Hierarchical challenges

A study on the obstacles that foreign specialist doctors encounter in their Danish workplaces

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Abstract

The Danish Healthcare System, for a long time, has continued in a situation whereby there is a critical lack of healthcare staff within many groups. One of the groups are specialist doctors, for which we now have to look outside of the national borders to recruit. However, it is also of importance to retain this highly skilled workforce, by ensuring a successful integration, adding to the well-being of the foreign doctors. Therefore, this paper seeks to understand what cultural challenges related to hierarchies in the workplace do foreign doctors experience during their job-start in Denmark, and what can be done to ease these.

It is with the purpose of broadening the perspective on a currently rather underdeveloped area, which can on a longer term contribute to the successful integration and thereby retention of a highly important group. Furthermore, this contribution is also meant as an incentive to continue the investigation of this part of the Danish Healthcare System.

Ontologically, this paper takes a constructivist stance to reality, with an interpretivist lens on knowledge. The research was carried out inductively, and based on qualitative methods. Five semi-structured interviews were conducted with foreign specialist doctors, who now reside and work in Denmark. The data was analysed with the six-step thematic analysis as proposed by Braun and Clarke (2008), through which the themes *forms of addressing, hierarchies in the workplace, discrimination, upholding status, insecurity,* and *culture* were found. The investigation draws inspiration from Goffman's theories on face and framework, and with a non-essentialist approach to the notion of culture, five challenges were identified from the themes. Challenges that can affect foreign doctors' well-being during job-start in Denmark. Some of the challenges appeared to be unconsciously constructed by the foreign doctors and their Danish colleagues, and were therefore difficult to provide specific solutions to. However, being aware of the challenges, as well as distributing knowledge on them, was found to be a step towards easing them. Moreover, general patterns in the data made it possible to point towards initiatives which should be taken by the managerial departments in order to enhance cultural competence amongst employees, to contribute to the creation of an environment in which the successful integration foreign doctors can take place.

Keywords: Integration, foreign doctors, challenges, Goffman, culture, thematic analysis, the Danish healthcare System

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1 Introduction

In the Spring of 2020, as the Covid-19 pandemic hit the World, including Denmark, it became apparent how the Danish Healthcare System (DHS) was not properly prepared for such an emergent crisis. Suddenly, the news was overflowing with reports from hospital departments under pressure due to an increased stream of patients, interviews with overstretched nurses in stressed environments, and skyrocketing waiting lists for surgeries.

As the initial chaos caused by the pandemic calmed down, another issue arose in the DHS. The nurses continued to be present in the news, emphasising the stressful working environment and extreme pressure put on them. It was no longer only about Covid-19, but a general dissatisfaction with the conditions. Finally, this led to numerous strikes around the country, and the before-mentioned waiting lists grew even longer. This drew the Danish population's attention to the critically low number of nurses in the country, and that something had to be done from a higher level.

However, even before Covid-19, and before the nurses called attention to the issue of staffing, the need for more healthcare personnel was no stranger to the public. For several years, Praktiserende Lægers Organisation (*The Danish Organisation of General Practitioners*) has attempted to draw attention to the severe issue of shortage of general practitioners. Through numerous reports it has been shown how an increasing number of the Danish population either is not - or are in danger of not being - connected to a general practitioner. A lack of doctors choosing to specialise in general medicine, combined with an ageing population, led to the organisation stating that by 2030 there would be a need for an increase of 900 general practitioners (PLO, 2018, p. 1). Although the organisation downscaled this number a bit in October 2020, the problem is still not solved completely (PLO, 2020).

