

International medical graduates' perceptions of entering the profession in Norway

BACKGROUND There is little knowledge available about how it feels for an international medical graduate arriving in Norway. We have investigated how the initial period as an employee of the Norwegian health services is perceived.

MATERIAL AND METHOD We conducted semi-structured interviews with 16 international medical graduates who had foreign training and citizenship. They had worked as doctors in Norway for less than two years. Transcriptions of the interviews were analysed using the Systematic Text Condensation method.

RESULTS Their background for working in Norway varied. Some had an affiliation to the country and a social network, which appeared to be a support during the initial period. Many perceived the authorisation process as bureaucratic and as throwing suspicion on them. The doctors felt that they could cope with most of their work assignments, but reported having faced challenges in terms of language, a lack of insight into systems and uncertainty regarding what was expected of the doctor's role in a Norwegian context. There was also uncertainty associated with a perceived absence of collegial support. Because of the availability of jobs, some had adjusted their career plans towards psychiatry, geriatrics or general practice.

INTERPRETATION It appears that preparatory measures such as training courses, tests and the authorisation process fail to provide the practice-related experience and local knowledge that many doctors feel that they need in their new job situation. Measures such as language training and introduction to systems would be likely to improve their general well-being as well as integration.

In recent years, approximately 16% of the medical practitioners and 20% of the specialists in Norway are international medical graduates (IMGs) and hold foreign citizenship (1, 2). We know that foreign workers may perceive some uncertainty and difficulties adjusting to their workplace, for reasons including that in Norway, communication tends to be more informal and less characterised by hierarchical relations than is common in most other countries (3). Speaking Norwegian may also be a challenge to IMGs (4), even for those who speak another Scandinavian language (4, 5).

IMGs in the Norwegian health services have described the effect that they feel their cultural background has on how they are received by their colleagues (6). Studies conducted in the USA and Australia show that many IMGs feel uncertainty in interactions, loss of self-esteem (7) and fear of making mistakes (8). We have found no studies that investigate how doctors who have recently arrived in Norway perceive this situation. A direct transfer of results from studies undertaken abroad may be complicated by the fact that social conditions, culture and to some extent also medical practices are different. The group of doctors who immigrate to Norway also have a different mix of nationalities than is common in other countries, since there is considerable immi-

gration from the neighbouring Scandinavian countries (2).

In the literature of psychology, the concept of «acculturation» is used to describe the changes that a person goes through when moving from one culture to another (9–12). Knowledge about such psychological adaptation processes has proven useful in understanding how multicultural workplaces can facilitate the situation for workers of foreign origin (13).

The objective of this article is to provide an impression of the acculturation process that IMGs undergo in Norway, with an emphasis on how they feel that they are received and valued, and the ensuing consequences for each individual's sense of coping.

Material and method

We interviewed doctors who had been born and trained abroad. We used the Health Personnel Registry and lists of novice foundation doctors to recruit doctors who had been initially registered in the years 2010–2011. These lists gave access to their names, gender, age and nationality. We subdivided the list by geographical location (Table 1), since we deemed this the most relevant criterion for including participants with a variety of experiences. Persons whom the researchers knew personally were deleted from the lists.

The sample was random in the sense that

Erik Skjeggstad
erik.skjeggstad@gmail.com
HØKH, Research Centre
Akershus University Hospital

Gro Mjeldheim Sandal
Department of Psychosocial Science
University of Bergen

Pål Gulbrandsen
Institute of Clinical Medicine
Campus Ahus
University of Oslo
and
HØKH, Research Centre
Akershus University Hospital

MAIN MESSAGES

Of the 16 international medical graduates who were interviewed, many had experienced little follow-up and feedback during their initial period of working in Norway.

The majority felt that they could cope with their medical work, but gave voice to challenges in terms of language, lack of insight into systems and uncertainty regarding their role.

Many of them appeared to change their career plans with a view to the jobs they believed it possible to obtain.

Table 1 Overview of characteristics of the 16 participants

Gender	
Women	9
Men	7
Region of origin¹	
Nordic countries	5
Non-Nordic EU, USA, Australia	3
Asia	4
Africa	2
Central and South America	3
Russia and the former Soviet Union	3
Age group (years)	
Under 30	5
30–40	8
Over 40	3
Place of work	
Public or private hospital	8
In general practice	5
Unemployed ²	3
Last or current type of position	
Foundation doctor	4
Specialty registrar or doctor in the primary health services	7
Hospital specialist	5

¹ Four participants reported having affiliations to more than one country.

