licensing

Like the USMLEs, matching into residency after having completed the aforementioned requirements is also a very costly process. The Association of Medical Colleges (AAMC) analyzed data from a yearly school-level survey and found that in recent years, costs associated with interviewing for residency ranged from $1,000 to $13,225 with a median value of nearly $4,000, not including the USMLE Step 3 registration fee of $895–$915 (AAMC 2022). In order to take part in Graduate Medical Education (GME) residency or fellowship training, immigrant physicians also need to obtain a visa, either J-1 or H-1B. Typically, a residency program will take at least three years to complete but may range up towards seven depending on specialty.[11]

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[10] Read more about USCE requirements and options at MedClerkships.com (https://medclerkships.com/explaining-clerkships-observerships-externships/), and about American Medical International Quality Training (AMIQT) observerships at AMA-assn.org (https://www.ama-assn.org/education/international-medical-education/observership-program-listings-international-medical)

After having overcome these various hurdles, achieving equal footing with US medical graduates and doctors can still be a struggle. In the US, there are many journalistic accounts, reports and studies that call for support and resources on behalf of immigrant physicians (e.g., McMahon 2004; Han and Vapiwala 2017; Kalra, Shah and Zoghbi 2017; Malhotra 2021), yet there seem to be few structural interventions in sight. The visa system represents a significant bureaucratic bottleneck that is difficult for employers and program directors to impinge on, but superiors could take measures to allow for cultural and professional learning curves and offer English immersion courses to international medical graduates if need be. Extending eligibility to non-citizens for research training, grants and awards would also help remove constraints (McMahon 2004).

Swedish Medical Licensing

A major point of difference that this project will seek to examine is the extent to which the two different countries attempt to facilitate the professional and social incorporation of the medical staff they urgently need, and the results of providing (or not providing) this support. Obtaining a medical license is a paramount step on the path towards a medical career in a new country, and a process each candidate must prepare themselves carefully for — some more than others.

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[11] Read more about these procedures at AMA-ASSN.org (https://www.ama-assn.org/education/international-medical-education/residency-program-requirements-international-medical)

The path to a Swedish medical license will differ based on whether the applicant is licensed in another EU/EEA[12] country or not. For non-EU/EEA IMGs, the road to medical practice in Sweden holds five official steps, starting with submitting a copy of one's medical diploma to the NBHW. They assess if the education level, length, and content is comparable to Swedish standards. An applicant does not need to speak Swedish for the first step but will need to be fluent enough in order to complete the second — an exam in medical proficiency equivalent to the clinical knowledge of a medical degree and the clinical skills involved in clinical rotations. By order of the NBHW, the test is hosted by Umeå University and applicants have five chances to pass the clinical knowledge part, and three times to pass the clinical skills part. The test is free of charge and is graded on a pass/fail scale. The third step is an online college level course in Swedish medical law and regulations, tailored to IMGs from outside EU/EEA (7.5 Swedish credits, the equivalent of 25% part-time or 10h/week for one semester), also given at Umeå University and free of charge.

Step four is six months of paid probational clinical training, which is mandatory even for applicants who hold specialties. IMGs are responsible for finding their own employer for this period, who will also submit a request on their behalf for special authorization to practice medicine before a license has been issued. The clinical training serves as both an assessment and orientation in Swedish medical practice, and the employer and supervisor’s evaluation will be an important part of NBHW’s final decision in issuing a medical license. Submitting the final application for licensing after completing clinical training in Sweden costs 2,900 SEK (≈ 280 USD). While timeframes vary depending on individual circumstances, the NBHW estimates that the completion of the five steps typically takes between 2–4 years.

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[12] EEA stands for European Economic Area, representing an international agreement in which Iceland, Liechtenstein and Norway (the members of the European Free Trade Association) are allowed access to the European Union's singular market, enabling free movement of persons, goods, services, and capital.

Step 1	**Unofficial step**	**Step 2**	**Step 3**	**Step 4**	**Step 5**	**Step 6**
NBHW education assessment	Swedish language proficiency training	Clinical knowledge exam	Swedish medical laws and regulations course	6 months of probational clinical training	Pay medical license application fee and submit to NBHW	Apply for residency, specialty validation, or supplemental residency training

Table 2. Swedish Medical Licensing for Non-EU/EEA IMGs

A second option is to complete supplementary training at a select list of Swedish medical schools followed by an internship. Admission to these university-based training positions is limited and require proficiency in Swedish. In addition, many of the universities will require a decision from the NBHW that states that the candidate’s education is equivalent to Swedish standards. After completing the internship, candidates will pay the application fee and submit their license application to the NBHW. This alternative pathway tends to take 1–3 years. You may obtain a Swedish medical license even if you do not have a Swedish personal identity number, residence permit or address. In order to practice or study in Sweden however, non-EU/EEA IMGs will have to obtain a residence permit or work permit from the Swedish Migration Board.

After the NBHW has issued a license, new regulations from 2021[13] mandates that if an IMG has completed portions of a residency in an EEA or third country[14] but under conditions that are comparable to Swedish standards, they may credit up to 4 years and 6 months of that training towards their residency in Sweden. Specialists from third countries may have their certifications recognized by the NBHW if they have 1) completed at least three years of residency and then practiced as a specialist for a total of five years, 2) completed one years of Swedish residency training, and 3) fulfil all the competency requirements and criteria for a Swedish internship (also referred to as basic training or rotations) and residency.

Although non-EU/EEA trained IMGs are in minority among Sweden's immigrant physicians, the number of licenses issued to them have been increasing as the validation system has been made more efficient. 2020 was a record year in which 279 non-EU/EEA doctors received a Swedish license, representing a big leap from the average of 196 per year over the previous decade. Still, there are still reports of malcontent among non-EU/EEA IMGs regarding the current system (Ström 2021a; 2021b), likely exacerbated by the relative ease with which their EU/EEA colleagues obtain their licenses.

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[13] Changes to the Swedish medical training system were introduced on July 2021, with the most significant reform being the minimum residency training period being extended from 5 years to 5 years and 6 months, incorporating a 6 month – 1 year basic training period, resembling clinical rotations.

[14] The EU defines a third country as: "A country that is not a member of the European Union as well as a country or territory whose citizens do not enjoy the European Union right to free movement." Countries in the EU and EEA are Austria, Belgium, Bulgaria, Croatia, Republic of Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain and Sweden.

In order to meet the demand of their communities, many Swedish regions and county councils have resorted to active international recruitment of doctors, predominantly from EU/EEA countries for which migrating to Sweden and earning a Swedish license is less extensive (Berbyuk, Allwood and Edebäck 2005). Since the mid-1970's, the EU has been working towards ensuring the mutual recognition of physician diplomas and qualifications, aiming to make the medical field more easily traversed internationally within the EU/EEA. The most important obligations for mutual recognition of physician certificates are outlined in the so-called "physicians directive" passed in 1993, stipulating an automatic recognition of diplomas and certificates for medical doctors. This automatic recognition applies when the following three criteria are fulfilled: 1) the physician is a citizen of one of the Member States; 2) the diploma in question is a qualification from one of the Member States; 3) the training was completed in one of the 52 officially recognized specialties listed in said directive both for the country of origin and the target country (Gerlinger and Schmucker 2007).

EU/EEA IMGs and passport holders enjoy the right to live and work freely within the Union borders and if their medical schools and clinical rotations are consistent with EU standards, NBHW will issue a Swedish medical license without additional exams or training. With the license application, NBHW will require proof of Swedish proficiency, either through completed coursework (typically "Svenska C1," a NBHW endorsed course tailored to non-Swedish speaking professionals) or employer attestation of proficiency. Previous or additional language courses are common and will often be funded and provided by the employer — either directly or through a physician recruitment company.

Physicians who come through recruitment tend to be sent to Swedish class before migrating for a sponsored period of full-time study. After relocating to Sweden, an EU/EEA IMG (or their recruiter) will need to apply for a Swedish medical license and specialty validation with the NBHW. The fee for applying for a license is 2,900 SEK (≈ 280 USD) if you have completed an internship (AT) in Sweden. The application fee is 870 SEK (≈ 85 USD) if you have not completed an internship (AT) in Sweden. The fee for applying for recognition of a specialist qualification is 2,900 SEK (≈ 280 USD). EU/EEA trained IMGs may apply for both their medical license and validation of residency training at the same time.

Unofficial step	**Step 1**	**Step 2**	**Step 3**
Swedish language proficiency training	Pay medical license application fee and submit to NBHW	Submit proof of Swedish language proficiency to NBHW (designated coursework or employer attestation)	Pay specialty validation application fee and submit to NBHW (some supplemental residency training may be required)

Table 3. Swedish Medical Licensing for EU/EEA IMGs

Depending on said employer, supervisor or recruiter, immigrant physicians may receive relatively holistic and continuous support ranging from professional mentorship and additional language and professional training[15] to help with government communications, finding employment for spouses, housing and school enrollment for their children. Although the employment of the physician may be secured by an accepted job offer, these additional measures are meant to ensure that the clinic and community will keep the physician in the long haul and limit the risk of losing the new recruit to another employer or having them return to their home countries.

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[15] IMGs from both EU/ESS and non- EU/ESS typically completes standardized Swedish language training in order to practice medicine effectively. Still, a recent Swedish study indicate that a majority of immigrant doctors see language barriers as one of the most difficult obstacles to overcome in their new work environment, and many find the required level to be insufficient and without attention to personal needs. The study also points to a correlation between job dissatisfaction and lacking language skills (Albadri and Mattson-Mårn 2019).

Literature Review

Migrating Physicians

When considering the vast diversity of the immigrant and refugee physicians around the world, their origins and destinations, it becomes a futile pursuit to find one-fits-all explanation as to why they migrate. Labelled as specialized high-skilled workers by host countries' visa systems, one might presume that they are motivated by professional aspirations. The road to a medical career is long and strenuous, often necessitating financial resources, family support and great personal resolve over time. To then pursue a career abroad requires another level of commitment and ambition, deterring a vast majority (van Heelsum 2016; Castles, De Haas and Miller 2013). It follows that we may picture immigrant physicians as determined, goal-oriented individuals propelled forward by the desire to achieve something more advantageous than their home countries could offer.

Studies and reports have often placed physician migration within the frameworks of functionalist approaches, such as basic neoclassical economics or push-and pull models, emphasizing a rational choice and a conscious assessment of costs and benefits (Mej'ia, Pizurki and Royston 1979). Neoclassical economics argue that migration is caused by geographical disparities of supply and demand in the global labor market where some countries hold a surplus of labor and others of capital. Where wages are low, people will leave for destinations that promise more lucrative employment, professional development opportunities and job security (Harris and Todaro 1970; Hicks 1932; Lewis 1954). Similarly, push-and-pull based explanations suggest that migration is initiated by calculations of "pros" and "cons," the push factors of the home society and the pull factors of another; people will leave places where life comes at a high cost and move to more favorable locations (Bauer and Zimmermann 1999; Passaris 1989). For immigrant physicians, push factors would often include low wages, poorly equipped work environments with shortages of basic medical supplies, lack of mentorship and limited career opportunities. Depending on sending country, more urgent factors may also be significant, such as humanitarian crises, ethnic or religious conflicts, or political unrest (Ahmad 2005).

While functionalist models tend to portray the immigrant physician as an economically motivated careerist, traditional stereotypes associated with the medical profession often entail a selfless ideal; one *is* a doctor as opposed to *working* as one. Shuval and Bernstein describe how being a physician is often thought of as not just a job or a paycheck, but a "calling:"

> "This concept refers to an all-encompassing devotion to work characterized by total personal involvement that focuses on the intrinsic rewards of work, transcends the monetary reward and spills over to invade the professional's leisure time leaving little space for extra-occupational concerns. Medicine, seen as the prototype of the professions, has been thought to express this 'calling' or 'vocation' in a total dedication to the intrinsic goals of healing geared to the patient's welfare." (1996:966).

This altruistic stereotype is challenged by the fact that many IMGs come from developing states and gravitate towards Western countries, such as North America, Australia and (Western/Northern) Europe, which often offer more favorable and/or rewarding work conditions. This pattern raises concerns about brain drain and health professional poaching, leaving sender countries with increasing healthcare shortages while their medical professionals relieve those of other countries (Ahmad 2005; Boeri et al. 2012; Ouaked 2002).

While it is tempting to make *doctor* the master status of this group of migrants, it is also necessary to place motivation to migrate within the context of households and social networks (Stark and Bloom 1985). Next to *doctor*, we need to consider other social statuses, such as *parent*, *child*, *provider* or *refugee* and the responsibilities or desires that come with those positions. As many scholars have pointed out, functionalist models of migration are ahistorical and lack attention to global and local structure. Many scholars (Donato and Massey 2016; Massey 1999; Sassen 2007; Skeldon 1997) underline the importance of an initiation for a migration to be set in serious motion. Bonds formed during the colonial era left pathways and bridges increasingly travelled in our economically globalized world. Studies on immigrant medical professionals often centers a certain nationality or origin, such as Soviet (Bernstein and Shuval 1998; Factourovich et. al 1996; Remennick, and Shtarkshall 1997), Korean (Shin and Chang 1988), Indian (Mullan 2006; Sharma et al. 2014), or Sub-Saharan (Tankwanchi et al. 2015), demonstrating how initiation and pathway will facilitate a migratory flow and shape a shared experience of professional and cultural integration.

Signed in 1985, international treaties such as the Schengen Agreement are both a result and a perpetuation of globalization, allowing European citizens to reimagine and expand their labor markets. In 90's, the US saw a significant increase in H-1B visas for skilled professionals because of the tech boom, and with it came STEM experts — including physicians. Since then, the visa category has been subject to debate and experienced a decrease as a result of US programming jobs being relocated offshore, and the issuing of the Patriot Act following the terrorist attacks on 9/11 (Kibria, Bowman and O'Leary 2013; Lewin, Massini and Peeters 2009). While some policymakers and interest groups have been opposed to allowing immigrants — including high skilled workers — to take up a larger space in the US labor market, others argue that further restrictions would potentially be detrimental to American hubs of innovation, science and technology. The shortage of physicians is often found in the center of this debate, illustrating an urgent humanitarian need for skilled immigrant medical professionals that few can argue with (Chellaraj, Makus and Mattoo 2006).

By centering the immigrant physician, we are able to connect political debates on immigration with matters of public health — both as it pertains to the communities that immigrant doctors serve and for those left behind. Furthermore, migrating physicians are often manifest of the interplay between the global and the local, emphasizing how the scope of modern medicine is becoming increasingly globalized, yet with significant impact on local circumstances (Sassen 2007). While other high-skilled migrants in the tech industry or high-level management tend to operate and communicate transnationally, immigrant physicians' time and energy are often deeply invested in the particular communities they serve and their opportunities to obtain research grants or take part in international collaborations or exchange are often limited (McMahon 2004).

Immigration and Public Health

Locating the case of immigrant medical professionals in the literature requires bridging matters of immigration and public health. In order to understand medical migration and immigrant physician integration, we need to grasp the nature of the demand that they are supplying. Medical shortfalls are of great concern within healthcare literature and many studies centers how this problem is particularly exacerbated in rural areas. Often solution-oriented or with policy recommendations, healthcare researchers have explored and suggested a variety of operational practices that may alleviate the lack of physicians. Some highlight the potential of telemedicine, a technological innovation gaining increasing traction in both the US and Sweden (Groth et al. 2014; Marcin, Rimsza and Moskowitz 2015). Others point to increased use of non-physician professionals, such as nurse practitioners (NPs) and physician assistants (PAs) (Cooper 2007), or some rationalized combinations of said efforts (Green and Savin and Lu 2013).

Although these studies offer optimistic findings, others maintain the inescapable need for international medical graduates, which is expected to grow even more acute as a majority of baby boomers will be over 70 years of age by the year of 2020. Salsberg and Grover (2006) maintain that the US has allowed itself to become reliant on expanding foreign medical schools and immigrant physicians to respond to the country's shortfall. The authors call on US medical schools, teaching hospitals and policymakers to rise to the occasion and effectively address the shortage in the next few years before the situation becomes unsustainable. Other researchers make few to no pleads to US institutions and focus instead on the extent to which immigrant physicians are able to meet the demand of rural communities and how variations in state policies influence their distribution in underserved areas (Baer et al. 1998).

Even with an expansion of US teaching hospitals and increased enrollments in US medical schools, the issue of attracting domestic doctors to underserved areas remains. Rosenblatt et al. (2006) find that although the US government is attempting to relieve underserved areas by expanding the capacity of community health centers, rural community health care centers are struggling to fill vacancies and adequately serve their populations. In order to recruit physicians, the rural health centers find themselves dependent on National Health Service Corps scholarships, loan repayment programs, and immigrant doctors. Uncompetitive salaries, cultural isolation, low-quality schools and housing and lack of spousal job opportunities render the countryside less attractive, and therefore largely staffed by IMGs with J-1 visa waivers whose immigration status is contingent upon accepting the conditions outlined above (Rosenblatt et al. 2006).

Integrating Immigrant Medical Professionals

Immigration studies have rich subfields concerned with the challenges of low-income and undocumented persons (e.g., Das Gupta 2014; De Genova 2004; Gonzalez 2011; Ngai 2004), and globalization literature is often concerned with the mobility of cosmopolitan, transnational elites (e.g., Bauböck 2005; Bosniak 2000; Ong 1999; Sassen 2008). However, the integration process and experiences of the academically trained immigrant is relatively understudied. There is a substantial body of literature concerned with (predominately female) immigrant nurses and their experiences of integration. Many of them are concerned with the interplay between legal constraints and sociocultural clashes and stressors; Xiao, Willis and Jeffers (2014, also see Xu 2007) show that immigrant nurses' integration is hampered by a combination of the employer-sponsor visa system and erasure of experiences and expertise. The authors argue that the recruitment, classification and validation of immigrant nurses at both the organizational and national levels need to be improved in order for them to successfully adapt to the workforce. A Canadian study reveal the increased vulnerability of immigrant nurses of color, finding that they are both subject to marginalization and racist experiences, and reprimanded when attempting to file grievances or complaints. As a result, they are forced to develop personal coping strategies while suffering physical and emotional pain (Hagey et al. 2000).

Research with Indian immigrant nurses in the US demonstrate similar findings of cultural limbo and marginalization, while also highlighting the intersectional aspect of sexism and racism (Dicicco-Bloom 2004). Examining immigrant Filipina nurses, clinical research has also found that long-term exposure to American society is associated with increased blood pressure both within and outside the workplace (Brown, Daniel and James 2000). The more developed literature on immigrant nurses in comparison to immigrant physicians is perhaps an indication of the middle/upper middle class being an academic blind spot — a common occurrence within empirical sociology. While "studying up" has become more prevalent in sociology of migration as indicated above, examining immigrant physicians' integration will contribute to a "horizontal gaze" while also accumulating knowledge about an issue that is in need of political attention.

When contrasting research on immigrant nurses and immigrant doctors, it seems like immigrant doctors are less concerned with systematic or chronic marginalization and more oriented towards a more temporary loss of status and the struggle to reclaim it. Shin and Chang (1988) conducted a survey-based study of what they call the ”peripheralization” of Korean doctors in the US during 1980’s, and there are several interdisciplinary studies from the late 1990’s examining the case of doctors from the former Soviet bloc migrating to Israel (Bernstein and Shuval 1998; Factourovich et. al 1996; Remennick, and Shtarkshall 1997). In addition, Bernstein and Shuval (1997; also see Shuval 2000) compare Soviet doctors’ professional integration in Israel to their co-national colleagues migrating to Canada and the US, mapping the physicians’ efforts to reestablish themselves and their professional identities while experiencing the different sets of structural constraints in the three industrialized host societies. Like Shin and Chang (1988), Bernstein and Shuval (1997) finds gender to be a salient factor in the struggle to reclaim a professional status; women took longer time finding medical employment and when they ultimately caught up with their male peers in the medical workforce, they were less likely to be enrolled in or pursuing residency. In sum, traditional gender roles allowed men to overcome economic exclusion fairly quickly while women had to balance professional status recovery with family life, resulting in prolonged economic and social exclusion.

The fact that IMGs in the US are at a professional disadvantage is becoming increasingly documented in recent years by scholars from both social sciences and healthcare fields. Jenkins (2020) show that IMGs have to outperform their domestic counterparts in order to match into residency, yet still often end up in less prestigious programs while US physicians dominate elite positions in the medical field, causing an informal professional segregation and status segmentation. Jenkins argue that IMGs tend to be largely accepting of this hierarchy, which has also been corroborated in other studies (Ahmed et al. 2018; Chen et al. 2010).

On an interpersonal level, scholars have also observed how immigrant status among physicians is intersecting with other forms of minority identity, such as race and religion. Saha et al. (2000) find that Black American and Hispanic patients prefer to be treated by physicians of their own race or ethnicity, and the cultural knowledge and sensibility that is associated with it. The authors subsequently call for a medical school admissions and policy reform that will increase the supply of minority physicians whose ethnicities correspond with underserved patient bases, which is also seconded by Reede (2003) and Marrast et al. (2014). Research on general practitioners in Norway also find that immigrant physicians develop a bicultural competence, which often results in them treating more immigrant patients and experiencing a heavier workload than their domestic peers. At the same time, they also feel pressure to outperform and be more cautious than their Norwegian colleagues in order to gain acceptance and avoid complaints from patients (Díaz and Hjörleifsson 2011). This finding is reminiscent of the John Henryism phenomenon coined by Sherman James, describing the physical and mental detriments of prolonged overachievement often experienced by persons that are vulnerable to social discrimination (for example, see James, Hartnett and Kalsbeek 1983; James 1994).

Other studies from both the US and Sweden also show how minority physicians, including immigrants, face prejudice and discrimination, often in intersection with gender (Crutcher et al. 2011; Spak, Holmberg and Gambe 2014). After 9/11, studies also show how Muslim physicians are experiencing increased racial discrimination, rattling not only their professional identities but also their sense of collective identity (Abu-Ras, Senzai and Laird 2013; also see Selod 2015). It follows that discrimination can take many forms and generate different consequences for IMGs depending on their individual categories of social advantage and disadvantage. Immigrant physicians may experience both heavier workloads as a result of taking on more immigrant patients, but they are also at risk of being discriminated against by patients who may prefer a native-born doctor. While workplace discrimination or difficulty to adapt can take a financial toll, interpersonal slights can compromise emotional and mental well-being. The psychosocial tools with which an elite professional may overcome, disregard, or downplay these obstacles should also be acknowledged. IMGs often come from high socioeconomic status backgrounds and as such may be less likely to internalize or identify with marginalization (Kahn 2010).

Theoretical Frameworks

Nation Branding and Contexts of Reception: IMG Expectations versus Reality

I synthesize scholarship on *nation branding* and *contexts of reception* in order to examine how immigrant physicians in both the US and Sweden come to perceive their countries of destination — before and after arrival. I use the concept of nation branding to understand how the US versus Sweden directly or indirectly promote themselves on the international medical labor market, and IMGs' motivations behind choosing each destination country. I use contexts of reception to understand how IMGs expectations compare to reality as they go through the licensing procedures and start to establish themselves in their new medical field and host society.

Hao et al. (2021) argue that all nations can be conceptualized as brands since a nation can be thought of as a compound of historical and contemporary associations that are relevant to international marketing strategies and reputation management. The definition of nation branding is under debate but has been briefly operationalized as utilizing branding and marketing communications techniques in order to promote a nation's image (Fan 2006). Others highlight how complex and all-encompassing nation branding is, involving several levels, components and fields and engaging a variety of stakeholders catering to multiple audiences. According to Fetscherin (2010), nation branding is inherently public and concerns a country's entire image, covering political, economic, social, environmental, historical and cultural facets. It follows that nation branding can be broadly applied, ranging from international marketing campaigns featuring nation-specific products or industries (e.g., refreshing Coca Cola from the US or family-friendly IKEA from Sweden), to master narratives or historical myths (e.g., the American Dream or the Swedish utopia of "the people's home" [*folkhemmet*]). Both material and non-material products of a nation's brand influence its reputation and target audiences (such as consumers and migrants) receive a country's brand on the basis of both personal experiences and other sources of information (Kang and Yang 2010).

Nation branding is intimately connected to the studies on the cultural wealth of nations, examining how political economies enhance their prosperity though symbolic and cultural means. Bandelj and Wherry (2011) argue that a nation that is able to harness its symbolic resources (such as collective narratives, reputations and ideas) will likely be more successful in attracting foreign investment and tourism.

My work puts nation branding in conversation with physician migration and shortfalls, examining how IMGs perceive the US versus Swedish nation brand and the role it plays in their decision-making processes. A major part of comparison is the extent to which these two host countries in need of physicians actively brand themselves to IMGs, and how IMG positionality, background and nationality may affect the kind of message they receive or internalize. Here, binational relationships between sender and destination country have to be taken into consideration, i.e., India's historically established chain migration to the US, free movement between EU countries Poland and Sweden, the US invasion of Iraq, and Sweden's considerable Iraqi refugee reception.

If these nation brands represent a "front stage" in international impression management, contexts of reception can be seen as a "back stage" (Goffman 1959) — the unadulterated realities of immigrant life in each society. Portes and Rumbaut (2001) describe context of reception as individual perceptions of the overall valence that a destination society projects toward an immigrant group, and the level of acceptance, support and opportunity made available to said group. Contexts of reception can be thought of as a spectrum where positive ones will allow immigrants to be received with openness, find employment and grow social networks. A negative context entails experiences with hostility, isolation, discrimination and difficulty finding a job (or in the US case, residency position) (Schwartz et al. 2014). Within this framework, there are also *perceived* contexts of reception, emphasizing how host societies may vary in their levels of openness towards immigrants; larger cities or settlement areas with immigrant enclaves may present different sets of difficulties and possibilities in comparison to smaller communities or rural areas that are not as well-versed in immigrant incorporation. This point is particularly important in the case of IMGs because of the crucial role they play in rural and remote spaces in both the US and Sweden. Furthermore, host societies can have dissimilar attitudes and assign varying levels of desirability towards different immigrant nationalities or ethnicities, presenting some with more favorable receptions than others (Schwartz et al. 2014). There can also be variations within an immigrant group; individual perceptions of local contexts of reception can be a result of personal levels of acculturation in addition to other individual, social and economic resources (e.g., language skills [Bleakley and Chin 2010]; lighter skin tones [Bonilla-Silva 2004]).

I provide new insights by applying (perceived) contexts of reception to a group that is not just characterized by their nationality, but also their profession — a profession that both receiving societies are in need of. IMGs are at intersections of multiple immigrant group categorizations that may all play into their perceived contexts of reception. They are all part of the same high-skilled academic immigrant group, yet they also belong to separate nationalities that each have their own specific binational relations and agreements with the US versus Sweden, as indicated above. As a result, some IMGs arrive at their destinations through facilitated migration flows while others (most prominently refugee IMGs) spend significant amounts of money, time and energy in their efforts to reach and establish themselves in their host societies, which will differentiate their perceived context of reception. I argue that nested within nation branding and contexts of reception are the crucial impacts that visa regimes and migration industries have on IMG motivations and incorporation.

Visa Regimes and Migration Industries

As visa regimes regulate entry into and the conditions of immigrants' stay in a receiving country, they are at the heart of any issue related to migrant workers. Salter argues that "the global visa regime and international borders are crucial in constructing both international mobile populations and international mobile individuals" (2006:167). At their core, visa regimes are expressions of sovereignty and a manifestation of power that a receiving country has over its migrants and populations. Aygül (2013) emphasizes the puzzling fact that labor mobility across borders is a vital part of all capitalist economies, yet the inner workings of this process can be elusive and difficult to grasp. Paradoxically, the age of globalization has also brought concerted efforts of states and other political agents to control or even restrict labor mobility. Scholars point out that transnationalism is often reserved for citizens of the Global North while workers, refugees or tourists from the Global South are generally subject to more vetting and visa requirements due to underlying suspicion of overstays, crime and terrorism (Czaika, de Haas and Villares-Varela 2018). The executive orders by President Donald Trump on January 27 and March 6, 2017 that banned citizens and refugees from seven majority-Muslim countries is a prominent example of this dynamic, which affected thousands of

IMGs practicing in the US — and their patients (Kalra, Shah and Zoghbi 2017).[16]

In the US case specifically, it is nearly impossible to analyze IMG contexts of reception and the role that IMGs play in the physician shortfall without centering the impediment that is the US visa regime. It is not finding employment or fellowships that is the biggest hurdle for immigrant doctors, neither do extensive licensing procedures deter IMGs from pursuing medical careers in the US. Rather, the major challenge (over which they have limited control) is obtaining an immigration status that will allow them to work and live in the US long term (Kavilanz 2018; Malhotra 2021). Since the 1990's, the US has received thousands of skilled workers from the Global South (predominately India) on temporary nonimmigrant visas, creating a malleable workforce with tenuous legal and work status. This labor force is strategically built on a complex constellation of visas, each with their own stipulations and purposes that tend to serve neoliberal, corporate interests and provide little security to workers (Banerjee 2010).

IMGs pursuing US licenses and residency have two of these visas available to them: J-1 and H-1B. J-1 visas are sponsored by the ECFMG at no cost to the residency program, while H-1B requires sponsorship from the training hospital, which typically costs between 3,000–4,000.[17] Due to the cut in Medicare graduate medical education funding in 2016, many residency programs stopped offering H-1B visas. As a result, the majority of current IMG residents are J-1 visa holders — a visa that mandates a two-year home country physical presence requirement following the completion of the program. This requirement may be waived and the J-1 turned into an H-1B if an IMG is able to practice in a federally designated underserved area for at least three years through a government-sponsored program known as the Conrad 30 Waiver Program, run by each State's Department of Health. However, the slots in this program are limited. Furthermore, both J-1 and H-1B visas can be subject to delays for several months pending security clearance, which can jeopardize residencies and fellowships. If an IMG has dependents, their status in the US will also be contingent upon the IMGs visa.

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[16] Read more about how these orders affected IMGs at The Immigrant Doctor Project (https://immigrantdoctors.org/).

[17] While this is the standard amount, costs can range from $1,700–$6,500 in 2023. The exact amount will vary depending on many variables such as optional fees, attorney fees, and employment criteria. Read more at immi-usa.com (https://www.immi-usa.com/h1b-visa-processing-fees-2016/) and at USCIS.gov (https://www.uscis.gov/forms/all-forms/h-and-l-filing-fees-for-form-i-129-petition-for-a-nonimmigrant-worker)

It follows that visa-related uncertainties and anxieties follow most IMGs for years into their migration, inhibiting their ability to take advantage of professional opportunities and spilling into their personal lives, ultimately shaping their perceived context of reception. Even the path from H-1B to green card is not straightforward; due to an annual cap on employment-based green cards and a 7% quota per country, studies have estimated that more than two million Indian nationals will be held up in the green card backlog by 2030. Many IMGs will likely wait for decades before gaining permanent residence and a path to citizenship (Kandel 2020). The many bottlenecks in the US visa regime have caused significant frustration for not just IMGs themselves, but the US medical community as whole and some express concern that the current visa system will ultimately rob the US of future IMGs. In the *Journal of General Internal Medicine* for example, Al Ashry, Kaul and Richards assert that, “Despite FMGs [foreign medical graduates] being welcomed in the medical community, the current visa system for FMGs is a significant reason for delays in effectively recruiting and incorporating FMGs into clinical and academic practice in the US and may prompt future FMGs to seek positions in other non-US countries” (2019:1340).

In the Swedish case, I center the role that migration industries play in the Swedish nation brand directed at IMGs, their pathways to Sweden, and their perceived contexts of reception. The Swedish visa regime is largely linked to the EU/EEA visa regime, which entails internal free mobility and work authorization, as well as mutual recognition of medical diplomas and certificates. Citizens from non-EU/EEA countries who have completed an advanced degree (college or graduate degree) may apply for a temporary residence permit that lets them spend 3–9 months in Sweden while looking for employment. Securing a job then lets one apply for a work permit and after holding a work permit for 48 months, one may apply for permanent residence which provides a path to family reunification and citizenship. However, citizens from active war zones (including IMGs) often experience difficulty obtaining visitor’s visas to Schengen area due to perceived security risks and are often forced to find their own way to the Swedish border through illicit routes.

In the favorable climate that is internal EU/EEA mobility, a migration industry of international IMG recruitment has thrived, expediating pathways predominately Eastern and Central to Western and Northern Europe by connecting IMGs to foreign employers, provide language courses, and other miscellaneous services meant to soften the transition. The border between EU and the MENA region has also given rise to a smuggling industry through which refugees (including physicians) often find their way to Sweden and other European destinations. Hernández-León defines the migration industry as "the ensemble of entrepreneurs who, motivated by the pursuit of financial gain, provide a variety of services facilitating human mobility across international borders" (2008:154). Within the migration industry, scholars have mapped out a variety of actors (ranging from state sanctioned to illicit) serving different roles. Intra-European physician recruitment firms belong to a set of actors that facilitate access to legal migration while the smuggling industry is part of another sector comprised of smaller enterprises typically organized by migrants themselves, capitalizing on their transnational knowledge and networks by providing assistance and services to prospective migrants. Some agents in this sector are formal, such as transportation companies and lawyers while others are informal so-called "people-pushers" who facilitate border circumventions and falsify papers for asylum seekers and unauthorized migrants (Gammeltoft-Hansen and Nyberg Sørensen 2013). Importantly, the former industry is financed by IMG employers while the latter comes at a cost to individual migrants and IMGs.

I argue that the latter falls into the shadow of the former, which is behind large portions of the Swedish IMG workforce (Gunnarsdotter 2005; Linnersten 2005). In a sharp contrast to the obstacle course that is the US visa regime, the purpose of the European physician recruitment industry is to level obstacles to physician migration that are already relatively low within the EU/EEA. This radical advantage enjoyed by European IMGs creates a formal segmentation between EU/EEA and non-EU/EEA IMGs, potentially reproducing racial hierarchies already existing between ethnic Europeans and racialized groups in Europe, often based on the presumed incompatibility between Muslim immigrants and Western norms and values (for example, see Kundnani 2014; Morgan and Poynting 2016).

CHAPTER TWO: METHODS AND PROCEDURE

The empirical contribution of this international research project is built on 63 interviews with Indian, Polish and Iraqi IMGs who have migrated to the US and Sweden respectively; 21 Indian and 12 Iraqi IMGs in the US, and 20 Polish and 10 Iraqi IMGs in Sweden. Data collection spanned over a total of four years, starting in 2019 and wrapping in 2022. Apart from my interview series, I compile and synthesize official statistics and organizational documents on both countries to help contextualize interviews and findings, most of which inform the structural and institutional comparisons in the previous and upcoming chapter.

As with all qualitative research conducted at this point in time, my study procedures were impacted by Covid-19. While the pandemic does not have a huge bearing on the interview content because large parts of the interview protocol ask participants to reflect upon past experiences and processes that took place before the breakout, Covid-19 did influence the research design and it most certainly affected the participants' professional and personal lives at the time of the interviews. Importantly, the pandemic lent weight to one of my dissertation's overarching points: the fact that IMGs are an invaluable yet understudied group, bringing crucial numbers, contributions and skillsets to US and Swedish healthcare. Understanding their motivations for migrating, their pathways to host countries, and the different constellations of obstacles opportunities they are presented with in different political economies is of vital importance, illuminating important facets of both healthcare and immigration policy in the US and Sweden.

In this chapter, I go over the research design and methodology behind the project, their strengths and challenges and the different stages of data collection. I maintain that while the research design underwent some adjustments from the planning stage to the project's conclusion due to the pandemic, these were adaptive and necessary and ultimately generated a sample that was both rich and diverse, incorporating more geographical areas and settings than would have been possible with in-person interviews.

Method

Since the primary focus of this study concerns how immigrant physicians' experiences and motivations are shaped by their different national and institutional contexts, semi-structured in-depth interviewing emerged as the most appropriate method. In-depth interviews allow us to gain insight into how people make decisions; their motivations for doing so; the meaning they attach to certain events and experiences and how they feel about them. In other words, interviewing helps us understand the individual's narrative and the context in which it takes place (Hennink, Hutter and Bailey 2011). In order to address my research objective, I asked IMGs questions related to their decision to migrate, immigration process, professional integration and workload, acculturation and policy recommendations. At the end of each interview, I would also ask each participant if there was something I should have touched upon that I had not, which often yielded new directions, perspectives and important insights into what IMGs thought of as significant or meaningful about their own experiences or the experiences of immigrant physicians in general. Each interview ranged from 30 minutes to over two hours, depending on each participant's bandwidth, time constraints and elaboration.

Interviewing Physicians as an Elite Group

Interview methods are considered one of the most effective tools for researching elite populations and individuals, as they tend to engender more transparency, responsiveness and novel data in comparison to surveys or questionnaires (Harvey 2010). To this point, studies have indicated that physicians as a group have long been challenging to survey, likely due to their long work hours and heavy administrative burdens resulting in paperwork fatigue (Berk 1985; Kellerman and Herold 2001). My experience confirmed these findings as I struggled with slow response rates for the demographic survey that accompanied each interview. Questions that required participants to reflect or count back, such as the number of years they had practiced medicine, seemed to have a higher threshold than more straight-forward ones, such as questions related to their specialty or marital status. I therefore found it prudent to limit the number of questions that required an active thought process in the survey and reserve them for the interviews. Flexibility such as this was key, adapting the research design and interview format to the needs of the participants. Although Covid-19 prompted a shift away from in-person to digital interviews, being open to the interview format of each participant's choice as opposed to committing to a standard procedure of in-person conversations in a certain context or setting soon became a necessity — pandemic or no pandemic. Being accommodating in your research design is also a standard recommendation for scientific inquiries with elites (Harvey 2010).

While there is a rather robust body of knowledge on methodological strategies for researching elites, they tend to focus on target populations in the corporate, financial and political world (for example, see Harvey 2010; Mikecz 2012). I find that physicians as an international group present some ambivalence towards their own status as elites; most of them engage with and help people in vulnerable states on a regular basis (especially IMGs who tend to serve the underserved more so than their domestic colleagues), yet their cultural, symbolic and material capital associated with academic credentials, generally well-respected status positions and high salaries sets them apart from a majority of their patients and other community members.

In social science settings, elites have been described as “generally hav[ing] more knowledge, money, and status and assume a higher positions than others in the population” (Odendahl and Shaw 2002: 299). It follows that the esteem that an elite group is held in is relative to the norms and values of the particular population or society in which it operates. I maintain that while physicians are elites globally, the degree of their elevation varies based on national context and the capacity in which they serve, such as region and specialty. Throughout my research, I found IMGs in Sweden to be more accessible in general, which I attribute partly to my positionality as a local, partly to the Swedish cultural norm of equity or taboo related to self-importance or elitism, and partly to the more generous work-life balance that the Swedish based IMGs generally enjoyed. In fact, many participants in the Swedish case study described being motivated by “everyone being equal” in Sweden, while many in the US sample were driven by ambition and financial success, mirroring each country’s nation brand.

In-Person versus Digital Interviews

Following the outbreak of Covid-19, the National Science Council reported that 87% of US researchers experienced disruptions such as lack of access, termination of projects, and lack of control over future research agendas (Levine et al. 2021) and I was no exception. In the beginning of this project, I was committed to in-person interviews with physicians in both Sweden and the US, expecting geographical clusters and limitations. At the breakout of Covid-19, I transitioned to digital interviews and video calls with IMGs from all over both countries. As data collection began in Sweden in 2019 before the onset of the pandemic, one third of the Swedish based interviews (along with ten pilot interviews with IMGs from a variety of nationalities) were collected in person; I would travel to different primary healthcare centers, hospitals, coffee shops and other locations based on participant preferences. In the same fashion, one third of the US based interviews were also collected in person, some in the Boston area and some in the Atlanta area.

I soon found virtual interviews to be just as (if not more) personal than traditional ones, meeting people in the comfort and calm of their homes rather than offices or busy coffee shops. While Covid-19 had made some IMGS busier than ever and preferred to do the interview over the phone while they were driving to work, others found themselves in quarantine after an exposure and with more time on their hands than they were accustomed to which usually led to longer and richer interviews. While I had previously sat across from a physician in the same chair a patient would while conducting an interview, I now met with many participants “backstage” where they seemed more inclined to be personal and less concerned with impression management (Goffman 1959). It is clear that the location of an interview can have a significant effect on the amount or kind of information a participant is inclined to share. Conducting an interview in a workplace may make the interviewee less comfortable discussing confidential information or go over a certain time allotment, for fear of being overheard or have co-workers or supervisors be unhappy with them taking time off from other duties (McDowell 1998). This dynamic could be particularly problematic for participants with less autonomy in their workplace, and for those who had complaints about their work situations. Since my insight into these sentiments were limited before an interview, I would always leave it up to the participant whether they wanted to do digital interviews in their office or at home, before or after working hours.

Sampling Techniques and Challenges

Participants were recruited using wide outreach and randomized recruitment, followed by snowball sampling strategy. Since a snowball sample is next to impossible to replicate or generalize, it has frequently been banished to the margins of social science methodology. Still, snowball sampling is both advantageous and appropriate when attempting to access certain populations that could otherwise be challenging to recruit, including elites (Harvey 2010). While snowball sampling strategies have traditionally been associated with accessing target populations that are considered vulnerable or deviant, they have proven to be just as useful for accessing participants in prestigious positions, which can be equally as challenging to come into contact with. Atkinson and Flint write: “The main value of snowball sampling is as a method for obtaining respondents where they are few in number or where some degree of trust is required to initiate contact" (2001:2). In this sense, a snowball strategy is a pragmatic way of making use of "a foot in the door" once a first connection has been made. After a good relationship is established between researcher and the first few participants, they may help initiate a chain referral to other members of the target population that might otherwise have been extremely difficult for an outsider to get in touch with (Atkinson and Flint 2001).

Participant recruitment remained challenging throughout the data collection process, and I was never able to be particularly choosy with interviewees outside of the inclusion criteria, i.e., being an IMG from India or Iraq living in the US, or a Polish or Iraqi IMG living in Sweden. Still, I made an effort to pair my convenience or snowball sampling with a theoretical sampling strategy (Glaser and Strauss 1967; Charmaz 2006). After having mapped out a few thin categories of relevant findings, theoretical sampling helped me elaborate and refine these categories by focusing my recruitment on participants that could provide further insights into said findings. The most significant theoretical direction in my sampling strategy was connecting with a fair number of IMGs who had perspectives on or experiences with working in underserved areas. I gathered data until my categories were saturated and no new significant patterns emerged. I reached satisfactory saturation at around 20 interviews with each nationality (Indian, Polish and Iraqi, the latter split between the US and Sweden).

Data Collection Process

In Sweden, I had pre-established access to an education center[18] for immigrant doctors as well as the administrative management of the *Bra Liv* public healthcare center network in Jönköping County Council (*Region Jönköpings län*). I had further connections in several other regions, such as Västra Götaland County Council (*Region Västra Götaland*), and Västernorrland County Council (*Region Västernorrland*). All of these areas have been active in the recruitment of IMGs. In the summer of 2019, I undertook pilot fieldwork in Sweden, in which I interviewed fifteen immigrant physicians of various national backgrounds in-person, two of which had come to Sweden as refugees from outside of the EU. I also interviewed an IMG recruiter who had previously worked for a recruitment company but was now employed directly by a county council. While I did not include any of these interviews in the official sample that this dissertation is based on, this preliminary study helped refine the interview protocol and facilitated early identification of emerging patterns and themes in the Swedish leg of the research. I would return to resume my data collection in Sweden the following year, and later switch to interviews over Zoom, WhatsApp, Skype, FaceTime and Microsoft Teams when Covid-19 put a stop to international travel.

In the US, I started my data collection by casting a wide net and approached a variety of organizations, associations and hospitals in the greater New England area, most importantly the Indian Medical Association of New England (IMANE). I did a smaller ethnography at one of their yearly meetings, which also served as a recruitment opportunity. While IMANE served as a springboard for early recruitment and allowed me to circulate calls for participants through their organization, only a handful of my interviews came out of their membership. I also connected with and circulated calls through Iraqi Doctors in USA (IDUSA), a nationwide social network of Iraqi IMGs. Much like with IMANE, general calls generated fewer interviews than personal chain referrals, often to friends and colleagues that might not necessarily be members of the same organization.

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[18] *Utbildningscentrum* in Swedish. At this education center, the administration of the public healthcare system in Jönköping County has decided to offer supplemental cultural and language training for their international recruits during their first few months in Sweden. This is meant to facilitate both their social, cultural and professional integration process.

The Boston area is not underserved, and so I wanted to expand my search to regions and participants that have experience with physician shortfalls. In order to diversify my sample and include IMGs from both rural and urban areas around the country, I traveled to the Atlanta area and conducted in-person interviews there, which also came to generate another strain of virtual interviews through referrals. In the end, my sample included IMGs who had practiced all over the US, from East coast to West coast, from the South and the heartland and Midwest.

In order to capture the institutional component of immigrant physician integration, I also interviewed representatives of licensing institutions; the National Board of Health and Welfare (NBHW) on the Swedish side and the Educational Commission for Foreign Medical Graduates (ECFMG) on the US side. NBHW and ECFMG are primary gatekeepers as they oversee the certification of all IMGs and the language and clinical skill requirements associated with practicing medicine in each country. By interviewing staff members, I was looking to gauge what role that these institutions play in each country's physician shortfall. In addition to interviews with staff, I also analyzed organizational documents outlining procedures and policies of these gatekeeping agencies, and the legal frameworks that govern them. These interviews and analysis helped lay the groundwork for the *Introduction* chapter and informed the third chapter; *Two Political Economies: Physician Shortages and Migrating Physicians.*

Lastly, I also spoke with physician recruiters. In Sweden in particular, international recruitment agencies will often help establish connections between immigrant physicians and their new workplace and provide additional guidance throughout the resettlement process. At times, Swedish recruitment agencies or representatives of healthcare networks will not only place advertisements for positions in foreign medical journals, but also travel internationally (typically within Europe) to take part in migration fairs and the likes in order to connect with physicians considering a career abroad. To supplement my interviews, I was initially planning on visit one or more of these fairs and gather ethnographic data, but the onset of Covid-19 made this unfeasible within the timeframe allotted for this research.

Collecting International Participant Demographics

Conducting an international research project entailed complying with two separate review boards; the US Institutional Review Board (IRB) at Boston University and the Swedish Ethical Review Authority (SERA), a national free-standing organization that reviews all research on advanced levels in Sweden. While the IRB does not oppose data collection related to national origin, race/ethnicity or immigrant status, SERA is far more conservative as it complies with restrictive national and international regulations for the protection of so called "sensitive personal data." In accordance with the Swedish Authority for Privacy Protection (*Integritetsskyddsmyndigheten* [IMY]), the processing of sensitive personal data is prohibited under the General Data Protection Regulation (GDPR) established by the European Union (EU). Sensitive personal data includes trade union membership, political, religious or philosophical beliefs, race or ethnicity, sexual orientation, genetic or biometric data. SERA does not only restrict direct questions related to the aforementioned categories, but also takes a protective stance towards adjacent topics or attributes that may lead research participants to disclose information about themselves that are considered sensitive personal data. I was advised that asking IMGs in Sweden openly about their origin or immigrant status was considered risky as it could potentially breach the protected territory. I therefore refrained from any direct prompts, but allowed interviewees to divulged what they pleased by ways of more open-ended questions, such as "Can you please tell me a bit about your background?" and "Can you describe the migration process?"

Another challenge related to comparing IMGs *in* different national settings and *from* different national settings is that there are divergences across medical school standards, specialties and what kind of clinical work counts towards years of medical practice. Matching survey responses to interview transcripts, most participants seem to count medical practice as any work conducted post-graduation in the capacity of licensed medical doctor (including internships, general practitioner practice, and supplementary/probational training periods in host countries), but there may be exceptions in which participants have entered only the number of years served as a resident and certified specialist.

In the charts below, I aggregate primary care and family medicine because they are largely synonymous across the two national settings yet have slightly different functions rooted in each healthcare system. Notably, no US participants referred to themselves as primary care physicians, and no Swedish participants referred to themselves as family medicine specialists, even though they served in largely the same settings. In Sweden, the term "family medicine" is largely obsolete and not recognized as an official specialty. Detangling internal medicine from primary care is also tricky — the difference between a primary care physician and an internist in Sweden is that a primary care physician would typically practice at a primary care healthcare center, also known as "open care," and an internist at a larger hospital, known as "closed care." A Swedish primary care physician sees both children and adults but will refer each patient to the appropriate specialist in closed care if need be. In the US, internal medicine physicians are often described as primary care physicians who treat only adults, while family physicians treat both adults and children. Another important difference on the topics of specialties is that Swedish specialties all require five years of training while US residency programs can vary greatly. For example, a licensed primary care physician in Sweden undergoes two more years of specialist training than the standard three years required from a US based primary care physician, and a Swedish residency in internal medicine is one year longer than the standard four years in the US. Bearing in mind these national differences provide valuable contexts to the survey responses reported below.

