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Long time in the waiting room: migrant physicians in Sweden and their struggles to mobilise cultural capital

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ABSTRACT
The mobilisation of assets from one national field to another is a topic that has attracted significant sociological attention. In this paper, we investigate migrant physicians who obtained their medical degrees outside the EU/EEA and trace the process of validating their degrees in Sweden. The study is inscribed in Bourdieu’s sociological tradition and is based on a questionnaire and interviews with physicians. Analysing the mobilisation of cultural capital across national borders, we emphasise the importance of distinguishing its different states in the context of migration. Based on our case, we argue that the time physicians spend in the ‘waiting room’ challenges their ability to maintain and perform their medical craft. We show that the time it takes to institutionalise assets and accumulate capital in another national context can lead to the risk of losing its embodied state.

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Introduction

In an age of migration, mobility has become ordinary, whether as a result of living in a globalised world, or of war and crisis (de Haas, Castles, and Miller 2020). Research has shown that migration will continue and is only increasing (van Heelsum 2016). Transferring resources across different spaces and geographical contexts, however, often becomes a struggle. Although assets seem accumulative, sociologists have criticised scholars’ tendency to define them as increasing over time (Clément, Gellereau, and Steinmetz 2021; Dugonjic-Rodwin and Mladenovic 2023; Erel and Ryan 2019). The value of educational qualifications, for instance, ‘varies according to the worlds in which they find themselves, the forms of domination that prevail there, and the other resources that may be available and legitimate there’ (Serre and Wagner 2015, 445–446). Studies in migration have shown that the migration of educational and occupational assets often causes their devaluation as they might not be valued and recognised in the new setting (Erel 2010; Erel and Ryan 2019). Therefore, migrants enter a bargaining process about the value of their resources when entering a new country (Erel 2010). It is thus not the possession of...
different types of resources, but their composition, mobilisation, and recognition that matters in the cases of migration.

Drawing on the sociology of Pierre Bourdieu, we work with his concept of cultural capital, which he defined as cultural resources, i.e. various forms of knowledge, skills, education, and cultural experiences that contribute to an individual’s social status upon their recognition and their legitimacy by dominating social groups and institutions in a society (Bourdieu 1984, 2020a).1 This work departs from studies confirming the struggle to mobilise educational and occupational assets across national borders (Clément, Gellereau, and Steinmetz 2021; Erel 2010; Erel and Ryan 2019; Maxwell, Yemini, and Gutman 2022; Ryan and Mulholland 2014; Waddling, Bertilsson, and Palme 2019), and contributes to studies analysing the relationship between different states of capital (Serre and Wagner 2015) in order to better understand the complex processes involved in its mobilisation.2

Cultural capital was deconstructed by Bourdieu into three states: institutionalised, embodied, and objectified. In the form of its institutionalised state, it refers to cultural assets corresponding to educational credentials and qualifications; in its embodied state, it refers to the knowledge, perceptions, and abilities stored in the body; and in its objectified state, it corresponds to cultural goods that are tangible such as objects of culture (Bourdieu 1986, 17). In our analysis, we found that the objectified state did not emerge as prominently relevant in the mobilisation of educational and occupational assets across national borders. In this paper, we thus focus on the institutionalised and embodied states as the former highlights the accumulation of cultural assets corresponding to qualifications ‘in the forms of titles’ (Bourdieu 2020a, 162), while the latter is defined as the ‘long-lasting dispositions of the mind and body’ (Bourdieu 1986, 17). The accumulation of cultural capital in its embodied state costs time as an external skill needs to become internalised and a part of one’s dispositions; in other words, a part of one’s habitus. Capital, however, only exists in relation to a field. Therefore, when cultural capital crosses national borders, hence national fields, its recognition and legitimation are disrupted, and the ‘rules of the game’ change (Bourdieu 2020b).

Working with the different states of cultural capital in the context of migration draws further attention to its characteristics. Taking the case of migrant physicians who received their medical degrees outside the EU/EEA, we investigate their medical degrees and medical craft respectively as institutionalised and embodied cultural capital from their respective countries. The embodied state, in this case, does not include manners, taste, style, etc. Instead, our focus is primarily on work-related practices and dispositions of embodied cultural capital. We analyse what happens to migrant physicians’ qualifications and skills during the time they spend validating these assets in order to be able to work as physicians in Sweden.