Behind all this, the general conditions in the DHS, the lack of nurses, the lack of general practitioners, we find a so far rather disregarded call for attention. In June 2022, the chairperson of Overlægeforeningen, (*The Association of Consultant Physicians*) Susanne Wammen, commented on the need for specialist doctors in many other areas than within general medicine (Nielsen, 2022). By asking chief physicians in every department in the Danish hospitals, the association uncovered how approximately 773 specialist doctors were needed (Overlægeforeningen, 2022). This significant number of vacant positions has already shown to have consequences. In the psychiatric departments, every fifth position is vacant on a national plan, meaning it is therefore difficult to sustain even a decent level of treatment for those in need. Another example is how the lack of

specialist doctors in the Central Denmark Region was an important factor in a case concerning multiple patients undergoing surgical amputations that could potentially have been avoided (Nielsen, 2022).

1.1 Problem area

Based on the above-mentioned numbers, statements and cases, it is very apparent that the DHS finds itself in a severe issue that must be solved. As it can be seen, it is within several groups, such as both nurses, general practitioners, and specialist doctors, but to limit the research scope, this paper focuses on the lack of specialist doctors.

So far, two solutions are proposed to overcome the lack of specialist doctors. One is to open more positions within specialised areas for doctors to follow, but an issue is that it typically takes six to seven years for a doctor to achieve any speciality (Region Hovedstaden, n.d.). Therefore, this is not a solution that can ease the crisis within a short timeframe. Another option is to recruit the workforce from outside of the Danish borders, and this is where foreign doctors enter the picture.

Recruitment and employment of foreign doctors is not a new phenomenon, nor is it an unimportant one. Doctors with a medical degree obtained outside of Denmark make up a not insignificant number of the staff in Danish healthcare. A report on healthcare staffing published by the Danish Health Authority in 2022 presented the current picture, and furthermore a prognosis for the next 23 years to come. In the report it was stated that an average of 19% of the issued authorisations in the period between 2014 and 2021 were given to doctors with a medical degree obtained outside of Denmark. Furthermore, in this period, approximately 17% of all issued authorisations to specialist doctors were given to doctors with a degree from institutions outside of Denmark. This significant number of foreign doctors was present on a national plan, with an increasing number of foreign doctors in all regions. In 2019, about 9% of the doctors in Denmark were foreign (Sundhedsstyrelsen, 2022, pp. 12-13).

These numbers, along with the need for specialist doctors, show that foreign doctors are a highly relevant group to look into. Especially since it is not enough to recruit them - it is also of high importance to ensure that they remain working in Denmark.

To ensure that they continue their career in Denmark, a successful integration must be in place, but previous research and reports have shown that the language barrier is a huge obstacle for this. The North Denmark Region conducted a study on the foreign doctors in Denmark, with a focus on language and communication. A survey sent to Danish doctors showed that almost half of them

experienced that foreign doctors had general issues with the Danish language, and that it also affected the communication with patients (Regionshospital Nordjylland, 2020). Before this, the Danish Broadcasting Corporation aired a documentary showing real-life cases with foreign doctors and their patients struggling to communicate with each other. It also included testimonies from patients who believed they had been mishandled by foreign doctors, as a consequence of a language barrier (DR, 2019). Although the documentary was criticised for showing a one-sided picture of the situation, it did however emphasise an issue.

A google search on foreign doctors in Denmark, results in many news articles, often concerning the consequences of the language barrier. However, it is much more difficult to find academic research on the area, and even less research that takes the perspective of the foreign doctors. This perspective is needed in order to ensure a successful integration, which must be in place if we wish to avoid the critical lack of specialist doctors in the near future. Therefore, I argue that there is a need for a more nuanced perspective on the employment and integration of foreign doctors in Denmark.

1.1.1 Problem formulation

As it has already been established that the language barrier is an obstacle for the successful integration of foreign doctors in Denmark, I wish to shift the focus in order to investigate whether there might also be other areas in which obstacles for integration exist. Therefore, this paper concerns challenges related to the doctors' cultural backgrounds rather than their linguistic capabilities. More specifically, what will be looked into is *if* and potentially *how* foreign doctors' cultural background influences their behaviour and well-being in the workplace, and in what manner this affects the integration. As our behaviour can be shaped by multiple factors and aspects, the focus is here on whether cultural differences in relation to our view on and understanding of hierarchies can have any influence.