Origin	Gender	Year of arrival in US	Average years of US practice	Average years of total practice	Predominant medical specialties	Immigration status
Indian (N=21)	32% female; 68% male	Median: 2003 (range: 1967–2015)	Mean: 14 Median: 11 (range: 3–50)	Mean: 16 Median: 11 (range: 3–60)	Internal medicine (33%); family medicine/ primary care (33%)	US citizen (14); green card holder (2); H-1B visa holder (3); missing value (2)
Iraqi (N=12)	10% female; 90% male	Median: 2012 (range: 2008–2019)	Mean: 3 Median: 2 (range: 0–8)	Mean: 9 Median: 9 (range: 4–17)	Internal medicine (33%); surgery (25%)	US citizen (5); green card holder (6); J-1 visa holder (1)

Table 4. US Participant Demographics (N=33)

Origin	Gender	Year of arrival in Sweden	Average years of Swedish practice	Average years of total practice	Predominant medical specialties	Immigration status*
Polish (N=20)	50% female; 50% male	Median: 2007 (range: 2001–2021)	Mean: 12 Median: 13 (range: 1–17)	Mean: 24 Median: 27 (range: 10–35)	Family medicine /primary care (40%); pediatrics (35%)	100% EU/EEA citizen
Iraqi (N=10)	30% female; 70% male	Median: 2007 (range: 1999–2020)	Mean: 13 Median: 14 (range: 1–22)	Mean: 24 Median: 26 (range: 2–31)	Family medicine /primary care (40%); internal medicine (20%)	100% asylee/legal resident/work permit holder

Table 5. Swedish Participant Demographics (N=30)

*These data were not collected through the demographic survey but inferred or assumed from the fact that these IMGs have been able to practice in Sweden as physicians, of which an EU passport of legal residency is a prerequisite.

The specialties outlined in the figure are issued both in and outside of host societies. Values add up to more than 100% because nearly 25% of US-based interviewees and 40% of the Swedish-based interviewees reported more than one specialty.

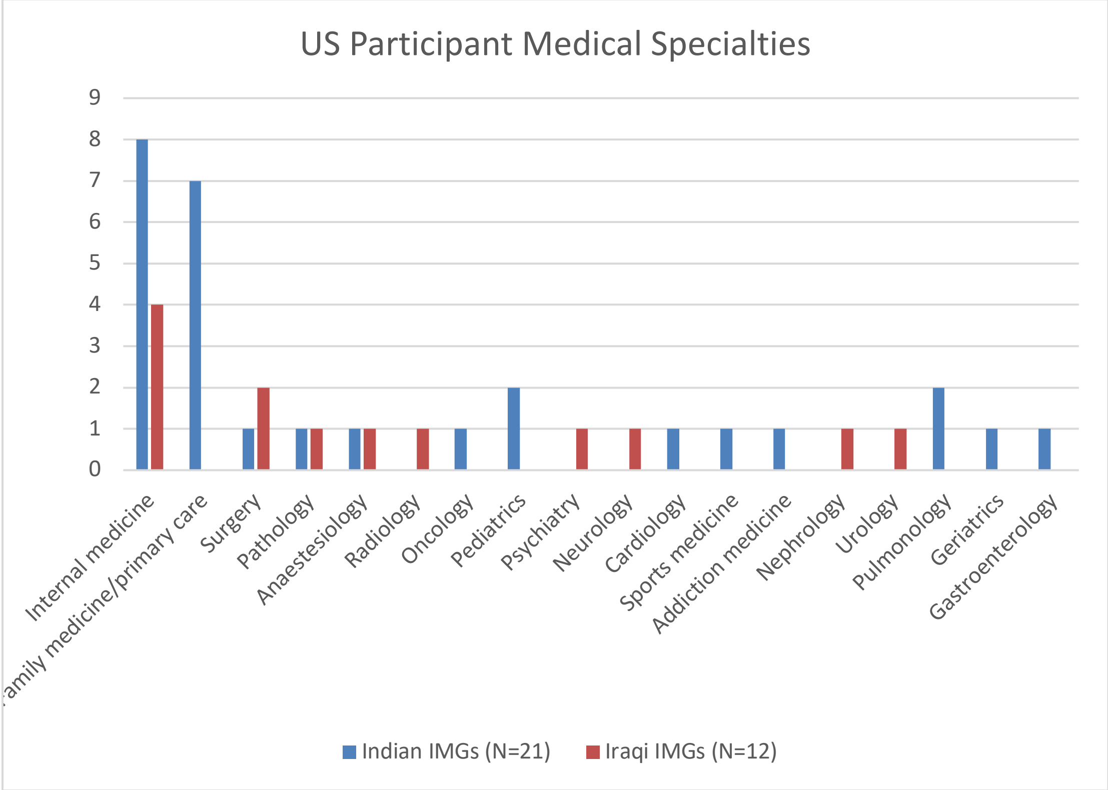

Figure 1. US Participant Medical Specialties

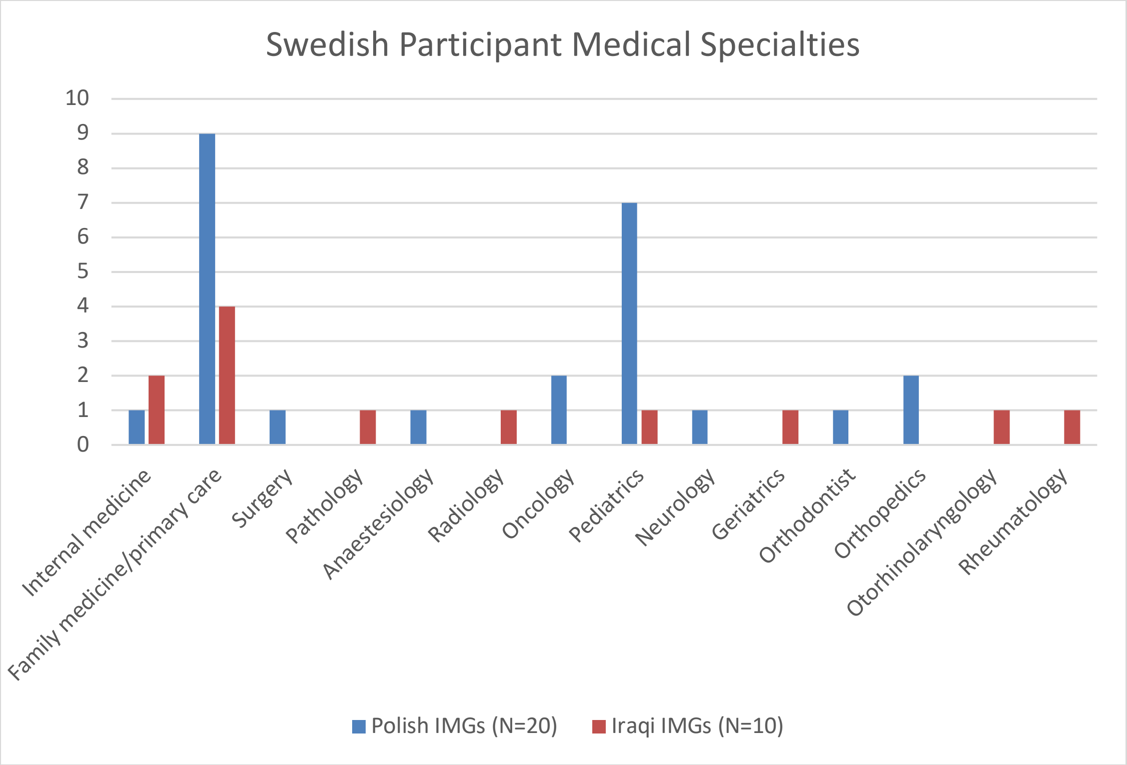

Figure 2. Swedish Participant Medical Specialties

Data Analysis

The analysis started as data collection progressed. While still being in the process of conducting the interviews, I simultaneously transcribed them and analyzed the data through a coding scheme in NVivo, including open coding followed by focused coding (Emerson, Fretz and Shaw 2012). In accordance with my grounded theory approach, I asked myself as I coded, which theoretical categories might these statements indicate? What are the underlying processes? What is meaningful? How are participants assigning importance to events? (Charmaz 2006; Emerson, Fretz and Shaw 2012). First, I went over the data carefully, naming terms, sections and lines in the transcript. Second, I identified the most salient codes and organized and categorized the data accordingly

(Miles and Huberman 1994; Charmaz 2006). During this process, I allowed myself to be guided and surprised by the findings, letting them take me in different and potentially unexpected directions. Studying and interacting with the data while it emerges was a crucial part of the process, as it helped me hone my interview protocol to better address reoccurring concepts and phenomena. After every completed interview, I found it useful to “dump” and process all my initial impressions of the conversation into in-process memos and integrative memos (Emerson, Fretz and Shaw 2012). These notes facilitated reflexivity and informed the analysis.

Although this is an interpretivist project inspired by grounded theory (Glaser and Strauss 1967; Charmaz 2006), I did not take an approach to theory that was strictly inductive. Rather, I made use of an abductive style of theory building, as proposed by Timmermans and Tavory (2012). They argue that we need to be more proactive in our views on the relationship between data and theory production, and not just expect theory to emerge on its own. Instead of pure induction, they propose an abductive strategy that involves identifying surprising findings and puzzles in the light of existing theoretical frameworks. This strategy requires a vast familiarity with a range of theories and no particular loyalty to any of them — it is under these circumstances we may move from old theoretical assumptions to new conceptual insights. It follows that the illustrative claims and observations I put forward are based on socially constructed meaning embedded in local context rather than observable conditions that can be quantifiable or replicated. Their validity stems from the intimate connections between data and theory, where the data is allowed to guide the theory rather than the other way around.

CHAPTER THREE: COMPARING TWO POLITICAL ECONOMIES – HEALTHCARE SYSTEMS, PHYSICIAN SHORTAGES AND IMMIGRANT PHYSICIANS

At the heart of this research is an argument about the largely understudied interconnectivity between immigrant labor and healthcare delivery in Sweden versus the US, especially as it concerns underserved areas and communities. The vital contributions that immigrants provide for both US and Swedish healthcare have only become even more apparent after the onset of Covid-19. In early 2020, the pandemic brought with it exacerbated shortfalls of medical staff, in addition to the closing of borders and normal embassy operations, and suspension of visas. While both the US and Europe scrambled to fast-track medical school graduations and exempt immigrant physicians' visa processing from other temporary hiatuses in order to increase the supply of medical staff, many immigrant physicians still faced uncertainty, caught between the urgent need to care for families and loved ones in countries of origin, and travel bans preventing their return to their host communities and patients (Malhotra 2021). While Sweden experienced few travel restrictions and border closings, the US opted for full lockdown along with many other countries around the world. It is estimated that more than a third of all frontline healthcare workers who died fighting Covid-19 in the US were immigrants (The Guardian 2021).

The pandemic has shone a light on how Swedish and US healthcare and immigration policy function under severe duress, and how they intersect in critical ways. In order to understand these junctions, we must situate them in a larger context of how each healthcare system is organized, how physician shortages have emerged, and the growing role of IMGs in each political economy. In this chapter, I return to and elaborate on the conceptual framework of comparison that is Varieties of Capitalism (VoC), initially mentioned in the subsection on Case Selection, situating the US and Sweden's physician shortage and IMG incorporation in two different broad types of market economies: the liberal market economy (LME) and the coordinated market economy (CME), in which the US and Sweden are considered prime examples of each model. I find that while there is an ongoing conversation between VoC and labor migration theory and policy, the specific case of migrating medical professionals to different kinds of political economies is understudied, especially as it involves a non-European country like the US. Along with other scholars, I put VoC to an empirical test and explore the extent to which the typology may help us account for the emergence of the physician shortage in each economy, and the responses with which each set of policymakers attempts to address it.

Prominently formulated by Hall and Soskice, VoC falls under the comparative capitalisms umbrella, and sets out to understand "the institutional similarities and differences among developed economies" (2001:1). Among OECD countries, the authors describe two categories of capitalist market economies — LMEs and CMEs — that set themselves apart by the ways in which firms relate to and navigate each other and other organizations and actors, such as the trade union movement for example. While firm operations in LMEs are governed by market hierarchy as opposed to state-imposed regulations, firms in CMEs adhere to more non-market codes of conduct in their relationships amongst themselves and with other agencies. While the LME and the CME are primarily considered two separate categories to be compared, it is also important to think of them as ideal types on a spectrum on which capitalist economies fall, relative to one another. Hall and Soskice are confident in classifying Australia, Canada, Ireland, New Zealand, the UK., and the US as LMEs, and the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), the Netherlands, Austria, Belgium, Switzerland, and Japan as CMEs. The Mediterranean countries (France, Spain, Italy, Portugal, Greece and Turkey) are more ambiguous, forming their own institutional trends around their distinct capitalist development (for example, see Glassmann 2016; Rhodes 1998). In many ways, the US and Sweden are particularly quintessential examples of each archetype; the US political economy is in many ways more liberal than many other LMEs (e.g., a healthcare system with many private actors, fewer federally funded social benefits), and the Swedish political economy is particularly coordinated (e.g., a strong welfare state with exceptionally heavy union involvement).

It should be noted that VoC is concerned with the private sector more so than the state, focusing on firms as the “key agents of adjustment in the face of technological change or international competition whose activities aggregate into overall level of economic activities” (Hall and Soskice 2001:6). However, while many firms operate on a micro-level, Hall and Soskice emphasize how their approaches to coordination have macro-level outcomes. In addition, they make the important point that the most significant institutional spheres are dependent on regulations that are established and reproduced by the nation-state. This interplay of state and free agents is particularly important when contrasting the US and Sweden’s healthcare system, physician shortfall and IMG incorporation.

The authors centers the VoC typology around five institutional spheres in which firms are compelled to establish relationships in order to coordinate their core competencies successfully: 1) *industrial relations,* in which firms navigate bargaining power over salaries and working conditions with their employees, their representatives and other firms; 2) *education and vocational training*, referring to how firms coordinate securing a workforce with the appropriate skills, and worker’s motivation to acquire and invest in those skills; 3) *inter-firm relations*, addressing how firms form relationships with other enterprises (and their suppliers or clientele) in order to establish a steady demand for its supplies, products, input and technology; 4) *corporate governance,* where firms balance their dependence on financial capital with investors’ prerequisites for returns of investments; and finally, 5) firms relationships with their own workforce, or *intra-firm relations*, where firms need to make sure their employees have the necessary competencies and skillsets to collaborate with each other towards the advancement of the firm’s objectives (2001:6–7).

For the purpose of examining physician shortages and medical labor migration to the LME of the US, and the CME of Sweden, I will pay primary attention to two particular spheres: Industrial relations as they pertain to the physician working conditions and attractions of healthcare system, and education and vocational training, as in the production of physicians through medical schools and residencies. Looking at industrial relations will help us understand the organizational structure of firms and other actors involved in healthcare delivery in each political economy, along with the “pull” or attractiveness that US. And/or Swedish firms and employers may have to immigrant physicians coming from other national settings with less bargaining power. The sphere of education and vocational training is key to mapping out how both the US. And Sweden, at two such opposite ends of the VoC spectrum, have ended up incapable of supplying enough medical professionals with the suitable skills to serve all members and communities in their populations — ultimately compelling them to recruit and enlist physicians from abroad in more or less active ways.

Applying Varieties of Capitalism to Migrating Physicians

As previously mentioned, the VoC framework uses an actor-centered analysis for understanding differences across political economies. These actors all have their own sets of goals and interests that they seek to strategically advance in relation to others. When we think of actors at play in modern capitalist societies, we may take individuals, producer groups, and governments into account, but the most important drivers of for-profit production innovation and distribution of goods and services are firms. This capacity can be referred to as the development and exploitation of *core competencies*, or *dynamic capabilities* (Teece and Pisano 1994; Teece, Pisano and Shuen 1997; Suter et al. 2009; Cegliński 2020). When studying how political economies grapple with the phenomena of physician shortfalls and the incorporation of immigrant physician labor, we need to examine the entanglement of free market agents (e.g., IMGs themselves, recruitment firms, private employers, etc.), and state legislation and government actors (e.g., healthcare system and immigration policy, medical licensing institutions, federally/public funded employers, etc.). Healthcare is different than other Western industries with large portions of high-skilled immigrants such as the tech industry for example, which tend to belong more categorically to the private sector with relatively limited government involvement. In contrast, the healthcare sector is not self-regulating to the same extent — particularly not in CMEs. This is largely due to the moral interpretation of healthcare provision as right-based as opposed to privilege-based in countries with universal health coverage funded by taxpayers. Compared to other labor shortages, medical shortages and their solutions emerge as ethical considerations concerning governments, especially as they involve the health and wellbeing of underserved communities and groups, and prudent distribution of government subsidies.

Under such premises, we may ask ourselves to which extent firms are involved in facilitating immigrants providing healthcare in the LME of the US versus the CME of Sweden, and to what extent the VoC framework may help us understand this specific strain of labor migration that in most industrialized societies is so closely related to the public sector, and the welfare state. There is a substantive body of work that applies VoC theory to empirical studies of migration, and labor migration policy specifically, as it corresponds with economic and political upheaval in Europe. While some scholars choose to put VoC in conversation with migration theory for fortification of both frameworks (i.e., Menz 2010; 2011; Devitt 2011), others are more critical of VoC's ability to accurately predict and account for state responses to crises and challenges (i.e., Paul 2016; Consterdine and Hampshire 2020; Bucken-Knapp 2007). I suggest that VoC helps us understand the foundations of IMG migration patterns and what gets translated into the Swedish and US nation brands — the systems behind the power of attraction that these nations exert onto foreign physicians. A VoC analysis is also useful for understanding the relationship each country has with its physician shortfall. On the other hand, I also observe how the VoC paradigm can be insufficient when analyzing dynamic problems involving both private and state actors, including healthcare systems and visa regimes.

Menz (2010; 2011) outlines the rapid changes that European immigration policy has undergone since the mid 1990's, liberalizing and internationalizing labor markets after a restrictive era initiated in the 1970's. Bridging comparative political economy studies and migration theory, Menz emphasizes how employer associations have tried to lobby governments in different European political economies (prominently the UK and Germany) to reform immigration policy for the benefit of firms recruiting high-skilled immigrant professionals that can seamlessly fit into and complement existing corporate strategies and objectives, but also fill shortages that the domestic education and vocational training sphere is unable to supply. Menz argues that different varieties of capitalism produce different blueprints of the ideal immigrant worker due to their distinct sets of production strategies and education and training systems, in which LMEs are able to accommodate both sector-specific and generalized labor; both low- and high-skilled migrants. CMEs on the other hand, which tend to have a smaller low-wage service-sector than LMEs, are primarily concerned with incorporating high-skilled professionals (Menz 2010). Importantly, many CMEs (e.g., Sweden, Denmark, France, Germany, Belgium and the Netherlands) are located in Europe in which free intra-European mobility allows low-wage and seasonal migrant workers from Central and Eastern Europe to fill labor shortages in Northern and Western Europe without being formally recognized as immigrants in need of incorporation.

Devitt (2011) renders existing theories of labor migration insufficient when it comes to accounting for both the extent and types of economic migration across European states, and points to welfare regime variation as a major determinant of what kind of immigrants and how many immigrants Western political economies attract. She expands the LME versus CME typology into four types of European socio-economic regimes: 1) the Nordic, 2) the Conservative, 3) the Southern-Statist, and 4) the Liberal model (Devitt 2011:586). Like Menz, she finds that there are few employment opportunities for low-skilled labor migrants in the Nordic countries, including Sweden. Unlike other European countries that still experience high concentrations of labor migrants, Sweden went from employing a significant number of foreign workers in the postwar period, to implementing a comprehensive labor policy that sought to tap into existing domestic workforces (e.g., women) and internal mobility in order to correct employment imbalances. When it comes to immigrant physicians, Devitt traces medical professional deficits to the education and vocational training sphere, where disconnects among educational institutions and employers leads to mismatches between skill supply and demand, especially salient in liberal regimes. She points to LMEs as UK and Ireland as the biggest importers of international medical graduates, which have implemented strict regulations on medical school admissions for many decades (Devitt 2011). It should be noted that although Sweden is of the Nordic model on the other side of the spectrum which is usually characterized by a closer coordination of demand and supply of professional skills, the Swedish government has also imposed similar caps on medical school admissions in the 80's in order to avoid a looming surplus after an earlier expansion of the healthcare system, causing similar urgent shortages of physicians (Simoens and Hurst 2006:29).

Similar to Menz, Paul (2016) wishes to put the theory of VoC to empirical tests, pushing back on the deterministic idea that a certain political economy automatically would engender a certain labor migration policy. Also contrasting the UK and Germany, Paul observes a trend of restriction in the former and liberalization in the latter, contradicting some of the presumed attributes of labor migration policy in a LMEs versus CMEs. While both countries are perceiving crises in economics and demographics, the British government feels the need to scale back their traditionally permissive stance on profit-seeking firms hiring foreign workers in order to address a deeply felt loss in immigration control. On the other hand, Germany maintains that allowing the market economy to acquire skillsets through liberalized immigration policies is key to solving the notion of a demographic crisis. In conclusion, Paul argues that a cultural political economy perspective more accurately explains these separate developments than the VoC typology, disrupting VoC reign as what Howell has called "the state of the art in institutional analysis" (2003:121).

Paul's research may have relevance to the case immigrant physicians coming to the US versus Sweden, in which the American medical field has increasingly become more difficult to break into for IMGs while Sweden has opted for active recruitment of foreign doctors (notably, EU-based MD's more so than non-EU physicians), further suggesting that this type of labor migrant complicates the VoC mode of explanation. Some scholars have pointed out that while diversities of capitalism do have bearing on formations of immigration policy in LMEs versus CMEs, one must pay attention to local party competition and national debates in order to fully understand the rationale behind them (Consterdine and Hampshire 2020). In his study of VoC's applicability to Swedish labor migration policy, Bucken-Knapp (2007) finds that the Swedish Social Democratic Party (SAP) in the face of a declining workforce adopts another line of reasoning than one that would optimize efficiency or economic growth.

The VoC literature upholds a functional logic in which policymakers are presumed to implement measures that maintain and support the institutional environment of their particular market economy (LME, CME or the Mediterranean model), which SAP's actions seem to reflect when the party backed migration policies that restrict low-skilled migrant labor, consistent with the CME model. However, Bucken-Knapp argues that SAP's resistance against liberal reform that market actors and firms were pushing for had little to do with economic incentive and more to do with the need to protect the Swedish model, with its strong unions and labor policies. The apprehension with which SAP safeguards its policies demonstrates how CMEs are difficult to build but easy to dismantle (Goodin 2003). SAP's historical hold over Swedish politics have in more recent elections experienced significant challenges from a growing bourgeoise and nativist wing.

Importantly, Bucken-Knapp's account of Swedish labor migration policy also indirectly illustrates how EU migrants by virtue of their passports can bypass laws drawn up for others, almost rendered invisible or less relevant to immigration crisis discourse in Sweden. Furthermore, SAP's standpoint demonstrates how state actors in CMEs engage in political conflict with firms and may prefer to make economic policy decisions that respond to culture and ideology more so than market strategies and gains. Considering how central healthcare equity is to the Swedish welfare model, we may at this point draw parallels to similar protectionisms that would traditionally exist around the medical profession, and considerations around the supply of physicians — perhaps more so in a CME like Sweden over an LME like the US. In the case of the latter, scholars such as Trotter (2020) have recently expressed concerns that the American medical field has come to prioritize world-class biomedical advancement at the expense of patient care, leaving nurses (and we may here also add IMGs) to provide a broad spectrum of care work for disenfranchised communities and minorities. Trotter sees this as a structural symptom of the US political economy's divestment in social policy, along with its unresolved issues related to physician shortfalls and rising medical expenses.

As briefly outlined above, there are plenty of studies conducted on VoC and labor migration across Western Europe, but institutional comparisons between the US and European countries and IMG incorporation are scarce. There is also a lack of contributions to the VoC framework that concern healthcare systems in different political economies, even though market agents are major parts of the US healthcare structure and are increasingly making their way into the Swedish arena as well. The specific case of immigrant physicians solving shortfalls in the US versus Sweden is a compelling test of the VoC mode of explanation as it presents a problem of coordination that engages both market and non-market actors. We now turn to a brief comparison of US and Swedish healthcare systems under a VoC lens, followed by a review of the industrial relations and educational spheres of each country as they concern working conditions in the medical field, training of medical professionals, the physician shortage, and the emerging role of IMGs. By comparing the two spheres of industrial relations and vocational training, I examine how each country has developed a physician shortfall, the discourse around the issue and the role that immigrants have come to play in it.

Comparing Healthcare Sectors in Two Varieties of Capitalism

The US Healthcare System: A Market of Public and Private Actors

When it comes to healthcare, the US sets itself apart from other wealthy, industrialized OECD countries that elected to provide universal healthcare for its populations decades ago — including other economies often categorized as LMEs, such as the UK, Ireland, Canada and Australia. In other words, not having universal healthcare is not a standard characteristic for an LME. With a government under no articulated obligation to provide its population with healthcare, Americans rely to a much larger extent on the private market for healthcare delivery and risk/cost management (i.e., health insurance) than most of their Western and LME counterparts. In addition, the US presents a complex paradox: the country's healthcare spending per capita is the highest out of all wealthy democracies in the world, but Americans are still experiencing the highest suicide rates among the 11 OECD nations, higher chronic disease burdens and obesity, lower average life expectancies, and more difficulties accessing healthcare. Notably, public spending is not drastically different from other countries; it is the out-of-pocket and private spending that adds up to the 16.9 % of gross domestic product (GDP) that the US spends on healthcare, which is nearly double the amount of the average OECD country (Ho 2013; Tikkanen and Abrams 2020). In 2018, 15% of the US population were 65 and older with a projection of reaching 22% in 2050 (Kaneda, Greenbaum and Patierno 2018).

In order to understand how US became the exception to universal healthcare, we need to go back to the Great Depression in the 1930's, which is when the market for healthcare insurance started growing rapidly. In 1929, the American Hospital Association (AHA) founded Blue Cross and Blue Shield insurance, each designed to cover medical care inside versus outside hospitals. This marked the emergence of the fee-for-service insurance model, in which a patient pays a co-pay for an appointment and an insurance company covers the majority of the costs and procedures associated with that particular appointment. Unlike in many other industrialized economies, this model creates a supplier-induced demand, in which physicians are financially incentivized to order more tests and procedures as well as follow-up visits. While other countries set limits on how much new treatments can cost, the US lacks a master price list which allows actors in the healthcare industry such as insurance companies and hospitals to consolidate bargaining power and drive up medical spending. Health management organizations (HMO) were established to counteract the rising costs by replacing the fee-for-service with a fee-per-person or patient. In this model, patients are still charged a co-pay, and physicians receive a more or less fixed salary regardless of how many times they see a patient. The incentive is meant to shift from overtreatment to keeping patients healthy enough for fewer visits. However, it follows that another implication may be undertreatment.

After the Great Depression came WWII, which brought strict regulations on pricing and wages that prohibited salary raises for a large portion of the American workforce. To compensate for these caps, employers would provide health insurance free of tax as a benefit for their employees, which engendered the employment-based health insurance model that prevails in the US today. This also created a market for competition between insurance companies; one provider will make an estimate for the healthcare need of a body of employees and calculate based on that assessment what the premium rates, co-pays and deductibles should be for said company. If the calibration is too low or too high, the insurance company either risks losing money, or being outrivaled by a competitor with more affordable rates. A bigger workforce with a clearer demographic makes calibrations easier, while a smaller one makes for less educated guessing related to cost and benefits, presenting a higher risk for insurance companies. In 2019, about 55% of the US population received healthcare insurance through their employer (Keisler-Starker and Bunch 2020). Notably, women, minoritized communities and people with lower levels of education are less likely to have full-time jobs for larger employers that provide health insurance (Tolbert, Drake and Damico 2022).

A quintessential feature of an LME is that it approaches coordination between firms and other agents (such as employees, suppliers, customers, and others) by ways of market mechanisms, with little to no involvement of regulatory bodies or institutions. The

US healthcare system emerges as a prime example of such an economic structure. Healthcare delivery and spending in the US is disseminated across a multitude of different firms, agencies and actors, each with their own motives, obligations and capacities — a fragmented structure which is not necessarily conducive to sustained relationships and information flows, or close coordination around patients' health outcomes. Much like there is concern for physicians' economic incentives for either over- or undertreating patients as described above, medical scholars have also examined how the employer-based insurance model fosters high levels of insurer turnover as people leave and enter employment. In the light of the organizational disintegration between healthcare entities and transience in healthcare provision and insurance, Cebul et al. (2008) call into question if insurers have the right incentives for investing in long-term health for their policyholders. In other words, the US healthcare system is traditionally dominated by market agents, but critics are often leveled with regards to their ability to successfully coordinate the problems that arise in the healthcare sector. In many ways, burdens of risk and choice lies with individual workers more so than with employers.

It is not only corporations and organizations that may have perverse incentives when it comes to health insurance. When it's up to an individual to choose and purchase insurance, the problem of adverse selection arises — studies have found that healthy people feel less motivated to purchase comprehensive insurance (or any insurance at all), while persons with a lot of health concerns are compelled to buy a more expensive insurance policies with a fuller coverage (Browne 1992; Cutler and Zeckhauser 1998). This adverse selection causes a negative spiral in which people who are unwell take on the highest costs for health insurance, which drives up the prices and deters more healthy potential policyholders. The business model for insurance companies relies on distributing risk across the body of their buyers, and so having an imbalance of mostly bigger consumers of healthcare will cause problems for the insurance market.

In 1965, the Social Security Act allowed the establishment of the first public insurance programs — Medicare and Medicaid. This brought the US a few steps closer towards a right to healthcare, but only for select eligible groups. Medicare provides universal health coverage for policyholders at the age of 65 and older, and for persons with long-term disabilities or end-stage renal disease. Policy holders can either enroll in traditional Medicare, a fee-for-service program that provides hospital insurance as well as medical insurance, or Medicare Advantage under which people enroll in a private HMO or managed care organization. Medicaid, on the other hand, extends the ability for individual states to receive federal matching funding to cover healthcare provision for low-income households, blind individuals, and persons with disabilities — an expansion that far from all states have agreed to.[19] In addition, Medicaid coverage has progressively been made mandatory for low-income expecting mothers and children. As of early 2021, over 74 million Americans were covered by Medicaid.[20] Since the program is not administered at the federal level, states have some freedom in setting eligibility criteria, which makes coverage more or less available across the country. Furthermore, the onus is on policy holders to apply and recertify annually in order to receive Medicaid coverage. In some states, Medicaid operates in tandem with the Children's Health Insurance Program (CHIP), which was introduced in 1997. CHIP is another public program that aims to cover children from families with incomes that are just too high to be eligible for Medicaid, but still too low to be able to pay for private health insurance. Today, almost 7 million children receive healthcare through CHIP (Centers for Medicare & Medicaid Services 2022.)

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[19] For 2013 and 2014, there were 26 Medicaid expansion states including District of Columbia. For 2015, there were 29 Medicaid expansion states. For 2016–2018, there were 32 Medicaid expansion states.

[20] Read more at Medicaid.gov (https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html).

Importantly, the presence of Medicaid and Medicare does not necessarily solve problems related to health care access. In some states, a relatively modest fraction of health care providers takes new Medicaid and Medicare patients due to low reimbursement rates (Matthews 2015). Instead, some patients turn to Federally Qualified Healthcare Centers (FQHC), federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. As FQHC's provide primary care services in underserved spaces, they disproportionately come to employ IMGs because of their overrepresentation in such specialties and geographical areas.

With this patchwork of healthcare insurance provision, the US still experiences a concerning number of uninsured populations and individuals. In 2010, the Obama administration passed the Patient Protection and Affordable Care Act (ACA), which was the most comprehensive step towards universal health coverage in US history, involving a large expansion of the government's role in providing and regulating healthcare insurance. As ACA officially went into effect in 2014, Americans now became required to acquire health insurance or deliberately opt out with a penalty fee (which eventually was lifted). In addition, ACA allowed persons under the age of 26 to still be beneficiaries under their parents' private insurance plans, opened federal insurance marketplaces that provided premium subsidies for low-income individuals and families, and offered states the option to expand Medicaid with financial federal support. The enactment of ACA provided 20 million previously uninsured individuals with healthcare coverage, which brought down the percentage of adults (age 19–64) without any form of insurance from 20% in 2010 to 12% in 2018 (Collins, Bhupal, and Doty 2019). The ACA has established significant coverage for low-income households, which indirectly has also entailed greater coverage for Black, Latinx, Asian American, and Indigenous peoples in the US

According to the National Health Interview Survey (NHIS), the number of nonelderly Americans without insurance fell from 48 million in 2010, and to 28 million in 2016, before rising back up to 30 million in the first half of 2020 (Finegold et al. 2021). The authors ascribe the reverse trend to recent changes to ACA and Medicaid policy, in which the coverage eligibility have been scaled back in certain instances and in certain states. The socioeconomic, racial and ethnic groups mentioned above that initially were the major beneficiaries of ACA and Medicaid expansions are the same ones that are disproportionately experiencing a loss of coverage in the downturn development. While the insurance rates during early 2020 show no significant fluctuation, the Covid-19 pandemic represented significant challenges to the conduction of the NHIS, and so these estimates could hold inaccuracies.

In spite of its many challenges and flaws, the US healthcare system holds a great power of attraction in its high rankings in innovation and technology. In the 2021 World

Index of Healthcare Innovation (WIHI), the US receives an overall “Excellent” score of #6. While Quality is rated “Good” and Fiscal Sustainability are among the lowest of the “Poor,” it ranks #1 Science and Technology with an impressively wide margin, which drives up the overall score in spite of moderate to poor achievements in other areas (Girvan and Roy 2021). While exorbitant medical spending, affordability and access to care continues to be a problem, Americans are often the first to be offered the products of major medical advancements discovered at US research institutions and companies.

The Swedish Healthcare System: Decentralized Universal Healthcare

The Swedish state adopts a socially responsible stance toward healthcare, with an explicit commitment to ensure good health to all residents and citizens. Rather than viewing healthcare as a privilege, it is considered a right which should be equitably delivered, without discrimination. However, much like the US, Sweden has faced long term challenges with providing equitable care to its remote and rural regions and providing timely care to patients with chronic illness. The system that exists today reflects a long tradition of public funding and ownership, decentralized in local self-government. In spite of its decentralization, it is a highly integrated organization and while critics have voiced concerns about fragmentation in the US healthcare system as mentioned above, Sweden has focused recent efforts and government grants on promoting care coordination and accessibility (Glenngård 2020). While Swedish health spending is significantly lower than in the US, it is still the third highest in the European Union at 11% of the GDP. Sweden also has a life expectancy that is higher than the EU average (OECD 2019). In

2018, 20% of the Swedish population were 65 and older with a projection of reaching 24% in 2050 (Kaneda, Greenbaum and Patierno 2018).

Swedish health coverage is universal, and disseminated through three administrative levels: national government, counties (often referred to as regions), and municipalities. Each tier is governed by democratically elected officials. On the national government level, the Ministry of Health and Social Affairs is tasked with overseeing the healthcare legislation and regulation, public health, social insurance, and social policy. Central to both the regulation and provision of healthcare is the Health and Medical Services Act (HMSA) from 1982. As a cornerstone in the Swedish welfare state, it outlines the responsibility of the 21 country councils to finance and provide health equity to their residents, including equal access to healthcare across urban and rural settings. The 290 municipalities are responsible for housing and short- and long-term care for older and disabled people through the Social Services Act of 1980 (in some ways comparable to Medicaid), which asserts the rights of senior residents to receive public services and support at all stages of their lives. People with disabilities have additional rights under the Act Concerning Support and Service for People with Certain Functional Impairments from 1993. Although the organization of the Swedish political economy is in great contrast to the US federal system, Sweden does have a long history of local self-government, which is manifested by the freedoms that the regional and municipal authorities enjoy next to their responsibilities with regard to the organization of their health services. These administrative tiers are represented by the Swedish Association of Local Authorities and Regions (*Svenska Kommuner och Regioner* [SALAR]) (Anell, Glenngård and Merkur 2012).

Swedish universal health coverage is guided by three key principles: 1) *human dignity*, asserting that all human beings are equally entitled to dignity and rights, regardless of their status, 2) *need and solidarity*, meaning that treatment will be where it is most urgently needed first, and 3) *cost-effectiveness*, stating that there should be an appropriate balance between costs and benefits, weighing costs against improvement in health and quality of life (Glenngård 2020). Primary care constitutes the foundation of the healthcare system and is defined in HMSA as healthcare where open care is provided without delimitation in terms of illnesses, age or patient groups (Office of Clinical Studies 2017). Primary care is conducted out of over 1000 healthcare centers, district nurse's offices and family practices around the country, and is meant to be the first point of contact for patients in need of non-urgent care. Primary care provides most basic medical treatments, nursing, preventive care and rehabilitation that do not require the advanced technical and medical equipment or medical specializations that are found at the hospitals. Healthcare centers for primary care are staffed with general medicine physicians, nurses, physiotherapists, occupational therapists and counselors. For more demanding medical problems, a referral will be written to the appropriate specialist care provider.

Not only is Swedish healthcare universal, but it is also automatic and requires no active enrollment in healthcare insurance. While not all healthcare facilities are publicly owned in Sweden, they are generally publicly funded with little to no extra cost to patients. Regions are obliged to let all healthcare providers — public or private — who meet the criteria of the healthcare system establish themselves with public compensation. Qualified private suppliers of healthcare services enter into agreements with county councils, and patients have the right to choose which primary care facility to register with. While medical fees and consultations are not entirely free for adults over 18 years of age, they are heavily subsidized and capped at very low co-payments for the patient. Depending on the region, a primary care visit typically costs between 150–300 SEK (16–33 USD), a specialist consultation approximately 200–400 SEK (22–42 USD), and hospitalization is legally mandated to cost the patient no more than 100 SEK (11 USD) per day. Serving the population that recently reached over 10 million people are 70 regionally owned and operated public hospitals, seven university hospitals, and six private hospitals.

Unlike the US, firms and market agents are only permitted to play a small (if slowly increasing) role in the Swedish healthcare sector. 88% of all healthcare is provided by the regions, with a remaining 12% being supplied by private actors under contract with the region county councils (Swedish Insurance Federation 2020). Outside of the publicly funded universal healthcare is a small yet growing percentage of private health insurance. Observers have pointed out one significant Achilles heel of the Swedish healthcare system: long waiting times for diagnosis and subsequent treatment (Anell, Glenngård and Merkur 2012). Under state minister Fredrik Reinfeldt's bourgeois administration, Sweden underwent a health insurance reform in 2008 that has allowed market agents more room in coordinating the problem of access to healthcare — albeit for a minority. The National Guaranteed Access to Healthcare (NGAH) from 2005 mandates that patients have the right to see a healthcare provider within 3 days after seeking help, a specialist within 90 days after referral, and receive the approved treatment from said specialist within another 90 days. Dissatisfaction with NGAH or wanting to access elective treatment faster are common reasons why individuals decide to purchase supplementary health insurance, which typically guarantees a specialist appointment within a week, and treatment or surgery (most commonly orthopedics at 30%) within 2–3 weeks. At the end of 2020, less than 690 000 Swedes were covered by private health insurance, which represented an increase by 1% in comparison to the year before. Over the same time span, individual insurance policyholders had gone up by 5% while employment sponsored insurance has risen by 2%. Since 2010, there has been a slow yet steady increase in private health insurance (Swedish Insurance Federation 2021).

Although it may be growing, the for-profit private insurance market in Sweden is highly regulated and does include a significant involvement of non-market actors and labor unions, which is on brand for a CME. Individual policyholders that are not sponsored by their employers often obtain their private health insurance as a part of their membership fees when joining a labor union. However, the most common occurrence of private health insurance is employment sponsored, with around 60% of all private policyholders being covered by their employer. Typically, workers and professionals with employment sponsored private health insurance are considered irreplaceable or essential to the organization, and so their employers are unwilling to have them go through the regular waiting periods in case they need specialist care or surgery. Covering their workforce with private health insurance may allow employers to ensure speedier treatments and recoveries for key members of staff, which helps safeguard firm operations and increases productivity. Another commonly articulated rationale in the context of the Swedish CME is that private health insurance provides access to independent expertise in matters of promoting healthy working conditions, which helps employers fulfill requirements specified in the Work Environment Act.

Although the Swedish healthcare system is often lauded for its commitment to equity and high standards of care, Covid-19 has been detrimental to its WIHI rankings. From 2020 to 2021, Sweden dropped from #15 in overall score to #18, representing a mere "Moderate" grade below both "Good" and "Excellent." Notably, Sweden slid from 10th place to 21st in Quality, and received poor scores in Fiscal Sustainability. However, the overall economy remained strong throughout the pandemic, which allowed for a high National Solvency score. Sweden received its highest score in Science in Technology, ranking at #6 (Girvan, Dornauer and Roy 2021).

Comparing Industrial Relations: Working as a Physician

The US Medical Profession: An Elite under Pressure

The industrial relations sphere in an LME is characterized by little to no outside intervention into the relationship between employer and employee, where top management hold substantial control over the firm and reserve the right to hire and let go of staff as they see fit. There are no legal requirements for companies to establish work councils or other representative bodies, and the role of labor unions is less significant than in a CME. Since trade unions and employer organizations are less prevalent and cohesive, establishing wage coordination across the economy becomes more difficult. Instead, LMEs tend to adhere to macroeconomic policies and market competition in regulating salaries and inflation. The fluidity of the LME labor market allows for frequent turnover in workforces and is less conducive to production strategies that require long-term employment of key members of staff (see Hall and Franzese 1998).

The healthcare field in the US is no exception to frequent employee turnover, including physicians. The annual National Healthcare Retention & RN Staffing Report shows a steady trend of increasing hospital staff turnover, reporting a rate of 19.5% in 2021 (NSI Nursing Solutions, Inc. 2021). Studies from before the onset of Covid-19 are also worrisome; in another report from 2018 conducted by Merritt Hawkins for The Physicians Foundation, 46% of the 700,000 surveyed physicians from across the country said they were planning on leaving their current employment within the next three years and over 10% were considering switching to non-clinical jobs within the healthcare sector — or leaving it altogether. The same survey shows that physicians in the US consistently work overtime, mapping out a span of between 41 and 60 hours per week, with an average of over 51 hours (Merritt Hawkins 2018). While turnover in other fields may entail new lifeblood, skill optimization and increased success, it is often described as a serious and expensive problem for the field of healthcare, and a result of employee dissatisfaction. Furthermore, turnover in healthcare has potentially harmful consequences for patients, given the value of continuous care.

Working conditions in the US medical field are notorious for being stressful, so much so that scholars are describing physician burnout as an epidemic and a public health crisis (Linzer et al. 2009). In the previously mentioned report, 78% reported symptoms of burnout on a regular basis and 62% say they are feeling pessimistic about the future of medicine. Burnout in the medical field is often attributed to problems within healthcare organizations and systems and include overwhelming workloads, inefficient work processes, administrative burdens, lack of control over work-life balance, and insufficient support and leadership (West, Dyrbye and Shanafelt 2018). Doctors often experience time constraints with patients, navigate complicated regulations and HIPAA protections, and rapid technological changes accompanying new payment paradigms (like the shift from fee-based payment models to value-based ones mandated by ACA).

More than many other industries in an LME, the US medical field is steeped in heavy external regulations, which often entails an added stressor to the work environment. Symptoms of burnout include physical as well as emotional exhaustion, depersonalization, and a feeling of low personal accomplishment, and front-line care doctors (such as those in family medicine, emergency medicine, general internal medicine, and neurology) are at the highest risk of excess-work related stressors (Patel et al. 2018). Some of these fields, like internal medicine and family medicine, are considered less prestigious in the status hierarchy and are dominated by IMGs (Jenkins 2020). Although Covid-19 has seriously exacerbated physician burnout, industrial relations between doctors and employers have been tenuous even before the onset of the pandemic. Studies commissioned by recruitment firms show that a vast majority of doctors often feel disengaged from administrators, and that there are few concrete retention plans in place to prevent both physician burnout and turnover. While administrators are attempting to address these problems, their efforts have often been deemed insufficient in the eyes of their physicians (Stajduhar 2021).

One major stressor that administrators have limited ability to mitigate is legal action against individual physicians. Apart from the healthcare insurance industry aimed at prospective patients, there is another significant market that targets physicians — medical malpractice insurance. Derived from common law, the US employs what is legally referred to as tort (i.e., malpractice) liability law in healthcare, in which patients may request compensation if they believe that harm has been done to them by a doctor, medical facility or other healthcare organization. The burden of proof lies with the patient, and it is often critical to enlist legal representation and expertise to properly demonstrate evidence of negligence and win a malpractice claim. Still, malpractice suits are not uncommon, and most physicians are sued for medical malpractice at least once, which is described as one of the most stressful events in a doctor's career (Bookman and Zane 2020). As such, tort liability law is a significant factor in the industrial relations of the US medical profession. Because of the prevalence of malpractice suits, most states require all physicians to be insured in order to manage the costs of potential litigation. The US tort liability system has been criticized for being unfair, inefficient, and expensive for both patients, physicians and the healthcare system, and there is an ongoing debate concerning what many stakeholders refer to as a medical malpractice crisis (Mello 2006; World Bank 2013).

With industrial relations this troubled, labor unions might appear as an attractive option for doctors practicing in the US. Physician unions offer collective bargaining power for improved working conditions and protection from litigation. However, unionizing does not just benefit physicians themselves, it also allows doctors to advocate for better patient care and may reduce patient mortality. Furthermore, unions entail increased autonomy for physicians, which can mitigate symptoms of burnout related to depersonalization and a lack of control over their work situation. Despite the many benefits of unions, only 11.4% of health care practitioners and technical workers reported union membership in 2018 (Howard 2020). Even with increased uptake during the pandemic, only about 15% of US medical residents are represented by the Committee of Interns and Residents, the country's largest resident union which is part of the Service Employees International Union. A smaller portion of residents have created their own local unions or joined one for healthcare providers more broadly, such as the Union of American Physicians and Dentists. More so that certified specialists, residents often work longer hours with relatively low wages, which creates a greater incentive for unionizing (Weiner 2022). As a point of comparison, a mere 7.9% of surgeons and 5.8% of other physicians reported union membership in 2021, totaling 13.7% (Cheney 2022).

Low union membership among US physicians is consistent with the limited role that trade unions typically occupy in an LME. Hesitations towards joining a union can ironically be the loss of individuality against the shared goals of the collective, and the ethical considerations of prioritizing patient safety over the interests of the physician group. That being said, collective action does not need to involve strikes and even if it would, there is historical evidence which suggests that strikes are more beneficial than harmful to patients (James 1979). While there is little to no information available on the relationship between IMGs and unions, or what percentage of physician union membership is constituted by IMGs, we may deduce that it is small considering the fact that studies show that IMGs in the US are more accepting of less favorable working conditions than domestic physicians (Chen et al. 2010; Jenkins 2020).

In comparison to unions, membership in the American Medical Association (AMA) is slightly higher. In 2021, AMA reports a membership of over 271,000 physicians (American Medical Association 2021), which constitutes around 26% out of the total licensed physician workforce at over 1,018,000 (Young et al. 2021). AMA takes on many union adjacent values when citing their driving factors; “1) advocacy — representing physicians with a unified voice; 2) innovation — ensuring technology is an asset, not a burden; 3) equity — embedding equity in the AMA and throughout health care” (American Medical Association 2021). The organization also argues that burnout is a health system problem that needs to be fought on multiple levels. While there is limited detailed information on its IMG membership, AMA seem to have made an overt effort to brand themselves as an asset to IMGs, hosting the annual “IMG Recognition Week” in which they center IMG voices and put together useful resources and toolkits for the benefit of IMGs navigating both the US medical field and immigration system. The AMA describes itself as “the IMGs powerful ally,” citing political advocacy for expediated visa processing for IMGs and extensions of the Conrad 30 program (American Medical Association 2022).