The case of ‘non-EU migrant physicians’ in Sweden

Sweden provides a unique case as healthcare and education are the public sectors most affected by the labour shortage (Hörnsten, Asplund, and Berglind 2016), which has led to the introduction of a variety of policy initiatives regarding the labour integration of the arriving population with the aim to include them in the labour market as fast as possible
(Bengtsson and Mickwitz 2022; Hultqvist and Lidegran 2018; Lidegran and Collsiöö 2018; van Riemsdijk and Axelsson 2021). This being said, the demand for physicians still exceeds supply (Göransson 2017), which suggests that Sweden has a need for medical doctors that migrate to the country (Johansson and Svensson 2019).

However, as studies have shown, the requirements to complete ‘migratory processes’ often do not allow migrants to work in jobs for which they are qualified (Anderson 2010), forcing them to accept jobs for which they are overeducated (Andersson and Osman 2008; Behtoui and Neergaard 2010; Chiswick and Miller 2009; Dahlstedt 2011; Nordin 2011; Zimmermann and Bauer 1999). Although ‘classed resources’ provide support in the post-migration context (Bygnes 2021), highly skilled migrants in regulated professions struggle to obtain recognition for their education and professional skills and have low employment rates (Colic-Peisker and Tilbury 2007; Creese and Wiebe 2012; Irastorza and Bevelander 2017; Morrice 2009; Salmonsson and Mella 2013; Smyth and Kum 2010; van Riemsdijk and Axelsson 2021, 2007). The experiences and struggles faced by highly skilled migrants in Sweden are no exception (Frykman and Öhlander, 2018). Often analysed in terms of the devaluation of migrant labour, these studies have further emphasised the reasons behind migrants’ ‘deskilling,’ such as their language proficiency, lack of labour market information, and occupational certifications. Their findings have contributed to our understanding of the migrant condition, i.e. their downward mobility and associated socio-economic inequalities. While our study pertains to such findings, we emphasise what happens during the process of obtaining recognition for educational and professional skills. This approach allows for a comprehensive discussion on the nuances involved in mobilising cultural capital across national borders.

To work as a physician in Sweden, a migrant is required to validate their degree, a process which depends on whether it was obtained from a country within or outside the EU/EEA. The former group of physicians is evaluated based on the EU legislation which governs the medical profession. This group’s medical degrees are recognised in Sweden following certification of their Swedish language skills. On the other hand, the latter group undergoes a particular process to validate their degrees. The possibility to mobilise their educational assets is based on a standardised test through which their medical degrees receive the same validity as those obtained within the EU/EEA. The standardised test can thus be seen as a route through which to accumulate the resources required to institutionalise one’s educational assets in Sweden, thus gaining European validation.

Regardless of their years of experience, non-EU physicians are required to learn Swedish; submit and validate their documents (and degrees) through the National Board of Health and Welfare; pass the proficiency exam, consisting of a written exam taking place twice a year and a practical exam (since 2019, both are required to be completed within five years and three attempts); attend a Swedish laws and regulations course; undergo a clinical internship with a six-month training period; and finally, apply for a practice license. This includes a requirement to demonstrate their ability to manage ‘Swedish cultural codes in the health context’ (Salmonsson and Mella 2013, 8). According to a newspaper article written by authorities responsible for the proficiency exam, the objective behind this process is to place the same demands on foreign doctors as those trained in Sweden so that there is a level of trust that all qualified doctors have the same knowledge and skills required regardless of where they obtained
their education (Hultin, Själander, and Edin 2019). Alternatives to this route include taking part in a complementary course that takes place in selected universities and is significantly limited in its admission process, or studying the medical programme in Sweden.

Medical knowledge has a wide international spread and medical programmes have relatively similar content across national borders. At the same time, the medical profession is highly country-specific regarding its history, language proficiency requirements, and cultural codes for treating human bodies (Connell 2012). Healthcare is organised in different ways across the world, and the professional culture varies both between and within countries (Wolanik Boström and Öhlander 2018). In Sweden, this culture is characterised by reference to autonomy and a strong union spirit (Broady 2002; Carlhed Ydhag 2013; Carlhed Ydhag 2020; Funck 2019), and is tightly regulated through the national education system. Being a physician means occupying one of the most privileged professions in Sweden, with clear requirements for entry.