The notion of culture is of a very broad character, but for this paper, focus is on the national aspect of the individual's cultural background. What is meant, is that it is the reality surrounding specifically the doctors that can be labelled as 'foreign', that are of an interest. However, this does not entail that I do not acknowledge that a cultural background consists of multiple other factors, nor do I assume that being born and educated outside of Denmark automatically impacts the doctors' interaction with others. However, what I do presume, is that in

the meeting between doctors of different nationalities, intercultural communication happens, including a mutual exchange of cultural norms and practices.

This leads to the following problem formulation that will be guiding the research:

What cultural challenges related to hierarchies in the workplace do foreign doctors experience during their job-start in Denmark, and what can be done to ease these?

Investigating the research area through this problem formulation, is with the purpose of broadening the research on integration of foreign doctors in the DHS. Research on the area is limited so far, if you look beyond the linguistic focus. By expanding the research to include other perspectives, it enables me to contribute to a better understanding of some of the current conditions and obstacles that foreign doctors experience. Furthermore, it is a step towards a better understanding of the paradox we see in Danish society, with a great need for these foreign doctors, but a limited understanding of their social reality.

1.2 Theoretical approach

To answer the problem formulation, the research takes inspiration theoretically from Erving Goffman's theories on front- and backstage, as well as his theories of frameworks. The analysis is not based on these theories, but rather draws on them in order to understand the foreign doctors' social reality.

In his acknowledged book, *The presentation of self in everyday life*, Goffman (1959) presents his sociological approach to human action as being a social stage, and the individuals as the actors. To act in this world, this scene, we put on a *front*, also referred to as a *face*, which depends on the context in which we find ourselves. In the workplace, we take on a role and a face with the purpose of fitting in and managing the image we present of ourselves. However, presenting the most idealised image will consequently conceal all the effort we put into creating and upholding this front. Moreover, despite the effort, it can happen that we give off cues that might not be perceived as ideal for the situation, thereby tainting the idealised image (Goffman, 1959).

Goffman also describes how we, in other situations, have the *backstage* where we are closer to our true self. Here, we do not put on a face with the purpose of fitting in. The significance of this theory lies in the fact that, in order to create real relations, we need to gain access to this backstage area, or at least have an understanding of it. As a researcher, this is what I will attempt to

do through interviews with foreign doctors as the participants. The theory of front- and backstage is interesting in the aspect of investigating well-being in the workplace, as a discrepancy between the frontstage and the backstage can put pressure on the individual. The bigger the discrepancy, the more we have to work to uphold the ideal front (Goffman, 1959). The hope is that due to my role, as an external actor to their workplace, I will be perceived as someone to whom they can describe both their frontstage and backstage areas, concerning their well-being at work.

Another theory from Goffman that will be drawn on, is the application of frameworks. In his terminology, this application is a mental tool the individual makes use of to decode and make sense of social events they observe or take part in. Applying frames to a situation helps us put order in our surroundings, thereby making it possible to manage oneself in it and respond reasonably to it.

Goffman distinguishes between the *natural* and the *social* frames. The natural frames are used to identify situations that are purely physical. There is no activity, agency or consequences involved. It can, as an example, come into use when you enter and interpret a physical space, such as a Danish hospital. The social frames include background understanding of an event, meaning it affects the individual's sensemaking of a situation (Goffman, 1986). These frames come into use when individuals collaboratively seek to make sense of a certain event, where the end goal typically is to agree on how the situation should be understood and defined.

For this study, the natural and social frames will be relevant in terms of how we understand the environment and hierarchies in a Danish hospital. Does our application of a framework concerning medical institutions differ? And does the pre-understanding of our relations in a workplace differ amongst the doctors, depending on country of origin? With inspiration from Goffman, questions like these are relevant in terms of answering the problem formulation.