Instead of turning to unions or other organizations when craving more autonomy, better work-life balance and a healthier work culture, many physicians in the US go into private practice. In 2021, the number of physicians in private practice were 26% and about 46% of all practices are physician-owned (Newitt 2022). In addition, private practices make up a significant part of US primary care infrastructure; 32% of family doctors work in private physician practices (Rittenhouse et al. 2021). While there is little data available on the proportions of IMGs in private practice, it is important to note that IMGs' ability to change employers or start their own practice (or businesses in general) is often limited by their visa stipulations; only with a green card does an IMG have the same legal and professional mobilities as a domestic physician, and that status is typically not obtained until several years after arrival — unless they are marriage-based. Indian IMGs in particular are also affected by a severe green card processing backlog stemming from a nationality-based quota. In the same vein, many smaller private practices and clinics lack routines for work visa (H-1B) sponsorship for IMGs without green cards, which often entails enlisting the service of an immigration lawyer and paying steep application fees that together can add up to several thousands of dollars.[21] In addition, H-1B visas are capped at a yearly quota of 65,000[22] and applications need to be both approved for and randomly selected in a yearly USCIS lottery in order to result in a work permit. It follows that visa sponsorship can be an intimidating, lengthy and risky process for smaller employers. It is difficult to draw conclusions on whether public or private practices are more inclined to hire IMGs; what seems to matter more is the financial situation and comfort level of the employer in question and positive previous experience with IMG sponsorship.

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[21] H-1B visa sponsorship for an IMG tends to cost $3,000–4,000 but can range from between $1,700 and $6,500 in 2023. The exact amount will vary depending on many variables such as optional fees, attorney fees, and employment criteria. Read more at immi-usa.com (https://www.immi-usa.com/h1b-visa-processing-fees-2016/) and at USCIS.gov (https://www.uscis.gov/forms/all-forms/h-and-l-filing-fees-for-form-i-129-petition-for-a-nonimmigrant-worker)

[22] Universities and related nonprofit entities, nonprofit research organizations and government research organizations are exempt from the cap.

While working as a doctor in the US can be challenging, it is also a well-compensated job — physician salaries in the US are among the highest in the industrialized world, let alone the developing world from which a majority of IMGs come (Hughey 2021). Wages for physicians and surgeons are also among the highest of all professions in the country itself, with a median wage equal to or greater than $208,000 per year in 2020 (Bureau of Labor Statistics 2020). For comparison, the average annual income for a physician in India where most IMGs in the US come from is around $12,000 (900,000 INR based on a 75,000 INR monthly salary) (Doctors Review India 2021). While these wages must be weighed against the common burden of heavy student debt, most doctors are able to pay off their loans within 13 years (Fay 2021). This leaves a considerable number of years of practice during an average length medical career in which a physician can accumulate significant wealth. Furthermore, the US medical field offers competitive professional growth and as previously mentioned, and the country is world leader in scientific and technological development. It follows that not only is the US an attractive destination for medical practitioners and clinicians — its hubs of innovation also draw skilled medical professionals from around the world with a keen interest in research, who in turn continue to contribute to the country's great biomedical discoveries and breakthroughs. It should be noted however, that most IMGs are clustered in lower paying fields, such as internal medicine and primary care (Jenkins 2020).

The Swedish Medical Profession: A Comfortable Middle Class

Unlike the US and other LMEs, Sweden's industrial relations are characterized by the considerable strength of its trade unions; in fact, trade union density in Sweden is among the highest in the world. Another salient feature of the political economy is the combination of very influential central *and* local organizations, as with SALAR representing local government (municipalities and counties) in the healthcare system. The centralized organization allows union coverage to remain consolidated, which promotes bargaining power and facilitates solidary wage coordination. Local bodies stay in close integration with national trade unions and help them stay connected to their members and their needs. Physicians as a particular professional group are represented by one major labor union which also serves as Sweden's biggest organization for medical professionals — the Swedish Medical Association (*Sveriges Läkarförbund* [SLF]). Founded in 1903, SLF is an increasingly influential organization with over 55,000 members — an all-time high in 2021 after a 3% increase during the pandemic (Sveriges Läkarförbund 2021). This entails the vast majority of all practicing physicians in Sweden; in 2021, there were over 73,000 licensed physicians in Sweden out of which 30% were over the age of 65. Around 44,000 were practicing (Socialstyrelsen 2021a). It follows that around 75% of all licensed physicians in Sweden (retired and practicing) are members of SLF. The union not only provides support with regards to wage negotiation, work conditions and terms of employment, but is also a strong actor in matters of education, research, ethics, healthcare policy, private practice management and leadership. SLF also offers information and resources for IMGs looking to get licensed in the Swedish healthcare system, with a pronounced commitment to accelerate their entry into the labor market — regardless of EU or non-EU passports. Membership costs around $30/month for practicing physicians but varies depending on local branch.

Through SLF, physicians may also purchase discounted occupational insurance that covers a wide variety of incidents and scenarios, including malpractice. However, being faced with a malpractice claim is a rarer event in Sweden than in the US, although Covid-19 has increased the number of reports significantly (Björkman et al. 2021). Furthermore, Swedish malpractice cases rarely reach judicial court, but are instead investigated internally by a court-like public authority called the Medical Responsibility Board (*Hälso- och Sjukvårdens Ansvarsnämnd* [HSAN]). While the US exemplifies the tort-liability system, Sweden adopts the so-called no-fault system in which patients may be compensated in the spirit of goodwill without carrying the burden of proof against the caregiver. In other words, compensation can be paid through the county's tax-funded insurance policy without a health provider being proven culpable. Under the 2011 Patient Safety Law, it is mandatory for healthcare providers and organizations to report any malpractice and collaborate with the system in limiting patient injury. The no-fault system has been described as more efficient and affordable for compensating patients, but it does restrict their right to appeal and create a trade-off between dissuasion and lower litigation costs (World Bank. 2013). Still, scholars have upheld the Swedish system as an inspiration for a much-needed reform of the US medical malpractice system (Danzon 1994).

While stressors of getting reported among physicians in Sweden are real, the overall work conditions in the field of medicine are generally favorable in comparison to other political economies. In one of the largest international reviews on average time allotted to primary care physicians for patient consultations, Sweden tops the list at over 22 minutes per patient. While the US is only a couple of minutes behind, we find many European countries at half of the allotted time (Poland at 10 minutes), some Middle Eastern countries at even less (Iraq at 5 minutes) and Southeast Asian countries which send a lot of IMGs to the US near the bottom (India at under 3 minutes) (Irving et al. 2017). In fact, more time per patient along with a more generous work-life balance are two of the main selling points that physician-recruitment firms emphasize when addressing foreign doctors considering migrating for a career in Sweden (Stoicescu 2021).

A report commissioned by SLF show that physicians regularly work overtime with an average of a 41.1-hour work week, even after having received compensatory time off for on-call hours. Including on-call standby, physicians are at their employer's disposal for an average of 44 hours per week. The Swedish Working Hours Act mandates that a regular workweek should not exceed 40 hours, including the collective bargaining agreement between SLF and SALAR requiring physicians to make themselves available for on-call duty outside of regular hours of operation. Commenting on the report, SLF chair Heidi Stensmyren asserts that the on-call agreement is cost-effective and provides great value for administrators and patients, but that it needs to be acknowledged that physicians take on great responsibility for the current organization while still being undercompensated for some of the abnormal working hours (PwC 2016).

As previously indicated, the Swedish healthcare system is built on universalist and solidaric ideals related to safeguarding of the welfare state and the slowly increasing interest in private practice is subject to both internal and political controversy. While US physicians may opt for private practice in order to improve industrial relations and working conditions in healthcare system that can be extremely demanding and unregulated by unions, Swedish physicians going into private practice diverge from a cultural social democratic norm that has long held that there should be no profits off of the welfare state and that healthcare should be equal for all.

Swedish statistics that compare the exact proportions of physicians in public versus private practice are largely non-existent. The line between public and private employment is blurred due to the fact that some physicians work in the private sector but are contractually hired by public employers and vice versa. For example, locum tenens physicians in private practice are sometimes hired for longer periods of time by public county councils that are short on staff, and physicians in public sector may also work in private practice part-time. There is also a difference between privately produced care and privately funded care — while privately funded care operates separately from the welfare state, privately produced care refers to private clinics in which physicians are entitled to the same reimbursements per patient as public facilities but are financially responsible for the start-up and maintenance of their organizations. In addition, private practices do not necessarily serve in the same capacity as public organizations — most are smaller healthcare centers and specialized clinics in larger cities. Still, there are some indicators that show that newer generations of physicians who tend to prioritize personal freedom are increasingly drawn to private practices, which may offer more flexibility and influence over work environment (Widberg 2012). Private practices are also at liberty to determine their own salary ranges since they lack proximity to unions. On the other hand, employers in the public sector have limited flexibility to offer higher salaries to individual staff members but can in the same vein offer a stronger sense of job security due to its adherence to collective agreements struck with labor unions.

While a physician's yearly salary in Sweden is only little over half of that in the US at nearly $111,000 (950,400 SEK based on a 79,200 SEK monthly salary), it was still ranked #6 of the highest paying jobs in the country in 2020 (Statistiska Centralbyrån 2021). It may also be worthwhile to contextualize the physician salary in relation to other social benefits of living in Swedish society, such as free (or virtually free) college tuition, K–12 and of course, healthcare. While many doctors in the US often end up spending significant amounts of their salary on paying off student debt, financing their children's care and education, and purchasing malpractice insurance, Swedish (and many other European) physicians are largely relieved of these costs. Under Swedish law, they are also entitled to a minimum of 25 days of paid vacation per year, and up to 120–180 days of parental leave.[23]

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[23] Married or cohabitating parents receive up to 120 days of paid parental leave, while single parents receive up to 180.

Comparing the Educational Sphere: Training and Supplying Physicians

The US Physician Shortfall: The Makings of Multiple Hierarchies

It is clear that the road to a medical degree and career in the US is competitive, lengthy and expensive — and depending on specialization, sometimes less financially rewarding than other high-skilled professions in the US. The investment is high, and the hours can be long and irregular, and many physicians find themselves saddled with huge student loans and strenuous working conditions. Before applying to medical school, a vast majority of candidates complete 3–4 years of "pre-med," an undergraduate program which includes not only coursework geared towards natural science and medicine, but also volunteering in the healthcare industry, acquiring clinical experience, conducting research and other activities in order to strengthen one's application to medical school. Admission into one of the 154 accredited schools and colleges in the US is also based on GPA and MCAT scores, along with a personal essay and interview. Since a standard medical degree takes 4 years to complete, most students study for around 7–8 years in total before they graduate from medical school and enroll in an internship and residency program. 73% of all medical students graduate with debt and the median medical school debt according to the Association of Medical Colleges (AAMC) is $200,000 (Budd 2020).

According to the VoC comparative framework, education and vocational training in LMEs are generally organized to be adaptive to a more fluid labor market. Vocational schooling and formal education tend to provide more general skills since firms in liberal labor markets are reluctant to invest in apprenticeships or in-house training schemes disseminating sector-specific skills when they cannot be assured they will not lose their apprentices to competitors when training is complete. As we have seen, applicants for US medical schools and residency programs are increasingly compelled to present rich and diversified resumés in order to be competitive. Not only are they expected to have medical knowledge and experience before even being admitted to medical school — strong candidates frequently demonstrate experience with social sciences, studying abroad, leadership, and community service. However, the reason behind the increasing pressure on aspiring physicians to show versatility is perhaps less related to the need to adapt to different workplaces and more due to the medical field attracts more and more applicants every year while acceptance rates decrease, intensifying the sheer competition for admission. The current average medical school acceptance rate is at a mere 7% (Freedman 2021).

If we continue to place the production of medical doctors in conversation with the VoC framework, we may note that workers in LMEs are likely to experience shorter employment tenures (hence more frequent health insurance turnover, as mentioned in the previous section) as a result of a more changeable labor market and are therefore prompted to acquire a versatile set of qualifications that are more easily transferred across workplaces in order to be successful at different sets of firms. As Hall and Soskice point out, the downside to producing a workforce that is incentivized to develop general skills is that some employers are facing difficulties securing employees with highly specialized skills (2001:30), of which physicians can be considered an example.

The shortage of physicians in the US is not a new phenomenon. Since the establishment of formal residency training in the 1950's, US medical schools have long produced too few graduates to fill all residency positions around the country by 20–45% (Jenkins and Reddy 2016). However, medical schools have responded and a more recent survey from Association of American Medical Colleges (AAMC) show the pendulum swinging in the opposite direction; while US medical school enrollment has expanded significantly, the availability of residency slots has remained rather stagnant. Medical school enrollment has expanded by 31% since 2002, but the number of residency positions have only increased by 1% a year. These results show that averting a physician shortage now depends on creating more residency training slots (Finnegan 2019).

In 2020, the AAMC released its 6th annual report on the problem of physician scarcity, predicting that in the early 2030's, the US will face a shortage of 54,100 — 139,000 of both primary care physicians and specialists (Dall et al. 2020). The association's president and CEO David J. Skorton, M.D., expressed considerable concern about the widening gap between demand and supply and Michael Dill, the director of workforce studies, attributed the physician shortage to a number of additional factors, including mass retirements of an older generation of physicians in combination with the exacerbated needs of an aging population and the Covid-19 pandemic (Burns 2021).

While many scientists and medical scholars concur that an impending physician shortage is palpable in too many spaces (for example, see Cooper et al. 2002; Fodeman and Factor 2015; Gudbranson, Glickman and Emanuel 2017), others argue that it is more complex than a mere issue of supply and demand of doctors (Bodenheimer and Smith

2013; Kirch and Petelle 2017). In a specific commentary on the AAMC report, Christopher Kerns and Dave Willis from the Advisory Board call into question whether their shortage of primary physicians is an accurate observation. Pointing to recent reports from the Department of Health and Human Services and other studies, they assert that rather than scarcity, the real problem is the inefficiency with which US physicians are distributed and accessed across the country and across communities. Kerns and Willis urges their audiences to stop concerning themselves with the perceived shortage, and instead focus their efforts towards overhauling the current “one-size-fits-all” approach to primary care and provide more tailored solutions for different patient groups — including addressing the lack of insurance coverage, employing telehealth options, and relying more heavily on non-physician medical professionals such as NPs and PAs in high-need areas (Kerns and Willis 2020). Versions of the latter suggestion are rather common in the physician shortage debate, and scholars such as Auerbach et al. (2013) have argued that patient-centered medical homes and nurse-managed health centers may substantially reduce the severity of the shortage.

In response to Kerns and Willis, director Dill counters that team-based care in which non-MD care providers take on a larger share of patient care is already in widespread practice, and that AAMC’s analysis had accounted for this added support when making their predictions about future physician shortages in their report. However, he agrees that the solution cannot be reduced to simply producing more MDs; since there is no control to be had over where physicians decide to locate, and training more primary care doctors does not guarantee that they will settle in underserved communities. With this fact in mind, he concedes: “We need to spend less time figuring out how to get exactly the right number of physicians in exactly the right places. Instead, we need to spend more time determining how to connect people who don’t have access to physicians” (Burns 2021).

With regards to the reoccurring argument for involving more non-physician medical staff in underserved areas, we may recall Trotter’s (2020) research on how many NPs are already saddled with a complex variety of care work for disenfranchised communities of color, ultimately calling into question the nation’s willingness to adequately invest in sustainable solutions for its most needy patients — and care providers. In many ways, the common proposition to “empower” care providers to take on a more diverse set of tasks and responsibilities to help fill the gap of primary care physicians reflects the LME tendency to foster a wider set of skills amongst its workers. While a variety of skills in the VoC framework are perceived as a key to success (or at least employment) in a fluid labor market, the problem of physician shortage requires an analysis of how expanding the authorizations of non-physicians effects the sustainability of their workloads.

It also calls for an examination of how of the scarcity (or uneven distribution) of physicians is related to both formal and informal hierarchies within the medical field. When it comes to IMGs, Jenkins emphasizes that the medical profession is unique in the sense that immigrants and foreign trained doctors are generally sorted into less prestigious positions, seemingly without formal reason. In other US sectors that attract a lot of high skilled foreign labor such as engineering or the tech industry, there are less of an observable hierarchy between native born professionals and their migrant colleagues. In the medical field however, IMGs are consistently matched into less competitive residency programs, training institutions and specializations, which are intimately connected to less attractive geographical areas. Like multitasking nurses and physician's assistants, IMGs are disproportionately serving in more general skills capacities, such as primary care.

This is somewhat puzzling considering the fact that mean licensing exam scores are virtually identical between matched USMDs and at least matched IMGs, and immigrant physicians even tend to outperform US citizen physicians in Step 1 of the USMLE (Jenkins 2020:3). Jenkins refers to this as a horizontal status separation (as opposed to a vertical one as in between a specialist and a generalist) that is informally reproduced and largely accepted by IMGs. Other studies also argue that IMGs recognize professional limitations (such as limited choice of geographic location, specialty or opportunities for advancement within their field) as "part of the deal;" the transactional price they pay for living and practicing as a physician in the US. This dynamic potentially has the power to reproduce itself in the sense that IMGs may also be deterred from applying for more prestigious specialties, assuming that they have little chance of being accepted (Chen et al. 2010). General explanations as to why younger generations of domestic physicians in the US are less interested in primary care or generalist specializations has been summed up as "half the money and none of the respect," and a trend in which the US medical motivations and focus have increasingly moved away from public health supported by primary care infrastructure in favor of technological innovation and cutting-edge interventions (Mitra 2016). Ironically, while IMGs are drawn to the US for the sake of opportunity and professional development, research shows that these things are not readily available to them to the same extent as US medical graduates.

Immigration and visa stipulations are important factors in the geographical distribution of IMGs. Due to difficulties finding a training hospital that sponsors H-1Bs, most IMGs complete their residencies on the non-immigrant J-1 visa sponsored by the ECFMG's Exchange Visitor Sponsorship Program (appointed by the US Department of State), which mandates a two year stay in one’s country of residence upon completion of the program. Still, IMGs on J-1 visas may transfer to an H-1B visa if they apply for and obtain employment in a federally designated underserved area for at least three years through a government-sponsored program known as the Conrad 30 Waiver Program, which is run by each State's Department of Health. This pathway to immigration in exchange for practice in a community with a physician shortfall has become one of the most common points of access to the US medical profession for IMGs. Still, IMGs who have been approved for the Conrad 30 Waiver Program are not guaranteed employment, and some claim having a hard time finding an employer that is comfortable taking on the responsibility for the waiver filing process and cost of future sponsorship. Ironically, underserved communities where 70–80% of patients are uninsured or on Medicaid/Medicare sometimes find themselves in a catch-22 situation where they have a hard time affording the immigrant physicians they desperately need (Nabity 2021).

Against this backdrop, it becomes clear that the US physician shortfall are not just a problem of coordination; its implications are both political and social and need to be situated in both local and national contexts. While generous government spending on healthcare and adjusted care models across communities are significant, there also needs to be an acknowledgement about how eliminating healthcare delivery disparities requires a broader commitment to social policies aimed at addressing both poverty, segregation, racism, nativism and social inequality — both as it concerns patients and care providers (for example, see Marmot and Bell 2009; LaVeist 2011; Barr 2014).

The Swedish Physician Shortfall: Optimizing Work-Life (Im)Balance

Becoming a physician in Sweden is a very competitive process that typically requires devotion and commitment at a fairly young age for most applicants. Unlike the US, Sweden lacks a pre-med college major, and admission into medical schools is predominately dependent on the highest possible GPA from the natural science high school track, or equivalent coursework. If an applicant has a less competitive GPA, many try for a high score on the Swedish Scholastic Aptitude Test (*Högskoleprovet* [SweSAT]), which is not mandatory but is often used as an alternative to high school grades as a basis for medical school admission. Acceptance rates are generally low in relation to the number of applicants; most medical schools receive between 4,000–6,000 applications each year and accept around 200–400 students.[24]

Due to steep competition for spots, the strongest candidates will have both perfect GPAs and excel at the SweSAT. While some colleges have incorporated interviews into their admissions process, it is not standard practice and neither do medical schools consider personal essays, recommendation letters or extracurricular activities. A Swedish medical degree takes 6 years to complete and each year, around 1,500 students graduate from Sweden’s 7 medical schools (Saco 2021). It includes an 18–21-month-long internship (*Allmäntjänstgöring* [AT]) and is followed by residency (*Specialisttjänstgöring* [ST]), which typically at least 5 years to complete. While many medical students take out loans for their living expenses during their college years, tuition at universities and colleges is free for Swedish citizens, along with other EU/EEA and Swiss citizens.

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[24] For specific statistics for each medical school, please visit Antagningspoäng.se (https://www.xn--antagningspong-hib.se/?q=L%C3%A4karprogrammet)

More so than LMEs, CMEs generally fosters and relies on workers with more specialized skills, which presents significant challenges of coordination in order to ensure that industry-specific professionals are both produced and employed after going through education and training. A common concern for CMEs is miscalculated investments in labor forces with niche skills that then may fail to secure lucrative employment. However, the medical profession seems to constitute an important exception to many of the rules applying to sector-specific skills in the sense that it is in consistent high demand in most European countries, especially when it comes to primary care physicians in remote areas (OECD 2021), and Sweden is no different. In this country in particular, it is important to remember that primary care is a specialization that requires the same amount of training as any other specialty and as such, the primary care physician workforce cannot be expanded by other specialists without supplemental residency training.

When it comes to the supplying physicians, the Swedish government has felt compelled to take decisive measures to produce more doctors in order to address the prevalent shortfalls around the country. In 2017, the SAP administration entered into agreement with all 7 medical schools to increase enrollment with an additional 440 spots per year; a gradual expansion set to be fully realized in the year of 2023 (Åsgård 2017). Still, much like in the US, predicating the need for physicians is a complex matter. There are members of the medical community claiming that Swedish medical schools matriculate too many doctors, creating a buyers' market for SALAR (Breimer 2019). Furthermore, only two counties report experience a shortfall of general practitioners,[25] and two other regions even claim to have a surplus (Ström 2021c). However, several well-established organizations including Statistics Sweden (*Statistiska Centralbyrån* [SCB]), the Swedish Public Employment Service (*Arbetsförmedlingen* [SPES]) and the Swedish Higher Education Authority (Universitetskanslersämbetet [UKÄ]) report on a worsening physician scarcity and UKÄ recommends admitting an additional 2,341 medical students per year during 2024–2035. This number represents a 29% increase from the previous year (Faraz 2019; Ström 2019).

Even with training more doctors however, Sweden still has to grapple with the problem of skewed distribution of physicians across the country, and the challenge of both recruiting and preventing turnover of specialized and experienced doctors in rural clinics that are considered less attractive than urban spaces. According to NBHW's yearly report on the supply and demand of medical staff, 19 out of 21 county councils report experiencing a physician deficit, especially for physicians specialized in primary care but also in other fields (Socialstyrelsen 2021b).[26] They trace the difficulties in recruitment to a deficit of medical graduates, steep competition with other employers and mass retirements. Regardless of gender, the counties are also struggling with finding staff that are willing to work in an organization that operates outside of regular business hours. NBHW investigator Katarina Sandberg expresses a similar sentiment as AAMC's Michael Dill when commenting on the challenges with hiring and keeping physicians in rural areas, affirming that increasing graduations will not address the imbalance in physician density between urban and remote communities. She asserts that utilizing teams of medical staff and practitioners as efficiently and as possible through new innovative methods will be important, along with telehealth and digital solutions. Sandberg also urges the counties to find ways to become more attractive to physicians, to offer them supplementary training and make other efforts to prevent loss of staff (Ström 2021).

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[25] *Underläkare* in Swedish, which typically refers to interns or residents; MD's that have yet to become certified in a specialization.

As in the US, the Swedish medical profession is often considered at-risk job for burnout (or exhaustion syndrome, as it is more commonly known as in Sweden) and other mental health issues, especially during the pandemic (for example, see Ström 2017; Gunnarsson 2019; Cederberg 2021). However, with more favorable industrial relations than their US peers, some Swedish physicians seem to respond to challenging working conditions with taking advantage of options leaving for working part time, which combined with generous vacation and parental leave policies can lead to increased staffing difficulties for administrators. While US physicians are experiencing a burnout epidemic with little intervention from unions, observers in Sweden have for some time expressed concerns over an increasing number of physicians prioritizing their free time and personal life over their vocation to a point that may also contribute to the physician shortfall. As mentioned above, many county councils find that physicians are increasingly unwilling to accept and stay in positions that make demands on them outside of regular hours, and SLF leadership has expressed that physicians working on-call hours in the public healthcare sector do not always feel appropriately compensated. Studies from SLF have indicated that nearly half of all primary care physicians in the public sector work part time, and the numbers are expected to be even higher at private clinics. While some resort to part-time (or worse; gets placed on medical leave due to burnout) out of a sense of desperation and helplessness over the strained working conditions and increasing workloads in primary care (Ströberg 2017), others choose part-time as a way of strategically optimizing their lives and wellbeing. Maximizing hours in order to maximize a salary seems to be less of a priority than striking a work-life balance that creates a pleasant work situation for oneself. In a research paper conducted by part-time primary care physician Magdalena Elfwén, doctors working less than 100% claim that they are able to not only spend more with their children and families, but also maintain the joy in properly caring for each patient without getting bogged down by the stressors and demands of full time (Agerberg 2013).

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[26] It is important to note that primary care is a specialization with the same amount of training as any other in Sweden, and should not be conflated with general practice, which implies no specialization training.

However, chief physician and pediatrician Anna Hedlund in Västerbotten county sees a problem with individual physicians responding to structural challenges in the healthcare delivery system by limiting their sense of responsibility to just their own situation (2011). Hedlund argues that there is a shift in which Swedish physicians think of their job as a means to more self-recreation and less as a calling. In order to fully understand the physician shortfall, she argues, we need to not just look at the number of the physicians produced, but also where they work, how their work is structured and how many hours they put in. While small town male physicians with a stay-at-home spouse could dedicate more hours serving their communities many decades ago, younger physicians in modern Swedish society are of a different mindset. With increasing administrative burdens and more options for employment (including a growing private sector and lucrative locum tenens physician opportunities), doctors are developing a protective mentality around time with family and other interests outside of work, and they utilize existing systems and rights to take more time off while also exploring a wide range of opportunities to maximize income while working fewer hours. While Hedlund claims to understand the desire to spend nights and holidays with families and loved ones, she expresses a concern for the negative spiral it creates and the lack of solidarity with colleagues and employers who are left short staffed (Hedlund 2011).

It follows that the understaffed regions and healthcare facilities are those that resort to the most recruitment of immigrant physicians, especially from other EU/EEA countries that enjoy free mobility and automatic recognition of medical diplomas and certificates. A special issue of the union journal *Sjukhusläkaren* from 2015 is titled “They are Saving Swedish Healthcare” and features several voices attesting to the contributions of IMGs where domestic physicians fall short. Looking back on the last 15 years, statistician Hans Schwarz at NBHW observes a strong commitment among immigrant physicians to Sweden, with few return migrations after completing licensing and learning the language (Lindgren 2015). Chief of medicine Karin Lundin at small town hospital in Torsby describes her staff as a mixed bag of nationalities; nearly 90% of the 45 physicians are IMGs. While Swedish physicians go for the professional opportunities of urban areas and find the countryside unappealing, Torsby hospital attracts international physicians who crave the quiet calm for themselves and their families, escaping everything from conflict and economic crises to long hours and strict workplace hierarchies. Lundin sees large refugee receptions such as those from Iraq and Syria as a "golden opportunity" for the Swedish countryside, arguing for dispensations allowing refugee physicians from non-EU/EEA countries to start probational internships while waiting for their Swedish medical license (Gunnarsdotter 2015).

If the Swedish political economy sustains fewer struggles related to social divisions and inequalities, it still faces strikingly similar challenges related to physician scarcity and distribution — predominately in rural areas. Like in the US, the Swedish countryside lacks a power of attraction over domestic doctors, and therefore often attempts to recruit foreign healthcare professionals that are less motivated by the attractions of prestigious urban spaces, and more so by the holistic qualities that a life the countryside has to offer — both as work *and* free time are concerned.

Conclusion

I conceptualize the US and Sweden as a comparison of how a physician shortfall is situated within two different kinds of market economies — a liberal and a coordinated one. The US LME is a strong market economy with insurance-based healthcare while the Swedish CME has a strong welfare state that openly articulates a commitment to universal healthcare for people in all regions of the country. In the US, physician unions play a very small, fluctuating role in spite of challenging working conditions and heavy administrative burdens. In Sweden on the other hand, union membership is the norm and industrial relations in the public healthcare sector are largely shaped by union collective agreements. The US boasts some of the highest physician salaries in the world along with leading technological advancements, which are major points of attraction — still, IMGs tend to be clustered in less prestigious, lower paying specialties that are easier to match into. While physician salaries in Sweden are among the highest in the country, they are sometimes half of what an American physician makes, and union collective agreements prevent large salary discrepancies among physicians employed by the public sector. Perhaps partly due to the lack of union influence over US medical industrial relations, burnout and turnover has been described as a health crisis and epidemic among US physicians. Being a doctor in Sweden can be very stressful as well, but Swedish doctors tend to take advantage of several available benefits to establish work-life balance, including long vacations and working part time. All of these dynamics and characteristics inform the reputation that the US versus Sweden hold on the international physician labor market, and likely shape IMGs motivations and expectations.

Both political economies address physician shortfalls but in very different ways; the US relies on its historical power to passively attract high-performing immigrant professionals, and retains IMGs temporarily in underserved areas through a special government program (Conrad 30 Waiver Program), that waives the mandatory home residency requirements for IMGs completing residency programs on the J-1 visa, a common non-immigrant visa category for IMGs that is originally sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG) by appointment of the US Department of State. Sweden on the other hand has partnered with international recruitment companies in order to actively bring in foreign physicians from other EU/EEA countries that enjoy free intra-European mobility and share mutual recognition of medical diplomas and certificates. This recruitment has led to an overrepresentation of European IMGs over non-European IMGs, who are faced with more comprehensive licensing procedures.

Ironically, comparing how the US LME versus the Swedish CME handle physician shortages and IMG incorporation disrupts some VoC paradigms in the sense that the Swedish CME have come to rely on international firms for European immigrant physician recruitment, making unusual bedfellows with private actors when solving a physician shortfall that is inherently a government responsibility. Mirroring a similar paradox, the US which traditionally relies more on market powers to solve problems of coordination relies more heavily on a government-sponsored visa-related program (Conrad 30 Waiver Program) to distribute IMGs to underserved areas.

The US: A Liberal Market Economy (LME)	Sweden: A Coordinated Market Economy (CME)
Capitalistic market economy, insurance-based healthcare	Market economy regulated by strong welfare state, universal healthcare
Around 13.7% of specialists are unionized and 15% of interns and residents unionized (membership divided over multiple unions)	Around 75% of all physicians unionized (one unified union)
Unions and American Medical Association as separate entities	The Swedish Medical Association serves as both union and professional organization
Private practice can represent more work/life balance and better working conditions	Private practice can mean higher salary and flexibility but also fewer union protections and benefits
Physician salaries (median $208,000/year) and technological advancement among the highest in the world (med school tuition is expensive)	Physician salaries among the highest in the country (median $111,000/year), but half of what US physicians make (med school is tuition free)
46% of physicians consider leaving their current position and 78% report symptoms of burnout in 2018	At-risk for burnout, but nearly 50% of all primary care physicians opt for part-time
Relies on power of attraction and employs immigrant physicians on special J-1 visa waivers	Resorts to active "courting" and recruitment of European immigrant physicians through recruitment companies

Table 6. Political Economies Comparison: The US versus Sweden

CHAPTER FOUR: THE US BRAND – THE LONG ROAD TO THE TOP

In this chapter, I examine how IMGs' perceptions of medical migration to the US compares to their realities and how these dynamics differ between Indian IMGs and Iraqi IMGs. I conceptualize perceptions of a US medical career by using the framework of nation branding (e.g., Fetscherin 2010; Bandelj and Wherry 2011), exploring how collective narratives, reputations and ideas surrounding the US medical field and society are reproduced among IMGs, and how they influence their motivations and expectations for relocating. I use contexts of reception (Portes and Rumbaut 2001) to understand how these expectations compare to the realities of IMG life in the US. Because of its vital impact on the IMG experience and (im)mobility (Al Ashry, Kaul and Richards 2019), I center the role of the US visa regime, which also separates IMGs from refugee versus non-refugee backgrounds into different immigration pathways. Lastly, I look at the tools and resources that Indian versus Iraqi IMGs draw upon to overcome obstacles on the road to a US medical career.

On a rainy and chilly October day in 2019 a few months before the Covid-19 pandemic hits, I take an Uber to a hospital in the outskirts of Boston in order to interview Dr. Anya, a pulmonologist who I had found through a regional Indian medical association. Dr. Anya has a serene, yet assertive presence and speaks with careful intention. Although she first set foot on US soil nearly two decades ago in the early 2000's, her journey towards becoming a physician in America started even earlier, as part of a cohort at an Indian medical school where a majority had their goals set on migrating. Dr. Anya's account demonstrates how a strong US nation brand permeates Indian medical schools, and how social networks provide Indian IMGs with important toolkits for a career in US medicine. “Coming to the US was driven by your peers,” she says. “And like everybody, I came to the US to get a better education. It was always the greener land for us. Right? It always looked appealing, you felt like you could become a better physician coming here. And also make money. Money was one big driving factor. And the lifestyle and quality of life.”

Dr. Anya and her classmates would bring their lunch boxes and meet up in the library where they would study from morning to night, sharing notes and running through practice test questions while preparing for Step 1 of the USMLEs (US Medical Licensing Exam). Not everyone could afford a tutor or the Kaplan prep course, and so pooling study materials and creating peer networks became a significant help in taking on what Dr. Anya calls the “painstaking task” of getting licensed to practice medicine in the US Completing the USMLEs is only one step towards that goal, and so is setting foot on US soil for the first time. What really counts as “getting in” according to Dr. Anya is professional establishment, which starts with residency matching:

> The toughest challenge I see as an immigrant, a physician immigrant going to this country, getting into the professional life, is the first entry. Not stepping into the country, but the professional field. You go through your matches, you apply for each program and it’s expensive, it’s not easy. It’s expensive in terms of time, in terms of effort, and financially as well. You have to be resilient, and when you come to a foreign country, you have this sense of ‘there is no looking back.’ You have to move forward. That’s the way it is. You just have to have the courage and the motivation and the energy to move forward and that’s exactly what I did.

While describing this challenging process and the immense investment that goes along with it, Dr. Anya asserts that the mindset one must adopt in order not to falter is one of absolute commitment. With this expectation, there are little room for complaints about the realities of the IMG establishment process.

However, grit alone may only get you so far. Dr. Viraj was able to come to the US on a spousal green card in 2003. He is an outspoken family physician with a kind smile. After a recent recovery from burnout, he took on new roles in his professional community in which he advocates for a more holistic approach to healthcare. Unlike Dr. Anya, Dr. Viraj highlights importance of immigration status, socioeconomic background, and networks next to hard work, illustrating how the US context of reception for IMGs as a professional group has deteriorated; a combination of a decreased availability of high-skilled worker (H-1B) visas (Chakravorty, Kapur and Singh 2016; Al Ashry, Kaul and Richards 2019) and increased competition for residency spots (Finnegan 2019) seems to have made the road to the US a lot more challenging. Looking back on his journey to the US, Dr. Viraj considers himself lucky in comparison to other IMGs, especially in current times:

> Unfortunately, the situation has even gotten worse. I told a friend, if you don't have scores more like in upper 90s in all the steps of the USLMEs and you're not a green card holder, don't even bother, because it's so tough. Most of the kids come at the backing of their parents, the parents are using their savings. I have a few friends who are going on two or three years of repeatedly trying, and then they end up changing their careers because they couldn't get into the Match. A green card was definitely helpful and meaningful for me because I'm not an upper 90th percentile student. I barely passed the USMLEs. This day and age, you won't even make it because the algorithm will pick you out.

While putting slightly different emphases on agency versus external or inherited factors, Dr. Anya and Dr. Viraj both point to a constellation of required puzzle pieces — some that they may influence themselves and some that are outside of their control. Their statements capture reoccurring experiences among the participants in this study, suggesting that in order to be successful in the pursuit of becoming a practicing physician in the US, an IMG benefits from a combination of family support, financial resources, social networks, ability to achieve high USMLE scores, match into a residency program, and an immigrant visa or green card.

If Indian IMGs have the benefit of an extended preparational stage and a shared toolkit for how to maneuver US licensing requirements, they often struggle with long-term legal certainty under the current visa regime. Iraqi IMGs on the other hand tend to miss out on the preparational stage due to unexpected or sudden departures and lack the institutional knowledge that long-standing physician network migration brings. However, they often have a shorter path to legal permanent residence if they obtain refugee or asylee status. As such, one IMG group needs what the other group lacks, as Dr. Ibrahim's case illustrates. Now a fellow at an ivy league university, Dr. Ibrahim came to the US in 2010 on a Fulbright scholarship for an M.A. in public health. While he had initially not intended to make it a permanent move at the time, he had long been looking to further his education in the West; a consistent activist collaboration with European and American non-profits in Iraq had contributed to Dr. Ibrahim identifying more with Western values than Iraqi or Muslim ideals. "My Westernized approach to life and my secularism alienates me from the Iraqi community," he explains.

Dr. Ibrahim claims that a combination of being associated with the US Department of State (DOS) and his radical political activism in his home country caused him to have his Iraqi citizenship revoked during his studies, requiring him to become a political asylee. Although asylum granted him work authorization and legal permanent status, he remained stateless until he could obtain US citizenship in 2018. While Indian IMGs would draw on each other’s resources and network support for an accumulative advantage as they prepare for migration and the US licensing process, Dr. Ibrahim found himself with accumulating disadvantages; while struggling with a debilitating case of PTSD, he soon realized not only that there was no turning back but also how long the road was ahead. Similar to Dr. Anya, he describes effectively pulling himself up by his bootstraps:

> I realized, "Well, I did not plan this, but I wish I knew. Now I have to restart from scratch." I was a practicing family physician in Iraq and now I have no job back home. I have no license to practice, and I have no job here and no license to practice in the States. I used to work part time in the morning. Come home, study for my relicensing until 9:00 PM, then do tutoring from 9:00 till 11:00 PM for international students. I lived off food pantries for a while. I shared an apartment with three people. One of them was a drug dealer. That was an interesting time of my life. You have to be adaptive; you have no other choice. It's an unfortunate situation but you don't have time to think about it. You just need to act and get out of it. That's it. It took me until 2014 to become relicensed.

While Dr. Ibrahim’s context of reception was far from ideal, he still kept the US nation brand in high regard as it would come to represent a sense of opportunity he could not find at home. To him, the US represented more than financial comforts; a classic American dream-version of the US nation brand comes through in his story when he says, “America is a place of reinventing yourself and being at peace with your desires and the abilities at the same time.”

Triangulating Dr. Anya and Dr. Viraj experiences against Dr. Ibrahim’s highlights how motivation to migrate to the US and the ability to prepare for said migration can differ greatly among non-refugee and refugee IMGs and have significant bearing on their contexts of reception. As Dr. Anya and Dr. Ibrahim illustrate however, goal-oriented

IMGs who successfully manage to both obtain immigration status and break into the medical field may perpetuate a US nation brand that ultimately overshadows the structural obstacles that Dr. Viraj points out. In the sections that follow, I elaborate on Indian and Iraqi IMG pathways to the US, how they navigate hurdles related to immigration and professional establishment, and how their expectations relate to the realities of the IMG experience in the US.

The Path to a US Medical Career: Motivations and Navigating Immigration

Indian Network Migration and the US Nation Brand

A majority of participants come from high socioeconomic status backgrounds and describe their choice to go to medical school as a result of family role models, encouragements or expectations. This is perhaps not very surprising — many studies have shown how the medical school trajectory is deeply embedded in existing social hierarchies, and often serve to reproduce class relations (for example, see Pascarella et al. 1987; Bonner 2000; Whitney 2002; Jenkins 2020). Among the Indian doctors primarily, the decision to become a physician in the US came not too long after entering medical school. Similar to Dr. Anya, many of the Indian physicians describe being part of a college or cohort where a significant portion of the students intended to leave their home country in order to advance their careers in the West around the turn of the millennium — a time when India had firmly established itself as a prominent player in the global economy and the current US visa policy was relatively favorable towards high-skilled immigrants because of the tech boom in the 1990's (Chakravorty, Kapur and Singh

2016). Just as many of them had found themselves on a charted path to medical school, they were also part of a well-established chain migration between India and the English-speaking world, where the UK and the US nation brands came to represent a natural next step for an ambitious and talented medical graduate, associated with first class medical training and a comfortable lifestyle. Dr. Farhan remembers choosing the US after medical school graduation thirty years ago, before immigration policy was made more restrictive:

> We came to America because back then, you had to go for post-graduation, and the options were the US and the UK. People who were successful either went to the UK. or the US for training and fellowships. I didn't want to stay in my country and the US was a lot easier back then than the UK. I could have gone to the UK too, but everybody wanted to come to US.

In many ways, elite Indian medical schools become hubs in which a US brand associated with a superior medical field is reproduced and disseminated as students share information, resources, experiences and aspirations. Dr. Ashok also went to a medical school were a majority had their minds set on the US. He speaks to how predecessor peer support coupled with Indian educational ideals helped expediate medical migration to the US for himself and others at his particular institution:

> Many people from my medical college came to the US for their postgraduate training. You're going to go abroad for your training, so I got a lot of peer-mentoring in how to crack the USLME exams and how to come over here, like how's the path to get into a postgraduate training in US I knew that much better than how to get into a postgraduate training in India. Very few people are staying there from my medical college. So, I think that the path to coming to US was better known.

Among others, Dr. Ashok and Dr. Farhan's experiences illustrate how being at an elite medical school constitutes a significant factor in pursuing an international medical career. Research shows that graduates from more prestigious Indian medical schools account for a disproportionately large share of emigrating physicians (Kaushik et al. 2008). Even within high-end institutions (such as the top-ranked All India Institute of Medical Sciences [AIIMS]), there is a hyper selection in which the highest performing doctors are more likely to emigrate to Europe or the US, causing the authors to call attention to not only the number of Indian physicians leaving the country, but the academic and leadership quality of the medical professionals who emigrate compared to those who stay behind. Kaushik et al. (2008) suggest that the ambitions of these high achieving physicians are motivating them to seek out international destinations where they can access cutting edge training, technology and equipment — all attractions that the US medical field is world-renowned for. Dr. Krish, an accomplished surgeon who went to an elite Indian medical school where half of his cohort migrated, echoes this sentiment:

> Why I chose to migrate to the US was because I felt like the advances in science and surgery tended to happen more from the United States than from other parts. I think in Europe or UK, there was always a ceiling, like you wouldn't reach sort of your full potential in the UK. And I think Australia, New Zealand, all these other societies, they all had barriers and I didn't particularly perceive them as being vastly superior in their science or medicine, or practicing medicine… So, I was pretty intent on coming to the United States.

Despite the well-known hierarchy between IMGs and US medical graduates in which most IMGs are informally sorted into less prestigious specialties such as internal medicine and primary care (Ahmed et al. 2018; Jenkins 2020), Dr. Krish also describes the US medical practice as more meritocratic than Asian systems, articulating a version of the American dream in which hard work is rewarded. “It doesn't have the hierarchies and corruptions and things like that that you can see in some places,” he says.

Dr. Ashok, Dr. Farhan and Dr. Krish illustrate a spectrum of agency in how

Indian IMGs from elite colleges end up choosing the US for their migration destination; some describe being fostered by a school culture with a collective bias towards migration, while the other speaks to an individual drive to pursue the professional development that they felt could only be obtained in the US, again illustrating the strength of the nation's brand in the global medical labor market. In this sense, determined individuals like Dr. Krish can create a spill-over effect on people like Dr. Ashok and Dr. Farhan, who initially may have teetered between different options. At the same time, master narratives surrounding the superiority of the US medical field are not always anchored in facts or concrete examples. Dr. Mitesh was the first person in his family to go to the US and says that all the images he had of the country growing up came from "Hollywood."

While Dr. Mitesh agrees that medical research in the US is well supported, he also found himself disillusioned about the US being the best place of practicing medicine:

> It was also an imagination of what the physician lifestyle might be. Americans seemed so well-off. I didn't have any benchmarks though; I didn't know what the income levels were. I think the aspiration was just to live a comfortable life, first of all. Number two, to practice medicine the best way you can. Technology, financial resources… Without having to worry about, or the patients having to worry about if they have the money… You don't have to worry about the fees as a physician. And since I've arrived, I've learned that isn't true.

As many other IMGs in recent cohorts who come without sponsorship through kinship ties, he utilized the student visa (F-1) and a US graduate degree as a steppingstone on his way from Indian medical school to US residency training. Unlike other medical students who were better connected or embedded in a migration "stream," Dr. Mitesh felt the disadvantage of not being privy to the hidden curriculum of how to orchestrate medical migration in the most strategic way.

> I do think America offer immigrants a lot of opportunities. At the same time, there is a lot to be said about *the game*. The game, the process that different people can access. There is a stream a people, and if you can join a stream of people, it's easier. If you know what people to talk to, and to get help from. Coming from India before I had my PhD, I don't think I was necessarily in the stream. I'm very happy where I am, but at the same time, I know a lot of young people coming from my med school who have a better idea of how to navigate, how to put themselves in positions where they could have access to better opportunities to be more successful. Once you get here, you know how to play the game and how to be successful.

Dr. Mitesh choice of the word "game" emulates a Bourdieusian definition of *habitus* as a "feel for the game" (Bourdieu 1990:66), a learned set of dispositions and abilities used to navigate a certain social sphere of activity — a *field*. While habitus can be understood as a feel for the game, a field is characterized by its own particular regulative principles — or "rules of the game." A field contains power struggles among different interests seeking to control the capital (and 'rules') in that particular field (Edgerton and Robert 2014). In this sense, medical migration from India to the US could be considered a field in which a school that produces a large number of IMGs constitutes a significant part. In this field, the students with the right habitus, or most powerful combination of social, cultural and economic capital, are often the most successful players.

Bourdieu's theoretical framework has had a significant influence on network theories of migration. Related to migration system theories and transnationalism, which assert the importance of acknowledging the connectivity between migrants and their native communities (Vertovec 2009; Castles, De Haas and Miller 2013), network theories emphasize the significance of social networks and diasporas when analyzing migration patterns (Bryceson and Vuorela 2002; Vertovec and Cohen, eds. 1999). Arango (2000:291) defines a migration network as a "set of interpersonal ties that connects migrants with relatives, friends or fellow countrymen at home who convey information, provide financial backups, and facilitate employment opportunities and accommodation in various supportive ways." Sometimes referred to as chain migration, network migration emphasizes how interpersonal ties between current migrants, past migrants and non-migrants in sender societies form social capital that can be utilized to gain access to resources that would otherwise be out of reach. This model can also be described as the social capital theory of migration, utilizing Bourdieu's elaboration of different forms of capital, where he describes social capital as "the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (Bourdieu 1985:248). In sum, migrants drawing upon the accumulation of social capital in widespread networks can lower the economic, cultural and psychological costs of migrating, facilitating transitions by migrants providing their own economic and social infrastructure (Castles, De Haas and Miller 2013; McKenzie and Rapoport 2007).

As indicated above, the decision to relocate to the US may range from a strong personal drive to an indirect gravitation stemming from social context or family ties. Not all Indian participants assumed that postgraduate training in the US would lead to a permanent move but ended up finding themselves pulled into "the stream" by marrying a co-national professional who was more committed to a career in the new country. Following a husband is more common than following a wife; Dr. Seema, Dr. Saanvi and Dr. Priti all moved to the US in order to join their husbands. However, joining a husband did not mean that any of these female participants had not entertained the idea of migrating to the US themselves, or had their own ambitions there. In addition, the opposite is not unheard of, as in the case of Dr. Viraj coming to the US on a spousal green card to join his wife. While a handful of participants describe an individual, goal-oriented longing for the US that they cannot link to family or friends, a more common pattern consistent with chain or network theories of migration is deciding on the US because one's partner, classmates, or family members are blazing that trail, illustrating an overlap between family migration and professional migration categories.

Iraqi Conflict-Fueled Migration and a Mixed US Nation Brand

Armed conflict and war are radically different drivers of physician migration than professional development, although not mutually exclusive. While Indian participants show little ambivalence towards migration, the Iraqi participants share diverse sentiments towards leaving their country behind, and towards the US nation brand. Among Iraqi physicians, the US nation brand is largely relative to and produced by their experiences with the country's military intervention along with their own positionality in Iraqi social, religious and ethnic fabrics.