The medical programme also occupies the most dominant position in the higher education field, and includes the students with the most resources of all programmes regarding merits and inherited educational assets. When the Swedish higher education system expanded during the 1990s, the number of places in the medical programme remained largely the same (Börjesson, Ahola, and Helland 2014). Migrant physicians such as those discussed in this study are required to learn how to work according to the Swedish medical, administrative, and organisational routines and communication patterns in order to become physicians in Sweden (Wolanik Boström and Öhlander 2018).

For migrants in Sweden, entering and advancing in the medical profession often comes with experiences of discrimination on the grounds of ethnicity, religion, and gender (Sturesson, Öhlander, and Nilsson 2019), which hierarchically puts them in lower positions in comparison to those who have been educated in the country (Boström and Öhlander 2012; Sturesson, Öhlander, and Nilsson 2019). For instance, having a Muslim-sounding name can cause rejection on the labour market, which may lead migrants to use a strategy of changing their names to more Swedish-sounding ones. Working with refugee physicians in Sweden on questions regarding ‘the processual nature of identity’, Mozetič empirically shows the frustration and depression physicians experience in the process of becoming validated, supporting the argument that migrants occupy the same or even a lower position than their less experienced Swedish colleagues (Mozetič 2018, 249–250). Mozetič draws on migrant physicians’ perceptions of their validation process and emphasises the temporal aspects impacting their experiences entering labour markets (Mozetič 2022).

Given the requirements to become a recognised physician in Sweden for non-EU migrants, it takes longer for them to obtain their Swedish license in comparison to those educated in the country (Nilsson and Viberg 2016). Cwerner has drawn attention to the relationship between time and migration, arguing that migration has significant temporal dimensions (Cwerner 2001). Based on this argument, previous studies on time and temporality in migration studies have emphasised how ‘waiting’ is a crucial dimension when trying to understand the experiences of migrants (Bhatia and Canning 2021; Griffiths 2014; Ibañez Tirado 2019). Scholars mainly approach migrant experiences concerning time as having an uncontrollable element due to structural constraints such as legal status, visa procedures, and infrastructures of nation states.
(Griffiths, Rogers, and Anderson 2013). In other words, ‘control over time lies beyond the migrant’s reach’ (Baas and Yeoh 2019, 164).

Hage has proposed another fruitful angle to understanding time and temporality in migration by arguing that there is an element of immobility to migrants’ mobility which entails an existential movement that is beyond a physical one (Hage 2005). ‘The fear of being stuck’, according to Hage, describes a potential perceived certainty of immobility (Hage 2005, 470–474). We believe that the ‘waiting’ aspect resonates with ‘being stuck’ as both highlight the existential immobility of migrants related to the structural constraints they face.

Analysing what happens to migrant physicians in the ‘waiting room’ unpacks what kind of process is dominating when time is beyond the migrant’s control. To put it differently, we examine non-EU migrant physicians’ experiences with time during their process to mobilise their assets to Sweden, analysing what happens in times of ‘waiting’ and what the consequences are for migrants trying to access the Swedish labour market.

**Material and method**

To investigate this particular group, we used a qualitative approach where our primary source was based on a detailed survey prepared in 2019. The survey consisted of different types of questions, including open-ended, concerning non-EU physicians’ educational background, professional skills, their experiences with validating their medical degrees in Sweden, and lastly their experiences with the training and potentially working process. The survey was available in both Swedish and English. 28 respondents (14 female and 14 male) participated in the survey, residing in different parts of Sweden and coming from different countries such as Syria, Iran, Iraq, Turkey, India, Colombia, Russia, and Ukraine.

