

A deeper understanding of what international doctors experience upon entering the profession in Norway may help establish a better climate of cooperation with their Norwegian colleagues.

Our international colleagues

An international doctor who comes to Norway needs to acquire a good deal of knowledge and skills in order to fit into the medical community. Explicit as well as implicit learning takes place. These efforts to adapt will often divert attention from the processes that go on inside the doctor's psyche. For when a person sets foot in an unknown environment, psychological defences are mobilised to cope with the emotions that are engendered by this new situation. These processes take their toll, and will have an effect on the person him-/herself as well as those around him/her, including colleagues, employers and sometimes even patients.

In this issue of the Journal of the Norwegian Medical Association we can read two articles on how international doctors experience the practice of medicine in Norway (1, 2). «International doctor» is defined here as a doctor from a non-Norwegian ethnic background who has not completed his or her medical training in this country. As for myself, I am not ethnically Norwegian, although I completed my medical studies here. I can recognise some of the experiences recounted by our colleagues, and as a support colleague and psychoanalyst I have also undertaken many therapeutic conversations with doctors from other countries.

The article by Skjeggstad and collaborators shows that international medical graduates pass through a difficult stage at the start of their career in this country (1). Major elements of a doctor's identity are linked to the medical profession; this develops during studies and specialisation training. A doctor who comes to Norway has worked hard and passed his or her examinations. Having arrived here, these doctors must prove all over again that they are good enough and qualified for the job as doctor. In a way, they become degraded – they may feel that employers, colleagues and patients doubt their skills, and they may also feel quite alone. Our self-image depends on how others regard us, or – to be more precise – how we *believe* that others regard us. In such a situation where doubts are cast on a doctor's professional skills, he/she might start looking at him/herself with a critical eye.

This is a vulnerable stage, and Norwegian doctors will not invariably see this. This could be because many conceal their vulnerability and appear to function well. To conceal troublesome emotions, appear calm and polite – are these not key virtues in our profession? Troublesome emotions must be largely repressed, at least in the workplace, so we think – consciously or unconsciously. Thus, the international doctor may mobilise a number of psychological defences to keep troublesome emotions in check. I think that Norwegian colleagues ought to be aware of this.

In the article by Sandbu and collaborators it transpires that international doctors do not feel that they have any particular problems with the language and communication with colleagues and patients (2). Norwegian doctors, on the other hand, perceive this as a problem. On the one hand, the authors point to generalisations and stereotyped attitudes to foreign groups – frictions between ethnic Norwegians and non-ethnic Norwegians occur in the health services as well. On the other hand, their explanation of this finding is that our international colleagues are in denial of this painful reality – their shortcomings. I want to draw attention to a third explanation based on psychodynamic theory: projection and identification with the projective. Projection means that difficult issues that have not been processed and psychologically digested are split off and projected onto somebody else. By identification, the other who has been the target of this projection will be pressured or seduced into a specific affective/cognitive mode or relational role (3).

Deficient communication is often seen as a factor that triggers projective processes, but such projective processes will by themselves lead to *poor communication and misunderstandings*. My theory is that international doctors may easily become the target of projections from Norwegian colleagues, employers and patients. The opposite may also happen – the international doctor projects what is difficult onto Norwegian colleagues and employers. Once projection is underway, the realities of the two parties become twisted – they start to detect characteristics in each other that their counterpart does not recognise. Both may often unconsciously make disparaging comments and regard themselves as the stronger or superior party. Lack of knowledge about each other – and distance – help perpetuate this projective identification. If we understand these processes and work our way out of them, better relationships and easier collaboration may come as a result.

Skjeggstad and collaborators describe a feeling of insecurity in international doctors, and this may stem from a lack of collegial support. Sandbu and collaborators point out that international doctors took a less positive view of a mentoring scheme than did the Norwegian doctors. A feeling of being belittled may lead to humiliation and shame. In such a situation our international colleagues may withdraw instead of establishing new relationships and accepting help. Such is the paradoxical effect that humiliation and shame may produce. Someone who has been humiliated and feels shame needs a positive and safe affiliation more than anything else. Shame can only be overcome in relationships, never in solitude.

Each in their own way, these articles elucidate topics and challenges that we as doctors need to cope with in order to function as a community in everyday practice, irrespective of our international or Norwegian background. Both articles suggest that this topic merits further inquiry. On the basis of my experience as a support colleague and therapist, I have seen that even colleagues who are sceptical of receiving help and support have a deeply felt wish to be seen and acknowledged. Time, patience and an attentive and dynamic attitude are crucial for persuading a fellow human being to accept help.

I have always regarded interpersonal challenges also as opportunities. At times when I have succeeded in working with projections, subconscious troublesome emotions and thoughts in a constructive manner, I have felt the magic of therapy. I believe that something similar may also happen between colleagues who come from different ethnic and cultural backgrounds but work in the same place.

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