Dr. Ahmed exemplifies a reluctant migrant who did not hold the US in high esteem. He clearly remembers the invasion of 2003 and Saddam Hussein's regime being toppled by US forces. With great sadness, he recalls the massive toll that the war took on healthcare and the dangerous conditions that he and his colleagues faced when trying to do their job. He himself was in medical school at the time and rushed to graduate in order to serve his people — a pursuit that was severely complicated for many of the Iraqi participants. Dr. Rashad says:

> Oh, my God. It was chaotic, especially in 2003, because after the invasion, we didn't have any classes anymore. We need to return back to the medical school after, I think 60 or 90 days. Then we need to catch up with all the subjects that we missed by ourselves, then we need to prepare for the finals. I remember a couple of times the final exam was just postponed because we have bomb threat, or we have bombing near the medical school. A couple of my friend were kidnapped because of the situation, so it was scary.

While the circumstances had many planning to leave upon graduation, Dr. Ahmed and his fellow students were motivated to complete their studies in order to get out into the Iraqi communities that needed them. He says:

> As medical students at that time we did our best, just to graduate, because the country needed us, and the situation at that time really needed us, because they had so many medical doctors dying, dying in that country, or may be killed, or kidnapped, or whatever. So, we had a shortage of doctors. So, we were happy and excited just to graduate and take over and be responsible for that.

While still in medical school, he started volunteering for the United States Agency for International Development (USAID) but was disappointed to find that they seemed more interested in dealing with the Iraqi government than supporting the reconstruction of Iraqi healthcare and medical infrastructure. As the situation deteriorated further, he came to the US on a Special Immigrant Visa (SIV) in 2009 for his services to the US government but returned two months later after concluding that the country was not the right cultural fit for him and his family. For many years, he worked long hours in several cities, in hospitals and primary care centers. While Dr. Ahmed persisted, many of his fellow physicians were not able to. He says:

> I saw the war made the Iraqi doctors scared. Made the Iraqi doctors think twice. Made the Iraqi doctors to choose to leave their country. And leave their own people. If I had a choice, I would never leave Iraq. I would stay with my people. Try to help them. Try to be with them. And do my best.
>
> While Dr. Ahmed maintained a strong bond to his fellow co-nationals, others felt

alienated from Iraq due to ongoing conflict and injustice. Dr. Abdul says:

> I think most of my life I have felt this inequality back from Iraq. You know when you start a race, and you don't start from the start line. You start 10 kilometers behind the start line. In Iraq, you live in the south, the government doesn't like the south and the previous regime. You don't have equal chances in life.

Similar to Dr. Abdul, Dr. Mohammed describes how financial seizure, armed conflict, kidnappings, and persecutions perpetuated by extremist militias expunged his feelings of community and belonging from an early age. As a teenager, Dr. Mohammed saw beheaded bodies in the streets, spent many sleepless nights listening to bombings in the vicinity, had his family's movement restricted by checkpoints, and missed several months of high school that were crucial to his future in medicine. He describes it as one of the most depressing times of his life. "It was as if you're breaking your dream. You're feeling that something that you've been working very hard for 18 years… Everything is being broken down because circumstances out of your hand." Unable to return to his original high school due to looming threats, he switched to another school and achieved test sores high enough to get into medical school. Still, he saw his future in Iraq as a dead end:

> I was not feeling that I'm being the type of the doctor I will be there. Dealing with the society there was challenging, I would say. I couldn't relate myself to people there. We are doctors and we have to treat people regardless of their backgrounds, but you have to feel that you're safe. You have to feel that you're comfortable and happy with what you're doing. Simply, I was not happy with what I am doing there. I had that big passion, that I needed to come to the US I know what I want to do, and I know what specialty I want to choose. This is not the environment where I would develop my skills. I was seeing my senior attendings and residents, I was seeing how sad they were and I'm like, "Oh what a poor life they have overall." They were frustrated all the time, they can get threatened, they can get killed. It was just very, very, very intense.

Knowing that he wanted to leave, he began to purposefully distance himself from his fellow Iraqis and focus all of his efforts on his medical studies and finding an exit:

> It was an established thought and that's why I was not even open to have any social relationship to people there. I have a lot of friends, but I was not even thinking of having a partner at that time. Not doing anything, just my classwork, kind of postpone everything for now until I get out of there.

Dr. Mohammed was eventually able to obtain a visitor's visa to complete his USMLE Step 2 Clinical Skills and applied for asylum after that. For Ahmed on the other hand, migration was "Plan B," and only allowed to seriously enter his mind after he had exhausted every ability to stay. It was not until 2014 when the Islamic State (ISIS), or Daesh, invaded Iraq that he reached a breaking point. In 2014, he told his mom and family, "In 2009 I led you to decide to stay. Now I'm going to decide we are not staying. We are leaving the country." Although he still maintained documentation and "clearance" to come to the US, his new SIV visa application took three years to process during which him and his family tried to stay safe in a country being torn apart by multiple militias, terrorist groups, and horrifying violence.

As Dr. Ahmed's case demonstrates how winding and sometimes circular the path to departure can be for refugee physicians. His dual commitment to both his patients and his family placed him in a space of ambivalence and internal struggle. Without negating the point of no return, it is important to disrupt any reductionist notion that would imply that forced migration entails little to no decision making — especially for refugees from more affluent socioeconomic backgrounds. The lack of agency associated with being a refugee does reflect the complexities of the Iraqi physicians' realities; their migratory existence is often an intricate intermingling of different levels of ambition and fear, ideals and self-protection, action and constraint. Dr. Ahmed's passion for his compatriots also illustrates a tension in how individual IMGs (both with refugee and non-refugee backgrounds) interpret their vocation or role as physicians — to serve their compatriot patients with little to no resources, or to go where they may practice medicine under better circumstances, albeit to the benefit of foreign patients.

While Indian and Iraqi participants have different push factors and visa journeys, they often describe similar considerations in their choice of destination; next to the quality of the medical field, both Indians and Iraqis alike often end up in the US because they find it to be a path of lesser resistance than other Western options such as the UK — although, certainly not without obstacles. The Iraqis consider the difficulties with which to obtain both legal entry (or asylum), and access to the medical field in the country in question, and it is not rare for peers and kin to be part of the decision-making process, and then support each other in a collective pursuit. Even though Dr. Abdul had some relatives in the UK, he and his fellow group of students opted for the US because he saw the path to licensing there as more straightforward and the opportunities for education and training as richer. Similar to Indian peers, he perceived the US nation brand as synonymous with opportunity and an unbeatable medical field:

> I decided, me and my friends, that the United States is one of the best places to go. Education is better, opportunities are better in terms of subspecialties, and it's a continent with like 50 states. It's like 50 countries to choose where you want to practice. It's a lot of places to explore and enjoy and a lot of funding for medical research and I was really interested in getting involved. It's the land of opportunities. Europe is great as well but in terms of funding and research, this country is still the number one in the world. That was the reason why. For example, now, for me, it takes me three years to obtain a specialty in internal medicine in this country. That would mean maybe more than five to six years, double the time in the United Kingdom.

Like Dr. Abdul, Dr. Shams went to medical school in the UAE after her family had fled Iraq. They both describe the country's unyielding immigration policy for non-natives, effectively preventing them from forming any feelings of belonging in their temporary host society. While Dr. Shams' school had given her a full scholarship based on being valedictorian in high school, she was experiencing difficulties obtaining security clearance for an internship due to her family name, which reinforced the trauma she had already experienced in her home country:

> Because of the background of my father or sectarian issues and all this, which I had nothing to do with because I'm not a religious person. I don't even have a religion. It was very, very traumatizing to feel this way. Deep down, I had a clear path. I knew I wasn't staying anyway.

Instead of trying to pursue a career in the UAE, she took advantage of her school's affiliation with the Cleveland Clinic and went there to complete rotations during her last year before graduation. At the time, she carefully studied and weighed the obstacles that different destination countries presented as she planned her migration, preparing for each possible outcome:

> When I did my internship, I decided to do all my USMLE and Canadian exams at the same time, because my plan was either to go to Canada or to go to the States based on how easy immigration is for Canada when it comes to doctors and for the US because of the residency spots available for IMGs. I had a third option if all that failed, New Zealand.

Much like their Indian peers, Iraqis describe wanting a better (or safer) life for themselves coupled with advanced medical training. These two goals are deeply interconnected as the participants maintain a sustained commitment to their profession, unwilling to risk losing their hard-earned vocation in the process of seeking refuge. Dr. Abdul summarizes a sentiment echoed by many participants from each country when he says, "Right in med school, you understand that if you want to really learn medicine or be on the edge of research, if you want to be on the frontier of science, you have to go to a

Western country." Dr. Abdul and Dr. Ali are vocal about their longing for the resources that would help them grow as medical professionals — individually and collectively.

With the help of the International Organization for Migration (IOM) and the UN, Dr. Ali migrated to Denver with his family after his father was assassinated in 2007. At this tragic point, he had long tired of the resource-poor medical environment that prevented the Iraqi medical field from advancing technologically — a major strength of the US medical field. While Dr. Ali watched physicians develop advanced clinical skills from all the hands-on patient care that the war brought, medical research and science suffered from institutional instability, frequent disruptions and lack of government attention. At a detail-oriented pathologist, he describes his frustration with his inability to obtain new editions of books, and that it would be "a fantasy" to receive funding for new projects or studies. With some overlaps with Dr. Ali, Dr. Abdul's migration narrative illustrates a combination of professional ambition, self-preservation, and peer examples when he says:

> I've always loved research and always wanted to get the highest education wherever I go. I worked for one or two years at a research center in Baghdad, but it was miserable. We don't follow any guidelines, we treat patients with only what is available to us, which is really wrong. I always want to be in the front, doing the guidelines, working with these high people. So, I said, "Okay, it's bad, the medical situation is bad and also the living situation is bad." And I saw all my friends started to come to United States. So, I said, "Okay, it's my turn." So, I applied for [a student] visa in the beginning of 2014, then I got the visa and I came later in 2014.

Like the Indian counterpart, the Iraqi medical school system is designed after the British model and classes are traditionally taught in English, and so the UK, Australia, and other OECD English speaking nations emerge as contenders for Iraqis and Indians alike. While both groups are faced with visa-related challenges on their path to a medical career abroad, Iraqi testimonies describe bigger difficulties in getting their foot in the door. Urologist Dr. Ghazi says:

> I've always wanted to get a degree from England or US, one of those two. And I tried so many times to go to England, applied for visa because a couple of times that rejected, applied for studies and that approved, but then with the visa was an obstacle. So, it was an opportunity for me to come to the United States through a Fulbright scholarship program.

After a year as a student in the US, Dr. Ghazi started receiving threatening letters based on his perceived Sunni affiliation. “Like if you come back, if you ever come back to this hospital, it'll kill you,” he explains. “If you ever come back, we'll do this, we'll do that. And they posted that on the hospital walls, like close to where our room was.” He decided to apply for asylum.

More so than the Indian participants, Iraqis physicians also mention considering other European countries with histories of significant refugee receptions from the Middle East, such as Germany and Sweden. Dr. Waleed’s uncle and fellow physician had left Iraq for Germany and has always encouraged him to complete his medical studies abroad. Dr. Waleed remembers how the war made everyone scramble for safety, and in 2005 he started looking around for a country that would receive him: “I tried to go. I applied for a lot of immigrations, but nothing fit for me. I applied for Canada, and it was not a fit for me. I looked for Europe. I looked to come to Europe as a refugee. I looked to come on a visa. I couldn't find anything.” Based on the violence and crime he had seen in American movies; he did not want to consider the US.

After Dr. Waleed’s father was kidnapped, he and his family decided to go to Syria where he continued searching for a way out among the European embassies and the UN. He found a recruitment and training program for IMGs in Germany and with the financial support of his uncle, Dr. Waleed started applying for a German visa and studying German. At the time, there was an explosion at a US owned press office where his brother worked, and the employees and their families were offered the opportunity to apply for SIV visas. Dr. Waleed applied together with his brother, thinking it would be unlikely that he would go. While his German visa delayed, he got a call from the US embassy saying he was approved and needed to be ready for departure in two weeks. A German visa would not permit him to bring his wife and daughter, and he needed a budget of $50,000 to sustain himself and his family until he could start practicing. The US would sponsor them financially for 6 months, but his surgery specialty would not be recognized. “If I go to US, I will take the whole family, but I will lose my degree. I will lose everything. So, this is the comparison.” Unwilling to give up on Germany, he considered how US green cards could eventually put them in a better position for European immigration. On October 29th, 2013, Dr. Waleed and his family left for the US They had a long road ahead.

Indian and Iraqi IMGs navigating the US Visa Regime

As shown above, access to immigration is an important factor in determining IMG destinations. IMGs coming to the US without green card sponsorship rely on obtaining the H-1B or J-1 visa for beginning their residencies. The drastic reduction to the H-1B visa category in 2004 reverted the annual allotment from 115,000 to 65,000 distributed through a yearly lottery,[27] which took away work authorization with a path to legal permanent residence for many high-skilled immigrants including as physicians — even if they had been offered employment and sponsorship. Not only has the annual H-1B quota been cut significantly, the number of residency programs sponsoring them has dwindled due to the 2016 cut in Medicare graduate medical education funding.

The challenge in obtaining an H-1B visa is exemplified by the fact that only two out of the 21 Indian participants in this interview series report having received an H-1B when first joining a fellowship or residency program in the US. What is predominant is either spousal or family sponsorship, or the exchange visitor J-1 visa which is sponsored by ECFMG, designated by the US State Department. While the H-1B is directly sponsored by an employer and allows for dual intent, meaning that the holder may or may not intend to pursue legal permanent residency in the US, the J-1 comes with stipulations where applicants have to profess they do not intend to immigrate, and promise to return to their home country for two years before they can pursue a path to permanent resident status — which includes being eligible for the H-1B visa. This entails the following paradox: IMGs completing residency training in the US in order become licensed to practice in the country are doing so on a visa that is originally designed to prevent immigration.

A common way to eventually obtain an H-1B visa after having been on J-1 status is to apply for a waiver based on the request of a US government agency or state health department where a physician agrees to work full time in a community designated by the Department of Health and Human Services (DHHS) as having a shortage of healthcare professionals, or in a Veteran's Affairs (VA) facility. A J-1 visa waiver removes the two-year home residency requirement and allows IMGs to transfer from a J-1 to a H-1B visa status that will allow them to remain in the US to practice in a federally designated primary care or mental health Health Professional Shortage Area (HPSA). On what is known as the Conrad 30 J-1 Visa Waiver Program, IMGs may apply for thirty slots in underserved areas made available by each state government each fiscal year. IMGs unable to secure a slot will have to return to their home countries for two years upon completion of their graduate medical education before they can try to re-enter the US labor market as licensed specialists. As we shall see in later sections in this chapter, immigration status and visa related uncertainty have a great impact on physician integration — both professional and social (Kavilanz 2018; Al Ashry, Kaul and Richards 2019).

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[27] Universities and related nonprofit entities, nonprofit research organizations and government research organizations are not subject to the cap. In 2020, USCIS approved 426,710 H-1B petitions for entry into the yearly lottery pool. Read more about recent petitions filed and approved in the report *Characteristics of H-1B Specialty Occupation Workers* (US Citizenship and Immigration Services 2021).

As competition for residency spots are getting steeper due to the expansion of US medical schools and H-1B visas are rarer, more recent IMG cohorts seem to make use of the F-1 student visa as a steppingstone. Four of the Indian participants first gained accessed the US healthcare field as graduate students, as illustrated in Dr. Mitesh's story. Depending on the applicant's background, the F-1 visa is often easier to obtain than the competitive H-1B after one has been admitted to a higher ed institution. Although it can be both a significant expense and a delay on the way to practicing medicine, a US graduate degree comes with many benefits, including contacts that can lead to valuable recommendation letters and employment opportunities, a temporary work authorization (Optional Practical Training [OPT]), a stronger CV, and a general opportunity to get into “the stream,” as Dr. Mitesh describes it. When Dr. Dev reflects on the visas that he and his contemporaries arrived on, he does not mention the H-1B, but emphasizes spousal sponsorship and the F-1:

> When I came at that time in 2007, 2008, I think that more people were coming by student visa, and doing the master’s first. During the master’s degree, people were applying for residency. Seven of my friends also married a US citizen, and then went back to residency program, and did fellowship. A few of friends also came by visitor's visa, that I know, but mostly it was student's visa to pursue some Master's in either hospital administration, or public health, or public administration. That was the trend at that time.

Dr. Ashok corroborates Dr. Dev’s observation. Coming from a cohort where around 60–70% students migrated, he remembers how the cohorts above him had much higher percentages — 80–90% in his estimation. He describes how restrictions to the US visa regime both deterred and reorganized Indian medical migration, compelling IMGs to shift in an academic direction:

> I think with our class, many people stayed back in some part because of the visa. More people stayed back in the country and got trained there and are actually doing very well now. So that's one impact that the visa situation had, another impact that it had was that some people started finding alternate ways to get their visa. So, in our year and years subsequent to ours, many people started doing Masters degrees in public health or taking other Masters courses to come to USA, and that actually had an impact because once they got into that route, they had a different academic trajectory than those of us who came through the usual clinical route. So, I think that that has also had an interesting unforeseen consequence.

It is hardly surprising that Iraqi physicians who arrive in the US as refugees have a radically different path than their Indian colleagues. Still, the F-1, J-1 (which is also held by international students in the Fulbright program), and B-1 are common entry visas for the Iraqi participants as well. In the Iraqi case, however, the graduate school route on a student visa is not only used to increase one's competitive standing in preparation for residency application, but also to simply establish a legal way out of Iraq by entry to the US. Only Dr. Shams, who first escaped with her family at the age of fifteen to the UAE after her father was assassinated, came to the US on an H-1B to do her residency in Georgia. The other Iraqi participants would reach the US on the following three pathways: enter on one of the aforementioned visas and shortly thereafter become an asylum seeker; receive Refugee Status Determination (RSD) under United Nations High Commissioner for Refugees (UNHCR) and be resettled to the US through United Nations (UN) channels; or enter the US on a so-called Special Immigrant Visa (SIV) for their service to the US government.[28]

It follows that while many Indian IMGs enter the US without knowing for many years when or if they will obtain legal immigrant status,[29] their refugee colleagues have already been granted a path to permanent residency (and citizenship) before they arrive. If they arrive on tourist or student visas and fear persecution upon return, they can apply fairly quickly for asylum with USCIS. If granted, the Department of Homeland Security (DHS) issues a Form I-94, which is a US record of arrivals and departures. The I-94 will be stamped or noted with a statement, such as "asylum granted indefinitely" or the appropriate provision of law demonstrating the asylee's employment authorization (US Citizenship and Immigration Services 2022).

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[28] Iraqi nationals who served as translators or interpreters to the US armed forces or Chief of Mission authority, or has been employed by or on behalf of the US government in Iraq on or after March 20, 2003, for a period of at least one year may be eligible for Special Immigrant Visa (SIV) processing.

[29] Read more about how green card backlogs affect Indian nationals (and IMGs) in the following subsection.

Initial Contexts of Reception: Relocating, USMLE Exams, and US Clinical Experience

Indian Networks Accumulating Advantages

While it often takes a long time to orchestrate a relocation to the US, the process towards a US medical career is in many ways just getting started as an IMG lands in the country. The first year or few years in the US are typically organized around a number of qualifications one must obtain before being eligible for residency, such as ECFMG certification and gaining the US medical experience required for residency, such as externships, rotations, clinical clerkships, observership, or the like. While the former entail more hands-on experience, others such as observerships resemble shadowing with little to no direct patient care. Since the tourist and student visas are very restrictive when it comes to work authorization, IMGs can rarely get paid if gaining work experience on these statuses — even after they earned an MD.[30] Some complete these qualifications shortly before medical school graduation, and some after. The IMGs interviewed in this study passed their USMLE's before the 2021 reform which permanently discontinued the Step 2 Clinical Skills test, an on-site exam of a medical graduate's applied clinical aptitude. Before this groundbreaking reform, completing the USMLE's and receiving high test scores was one of the first things the Indian participants wanted to tick of their list as they prepared for matching into residency. It is not an uncommon procedure among those who do not have a spousal green card sponsorship to first visit the US as a tourist (B-1 visa), complete the exam and achieve the experience in the period of a few months, and then needing to return to India before matching and obtaining a J-1 or H-1B visa. Throughout this relocation period, Indian IMGs continue to benefit from both financial, professional and social support from their family and networks, resulting in a collective and accumulative advantage that IMGs from less established immigrant groups are unlikely to enjoy.

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[30] It should be noted that regardless of work authorization or citizenship, medical students in training are not compensated for clinical-based learning before graduation.

Before graduating, Dr. Samesh made his first trip to the US in 2009 after securing a clerkship as a visiting medical student at Harvard medical school at Beth Israel hospital in Boston. The first few weeks he spent identifying the differences in the medical system, adjusting to the use of electronic medical records and the culture of the hospital environment. Wanting to make the most of his visit, he made sure to complete the USMLE Step 2 Clinical Skills before returning to India for his medical school graduation. While his 6-month stay came at a financial cost, he describes gaining not just the clinical experience, but also the social and cultural capital that is necessary to become a well-rounded and competitive candidate during the upcoming matching process:

> I did rotations at the med school at Harvard, I did urology and hematology, oncology, for the good experience. And with that experience, I got to meet some attending physicians who were doing research. One of them a urologist, and another one in ophthalmology. I got to meet them, and I did some research volunteer work as well at that time, and ended up in some publications, so with that experience I got some letters of recommendation and reference letters.

While Dr. Samesh lacked family members in Boston, he found both social and professional support among Indian friends and predecessors:

> I had some friends from high school who were engineers, doing their master's at Northwestern University in Boston. So, I used to stay with them. They were all already here, so they helped me during my first few months of my stay here in the US And regarding the career, I got a lot of help from my seniors who moved to the US They helped with guiding and everything. In 2009, I came alone. And when I came in 2011 for my interviews, I came with my fiancé, and later we got married and when she started residency, we came back together.

As mentioned earlier, the academic trajectory (F-1 visa) allows for a longer immersion period that may also serve as an uninterrupted bridge to the H-1B or J-1 visa. Financial support and security are often a prerequisite for reducing a significant amount of stress related to the costs of unpaid US clinical experience, test taking and graduate studies, for those who opted for the academic track. While Dr. Krish was in medical school, he gained a lot of knowledge about the immigration process by carefully watching his senior peers go through the steps. Unwilling to lose a year to the lengthy logistics associated with applying for a tourist visa and being in the US just to finish the USMLE Step 2 Clinical Skills and gain clinical experience, he decided in his 4th year of medical school that it would more efficient to apply for a Master's program, during which time he would be able to take the exams, interview for residency programs, and obtain a visa. He got accepted into a prestigious university with a scholarship and remembers his first year in the new country with great relish, an enjoyment that was facilitated by his family's financial and social support:

> It was awesome, 'cause I was a graduate student, I was master's student at John Hopkins in a very international class, I didn't have any financial pressures, my brother was here and so even though we were from a middle class family, it was still worthwhile for me. I don't have any debt that I accrued, so I got to see the US, I got to hang out with all kinds of fun people, and so I think it was incredible.

During his studies, Dr. Krish started interviewing for residency programs and was able to seamlessly segue into a surgery training position — a highly competitive specialty very few IMGs are able to match into.

It is clear that, while the first period in the US can be intense for IMGs, the stressors may be significantly mitigated by factors associated with network migration, in which migrants rely on transnational kinship ties to navigate social, cultural, financial and professional challenges. Dr. Suhani's brother was an engineer who had initially moved to the US to pursue a graduate degree. He encouraged her to consider a medical career there after having seen a friend of his successfully go through the process. Dr. Suhani took the computer based USMLE tests while doing the equivalent of an internship at a hospital in New Delhi, and later flew to the US and moved in with her brother for a while for in order to complete the remainder of the steps required to be eligible for residency. She says:

> I was living with him and studying, and I took the USMLE Step 2 exam while I was here. He, through his friends, also arranged for an observership at the time and I was living with a family friend's family, my brother's friend's uncle. I lived in their house while I was doing the observership to kind of buff up my CV. He did support me socially, emotionally, because he's my older brother. He taught driving, how to buy things, how to do everything, basically. When I did get my residency which was less than a year after I came, he also helped me settle down in the new state. He was a financial person basically, even before I started earning on my own.

Much like Dr. Samesh had the support of friends and guidance of senior peers during his initial period, Dr. Suhani's speaks to the powerful combination of both having a colleague pave a professional path, and family members soften the transition into everyday life in the US until one is able to navigate society independently. Dr. Farhan shares a very similar arrival story, where his father provided for his sons and his brother facilitated acculturation. Knowing that not everyone had these privileges, he refers to himself as both “blessed” and “lucky:”

> You know I want to say I was blessed, because money was not an issue for me, because you know, my dad gave us the funds, and I got my brother already here, so I had the housing and everything, so that was not an issue. Day-to-day minor things to get, you know, just to get used to the environment, and hard to drive, but you learn that very quickly. So yeah, I don't think it's a big problem for me. I'm lucky that you know, I did not struggle.

It follows that while IMGs do leave their home country, many of them do not leave all their family members behind. Rather, it is not unusual to move from one family home into another, albeit in a new setting. Importantly, family is not just a career facilitator — it also constituted a major responsibility for some participants. While the Indian participants themselves rarely emphasize gender roles in their professional or personal lives, descriptions of care work or family building alongside professional pursuits are more elaborative in some of the women’s stories, particularly Dr. Radhika and Dr. Saanvi.

Dr. Radhika’s mother had lost her husband in a car accident, making her unable to pay for her daughters’ higher education. On her own accord, Dr. Radhika’s sister was able to receive a full scholarship to get a master’s degree in chemistry in the US while Dr. Radhika was still in medical school. Their mother had two wishes; she wanted her children to get a good education and do well in life, and for the family to be together as one unit, and so she encouraged Dr. Radhika to start taking the USMLE exams and prepare for a US medical career. Around the time of her medical school graduation, Dr. Radhika married her husband who had also come to the US by way of a master’s program in 1996, and joined him in Boston on an H-4 spousal visa in 1999. She spent her first period in the US not only preparing for residency, but also caring for her mother who suffered from terminal illness:

> I came in July and I and started taking my USMLE exams, so I finished them within a year. I got interviews and everything and so my mom was able to come join us. She used to stay here six months and stay with my sister 6 months, so we were able to spend time. Mom passed away in 2015 but you know, by the time I was here as an oncologist I was able to take care of her. At least we were able to be together at the end, and it wasn't like… Because my sister is here, she had all her grandkids here. We don't like leaving our parents , but she knows that we both are close by and we're there for each other and that we were all there when she passed.

Much like Dr. Radhika, Dr. Saanvi describes migrating to the US as a newlywed, moving in with an Indian spouse who was already settled and without having any clear images in her mind about what her new life would look like. She remembers the calm of their Connecticut suburb as a stark contrast to the "noisy" and densely populated India she had left behind, and how much she loved watching the seasons change. "My first year was full of those wonders," she says. Having arrived on a spousal green card, she bypassed the pressure to quickly match into residency and obtain a work visa. Instead, she was able to focus on getting to know her new country, her new partner and building a family. When later she decided to start studying for the USMLE's, her secure setup and academic inclination made it an easy task:

> Because it was marriage that was a new relationship, my first year was relationship oriented. And then I was like, OK I have to take my USMLE, so I started getting the books and started studying, but that wasn't intimidating. I can't even call it a process; it was just going back to school. So, I did my studies and I was pregnant at the time that I took my USMLEs and finished it in record time, eight months pregnant!

It is important to remember that the participants in this study represent success stories; accumulations of puzzle pieces that allowed individuals to navigate the financial, academic, cultural and visa-related obstacles along the path to a US medical career. Missing just one of these puzzle pieces has the potential to severely complicate matters, preventing candidates from moving forward towards a US medical license. As we may recall from Dr. Anya and Dr. Viraj's accounts in the beginning of this chapter, preparing for USMLE tests is often an early group effort for Indian medical students with their eyes set on a future in the US, and failing to excel might propel an IMG into a limbo, caught between an Indian career left behind, and an inability to match into US residency. Along with others, they both perceive that the road to a US medical career is becoming more and more competitive. While Dr. Anya trusts that candidates can find creative ways to navigate the visa and immigration system, she shares Dr. Viraj's worries about the development in which only IMGs with next to perfect USMLE test scores are able to make it:

> I know so many people who got through their exams and they are still not able to get into residency programs. It's become very competitive. In my school, I was in the 90th percentile. Now it's come to the 99th percentile. Every year it seems to be getting more competitive and all of them are doing so well in their exams, they have all kind of mastered it. So, the programs now have a good pool of people they can select as their residents. So, either you're on top of the cream, or you're somewhere in between or less, and you're not getting an opportunity. If you're not a good test-taker — that's it. If you don't score well on your USMLE's, you don't even have an opportunity. In spite of any clinical experience, they might have or what research background they have, they're not able to get in at all. And it's really heartbreaking, they put all their money and time into becoming a doctor, they went to med school, they got loans from their parents or the bank, they go to med school, they finish their training, they aspire to become a physician, but then they are stuck there.

As previously mentioned, this increasingly competitive nature of the process is likely due to the fact that medical school enrollment has increased by over 30% since 2002 while residency spots have largely remained the same (Finnegan 2019).

Iraqi Self-Reliance and Gradual Orientation

If the Indian IMGs that Dr. Anya describes are hitting a wall in best laid plans, their refugee colleagues who leave their careers behind need to find their footing in a whole situation they tend to be much less prepared for — and excel in the process. Both Indians and Iraqis alike describe being unfamiliar with US infrastructure and technology, describing differences in everything from bathrooms, traffic signs and grocery stores to urban layout and banking systems. However, Indian participants are able to benefit from India’s unique brand of high-skilled chain migration to the US, in which skillsets and roadmaps are passed on and isolation mitigated. For the Iraqi participants, the period after arrival was often marked by struggle and disorientation, typically brought on by an abrupt departure, lack of social capital in the new setting, and uncertainty about the future. At time of their interviews in 2020, a few of them were still in the process of getting licensed, studying or working temporary jobs such as medical assistants or administrators in order to gain experience and pay their bills while they prepare for residency.

The most prominent aspect that differentiates the Indian from the Iraqi participants is the sense of loneliness and lack of community upon arrival. Dr. Aziz had long been preparing for a career in Germany but had difficulty receiving a visa. He had previously been given a B-1 tourist visa for a conference in the US, and decided to use it again when he started receiving death threats during his residency in pediatrics in Iraq. He left the program and the country in 2014 and flew to the US Dr. Aziz remembers how the combination of having no connections and no work permit made his arrival period incredibly challenging:

> Everything was difficult. Really, everything was difficult. From the beginning, the hardest part when you move to US, especially if you don't have real close relatives, just people that you know. I was just by myself. I don't know anyone in the city that I moved to. That's why I started the asylum process. When you move to the United States, you are not allowed to work until you get the work permit which would take around six months after applying for the asylum.

Dr. Aziz describes getting asylum as the first hard part, and the USMLE scores as the second hard part. While waiting for his work permit, he supported himself with a moderate amount of savings and studied for his exams. He knew that he was at a disadvantage against the domestic physicians, and that he would only have one chance to score high. Apart from that awareness, the USMLEs were largely unfamiliar to him, as he lacked both the example that many of the Indian participants received from their older peers and the pooled knowledge of study groups and communities. Not having these tools would not only cost him emotionally, but also financially:

> The process itself it is expensive for preparation and for taking the test. Actually, I lost my money the first time. I didn't even know the details of how long studying will take. I paid for the exam, and I scheduled it. Then after nine months when I scheduled for it, I found myself not prepared yet. I'm not getting the score that I want in preparation. I lost my money, so I have to pay it again. I think these are the main hard parts for me and for most immigrants having the same things, that your immigration status you don't know how it's going to be.

Dr. Ghazi echoes Dr. Aziz experience of arriving in isolation. He had been accepted into a master's program at New York University (NYU) as a Fulbright grantee and had been waiting for 10 months to receive his visa. The day after he received it he flew to the US, leaving the operating table in a warzone for a foreign city he knew very little about. He was already three days late for class. Dr. Ghazi remembers:

> It was a bit of a chaotic situation for me back home. I was doing surgery and I was in the emergency room, all kinds of stuff. So, I didn't really even know where I was going until I was on the plane. I looked at my papers. I was like, okay, it's NYU, it's in Manhattan. And I don't know where that is. I don't know where I'm going. I have nobody there. I Don't know anybody. So, I landed at JFK, and I went to a hotel room next to the airport. Because I don't know anybody. And then the next morning I asked them, I was like, how to get to this university? And they told me, just to take subway. I've never taken a subway before in my life, never used a credit card. We don't have that in my country. That was back in 2007. So, to learned all that, you get the money, you get the card, get the debit card or get the subway card, use the subway, use the map… All this was new.

When he arrived on campus at noon, he was told he needed to take an English test[31] within an hour in order not to lose his spot in the program, which also would have meant falling out of compliance with his visa. He ran to the test site in order not to miss the final testing period that ended at 1pm. After having cleared this hurdle, Dr. Ghazi started looking around for housing. Having arrived too late in the cycle to be eligible for student housing, he was soon made aware how challenging the rental market can be for a foreigner without any US credentials or contacts. “In New York, you have to have some kind of history,” he says. “You have to have a social security number. You have to have a letter from a previous landlord. You have to have a bank statement showing that you have money enough for at least a couple months.” He managed to find a temporary place in New Jersey where he stayed for a few weeks until he ran into some Iraqis at a bar in Manhattan who he turned out to have mutual friends with. They helped him find an apartment in their building, “and we've been best friends since then, inseparable.”

Dr. Ghazi realized that if he wanted to remain a urologist and surgeon, he needed not only superb USMLE scores and research experience — he also required a CV that was strong enough to compete with the US medical graduates that dominate the more prestigious residency programs. For the next two years he studied full time, took summer classes and did four different unpaid internships. After graduating from NYU, he had received asylum and was able to land a paid clinical research position at Mount Sinai hospital in Boston where he published over 50 articles before passing the USMLEs and applying for residency. When thinking back to that initial period some fifteen years ago, Dr. Ghazi recalls discovering how to Google himself through any obstacle that most of the Indian participants would lean on their social network for. “Any problem, I just Googled on my phone anywhere, whatever it was. Whether it was with social security issues, jobs, visas, lawyers, work, clinic research, or anything, just Googled it, studied it myself, and came up with a conclusion.”

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[31] Dr. Ghazi was most likely referring to the Test of English as a Foreign Language (TOEFL) exam, a standardized test that evaluates English skills among foreign students applying to US institutions for higher education. Typically, test results are submitted along with graduate school applications.

While Dr. Ghazi was (quite literally) left to his own devices during that chaotic first year, he eventually realized that being at a world-renowned university in a global city also entailed the availability of resources for internationals like himself, including fellow classmates, advisors and the international scholars and students’ office:

> The resources are just insane. They know whatever you want, there's like five, six different people whose job is to do this, and they're just ready to help. The help was everywhere. All you had to do is to ask really. And that's a problem, a lot of foreign graduates… When foreigners come in, they try to internalize everything. And they think that if you ask questions, people will think that you're stupid and all of those stereotypes. If you have a problem, just ask. I still take advantage of this.

Dr. Ghazi was not the only one who came to the US fearing an unsupportive or even hostile environment. Dr. Waleed had previously written off the US as a possible home for his family, and only reluctantly agreed to move there. For him, any prestige associated with the US medical field was obscured by a reputation for a very poor social safety net and anti-Iraqi discrimination. Dr Waleed remembers:

> We had this whole bad idea about US. They told us if you become sick and you don't have insurance, they will let you die in the street. If you don’t work, you will die from hunger. If you don't have money to pay, they will throw you out on the street. So, this is the idea about US that we have. Also, we have this impression that the people hate us because of the many US soldiers being killed in Iraq. So, we came with this idea.

Dr. Waleed is one of the Iraqi physicians who came to the US on a SIV visa. After three days of traveling, Dr. Waleed, his wife, and baby arrived in Lowell, MA. The apartment they were moved into was old, infested with cockroaches and the furniture was damaged. His wife cried and wanted to go return to Iraq, but Dr. Waleed insisted she resist the urge to call home in case their relatives would tell them to come back. They requested a better apartment from the International Institute of New England, their sponsoring organization, and spent the next few months moving from place to place. Dr. Waleed describes how the resettlement process took a toll on his sense of dignity for both him and his partner; the respectability and affluence they once enjoyed as a physician household was now reduced to what felt like begging. He says:

> So, when you came from the very top place, the very top socioeconomic place to very low social place… It’s enough to make you go back to your country, but we resisted that. I didn't... Doctors in Iraq are in a very high socioeconomic place. I didn't choose to take food from people, to accept thing from people. But what can I do? I don't have anything in the home, anything. So, we just got used to that.

Slowly, however, their conditions improved. While their location and organization may have been more resource poor than Dr. Ghazi’s NYU, they soon found themselves surrounded by a wealth of support from the community. Locals — both

American and Iraqi — brought them supplies and gifts, among which a bike felt "like a Rolls Royce" after having walked to and from the grocery store. The biggest and warmest support came from a Kurdish Iraqi family, who embraced his wife and daughter and eventually helped the family buy a much-needed car. Dr. Waleed noticed that when Americans learned about his background story and that he was a doctor, they refused to make him "feel like a refugee" and were more inclined to actively help. While the response could be read as classist, Dr. Waleed in his reduced state welcomed this unexpected benevolence and respect to the point where he convinced his brother to reopen his immigration case and join him in the US "Sometimes, the only help that you need is just a word, that they show you kindness," he says.

This sense of surprise at American warmth is echoed by Dr. Ahmed, who had previously been severely disappointed by the doings of the US government in Iraq. When he first arrived in North Carolina, he had an overwhelmingly positive experience with his local community and found himself astonished by their openness:

> Let me say something. The government is a thing, and the people is another thing. When you come over and you realize that as a people waiting just to help you. There are people wanting to help you, and offering you anything just to be safe, offering you any kind of help. So, it was really amazing. Because I got that negative impression about the government, because they let me down. But when I got over here, and then I've been around the community, I've been involved with the community, I realized there are so many nice people here, and they would like to help. They open their mind, hearts, their arms, just to hold you, hug you, and offer you whatever they could.

While kindness may mitigate the sense of isolation and disorientation, bureaucratic and financial challenges remain for many Iraqi participants during the arrival period. Dr. Waleed was unemployed for the first six months in the US before he got a job as a dishwasher at Whole Foods. He spent his free time preparing for the USMLEs, but soon realized that he would be unable to obtain ECFMG certification without his diploma from medical school, which had been lost in Iraq. At the time, ISIS had shut down University of Mosul and no records could be accessed, and no documents could be sent. Faced with this dead end and the responsibility to provide for his family, Dr. Waleed gave up his studying and conceded to explore a career as a medical assistant and started taking classes at a community college. It was not until his brother and their parents arrived and started sharing the living expenses that Dr. Waleed began to entertain the idea of getting certified and licensed again.

In 2016, his medical school had reopened, and he was able to obtain a translated copy of his diploma and he resumed his USMLE studies. However, he needed a government issued ID before he could register for the tests, and a missing dash in his name caused a mismatch between his registered name and the name on his diploma, which cause another year long delay. Dr. Waleed applied and reapplied for Iraqi passports with the right spelling, waited and studied. As he started looking for clinical experience in 2018, and an English teacher introduced him to a retired physician and associate professor at Boston Medical Center (BMC), who first tried to dissuade him from taking on the monumental task of getting relicensed:

> I told him, "No, I just want to be a doctor." He told me, "But when you become a doctor, it can take you about three or four years, and sometimes you still can’t do it. But when you work as medical assistant or surgical assistant, you can get the same money. If you make a simple calculation counting the years of your studies and the chances, you find that physician’s assistant or surgical assistant is better for you." I told him it is not a matter of the money; it is a matter of how I become a doctor again.

Surprised by Dr. Waleed’s devotion, he said “Okay, Waleed. I will help you,” and proceeded to put all his efforts behind his new mentee. They set up weekly meetings to go over his CV, strategize and expand Dr. Waleed’s professional network. The retired professor soon became a close family friend, and his greatest source of support and comfort in the process of reestablishing his medical career. While working as a medical scribe, Dr. Waleed finally passed USMLE Step 1 in 2018 and the first portion of Step 2 in 2019. At the time of our interview in 2020, he was waiting for his results from the Step 2 Clinical Skills and had just received word that the ECFMG had verified his diploma and that there were no further issues with his legal name. As a surgeon, he now faced the difficult decision of what residency path to aim for — a process made even more tenuous by a burgeoning pandemic.

Dr. Waleed’s case is illustrative of the many obstacles and delays — expected and unexpected — that a refugee physician may face, and the extraordinary resilience they muster in order to not only get licensed in the US, but also the extra effort they need to put in if they wish to remain in a prestigious specialty they may have already practiced in their home country. His story is also one of a male gender role, a husband whose responsibility to care for his family led them to the US instead of Germany, thereby slowing down his reestablishment as a physician. Dr Waleed’s case describes how the initial pursuit of fulfilling one male gender role of bringing your family to safety in another country comes at the expense of losing one’s professional status, ultimately leading to a prolonged difficulty fulfilling the role of the breadwinner. However, reclaiming the physician status is about more than the salary — the act of getting relicensed becomes a paramount part of shedding the refugee label and reclaiming one's education, identity, and agency.

Next to Dr. Waleed, Dr. Adnan's story exemplifies a very similar process. After having fled to Turkey following a death threat, Dr. Adnan and his family received refugee status in the US because of his work for IOM and the UN. Much like Dr. Waleed, he was forced to deal with name related discrepancies between his Iraqi and US records and the associated delays, reminding him that "When you are in the foreign country, no one understands your system." He also shared his colleague's sensation of debasement associated with becoming a dependent, robbed of the credentials that had previously allowed him to provide for his loved ones:

> And now my university is not providing me with papers. When I came to the US, it was early 2008 and I just wanted to do something because I need to feed my family because the amount of the benefit you get is just nothing, number one. Number two, it just doesn't work for me to get paid by the government. It just sucks. It just... It's humiliating. You don't have... You don't have dignity when you come.

Unable and unwilling to remain passive, Dr. Adnan explored the medical assistant path, but made connections on the way that lead him to a teaching job at a university in New Hampshire, which later turned into to a faculty and department chair position. When offered a job as a dean in Maine, his desire to return to medicine became greater than his love for teaching, and he declined the promotion. To everyone's great surprise, asked his department to let him go:

> "What are you talking about?," they said. I was like, "Yeah. My passion, I want to get my license." They respected that. They gave me a severance package. They didn't regard me as resigned. They just worked it out... When they like someone, they do anything for them.

Dr. Adnan took up is USMLE studies and later applied for a residency in psychiatry, which would allow him to pursue his burning interest in eating disorders — a field he had already been able to advance in through a master's program he had enrolled in while still working at the university.

As described above, the multitasking and balancing of multiple responsibilities during the arrival period is exacerbated in the Iraqi IMG accounts. In contrast, financial problems or having to shoulder the role of the provider is largely non-existent in the Indian recollections of the arrival period, and none of them describe migrating with children. Instead, most of the married Indian participants describe migrating alongside spouses that are either well-prepared or already established professionals, and a vast majority of them build a family only after getting licensed. This means that their arrival period may be focused on the initial stages of acculturation and professional advancement, without the added stressors of providing for a family.

Dr. Shams, the only Iraqi participant who arrived on a work visa, happened to meet and get engaged to a well-established colleague in the US during her residency application process, and consequently had a very similar experience to many of the Indian participants, with a lot of practical support and guidance from her partners and fellow residents. Landing on this clear path is very foreign to those who arrived with their families in displacement with limited resources. When such Iraqi physicians decide to pursue relicensing, they typically have to anchor their decision with their family in order to ensure that they are prepared for the upcoming strains associated with that process. After Dr. Ali's family had spent a few weeks in Denver, he began to realize how different the new system was. “I had two options,” he says. “Whether to just do something to live or start all over again. So, my wife and I decided, we thought about it and I said no, I'm not going to do like an entry level job or live on some kind of government support — I'm a doctor.” The short-term financial sacrifice of intense USMLE studying and unpaid observerships motivated Dr. Ali to excel, and he soon impressed his colleagues and supervisors to the point where he was offered a residency in pathology in Baltimore.

The intense aversion towards having to identify as a refugee or victim in a new country is very pronounced in multiple Iraqi accounts. Before arrival, they have all worked hard to maintain agency in situations that continuously robs one of it and are consequently unwilling to submit to a state in which they are made reliant on foreign institutions and the credentials they have fought for since they were teenagers are invalidated. Even the younger Iraqis who were less professionally established before arrival in the US describe resisting the idea of being categorized as a refugee. Among them, Dr. Abdul was the most adamant about avoiding the asylum path altogether after having overcome a lot of obstacles and delays to obtain a J-1 visa for his residency. “Life will keep slapping you, but you just keep going on,” he says. When visiting the US for his USMLEs, he met with Iraqi relatives whose immigration paths he did not want to emulate:

> I don't like the asylum idea. When I came here back in the time, I have family here. Some of them are on lottery visas like a lottery green card. Some of them have applied for asylum. I don't think I need to apply for it. I refused the idea since then because I think it's a desperate measure and I thought I have other options. I'm here working and contributing. I'm on a visa which allows me an option of staying here if I want to do a waiver.

Dr. Abdul’s rationale is remarkable in the sense that he prefers the path of a high skilled labor migrant with few guarantees out of principle, even though the asylum path could have allowed him to bypass the visa related restrictions and bottlenecks that his non-refugee fellow IMGs often end up struggling with for years. He describes an uncertainty about remaining in the US in the future since he left his parents and sister behind but is still unwilling to pursue asylum as a means of family reunification. “If I have other options, I'll not. I hate to… We have this feeling that if I can do it myself, let me do it myself.” This statement is indicative of a significant difference between the two sets of physicians; while Indian participants’ strength lies with their networks, the Iraqi participants are channeling a sense of fierce independence — a self-reliance they have often been forced to hone for years in spaces of disrupted infrastructure and torn social fabrics. As they head towards residency, Indians and Iraqis alike will have to keep developing their strengths in order to succeed.

Continued Contexts of Reception: Residency and Establishment

IMGs and the Match

While the US has a shortfall of certain medical specialties more so than others, the system does not allow for trained specialists from other countries to directly fill that gap. Instead, IMG specialties are shaped by their ability to match into a residency. Through an annual process known as “the Match,” graduating medical students (and graduates) apply for an interview with residency programs in the specialties of their choosing. After the interview period is over, applicants will rank the programs based on their preferences, and the program directors will rank their applicants in turn. All parties’ lists are submitted to the National Resident Matching Program (NRMP), the organization that instituted and maintains the Match. The NRMP processes the lists through a computerized mathematical algorithm in which applicants and residency positions are matched. These proceedings culminate the third Friday of March each year when the results are released to applicants nationwide and at many medical schools around the country, “Match Day” constitutes an annual ceremony where matches are openly announced. On the Monday prior to Match Day, the NRMP will notify all applicants on whether they have been matched or not, withholding the location. Applicants who failed to match may obtain an unfilled training position through the Match Week Supplemental Offer and Acceptance Program (SOAP), or “the Scramble,” that concludes the day before Match Day.[32]

The Match is notorious in the medical community for being anxiety-inducing, and the odds are in many ways stacked against IMGs. While the NRMP prides itself of the Match being “Fair, Equitable, Efficient, Transparent, and Reliable,”[33] the statistics send another message. Fluctuating around the 50%-mark, IMG match rates are traditionally significantly lower than for US medical graduates, who typically hold a match rate at over 90% (PR Med 2016). While the 2022 IMG match rate was over 60%, the registration pool also held 1,433 fewer US citizen and non-US citizen IMGs than the previous year, likely due to Covid-19 related obstacles (NRMP 2022).[34] As IMGs are less likely to match than their domestic peers, they are consequently more likely to end up in the Scramble. By design, the Scramble holds slots and candidates that are considered less competitive; a residency slot in a less prestigious specialty in an underserved or underfunded area is generally considered less attractive to a candidate, and an IMG is statistically less likely to be preferred over a US medical graduate. Consequently, the Match and the Scramble often serve to perpetuate geographical segregation, status separation and horizontal stratification among international and US medical residents (Jenkins 2020).

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[32] The 2022 Match was the largest in its history with 47,675 registered applicants and a record of 39,205 certified positions. Out of those, 36,277 were first-year (PGY-1) positions, which is also a record high and a 3.1 percentage point increase over last year. US medical seniors matched at 92.9% (an increase by 0.1% from 2021) while non-US IMGs matched at 58.1% (an increase by 3.3% from 2021). For the 2021 Match, 2,262 positions were unfilled after the matching algorithm was processed, 335 more than the previous cycle (NRMP 2022).