² Was working extra shifts or had been on temporary contracts until recently.

we started from the top of the lists. Towards the end of the recruitment process, however, we chose to select participants strategically in light of their age and gender in order to include more doctors older than 40 years and achieve a more balanced gender distribution. The lists that were available to us did not include any contact information, so we used telephone information services. Some we failed to trace.

All of the 18 doctors whom we contacted by telephone were willing to participate in the study, although two of them were unable to come to an interview in Southeast Norway. The 16 participants chose the time and venue of the interview. Their work experi-

ence in the Norwegian health services ranged from some months to two years, and they had worked in all regions of the country, both rural and urban. We stopped the recruitment after 16 interviews, since we deemed these to reflect a sufficient range in terms of the participants' age, work experience, workplace, type of position and background, as well as a reasonably adequate gender distribution.

Qualitative interviews are suitable for providing insight into the participants' perspectives on the world and to explore experiences and reflections on these (14). The first author conducted the interviews on the basis of a semi-structured interview guide that included the following topics: background, knowledge about and expectations of the Norwegian health services, entry into the new job, ideas about motivation and future prospects. Emphasis was placed on description of specific personal experiences, rather than general comments. The interviews lasted from 30 to 90 minutes.

The project was approved by the local data protection officer. The regional committee of medical and health research ethics deemed that the project did not require a formal submission. Written consent was collected from all participants.

For our analysis of the transcribed interviews we chose Malterud's method of systematic text condensation (14). The method is empirically based and suited for analyses across the dataset to develop descriptions of a field such as the experience of being a new, IMG in Norway. In this article we present four topics that appear to reflect the main experiences recounted in the interviews. These topics appeared in all of the interviews, in various forms.

The quotations used have been lightly edited for written presentation.

Results

Leaving behind, going to, or just making a stop

The participants had a variety of main reasons for coming to Norway. Some had emigrated because of war or crisis. For example, many of the doctors from Southern and Eastern Europe referred to financial crises that had resulted in difficult working conditions in their home countries: «In my home country it is such that if you work in the public sector, the salary is too low to make a living. (...) The salary covers only the transport to and from work. You need to earn money by moonlighting or working privately. I worked privately, and it was very well paid. (...) But competition is extremely fierce. Also, you need to pay the fireman, the police, the tax authorities and such» (L5).

Others did not primarily describe condi-

tions at home as the decisive factor, but rather that they had travelled to something. Many of the participants had a relational affiliation with Norway, as a partner, relative or from a previous student exchange. Having a personal network was underscored as a resource for coping with life here: «I was lucky to have a husband who could teach me Norwegian, he has helped me a lot» (L12). Many stated that if it had not been for this affiliation, they would have chosen to go to another country, and the USA in particular was mentioned as more professionally attractive. Doctors from other Scandinavian countries stated the attractive wages and working conditions and opportunities for further education as their reasons for coming to Norway.

Two participants stated that they had a desire to explore the world, and working as a doctor in Norway was part of this: «I wished to try something new. Norway was the most available option» (L2). In contrast to the other participants, these two had no plans to work in this country for a long period of time.

A lengthy and uncertainty-inducing authorisation process

Obtaining a Norwegian authorisation was a thing of the past for the participants, although many of them started their description of the experience of arriving here by recounting this process. On the whole, they accepted the necessity for regulation and checking of professional knowledge, but the majority felt that the casework involved in authorisation was more cumbersome and time-consuming than they had anticipated.

A Scandinavian doctor with work experience from both Sweden and Denmark had his case rapidly processed in these countries, but stated: «When I applied for a Norwegian authorisation, I felt that the process was extremely bureaucratic and relatively complicated» (L8). The doctors had spent from a few days to nine years from their arrival until they could practise their profession. Those who came from the Nordic countries or Northern Europe had received job offers before their arrival and had no particular experience of a lengthy authorisation process.

The doctors from remote countries had needed to learn Norwegian, attend training courses and pass tests in order to obtain an authorisation. For these, it was common to have lived in Norway for many years before entering medical practice: «I couldn't work in the Norwegian health services in the meantime, but I needed a job to live. I worked delivering newspapers for 2–3 years and then as a postman for three years before I passed the professional test» (L4). Many had felt that the authorisation process cast suspicion on their qualifications.