1.3 Research design

When answering the problem formulation, the reality to be investigated is approached from a ontologically constructivist view, seeing it as something that is socially constructed between individuals, rather than something fixed. As it is created between individuals, this also entails that our reality is under constant revision and reconstruction (Bryman, 2016, p. 29). In this construction, the individuals play an active role, which is also reflected in the empirical basis of this research, as the data originates from actual actors in the DHS. Their experiences are what make up their reality, which I will seek to understand in this paper.

The ontologically constructivist approach to the viewing and understanding of our reality, connects with the epistemological approach to how knowledge created in our constructed reality is perceived. In this paper, the research is performed with an interpretivist epistemology, thereby entailing an interest in understanding the generated knowledge, rather than explaining it. The study revolves around actual individuals, and the empirical data for analysis is generated by *their* narratives, thereby focusing on how human behaviour can be understood, based on the meaning the participants assign to the events they experience (Porta and Keating, 2008, p. 24).

The study is performed inductively, meaning that I have not entered my research with any specific assumptions or initial conclusions in mind. Instead, focus is on acquiring specific observations, from which meanings can be derived and discussed (Bryman, 2016, p. 21). The inductive study aligns with the constructivist ontology, as this entails that our reality is not a fixed construction, in which you would find specific answers applicable for every case. Furthermore, in accordance with the epistemologically interpretivist approach, the purpose is to understand the generated knowledge, rather than being able to explain this knowledge, based on predetermined criteria and hypotheses.

Concerning research strategy, this study is qualitatively oriented. As a consequence, emphasis is put on what meanings can be extracted from the data, rather than seeking to quantify it, and furthermore, the research is based on qualitative, empirical data collected through interviews. More specifically, it consists of the narratives from five semi-structured interviews with specialist doctors who obtained their medical degree outside of Denmark, but who are now working in Danish hospitals.

I take a qualitative analytical approach by applying a thematic analysis to the collected data. The analysis is based on the six phases of thematic analysis as described by Braun and Clarke (2008), which will be further elaborated in section 5.3 *Thematic analysis*.

As the name suggests, the purpose of utilising the thematic analysis is to identify and define certain themes and patterns deducted from written data. In the case of this paper, the written data is transcripts of the interviews. As thematic analysis is a flexible tool for analysis, due to it not being bound to a specific theoretical frame, it is important to define the initial position to reality. In this case, the method will be used from the constructivist ontological approach, so that it is used to identify the themes that the interviewees express as constructed in their social world.

Now having broadly introduced the components of the research, what will follow from here on are the unfolding of these aforementioned areas. This means that the theoretical framework

will be further clarified, and moreover the approach to the concept of culture will be defined. Afterwards, already existing literature related to the research area will be presented. Furthermore, the methodological framework that surrounds the whole project will be described in detail, followed by a thorough analysis, which will lead to a discussion, finally leading to an answer to the problem formulation.

2 Theory

I will in the following present the theoretical framework that surrounds my research. This includes theories and terms, which will later on be supporting the understanding of the empirical data, enabling me to analyse and theoretically discuss it.

I have chosen the theories and terms that I have judged to be relevant for the research area. This includes a further development on Goffman's theories on face and framework, as his theories are highly useful when it comes to analysing the themes that were revealed in the data.

Moreover, I will present and explain my approach to the notion of culture. As so many definitions of this concept exist, it is important to define what is meant by culture and thereby its significance in this study.

2.1 Goffman

Although answers to the problem formulation for this study will not be the results of a frame analysis, Goffman's theories are highly relevant to include, as he manages to combine the social studies with social practices. Therefore, elaborating further on Goffman's face and frame theories is with the purpose of enabling me to focus on the details in the interactions and relationships surrounding the foreign doctors. Keeping the individual's need to uphold a face when being on the frontstage in mind, will provide a better understanding of the participants' behaviour at their workplace. Furthermore, the fact that we decode and understand situations based on the individual frameworks we apply to them, is important to draw on when it comes to identifying the challenges that might not be explicitly expressed by the participants.