[33] See NRMP.org (https://www.nrmp.org/)

While the participants are deeply aware of their structural disadvantage against domestic graduates during the match and residency process, very few express any outright complaints about it. This is rather consistent with previous studies of IMG versus US medical graduate relations, which claim that both parties tend to agree that domestically trained physicians are more deserving of higher ranked positions, or at least comply with informal hierarchies amongst themselves in the medical profession (Jenkins 2020). However, the absence of complaints does not necessarily equal an inferiority complex. While many participants revere the advancements and resources of the US medical field, they do not describe themselves as unfit for such a challenging space. Just as the participants see their disadvantage clearly, so do they see their overcompensation and in some cases — outperformance. Dr. Farhan says:

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[34] NRMP suggests that this decrease in participation can be traced back to sustained concerns about travel regulations and possible variant strain outbreaks related to the Covid-19 pandemic.

> I think in general, IMGs that have made it here, I want to say they are at least as good — if not better. So especially for internal medicine, because it's not like the Americans are the cream of the crop. They go into, you know, other higher… So, it's not like the American graduates in internal medicine are not as good… Where I did my training, it was an IMG program-based program and they were overall way better than the American graduates, way better. I mean our knowledge was way better.

Dr. Nirvaan, an internist who was born in India but went to medical school in the Bahamas, shares Dr. Farhan's experience with US graduates and echoes Farhan's sentiment about IMGs. Both of them indicate that in some cases, immigrants may be the actual "cream of the crop:"

> The people who come here, many times are very talented. There's over a billion people in India and the number of graduates that they have in medical school is also very small, so you're selecting a very small population out of a very, very large population. You're getting the cream of the crop, so I think they need to understand that these people are very talented and that the journey is very hard, and they should give them a chance to prove themselves. That they are worthy. I've also seen US graduates who are also not very good in many ways and had problems during their training. So, it can work both ways, it doesn't mean just 'cause you're from the US that you're going to be good. It doesn't mean that you're just your foreign graduate, you're going to be bad. We need to get away from those stereotypes.

While both Indians and Iraqis tend to have great confidence in their abilities, they focus their efforts not on openly critiquing or deconstructing an unfair system, but towards the long game of proper establishment and equal footing — both professionally and in terms of immigration. Their many years in school, training, test-taking and preparation have in many ways imbued them with a sense of patience for delayed gratification that should not be confused with passivity.

Indian IMGs and Residency Strategies

As a paramount gatekeeping event standing between a medical graduate and their board certification, the Match compels IMGs to carefully consider their ambitions versus their constraints. Dr. Anya continues to emphasize the importance of simply securing a residency spot in an increasingly cut-throat climate where program directors can take their pick among a plethora of outstanding applicants:

> They rank the students who went to med school here higher than they rank the students who got trained like in the Caribbean or India or Russia. The pool has become so big, and the applicants have become that much stronger, and so they have the opportunity to pick the best. So, when you look at the IMGs, they are able to pick the best among them, but if you are not the best, you're not top 5 or something, you're stuck. There is nowhere to go, you have to wait another year. And the challenge with that is that the residency programs don't like the gap year. It brings down morale. They have their loans, they don't know how to answer their parents or their friends, it's really hard. I really feel for them. Sometimes when they fail to go through the system they become taxi drivers.

Dr. Priti recalls the discrepancy between what IMGs and US medical graduates would worry about during the application process. "What goes on in their mind while they're applying is that, oh my God, will I get this specialty?," she says. "What goes on in my mind is, oh my God, will I even get into anything? It's not about the specialty."

To Dr. Anya's point about the detriment of gap years, Dr. Priti witnessed first-hand how her classmate and fellow IMG fell between the cracks by failing to match, and how every passing year made matching exponentially harder due to the associated stigma. She says:

> But to be honest with you, I'm so grateful that I matched because that person that I was studying with for Clinical Skills, she is still struggling. I think she's given up. She's the same year of graduation as mine, and now what they do is they don't take anyone beyond five or six years into graduation, which is kind of odd because why? We've gone through med school. We've gone through the training. I

> think I do okay in my program. Knock on wood, I've not given anyone a chance to complain again against me. I think every old graduate should be given a chance, rather than just, "Oh my God, they're old graduates. We cannot take them into the system."

As Dr. Anya and Dr. Priti describe, failing to match on Match Day or the Scramble can have significant emotional, financial, and professional consequences, leading to a downward spiral that can be hard to recover from. She therefore advises her younger colleagues to prioritize getting matched over matching into a particular specialty:

> Once you get into the program, you get into internal medicine, family practice but you want to do surgery, you prove yourself during the first year and then you can move into surgery, maybe you have to repeat a year, but it doesn’t matter in the long run. In the big picture of life, it doesn’t matter.

Six participants, including herself, emulate versions of this strategy in which they first complete a specialty in internal or family medicine, and then add another once they have established themselves. Among all 33 participants, no one reports holding a double specialty in which one of them is not internal or family medicine. Only one participant, Dr. Krish, was matched into a surgery residency.

As mentioned in the previous chapter, IMGs are statistically overrepresented in residency programs that are considered less competitive and prestigious, such as internal medicine and primary care (Jenkins 2020), which also constitutes the primary specialties of over half of the Indian participants. It is also the most common specialty among the Iraqis at nearly half. When it comes to residency, the informal hierarchy between IMGs and domestic doctors is well known to the point where it has become self-perpetuating, as illustrated in Dr. Ashok’s choice of specialty:

> So internal medicine is what I chose. Internal and pediatrics. It wasn't a choice coming from self-awareness. It was more out of what is the common path. While

> during my undergraduate years in med school, medicine, pediatrics and neurosurgery were at the top, there was a lot of glamour associated with these specialties, these were professions you wanted to get into. I think a large contributor is that it was easier to get into an internal medicine residency program in US than into a surgical field, so I think we had less role models or examples to follow in surgery in US in comparison to medicine.

Dr. Mitesh shares Dr. Ashok and Dr. Anya's perception about internal medicine becoming a self-evident path for IMGs, as well as the most rational choice. He says:

> I'm an internalist. My career and for most immigrants, we find ourselves competing with a lot of native-born people, so most people who migrated from my medical school ended up in internal medicine, because it has the most vacancies. So, in some ways I thought that internal medicine was the thing to do in the US for immigrants. Intellectually it made sense to me, it seemed to have shorter trainings, and also being an intellectual person, it aligned well with me.

In order to avoid "getting stuck," as Dr. Anya puts it, US graduates and IMGs alike tend to apply for as many residency programs as they can in order to garner interviews and offers. For many IMGs, getting matched is intimately connected with securing future legal status as immigrants. However, security comes at a price. Not only is there an application fee for each program, but the interview process can also become very costly; studies show that the average candidate spends a median value of nearly $4,000 on interview related expenses (AAMC 2022).

Despite one's best efforts during the match process, there are little to no guarantees for IMGs, which Dr. Aakesh had to experience. Like many others, he describes the interview process as his biggest obstacle and was well aware that his outstanding USMLE scores would not erase the fact that he was an IMG:

> Of course, even though I had excellent scores, but still, I'm of international graduation, so not many university's programs take international grads, even if you have excellent scores. I think that was the major obstacle, because even though I had good scores, I only had four interviews, so I was a little scared, and

> I'm like, "Okay, I don't know if I'm going to get it or not." And I actually did not match. All the applicants who don't have a seat and all the programs who have not filled the seats, they go into the Scramble. That's a very scary part, because you don't know what's going to happen.

Dr. Aakesh was lucky enough to know the program director at the University of Louisville where he had completed his clerkship. They had only been able to fill half of their residency slots, and so he gave the director a call and they said, “Yeah okay, we’ll take you.” He spent five years there, completing his residency and fellowship in internal medicine.

Iraqi Specialists Navigating Residency

Unlike Indian IMGs, Iraqi physicians often arrive as experienced specialists, unwilling to compromise their professional identities and credentials by submitting to the informal hierarchy in which IMGs resort to less competitive specialties in order to have a better chance at a match. Three of the Iraqi participants, Dr. Waleed, Dr. Ghazi, and Dr. Wesam arrived as certified surgeons. While Dr. Waleed and Dr. Ghazi were still both weighing their options for residency specialties, Dr. Wesam had been able to obtain a preliminary spot at a surgery training program. Unlike a categorical spot, this entailed no guarantees that he would be permitted to finish his training at that particular institution. “98% of the surgery spots will be occupied by American graduates,” he says. “2% will be us. By us, I mean the people who really persist till they get into categorical spot.”

However, commitment to a certain specialty comes at multiple costs. For the Iraqi participants in particular, applying for multiple programs needed to be weighed against their ability to support themselves — sometimes while still in the process of their immigration case. Dr. Aziz remembers a sense of gamble and intense dread as he applied, watching the staggering fees get added to what he had already paid for the USMLEs without knowing what the future held. It is a painful memory. He says:

> I think these are the main difficulties for me and for most immigrants going through the same thing, that your immigration status… You don't know how it's going to be. Your scores and your exams, how it's going to be, and if your money is going to be enough for you or if you have to work. After finishing your exams, you'll have to apply. The application itself cost me around $9,000 to $10,000. I remember one button I pressed to apply, with that button I spent $5,000, just by clicking one click I spent $5,000 applying for programs. All this money and the chance is really low, it's really stressful. It was throughout the days it came to me… These bad days where I was not able to talk to anybody, sometimes because of sadness, sometimes depression, sometimes anxiety. I got all kinds of psychiatric disorders.

Dr. Mohammed shared Dr. Aziz's financial woes while also being committed to a residency in neurology, much due to his passion for medical research. He was told by others to not feel confident about his chances in such a prestigious specialty; even his family asked him, "Why don't you just make it easy for yourself?" Dr. Mohammed remained undeterred. "No, I sacrificed enough," he said. "I just want to do this." He applied for 126 programs and was called to 11 interviews, which he felt was a good number for an IMG. He listed his top five choices, all university-based, and eventually ended up matching with a program in New Mexico. Living in San Francisco during the match period, Dr. Mohammed was grappling with some significant living expenses on top of the application costs that prompted him to supplement his income by becoming a part of the city's gig economy:

> Meanwhile, I was starting to like, financially become poorer and poorer. I did all types of work and I'm actually… I'm proud of them. I wouldn't even be ashamed

> to mention them.
>
> I worked in food delivery, I worked with furniture assembly. That’s what I was doing for almost six months, and one of the funny things that I keep remembering, I told my program director here, I told her, you know what, when I came here and interviewed, I was like looking professional, coming to an interview, but I was dusty and looking nasty yesterday because I was working with furniture! She was laughing. She couldn't even believe that. I told her, "No, this is exactly what’s happening." I'm applying for brain sciences, but I'm like yesterday I was assembling furniture. You’ve got to do what you’ve got to do.

It follows that Indian and Iraqi IMGs may interpret “doing what you have to do” differently — if Indians are referring to “getting in,” Iraqis are referring to reclaiming a part of themselves. While Indian IMGs recently out of medical school seem more willing to start with a more accessible specialty and later pursue another once they feel established, Iraqi IMGs who identify strongly with their specialty take a symbolic pride in obtaining that same specialty certification and recognition in the US medical field — especially as they have been stripped of so many other things in the process of becoming refugees.

Indian IMGs, the 30 Conrad Program and the Green Card Backlog

J-1 visa waiver placements in the 30 Conrad Program can have poor reputations in the IMG community due to the lack of leverage built into the contract and their inability to leave their positions without falling out of compliance with their H-1B visa status — an indentured work situation that can lend itself to exploitations in the hands of the wrong employer. Indian participants who work in diverse cities and did not need a J-1 visa waiver share stories of friends who did, and the difficulties they experienced in isolated and predominately white areas. Dr. Farhan says, “You know, IMGs on J-1 work hard and are not compensated well. They're not treated well.” Dr. Aakesh, who received a J-1 visa waiver by working at a small practice in Selma, AL, shared this perception and elaborates on the vulnerable positions of IMGs on waivers: “We do hear very scary things about the J-1 wavier, where the employers try to take advantage of the physician, because it's a three-year contract and they cannot leave it,” he says. “You have to be there to get the waiver and the employers take advantage and make you work more and pay less.”

Like Dr. Aakesh, Dr. Farhan also completed his waiver in Alabama, and they were both pleasantly surprised by their positive experiences which they ascribe to fair management and good colleagues. “I was fortunate,” Dr. Farhan continues. “I got to practice the right way, I was compensated well, in terms of what the going rate was. And I was not given more work than anybody else, I was like any other physician in the in the group. But I had to be in a small town,” he adds. Dr. Aakesh developed a close bond with the owner of his practice, an older physician in his 70’s who would come to treat him “like a son.” At the end of the three years, he asked Dr. Aakesh to stay and eventually take over the practice:

> He was like, "I want you to stay. I don't want you to leave." Eventually he would want to sell his practice to me, because now he's 72 and he's solo. But I just didn't want to stay there, because it's a very small town. There's not really much to do in town. And the closest big town was an hour drive away. My wife, she's a psychologist, and she had no job opportunity there and she wanted to work too. And we like to travel, so it's very difficult to travel from a small town, because then we have to drive two hours just to get to the airport. It's right in the Deep South Alabama, so it's a very, very, very conservative town. It's not the kind of place that I would want to live long-term, but my employer was nice. My practice was nice. People were nice. My staff was nice. I enjoyed my stay those three years.

Dr. Aakesh's story is illustrative of the complicated relationship between rural US and the IMGs that tends to serve its patients; a coerced symbiosis that can be hard to sustain past the mandated waiver period. Even with the good relationships and working conditions that the physicians describe, rural US struggles to meet the lifestyle requirements of more cosmopolitan high-skilled professionals — especially if they do not have kinship ties or roots in those rural communities.

The frequent turnover of IMGs on waivers is a pattern that Dr. Samesh has seen many times, and an issue he has put a lot of thought into. Dr. Samesh obtained a J-1 visa waiver in a small town in California and fulfilled his contract in 2019. He points out how visa sponsorship being tied to a single employer in many ways prevents doctors in rural areas to reach patients in multiple locations, as well as preventing them from opening their own practices. He says:

> We don't have any incentive to work in underserved area for more than three years. After three years, once I clear, I finished my waiver, I don't need to stay there. So, most physicians move. I talk to the clinics, and they are struggling to hire hospitalists or urology subspecialties, and patients drive like 60 miles to the city center if they want anything specific. The benefit of having a green card is that you can work in multiple places and you can contribute more to more patients. You can open a practice; you can do your own business and people will want to stay longer. They can root, their roots can deepen, and their kids can grow up.

Dr. Samesh became active in the California chapter of Physicians for American Healthcare Access (PAHA), an organization largely comprised of IMGs on waivers advocating for bill that would reform the Conrad 30 program to provide IMGs with expediated pathways to immigration after they work in an underserved area for five years — an incentive that would be particularly attractive to Indian nationals who are currently experiencing a severe green card backlog. In 2021, Indian nationals had over 720,000 approved green card petitions still waiting to be issued due to a quota system that limits the yearly amount of employment-based green cards that can be given to any nationality by 7%. Out of the 1.4 million employment-based green card cases that are affected by the backlog in 2021, Indians constituted 82%. With no change to the current law, only half of the Indian immigrants are likely to receive their green cards during their lifetime (Bier 2022). Dr. Samesh himself is part of these statistics, and the paradox between having to wait so long for permanent residency while also being crucial to the local healthcare delivery frustrates him:

> I applied for a green card in 2016 and right now the wait time is 7–8 years. I can go back and forth to the country, but whenever I go I need to make sure that they I have the right stamps on my passport, even if I have valid papers, I still need to go to the US embassy and get the stamps and all the things. And there are no guarantees that you can re-enter, even if you have a visa. It's not guaranteed that you would get in, even if you go to US embassy. Yeah, so the limitations, I mean even with the green card, even like we as doctors, we provide and we contribute a lot to society, to patient, and especially places like Stockton or Modesto in California… All over the country. Nobody wants to come here and work because of the living situation and underserved area, things like that. So, most of the healthcare system is dependent on immigrant doctors.

Dr. Samesh’s testimony shows how difficulties and delays in obtaining a green card does not only inhibit IMGs from finding stability for themselves and their children, but it also complicates international mobility and family reunification. “Because of that uncertainty, I can never feel that it is my home yet. Because we’re only here on visas, we're always dispensable,” he says. He thinks of his parents still in India and how he will be unable to bring them to the US until he receives his citizenship. Here, Iraqi participants who arrive through the refugee or asylum route tend to have an advantage as these statuses are associated with a path to citizenship and are therefore able to apply for family sponsorship at an earlier stage. Refugee resettlement decisions are also often processed on a family basis, as in the case of Dr. Waleed.

Indian and Iraqi Perspectives on Interpersonal Discrimination

While IMGs face structural disadvantages in comparison to domestic physicians when it comes to matching into prestigious specialties and obtaining permanent residency status or citizenship, many participants claim that IMG representation and overachievement has resulted in patients preferring immigrant physicians over domestic ones. Having spent his whole career working in the US, Dr. Sahil has a long-term perspective on this development:

> Discrimination is going to be there to some extent any place whether you're in India or anywhere else, but ultimately, the bottom line is that if one does his job right, that all goes away. The thing which we normally now hear after 40 or 50 years, the patient will rather see immigrant physician than local physician, because they care. The old tables have turned.

Many others echo Dr. Sahil's observation. Having survived the obstacle course that is migration, exams, certifications and residency, IMGs effectively embody the image of the model minority and even if the immigration system fails to reward it, their patients and communities do. Without denying the existence of microaggressions or the occasional racist, the norm in the participants' stories is a feeling of appreciation in interpersonal interactions — both in professional settings and outside of work. Dr. Samesh says, "For some reason, I feel like when you are not American, they feel like we are more talented than American doctors, honestly." Dr. Saanvi describes how being a doctor and being Indian has almost become synonymous. "As an Indian, I've always thought that I get more respect, not less," she says. "People say like, oh you guys are so smart!"

Emphasizing how immigrants have changed the face of US healthcare, Dr. Mitesh states:

> I haven't felt any discrimination. It could be very different for other people, but for me, I'm on the East coast. In the US, a quarter of the physicians are immigrants. I'm sure it happens, but in some way, American healthcare is really immigrant dominated, both nurses and doctors. It's nothing unusual.

While Iraqis do not have as large of a presence in US healthcare as Indians, the Iraqi participants' stories are full of interactions with mentors and close bonds being forged with members of their newfound communities, mitigating the severe hardships surrounding their situations. Dr. Ibrahim contrasts the reception he received in the US against his experiences with Europe:

> In Europe, racism is in your face. America empowers you when you come as an immigrant, at least on my end. America built me from scratch. I put the effort, but without the American people generosity and help, I wouldn't have made it in this country. They helped me every step of the way. The kindness, the generosity, the support, the empowerment is unmatched by any other. When you live here for a while and you embrace your American ideals, it's not because it is forced on you, but because this is who you become.

His final statement is one of ultimate integration, demonstrating a perception of meritocracy and freedom that often surrounds the US brand of immigration. While the master narrative may be a product of a mythology, the loving relationships Dr. Ibrahim describes are real.

Conclusion

To Indian IMGs, the US nation brand is strong and associated with superior professional development, advanced technology and financial success. Medical schools that produce a lot of US facing IMGs are significant reproducers of this brand, influencing and preparing new generations of Indian medical students for a career in the US. The same dynamic exists to some extent in the Iraqi case as well, but other Iraqi physicians associate the US with a poor social safety net and lack of moral or humanitarian values, which they base on interactions with US government forces and other agents in Iraq. Both groups come to the US anticipating delayed gratification and with low expectations of support provided by the US government or any other agency. Instead, they expect to rely on their kin or themselves as they work towards professional and social incorporation.

Two processes running parallel for both IMG groups, the licensing process and the immigration process. If Indians clear the licensing process more efficiently, they have few tools with which to circumvent the lack of autonomy associated with the retrenchment of the H-1B visa, the J-1 visa home residency rule, or the fact that they are severely affected by the green card backlog. For Indian IMGs, their large numbers are both a strength and weakness — large social networks and an established presence in the US medical field allows for significant support and institutional knowledge about the migration and licensing process. Still, steep competition over limited visas and the green card backlog based on national yearly quotas affects Indians more so than other national group *because* of their large numbers. For Iraqi IMGs with refugee background, these processes are largely reversed; their path to permanent residence is typically initiated either before or shortly after arrival while their paths to the US medical field are studded with obstacles they are less equipped to overcome than their Indian peers.

While Iraqis are often more experienced and established in the medical field (sometimes arriving in the US with multiple specialties under their belt), they still find themselves at a disadvantage in comparison to Indian IMGs. The US does not recognize or validate foreign specialty certifications but requires all IMGs regardless of experience level to undergo US graduate medical education — a matching process that has become increasingly competitive due to limited training positions. This means that the US medical field rewards those IMGs that successfully navigate the domestic training system rather than those already trained, which arguably represents an untapped resource during a physician shortfall.

In many ways, Indian IMGs show both more collective knowledge in how to navigate the US licensing process, but also more compliance with the informal hierarchy in which IMGs end up in less prestigious specialties, such as internal medicine and primary care. These decisions are often the result of agency versus constraints calculations — failing to secure a spot in a residency program can have serious financial, professional and psychological consequences, and so applying for a specialty that is less competitive can be a strategic way to ensure forward movement. For some Iraqi IMGs that are already specialized and came to the US because they were unable to continue their careers in Iraq, surrendering their specialty for a more accessible one is less acceptable as it conflicts with their sense of professional identity and pride.

Ultimately breaking into the US medical field allows Indian and Iraqi IMGs to reproduce a US nation brand in which hard work pays off, but many also describe watching others fail in dismay. Being required to outperform domestic physicians in order to be competitive both leads to frustration and exhaustion, but also a sense of empowerment and pride, seeing how the US healthcare field is increasingly constituted by immigrants.

Physician nationality	**(n)**	**Predominant immigrant category**	**Predominant immigration pathways**	**Resources**	**Obstacles**
Indian	(22)	Labor migrant	H-1B; J-1; F-1; spousal sponsorship (H-4 or green card)	Network migration, forerunner examples and resource pooling, financial resources, social capital	H-1B visa scarcity, 2-year home residency rule requirement (J-1 visa), green card backlog
Iraqi	(10)	Refugee or asylee	F-1 → asylum; J-1 → asylum; B-1 → asylum; SIV; refugee resettlement program	Expedited path to immigration/legal permanent residence, adaptability, some forerunner examples	Diverse delays caused by infrastructure disruptions, little preparation, social isolation (mitigated with time), financial constraints and responsibilities

Table 7. US IMG Pathways

CHAPTER FIVE: THE SWEDISH BRAND – SHOPPING FOR WORK-LIFE BALANCE

In this chapter, I return to nation branding (e.g., Fetscherin 2010; Bandelj and Wherry 2011), examining how an image of Sweden is marketed to and spread among Polish versus Iraqi IMGs, and how these messages influence their motivations and expectations of working and living in Sweden. By looking at their contexts of reception (Portes and Rumbaut 2001), I map out how expectations based in the Swedish nation brand compare to the realities of IMG life in Sweden, highlighting the institutionalized segmentation between EU/EEA and non-EU/EEA physicians.

In this national context, I draw on a migration industry framework (Gammeltoft-Hansen and Nyberg Sørensen 2013), illustrating how the coordinated market economy of Sweden — in which the healthcare system traditionally does not involve firms — has directly or indirectly come to rely on private actors to solve their physician shortfall through international recruitment of European physicians, including Poland. These IMG recruitment companies function as producers and intermediaries of a nation brand (Aronczyk 2019), marketing Sweden as a supportive and family friendly destination, brokering the relocation process and setting expectations generally high. Importantly, the services that these companies offer are only available to doctors within the EU/EEA whose medical credentials are automatically recognized; Iraqi physician pathways to Sweden tend to be facilitated by less licit agents of the migration industry such as smugglers and receive less active support breaking into the Swedish medical field, which effectively segments their contexts of reception and reproduces hierarchies between

European and non-European IMGs.

I meet with Dr. Aleksandra at a patisserie with a lakeview in a small Swedish town in the summer of 2019. She had moved here from Poland to work at the local primary care center four and a half years earlier, after having worked as a pediatrician and primary care physician for 10 years. She had previously considered the US but had been put off by the demanding work culture in the medical field and the focus on financial rewards and decided to stay in Poland. She had no intention of leaving when she received a phone call from a colleague in Sweden:

> My friend went to Sweden with that company that collects doctors from different countries. She said, do you want to come visit? The flights are really cheap! Me and my husband thought, why not? Let's go. We spent 2–3 days in another town here visiting the primary care center where she worked and then I met a colleague who was in charge of recruitment and she said, why don't you work in Sweden? I said no, I've been in Poland for a long time, and I don't want to move anywhere, we have children in Poland. But later they sent us e-mails and asked us to visit again and bring the kids, wanting to show us around. I thought it wouldn't cost us anything to just look. We came here and then we thought, why not try something new? You might regret it if you don't try.

Dr. Aleksandra and her husband, a programmer, migrated with their two children to a municipality of around 7,000 inhabitants. Work was still challenging due to the physician shortage at her facility, but the family enjoyed the green surroundings and were able to create a sense of community with a rich social network made up of both Swedes, other IMGs and members of their local Catholic church. Her younger daughter adapted quickly, but her twelve-year-old son could not adjust to his new school setting, desperately missing his old one. As the parents saw his socioemotional development stifled, they decided to plan their gradual return to Poland.

As exemplified in Dr. Aleksandra's case, family considerations are a large part of Polish IMG decision making processes. Financial gains are rarely at the top of the list so much as a professional life that is conducive to balance and stability. Most migrate as trained specialists, many with years of experience in their field — and nearly all of them are parents. Although they find working conditions in Polish medicine less than ideal, they are not driven to move by major push factors. For them, any migration destination worth exploring will have to offer both stimulating yet manageable work and be suitable for their families. With so many surrounding Western countries to choose from, Polish physicians have become highly sought after in a migration industry of international physician recruitment in which companies may charge Swedish county councils approximately 400,000 SEK (≈38,480 USD)[35] per recruit, sometimes even including costs related to providing an IMG's family members with language training (Hårdänge 2019). A successful recruiter knows to accommodate both professional and personal needs when matching an EU/EEA IMG with an employer, and that this is exactly what the Swedish migration industry of physician import specializes in.

This soft value approach to attracting IMGs is particularly salient in the case of Dr. Anna. While family was the main reason Dr. Aleksandra ended up returning to Poland, family considerations in relation to the political climate under right-wing ruling party Law and Justice (*Prawo i Sprawiedliwość*)[36] were a big part of why Dr. Anna wanted to leave:

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[35] Informal interviews with county council representatives suggest that this number is increasing.

[36] *Prawo i Sprawiedliwość* is a populist and nation-conservative party that has held the Polish presidency since the 2015 election.

> Our politicians started going a bit crazy. It didn't feel good to stay there. They are against gays, and they are against women. They say women should stay in the home and not study, not study math programs in school and so on. I don't want my kids to grow up in an environment like that.

In addition, new punitive regulations being introduced where physicians were fined for prescribing medications or treatments deemed too expensive by government representatives, pushing Dr. Anna towards emigration. She her resume to a recruitment company and was soon interviewed over Skype by a Swedish representative born in Hungary. "It felt like a conversation with, if not a friend, then a good acquaintance," she remembers. The family was flown in and put up at a hotel while she was interviewed in person at the healthcare center. "We were so impressed, and everyone was so nice. The recruiter drove us around and showed us the area and the neighboring towns and we really liked it. So, we decided to come here," Dr. Anna concludes. She started working part-time at the facility while spending the rest of her work hours at a special language and training center for medical recruits, sponsored by the county council.

Intra-EU/EEA mobility facilitated by with what resembles courtship from recruiters is what gives Polish IMGs drastically different context of reception compared to their Iraqi colleagues. While Polish IMGs may be flown in courtesy of a recruitment company or county council, it is not uncommon for Iraqi IMGs to have paid thousands (if not tens of thousands) of dollars to be smuggled through Europe to Sweden by an illicit, less benevolent migration industry. I met with Dr. Mustafa and his baby daughter at the hospital cafeteria where he works as a radiologist, 30 minutes away from Dr. Aleksandra and Dr. Anna's primary care center. He left Iraq in 1996 by way of Libya where he practiced for two years before leaving for Sweden. When asked about the process of migration, he says, “I can’t really call it a process. It’s smuggling and stuff, and what country is accepting immigrants at the time.” While Sweden was an option to be carefully considered for Dr. Aleksandra and Dr. Anna, Dr. Mustafa found himself without much of a choice:

> When I left Iraq, it was very difficult. At that time, I couldn’t go back, and Libya was not a place I could continue in. So, I had some friends here [in Sweden] and some family. At that time, it was not easy to get permanent residence in any other country but Sweden.

He moved to Malmö where he had some extended family and spent the first four years living off of meager asylee social security benefits and studying advanced Swedish so that he could take the mandatory medical licensing exam for non-EU/EEA citizens, which he had to retake before he was able to pass. He applied for over twenty internships, secured one interview but was not accepted due to lacking language skills. “I wasn’t really integrated then,” he explains, echoing a term frequently used in Swedish immigration discourse (often implicitly directed at Muslims). “I was just focused on learning the language.” He tried to get a job as a nurse but was told he was overqualified. After working as a substitute general practitioner at a psychiatric ward in a rural area, Dr. Mustafa’s supervisor helped him obtain an internship position at the same hospital, which finally put him on track towards residency. It was difficult for him to watch European IMGs secure positions and learn the language quicker, but “I don’t complain,” he says. “Those are the rules and that’s the law, so I just accept it.”

When comparing Dr. Aleksandra, Dr. Anna and Dr. Mustafa’s stories, a stark contrast emerges in reception, levels of agency versus constraint, and institutional support. While the process of obtaining a license for non-EU/EEA physicians has been streamlined since the time of Dr. Mustafa's arrival, mutual recognition of medical credentials among EU/EEA member states still puts Polish IMGs at a radical advantage over their Iraqi colleagues. This advantage radically accumulates with the recruitment services offered exclusively to European physicians.

The Path to a Swedish Medical Career: Intra-EU Recruitment versus Refugee Routes

European Recruitment Companies and Swedish Nation Branding

Since the bicentennial, the intra-European physician recruitment industry has grown widespread with agencies based in both sender and recipient countries, including Poland, Hungary, Spain, Sweden, Denmark, the UK and others.[37] The recruitment companies are predominately private enterprises establishing supply contracts with individual medical practices and county councils (depending on healthcare system in the recipient country), charging employers a larger lumpsum per delivered recruit. Some of the major expenses that recruitment companies incur during recruitment are language classes (usually around 6 months) and IMG stipends while in language class. Apart from the recruiters themselves, the firms also employ interpreters, administrators, teachers and other relocation staff. They also pay IMG travel expenses, participate in job fairs and rent training facilities.

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[37] Large receiving countries include Scandinavia, the UK, the Netherlands and Ireland. Traditional sending countries include Eastern and Central European countries such as Poland, Romania, Hungary and Bulgaria, but Scandinavia is also a popular destination for physicians from Spain, Greece and Germany, according to requested NBHW statistics.

As medical training is becoming increasingly standardized within the EU, recruiters do not tend to target certain nationalities based on perceptions of superior skillsets. Instead, the main goal is long-term retention and a successful match between IMG and employer. Factors going into IMG retention are both structural and personal. In order to minimize temptations for return migration, recruiters may focus their efforts on IMGs from countries with less competitive salaries, such as Hungary or Poland over Spain or Germany.[38] However, individual fit may be more of a deciding factor, making IMG recruitment a very personal business. An important function that recruiters serve is to vet potential candidates during an initial interview, assessing their expectations, motivations and adaptability for migration. Selectivity during this process is meant to ensure a more successful recruitment.[39]

Swedish county councils experiencing physician shortfalls now have a long tradition of partnering with or co-founding recruitment companies which specialize in intra-European physician migration, focusing on lowering thresholds for the more practical logistics of employment, language and relocation, enticing doctors that might still be undecided about leaving — and where to go. Occupational burnout syndrome is a widespread problem among Polish physicians and has received special attention in multiple studies (Zgliczyńska et al. 2019), making the profession susceptible to attrition. A survey from 2019 of over 1,000 Polish physicians showed that nearly a third had an intent to migrate, citing a constellation of incentives including higher earnings abroad, improved working conditions, the ability to achieve better work-life balance, and opportunities of professional development. Almost 62% of doctors with the intention to leave Poland considered a temporary stay abroad, around 2–5 years. 70% of respondents indicated "leaving family" as the main deterrent (Domagała and Dubas-Jakóbczyk 2019). In many ways, Swedish employers and recruiters tap into these "wish lists," branding Sweden as an egalitarian "physician paradise" with generous vacation policies, parental leave and lighter workloads (Boström and Öhlander 2011; also see Boström and Öhlander 2015). Successful and satisfied recruits play an active role in reproducing and spreading the nation brand to colleagues, becoming unofficial recruiters themselves.

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[38] In 2020, the annual gross income for specialists in Hungary was €32,988 and €20,200 for Polish specialists. In comparison Spanish specialists earned €79,544 and German specialists €146,200 (Yanatma 2023).

[39] There is no comprehensive or official survey data outlining the general level of satisfaction among recruited IMGs in Sweden and country councils may have agreements with multiple recruitment companies, further complicating standardized evaluation. However, one of the county councils for which many participants in this study work report that retention[39] (as a proxy of satisfaction) of IMGs in their primary care had gone up from around 60% to 90% after working with a recruiter that conducts a more careful selection and provides more tailored support that acknowledges cultural and knowledge-based differences among IMGs and native physicians.

Two prominent recruitment companies in participant accounts are MediCarrera and Kalmena Rek AB/Medena Rek Polska,[40] each collaborating with different Swedish county councils and regions.[41] MediCarrera is currently the biggest recruiter in Europe while Kalmena Rek AB/Medena Rek Polska was the first IMG recruitment agency in the EU.[42] Founded in 2003, the Swedish-owned Scandinavian physician recruitment company MediCarrera is based in Spain and employs international staff with connections to Eastern and Central Europe. Well-informed of the soft factors that impact physician migration and retention, they acknowledge that migration is a family affair and emphasize how they may help offset a variety of difficulties related to relocation. The following statement is prominently featured on the elaborate company website:

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[40] Other recruitment companies for international physician recruitment that Swedish county councils work with include but are not limited to Paragona, Mediflexible Medicolink, and Lireco. However, these were not named by the participants.

[41] MediCarrera had a long-standing working relationship with Jönköping county council before they switched to in-house recruitment, and Kalmena Rek AB has been part owned by Kalmar county council.

[42] Information based on interview with a recruiter with experience from both companies.

> *Moving to another country can provide you and your family with outstanding opportunities for personal and professional development. A new career, a new lifestyle and new challenges can also be very stressful if not carefully managed. We would like to be your career advisor, guiding you through the whole process from assessing your possibilities based on your professional medical experience, interests and expectations, through offering a suitable position, signing a contract and beyond. We accompany you until the day you arrive in your new country and start to work* (MediCarrera 2022).

Apart from connecting EU/EEA IMGs with employers, MediCarrera currently provides a 6-month language course in Barcelona, free of charge to IMGs and their partners prior to migration, complete with in-house childcare. Once it is time to migrate to Scandinavia, the firm offers comprehensive relocation support for IMGs and their dependents, ranging from finding housing, kindergarten or school enrollment, to handling contacts with the relevant authorities in the new country and filing for license validation.

While MediCarrera's organization is broader in the sense that it recruits to all the Scandinavian countries, Kalmena Rek AB specializes in bringing IMGs to Sweden with a particular focus on Poland. Founded in 1999, Kalmena Rek AB is owned by a Swedish county council and Affärsutveckling i Polen AB, which goes under ENA Group. Kalmena Rek AB operates in Poland through the affiliated subsidiary company Medena Rek Polska (Linnersten 2005; also see Czechowski and Arvidsson 2004). The firm has traditionally been operating in Southeastern Sweden and the county attributes its focus on Poland and the Baltic countries on a long-standing political collaboration between the regions, emphasizing the great contributions of Polish IMGs to Swedish healthcare (Peterson 2005). Like MediCarrera, Kalmena Rek AB/Medena Rek Polska offers in-house tailored coursework in preparation for medical migration to Sweden in their own facilities in Warsaw.

Their website describes Sweden as sparsely populated, which means that "there is a lot of beautiful, untouched nature that is available for everyone to enjoy." While the company admits that Sweden's cold climate is not "like Italy," they emphasize light summer nights and opportunities for skiing in the winter. "Being a star or not does not matter in Sweden, because there you start with the premise that everyone is of the same worth," the website further asserts. "There is a well-developed social safety net, and the general living standard is high." Finally, Sweden is proclaimed a multicultural society with many facets to be discovered and potential applicants are invited to "get a taste of Sweden" for themselves, again emulating an easygoing IMG destination that can be savored before one decides to make it a permanent home (Kalmena Rek AB/Medena Rek Polska 2022).

The astute accuracy with which these recruitment companies pinpoint Polish IMG priorities and mindsets can be considered rather remarkable. While many participants lament what Dr. Antoni describes as the "lack of influence" and the "hierarchies of Eastern European medical schools," academia and hospitals, Sweden boasts of egalitarian industrial relations and flat organizations. When Polish doctors want the best for their children, recruitment highlights Swedish social benefits, high living standards, and assure a family friendly mode of migration. In addition, both the MediCarrera and Kalmena Rek

AB websites speak (in true Swedish fashion) to values outside of work, such as accessibility to a pristine nature — both websites feature images of serene Scandinavian scenery, archipelagos, kayaks and sailboats. Even these attractions correspond to Polish IMG cravings; Dr. Piotr, a primary care physician who toured the Nordic coastlines before moving in 2008 says, “I didn’t come here just to work. I moved to go kayaking, to maybe get a boat. To have some more time, not so many patients and to be in a healthcare system where everyone is super nice to each other. It seemed so perfect.” Dr. Radek, another primary care physician also specialized in pediatrics, oncology and emergency medicine shares a similar sentiment when asked why he chose Sweden:

> Because of nature. Here in the North of Sweden, there is so much nature. I was also thinking about a different tradition, that everyone is equal, you could say. It’s not the same as when you work in Poland, there a professor is a professor. There is a hierarchy.

In this vein, recruitment websites understate money as a point of attraction. While professional development and opportunities are important to most participants, they all refrain from phrasing their main migration motivation in terms of higher salaries or prestige. On the contrary, some like Dr. Aleksandra, express deep discomfort with a medical career based on financial gain. When asked what Sweden represented to her, she responds:

> Calm. In my experience, you didn’t talk about money at all. You make enough, you don’t have to show that you’re better in any way. Everyone is the same and it and it suits me much better. I don’t have to dress up because I'm a doctor. I want to spend my energy on other things.

Dr. Jan seconds this sentiment and says, “Many people thought we moved here because the money would be better, but we made good money in Poland.” His wife, Dr. Dorota, elaborates, “We had no time for family. That was the reason we came. And the German doctors here say the same — money was never the issue. It was time. Now we have time for family, music, sports, the boat, fishing. Everything.”

While participants downplay money and status in their accounts of motivations and pathways, Polish IMGs nonetheless form an essential part of a large European migration industry resembling a buyer’s market in which they have the upper hand. Importantly, these favorable services and conditions for migration rarely extend to IMGs from outside of European borders.

Agentic Polish IMGs and Recruitment Services

In comparison to many other migrating physicians around the world, IMGs from EU/EEA countries coming to Sweden often have the comfort to think of their migration in terms of relatively risk and low cost. Like many other IMGs, Polish physicians have considered the path of less resistance when choosing their destination, but since they do not have to concern themselves with barriers related to citizenship, immigration policy or medical relicensing, they place significant emphasis on the specific pull factors that Swedish society and professional life may offer them and their families. This indicates few constraints and high levels of agency among Polish IMGs, in which their capacity to be agentic in their choices is largely due to the low levels of structural constraints surrounding their migration as physicians (Kelly and Hedman 2016; Heckhausen and Buchmann 2019).

Trained specialists, such as Dr. Aleksandra and Dr. Anna, had previously considered the US but found the notion of starting over with exams and residency too high of a threshold. Dr. Aleksandra visited the US but was soon put off by the financial pressures of the US medical profession. “It was so tough,” she explains. “They emphasize money all the time, it’s not a good country for me. All they talk about is money and I don’t want to live like that. If you are a doctor there, you have to make a lot of money and you have to buy into that. You have to be at that level and that did not suit me. You have to work so hard, so I thought no, I’d rather stay in Poland.” Dr. Anna had also briefly considered relocating to the US in her mid-thirties; she spent some time in Detroit where her husband was completing a postdoc in chemistry. Ultimately, Dr. Anna was deterred by the US not validating foreign specialty certifications. “Doctors from Europe have to redo everything there,” she says. “I decided I was too old to start over from the beginning. I was already three years into my residency.” These considerations highlight the competitive environment of the global IMG labor market in which Polish IMGs are committed to making the right choice. What is prevalent is the desire to achieve a better future for not just oneself but for the family as a whole — both in terms of professional or educational opportunities, and a fulfilling life outside of work. With such comprehensive ambitions, they take their time to “shop around” for the right fit.

The importance of personal preferences related to family and suitability demonstrates a strong sense of agency among the Polish IMGs, and an unwillingness to commit to a destination that entails too many constraints, which Dr. Kasia will emphasize. She and her spouse had planned to migrate for a long time and carefully weighed their options. They lived in London for a while where her partner worked but did not take a liking to it. “It wasn’t so great,” she says. “I don’t know. It didn’t feel good.” They also ruled out Canada based on having to redo clinical rotations and their limited availability, and the US based on everything that goes into the ECFMG certification requirements. “We have three children,” she explains. “It was so much.” Dr. Kasia finally started planning for Australia but had concerns about the distance. “Then Sweden came up,” Dr. Kasia explains. “We knew a bit about it because my husband had to travel there for work. So, we thought, why not? We can try, it’s not so far away. We can go back if we want. It’s not like we had to, but we were curious.”

Primary care physician Dr. Zofia and her partner, a tech specialist, shares a strikingly similar story. They spent some time in the US but had difficulty finding a path to legal permanent residence under the US visa regime; an uncertain situation they found unacceptable considering their growing family. They returned to Poland but kept entertaining the idea of moving. Dr. Zofia says:

> We thought about the economic situation and the future conditions for our kids. We lived in Poland for about 10 years and during that time, we always had these reoccurring thoughts about trying another country. We weren’t really happy [in Poland] even though it was our country. So, in the beginning, we thought maybe England or somewhere in the UK. We thought it would be easier language wise since we had the basics of English, but we hadn’t made any definite decision. And then my husband was browsing through my physician’s magazine and then there were all these ads for recruitment to Nordic countries. He motivated me to maybe try to apply. I did and then everything happened fast.

Within a week, Dr. Zofia went to Warsaw for an interview with a recruiter and was offered a spot at a 6-month long Swedish course in the same city shortly after. Following another two weeks, she went to Sweden for an interview with a potential employer after which she was able to choose between two different positions.

The role that recruitment plays in attracting Polish IMGs to Sweden is undeniable as nearly all participants mention directly or indirectly being involved with this particular migration industry. For some who have decided to migrate before they have chosen a specific destination, a recruitment firm will even have great influence over where they end up. The prevalence of the recruitment advertisements and normalization of physician migration in Poland is summed up in Dr. Jakub's account when he says:

> I applied through a regular ad. You know there are a lot of physicians that come through recruitment companies, and they receive a kind of education. First language class and then they get a contract before they move.

While Dr. Jakub had a sister in Sweden which affected his choice of destination and facilitated his transition, kinship network migration through family ties is not a common phenomenon among the participants. Borders within EU/EEA are fluid, travel back and forth is unimpeded and the distance between Sweden and Poland is short, which makes family reunification less pressing. Rather, the reoccurring story is one of tepid curiosity about a life in Sweden, an interest that is often piqued by an opportune intervention from a persuasive recruitment firm. At a time when hours are long at the clinic and future prospects seem unsatisfactory in Poland, many participants mention coming across an advertisement from a recruitment company in a medical periodical or the like or being convinced by a colleague who had recently been recruited, as in Dr. Aleksandra's case. Similar to her, Dr. Jan and Dr. Dorota remember being called up by a persuasive Swedish recruiter after first having an offer from Scotland fall through. "It was a coincidence, it wasn't planned. It just happened," Dr. Dorota remembers.

In some cases, the intervention from a recruiter can be remarkably opportune. Dr.

Antoni, a primary care physician, remembers the growing feeling of needing to make change for the sake of both him and his children. “I was thinking a lot about my family and kids. That maybe they should get a better start in life than I had,” he says. “I was very exhausted at work over a long period of time. Almost occupational burnout syndrome,” Dr. Antoni explains. “I cut back on my hours, and it got better, but I thought, this isn’t enough. I have to do something. And the very moment I thought that, I got an email from MediCarrera that they were looking for doctors in Jönköping, Gävle and Västra Götaland.” Other participants reached out to recruitment companies, like Dr. Anna. Like her, many express grievances against the Polish medical system and the politicians that govern it. Dr. Anna remembers the situation as unsustainable for primary care physicians in particular:

> You want to do what is best for the patient, but you also don’t want to receive punishment for it, and us family physicians bore the brunt of it because we prescribe the most medications. It doesn’t feel good, because you want to help people. You want to use good drugs, and then some civil servant who isn’t even a doctor is counting the money and says no to your recommended treatment, saying, why did you prescribe that? You have to pay for that. That’s sick, I think. So, it was very stressful to keep working in Poland, for patients too, the healthcare system in Poland isn’t good at all.

In a fit of rage at yet another discouraging political event, Dr. Anna remembers reaching a breaking point and sending her CV to a recruitment company in the middle of the night.

While Dr. Anna is a fresh migrant, Polish IMGs have shared similar concerns for decades. Dr. Milena migrated to Sweden in 2000, over 20 years before Dr. Anna. After completing her residency in primary care in 1999, she also found herself unhappy with the fluctuating industrial relations of Polish healthcare. “Then I saw and ad, that they were looking for people [in Sweden] and I thought I’d check it out. It was a bit of a coincidence, not a very conscious choice," Dr. Milena says. Almost apologetically, she adds, "Maybe it was a bit cowardly. Sweden was looking actively. I wasn't looking actively, it was mostly the ad," echoing Dr. Dorota's words. Dr. Milena's narrative reflects the effectiveness of reaching a potential candidate for recruitment in a state of exhaustion and disappointment, tipping the scales with the promise of a path to a different career in which obstacles are either carefully managed or cleared altogether.

Dr. Stanisław, an accomplished pediatric orthopedic surgeon with a PhD, migrated to Sweden around the same time as Dr. Milena. While he would have liked to stay in Poland for the sake of his patients, the system continuously disappointed him. "They have made promises in Poland many times since World War II that things will soon be better for the healthcare sector, but it's never happened. So, you can't trust them. It's like a mantra, the same thing over again — they promise, and nothing happens. It's not okay." He remembers strangers taking credit for his and feeling overwhelmed by a multitude of institutional dysfunctions. After completing comprehensive fellowships in the US and Canada, he was disappointed to find upon his return that his employer in Poland did not value his prestigious foreign research experience, but instead emphasized how academic research had come at the expense of maintaining practical skills essential to his position as surgeon. Ultimately, Dr. Stanisław was deemed out of surgical practice and delegated to the clinic. "It was like a punishment," he says. "A year in the clinic. Hell." This bitter disappointment further spurred Dr. Stanisław and his wife, Dr. Nina, to consider migration.

Like her husband, Dr. Nina saw the Polish healthcare field as stagnant and unstimulating. She had completed her residency in pediatrics and started branching into pediatric neurology but felt like there were few opportunities for professional development and training. On impulse, she responded to a recruitment ad in a medical journal in the early 2000's. Initially, Dr. Nina was offered a position while Dr. Stanisław was not since pediatricians were in higher demand in the particular Swedish town she was recruited to. "But I told them I wasn't leaving without my husband," she says, illustrating the bargaining power that the right IMG specialist can have in the market of European physician migration. "So, they had to find a position for him, and so he got one." At the time, Poland had yet to become an EU member state, so the couple had to take a licensing exam before they signed a three-year contract that also involved 10 months of preparational and training, Swedish language class, and some Swedish healthcare law and to be completed before the actual move. The couple was not alone in their migration. "Let me tell you," Dr. Stanisław asserts, "there were about 115 or 120 people in my graduating class at my med school in Krakow. Now, little over 10 years later, 70% have worked abroad."