As part of the survey, we asked participants if they would consider being interviewed, and 10 of the 28 respondents agreed to participate. Using this as secondary material, we deepened our understanding of migrants’ experiences by conducting interviews with these 10 respondents between 2019–2020, each lasting approximately one to two hours. The questions were similar to those in the survey, but focused on physicians’ experiences on a deeper level, which led to discussions regarding their social networks and the impact of their migration to Sweden on their professional skills. During this time, we also interviewed a retired Swedish physician acting as a teacher in a study group preparing non-EU migrant physicians for the proficiency exam. The retired physician put us in contact with two separate study groups that we managed to observe. Our ambition was to understand physicians’ experiences beyond their narratives. Our interest in analysing time as a dimension of their experiences led us to conduct additional interviews with three of the previous participants two to three years after our initial meeting, each lasting one to two hours. These participants were selected based on their availability for a second interview. While each case was unique, we found broader patterns in our empirical material relevant for a sociological analysis.

All participants received information regarding the aims of the research project, their rights as participants, and the authors’ contact information. Those who were interviewed received an additional form to give their consent regarding the recording and storage of
data, analysis, and use of the interview. All of the interviews were conducted by the authors in English, Swedish, Turkish, and Kurdish depending on physicians’ preferences. The interviews in English and Swedish were transcribed by a transcription firm in Sweden while those in Turkish and Kurdish were discussed in detail among the authors. This led the first author to transcribe the relevant sections of the interviews illustrating the analytical points made in this article. The first author further translated all the quotes that were not in English. The names in this article are pseudonymised.

Employing Bourdieu’s research tools, we have analysed both the survey and interviews qualitatively with the ambition to detect differences in how migrant physicians used and experienced their time during their process of mobilising their cultural capital to be able to work as physicians in Sweden. The group of non-EU migrant physicians we investigated was heterogeneous, not only in terms of their nationality but also in their age, education, and years of experience in their profession. The majority of participants were aged between 25 and 35, but the group also included people in their late 50s. While some held refugee status, which prevented them to go outside of Sweden, others had temporary residency based on work which did not prevent their mobility unless they had issues with visa applications. Although some of the migrant physicians could leave Sweden and possibly work in other countries as opposed to others, in our data we observed that none of the participants expressed the wish or possibility to migrate to another country for work. There were physicians from various areas of specialisation, some with several years of experience and others with decades of medical practice. All of them had the same goal, which was to work as a physician in Sweden as soon as possible.

**Time on standby**

For migrant physicians in Sweden, ‘waiting is a substantial part of their validation process. According to the survey and interviews we conducted, it usually takes six months to two years for documents regarding previous educational and occupational qualifications to be confirmed by the Board after already having completed the language requirements. Shirin, having two and a half years of work experience as a physician in Iran, received confirmation after six months and immediately wanted to complete the next stage, which is the written exam. The registration process was a source of stress for her, as she had received an email stating ‘first come, first served’, indicating that the exam had limited spaces for physicians. Shirin expressed her shock as follows:

> They opened the website in order to register and it got fully booked in like five minutes. The day before we got an email. It was really strange for me […] I was on the website from a quarter to ten, so I got the place but it was fully booked within five minutes. (Shirin, Iran, age 34)

The limited places for the proficiency exam were fully booked within a short time, requiring physicians to compete with each other based on their technical skills. Shirin understood that her promptness and computer skills had guaranteed a place for her. However, she did not pass the exam on her first two attempts. Due to her failed attempts and the limitations on the number of times she could take the exam (three times within five years), she became afraid to register unless she was fully prepared. She was also afraid to wait for too long without practising her medical knowledge because she was
worried she would forget how to practice. About to give up on the process, it was not until the third attempt that she managed to pass the exam, after which she found herself waiting yet again for several more months for the practical part of the exam. After passing the practical exam, she then needed to find a placement to start her six months of practical training. This was another stressful process, as she did not know where or how to find a place, and when it would be starting. Searching for jobs in hospitals, she eventually wanted to become a specialist physician.

The time physicians spent on standby during the process of validating their degrees often led to anxiety and depression (Mozetič 2018). Having to wait for months for their paperwork or the next step in the process increased their fear of losing time without practising, and thus losing their occupational skills. This experience of waiting, which can be interpreted as being stuck existentially (Hage 2005), was also voiced by other respondents.