2.1.1 Face

Goffman's (1959) theory on face can be applied as a dramaturgical analysis with two scenes; the frontstage where the individual is performing a role, and the backstage where the individual can

take off this role. The performance on the frontstage will always be relative to the audience, meaning that we perform based on what we believe is most likely to be received in the manner we hope for by the audience. In other words, we seek to control the impression the audience will have of us (Cho et al., 2018, p. 867).

Goffman uses the term *performance* to cover whenever an individual is present in a situation in which others, also described as observers, are present. In this situation you have the *front*, which is the part of the performance that the individual, consciously or unconsciously, applies to their performance, and which helps to define the situation for the observers (Goffman, 1959, pp. 27-28).

The front can furthermore be divided into two parts. There is the *setting*, which is the physical and usually not movable elements, such as buildings, furniture, or decorations. It is the geographical setting so to say (Goffman, 1959, p. 28). Second, there is the *personal front*, which is the personal expression that we expect would belong to the individual itself, and therefore also expect to follow them in any situation. These can, amongst others, include physical appearance, gestures, and looks (Goffman, 1959, p. 29).

Finally, the personal front can further be divided into *appearance* and *manner*. The appearance refers to those aspects that tell the observers about the individual's social status, and what they are doing. Manner is what tells us, in the specific setting, what role the individual will play in the situation (Goffman, 1959, p. 29). So, as an example, a patient at a hospital could encounter a doctor wearing a white coat, and this appearance will immediately tell the patient that they are interacting with a doctor, meaning it is someone who went through many years of training within the medical area. At the same time, the manner will tell the patient that they can expect the doctor to describe their medical status, future procedures, treatment etc., based on a scientific foundation. Consequently, one will moreover often discover, that when entering an already established role in society, such as the role as a doctor, there will already be an existing front for this role, which they are expected to adhere to (Goffman, 1959, p. 31). For that reason, we will most likely also expect some degree of consistency between the appearance and manner.

All of the above represent our frontstage, meaning what we present and do around others. Opposite to this is the backstage. This region is where the individual can relax, let the facade fall, and break out of their role (Goffman, 1959, p. 104). It is where the individual will show their true self, because it is also an area where you expect no observers to enter. What is more, this is also where the preparation to enter onto the frontstage happens. Exactly because it happens backstage, it

also means that our preparations are often not visible to any observers. It can be compared to the physical backstage area you would find at a restaurant. Most kitchens are closed for the guests, so the work and effort that the cooks put into their craft of making the plates are not seen. The guests only see the final and polished result. Another example is the hours of studying Danish that a foreign doctor might invest, yet their audience will only hear the final result. Metaphors like these illustrate how time in the backstage area is crucial for us in order to be able to function in public settings, due to this need for preparation. We prepare to go back and adhere to whatever rules might apply to the specific setting, in order to portray ourselves the best way possible (Lewin and Reeves, 2011, p. 1596).

Though Goffman makes a clear distinction between the front- and the backstage, he also argues how it is always possible to turn a frontstage into a backstage with one's behaviour. If one starts to act as they would, had they been alone, they turn the setting into a much more private sphere. In some cases, this is a natural thing to do if it is expected, for example between two individuals who are intimate with each other. However, in other cases it can create uncomfortable situations for the observers, as it will be too far from what they expect from the individual, meaning it breaks with the norm to the point where it becomes inappropriate (Goffman, 1959, p. 116). Moreover, should the individual realise that they have behaved in a manner that turns a frontstage into a backstage in a situation where this was not to be expected, it can result in an uncomfortable situation for them as well.

2.1.2 Framework

When investigating how individuals behave around others and perceive their surroundings, it is also relevant to develop further on Goffman's theory of *frameworks*. Namely because the concept of frames comes into use when an individual seeks to decode the situation and thereby choose what front is most suitable.