Importantly, even participants who migrated to Sweden before Poland joined the EU in 2004 speak of their migration decision with a similar ease those who came after the accession, even though this entailed having to take a licensing exam and some additional training. This can largely be attributed to both geographical proximity and significant handholding from physician recruitment companies, who have been active in Eastern and Central Europe for years prior to the EU enlargement in 2004. Dr. Kamila, a primary care physician who migrated in 2003 says:

> It was them who handled everything, with the Swedish language class in Warsaw and all the papers and all the visas and work permits, and residence permits and all the formalities. Poland was not a part of the EU, so we started like all non-EU physicians with probationary [paid] practice comparable to a Swedish internship, even thought we were certified specialists. In order to be recruited by that particular company at the time, you needed at least a few years of experience. But after 6 months, Poland became a member.

The accession meant that all most foreign specialists had to do in order to practice in Sweden was to submit their paperwork to the NBHW for validation (and informally, learn Swedish). However, depending on experience, international primary care physicians like Dr. Kamila were often compelled to undertake tailored supplementary residency training to compensate for the fact that primary care residencies in many other countries were less extensive than Sweden's standardized 5 years. Notably, even with the disappearance of the legal barriers Dr. Kamila describes the recruitment industry as a facilitator of European IMG migration to Scandinavia and Sweden remained in seemingly steady business.

Iraqi IMGs, the Smuggling Industry and the Swedish Nation Brand

To some extent, non-EU/EEA IMGs who come to Sweden as refugees and asylum seekers have often been forced to solicit the services of the global billion-dollar industry that is migrant smuggling, an industry that is particularly active along pathways from the MENA region to Europe. In a report from 2010, United Nations Office on Drugs and Crime (UNODC) estimates that some 55,000 migrants are smuggled each year through these routes, generating around $150 million in profit for illegal networks and organizations. While recruiters and employers largely defray costs for European physicians, IMGs from non-EU/EEA countries experiencing armed conflict in the MENA region pay their own way to come to Europe and Sweden as asylum seeker. Fees charged to the individual migrant varies greatly based on point of departure, but typically range between $2,000–$10,000. Migrants coming from the Middle East and Asia (including Iraqis) often travel to Turkey and cross over to the Greek islands by boat (UNODC 2010).

Ethnographic research finds that the smugglers that operate the transit points from other Middle Eastern countries to Turkey are independent local agents or brokers, dividing up responsibility for different legs of a migrant's journey. Here, migrants and smuggling agents tend to come into contact with each other through national, ethnic, kinship or friendship ties, as we soon shall see exemplified in the case of Dr. Hasan, illustrating how this migration industry overlaps with network migration. These regional smuggling characteristics differ from mafia style hierarchical crime groups that are traditionally associated with the migrant smuggling industry, adding potential complexity to the interpersonal relationship between smuggler and migrant while also not denying how the industry is permeated by human rights violations (Içduygu and Toktas 2002).

Similar to the Polish case, the migration industry that brings Iraqis to Sweden is also fueled by a kind of nation branding that is disseminated throughout refugee networks. While it may not be spelled out on recruiter websites, Sweden's reputation as a destination country travels by word of mouth between those who have resettled there and those who are deciding between destinations, proving that nation brands in transnational immigrant communities can initiate migration without kinship sponsorship. For example, Dr. Ammar’s family did not have any kin in Sweden but were still attracted by the country’s strong reputation. He says, “Sweden was just the best country. We heard so much about the quality of life in Sweden, what it’s like living here. The humanity here. You have your rights and you’re accepted and how you can create a home here. My parents chose that and are happy and feel like it was the right decision. We left everyone to come here.” Dr. Mahmoud uses some of Dr. Ammar’s exact same words when he says, “They told me working conditions are great. They told me the quality of life is good. You're protected. If you get sick but then the working conditions is great, that's one thing that I heard of. Many people said that to me.”

While many participants traversed multiple borders to reach Sweden in one of Europe’s more remote corners (as an asylum seeker must), some, like Dr. Mustafa, place little focus on the journey itself in their accounts. Dr. Omar, rheumatologist and chief of medicine frequently took what he refers to as week- or month-long “holidays” to Lebanon, Syria or Egypt when the threat against him and his family became too palpable. When he was informed that it was unsafe for him to return to Iraq, Dr. Omar decided to go leave for what he refers to as an “extended holiday” to Sweden. Dr. Omar simply says, “My brother said I couldn’t come back. And so all of a sudden, I ended up in Sweden, that’s where I could go. It was a coincidence, it wasn’t planned. And after a few months, I got a permanent residence.” Two years after his arrival in 2007, he was able to sponsor his family who had been forced to seek refuge in Syria.

Dr. Fatima, a primary care physician and geriatrician, also describes her migration to Sweden in mere terms of a before and after. She remembers how conditions deteriorated rapidly as the religious and political minority her family belonged to was threatened. The decision to leave was still not easy; Dr. Fatima had been providing essential women's healthcare to destitute communities in the Iraqi countryside where both water and electricity were in short supply in the aftermath of the Iraqi invasion of Kuwait in 1990. "Still, I didn't want my kids to experience what I had experienced during war," she says. Summing up their entire escape in just a few sentences, she explains, "We had to leave the country in a day and a night, and then I had my daughter who was only two. Then it took a while before we got permanent residence because they didn't know what would happen to the regime after 9/11. So, there was a delay, but then we got it and a new phase in our lives began."

The participant that is the most forthcoming about the inner workings of the smuggling industry is primary care physician Dr. Hasan. In 1997, he left Iraq for Yemen where he worked temporarily for four years before coming to Sweden in 2001. "The economy was bad," he says, referring to Iraq. "The situation in the country was unsustainable for different reasons and you became subject to external pressures. I just wanted a better life, not for social or political reasons… I didn't leave for political reasons honestly, I left to have a better life and a better future for myself. I wasn't married then. It was for *my* future." While in Yemen, he married a fellow Iraqi physician and together they started saving money for the next leg of their refugee journey. "It goes without saying that a person from Iraq can't come to London or Stockholm or Italy," Dr.

Hasan explains. “You can’t get a visa.[43] And you can’t afford to pay a smuggler either. So, you go somewhere else and at that time, Iraqis could go to Yemen and there were a lot of jobs there for physicians. So, I went there to work and save some money.” Remaining in Yemen was never part of his plan; Dr. Hasan describes the infrastructure as severely underdeveloped in comparison to Iraq, working endless hours and needing to see up to two hundred patients per day.[44] “I did not enjoy living there,” he concludes.

The couple first considered the UK because of their familiarity with English and the British medical school system, but failed to find a smuggler that would take them there.[45] Second on their list was Scandinavia, preferably Sweden; a country with a “good social system” where Dr. Hasan’s sister had already lived for two years. “Her husband had been smuggled there and then she came after,” he says. “Same as all refugees.” However, money was still an issue for the young newlyweds. Dr. Hasan continues by describing the gruesome uncertainty that goes into hiring smugglers, illustrating how the actual costs might be a lot higher in reality than the previously mentioned UNODC estimates since each link in the chain has the potential to break:

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[43] People in warzones are often unable to leave the country through regular routes. They can be forced to depart suddenly, foreign embassies responsible for issuing visas often close and airports or train stations may be inaccessible. Refugees who have left their homes without passports and other personal documents are generally unable to obtain visas later. Furthermore, an EU directive (the Carrier Sanctions Directive 2001/51/EC) imposes steep sanctions on carriers (including airline companies) if they transport passengers without valid travel documents. Importantly, there is no visa category for prospective asylees (so called “humanitarian visas”) for EU territories. If a person in or from a war-torn country applies for a tourist visa to a Schengen country stating that the purpose of their visit is for pleasure or recreation, case workers may doubt that intention and reject the application based on suspicion that the person might try to overstay their visa and/or constitute a security risk.

[44] According to the Physician Foundation, primary care physicians in the US see around 20 patients per day on average (Ollier Weber 2019).

[45] Participants tend to use the word “smuggler” to designate a black-market professional that is paid to assist people in crossing borders illegally on a regular basis. Dr. Hasan does not use the term when referring to a friend who facilitated their border crossing free of charge as a favor to him and his wife, likely because this individual did not perform these services for a living.

> It wasn't easy of course. First, you had to have enough money. There is always a risk that you're getting cheated. You might be paying €10,000 per person, for example, and you have to pay them at least half in advance up front with no guarantees. There are a lot of people who are dishonest, and your money disappears. You run that risk all the way to the country you want to go to, and it could take anywhere from between 1 week and 6 months. And it could be a problem if your money disappears mid-way and you need money to return or pay more to find new solutions. So even if the agreement is €10,000 per person, you need a margin of an additional €5,000. I didn't have that kind of money at the time.

In the end, Dr. Hasan and his partner lucked out in a true manifestation of Granovetter's strength of weak ties argument in which distant or irregular social connections may present individuals with novel opportunities for mobility (Granovetter 1973); an acquaintance of Dr. Hasan's wife offered to help them come to Sweden free of charge — an opportunity that was completely unheard of at the time. "He wasn't a smuggler," he asserts, illustrating how facilitators of illegal border crossings are not always perpetrators acting out of self-interest — they can also be individuals who possess the knowledge and capacity, but only selectively extending this to others as favors, refraining from capitalizing off of it. "So we were in luck, it was a miracle that it happened. And it happened while we were having the worst time in Yemen, we had lost hope after four years. We thought, this won't happen. We'll live and die here."

As in the cases of Dr. Omar and Dr. Hasan, many Iraqi physicians in the diaspora relocated temporarily to surrounding Middle Eastern countries, such as Yemen, Iran, Syria, Jordan, Egypt, or the UAE, before migrating to Europe and Sweden. Some IMGs, like Dr. Mahmoud and Dr. Zahra, also lived and worked in the English-speaking European countries before deciding to move to Sweden. Participants who may not personally have any extensive dealings with the migrant smuggling industry could still often be indirectly linked to them through having their Swedish residence or visitor's visa sponsored by family members or friends who had received asylum in Sweden after hiring smugglers to take them there — either fully or in part. In order to apply for family reunification, Iraqi IMGs would typically have to journey illegally across the Iraqi border to reach an operational Swedish embassy, as in the case of Dr. Malik.

Dr. Malik, a Chaldean pathologist, grew up in a secluded, close-knit Catholic village close to Erbil where a big portion of the inhabitants were resettled to Sweden and Australia after receiving UNHCR's refugee status determination during the Iran-Iraq war in the 1980's. Remarkably, the war shaped the number of aspiring doctors among the students in the small community. "Everyone wanted the highest grade so that they could go to medical school and avoid the war," he says. "Doctors wouldn't be sent into battle, and so all parents pushed their children to study as much as possible and overachieve so to not have to go to war. We became doctors to avoid the war. That was the tendency in our village, and I think that was wise of our parents there, to push us. They wanted no part of the war." In this sense, pursuing medicine was an exercise of choice in relation to constraint, potentially shielding young community members from a violent fate.

While Dr. Malik's family remained in the village throughout the armed conflicts of the 1980's, they eventually fled to Iran in 1991 where they lived as asylum seekers for three months before returning to their hometown. As Dr. Malik transitioned into adulthood and graduated medical school, the family realized they had to leave again. "Thank God for Sweden," he says. Because of the country's significant refugee reception, a foundation had been established for future network migration motivated by ethnic and family reunification, influencing Dr. Malik and his fiancé's decision to follow their community members to Sweden in the mid-90's. Dr. Malik describes his village's transnational, long-standing relationship with the country, with communication lines kept alive partly through the smuggling industry:

> At the time [of the Iran-Iraq war], people went to Sweden through the UN. Since then, they kept in touch over the phone or through letters, they had to smuggle out letters because it was illegal during the Saddam period to be in contact with people who had fled the war. We want that same sense of village community and there are many of us in Sweden. I think there are over 3,000 people from my village living in Sweden, and we're all related or friends. So, there is a sense of security in Sweden. That's why we went there.

Ultimately, this local binational diaspora would split Dr. Malik's family of six between Australia, Sweden and Iraq, with one brother in Melbourne and two brothers in Sweden, all physicians. Newly engaged, Dr. Malik fiancée fled with her family to Sweden as asylum seekers, with the hopes of the young couple uniting there through fiancé sponsorship. Dr. Malik remembers:

> When my fiancé obtained her permanent residence, I had to escape across the border, without my passport and without papers, to Damascus because there were no flights between Iraq and Syria. I had to apply for papers at the Swedish embassy and wait a year before I got a visa, and then I went to Sweden through that process.

Like Dr. Hasan and Dr. Malik, most Iraqi participants describe drawing on some constellation of strong and weak ties in creating pathways to Sweden, including family, friends and smugglers — but with little involvement from the Swedish employers courting EU/EEA IMGs. As subsequent sections will illustrate, this discrepancy continues to influence IMG arrival periods.

Initial Context of Reception: Relocating, Language Training and Relicensing

Polish IMGs Navigating Language Barriers

After being recruited, interviewed, and introduced to a place of employment in Sweden, the Polish IMGs begin to prepare for relocation. For most, this entailed resigning from their current positions and enrolling in the full-time Swedish immersion course provided (and often contractually mandated) by their recruitment company. Apart from brokering the connection between IMG and employer, designing and hosting Swedish language classes is one of the most significant services that this migration industry offers, giving EU/EEA physicians an advantage in a foreign sector in which communication skills in patients settings are vital. Lacking language skills would easily result in the possibility of medical error and mental exhaustion during the initial period, as Dr. Jakub would attest. "Me and my colleagues who came here from Poland, we all experienced this fatigue over a very long period time," he says. "You're mentally tired after each day at work, working in a foreign language. It got better after two years maybe." Dr. Piotr describes having constant tension headaches, dreading every knock on his office door. Similarly, Dr. Dorota remembers the same exhaustion, forcing herself through the first few months with rudimentary Swedish, trying handle the practicalities of setting up their new life while her partner was away at Swedish class. Her account illustrates how the services of recruitment are not without strings attached when she says, "We received financial support while taking the Swedish class, so it was mandatory to work for half a year if we didn't want to pay them the money back. So, I told myself I have to get through at least six months." While the couple had a lot of help from a fellow Polish family, Dr. Dorota remembers questioning her decision every morning, contemplating to call in sick. The couple's fourteen-year-old daughter could speak neither Swedish or English and soon came to struggle with bullying at school. Dr. Dorota remembers thinking, "God, what have I done? Not just to me but to my children?"

While the majority of the Polish participants attended Swedish class alone (or with a physician spouse), a few more recent recruits were invited to bring their whole family, free of charge. Presumably, this investment is meant to counteract a difficult situation such as Dr. Dorota and Dr. Jan's in which not all family members are equipped with the basic tools to start navigating Swedish society, ultimately preventing any detrimental family dynamics which could lead to return migration. When many were reluctant to take their kids out of school before moving, Dr. Kasia decided to prioritize their Swedish proficiency and therefore opted for a recruitment company that offered language courses tailored to migrating families. Before they arrived in Sweden in 2019, she and her family were sent to Budapest, Hungary, for a six-month long language course. "It was important for my family," Dr. Kasia explains. "Other recruitment firms only offered classes on the weekends for my husband and children. It was important to them, so we moved to Budapest for six months to study Swedish."

Although tailored comprehensive coursework in language and medical systems is helpful, it can also prove a challenging and taxing undertaking for IMGs. While recruits did not have to travel to Sweden to attend these classes, they often had to leave or undertake long commute from their hometowns to the course site for months on end, disrupting their household routines. As Polish IMGs are looking to improve their work-life balance by moving to Sweden, many of them experienced this stage of the migration as a challenging set-back, especially if it entailed a family separation. Dr. Zofia recalls the toll the process took on her family:

> After I got the job in Sweden, I only had a few weeks to quit my job in Poland start Swedish class in Warsaw. It was a six-month course that was really intensive, and it was a pretty difficult period for my family because of all the duties. My husband had to take care of all three kids while working full time. It was hard for me to learn a completely different language and I had no idea how I was going to do that. It was really stressful, but I did it.

Similarly, Dr. Stanisław remembers him and Dr. Nina attending a briefing session hosted by a recruitment company in Warsaw for physicians interested in Sweden, during which they and their fellow Polish physicians were first introduced to the Swedish language. “Turns out most people there had already worked abroad or been abroad,” he says. “It was almost like a daylong interview, it was really tough because they talked non-stop, first Polish and English and then English and Swedish. And then after an hour it was just Swedish and it was terribly hard to understand, but we started practicing.” As the meeting concluded, the couple were tired but remained excited at the prospect and decided to move forward. As for Dr. Zofia, this entailed immediate sign-up for an upcoming full-time Swedish class which required them both to resign and start commuting to Warsaw. It was not an easy adjustment for the family:

> We had different problems you could say, two small kids and a dog, jobs we had to leave, and then going to Warsaw. We commuted on a weekly basis, so we had to organize help. Our parents really came through for us, it was them who really helped us out so very much. It was a very long process. They were long days. Only in Swedish. I call that period a kind of brainstorm.

While having two parents away at Swedish class can create problems related to childcare, others point out how having a partner without any Swedish skills can make the arrival period feel disjointed between spouses, with an imbalanced onus one the IMG to handle relevant contacts while also getting a head start in acculturation and professional integration. Before leaving for Sweden, Dr. Radek enrolled in a ten-month long class organized by a recruitment agency. “It was Monday through Friday, and it was all Swedish teachers. We had to speak only Swedish to each other, it was pretty intense. But I'm very happy with it really, because when I moved here I could speak Swedish. But my wife didn’t, of course. And neither did my kids so it wasn’t easy.” Like Dr. Radek, Dr. Zofia also asserts that the language barrier was one of the biggest hurdles for her and her family during the first few months in Sweden, presenting yet another challenge following the imbalance that the language course had brought into their lives. “After six months of studying, you know a little bit, but it’s easier to write and read than to understand people speaking to you. It was so stressful and medical language is not easy either,” she says. “But things got better with time.”

A common occurrence in participant accounts are partners finding themselves struggling with breaking into the labor market, restricted by both limited language skills and geographical location — not rarely having relocated to a small town with limited opportunities for high-skilled professionals or academics. Dr. Kasia and her family arrived mid-winter in 2019 and in spite of their acquired language skills, her partner struggled to find work. “And then Covid-19 came, and it was so, so hard and we thought, okay, he would have to start his own business again. He didn’t want to, so we waited and it was a long process. We thought it would be quick, but it wasn’t.” A few months after arrival, Dr. Kasia’s husband started working remotely for some Polish companies before slowly starting to freelance in Sweden. “Little by little,” she says. “It’s going well.”

Dr. Anna’s husband faced similar struggles when arriving in Sweden in the aftermath of the pandemic. A PhD in chemistry, he had taken some Swedish classes prior to arrival but not full-time like her. “Now I think it wasn’t enough,” Dr. Anna regrets. While she turned out to have a natural proclivity and proved to be largely fluent in Swedish just a few weeks upon arrival, she felt her husband falling further behind and struggling with the demoralization of not being able to fulfill his traditional household tasks. She says:

> He is still taking lessons, but when I started my intensive course, he continued working so we didn’t go together. Maybe he should have taken the time off and gone with me. I know he understands a lot, but he has difficulty speaking. It’s important to us that he speaks good Swedish, so maybe I wish he would have had more time. We only focused on my course, and I feel like that was wrong. He tries but I can see that he’s struggles. He has to ask me about everything. Bills and stuff, setting things up. I'm the only one that can take care of it and maybe it’s hard for him because he was the one that took care of all of this back in Poland.

On top of lacking Swedish skills, moving from a bustling metropolis of 2.5 million inhabitants to a small town of less than 10,000 people also meant little to no job openings for a scientist. Importantly, what helped contribute to his resilience and patience with the process of relocation was Dr. Anna’s husband’s love for one of Sweden’s strong suits: nature. It was something he had been craving in “claustrophobic” Warsaw, motivating him to move to Sweden with his wife. Until he was able to find work, Dr. Anna’s partner thoroughly enjoyed going on long bike rides along the lake with his children, foraging in the forest, and breathing in the clean air.

Resources and Support for Polish IMGs

Polish participants describe drawing upon a variety of resources when navigating the arrival period, including support from their recruiter, employer and fellow IMGs and co-nationals. As they have all secured jobs long before coming to Sweden, they are typically expected to hit the ground running and start working fairly quickly. They are each connected to an advisor at their new workplace that will supervise their introduction and any potential supplementary training. Dr. Zofia's advisor at the healthcare center was also a Polish IMG, having migrated five years prior. "She was so helpful, she introduced me to everything that had to do with work, but she also took the time to help me with the general stuff. How you connect with landlords and rules around leases and stuff. It was so good to have her." Dr. Kasia on the other hand did not know any other Polish nationals in her new community but received great support from her recruiter. "It was the recruitment company that really took care of many, many things, like even the kids' school. So, we didn't have to worry about a lot of stuff, and we were also lucky to meet another couple at our Swedish course in Budapest. She was a gynecologist from Romania. They had three children, and they were also moving to our town, so now she works with me. So, we were very lucky, we talked a lot and we still do, I think we helped each other. They also knew more people here in the community and they knew a bit more than we did." While recruitment companies sometimes failed to deliver the rosy pictures they had promised, Polish IMGs would consistently prefer moving to Sweden through a recruitment company due to the services they offer, including locating an employer and providing Swedish lessons.

In addition, some Polish physicians moved to county councils that had an additional tailored education program for IMGs which they attended part-time as a part of their formal introduction to both Swedish society and medicine. “It was so tough,” Dr. Aleksandra remembers. “For like half a year, I had to commute to the education center two hours away. So, I was gone from like 7am to 7pm, twelve hours every day, so I barely saw my children. I was exhausted. It was very demanding, the language. The system too, but medically it was basically the same. You have to adjust; the language was the hardest.” Still, Dr. Aleksandra asserts her positive experience. “But otherwise, it went great, we’ve met so many great people, we’ve found our footing fast and been happy from the start.”

Dr. Kasia and Dr. Aleksandra’s statements speak to how the hard-earned advantage of tailored IMG education is still an advantage. While the recruiter and employer mandated crash courses represent a challenging stage in IMG migration processes, they ultimately remain an invaluable resource — sometimes not only in terms of the development of Swedish vocabulary and communication skills; a significant number of Polish participants ended up developing friendships with classmates and fellow migrating physicians that also nourished and buffered their relocation experience. These relationships can be particularly important to unmarried migrants, like Dr. Szymon, an internalist. Dr. Szymon struggled with language overload in class, having previously crammed English when briefly considering moving to the US. “Every time I tried to say something in Swedish, English came out," he laughs.[46] "It was tough, but it was also fun, I made more friends and you get motivated to move forward." By the end of the class, many of the classmates migrated together to the same town. "I think about ten people," Dr. Szymon estimates. "Doctors and dentists that moved here with their families. Also, when we got here, there were Polish doctors already here who had moved a year or two before us, recruited in the same way. And so, step by step, you settle in." At his new hospital, he received practical support from both HR and a from another Polish national who worked for the county council with Polish IMG settlement. "They helped me get an apartment, a Swedish person number, a bank account and all the things that are important to get life started in Sweden," he remembers.

On occasion, a handful of Polish participants reflect upon the experiences of non-European IMGs during the arrival period. Dr. Antoni had purposefully chosen a position in the region that had the additional education program that Dr. Aleksandra attended. In comparison to other regions where IMGs would start working full-time immediately, this entailed a temporary pay-cut, but allowed IMGs to ease into their new positions with improved skillsets. "I heard it worked well, you can take it easy and not start as a specialist right away like in many other places. It was a smooth process." While enrolled in the class, he noticed the absence of physicians from outside the EU in his cohort. He remembered learning valuable lessons in how to navigate Swedish culture in the workplace, realizing that non-EU IMGs were often unlikely to access this hidden curriculum that the recruitment industry affords European IMGs — on top of facing more comprehensive licensing requirements. Dr. Antoni was reminded of a Syrian pediatrician he had met previously and the difficulties she had faced trying to break into the Swedish medical field.[47] Dr. Antoni says:

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[46] English proficiency varies among Polish participants, but all preferred to conduct their interviews in Swedish, suggesting a higher comfort level. During interview scheduling, some suggested that they had "forgotten" their English in the process of Swedish. Both English and Swedish are Germanic languages while Polish belongs to the Slavic language family, so neither English nor Swedish is inherently intuitive to a native Polish speaker.

> She was like in her last year of residency in Syria. Then she had to move to Sweden, and it took like three or four years before she got a Swedish license and it was really hard to get a job in pediatrics anywhere. She finally got a substitute position, like if you show us that you work well then maybe we'll extend your contract. She didn't have any of these courses. She learned Swedish on her own through SFI,[48] like Swedish as a second language. They might learn a little about Swedish culture there but not a lot, I think.

While many participants attest to unreserved friendships with IMG colleagues from all countries, Dr. Antoni senses that the segmentation between EU/EEA and non-EU/EEA physicians stems from the arrival and licensing period. Dr. Antoni continues:

> There is a clear advantage because those coming from EU don't have to do the big exam to get a Swedish license. We just have to show we know the language. So, I think when we speak amongst ourselves, EU doctors and those from Syria or Lebanon or some other place, they are a bit… They have some anger, that we didn't have the same path. That we had it easier. I think it's unspoken, and maybe not noticeable everywhere. It's hard to explain. It's just a feeling.

Although getting your medical credentials verified in Sweden may be less extensive for non-EU/EEA IMGs than for example the in US, the vast institutionalized — and cultural

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[47] The main language of medical schools in most Arabic-speaking countries is English, followed to a lesser extent by French. Syrian medical schools are the only ones using Arabic as the main language of instruction (Alshareef et al. 2018). English skills vary among Syrian nationals.

[48] Swedish for Immigrants; a government sponsored language education program designed to teach adult immigrants basic knowledge of the Swedish language, comparable to English as a Second Language (ESL). The course is free of charge and open to immigrants who have received asylum or permanent residence.

— head-start given to EU/EEA IMGs can have a disheartening effect on refugee physicians that have already long been under duress.

Iraqi IMGs Undergoing Relicensing

While requirements have fluctuated some over the years, IMGs without medical degrees from other EU/ESS member states are required to pass an exam that tests their clinical knowledge (in Swedish), take a class in healthcare law and regulations, and successfully complete a six-month probation period of clinical practice, culminating in a clinical skills test. Non-EU/EEA IMGs are responsible for finding a clinic that will agree to supervise their clinical practice. After obtaining their license, they may apply for internship or residency validation or supplementary training depending on their level of experience. Although the Iraqi participants go through significant hardship migrating to Sweden and navigating the steps towards both permanent residence and medical licensing, they rarely take the time to express any extensive grievances. Instead, they tend to describe them as steps to be tackled in their process of re-establishing themselves in their host society. As Dr. Fatima puts it, "You just had to keep fighting. I was happy each time I passed one test after the next. We're happy here in Sweden and I've never regretted our decision to come here, but it was really tough."

Even if an Iraqi IMG like Dr. Fatima were to regret their decision, they are often unable to return home and rarely hold passports that will allow them to easily transfer to another destination country. Under these circumstances, many manage their expectations, put their heads down and approach their licensing and job hunts with the necessary grit and determination, attempting avoid any demoralizing comparisons to those who are practically brought into the open arms of an employer. Much like Iraqi IMGs of refugee backgrounds in the US, the process of regaining one's identity as an officially recognized, practicing medical professional is often understood as an act of self-respect and recovery. For those who find themselves stuck along the way, the emotional toll can be devastating.

After receiving asylum in 2008, pediatrician Dr. Layla cleared her exam and coursework in record time and started working as a general practitioner outside of Stockholm before she got her internship in Jönköping County in 2010. She had waited a year for her asylum application to process, not knowing if it would be approved. "You are insecure during that time," she explains. "It took so long to receive their decision, whether you will be allowed to stay or not. I wanted to start working. But it took such a long time and during that year, I didn't know whether I should start investing my time and energy [into the licensing process]." She received permanent residence in 2008 and was licensed 6 months later. Without much help from the Swedish side, Dr. Layla relied on family support — and her own resilience and determination. "It just takes time," she says. "And you have to have will, the motivation. You had to do it and if you wish to continue, there is no way around it."

Much like Dr. Layla, Dr. Malik braced himself for an intense study period after obtaining permanent residence. He had been in his third year of residency when he left Iraq, but now faced the mandatory exams and coursework required for a Swedish medical license. "I assumed I'd have to start over. I did everything," he remembers. "I did the clinical knowledge test, I studied medical literature on my own. It only took a year. I got my license, then I got an internship right away in Värmland and then I did my residency in the Stockholm region." After completing his specialty in pathology, a nationwide successful career followed; he eventually became chief of medicine in 2010 and started pursuing a PhD at a prestigious university. While getting to where he is was hard, not working was harder. He says:

> As a doctor, it was awful not to work, to stay at home and just study, but I was motivated. I wanted to work as fast as possible, so I studied by myself for ten hours every day. I got medical books that NBHW had recommended, all in Swedish. I went to Umeå for the exam, I passed the course in medical Swedish in four months. After that, I sat at home for seven months studying medicine, psychiatry, orthopedics, pediatrics and surgery, thick books in Swedish. Then I passed the probation period at a healthcare center in Stockholm.

Iraqi IMGs Mobilizing Family and Kinship Support

As illustrated in both Polish and Iraqi accounts, IMG transition periods are a group effort and only a small minority of participants came to Sweden alone. While the Polish IMGs received support from both family, employer and recruiter, Iraqi physicians would often have to rely on themselves and their kin while finding their footing in Sweden, navigating lengthier challenges and often living on meager social benefits and savings. While Dr. Malik may have efficiently cleared the obstacles to accessing the medical field, he asserts he would have not been able to do so if it was not for his spouse agreeing to hold down the fort while he threw himself into his studies. Apart from practical support, Dr. Malik emphasizes how a healthy and tranquil and caring family environment helps feed the resilience a refugee IMG needs. Dr. Malik says:

> The first year was disastrous. I was so stressed. My poor wife did everything. I did nothing. I just studied all day. We agreed that this was for our family's future, things will be better if we get into society as fast as possible. I could do it because of her. We haven't had any family issues yet; our family situation is calm. I think you have to make sure that everyone is happy at home, then we can perform better at work. Then everything becomes enjoyable. There is a lot of pressure in working in pathology in Sweden today, but it's fine, my sense wellbeing comes from home.

Like Dr. Malik, Dr. Fatima would also come to come rely on kinship as she struggled through the licensing process, but illustrating how the challenges of motherhood are not as easy to place on hold during the licensing process. Dr. Fatima and her husband, a fellow physician, were living at refugee reception center when they first started attending the government sponsored Swedish class, Swedish for Immigrants (SFI), taking turns caring for their daughter while the other went to class. Dr. Fatima was an exceptionally fast learner and quickly progressed to advanced levels but was also nearing the end of a pregnancy. Against the advice of her friends, Dr. Fatima stayed in class right up until delivery but was unsure how to continue with a newborn baby. Her teacher told her, "You must not worry. You can bring your child with you and come whenever you want. Please don't think of this baby as an obstacle for you." Dr. Fatima tried her best but felt like her son was a distraction for her and the other students. "I was lucky though," she says. Her mother had just arrived to seek asylum in Sweden and offered to babysit while Dr. Fatima went to class. "I would wake up early in the morning, breastfeed him and take the bus to school. I was there for two or three hours and then go back home to feed him because he refused the bottle during his first two months." After completing her language studies, she went on to finish the licensing requirements related to clinical skills and medical law coursework, and soon landed an internship. "The

Swedish Public Employment Service paid the fees," Dr. Fatima remembers. "I can't say that I have ever been let down during those years I studied here in Sweden. I appreciate us coming here."

In stark contrast to Dr. Malik and Dr. Fatima, Dr. Mustafa's case demonstrates how insurmountable the licensing process can feel for those IMGs who relocate alone and have difficulty mastering the language, illustrating the critical role of family support. Arriving as a single man, it took Dr. Mustafa nearly four years to acquire enough Swedish skills, pass the clinical knowledge and skills exam and probation period, obtain his medical license and finally start practicing. "Those years were so tough," he remembers. As described in the beginning of this chapter, he struggled to find an internship and having spent a lot of his savings on the smuggling industry, he could not afford the travel expenses that expanding his search further would entail. The longer the process of breaking into the medical field dragged on, the harder it was for Dr. Mustafa to ignore how other IMGs who were better situated seemed to be shoo-ins due to a combination of immigration pathways and social capital.

If kinship ties and support are crucial during the study period, making friends with locals and growing professional networks is key to securing clinical training positions and jobs for non-EU/EEA IMGs. "I needed help with connections," Dr. Mustafa says. "I met some doctors who came here to study, sponsored by their countries, and they got jobs right away. Or at least they got into the hospital environment and learned the language. Those people learned so fast." Dr. Mustafa also watched his European colleagues navigate the authorities with ease and somehow pick up Swedish faster (likely due to the classes provided for them through their recruiters). “Every society has its positives and negatives, this is the country we’re in and we’re guests so we shouldn’t complain,” he resigns. Still, he sounds exhausted when describing the skepticism, he continuously sensed from potential employers during those first few years, indicating that lacking language skills in refugee candidates can be used as a proxy for mistrust or xenophobia: “When they tell me I'm not getting the job because of the language… Okay, I know. I'm not perfect. But it’s other people causing problems in society. It’s not us, do you understand?”

Dr. Mustafa’s found himself in an unfortunate vicious circle in which non-EU/EEA IMGs (and immigrants in general) have trouble securing a job due to insufficient language skills, but then consequently miss out on possibilities to improve their Swedish in a hands-on environment (Wixie and Pettersson 2020). Importantly, social and geographical segregation produce and reproduce language barriers, limiting the opportunities for immigrants to practice their communication skills with native speakers and expand their social networks. This results in an accumulative disadvantage (McKenzie and Rapoport 2007; also see Bağcı 2019). “I had my friends, some family connections and eventually my brother came here,” Dr. Mustafa says. “But from the Swedish side, there wasn’t much help at all. If Sweden needs doctors, they have to help the doctors that are coming here.”

As Dr. Mustafa was unable to do what Dr. Malik described as “getting into society” in a timely manner, his motivation waned, and a sense of alienation grew. His case demonstrates that while belonging to a professional elite, being a doctor can end up being a challenge for a job seeking immigrant as it constitutes a gatekept, high-stake field in which employers are averse to any risk-taking that could lead to any miscommunications or misgivings between patient and healthcare provider — especially in areas where the physician shortfall is less severe. As demonstrated in previous chapters, industrial relations in the Swedish healthcare sector are also characterized by a strong union, making it extremely difficult for an employer to terminate an employee in a permanent position should they fail to live up to expectations. Non-EU/EEA IMG that has not been brought up through trusted recruitment pipelines have more to prove than their European peers.

The hesitation or ambivalence with which some Swedish employers handle non-EU/EEA IMGs also shows up in Dr. Mahmoud's case, a primary care physician. In 2016, he and his wife moved to Sweden from Ireland in order to care for her aging parents. More so than any other participant, Dr. Mahmoud found himself in a grey zone between EU/EEA and non-EU/EEA IMG pathways; his Iraqi wife had a European passport, but he did not. As Swedish employers are eager to hire European trained physicians who are eligible for automatic license validations, Dr. Mahmoud's wife quickly secured a job offer and by virtue of being her spouse, he received one too. "I didn't know how this was going to work out," he remembers. Dr. Mahmoud had accompanied his wife on a visit with her prospective manager when they hold him, "You have a job." He responded, "But I can't speak Swedish!" The manager said, "We'll figure it out, you'll get some language courses and all that." Before he could officially settle in Sweden, his European visa expired, and he was forced to leave his family in Sweden and travel to Jordan in order to apply for a Swedish work permit.

Not being an asylee nor a recruited IMG, Dr. Mahmoud found himself ineligible for any sponsored language coursework but had to pay out of pocket. His potential employer promised to reserve the position for Dr. Mahmoud if he was able to reach a level of Swedish in which he could start communicating somewhat independently (level B2) within 10 weeks. This would later be followed by another two-month period in which he had to complete the standard level of professional Swedish (level C1). Failing to pass his exams would jeopardize his employment and by extension, his work permit and legal residence. Dr. Mahmoud ultimately obtained his license and got the contract, but as he started working alongside recruited IMGs, he came to uncover all the perks they had enjoyed while he had been scrambling. He says:

> I didn't come through a recruiting company like the others. I didn't get any payments or anything upfront like they did. I did some digging, I know all the others, they got flight tickets, they're getting flight tickets. They got to take a Swedish course in Spain, but I got nothing. I was in between.

Iraqi IMGs Strategizing Around Disadvantage

The fact that EU/EEA IMGs are the norm was something Dr. Omar also got to experience as he went through the motions of getting licensed. He was resettled to a small town in the Dalsland region and after completing SFI, he struggled to find a teacher that could take him through the more advanced stages he needed. “They focused more on the students that needed more help with the basics,” he explains. “I only got maybe three hours of class per week.” Similar to Dr. Mahmoud, Dr. Omar also found himself in a grey zone, stuck between fellow refugees who needed more language support than him, and

EU/EEA physicians who went through other channels of obtaining Swedish proficiency. After having completed the “horrible exams” in clinical knowledge, he started looking for a rheumatology clinic where her could complete the six-month clinical training probation period but had difficulty finding one in his specialty. He contacted NBHW and his case worker at the local Swedish Public Employment Service office to ask for guidance, but either did not hear back or did not receive helpful answers. “They had no idea what to do with me,” Dr. Omar concludes. “They only had a plan for EU doctors.” Eventually, he managed to befriend a Swedish rheumatologist who sent him an e-mail listing all rheumatology clinics in the country, including all the manager names and contact information. “So, I sent twenty letters to all those clinics in Sweden. Then I got an offer from Danderyd, Lund and Jönköping,” again exemplifying the strength of weak ties that “getting into society” may entail.

Experiencing that one’s grasp of the Swedish language (and cultural literacy, by extension) is inadequate is a common sentiment among the Iraqi participants during their first year or two. Less so than their Polish peers, the Iraqis often compelled to be proactive about their learning process and continuously agree to leave any comfort zones in order to merge with the Swedish medical field — and society. Unwilling to waste any time being stuck in a refugee limbo, Dr. Malik’s family made the conscious decision to leave the capital for a smaller town up north, even if it meant leaving behind an Iraqi enclave. “If you stay in Stockholm, you’ll just hang out with other foreigners,” he explains. “You won’t merge with society, and that’s wrong. You have to integrate yourself, so we went to Umeå right away, and that was the right decision from the start.”

Already belonging to a more liberal religious minority in Iraq, Dr. Malik found his family “blended in well” in Sweden, with “no culture shock.”

Next to Dr. Malik, Dr. Hasan especially embodies this exceptional robustness, pulling himself up by his bootstraps while keeping an exceptionally positive attitude. He arrived in Sweden with his partner and baby daughter during the large Iraqi refugee reception of the early 2000’s, first deciding to move in with his sister in Stockholm. While others such as Dr. Fatima describes feeling anxiety or uncertainty waiting for the asylum decision, Dr. Hasan approached it with a sense of calm and faith. “We didn’t feel stressed. We didn’t worry at all about being rejected,” he says. Like Dr. Malik, Dr. Hasan’s family soon opted to move out in order to gain more exposure to Swedish instead of staying with his kin. “We wanted to start studying right away in order to get into the system and if you live with another family, then you end up socializing with just them. It didn’t work,” Dr. Hasan explains.

The Swedish Migration Board moved them to a small town where Dr. Hasan started buying milk from a local farmer, overpaying him as he felt the milk was underpriced. Taken by Dr. Hasan’s kindness, the farmer told him about a local meeting place where Swedes and immigrant families got together each week. “That was the first step, you just have to learn the language,” he asserts. “The most important day in Sweden is the day you start school.” The couple were eager to start SFI and soon impressed their teachers. “They noticed right away that we were both very serious, so they took extra good care of us. If I show that I'm new here and I want to integrate myself, people will welcome me. I’ve had an incredible sense of welcome in Sweden.” In a nutshell, this statement would come to symbolize all encounters throughout the couple's licensing process; their disarmingly outgoing nature continued to attract Swedish friends and connections that would come through for them with everything from babysitting to clinical training positions. It is also indicative of a more general dynamic in which incoming non-EU/EEA IMGs have to create their own luck in a space which tends to help those who help themselves.

Continued Context of Reception: Professional Development and Acculturation

Polish IMGs Navigating Swedish (Informal) Hierarchies

In theory, medical expertise can be understood as transnational by nature, constituting a global professional field. While this statement is complicated by barriers related to verification of credentials and relicensing procedures in many OECD countries around the world, intra-EU/EEA physician migration may be one of the most facilitated international spaces for IMGs due to its free movement and mutual recognition of medical diplomas and credentials. What remains, however, are context specific social norms and cultural variations that may impede or complicate IMGs' abilities to navigate encounters with employers, colleagues and patients in a new national setting (Boström and Öhlander 2011). After the dust settles following the arrival period, these local differences in which Swedish medical practice is embedded become more apparent to the Polish participants.

Although many were drawn to Sweden because of the country's reputation for egalitarian ideals (which recruitment companies eagerly reproduce), some still described struggling with adjusting to disruptions to traditional hierarchies among medical staff and the lack of formalities in the workplace. While Dr. Kamil finds his Swedish workplace to be accommodating and friendly, he describes carefully choosing his words and tone when talking to nurses so to not come off as dismissive or superior. “I’ve learned how to not step on anyone’s toes,” he says. Dr. Radek had previously professed his attraction to a work environment with a flat organization, but it still took him a while to adjust to its realities and having people approaching him with such familiarity. Transitioning from being director and chief of medicine in one of Poland’s major cities to working as a primary care physician in one of Sweden’s smallest healthcare centers in the rural north was not entirely seamless. He remembers:

> I had heard that things were different here, and they really are. Assistants, nurses and doctors, they are buddies here without hierarchy and I wanted that, but when I first got here it wasn’t easy, considering I was coming from this high position. I had to start over here, at one of the smallest centers in northern Sweden. Everyone is equal here, so if a nurse has something to say, I have to heed what she says. In Poland it’s so different. There they have to go by what I say. And it was also not easy having a five-year-old call me by my first name! In Poland we don’t do that, we address people formally always. Here it’s “you, you, you.”

What Dr. Radek refers to is a long-standing social interaction practice that was institutionalized in the 1960’s, known as “the thou-reform” (*Du-reformen*). During this process, the second-person singular pronoun, *du*, became the universal form of address in Sweden, replacing the third-person address system and setting aside virtually all formal titles and surnames both in the public and private sphere.[49] Dr. Aleksandra shares Dr.

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[49] While gaining full traction in the 1960’s, this reform came out of a long-standing Swedish movement initiated as early as the late 1800’s, aimed at toning down social hierarchies during interpersonal interactions.

Radek’s experience, but also explains how the reverence paid to physicians in Poland comes with a level of pressure that she would rather do without. “The social status of a physician is much higher in Poland than here,” she says. “You can’t say ‘Aleksandra’ to a doctor. It’s strictly forbidden, but at the same time, everyone expects a doctor to have a nicer car, nicer apartment, for them to go on fancy vacations to nice places. And it was the same in the US I think. But here in Sweden we’re all at the same level,” Dr. Aleksandra says, echoing the historical Swedish reputation and nation brand.

As many participants would uncover however, the absence of formal hierarchies in the Swedish workplace would not mean that hierarchies are non-existent, especially at larger hospitals. Instead, they soon often ran into informal and unspoken rules of engagement which could be even harder to decipher with less than perfect Swedish fluency. In addition, many found it extremely difficult to not being able to communicate their thought processes. “In Polish I can explain things, I can elaborate,” Dr. Radek says. “But in Swedish I wouldn’t know when I had done or said something wrong. So, it wasn’t easy in the beginning, but a good experience. I'm very content and I’ve been happy here from the start. But that’s also my personality, I'm happy even though there are problems.”

While Dr. Radek was able to focus on the positive, others struggled with feeling like their medical proficiency was equated to their level of their Swedish proficiency, like Dr. Piotr. In his experience, the label associated inadequate literacy (or aptitude) could be particularly sticky. He says:

> I'm sorry to say it but in the beginning, your competence is judged by your language skills. The longer you work somewhere and the more Swedish you pick

> up, the better it gets. But at the same time, you learn from the start that you're the one who doesn't know the language and even if you improve, you're still that same person. It's so hard to erase that image. They'll appreciate your competence with time. It's not the same for everyone, but for many. And patients are different too, some people don't even think about your competence, all that matters is your language, even after ten years in Sweden.

Dr. Piotr found that these prolonged anxieties had the effect of a self-fulfilling prophecy in which he would blank on the most basic medical knowledge, like how to treat tonsilitis. "It felt like I was losing medical competence," he remembers. In so called Balint groups[50] where physicians would come together and discuss their relationships with patients, Dr. Piotr realized many other IMGs felt the same way, overthinking each encounter in which language could be a problem. While he continues by asserting that he has had many "fantastic" Swedish colleagues who have fiercely defended him and other IMGs against patients who have refused to be seen by a foreign physician, he still maintains that the Swedish nation brand of harmonious equality is not a reality. "I came with an idea that everyone is super nice to each other and it's so perfect and honestly it's not perfect," he says. Dr. Piotr attests to seeing similar hierarchies, albeit on a smaller scale, and the same patient "archetypes" as he did at home — just with the added stressor of navigating them in a foreign language. "I have experienced Sweden being just like Poland," he concludes.

Dr. Kamila's account both diverges from and overlaps with Dr. Piotr's. Unlike him, she never perceived any discrimination from anyone, but saw her initial missteps and lack of knowledge of the Swedish system as normal. While in Poland she had been conditioned not to ask for help, she soon learned that her Swedish colleagues welcomed her questions. She remembers:

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[50] Named after Hungarian-British psychotherapist Michael Balint, Balint groups are small gatherings in which family physicians may safely discuss and reflect upon clinical encounters that were surprising, confusing or challenging.

> I never had any problems with my Swedish co-workers, they were always nice and supportive and eager to help if you only asked. In the beginning when I didn't understand or know everything, all I would have to do was ask them. In Poland it was the complete opposite. It was shameful if you didn't know something, and shameful to admit it. So yes, in the beginning it might have been a bit harder for us in the sense that we're not used to asking questions, but when you did ask you usually got a good explanation. So, I never experienced discrimination or any feelings of inadequacy. Sure, the first period was hard that way, not knowing being able to speak properly and not knowing all the rules and regulations, but in some ways it was just natural.

However, as Dr. Kamila transitioned from more communal, small healthcare centers in the north to prestigious university hospitals, she also faced hierarchies built on social and cultural capital. She explains:

> I said earlier that Poland has very clearly defined hierarchies and that's still true. In Sweden, there are no hierarchies in theory, but in practice there are. I didn't experience it very much in primary care but at the university hospital it's very pronounced. It's not official, but very palpable. In a city like Lund, there are generations of physician families that are firmly anchored to both the university and the hospital. It's very clear that it's an advantage to know certain people. It's a big facilitator.

There are also accounts of significant IMG contributions in clinical settings, demonstrating how national diversity among hospital staff may bring new perspectives and challenge old routines. Dr. Stanislaw remembers going against the directives of his supervisor on the very first day at a Swedish hospital, insisting on ordering a CAT scan for a patient and subsequently finding a tumor in their knee, which ultimately earned him a great deal of respect. In Dr. Stanislaw's experience, international teams are able to bypass Swedish cultural and social norms that tend to favor agreeability and consensus over debate and challenge. He says, “I’ve worked with people from Poland, Germany, Finland, France, lots of people. The discussions in the international teams are much better. There you can have different opinions.”

While most Polish participants felt they had to play catch-up with their native colleagues, many of them, like Dr. Kamila, would come to obtain leadership positions and opportunities for research and professional development. Enjoying free movement and work authorization, many would seek to optimize both their careers and leisure time even if it meant leaving the employer that had initially sponsored their recruitment. Still, it is clear that IMGs are less seasoned in the Swedish medical field than native physicians who tend to be more comfortable navigating the system to their benefit, allowing them to work smarter — not harder. While Dr. Alexandra appreciated the egalitarian spirit in her Swedish community, she also observed how a lack of institutional literacy in combination with a survivalist work ethic can put IMGs in situations where they end up agreeing to more work hours than their domestic colleagues. Dr. Alexandra says:

> Maybe what I'm about to say is not very popular, but I think Swedish colleagues know better how to exploit the system, so they don’t have to work as much. I feel a bit more like I have to. That I came here to work. I have to work, maybe I can’t say no as often. I have that feeling. We’re used to working hard, those of us who come from Poland or Czech Republic or other post-communist countries. We don’t think so much about holidays or taking advantage of life, we used to be quite poor, so we work to get by. In Poland there is no such thing as burnout. We’re more flexible.