Farid was another physician from Iran who gained his specialisation in Europe and had 10 years of work experience upon arriving in Sweden. He experienced delays in his asylum process which meant that he had to wait to receive the permit to begin his validation process in Sweden. In other words, he was only able to start the process to validate his degree five years after he arrived in Sweden. Having passed the proficiency exam and waiting for a place for the practical part eight years after his arrival, he voiced his frustration in regard to this ‘waiting’ which often led him to ‘feel stupid’ and like a ‘loser’ as a result of not being recognised despite his years of experience.

It’s killing me to wait so much time for the process, just to start. It took a year before they analysed … That’s the … That’s what kills you. And then, when I got permission for the first time for the theoretical prov [proficiency exam], and I passed it – [it took] six months to go and be taken for the practical part. Six months. Simply because they haven’t got places, they haven’t got enough place for you to be examined. So, you lose time in extreme poverty. You suffer because you cannot reach the position to show that you can do things […] I’m just waiting to start working here in Sweden, and I just have to wait without any decision. I have waited. It is killing me you see? (Farid, Iran, age 49)

The time spent in ‘waiting’ to transfer his institutionalised educational capital from Iran to Sweden was described by Farid as ‘lost time’ due to his distance from the practice of the profession. He expressed the necessity to be in contact with medical practitioners in Sweden and use his occupational skills for practicing his professional knowledge rather than working in his current job as a part-time interpreter. His inability to perform his incorporated professional practices was weighing on him due to his strong work ethic, which had involved mastering his own time in his highly demanding education and professional life as a physician (Mozetič 2018, 248). For Farid, it took a year of waiting time until the Board confirmed his educational resources. His attitude towards his time on standby made him aware that he would ‘suffer time’ in different stages of his process to accumulate and institutionalise resources in Sweden and practice his specialisation. He was not able to make use of the incorporated resources acquired from his professional knowledge and skills, which is his medical craft. The objective conditions requiring the validation of his medical degree from Iran to establish his occupational position as a physician in Sweden thus caused him to ‘suffer time’.

The experiences of Shirin and Farid reveal struggles over time in regard to being on standby and having to wait for a long time to take the exams, complete the different
stages of the process, and become recognised physicians in Sweden. Being prevented from practising their medical craft during this time led them to consider how they could bargain their way into the Swedish healthcare sector to maintain a connection with their profession. In the following section, we emphasise the role of social ties for physicians aiming to practice their medical craft by discussing the experiences of Hassan and Ahmet in Sweden.

**Bargaining the way in during the time on standby**

Educational qualifications as well as links with other states of cultural capital and other kinds of capital associated with it have significant roles in determining social position (Serre and Wagner 2015). In the case of migrant physicians who gained their qualifications outside the EU/EEA, their social position in Sweden heavily depended on their social ties and networking activities (Keskiner, Eve, and Ryan 2022; Ryan, Erel, and D’Angelo 2015). Commonly, migrants engage in ‘bargaining activities’ with institutions and employers regarding the value of their skills (Erel 2010, 649). However, their skills are often undervalued (Chiswick and Miller 2009; Erel 2010). The medical profession is no exception. Being undervalued in this way, migrant physicians had limited or no access to the Swedish healthcare sector, as well as limited power over the rules of the game. It was often experienced as complex to get information, or even to know where information was available concerning the process of validating their degrees in Sweden, as well as how to apply for jobs associated with their educational and occupational background.

Migrant physicians often expressed that they were dependent on social media platforms for information, as this was a space where discussions were held regarding their particular process as physicians from outside the EU/EEA. These online communities created a sense of solidarity where those with different specialisation backgrounds and in different stages of their validation process shared detailed information about their overall experiences, as well as the bargaining techniques they used to access the Swedish healthcare sector. In the effort to build up their social contacts, migrant physicians also used the strategy of taking part in study groups, voluntarily arranged by groups of migrant physicians or Swedish physicians. These groups offered possibilities for migrants to study the specifics of Swedish medicine with those who were already part of the profession.