A new language and a new role in an unfamiliar system

When recounting their first working days in this country, the doctors were concerned with how the differences between Norway and their home countries in terms of everyday professional practices were greater than they had expected. Several of them cried during the interview when recounting difficult situations they had been in during the initial period. Some claimed that the disease panorama in Norway was somewhat different from what they were used to, especially in psychiatry. All of them nevertheless claimed that their medical skills were sufficient to practise here. The issues that were hardest to cope with were mainly related to language, insight into systems and the implications of the doctor's role. For some, this engendered a feeling of inadequacy; others regarded these issues as passing trivialities.

The ability to cope with the job situation was not necessarily correlated with originating from a nearby or distant country. For example, a recently arrived doctor from a Nordic country described significant feelings of linguistic inadequacy, while an Asian doctor who had lived in Norway for many years reported no such problems. The doctors who had attended language courses and tests told us that when entering medical practice, they had felt a dearth of practice-relevant language and interaction skills. «Recording case histories was difficult at first. Because the way of asking questions is somewhat different here» (L10).

The majority of the doctors told us that they had received little in terms of systematic training in their new workplace, and they had also felt expected to function as a proficient doctor within a short period of time. Receiving less feedback than they had expected made them feel insecure: «You never receive any feedback when you have done something well or badly – you never receive any feedback. (...) I have lived in Norway for many years, and I feel nearly able to adapt, but I constantly doubt whether I am doing the job properly» (L7).

The way in which doctors work and the job tasks that are part of the doctor's role were unclear to many during the initial period: «You mainly need to adapt on your own. It's a demanding period» (L16). Some recounted that the courses and examinations had provided little help in preparing them for a doctor's role in Norway, and they did not learn this until they entered work. «Having the foundation period was important; I learned something then. I learned how things function in Norway, such as guidelines, structures and how things are done. (...) That was what I needed, not the courses

and exams. But you need to have this in order to be able to measure» (L15).

Uncertainty regarding what was expected of the doctor and what was the job of others had in some cases resulted in unfortunate experiences. One doctor described how he had adapted: «The staff was surprised because I did their job. But I did not intend to interfere in their work, I just wanted to treat the patient in a way that I felt was right. For example, to me it's completely natural to measure the patient's blood pressure myself.» (The interviewer: «So what do you do now?») «I have learned to stay away and not interfere in the jobs of others. Even though it's my patient» (L4).

Doctors from outside Northern Europe described issues of authority in the interaction with nurses as particularly unclear. In other respects, most of them referred to a high degree of job satisfaction, although many gave little priority to getting to know their colleagues. Instead, they had devoted their time to learning about their job tasks and performing them.

Adjustments of career plans and levels of ambition

Among those doctors who were youngest and those who had a short career record in this country there was a pervasive feeling of job insecurity. One doctor described his fear that his temporary contract would be terminated: «I check every day when I come to the morning meeting. Is there a doctor who will come in and take my job, or isn't there?» (L14).

Most of them were in temporary or training positions and were concerned with doing a good job and obtaining the best possible references. At the time of the interview, three participants had recently completed their foundation period/temporary contracts and were job seekers. Ten of the others stated that they did not regard their present job as their future position because of insecure employment conditions or because they wanted something else. Many told us that they had changed their plans for the future after having entered medical practice in Norway. Several of them recounted that previous wishes for hospital work, preferably surgery, had been replaced by ideas of general practice, geriatrics or psychiatry. Doctors who were on temporary contracts and came from outside of Northern Europe showed the most concern regarding their future career plans in Norway.

Discussion

Preconceptions and transferability

All of the three authors have previously conducted research on how culture may affect professionals in their work. However, our own research as well as that of others pro-

vided us with little insight into *doctors'* perception of how it is to come to Norway to work. In light of this we chose a qualitative approach, seeking knowledge through descriptions from a group of people who are in this situation (14).

By recruiting participants randomly from a register and supplementing them with strategically selected persons, we believe we have ensured a sufficient range of backgrounds among the participants. The recruitment method enabled the participants to come to an interview without their employer and colleagues being informed about it. Several of them described their vulnerability with regard to their colleagues, and that confidentiality was needed for them to share their experiences and feelings.

During the interviews we sought to elicit the participants' narratives about their personal experiences. Such an open form of interviewing may have imposed some limitations regarding the topics that were relevant for them to discuss. The fact that the interviewer was not a doctor may have resulted in medical topics being touched upon less in the conversations than other aspects of the job situation. It is also conceivable that the project's concentration on experiences in the job situation may have provided us with less insight into the doctors' private lives, which also may have an effect on the practice of their profession.