Polish IMGs’ Social and Family Life

Although no participants admit to a firm division between themselves and Swedish doctors, the immigrant experience tended to bond IMGs together, perhaps especially

EU/EEA IMGs who have gone through recruitment. It is a reoccurring pattern for international relationships to be formed during the recruitment process where Polish physicians would make friends with classmates in the same Swedish course and maintain those relationships during and after the transition period. Some also formed IMG cliques in the workplace, built around a shared experience and a need to form new social connections in small, foreign towns. Dr. Kamila explains, “Us non-Swedish co-workers, we just understand each other a bit better. Because we came here in similar ways, and we had the same introduction and similar conditions.”

Furthermore, it is not uncommon for participants working at smaller healthcare centers to be in IMG majority, or even all IMGs, like at Dr. Anna’s clinic. “We’re all immigrant physicians, so everyone knows the path I'm on, they have taken it before me and they know how it feels,” she says, referring to the support she has been needing until she could work independently. Similarly, Dr. Kasia works with five other IMGs. “None of us are Swedes, we all talk with weird accents,” she explains. “We all make a lot of mistakes and sometimes I think they might be laughing at us a bit! But we have all Swedish nurses, and they are really great and helpful.”

While the Swedish nation brand may suggest niceties and inclusivity in the workplace and many attest to warm, supportive and even intimate working relationships with Swedes, few Polish participants found it to be easy to sustain connections outside of work. Dr. Antoni had been told by a friend who had come before him that, “The people are very helpful and open but there is a threshold you can’t get over. Or maybe, with time. You have to show that you are interested, that you want to connect.” While asserting that he has never felt left out at work, he admits, “We mostly spend time with other foreign physicians outside of work.” Similarly, Dr. Kasia cannot remember being invited into the home of any of her Swedish colleagues and the only other Polish or immigrant children her kids can play with at school belong to other IMGs.

As illustrated in previous sections, the wellbeing of children is a huge motivator for Polish physician migration to Sweden and is a major factor in IMG satisfaction. Three participants, Dr. Aleksandra and partnered couple Dr. Dorota and Dr. Jan, were faced with the heartbreaking challenge of having children suffer significant bullying in their new, rather homogenous small towns, making said parents seriously question their migration decision. The bullying concerned their older children whose adjustment to a new language and new social setting was not as seamless as for their younger siblings. While Dr. Jan and Dr. Dorota tried moving their daughter to a bigger school, Dr. Aleksandra and her family ultimately chose to return to Poland for their son’s sake. Still, Dr. Aleksandra still decided to keep a leg in Sweden and up until the start of the pandemic, she would still commute back to Sweden and spend a week per month at the clinic seeing her old patients and continued doing so virtually for a while longer after the onset of Covid-19.

What helps alleviate social hardships that IMGs and their families may face is local nature, access to family time and the generally friendly spirit that can characterize the Swedish countryside. Dr. Dorota and Dr. Jan savors their rich leisure time in the Swedish north and while Dr. Aleksandra found her situation to be challenging, she loved the relaxed atmosphere in the small community where her family had settled:

> I have only worked at this small-town healthcare center, and so people here are also different from the bigger city. So many I don't meet those who are a bit more high-performing, I don't know, but it so nice to just feel comfortable. I'll never forget this feeling.

In the same vein, Dr. Kasia says:

> The social part is difficult for us IMGS who are not from Sweden. But the country is not like that. We are so happy in our town. It's only 50,000 people, which is small with Polish measurements. We love the nature. It's perfect. There are so many lakes here and the forest and we have time to go for long walks. We can play with the kids outside, it's perfect for us.

Dr Anna had also fallen in love with her family's new home, in spite of living in a neighborhood where most of their neighbors were over eighty years old. "My kids are enjoying it to the fullest," she says. "When you are young, you want to go to restaurants and the movies and stuff. But when you start having kids, it's more important to have a place where they can play and run. The most important thing is that the kids are safe and happy." While traditional knowledge might suggest that cities are a more receptive places for highly skilled immigrants, Dr. Anna disagrees and echoes Dr. Aleksandra. "I find small towns to be more welcoming," she argues. "Everyone is so friendly and outgoing, it's not like the stereotype where no one talks to strangers. People are spontaneous and open, and we know each other's kids names and dog's names and talk about personal things. It feels like I've lived here a long time."

Iraqi IMGs' Capacities and Reliability in the Physician Shortfall

As previously established, Iraqi physicians migrate to Sweden with higher thresholds and with less buttressing than EU/EEA IMGs. It is in an employer's interest to keep the IMGs they invest in and prevent turnover, especially in underserved areas, and considering how the recruitment industry favors EU/EEA IMGs, they are effectively treated as a safer (or easier) bet. The fact is that there is no official data that establishes whether there is a difference in how frequently EU/EEA IMGs versus non-EU/EEA physicians change jobs, or if there is variation between domestic and immigrant physician turnover. However, some Iraqi participants reflect upon how their backgrounds have affected their sense of perseverance.

Dr. Hasan and Dr. Omar find that non-EU/EEA IMGs (predominately with refugee backgrounds) are less transient and more resilient than European physicians, who they describe as more inclined to focus on their professional development than the organization or their contribution to the physician shortfall. The two doctors are in management positions in different Swedish regions and have experience with being on the employer side of IMG recruitment, having supervised many Eastern and Central European residents. According to Dr. Hasan, they tend to lack both experience and cultural and institutional knowledge, in spite of the tailored introductory services that recruitment has afforded them. It follows that while the physician recruitment industry involves intensive education and training, the sheer pace of it might render some EU/EEA IMGs less prepared for Swedish medical practice than some of their non-EU/EEA IMG peers who have typically spent more time trying to integrate themselves into Swedish society before they have gained access to the medical field, not to mention having undergone a much more comprehensive licensing process. To this point, Dr. Fatima attests to the practical use of the mandatory coursework in Swedish medical language and systems assigned to non-EU/EEA IMGs, saying, “It took a long time, and it was hard, but it is so valuable. I draw on that knowledge all the time in my working life. We learned how to process administrative patient information efficiently, I wrote a thesis, we studied Swedish medical law, all in Swedish. It was very valuable, it still is."

While EU/EEA IMGs are still internationally recruited by eager employers and in clear majority among immigrant physicians in Sweden, Dr. Hasan and Dr. Omar illustrate how this preferential treatment may shift as non-EU/EEA IMGs gain more representation in leadership positions and hiring committees. Following their reasoning, this shift is not necessarily due to preferring one's own ethnic group, but to an observable sense of fickleness among European IMGs associated with their privilege of mobility and desire for self-realization — an attitude Dr. Omar and Dr. Hasan have a hard time accepting in the light of their own hard-earned success in the Swedish medical field and society. "It's so much work supervising them, they're often straight out of medical school, they have zero clinical experience," Dr. Hasan says. "They don't know Swedish society or the system. I talk to them as if they were my children." As indicated in previous sections, the combination of Swedish generous industrial relations with their extensive worker rights, free movement within the EU, and the transnational nature of the medical field puts EU/EEA IMGs in a strong bargaining position in any underserved area, in spite of their eventual shortcomings. Dr. Hasan continues:

> I sit down with them and show them how to do absolutely everything. But as soon as they have found their footing, they take off and go to big cities. I've had four now and I've had enough. There is something wrong with the system, that you are not allowed to demand of them to stay, then it's considered indentured labor. But we pay for their 6-month language education, and we pay them a salary while they study. We hire them before they enroll in the class, so we pay them while they aren't even here, they aren't seeing any patients. So, we pay for both their tuition and salary. And when they get here, they still barely speak Swedish, and

> they lack clinical experience. That means I have to devote 50% of my time to each one of them I supervise.

Dr. Omar very much shares Dr. Hasan's frustrations. In Dr. Omar's team of colleagues at a rheumatology department, they had come to collectively observe how residents from Europe took advantage of the availability of training spots in Sweden only to leave the hospital after obtaining their specialty, returning to their home countries or other more prestigious destinations, like the UK. It happened so frequently that if given a choice to decide between an EU/EEA physician and a residency candidate from outside the European Union, Dr. Omar and his co-workers would lean against the latter. He explains:

> In some European countries, it can take ten years to get into a residency program. Here, you can get a position in months. And then after three years or five years, you can return home or go somewhere else. If we put our efforts into training a resident for five years, we want them to stay here, at our hospital or in Sweden. But medicine is an international field so you can't hold people back. But still, that's what you want, with this shortfall and these workloads, you want people to stay. We've recruited five [EU/EEA IMGs] here that we've been struggling to keep for several years, just trying to find someone to help us out here. But they have all moved. So that's one reason. The other reason is that non-European doctors are a bit more patient and handle stress better. Sometimes they're just better.

Dr. Omar traces Iraqi or refugee IMGs stress management skills to their experience with working in less wealthy countries and seeing up to eighty or a hundred patients per day, being responsible for large regions but with fewer administrative burdens and less pressure to do everything by the book. To this point, Dr. Malik says, "Doctors just more practiced in clinical work in Iraq than they are here, some European doctors get too much into academics."

Importantly, IMGs with a larger capacity for heavier workloads are not necessarily encouraged to sustain them, considering Swedish employers' accountability towards labor union agreements. While many Polish physicians chose Sweden because of its slower pace, some Iraqi physicians were not fully prepared for it. When Dr. Mahmoud had recently arrived from the UK, he found himself baffled by the social practice of *fika*, a brief communal mid-morning and mid-afternoon coffee break that is institutionalized at a vast majority of Swedish workplaces. He says:

> When I first moved here I found this fika really interesting. I couldn't understand because when I worked in Britain, we usually see 40 patients a day. There is no lunch, there is no rest. We can eat and meet the patients at the same time. Over here, my boss knocked on my door. "It's 9:30, come on." I said, "No, not going. I don't want to go." He said, "Yes, you have to." I don't understand this. Why are we doing this? Now, I love the fika practice.

Obligatory coffee breaks aside, Iraqi participants still share their Polish peers' observations regarding how Swedish colleagues are superior at navigating local industrial relations. While Dr. Zayn never struggled making friendly connections with co-workers of all nationalities, he noticed how IMGs would end up compensating for Swedish doctors' clever strategizing around keeping their workloads light and their free time optimized. He says:

> They know how to avoid certain difficult situations, how to plan their vacation time and parental leave without any financial losses and how to take time off when the workloads are the heaviest. They know all these tips and tricks from the start. So, you have to learn to separate what is your responsibility and what isn't and stick to your schedule and say you don't have time, otherwise it's a slippery slope and if you say yes to everyone you'll get taken advantage of. To earn the respect as a doctor from Swedish co-workers, you have to show that you are indispensable and that you know more than others. Then you'll get status, then you have leverage. You have to prove that they need you more than you need them. Then you feel more comfortable.

Iraqi IMGs Navigating Cultural Differences and Microaggressions

While Iraqi IMGs clearly have a lot to offer the Swedish medical field and its underserved areas, they also find themselves grappling with its foreign cultural components. In comparison to Iraq, a Swedish workplace entails more unspoken rules related to both work and free time, as Dr. Mahmoud and Dr. Zayn would attest. Although Dr. Mahmoud learned to appreciate the mandated breaks throughout the workday, he laments how responsibility for follow-ups lies too much with physicians than with patients themselves, mandating a kind of handholding he is not used to. He is not alone in this sentiment; Dr. Leyla also describes feeling compelled to mitigate patient anxieties — a general phenomenon associated with Swedish healthcare culture that Iraqis usually have to discover and adjust to on their own accord. While Dr. Fatima appreciated the concrete lessons from licensing exams and coursework, they seem to contain little information on the social norms that govern doctor-patient interaction. To Polish Dr. Antoni's earlier point about many non-EU/EEA IMGs missing out important lessons in cultural literacy that was afforded to recruited IMGs in his particular county,[51] Dr. Layla was unprepared for the emotional labor that characterize Swedish medical practice. She says:

> Even if you pass all the licensing exams, it doesn't prepare you for reality. You have to explain so much to the patients and it can be tiring for a physician. They worry a lot, the patients, and it's your job to handle it and mitigate it. It's a cultural difference I had no idea about. We're much more direct. Swedish and Middle Eastern culture have nothing in common.

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[51] There is an overrepresentation of Polish IMGs who attended this post-arrival additional education program in this study, given that a large part of the recruitment took part in the particular county council that offer it. County councils and regions that recruit fewer IMGs tend to have fewer such resources.

On the topic of cultural differences, Iraqi participants pick up on many of the same dynamics their Polish peers observe: seemingly flat organizations underpinned by informal hierarchies; the lack of reverence paid to medical doctors; the importance of choosing your words carefully and thoughtfully when interacting with patients and co-workers of all ranks; the occasional mistrusting patient asking for a Swedish doctor; the relative difficulty to break into Swedish social circles. Far from all Iraqi participants report being subject to overt workplace discrimination. Still, it is on brand with Swedish indirectness for discrimination and xenophobia to be intangible and elusive, taking the form of microaggressions and what Eduardo Bonilla-Silva refers to as "racism without racists" (2006). Dr Zayn exemplifies how some may make the decision (consciously or subconsciously) to not process it in order to remain functional. He says:

> Discrimination happens. I don't have anything concrete, but it's a feeling, a gut feeling. Maybe I avoid digging into it because it's a way to distance myself from it. I can't take everything in, I filter things out, otherwise it gets hard to carry on. Maybe it's subconscious.

An important difference between the discrimination that Polish or European IMGs face in comparison to Iraqis is how the latter group is targeted by racialized anti-immigrant sentiment, Islamophobia and right-wing nativist (and even neo-Nazi) politics that have long been on steady incline in Europe. The ambitious and resilient Dr. Hasan maintains that he has received the same positive energy he has put out, but also indicates that belonging to a diverse immigrant group with a large influx can make members of the host society more apprehensive — or culturally racist. "I've always felt welcomed. But since 2001, it's gotten different because there are so many people coming, several thousands and more and more," he says. "There are people that are good and people that are less good, of course people are different. But I've been received in an incredible way." Among all participants, Dr. Omar bears the most concrete witness of a colleague expressing resentment against immigrants for taking up space or behaving in a way that violates Swedish social norms. Like Dr. Zayn, Dr. Omar is reluctant to register microaggressions and prefers to give people the benefit of the doubt but was shocked and deeply hurt by a comment his colleague made while showing him around a town he had just transitioned to. Dr. Omar remembers:

> I don't take things in because you never know what people have been through in life, but I remember one disastrous incident, or at least it wasn't kind. A co-worker was showing me the beach and said he used to come here a lot with his wife, but that he hasn't been there for the last ten years. I asked him why and he clearly said it was because of all these immigrant families coming there and their kids yelling and screaming and making the beach messy. Then he went on advising me to not go to certain immigrant neighborhoods. What am I supposed to say to that? But like I said, you never know what kinds of experiences or traumas people might have.

Importantly, this interaction evokes the racist trope of "I don't mean *you:*" a situation when a microaggressor insults an ethnic group to one of its members, conceptualizing the recipient as a model immigrant and assuming that they identify more with the white mainstream than other members of their race, ethnicity or background. It exemplifies the intersection of racism and classism, as Dr. Omar's colleague seemed to disaggregate him from "other immigrants" based on his status of being a working physician and thereby worthy of insider status.

Although they face plenty of difficulties (or in some cases, injustices) on multiple levels, most Iraqi participants remain committed to appreciate what they can and block out what they cannot, as exemplified above. While Polish IMGs had been promised a virtual physician paradise in a more overt way by eager recruiters, Iraqi participants had no such concrete promises apart from the second-hand information passed on to them through refugee networks. Furthermore, their reasons for coming to Sweden was contingent upon much more than the medical field. As such, Iraqis have been practicing expectation management from the start and none of them were or are actively considering leaving Sweden as a result of any professional or personal challenges. When Polish IMGs rely on Swedish nature when the going gets tough, their Iraqi peers emphasize the institutional safety and stability that was not available to them in their departure countries. Dr. Malik says, “You have to start somewhere. You have to suffer a bit to make a better future for yourself and your family. I'm a bit surprised when people sweat the small stuff — safety is number one.” Dr. Zayn expresses a similar sentiment; coming from a privileged background with a big house, private chauffer and housekeeper, he found himself slowly veering towards the political left after observing the benefits of Swedish welfare system from the inside. He says:

> I knew about the equality, the independence, how society was more favorable to women, but I didn’t fully understand the economy and the taxes shocked me at first. You finally start earning money and then so much is withheld, but then you see how many possibilities are given to your children in school and outside of school and so you accept that part. If you fall ill, you’ll receive healthcare, so I’ve become a *sosse,*[52] a social democrat more than anything. I don’t vote bourgeoise.

In this sense, the Swedish social safety net is a significant counterweight to any interpersonal difficulties Iraqi IMGs experience in Sweden. In. Dr. Zayn’s case, it also seems to have served as an assimilating factor as he echoes a master narrative associated with the Swedish nation brand.

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[52] Swedish slang for social democrat.

Conclusion

The IMG norm in Sweden is largely European, largely due to mutual recognition of medical credentials, free movement and the physician recruitment industry. AS EU/EEA physicians have the lowest thresholds to immigrating to and working in Sweden, Swedish employers and recruitment companies choose the path of least resistance by investing in them over non-EU/EEA IMGs. For Polish doctors, recruitment companies are significant producer of a Swedish nation brand associated with work/life balance, family friendliness, professional development and a fulfilling life outside of work. This industry is persuasive by nature, actively seeking and "courting" European IMGs and specialists, using the Swedish nation brand as a part of a marketing strategy. This approach sets expectations high among Polish IMGs and many migrate with the intention of returning or going elsewhere if life in Sweden is not fulfilling. To Iraqi IMGs, the Swedish nation brand is disseminated through refugee networks, representing safety, opportunity and equality. To some, Sweden was merely one of very few countries accepting refugees.

While Iraqi IMGs often had to pay steep fees to the smuggling industry in order to reach Sweden, Polish IMGs are effectively brought there free of charge courtesy of recruitment companies and Swedish employers, providing them with tailored language classes and relocation support. Once asylum is obtained, Polish and Iraqi IMGs both enjoy permanent legal residence and mobility. Iraqi IMGs receive language and refugee resettlement support from the government and have to obtain medical relicensing through exams, coursework and probational or supplemental training. They also have to find and apply for their own internship and/or residency positions. Both Polish and Iraqi IMGs suggest that they work harder than domestic physicians and are less inclined (or able) to optimize their free time, but some Iraqi participants that European physicians are less reliable in physician shortfalls as they tend to prioritize professional advancement over the organization that recruited them.

Comparing Polish and Iraqi IMG experiences highlights the significance of labor migrant versus refugee distinctions. Their pathways to Sweden are separated by both different migration industries and visa regimes and by different licensing procedures, creating a formal hierarchy. While the reason why Sweden gives preferential treatment to IMGs from other EU/EEA member states may be rooted in international agreements, I show that it is also entangled with broader notions of cultural differences and race relations in the European context. As such, it risks reproducing professional, cultural, and racial segregation between ethnic Europeans and non-European immigrants.

Physician nationality	(n)	**Predominant immigrant category**	**Predominant immigration pathways**	**Main resources**	**Obstacles**
Polish	(20)	Labor migrant	Free mobility within EU/EEA facilitated by recruitment industry	Recruitment services, employer support	Language barrier, informal hierarchies
Iraqi	(10)	Refugee or asylee	Limited mobility overcome with the smuggling industry → asylum	Family support, some community support	Language barrier, relicensing requirements

Table 8. Swedish IMG Pathways

CHAPTER SIX: CONCLUSION

By comparing the US to Sweden, this study has illustrated how the international physician labor market holds different nation brands that play important roles in attracting IMGs with different motivations to different kinds of political economies. Examining what different nation brands represent to IMGs provides insight into their expectations of each host society — and of themselves as immigrant professionals in each country. I argue that IMG interpretations of nation brands will influence how they perceive their context of reception, affecting their sense of valence and level of satisfaction. In addition, visa regimes and migration industries are significant factors in either impeding or facilitating physician migration, ultimately having a crucial effect on physician shortfalls.

In the first chapter, I situate the comparison within the theoretical framework of varieties of capitalism, categorizing Sweden as a coordinated market economy (CME) and the US as a liberal market economy (LME). By comparing their spheres of industrial relations and vocational training, I examine how each country has developed a physician shortfall, the discourse around the issue and the role that immigrants have come to play in it. This chapter also highlights the distinct characteristics of each national medical field that form the basis for each nation's brand. The following two chapters are based on empirical interview data outlining IMG perceptions of the US versus Swedish nation brand and their experiences in each context of reception. In the US case, I argue that while licensing requirements are the same for IMGs regardless of national background, social and cultural capital related to network migration gives Indian IMGs a clear advantage over Iraqi refugee IMGs when it comes to navigating access to the US medical field. However, their roles are reversed when it comes to US immigration — restrictive visa regimes and green card backlogs impede Indian long-term settlement while their Iraqi refugee colleagues are typically set upon a path to permanent residence status either before or shortly after arrival.

The US medical field is associated with world-class technological advances, innovation and exceptional training opportunities, and so most IMGs accept challenges and steep competition as implicit components of the US brand. Paradoxically, IMGs pursuing a career in the US because of its exceptional opportunities are statistically unlikely to reach the same levels of professional status as their domestic colleagues. The US does not recognize foreign specializations and requires all IMGs to go through the Match, which disproportionately tends to sort IMGs into primary care residency programs. In the US case, IMGs both Indians and Iraqis are well aware of the disadvantage that they have in relation to domestic graduates. However, they seem to reflect very little upon any internal hierarchies among IMG groups or nationalities. This could be explained by the fact that the licensing requirements are the same for all IMGs in the US and that the disadvantages that refugee IMGs (or any IMG group with fewer economic resources and socio-cultural toolkits) face are played out in the private sphere. Resources or disadvantages rooted in family relations, family money or social networks are not easily discerned from the outside or openly discussed in professional settings. In addition, the brand of the US medical field is not associated with fairness or equal opportunity, and therefore does not easily lend itself to such critiques.

This is in contrast to the Swedish case, in which the segmentation between EU/EEA IMGs and non-EU/EEA is openly codified in relicensing procedures, creating a delineation not just between domestic and immigrant physicians, but also a subdivision within the collective group of IMGs. In Sweden, hierarchies among IMGs are produced by EU/EEA membership, in which Polish physicians are allowed relatively open access to both Swedish medicine and society while Iraqi IMGs face a longer road, both in terms of coming to Sweden and breaking into the medical field. This stratification is exacerbated by a migration industry of active intra-EU/EEA physician recruitment from Poland to Sweden while IMGs of refugee backgrounds make use of the smuggling industry in order to reach Sweden as asylum seekers. If the US system produces informal hierarchies between IMGs and domestic medical graduates, the Swedish case represents a three-tier order where non-EU/EEA IMGs are the most disadvantaged. Even though their path to licensing may be comparatively less expensive and precarious than its US equivalent,[53] it can breed a sense of injustice or inferiority that clashes with the Swedish nation brand of egalitarianism. While the difference in licensing procedures may rest on an appropriate rationale well-anchored in EU/EEA guidelines and legal systems, the subgrouping emulates racial color lines between ethnic and non-ethnic Europeans, inadvertently serving as a mechanism of subordination for non-EU/EEA physicians from regions such as MENA. Still, the right to free movement also creates a mentality of lower investment associated with migration, potentially making Polish IMGs harder for the Swedish labor market to retain than their Iraqi colleagues.

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[53] While some of the Iraqi participants in the US case were still struggling to become licensed specialists and had taken up alternative temporary careers, none of their co-nationals in the Swedish case ever considered not being a doctor or going into a specialty different from their original one . Neither did anyone tell them to consider alternative careers due to the difficulties of breaking into the medical field, as some US Iraqis described.

IMG host country	Nation brand	Significant producers of nation brand	Nation brand effects	Vitality of nation brand
The US	Advanced technology, cutting-edge innovation, high financial compensation, “the best of the best”	Medical schools, media/popular culture, successful IMGs	IMGs expect little to no institutional support, obstacles and challenges perceived as implicit in the brand	Relatively strong, but undermined by visa regime and segmentation between US MGs and IMGs
Sweden	Work-life balance, family friendly, opportunity for professional development, egalitarian work culture	Recruitment company industry, happily recruited IMGs, settled asylees	IMGs expect more support, obstacles and challenges perceived as injustices or incompatible with nation brand	Relatively strong, but undermined by informal hierarchies and language barriers

Table 9. Nation Brand Comparison

Contexts of reception	Recognition of specialist certifications	Cost of relicensing/ license validation	Institutional support	Community support	Access to permanent resident status	Level of individual commitment required (relative)	Risk of return migration
Indian IMGs (US)	No	High	Low	High	Impeded	Medium	Low
Iraqi IMGs (US)	No	High	Low	Medium	Available	High	Low
Polish IMGs (Sweden)	Yes	Low	High	Medium	Automatic	Low	High
Iraqi IMGs (Sweden)	Partial	Medium	Medium	Medium	Available	High	Low

Table 10. Contexts of Reception Comparison

Policy Recommendations

While staffing rural areas with physicians has been a universal challenge for centuries (Bonner 2000), several studies suggest that the physician shortfall is becoming particularly dire in the wake of the global pandemic and that it is more important than ever to amplify the voices of healthcare workers globally. In April 2022, Forbes Magazine featured a mixed methods report titled Clinician of the Future published by Elsevier earlier that same year. The report shows some alarming survey results, including that 31% of clinicians globally and 47% of US healthcare professionals plan to leave their current position within the next two to three years. Furthermore, over 74% of doctors describe a growing concern for the physician shortfall (Goodchild et al. 2022). Considering the crucial role the IMGs play in this deteriorating situation, their perspectives are vital when establishing directions for the future.

Recommendations for the US

I offer policy recommendations that are both ideological and concrete. On an ideological level, I urge decision makers to divert investment into primary care and reevaluate policies and narratives that reproduce hierarchies among medical specialties and the healthcare field in general. The general focus of the US medical field is on superior elements related to technology, research and innovation — all linked to urban spaces such as university hospitals and research centers. It follows that the nation brand that IMGs consume is disconnected from what US healthcare system seem to need, which is a stronger emphasis on public health, health equity, and more sustainable working conditions. Without a conceptual shift in which rural spaces (and patients of lesser socioeconomic status) are deemed more deserving of medical infrastructure and investment, physician retention in underserved areas will remain chronically difficult with regards to both domestic and internationally trained doctors. While the current push for the development of telehealth is important, it cannot replace access to in-person care for some of the country's most vulnerable populations.

On a practical level, reforming the US visa regime and medical residency policy could provide a more favorable climate for IMGs. While a vast majority of IMGs have strong immigrant intent, they are predominately on non-immigrant visas with no guaranteed path to legal permanent residence. The IMG intent to migrate is especially clear in the Indian case, with whole cohorts having their sights set on a career in the US, to the extent to which they are not even prepared for post-graduate training in India. As the H-1B visa has become more unavailable, they use springboard visas such as J-1 or F-1 which explicitly require that applicants state that they have no immigrant intent in order to be approved. A clear path to legal permanent residence is important to IMGs; it impacts their ability to plan a future for themselves and their families,[54] as well as their ability to serve their communities long-term.

Another deterrent is the US medical residency policy. The fact that the US does not recognize foreign specialist certifications discourages more experienced IMGs who are unwilling to redo their specialist training or risk losing their specialty altogether if not being able to match into it again in the US context. Many prestigious specialties, particularly surgical ones, are very difficult for IMGs to match into. Notably, the US visa regime and residency policy deterred many Polish participants and some Indian participants described choosing the US destination only because they had family who were able to sponsor green cards or H-4 visas (H-1B visa holder spouse/dependent). Together, these two policies render the US less accessible to more established IMGs with families that could otherwise contribute with significant experience and skillsets. Instead, the current US system favors ambitious, well-prepared IMGs straight out of medical school, often of high socioeconomic status.

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[54] Children over the age of 18 cannot be sponsored by H-1B, J-1 of F-1 visa holders.

Recommendations for Sweden

In Sweden, hierarchies are not as openly produced among medical specialties — salary discrepancies are smaller and residency trainings are the same length regardless of specialty and the country does not have any equivalent of the Match or Match Day. Instead, residency positions are posted like regular job ads online and with employment agencies on a rolling basis and there are no well documented phenomena in which IMGs are consistently impeded from obtaining certain prestigious specialties as in the US case. Still, language barriers and other structural obstacles can put IMGs at a disadvantage.

Sweden has taken multiple steps towards creating a more favorable climate for EU/EEA IMGs, such as the provision of language classes, additional educational programs, and holistic family support. The main challenge for retaining EU/EEA IMGs lies with managing expectations during the recruitment process and not romanticize Swedish conditions. Instead, IMGs should be informed of the existence of informal hierarchies and how to navigate them without simply assimilating. Participants in this study highlight the benefit of open discussion among physicians from different countries and cultures and this may constitute an untapped resource for Swedish employers and healthcare in general.

There has also been some streamlining in the licensing process for non-European IMGs, but the clinical knowledge exam held at Umeå University has received sharp critique from the medical community for being too difficult and including questions that require specialist and research knowledge. According to administrators, only around 20% pass the exam on their first try and around half pass after three attempts. IMGs who fail the test will sometimes leave Sweden for other European countries with easier exams. In February 2021, 230 physicians signed a petition to reform the exam, asserting that they will boycott and demonstrate against upcoming tests (Ström 2021b, also see 2021c). Along with these protestors, I urge NHBW to review the clinical knowledge exam and remove sections and questions that are not level appropriate.

I also suggest increased use of domestic physician recruitment of healthcare staff that specifically targets immigrant populations such as refugees, creating a similar pipeline between arrival and employment. These recruiters could provide guidance through licensing requirements, tailored language and educational programs, and important connections with both employers and other IMGs. If successful, these agencies and networks could also facilitate physician migration to Sweden from outside of Europe.

BIBLIOGRAPHY

AAMC. 2022. “The Cost of Interviewing for Residency.” Retrieved August 31, 2022 (https://students-residents.aamc.org/financial-aid-resources/cost-interviewing-residency).

Abu-Ras, Wahiba, Farid Senzai, and Lance Laird. 2013."American Muslim Physicians’ Experiences Since 9/11: Cultural Trauma and the Formation of Islamic Identity." *Traumatology* 19(1): 11–19.

Agerberg, Miki. 2013. “’Deltid För Att Behålla Arbetsglädjen.’” Läkartidningen May 21. Retrieved December 8, 2021 (https://lakartidningen.se/aktuellt/nyheter/2013/05/deltid-for-att-behalla-arbetsgladjen/).

Agerström, Jens, and Dan-Olof Rooth. 2009. “Implicit Prejudice and Ethnic Minorities: Arab-Muslims in Sweden.” *International Journal of Manpower* 30(1/2): 43–55.

Ahmad, Omar B. 2005. “Managing Medical Migration from Poor Countries. *BMJ: British Medical Journal* 331(7507): 43–45.

Ahmed, Awad A, Wei-Ting Hwang, Charles R. Thomas, Jr, Curtiland Deville, Jr. 2018. “International Medical Graduates in the US Physician Workforce and Graduate Medical Education: Current and Historical Trends.” *Journal of Graduate Medical Education* 10(2): 214–218.

American Immigration Council. 2018. *Foreign-Trained Doctors are Critical to Serving Many US Communities.* Washington DC: American Immigration Council. Retrieved March 4, 2019 (https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf).

American Medical Association. 2021. *AMA Fact Sheet on its Decade of Membership Growth.* Chicago, IL: American Medical Association. Retrieved February 2, 2023 (https://www.ama-assn.org/system/files/2021-06/ama-10-years-2021-fact-sheet.pdf).

American Medical Association. 2022. “International Medical Graduates (IMG) Recognition Week” AMA-ASSN.org, October 21. Retrieved February 2, 2023 (https://www.ama-assn.org/member-groups-sections/international-medical-graduates/international-medical-graduates-img).

Al Ashry, Haitham S., Viren Kaul, and Jeremy B. Richards. 2019. “The Implications of the Current Visa System for Foreign Medical Graduates During and After

Graduate Medical Education Training." *Journal of General Internal Medicine* 34(7): 1337–1341.

Albadri, Zeyad and Magnus Mattson-Mårn. 2019. "Wake Up and Smell the Coffee! You are in Sweden Now." *Tidsskrift för Svensk Förening för Allmänmedicin* 2(40): 49–50.

Alshareef, Musab, Osama Mobaireek, Mohamud Mohamud, Ziyad Alrajhi, Ali Alhamdan and Bashir Hamad. 2018. "Decision Makers' Perspectives on the Language of Instruction in Medicine in Saudi Arabia: A Qualitative Study." *Health Professions Education* 4(4): 308–316.

Alvaredo, Facundo, Lucas Chancel, Thomas Piketty, Emmanuel Saez and Gabriel Zucman. 2017. "World Inequality Report 2018: Executive Summary." Paris, France: World Inequality Lab. Retrieved April 8, 2019. (https://wir2018.wid.world/files/download/wir2018-summary-english.pdf)

Anell Anders, Anna H. Glenngård, and Sherry Merkur. 2012. "Sweden: Health System Review." *Health Systems in Transition* 14(5): 1–159.

Arango, Joaquin. 2000. "Explaining Migration: A Critical View." *International Social Science Journal* 52(165): 283–296.

Aronczyk, Melissa. 2019. "Branding National Identity in an Unequal World." Pp 439–457 in *The Oxford Handbook of Consumption*, edited by F. F. Wherry and I. Woodward. Oxford, UK: Oxford University Press.

Åsgård, Samuel. 2017. "Läkarutbildningen Byggs Ut." *Dagens Medicin,* September 13. Retrieved November 13, 2021 (https://www.dagensmedicin.se/alla-nyheter/nyheter/lakarutbildningen-byggs-ut/).

Atkinson, R., and Flint, J. 2001. "Accessing Hidden and Hard-to-Reach Populations: Snowball Research Strategies." *Social Research Update* 33(1): 1–4.

Auerbach, David I., Peggy G. Chen, Mark F. Friedberg, Rachel Reid, Christopher Lau, Peter I. Buerhaus and Ateev Mehrotra. 2013. "Nurse-Managed Health Centers and Patient-Centered Medical Homes Could Mitigate Expected Primary Care Physician Shortage." *Health Affairs* 32(11): 1933–1941.

Aygül, Cenk. 2013. "Visa Regimes as Power: The Cases of the EU and Turkey. *Alternatives* 38(4): 321–337.

Baer, Leonard D., Thomas C. Ricketts, Thomas R. Konrad and Stephen S. Mick. 1998. "Do International Medical Graduates Reduce Rural Physician Shortages?" *Medical Care* 36(11): 1534–1544.

Bağcı, Şükrü Erhan. 2019. “Migration and Participation in Adult Education: The Matthew Effect on Immigrants.” *Adult Education Quarterly* 69(4): 271–294.

Balestra, Carlotta and Richard Tonkin. 2018. “Inequalities in Household Wealth Across OECD Countries: Evidence from the OECD Wealth Distribution Database.” OECD Statistics and Data Directorate. Paris, France: Organisation for Economic Co-operation and Development. Retrieved April 8, 2019 (http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=SDD/DOC(2018)1&docLanguage=En).

Bandelj, Nina, and Frederick F. Wherry, eds. 2011. *The Cultural Wealth of Nations.* Redwood City, CA: Stanford University Press.

Banerjee, Payal. 2010. “Transnational Subcontracting, Indian IT Workers, and the US. Visa System.” *Women’s Studies Quarterly* 38(1/2): 89–110.

Barr, Donald A. 2014. *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health.* Baltimore, MD: John Hopkins University Press.

Bauböck, Rainer. 2005. “Expansive Citizenship: Voting Beyond Territory and Membership.” *Political Science and Politics* 38(4): 683–687.

Bauer, Thomas and Klaus F. Zimmermann. 1999. *Assessment of Possible Migration Pressure and its Labor Market Impact Following EU Enlargement to Central and Eastern Europe.* London, UK: Department of Education and Employment; Bonn, DE: IZA (https://legacy.iza.org/en/webcontent/publications/reports/report_pdfs/report_pdfs/iza_report_03.pdf).

Berbyuk, Natalya, Jens Allwood and Charlotte Edebäck. 2005. “Being a Non-Swedish Physician in Sweden: A Comparison of the Views on Work Related Communication of Non-Swedish Physicians and Swedish Health Care Personnel.” *Journal of Intercultural Communication* (8):1404–1634.

Berk, Marc L. 1985. “Interviewing Physicians: The Effect of Improved Response Rate.” *American Journal of Public Health* 75(11): 1338–1340.

Bernstein, Judith H., and Judith T. Shuval. 1998. "The Occupational Integration of Former Soviet Physicians in Israel." *Social Science & Medicine* 47(6): 809–819.

Bier, David J. 2022. “1.4 Million Skilled Immigrants in Employment-Based Green Card Backlogs in 2021.” *Cato Institute,* March 8. Retrieved September 2, 2022 (https://www.cato.org/blog/14-million-skilled-immigrants-employment-based-green-card-backlogs-2021).

Björkman, Annica, Maria Engström, Ulrika Winblad, and Inger K. Holmström. 2021. ”Malpractice Claimed Calls Within the Swedish Healthcare Direct: A Descriptive–Comparative Case Study.” *BMC Nursing* 20(1): 1–8.

Bleakley, Hoyt, and Aimee Chin. 2010. “Age at Arrival, English Proficiency, and Social Assimilation Among US Immigrants.” *American Economic Journal: Applied Economics* 2(1): 165–192.

Bodenheimer, Thomas S., and Mark D. Smith. 2013. ”Primary Care: Proposed Solutions to the Physician Shortage Without Training More Physicians.” *Health Affairs* 32(11): 1881–1886.

Boeri, Tito and Herbert Brücker. 2005. “Why Are Europeans So Tough On Migrants?” *Economic Policy* 20(44): 630–703.

Boeri, Tito, Herbert Brücker, Frédéric Docquier and Hillel Rapoport. 2012. *Brain Drain and Brain Gain the Global Competition to Attract High-Skilled Migrants.* Oxford, UK: Oxford University Press.

Bohlen, Celestine. 2019. “Sweden Provides Some Perspective on Women and Equality.” *The New York Times,* March 8. Retrieved April 8, 2019 (https://www.nytimes.com/2019/03/08/world/europe/sweden-women-equal-representation.html).

Bonilla-Silva, Eduardo. 2004. From Bi-Racial to Tri-Racial: Towards a New System of Racial Stratification in the USA. *Ethnic and Racial Studies* 27(6): 931–950.

Bonilla-Silva, Eduardo. 2006. *Racism Without Racists: Color-Blind Racism and the Persistence of Racial Inequality in the United States.* Lanham, MD: Rowman & Littlefield Publishers.

Bonner, Thomas Neville. 2000. *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750–1945*. Baltimore, MD and London, UK: JHU Press.

Bookman, Kelly, and Richard D. Zane. 2020. “Surviving a Medical Malpractice Lawsuit.” *Emergency Medicine Clinics of North America* 38(2): 539–548.

Bosniak, Linda. 2000. “Citizenship Denationalized.” *Indiana Journal of Global Legal Studies* 7(2): 447–510.

Boström, Katarzyna Wolanik, and Magnus Öhlander. 2011. ”Polska Läkare i Sverige. Om Läkarroll, Status och Kulturella Processer.” *Socialmedicinsk Tidskrift* 88(3): 273–281.

Boström, Katarzyna Wolanik, and Magnus Öhlander. 2015. “Mobile Physicians Making Sense of Culture.” *Ethnologia Europaea* 45(1): 7–24.

Bourdieu, Pierre. 1985. “The Social Space and the Genesis of Groups.” *Information (International Social Science Council)* 24(2): 195–220.

Bourdieu, Pierre. 1990. *The Logic of Practice.* Redwood City, CA: Stanford University Press.

Breimer, Lars. 2019. “Sluta Utbilda På Tok För Många Läkare.” *Dagens Medicin*, July 30. Retrieved November 11, 2021 (https://www.dagensmedicin.se/opinion/debatt/sluta-utbilda-pa-tok-for-manga-lakare/).

Brown, Daniel E., and Gary D. James. 2000. “Physiological Stress Responses in Filipino-American Immigrant Nurses: The Effects of Residence Time, Life-Style, and Job Strain.” *Psychosomatic Medicine* 62(3): 394–400.

Browne, Mark J. 1992. “Evidence of Adverse Selection in the Individual Health Insurance Market.” *Journal of Risk and Insurance* 59(1): 13–33.

Bryceson, Deborah, and Ulla Vuorela, eds. 2002. *The Transnational Family: New European Frontiers and Global Networks.* New York, NY: Berg.

Bucken-Knapp, Gregg. 2007. “Varieties of Capitalism and Labor Migration Policy” in *University West Preprint Series Vol 1.* Trollhättan, Sweden: University West.

Budd, Ken. 2020. ”7 Ways to Reduce Medical School Debt.” *AAMC News*, October 14. Retrieved October 20, 2021 (https://www.aamc.org/news-insights/7-ways-reduce-medical-school-debt).

Bureau of Labor Statistics. 2020. *Occupational Outlook Handbook, Physicians and Surgeons. Office of Occupational Statistics and Employment Projections.* Washington, DC: US Department of Labor. Retrieved October 05, 2021 (https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm).

Burns, Joseph. 2021. “Does the US Have a Shortage of Physicians?” *Managed Healthcare Executive Publication* 31(2). Retrieved October 4, 2021 (https://www.managedhealthcareexecutive.com/view/americans-are-continuing-to-struggle-with-healthcare-literacy).

Castles, Stephen, Hein De Haas, and Mark J. Miller. 2013. *Age of Migration: International Population Movements in the Modern World.* London, UK: Palgrave Macmillan Education.

Cebul, Randall D., James B. Rebitzer, Lowell J. Taylor, and Mark E. Votruba. 2008. "Organizational Fragmentation and Care Quality in the US Healthcare System." *Journal of Economic Perspectives* 22(4):93–113.

Cederberg, Jesper. 2021. "Forskare: Många Läkare Kan Behöva Stöd I Pandemins Spår." *Läkartidningen*, April 15. Retrieved December 2, 2021 (https://lakartidningen.se/aktuellt/nyheter/2021/04/forskare-manga-lakare-kan-behova-stod-i-pandemins-spar/).

Cegliński, Pawel 2020. "The Relations Between Dynamic Capabilities and Core Competencies on the Case of Polish Companies." *Administrative Sciences* 10(3): 48.

Center for Disease Control and Prevention. 2021. ”Immigrant, Refugee, and Migrant Health: Iraqi Refugee Health Profile." Retrieved June 29, 2022 (https://www.cdc.gov/immigrantrefugeehealth/profiles/iraqi/index.html#ref-2).

Centers for Medicare & Medicaid Services. 2022. "October 2022 Medicaid & CHIP Enrollment Data Highlights." *Medicaid.gov,* 2022. Retrieved February 2, 2023 (https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html).

Chakravorty, Sanjoy, Devesh Kapur, and Nirvikar Singh. 2016. *The Other One Percent: Indians in America.* New York, NY: Oxford University Press.

Charmaz, Kathy. 2006. *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* Los Angeles: SAGE Publications.

Chellaraj, Gnanaraj, Keith E. Maskus, and Aaditya Mattoo. 2006. "Skilled Immigrants, Higher Education, and US Innovation." Pp in 245–259 in *International Migration, Remittances and the Brain Drain*, edited by M. Schiff and Ç. Özden. Washington, D.C: The World Bank; New York, NY: Palgrave Macmillan.

Chen, Peggy Guey-Chi, Marcella Nunez-Smith, Susannah May Bernheim, David Berg, Aysegul Gozu and Leslie Ann Curry. 2010."Professional Experiences of International Medical Graduates Practicing Primary Care in the United States." *Journal of General Internal Medicine* 25(9): 947–953.

Cheney, Christopher. 2022. "Physician Unions Described as Response to Healthcare Consolidation." *Health Leaders*, August 2. Retrieved January 31, 2023 (https://www.healthleadersmedia.com/clinical-care/physician-unions-prescribed-response-healthcare-consolidation).

Collins, Sara R., Herman K. Bhupal, and Michelle M. Doty. 2019. *Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter*

Coverage Gaps, But More Underinsured. New York, NY: Commonwealth Fund. Retrieved August 7, 2021 (https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca).

Consterdine, Erica, and James Hampshire. 2020. "Convergence, Capitalist Diversity, or Political Volatility? Immigration policy in Western Europe." *Journal of European Public Policy* 27(10): 1487–1505.

Cooper, Richard A., Thomas E. Getzen, Heather J. McKee and Laud, P. 2002. "Economic and Demographic Trends Signal an Impending Physician Shortage." *Health Affairs* 21(1): 140–154.

Cooper, Richard. A. 2007. New Directions for Nurse Practitioners and Physician Assistants in the Era of Physician Shortages. *Academic Medicine* 82(9): 827–828.

Crutcher, Rodney A., Olga Szafran, Wayne Woloschuk, Fatima Chatur, and Chantal Hansen. 2011. "Family Medicine Graduates' Perceptions of Intimidation, Harassment, and Discrimination During Residency Training." *BMC Medical Education* 11(1): 88.

Cutler, David M., and Richard J. Zeckhauser. 1998. "Adverse Selection in Health Insurance." *Forum for Health Economics and Policy* 1(1): 1–32.

Czaika, Mathias, Hein de Haas, and María Villares-Varela. 2018. "The Global Evolution of Travel Visa Regimes." *Population and Development Review* 44(3): 589–622.

Czechowski, Robert, and Emilia Arvidsson. 2004. "Kalmena/Medena: Organiserad Förmedling av Polska Läkare till Sverige." MA thesis, Faculty of Social Sciences, School of Business, Stockholm University.

Dall, Tim, Ryan Reynolds, Ritashree Chakrabarti, Kari Jones and Will Iacobucci. 2020. *The Complexities of Physician Supply and Demand: Projections From 2018 to 2033.* Washington, DC: Association of American Medical Colleges. Retrieved October 3, 2021 (https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf).

Danzon, Patricia M. 1994. "The Swedish Patient Compensation System: Myths and Realities." *International Review of Law and Economics* 14(4): 453–466.

Das Gupta, Monisha. 2014. "'Don't Deport Our Daddies': Gendering State Deportation Practices and Immigrant Organizing." *Gender & Society* 28(1): 83–109.

De Genova, Nicholas. 2004. "The Legal Production of Mexican/Migrant "Illegality." *Latino Studies* 2(2): 160–185.

Devitt, Camilla. 2011. Varieties of Capitalism, Variation in Labour Immigration. *Journal of Ethnic and Migration Studies* 37(4): 579–596.

Díaz, Esperanza, and Stefán Hjörleifsson. 2011 "Immigrant General Practitioners in Norway: A Special Resource? A Qualitative Study." *Scandinavian Journal of Public Health* 39(3): 239–244.

Dicicco-Bloom, Barbara. 2004. "The Racial and Gendered Experiences of Immigrant Nurses from Kerala, India." *Journal of Transcultural Nursing* 15(1): 26–33.

Doctors Review India. 2021. "What is Salary of MD/MS & MBBS Doctors in India?" *Doctorsreview.in*, March 19. Retrieved October 25, 2021 (https://doctorsreview.in/health/doctor-salary-in-india/).

Domagała, Alicja, and Katarzyna Dubas-Jakóbczyk. 2019. "Migration Intentions Among Physicians Working in Polish Hospitals–Insights from Survey Research." *Health Policy* 123(8): 782–789.

Donato, Katherine M., and Douglas S, Massey. 2016. "Twenty-First-Century Globalization and Illegal Migration." *The Annals of the American Academy of Political and Social Science* 666(1): 7–26.

Edgerton, Jason D., and Lance W. Roberts. 2014. "Cultural Capital or Habitus? Bourdieu and Beyond in the Explanation of Enduring Educational Inequality." *Theory and Research in Education* 12(2): 193–220.

Emerson, Robert M., Rachel I. Fretz, and Linda L. Shaw. 2012. *Writing Ethnographic Fieldnotes.* Chicago, IL: University of Chicago Press.

Esterline, Cecilia and Jeanne Batalova. 2022. *Frequently Requested Statistics on Immigrants and Immigration in the United States.* Washington, DC: Migration Policy Institute. Retrieved September 9, 2022 (https://www.migrationpolicy.org/sites/default/files/source_images/FRS2022-print_version_FINAL.pdf).