Hassan was one of the physicians who offered his knowledge to others during the process of validating their degrees. He had become a physician in Libya and came to Sweden with his family due to his parents’ occupation, both physicians. On coming to Sweden, Hassan wanted to legitimise his medical degree and work. However, his documents were not approved by the Board for two years. He contacted the Board regularly, but he was never told when he would receive his papers. During that time, he could not practice his medical craft. His contact with the Swedish Public Employment Service was disappointing to him in regards to what he was told he could do during this time of waiting. He was advised to look for jobs in fast food companies, and often found himself informing the employment service about his possible options considering his educational background. Not being able to work as a physician, he instead found work in a management company as an assistant, which was a job he found through contacts.
he had sought to establish in Sweden. Gaining his papers from the Board after two years, he activated his interpersonal networks by contacting some researchers in hospitals that were outside his immediate circle, what Granovetter would call his ‘weak ties’, enabling him to become a research assistant in a project at a hospital in Sweden (Granovetter 1973). As he described it during the interview, it was a way to ‘get your foot in the door’. Although he worked for free, it offered him an opportunity to practice his skills and build his network further as part of the Swedish healthcare sector.

A retired Swedish physician, Stefan, who was also the organiser of a study group for the proficiency exam, described that he often brought various old colleagues to meet the migrants in the group and discuss the questions in the previous exams. This was seen as a great opportunity for the non-EU migrant physicians to ‘bargain their way into’ the Swedish healthcare sector by meeting representatives of the sector and building their social contacts with those who were already within it. The study group thus became a space where they could attempt to decode what is required in order to gain access. However, these types of study groups were not available to all, due to either a lack of information or their unavailability in certain regions. For those who were able to partake in the study groups, this constituted an effort to encounter the healthcare sector. In the eyes of Stefan and the physicians, the study group offered the opportunity to study questions together and a space where further social contacts and job possibilities could be encountered. Stefan expressed his thoughts as follows:

As doctors in Sweden with all the experience we have, we feel that we can help. Meet with them. Discuss with them. It is a discussion on knowledge. On medical knowledge of course, which has to do with what they ask in the proficiency exam. But it is also getting acquainted with the Swedish medical system, you know, how we do things here in Sweden that could be different from Turkey or Syria or whatever. And it is language practice of course. It is also trying to help them out in a personal way, you know, to arrange for possibilities for practice in medical units. Because they are so anxious to get that sort of entry into the Swedish system, you know.

Physicians were used to spending long hours dedicated to their work due to the specifics of their job. Work had been a central part of their lives before migration. Therefore, they perceived the time spent on validating their degrees as lost and wasted and did not want to ‘sit around’ (Mozetič 2022, 2018). The study group had thus become a space where an informal collective ambition was exercised. It was a way to compensate for their ‘wasted time’ as they acquired more know-how about their validation process and the healthcare sector, as well as having the chance to meet working or retired physicians from Sweden.

Establishing social ties becomes crucial for migrant physicians for their possibilities for accessing the Swedish healthcare sector. Those who did not have any social contacts in Sweden, such as Farid, thus could not work in the healthcare sector before taking their exam and completing their process. Ahmet, a physician from Turkey in his late fifties, had a relatively similar story to Farid. He became a professor in 2008 and worked in his speciality as a general surgeon for 25 years. His frustration was, among other things, regarding the time he had spent preparing for the written exam in Sweden. Having taken the exam two times, he described his process as follows:

I have been here for two and a half years and I haven’t even done a simple injection. Why do you keep me out of the system? We are working in libraries, going to language cafes. I have
experiences in treatments for breast cancer, stomach cancer, colon cancer, pancreatic cancer

Ahmet was worried about his lack of access to practise his expertise. He occasionally visited another country outside of Europe to perform surgery to earn money and maintain his medical craft. This was not an ideal situation or country for him. Therefore, he did not consider migrating from Sweden. Hoping to pass the exam on the third try and take the practical exam within the same year, Ahmet was aiming to receive his specialisation as a general surgeon in Sweden. He was ‘suffering time’ in his position in Sweden as he could not practice his medical craft, which he perceived as losing time. In the end, it took him five years to become a recognised physician in Sweden.