In interviews, participants may tend to portray themselves in a positive light and be reluctant to discuss difficult issues and shortcomings. Most of the participants nevertheless and on their own initiative described experiences that had been hard for them or situations in which they had felt inadequate. Many of the interviews were quite emotionally charged. Some of the doctors cried when recounting their experiences. This indicates that the topics were important to the participants, and that they were sufficiently confident to show emotion in the interview situation.

The participants and the interviewer did not share the same mother tongue or nationality, and this may have given rise to misunderstandings. The doctors stated that it felt natural for them to have the interview in Norwegian, their current workplace language. Some, however, had challenges in terms of language, so that English was used for parts of the interview.

The objective of our analysis was to communicate the essence of the descriptions provided by the 16 participants (14). We believe that their experiences may provide insight into key phenomena associated with coming to Norway as a IMG. The results do not provide a basis for discussion of the content of the authorisation process or specific

interventions to ease adaptation, but they point to a need for further trials and research on such measures, since nearly all participants expressed a desire for more support and more feedback in their job situation.

Discussion of the results

This study shows that most of the doctors had felt that their initial period of working in Norway had been demanding and that the facilitation had been arbitrary. Research on acculturation has shown that the way in which immigrants adapt to a new culture is related to their personal resources and reasons for migrating, as well as how they are received by the host society (9–11). This study indicates that personal networks are a key resource when it comes to development of language skills, the understanding of norms and social conventions and the opportunity to find trusted conversation partners. The doctors who had an affiliation with Norway prior to their arrival had better access to such forms of support. Those who arrived because of the attractive working conditions or for other reasons felt compelled to emigrate from their home countries had little in terms of social networks in Norway. This group therefore appears to be more vulnerable.

Cultural distance is generally described as being associated with challenges to integration (9). Many of the doctors hailed from countries that are regarded as culturally different from Norway (15). Studies from Norwegian casualty clinics have shown that Norwegian and IMGs may have differing modes of work (16). None of the participants in our study felt that they lacked the knowledge required to perform clinical work, but all of them, on the other hand, referred to language, insight into systems and collegial collaboration as challenges. The results indicate that the doctors encountered many of the same challenges, irrespective of their background or nationality.

All the doctors, those working in general practice as well as those in hospitals, referred to a sense of insecurity that stemmed from insufficient training and follow-up and little feedback. Feelings of insecurity and uncertainty in the initial phase are not particular to IMGs; this is also known from the descriptions that Norwegian doctors have provided of their first period of work (17). This indicates that many workplaces in the Norwegian health services may do well to reconsider the way in which they receive newcomers. In particular, the immigrant doctors pointed to the need for more training in issues specifically related to the health services and more feedback. Many referred to the importance of the foundation period for providing insight into the health services. At a time when the foundation training

scheme is undergoing change, this is an interesting observation.

Many of the participants had changed their career preferences during their initial period of working in Norway. Nor is this particular to IMGs; it has been described by Norwegian doctors who had gained a certain amount of work experience (18). Previous studies have pointed out that the Norwegian language represents a challenge to many IMGs (4, 5). Our participants also referred to communication problems. Despite this, many appear to opt for disciplines that involve extensive patient communication – psychiatry, geriatrics and general practice. These fields are associated with less prestige (19). Employment opportunities appear to be the main reason for a change of career path.

IMGs may have a feeling of insecurity in their interaction with colleagues (6, 8). Many of them spoke of little access to professional support, fear of negative attention and a yearning for recognition. Previous research indicates that a sense of marginalisation is associated with emotional distress (12), including among doctors (7). A minority of the participants appeared to have largely lost their identity from the home country while also perceiving themselves as «outsiders» in Norway. The clearest expression of this emerged in their descriptions of inferiority in the authorisation process and their uncertainty regarding future prospects for work and a career in Norway because of their foreign origin.

On the whole, the results indicate that the initial period in Norway is a demanding one for many IMGs. Our findings and established knowledge on acculturation indicate that the Norwegian health services would be well served by developing measures to assist new IMGs during the initial period of their careers in this country.

Erik Skjeggstad (born 1978)

Master of professional ethics and PhD scholar. The author has completed the ICMJE form and declares no conflicts of interest.

Gro Mjeldheim Sandal (born 1962)

professor of psychology and leader of the Society and Workplace Diversity Group, University of Bergen.

The author has completed the ICMJE form and declares no conflicts of interest.

Pål Gulbrandsen (born 1955)

MD, PhD, specialist in public health, professor of health services research and senior researcher.

The author has completed the ICMJE form and declares no conflicts of interest.

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