Eurostat. 2019. "Population on 1 January by Age Group, Sex and Citizenship." Retrieved September 27, 2022 (http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=migr_pop1ctz&lang=en).

Factourovich, Alexander, Michael S. Ritsner, Binyamin Maoz, Kira Levin, Julia Mirsky, Yigal Ginath, Alexander Segal and Eliezer Bar Natan. 1996. Psychological Adjustment Among Soviet Immigrant Physicians: Distress and Self-Assessments of its Sources." *The Israel Journal of Psychiatry and Related Sciences* 33(1): 32–39.

Fan, Ying. 2006. “Branding the Nation: What is Being Branded?” *Journal of Vacation Marketing* 12(1): 5–14.

Faraz, Bahar. 2019. *Framtidens Behov av Högskoleutbildade: Genomgång av 15 Bristyrken Inom Offentlig Sektor Fram till 2035.* Stockholm, Sweden: Universitetskanslersämbetet. Retrieved November 10, 2021 (https://www.uka.se/download/18.3fcfbadf16dfa1b80b93f93/1572863119373/rapport-2019-11-05-framtidens-behov-av-h%C3%B6gskoleutbildade.pdf).

Fay, Max. 2021. “How to Pay Off Medical School Loans Faster.” *Debt.org,* April 26. Retrieved October 20, 2021 (https://www.debt.org/students/loan-consolidation/medical-school-loans/pay-off-fast/).

Fetscherin, Marc. 2010. “The Determinants and Measurement of a Country Brand: the Country Brand Strength Index.” *International Marketing Review* 27(4): 466–479.

Finegold, Kenneth, Ann Conmy, Rose C. Chu, Arielle Bosworth, and Benjamin D. Sommers. 2021. *Trends in the US Uninsured Population, 2010–2020.* Washington DC: Assistant Secretary for Planning and Evaluation, Office of Health Policy. Retrieved August 2, 2021 (https://aspe.hhs.gov/sites/default/files/private/pdf/265041/trends-in-the-us-uninsured.pdf).

Finnegan, Joanne. 2019. “More Medical Students Than Ever, But More Residency Slots Needed to Solve Physician Shortage, AAMC Says.” *Fierce Healthcare,* July 26. Retrieved February 13, 2023 https://www.fiercehealthcare.com/practices/more-medical-students-than-ever-but-more-residency-slots-needed-to-solve-physician).

Fodeman, Jason and Phil Factor. 2015. “Solutions to the Primary Care Physician Shortage.” *The American Journal of Medicine* 128(8): 800–801.

Fredlund-Blomst, Sofie. 2014. “Assessing Immigrant Integration in Sweden after the May 2013 Riots.” *Migration Policy Institute,* January 16. Retrieved May 1, 2019 (https://www.migrationpolicy.org/article/assessing-immigrant-integration-sweden-after-may-2013-riots).

Freedman, Jessica. 2021. “Medical School Acceptance Rates, Admissions Statistics + Average MCAT and GPA for every Medical School” *MedEdits.* Retrieved November 3,2021 (https://mededits.com/medical-school-admissions/statistics/).

Friberg, Jon Horgen. 2010. "Working Conditions for Polish Construction Workers and Domestic Cleaners in Oslo: Segmentation, Inclusion and the Role of Policy." Pp. 23–50 in *A Continent Moving West: EU Enlargement and Labour Migration from Central and Eastern Europe,* edited by R. Black, G. Engbersen, M. Okólski and C. Pantîru. Amsterdam, The Netherlands: Amsterdam University Press.

Friberg, Jon H., Jens Arnholtz, Line Eldring, Nana W Hansen and Frida Thorarins. 2014. "Nordic Labour Market Institutions and New Migrant Workers: Polish Migrants in Oslo, Copenhagen and Reykjavik." *European Journal of Industrial Relations* 20(1): 37–53.

Gammeltoft-Hansen, Thomas and Ninna Nyberg Sørensen. 2013. “Introduction.” Pp. 1–23 in *The Migration Industry and the Commercialization of International Migration*, edited by T. Gammeltoft-Hansen and N Nyberg Sørensen. Abingdon, UK: Routledge.

Gavelin, Malin. 2015. “Behov Och Metoder Olika Då Landsting Raggar Läkare” *Sjukhusläkaren*, December 14. Retrieved March 2, 2022 (https://www.sjukhuslakaren.se/behov-och-metoder-olika-da-landsting-raggar-lakare/).

Gerlinger, Thomas, and Rolf Schmucker. 2007. “Transnational Migration of Health Professionals in the European Union.” *Cadernos de Saude Publica* 23(2): 184–192.

Girvan, Gregg and Avik Roy. 2021. “United States: #6 in the 2021 World Index of Healthcare Innovation.” *FREEOPP.org*, June 25. Retrieved October 12, 2021 (https://freopp.org/united-states-freopp-world-index-of-healthcare-innovation-72256925520f).

Girvan, Gregg, Mark Dornauer and Avik Roy. 2021. “Sweden: #18 in the 2021 World Index of Healthcare Innovation.” *FREEOPP.org,* June 25. Retrieved November 1, 2021 (https://freopp.org/sweden-freopp-world-index-of-healthcare-innovation-8e5fd51ca2dd).

Glaser, Barney G., and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory; Strategies for Qualitative Research.* Chicago, IL: Aldine Pub. Co.

Glassmann, Ulrich. 2016. “Social Rights, Family Networks and Regional Varieties of Capitalism in Mediterranean Countries.” *Regional Studies* 50(1): 35–51.

Glenngård, Anna H. 2020. *International Health Care Systems Profiles: Sweden.* International Health Policy Center. New York, NY: The Commonwealth Fund. Retrieved September 21, 2021 (https://www.commonwealthfund.org/international-health-policy-center/countries/sweden).

Goodchild, Lucy, Adrian Mulligan, Elizabeth Shearing Green and Terri Mueller. 2022. *Clinician of the Future: Report 2022*. Amsterdam, NL: Elsevier and Paris, FR: IPSOS (https://www.elsevier.com/__data/assets/pdf_file/0004/1242490/Clinician-of-the-future-report-online.pdf)

Goffman, Erving. 1959. *The Presentation of Self in Everyday Life.* New York, NY: Doubleday Anchor.

Gonzales, Roberto G. 2011. “Learning to be illegal: Undocumented Youth and Shifting Legal Contexts in the Transition to Adulthood.” *American Sociological Review* 76(4): 602–619.

Goodin, Robert. E. 2003. “Choose Your Capitalism?” *Comparative European Politics* 1(2): 203–213.

Granovetter, Mark S. 1973. “The Strength of Weak Ties.” *American Journal of Sociology* 78(6): 1360–1380.

Green, Linda V., Sergei Savin, and Yina Lu. 2013. “Primary Care Physician Shortages Could Be Eliminated Through use of Teams, Nonphysicians, and Electronic Communication.” *Health Affairs* 32(1): 11–19.

Groth, Kristina, Göran Algers, Urban Arnelo, Git Eliasson, Jörgen Larsson and Thomas Molén. 2014. “Telemedicin Leder till Ökad Patientnytta.” *Läkartidningen* 111(C3XT): 1–4

Gudbranson, Emily, Aron Glickman and Ezekiel J. Emanuel. 2017. ”Reassessing the Data on Whether a Physician Shortage Exists.” *JAMA: The Journal of the American Medical Association* 317(19): 1945–1946.

Gunnarsdotter, Sara. 2005. “Var Tionde Utfärdad Legitimation till Läkare Utbildade i Polen.” *Läkartidningen* 42(102): 3010–3012.

Gunnarsdotter, Sara. 2015. ”’Vi är som en Påse Gott & Blandat.’” *Sjukhusläkaren* 8: 14–18.

Gunnarsson, Pär. 2019. ”’Läkare Är Ett Riskyrke För Att Drabbas Av Utmattningssyndrom.’” *Läkartidningen,* May 15. Retrieved December 2, 2021 (https://lakartidningen.se/aktuellt/podd/2019/10/lakare-ett-riskyrke-for-att-drabbas-av-utmattningssyndrom/).

Hagey, Rebecca, Ushi Choudhry, Sepali Guruge, Jane Turrittin, Enid Collins and Ruth Lee. 2001. “Immigrant nurses' experience of racism.” *Journal of Nursing Scholarship* 33(4): 389–394.

Hall, Peter A. and Robert J. Franzese. 1998. “Mixed Signals: Central Bank Independence, Coordinated Wage Bargaining, and European Monetary Union.” *International Organization* 52(3): 505–535.

Hall, Peter A. and David Soskice. 2001. "An Introduction to Varieties of Capitalism." Pp. 1–68 in *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage*, edited by P. A. Hall and D. Soskice. New York, NY: Oxford University Press.

Han, Jason J. and Neha Vapiwala. 2017. "America Needs to Keep the Door Open to Immigrant Physicians." *Stat News,* January 24. Retrieved April 16, 2019 (https://www.statnews.com/2017/01/24/immigrant-physicians-america/).

Hao, Andy W., Justin Paul, Sangeeta Trott, Chiquan Guo and Heng-Hui Wu. 2021. "Two Decades of Research on Nation Branding: A Review and Future Research Agenda." *International Marketing Review* 38(1): 46–69.

Hårdänge, Sofia. 2019. "Läkarbrist I Sörmland Rekryterar Från Europa." *SVT Nyheter,* March 29. Retrieved December 4, 2022 (https://www.svt.se/nyheter/lokalt/sormland/lakarbrist-i-sormland-regionen-rekryterar-fran-europa).

Harris, John R., and Michael P. Todaro. 1970. "Migration, Unemployment and Development: A Two-Sector Analysis." *The American Economic Review* 60(1): 126–142.

Heckhausen, Jutta, and Marlis Buchmann 2019. "A Multi-Disciplinary Model of Life-Course Canalization and Agency. *Advances in Life Course Research* 41: 100246.

Hedlund, Anna. 2011. "Läkaryrket – Inte Ett Kall Men En Genväg Till Ökad Fritid." *Läkartidningen* 41(108): 2005.

Hennink, Monique, Inge Hutter, and Ajay Bailey. 2011. *Qualitative Research Methods.* Thousand Oaks, CA: SAGE Publications.

Hernández-León, Rubén. 2008. *Metropolitan Migrants: The Migration of Urban Mexicans to the United States.* Berkeley, CA: University of California Press.

Hicks, John R. 1932. "Marginal Productivity and the Principle of Variation." *Economica* 35: 79–88.

Himmelstein, David U., and Steffie Woolhandler. 2016. "The Current and Projected Taxpayer Shares of US Health Costs." *American Journal of Public Health* 106(3): 449–452.

Hing, Esther, and Susan X. Lin. 2009. *Role of International Medical Graduates Providing Office-Based Medical Care; United States, 2005–2006.* National Center for Health Statistics. Washington, DC: US Department of Health and Human Services; Atlanta, GA: Center for Disease Control and Prevention.

Ho, Jessica Y. 2013. “Mortality Under Age 50 Accounts for Much of the Fact That US Life Expectancy Lags that of Other High-Income Countries.” *Health Affairs* 32(3): 459–467.

Howard, Danielle. 2020. “What Should Physicians Consider Prior to Unionizing?” *AMA Journal of Ethics* 22(3): 193–200.

Howell, Chris. 2003. “Varieties of Capitalism: And Then There Was One?” *Comparative Politics* 36(1): 103–124.

Hughey, Patricia E: 2021. “10 Highest-Paying Countries For Doctors.” *Medvocation.com,* September 8. Retrieved October 25, 2021 (https://medvocation.com/en/blog/10-highest-paying-countries-for-doctors/4).

Içduygu, Ahmet, and Sule Toktas. 2002. "How Do Smuggling and Trafficking Operate via Irregular Border Crossings in the Middle East? Evidence from Fieldwork in Turkey." *International Migration* 40(6): 25–54.

Irving, Greg, Ana Luisa Neves, Hajira Dambha-Miller, Ai Oishi, Hiroko Tagashira, Anistasiya Verho and John Holden. 2017. ”International Variations in Primary Care Physician Consultation Time: A Systematic Review of 67 Countries.” *BMJ Open* 7(10): e017902.

James, James J. 1979. “Impacts of the Medical Malpractice Slowdown in Los Angeles County: January 1976.” *American Journal of Public Health* 69(5): 437–443.

James, Sherman A., Sue A. Hartnett, and William D. Kalsbeek. 1983. “John Henryism and Blood Pressure Differences Among Black Men*.” Journal of Behavioral Medicine* 6(3): 259–278.

James, Sherman A. 1994. “John Henryism and the Health of African-Americans.” *Culture, Medicine and Psychiatry* 18(2): 163–182.

Jenkins, Tania M., and Shalini Reddy. 2016. “Revisiting the Rationing of Medical Degrees in the United States.” *Contexts* 15(4): 36–41.

Jenkins, Tania M. 2020. *Doctors' Orders: The Making of Status Hierarchies in an Elite Profession.* New York, NY: Columbia University Press.

Kaczmarczyk, Paweł. 2010. “Brains on the Move? Recent Migration of the Highly Skilled from Poland and Its Consequences.” Pp. 165–186 in *A Continent Moving West: EU Enlargement and Labour Migration from Central and Eastern Europe,* edited by R. Black, G. Engbersen, M. Okólski and C. Pantîru. Amsterdam, The Netherlands: Amsterdam University Press.

Kaczmarczyk, Paweł and Marek Okólski. 2008. “Demographic and Economic Impacts of Migration on Poland.“ *Oxford Review of Economic Policy* 24(3): 600–625.

Kaczmarczyk, Paweł, and Joanna Tyrowicz. 2015. "Winners and Losers Among Skilled Migrants: The Case of Post-accession Polish Migrants to the UK." Institute for the Study of Labor, IZA, Discussion Paper 9057.

Kalmena Rek AB/Medena Rek Polska. 2022. ”Sverige.” Warsaw, Poland: Medena Rek Polska. Retrieved November 7, 2022 (http://www.kalmena.com/).

Kalra, Ankur, Prediman K. Shah, and William A. Zoghbi. 2017. "Travel Bans and Threats to US Health Care—Our Hearts are at Stake." *JAMA Cardiology* 2(4): 351–352.

Kandel, William A. 2020. *The Employment-Based Immigration Backlog. Congressional Research Service.* Washington, DC: US Congress. Retrieved February 8, 2023 (https://sgp.fas.org/crs/homesec/R46291.pdf).

Kaneda, Toshiko, Charlotte Greenbaum, and Kaitlyn Patierno. 2018. *2018 World Population Data Sheet*. Washington, DC: Population Reference Bureau. Retrieved February 27, 2023 (https://www.prb.org/wp-content/uploads/2018/08/2018_World-Population-data-sheet.pdf).

Kang, Minjeong, and Sung-Un Yang. 2010. “Comparing Effects of Country Reputation and the Overall Corporate Reputations of a Country on International Consumers’ Product Attitudes and Purchase Intentions.” *Corporate Reputation Review* 13(1):52–62.

Kaushik, Manas, Abhishek Jaiswal, Naseem Shah and Ajay Mahal. 2008. “High-End Physician Migration from India.” *Bulletin of the World Health Organization* 86: 40–45.

Kavilanz, Parija. 2018. “Immigrant Doctors in Rural America are Sick of Waiting for Green Cards.” *CNN Business*, June 13. Retrieved April 17, 2019. (https://money.cnn.com/2018/06/08/news/economy/immigrant-doctors-green-card-backlog/index.html).

Keisler-Starkey, Katherine and Lisa N. Bunch. 2020. *Health Insurance Coverage in the United States: 2019.* Washington, DC: United States Census Bureau. Retrieved August 2, 2021(https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf).

Kellerman, Scott E., and Joan Herold. 2001. “Physician Response to Surveys: A Review of the Literature.” *American Journal of Preventive Medicine* 20(1): 61–67.

Kelly, Melissa and Lina Hedman. 2016. ”Between Opportunity and Constraint: Understanding the Onward Migration of Highly Educated Iranian Refugees from Sweden. *Journal of International Migration and Integration* 17: 649–667.

Kerns, Christopher and Dave Willis. 2020. “The Problem with US Health Care Isn’t a Shortage of Doctors.” *Harvard Business Review*, March 16. Retrieved October 3, 2021 (https://hbr.org/2020/03/the-problem-with-u-s-health-care-isnt-a-shortage-of-doctors).

Khan, Shamus Rahman. 2010. *Privilege: The Making of an Adolescent Elite at St. Paul's School.* Princeton, NJ: Princeton University Press.

Khosravi, Shahram. 2012. “White Masks/Muslim Names: Immigrants and Name-Changing in Sweden.” *Race & Class* 53(3): 65–80.

Kibria, Nazli, Cara Bowman and Megan O’Leary. 2013. *Race and Immigration.* Cambridge, UK: Polity.

Kirch, Darrell G., and Kate Petelle. 2017. “Addressing the Physician Shortage: The Peril of Ignoring Demography.” *JAMA: The Journal of the American Medical Association* 317(19): 1947–1948.

Kundnani, Arun. 2014. *The Muslims are Coming! Islamophobia, Extremism, and the Domestic War on Terror.* London, UK: Verso Books.

Lafta, Riyadh, Noor Qusay, Meighan Mary, Gilbert Burnham. 2021. Violence Against Doctors in Iraq During the Time of COVID-19.” *PLoS ONE* 16(8): e0254401.

LaVeist, Thomas. A. 2011. *Minority Populations and Health: An introduction to Health Disparities in the United States (Vol. 4).* Hoboken, NJ: John Wiley & Sons.

Levine, Felice J., Na’ilah Suad Nasir, Cecilia Rios-Aguilar, Ryan Evely Gildersleeve, Katherine J. Rosich, Megan Bang, Nathan E. Bell and Matthew A. Holsapple. 2021. *Voices from the Field: The Impact of COVID-19 on Early Career Scholars and Doctoral Students.* Washington, DC: American Educational Research Association; Chicago, IL: Spencer Foundation. Retrieved January 25, 2022 (https://files.eric.ed.gov/fulltext/ED610288.pdf).

Lewin, Arie Y., Silvia Massini, and Carine Peeters. 2009. “Why Are Companies Offshoring Innovation? The Emerging Global Race for Talent.” *Journal of International Business Studies* 40(6): 901–925.

Lewis, W. Arthur. 1954. “Economic Development with Unlimited Supplies of Labor,” *The Manchester School of Economic and Social Studies* 22(2): 139–191.

Lindgren, Malin. 2015. “De är Många och de är Trogna” *Sjukhusläkaren* (8): 12–13.

Linnersten, Lars. 2005. ” Läkarrekrytering Utomlands – En Personlig Betraktelse.” *Läkartidningen* 102(46): 3486 (https://lakartidningen.se/wp-content/uploads/OldPdfFiles/2005/30989.pdf).

Linzer, Mark, Linda Baier Manwell, Eric S. Williams, James A. Bobula, Roger L. Brown, Anita B. Varkey, Bernice Man, Julia E. McMurray, Ann Maguire, Barbara Horner-Ibler, Mark D. Schwartz. 2009. “Working Conditions in Primary Care: Physician Reactions and Care Quality.” *Annals of Internal Medicine* 151(1): 28–36.

Lundin, Tomas. 2020. “Polen Går På Knäna När Läkare Lockas Till Sverige.” *Svenska Dagbladet,* October, 28. Retrieved October 6, 2022 (https://www.svd.se/a/Vqbm66/polen-gar-pa-knana-nar-lakare-lockas-till-sverige).

Malhotra, Ashish. 2021. “Immigrant Doctors Fill US Healthcare Gaps – But Visa Rules Make Life Tough.” The Guardian, June 2. Retrieved February 2, 2023 (https://www.theguardian.com/us-news/2021/jun/02/us-healthcare-immigrant-doctors-visa?fbclid=IwAR27M7EiYbvLMb8AzX8XieGw6boAjFw498qnYbBwKIQP7YLPQJIc65mzDDA).

Marcin, James P., Mary E. Rimsza and William B. Moskowitz. 2015. “The Use of Telemedicine to Address Access and Physician Workforce Shortages.” *Pediatrics* 136(1): 202–209.

Marmot, Micheal G. and Ruth Bell. 2009. “Action on Health Disparities in the United States: Commission on Social Determinants of Health.” *JAMA: The Journal of the American Medical Association* 301(11): 1169–1171.

Marrast, Lyndonna M., Leah Zallman, Steffie Woolhandler, David H. Bor and Danny McCormick. 2014. “Minority Physicians’ Role in the Care of Underserved Patients: Diversifying the Physician Workforce May Be Key in Addressing Health Disparities.” *JAMA Internal Medicine* 174(2): 289–291.

Massey, Douglas S. 1999. “Why Does Immigration Occur? A Theoretical Synthesis.” Pp. 34–52 in *The Handbook of International Migration: The American Experience,* edited by C. Hirschman, P. Kasinitz, P and J. DeWind. New York, NY: Russell Sage Foundation.

Matthews, Merrill. 2015. "Doctors Face a Huge Medicare and Medicaid Pay Cut in 2015." *Forbes*, January 5. Retrieved January 30, 2023 (https://www.forbes.com/sites/merrillmatthews/2015/01/05/doctors-face-a-huge-medicare-and-medicaid-pay-cut-in-2015/?sh=2c5be0913173).

McDowell, Linda. 1998. "Elites in the City of London: Some Methodological Considerations." *Environment and Planning A: Economy and Space* 30(12): 2133–2146.

McEachrane, Michael, eds. 2014. *Afro-Nordic Landscapes: Equality and Race in Northern Europe*. London, UK: Routledge.

McKenzie, David and Hillel Rapoport. 2007. "Network Effects and the Dynamics of Migration and Unequality: Theory and Evidence from Mexico*." Journal of Development Economics* 84(1): 1–24.

McMahon, Graham. 2004. "Coming to America – International Medical Graduates in the United States." *New England Journal of Medicine* 350(24): 2435–2437.

MediCarrera. 2022. "The Process." Barcelona, Spain: MediCarrera. Retrieved November 2, 2022 (https://medicarrera.com/process/).

Mej'ia, Alfonso, Helena Pizurki, and Erica Royston. 1979. *Physician and Nurse Migration: Analysis and Policy Implications, Report on a WHO Study.* Geneva Switzerland: World Health Organization. Retrieved February 27, 2023 (https://apps.who.int/iris/handle/10665/37260).

Mello, Michelle M. 2006. *Understanding Medical Malpractice Insurance: A Primer. The Synthesis Project.* Princeton, NJ: Robert Wood Johnson Foundation. Retrieved October 12, 2021 (https://folio.iupui.edu/bitstream/handle/10244/517/no8_primer.pdf).

Menz, Georg. 2010. "Employers, Trade Unions, Varieties of Capitalism, and Labour Migration Policies." Pp. 25–35 in *Labour Migration in Europe*, edited by G. Menz and A. Caviedes. London, UK: Palgrave Macmillan.

Menz, Georg. 2011. "Employer Preferences for Labour Migration: Exploring 'Varieties of Capitalism'-Based Contextual Conditionality in Germany and the United Kingdom." *The British Journal of Politics and International Relations* 13(4): 534–550.

Merritt Hawkins. 2018. *2018 Survey of America's Physicians: Practice Patterns and Perspectives.* Boston, MA: The Physicians Foundation. Retrieved October 18, 2021 (https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/MerrittHawkins_PhysiciansFoundation_Survey2018.pdf).

Mikecz, Robert. 2012 "Interviewing Elites: Addressing Methodological Issues." *Qualitative Inquiry* 18(6): 482–493.

Mitra, Avir. 2016. “Why Don’t Young Doctors Want to Work in Primary Care?” *WHYY.org,* June 23. Retrieved January 27, 2023 (https://whyy.org/segments/why-dont-young-doctors-want-to-work-in-primary-care/).Morgan, George and Scott Poynting, eds. 2016. *Global Islamophobia: Muslims and Moral Panic in the West.* London, UK: Routledge.

Mullan, Fitzhugh. 2006. “Doctors for the World: Indian Physician Emigration.” *Health Affairs* 25(2): 380–393.

Murphy, Brendan. 2021. “2021 Residency Match: Examining Outcomes for SOAP, IMGs” *AMA-ASSN.org*, May 11. Retrieved August 29, 2022(https://www.ama-assn.org/medical-students/preparing-residency/2021-residency-match-examining-outcomes-soap-imgs).

Nabity, Justin. 2021. “Q&A With A J-1 Waiver Physician.” *Physicians Thrive,* March 6. Retrieved February 1, 2023 (https://physiciansthrive.com/contract-review/qa-with-a-j-1-waiver-physician/).

Newitt, Patsy. 2022. “Private Practice Physicians by the Numbers.” *Beckers ASC Review*, July, 14. Retrieved February 1, 2023 (https://www.beckersasc.com/asc-news/private-practice-physicians-by-the-numbers.html).

Ngai, Mae M. 2004. *Impossible Subjects: Illegal Aliens and the Making of Modern America.* Princeton, NJ: Princeton University Press.

NRMP. 2022. *NRMP Delivers a Strong Match to Thousands of Residency Applicants and Programs.* Washington DC: National Resident Matching Program. Retrieved August 29, 2022 (https://www.nrmp.org/wp-content/uploads/2022/03/2022-Match-Day-Press-Release-FINAL.pdf).

NSI Nursing Solutions, Inc. 2021. *2021 NSI National Health Care Retention & RN Staffing Report.* East Petersburg, PA: NSI Nursing Solutions, Inc. Retrieved October 18, 2021 (https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf).

Odendahl, Teresa and Aileen M. Shaw. 2002. “Interviewing Elites.” Pp 299–316 in *Handbook of Interview Research: Context and Method*, edited by J. F. Gubrium and J. A. Holstein. Thousand Oaks, CA: Sage Publications.

OECD. 2015. *International Migration Outlook 2015.* Paris, France: OECD Publishing. Retrieved March 4, 2019 (https://doi.org/10.1787/migr_outlook-2015-en).

OECD. 2019. *State of Health in the EU Sweden: Country Health Profile 2019.* Paris, France: WHO and OECD Publishing. Retrieved October 14, 2021 (https://read.oecd-ilibrary.org/social-issues-migration-health/sweden-country-health-profile-2019_2dcb7ca6-en#page2).

OECD. 2021. *Health at a Glance: Europe 2020: State of Health in the EU Cycle: Availability of Doctors.* Paris, France: OECD Publishing. Retrieved December 8, 2021 (https://www.oecd-ilibrary.org/sites/1d767767-en/index.html?itemId=/content/component/1d767767-en).

Office of Clinical Studies. 2017. "The Swedish Healthcare System." Gothenburg, Sweden: Swedish Research Council. Retrieved September 21, 2021 (https://www.kliniskastudier.se/english/sweden-research-country/swedish-healthcare-system.html#).

Ollars, Birgitta. 2015. "Statistik Över Hälso- och Sjukvårdspersonal 2014." Stockholm, Sweden: Socialstyrelsen. Retrieved January 16, 2019(http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/20006/2015-12-24.pdf).

Ollier Weber, David. 2019. "How Many Patients Can a Primary Care Physician Treat?" *American Association for Physician Leadership*, February 11. Retrieved February 17, 2023 (https://www.physicianleaders.org/articles/how-many-patients-can-primary-care-physician-treat).

Ong, Aihwa. 1999. *Flexible Citizenship: The Cultural Logics of Transnationality.* Durham, NC: Duke University Press.

Ouaked, Said. 2002. "Transatlantic Roundtable on High–skilled Migration and Sending Countries Issues." *International Migration* 40(4): 153–166.

Pascarella, Ernest T., Ellen M. Brier, John C. Smart, and Leslie Herzog. 1987. "Becoming a Physician: The Influence of the Undergraduate Experience." *Research in Higher Education* 26(2): 180–201.

Passaris, Constantine. 1989. "Immigration and the Evolution of Economic Theory." *International Migration* 27(4): 525–542.

Patel, Rikinkumar S., Ramya Bachu, Archana Adikey, Meryem Malik and Mansi Shah. 2018. "Factors Related to Physician Burnout and Its Consequences: A Review." *Behavioral Sciences* 8(11): 98.

Paul, Regine. 2016. Negotiating Varieties of Capitalism? Crisis and Change in Contemporary British and German Labour Migration Policies. *Journal of Ethnic and Migration Studies* 42(10): 1631–1650.

Petterson, Håkan. 2005. ”Rekryteringen i Polen ett Komplement Som Blivit en Stor Tillgång För Vår Sjukvård.” *Läkartidningen* 102(46): 3486 (https://lakartidningen.se/wp-content/uploads/OldPdfFiles/2005/30989.pdf).

Portes, Alejandro and Rubén G. Rumbaut. 2006*. Immigrant America: A Portrait.* Berkeley, CA: University of California Press.

Portes, Alejandro, and Rubén G. Rumbaut. 2001. *Legacies: The Story of the Immigrant Second Generation.* Berkeley, CA: University of California Press.

PR Med. 2016. “How Hard is it for International Medical Graduates to Match Into a Surgery Residency?” *MedClerkships: UCE & Residency Consultation*, July 13. Retrieved August 29, 2022 (https://medclerkships.com/how-hard-is-it-for-international-medical-graduates-to-match-into-a-surgery-residency/).

PwC. 2016. *Läkares Arbetstid: Undersökning av Läkares Arbetstid 2016.* Sveriges Läkarförbund. Stockholm, Sweden: Sveriges Läkarförbund. Retrieved November 1, 2021 (https://slf.se/app/uploads/2018/08/laxxkares-arbetstid-en-rappport-fraxxn-laxxkarfoxxrbundet1.pdf).

Rampell, Catherine. 2009. “How Much Do Doctors in Other Countries Make?” *The New York Times,* July 15. Retrieved May 3, 2019(https://economix.blogs.nytimes.com/2009/07/15/how-much-do-doctors-in-other-countries-make/).

REACH. 2017. *Iraqi Migration to Europe in 2016: Profiles, Drivers and Return*. Geneva, Switzerland: REACH at IMPACT Initiatives. Retrieved October 11, 2022 (https://www.impact-repository.org/document/reach/17c9868c/reach_irq_grc_report_iraqi_migration_to_europe_in_2016_june_2017-1.pdf).

Reede, Joan Y. 2003. “A Recurring Theme: The Need for Minority Physicians.” *Health Affairs* 22(4): 91–93.

Remennick, Larissa I., and Ronny A. Shtarkshall. 1997. "Technology Versus Responsibility: Immigrant Physicians from the Former Soviet Union Reflect on Israeli Health Care." *Journal of Health and Social Behavior* 38(3): 191.

Rhodes, Martin. 1998. "Globalization, Labour Markets and Welfare States: A Future of ‘Competitive Corporatism’?" Pp. 178–203 in *The Future of European Welfare.* London, UK: Palgrave Macmillan.

Rittenhouse, Diane R., Andrew W. Bazemore, Zachary J. Morgan and Lars E. Peterson. 2021. “One-Third of Family Physicians Remain in Independently Owned

Practice, 2017–2019." *The Journal of the American Board of Family Medicine* 34(5): 1033–1034.

Rosenblatt, Roger A., C. Holly A. Andrilla, Thomas Curti and Gary L Hart. 2006. "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion." *JAMA: The Journal of the American Medical Association* 295(9): 1042–1049.

Saco. 2021. "Studieval – Yrken A-Ö – Läkare." Retrieved November 14, 2021 (https://www.saco.se/studieval/yrken-a-o/lakare/).

Saha, Somnath, Sara H. Taggart, Miriam Komaromy, and Andrew B. Bindman. 2000. "Do Patients Choose Physicians of Their Own Race? To Provide the Kind of Care Consumers Want, Medical Schools Might Be Able to Justify Using Race as an Admissions Criterion." *Health Affairs* 19(4): 76–83.

Salsberg, Edward, and Atul Grover. 2006. "Physician Workforce Shortages: Implications and Issues for Academic Health Centers and Policymakers." *Academic Medicine* 81(9): 782–787.

Salter, Mark. B. 2006. "The Global Visa Regime and the Political Technologies of the International Self: Borders, Bodies, Biopolitics." *Alternatives* 31(2): 167–189.

Santhanam, Laura. 2018. "New Study Shows 1 in 6 US Health Care Workers Are Immigrants." *PBS.org,* December 5. Retrieved February 18, 2022 (https://www.pbs.org/newshour/health/new-study-shows-1-in-6-u-s-health-care-workers-are-immigrants).

Sassen, Saskia. 2007. *A Sociology of Globalization*. New York, NY: W.W. Norton.

Sassen, Saskia. 2008. *Territory, Authority, Rights from Medieval to Global Assemblages.* Princeton, N.J.: Princeton University Press.

Sassoon, Joseph. 2009. *The Iraqi Refugees: The New Crisis in the Middle East.* New York, NY: Palgrave Macmillan.

SCB. 2021. "Yrken Med Högst Genomsnittlig Månadslön 2020." Retrieved November 1, 2021 (https://www.scb.se/hitta-statistik/statistik-efter-amne/arbetsmarknad/loner-och-arbetskostnader/lonestrukturstatistik-hela-ekonomin/pong/tabell-och-diagram/yrken-med-hogst-genomsnittlig-manadslon/).

SCB. 2022. "Befolkningsstatistik." Retrieved October 9, 2022 (https://www.scb.se/hitta-statistik/statistik-efter-amne/befolkning/befolkningens-sammansattning/befolkningsstatistik/#_Tabellerochdiagram).

Schwartz, Seth J., Jennifer B. Unger, Elma I. Lorenzo-Blanco, Sabrina E. Des Rosiers, Juan A. Villamar, Daniel W. Soto, Monica Pattarroyo, Lourdes Baezconde-Garbanati, and José Szapocznik. 2014. “Perceived Context of Reception among Recent Hispanic Immigrants: Conceptualization, Instrument Development, and Preliminary Validation.” *Cultural Diversity and Ethnic Minority Psychology* 20(1): 1–29.

Selod, Saher. 2015. "Citizenship denied: The Racialization of Muslim American Men and Women Post-9/11." *Critical Sociology* 41(1): 77–95.

Sharma, Menaakshi, Sonu Goel, Sharad Kumar Singh, Raman Sharma and Pramod K. Gupta. 2014. “Determinants of Indian Physicians’ Satisfaction & Dissatisfaction from their Job.” *The Indian Journal of Medical Research* 139(3): 409.

Shin, Eui Hang, and Kyung-Sup Chang. 1988. “Peripherization of Immigrant Professionals: Korean Physicians in the United States.” *International Migration Review* 22(4): 609–626.

Shuval, Judith T. 2000. “The Reconstruction of Professional Identity among Immigrant Physicians in Three Societies.” *Journal of Immigrant Health* 2(4): 191–202.

Shuval, Judith T., and Judith H. Bernstein, eds. 1997. *Immigrant Physicians: Former Soviet Doctors in Israel, Canada, and the United States.* Westport, CT: Greenwood Publishing Group.

Skeldon, Ronald. 1990. *Population Mobility in Developing Countries: A Reinterpretation.* London, UK: Belhaven Press.

Socialstyrelsen. 2021a. ”13 000 Fick Yrkeslegitimation i Fjol – Fyra av Tio Var Sjuksköterskor.” *Socialstyrelsen.se*, September 14. Retrieved February 2, 2023 (https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/13-000-fick-yrkeslegitimation-i-fjol--fyra-av-tio-var-sjukskoterskor/).

Socialstyrelsen. 2021b. *Bedömning av Tillgång och Efterfrågan på Legitimerad Personal i Hälso- och Sjukvård samt Tandvård: Nationella Planeringsstödet 2021.* Stockholm, Sweden: Socialstyrelsen. Retrieved November 29, 2021 (https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2021-2-7200.pdf).

Spak, Emma, Kajsa Holmberg and John Gambe. 2014. *Upplevd Diskriminering i Underläkarkåren 2013.* Sveriges Yngre Läkares Förening. Stockholm: Sweden. Sveriges Läkarförbund. Retrieved March 19, 2019 (https://slf.se/sylf/app/uploads/2018/06/upplevd-diskriminering-i-underlakarkaren-2013-sylf.pdf)

Stajduhar, Tony. 2021. *On the Verge of a Physician Turnover Epidemic Physician Retention Survey Results — February 2021.* Alpharetta, GA: Jackson Physician Search.

Stark, Oded, and David E. Bloom. 1985 "The New Economics of Labor Migration." *The American Economic Review* 75(2): 173–178.

Statista. 2022. "Number of Foreign-Born Citizens from European Countries Living in Sweden in 2021, By Country of Birth." February. Retrieved September 27, 2022 (https://www.statista.com/statistics/525822/sweden-number-of-european-immigrants-by-country-of-birth/).

Stoicescu, Anda. 2021. "Working Conditions for Medical Professionals in Sweden." MediCarrera. Retrieved October 29, 2021 (https://medicarrera.com/blog/working-conditions-medical-professionals-sweden/).

Ströberg, Christian. 2017. "Jobbet Gör Läkare Sjuka." *Sveriges Radio,* April 24. Retrieved December 8, 2021 (https://sverigesradio.se/artikel/6678924).

Ström, Marie. 2017. "Sjukskrivningarna Bland Unga Kvinnliga Läkare Ökar." *Läkartidningen*, February 24. Retrieved December 2, 2021 (https://lakartidningen.se/aktuellt/nyheter/2017/02/sjukskrivningarna-bland-unga-kvinnliga-lakare-okar/).

Ström, Marie. 2018. "Färre Läkarstudenter Utomlands – Men Fler i Sverige." *Läkartidningen*, February 8. Retrieved April 8, 2019 (http://lakartidningen.se/Aktuellt/Nyheter/2018/02/Farre-lakarstudenter-utomlands--men-fler-i-Sverige-/).

Ström, Marie. 2019. "Fler Platser Behövs på Landets Läkarutbildningar." *Läkartidningen*, November 5. Retrieved November 11, 2021 (https://lakartidningen.se/aktuellt/nyheter/2019/11/fler-platser-behovs-pa-lakarutbildningen/).

Ström, Marie. 2021a. "Rekordmånga Utlandsutbildade Läkare Fick Svensk Legitimation 2020." *Läkartidningen*, January 28. Retrieved October 17, 2022(https://lakartidningen.se/aktuellt/nyheter/2021/01/rekordmanga-utlandsutbildade-lakare-fick-svensk-legitimation-2020/).

Ström, Marie. 2021b. "Utländska Läkare Protesterar mot Kunskapsprov: "Det Är För Dåligt." *Läkartidningen*, March 16. Retrieved February 27 2023, (https://lakartidningen.se/aktuellt/nyheter/2021/03/utlandska-lakare-protester-mot-kunskapsprov-det-ar-for-daligt/).

Ström, Marie. 2021c. ” Brist På Specialistläkare – Men Inte På Underläkare.” *Läkartidningen*, February 24. Retrieved November 16, 2021 (https://lakartidningen.se/aktuellt/nyheter/2021/02/brist-pa-specialistlakare-men-inte-pa-underlakare/).

Suter, Esther, Julia Arndt, Nancy Arthur, John Parboosingh, Elizabeth Taylor, and Siegrid Deutschlander. 2009. “Role Understanding and Effective Communicationas Core Competencies for Collaborative Practice.” *Journal of Interprofessional Care* 23(1): 41–51.

Svensson, Björn. 2008. “Regionen Inleder Ny Läkarrekrytering i Höst.” *Göteborgsposten,* June 23. Retrieved March 2, 2022 (https://www.gp.se/nyheter/sverige/regionen-inleder-ny-l%C3%A4karrekrytering-i-h%C3%B6st-1.1227951).

Sveriges Läkarförbund. 2021. ” Läkarförbundet Växer – 55 211 Medlemmar.” *SLF.se*, January 20. Retrieved February 2, 2023 (https://slf.se/pressrum/lakarforbundet-vaxer-55-211-medlemmar/).

Swedish Insurance Federation. 2020. “Såhär Fungerar en Sjukvårdsförsäkring.” Retrieved September 24, 2021 (https://www.svenskforsakring.se/om-forsakring/vad-ar-och-hur-funkar-det/sa-har-fungerar-en-privat-sjukvardsforsakring/).

Swedish Insurance Federation. 2021. “Sjukvårdsförsäkring.” Retrieved September 24, 2021(https://www.svenskforsakring.se/statistik/sjuk--och-olycksfallsforsakring/sjukvardsforsakring/).

Tankwanchi, Akhenaten Benjamin Siankam, Sten H. Vermund, and Douglas D. Perkins. 2015. “Monitoring Sub-Saharan African Physician Migration and Recruitment Post-Adoption of the WHO Code of Practice: Temporal and Geographic Patterns in the United States. *PLoS One* 10(4): e0124734.

Teece, David J., and Gary Pisano. 1994. The Dynamic Capabilities of Firms: An Introduction” *Industrial and Corporate Change* 3(3): 537–556.

Teece, David J., Gary Pisano, and Amy Shuen. 1997. "Dynamic Capabilities and Strategic Management." *Strategic Management Journal* 18(7): 509–533.

The Guardian. 2021. “Our Key Findings About US Healthcare Worker Deaths in the Pandemic’s First Year.” *The Guardian*, April 8. Retrieved February 2, 2023 (https://www.theguardian.com/us-news/ng-interactive/2020/dec/22/lost-on-the-frontline-our-findings-to-date)

Thörnquist, Annette. 2013. *False (Bogus) Self-Employment in East-West Labour Migration: Recent Trends in the Swedish Construction and Road Haulage Industries. S*wedish Council for Working Life and Social Research. Stockholm, Sweden: Themes on Migration and Ethnic Studies. Retrieved September 27, 2022 (https://www.diva-portal.org/smash/get/diva2:637985/FULLTEXT01.pdf)

Thörnqvist, Christian and Sebastian Bernhardsson. 2015. "Their Own Stories–How Polish Construction Workers Posted to Sweden Experience their Job Situation, Or Resistance Versus Life Projects." *European Review of Labour and Research* 21(1): 23–36.

Tikkanen, Rosa and Melinda K. Abrams. 2020. *US Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?* International Health Policy Center. New York, NY: The Commonwealth Fund. Retrieved October 10, 2021 (https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019).

Timmermans, Stefan, and Iddo Tavory. 2012. "Theory Construction in Qualitative Research from Grounded Theory to Abductive Analysis." *Sociological Theory* 30(3):167–186.

Tolbert, Jennifer, Patrick Drake and Anthony Damico. 2022. *Key Facts about the Uninsured Population.* Oakland, CA: Kaiser Family Foundation. Retrieved January 31, 2023 (https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/).

Trotter, LaTonya J. 2020. *More Than Medicine: Nurse Practitioners and the Problems They Solve for Patients, Health Care Organizations, and the State*. Ithaca, NY: Cornell University Press.

UNODC. 2010. *The Globalization of Crime: A Transnational Organized Crime Threat Assessment.* Vienna, Austria: United Nations on Drugs and Crime. Retrieved November 21, 2022 (www.unodc.org/documents/data-and-analysis/tocta/TOCTA_Report_2010_low_res.pdf).

US Citizenship and Immigration Services. 2013. *Iraqi Refugee Processing Fact Sheet*. US Department of Homeland Security. Washington, DC: US Department of Homeland Security. Retrieved June 8, 2022 (https://www.uscis.gov/archive/iraqi-refugee-processing-fact-sheet).

US Citizenship and Immigration Services. 2021. *Characteristics of H-1B Specialty Occupation Workers: Fiscal Year 2020 Annual Report to Congress October 1, 2019 – September 30, 2020.* US Department of Homeland Security. Washington, DC: US Department of Homeland Security. Retrieved June 8, 2022 (https://www.uscis.gov/sites/default/files/document/reports/Characteristics_of_Specialty_Occupation_Workers_H-1B_Fiscal_Year_2020.pdf).

US Citizenship and Immigration Services. 2022. “Refugees and Asylees.” Retrieved June 23, 2022 (https://www.uscis.gov/i-9-central/form-i-9-resources/handbook-for-employers-m- 274/60-evidence-of-status-for-certain-categories/63-refugees-and-asylees).

Vanderbush, Walt. (2014). “The Iraqi Diaspora and the US Invasion of Iraq.” Pp. 211–235 in *Diaspora Lobbies and the US Government: Convergence and Divergence in Making Foreign Policy*, edited by J. DeWind and R. Segura. New York, NY and London, UK: New York University Press.

van Heelsum, Anja. 2016. “Why Migration Will Continue: Aspirations and Capabilities of Syrians and Ethiopians with Different Educational Backgrounds.” *Ethnic and Racial Studies* 39(8): 1301–1309.

Vertovec, Steven and Robin Cohen, eds. 1999. *Migration, Diasporas and Transnationalism: Elgar Reference Collection.* Northampton, UK: Edward Elgar Publishing, Inc.

Vertovec, Steven. 2009. *Transnationalism.* New York, NY: Routledge.

Watson Institute for International and Public Affairs. 2021. *Costs of War: Iraqi Refugees. Brown University.* Providence, RI: Brown University (https://watson.brown.edu/costsofwar/costs/human/refugees/iraqi).

Weiner, Stacy. 2022. “Thousands of Medical Residents Are Unionizing. Here’s What That Means for Doctors, Hospitals, and the Patients They Serve.” *AAMC.org,* June 7. Retrieved January 31, 2023 (https://www.aamc.org/news-insights/thousands-medical-residents-are-unionizing-here-s-what-means-doctors-hospitals-and-patients-they).

West, Colin P., Liselotte N. Dyrbye, and Tait D. Shanafelt. 2018. “Physician Burnout: Contributors, Consequences and Solutions. *Journal of Internal Medicine* 283(6): 516–529.

White, Anne. 2011. *Polish Families and Migration Since EU Accession.* Bristol, UK: Policy Press.

Whitney, William T. 2002. “Becoming a Physician: Class Counts.” *Nature, Society, and Thought* 15(3): 261–274.

Widberg, Ida. 2012. ”Fler Läkare Väljer Privat Arbetsgivare.” *Netdoktorpro.se*, June 29. Retrieved February 2, 2023 (https://www.netdoktorpro.se/allmanmedicin/artiklar/fler-lakare-valjer-privat-arbetsgivare/).

Wilkens, Uta, Daniela Menzel, and Peter Pawlowsky. 2004. “Inside the Black-Box: Analysing the Generation of Core Competencies and Dynamic Capabilities by Exploring Collective Minds. An Organisational Learning Perspective.” *Management Revue* 15(1): 8–26.

Wixe, Sofia, and Lars Pettersson. 2020. Segregation and Individual Employment: A Longitudinal Study of Neighborhood Effects. *The Annals of Regional Science* 64(1): 9–36.

World Bank. 2013. *Medical Malpractice Systems Around the Globe: Examples from the US-Tort Liability System and the Sweden-No Fault System*. World Bank. Washington, DC: World Bank (https://openknowledge.worldbank.org/handle/10986/26120).

Xiao, Lily Dongxia, Eileen Willis, and Lesley Jeffers. 2014. “Factors Affecting the Integration of Immigrant Nurses into the Nursing Workforce: A Double Hermeneutic Study.” *International Journal of Nursing Studies* 51(4): 640–653.

Xu, Yu. 2007. “Strangers in Strange Lands: A Metasynthesis of Lived Experiences of Immigrant Asian Nurses Working in Western Countries. *Advances in Nursing Science* 30(3): 246–265.

Yanatma, Servet. 2023. “Doctors' Salaries: Which Countries Pay the Most and Least in Europe?” *Euronews.com*, January 3. Retrieved February 22, 2023 (https://www.euronews.com/next/2023/01/03/doctors-salaries-which-countries-pay-the-most-and-least-in-europe).

Young, Aaron, Humayun J. Chaudhry, Xiaomei Pei, Katie Arnhart, Michael Dugan, and Kenneth B. Simons. 2021. “FSMB Census of Licensed Physicians in the United States, 2020.” *Journal of Medical Regulation* 107(2): 57–64.

Zarocostas, John. 2007. “Exodus of Medical Staff Strains Iraq's Health Facilities.” *BMJ: British Medical Journal* 334(7599): 865.

Zgliczyńska, Magdalena, Stanisław Zgliczyński, Michał Ciebiera, and Katarzyna Kosińska-Kaczyńska. 2019. "Occupational Burnout Syndrome in Polish Physicians: A Systematic Review." *International Journal of Environmental Research and Public Health* 16(24): 5026.

Zong, Jie, Jeanna Batalova, and Micayla Burrows. 2019. “Frequently Requested Statistics on Immigrants and Immigration in the United States” *Migration Policy Institute,* March 14. Retrieved May 1, 2019

(https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states).

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