As a recognised physician, he could apply for jobs as a general practitioner. Being able to find a job within the healthcare sector, even if it was in a lower position than he was qualified for as a general surgeon, was an advantage, as it increased his opportunities to build his social ties and practise his medical skills. However, the lack of opportunity to use his specific skills as a general surgeon, which was a part of his work-related practices and dispositions before he migrated to Sweden, remained a heavy weight on him.

The weight of suffering during the time on standby

The medical craft is maintained not only by possessing a medical licence, but also by practising medicine (Mozetič 2018, 250). Talking about his worries for the future, Hassan mentioned how one loses an embodied part of one’s craft when it is not practised.

You lose clinical skills because of this. And that’s one of the things that most people feel very negatively about in Sweden, that you don’t get in. [...] You can read books, but there’s a very well-known idea that you don’t become a doctor by reading books, you become a doctor by seeing patients. You have to have theoretical knowledge, but you also have to have patient contact. Unless you want to keep just … on research. And then, if you want to remain in research, you don’t want to do the test. [...] Well, and then you lose a lot of knowledge and skills, quite simply. I know of trauma surgeons who worked as nurses for four years. A trauma surgeon who worked ten years as a specialist, so five years specialising and then another ten years as a specialist, for example. (Hassan, Libya, 30)

Compromising their specialisation for the sake of breaking into the healthcare sector, physicians often expressed that they could work in any job as long as it enabled them to be in a hospital working within their specialisation. However, many physicians went without exercising their medical skills for years.

During our follow-up interview, Ahmet was 57 years old and had recently received recognition of his qualifications in Sweden. He had lost hope of becoming a general surgeon, one of the most prestigious statuses in medicine, as this would require ‘waiting’ for many years to be able to perform surgeries. He expressed the feeling that he had ‘thrown away’ his years of experience as a surgeon and planned to work without validating his speciality in Sweden. When asked during job applications when he planned to retire, he said he believed that younger surgeons had a better chance than him in the Swedish labour market, as he was close to retirement age and had not performed surgery in over six years except for his limited work in another country.
Said, a relatively younger physician than Ahmet who had specialised as an otolaryngologist (ear, nose, and throat) in Syria, had lived in Sweden since 2014. He was one of the physicians who had managed to find a job as a nursing assistant in the country at the age of 42. Despite having a position in the healthcare sector, i.e. in a hospital, he was suffering from losing his medical craft. Said had previously worked in a private hospital as a surgeon for eight years in Syria and arrived in Sweden as a refugee in his late thirties. After studying the Swedish language for a couple of years, he submitted his documents to the Board, receiving confirmation after seven months of waiting. Following that, he made the maximum number of attempts for the written part of the proficiency exam, but failed to pass. Having spent five years during this process mostly waiting to take the exams, he managed to get a place on the complementary course, which was a big success given the course’s limited places. At the time of our initial interview, he had finished the first half of the course and was contemplating his medical craft, afraid of losing it. Said explained that he was losing his competence as a surgeon due to the time spent in ‘waiting’.

I am a surgeon. Here in Sweden, they say ‘händerna stelnar [the hands become stiff]’, they become stiff. I used to perform tonsil surgery in ten minutes. If I did it now, I wouldn’t be able to finish it in two hours. My hands are gone. It is good for them as well if we could enter the labour [market] sooner. Now if you ask my guide, for example […] she would say ‘this is a legitimate physician. He is hardworking, competent, and successful in his speciality, and patients like him. It is not just him, most of the physicians are good’. Why? Because there is experience. But this is about time. Sweden is losing them [physicians]. It is a shame. (Said, Syria, age 42)

Said appreciated his job as a nursing assistant as he was within the healthcare sector, unlike many others. However, he was afraid to lose his skills in operating on patients, which he had not done for over five years. Following his eighth year in Sweden, he completed his process and became a recognised physician. During our follow-up interview, he was working in the same hospital having been promoted from nursing assistant to physician. Yet, he still could not use his specialised medical skills as a surgeon. As a way to practice his skills and compensate for his lack of years working as a specialist, he read current articles on his specialisation outside working hours and occasionally treated patients requiring extra care when they had a problem related to his area of expertise. Given his relatively young age (42), he wanted to undergo speciality training so that he could become a surgeon in Sweden over the coming years, as he saw no other alternative for himself.

The narratives of the migrant physicians who obtained their degrees outside the EU/EEA shed light on their overall process of entering the Swedish labour market as physicians, which was characterised in terms of their struggles regarding the passing of time. Handling their time was an aspect of the experience that was perceived as difficult to manage regardless of their professional assets and background.

**Discussion**

Emphasising the relationship between migration and time, our study sheds light on the consequences for migrants of ‘waiting’ in the process of mobilising their cultural capital. Departing from Bourdieu’s sociology, we investigated the interaction between two states of cultural capital, namely institutionalised and embodied, to understand the complex
processes involved in its mobilisation. Contributing to research on the mobility of cultural capital (Clément, Gellereau, and Steinmetz 2021; Erel 2010; Erel and Ryan 2019; Maxwell, Yemini, and Gutman 2022; Ryan and Mulholland 2014; Waddling, Bertilsson, and Palme 2019), we focused on the time it takes for assets to be recognised and capitalised across national settings by opening a window into the experiences of migrant physicians in Sweden who received their medical degrees outside the EU/EEA. Based on the case of migrant physicians aiming to practice their profession in Sweden, we argue that there is a risk of losing work-related skills and dispositions due to the time it takes to mobilise the institutionalised state of cultural capital.

The experiences of migrants entering the Swedish labour market as physicians revealed their struggles with the time they spent on standby while waiting to get their education validated by The National Board of Health and Welfare, to get access to and pass the proficiency exam, to institutionalise their degrees in Sweden, and finally to become recognised physicians. Their experiences with time, in particular ‘waiting’, raised the fear of losing control over their ability to perform the medical craft they had embodied throughout their education and professional lives. Belonging to the profession but lacking access to practise their craft thus caused frustration and a perception of themselves as ‘second-class doctors’, especially in comparison to those who had obtained their degrees within the EU/EEA. Physicians’ experiences with time can be seen as an existential (im)mobility considering one does not migrate to ‘feel stuck’ (Hage 2005). They found themselves in a position where the structural constraints imposed on them led to a sense of feeling stuck given their long time in the ‘waiting room’. Their fear and frustration in this regard could be compensated based on the availability of their social resources (Keskiner, Eve, and Ryan 2022; Ryan, Erel, and D’Angelo 2015), which significantly determined their ability to maintain their embodied professional skills as opposed to losing them. Physicians therefore used certain strategies to build on the social contacts that helped them gain access to the healthcare sector.

To conclude, the challenges involved in mobilising cultural capital across national settings reveal the significance of distinguishing between its institutionalised and embodied states (Bourdieu 1986; Serre and Wagner 2015) and analysing them through the lens of time. This theoretical approach can be useful in studies concerning the devaluation of migrant labour. Based on our case of migrant physicians, we show that the time it takes to institutionalise assets and accumulate capital in another national context can lead to the risk of losing elements of its embodied state. The ‘long-lasting dispositions of the mind and body’ become endangered due to physicians’ lack of interaction with the specifics of their job when they spend a long time in the ‘waiting room’ (Bourdieu 1986, 243). Our findings mark an initial stride for future research, particularly in delineating the diverse states of cultural capital within the migration context and potentially making a substantial contribution to the sociology of migration. To advance this, investigating potential variations in our findings across different professions and nation-states is crucial. Further exploration of citizenship hierarchies (Kalm 2020) and incorporating ethnic and racial indicators into the analysis would broaden and deepen the scope of this research, contributing to its comprehensive understanding.
Notes

1. In the sociology of education in Sweden, the concept of cultural capital has primarily been used as a theoretical tool in analyses of how different social groups navigate in the education system (Hultqvist and Lidegran 2021).

2. Serre and Wagner (2015) argue that it seems important to disassociate different states of cultural capital and reconsider how they interact as the value and uses of institutionalised capital have transformed due to processes such as expansion and democratisation of educational systems, intensification of academic competition and internationalisation (Serre and Wagner 2015, 438).

3. We borrow this terminology from Darmon, who explored students’ attitudes towards time and classified some as ‘suffering’ as opposed to ‘mastering’ it, which she related to their volume and composition of capital (Darmon 2018).

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Ethics statement

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