According to Goffman (1986), the use of frames happens mentally whenever the individual finds themselves in a situation which they either simply observe, or actively take part in. As mentioned in the introduction, Goffman presents the *primary framework*, which can also be understood as a schemata of interpretation. It being primary, arises from the fact that the individual who applies the framework believes that it does not depend on any other previous interpretation. The framework enables the individual to make sense of their surroundings, and moreover it can be

of use to make otherwise meaningless aspects into something meaningful for the individual (Goffman, 1986, p. 21).

This primary framework consists of the *natural* and the *social* frames. The natural frames are used to identify purely physical situations; Situations that do not involve any human activity or agency. Goffman himself uses the example of reporting on the state of the weather. The meteorologist performs an interpretation of the weather conditions, but the interpretation is based on physical and biological happenings.

The social frames come into use when the situation "include mechanisms controlled by human volition, such as laws, rules, norms, habits, power, culture, institutions, and organisations" (Persson, 2019, p. 50). As Persson describes it, the social frames are in use when human action and agency are present. The frames consist of our individual background understanding of a situation, and consequently this leads to an individual decoding of it (Goffman, 1986).

The last important aspect of framework to be included here, is the fact that a primary framework is the outcome of the doings of a social group, thereby being an element of this respective group's culture. By so, it entails that there is not one fixed set of frameworks that can be said to cover everyone (Goffman, 1986, p. 27).

A relevance of Goffman's theories lies in the fact that if we truly want to understand others, then we must actively engage in interpersonal relations with them, because only when we experience others in their backstage area, will we see them as not performing. Conducting interviews might not allow me to fully enter into the participants' personal backstage areas, but hopefully they will reveal a backstage area related to their Danish workplace, thereby providing me with their honest thoughts and experiences. By including Goffman, the aim is to understand how the foreign doctors decoded the situations during their initial time in a Danish workplace, and what fronts they believed were suitable to put up here. Furthermore, as it is mentioned that the primary frameworks, which we cannot avoid applying, are an outcome of the doings of a certain social group, this entails that one doctor's framework might differ from another's, potentially resulting in several perspectives to the same issue.

Understanding Goffman's theories, and thereby being able to include these when analysing the foreign doctors' narratives, will enable me to see what the participants choose to foreground and background. I can focus on the details of the actual communication, thereby gaining an understanding of what matters to the participants.

2.2 Culture

Numerous definitions of the concept of culture exist, and it is therefore important to define how you approach it. For this paper I take a point of departure in Nygaard's (2012) description of culture from his research on cultural encounters in the workplace. Nygaard states that culture is first and foremost the special and, as a rule, unconscious way a group thinks, communicates and acts, that is to a greater or lesser degree passed on from generation to generation (Nygaard, 2012, p. 18).

I aim to avoid applying an essentialist perspective on culture, so although this paper revolves around a group with different nationalities than Danish, I do not state that a 'group' can only be defined by geographical borders. Instead, I acknowledge that groups can be bound to much else than nationality, such as for example a specific football team or a specific musician (Holliday, Kullman and Hyde, 2021, pp. 72-73). In this case, I am looking into a group represented by doctors from specific countries elsewhere than Denmark. This focus on avoiding essentialism is important, as our understanding and idea of culture has a major influence on how we meet those that we perceive as belonging to another group.

Nygaard (2012) emphasises how culture is not something one can see or measure, making it difficult to fully understand and identify for the individual. However, he does point out some characteristics that can be of help to understand what culture is. In the following, I will present some of these, in order to unfold the complexity of culture.

One characteristic is that culture is made up of patterns. What is meant is that something must be repeated for it to be a part of culture. Should a doctor be late for a meeting, it should not be excused by their nationality as a rule. There could be many other reasons, and therefore it must be a repeated pattern existing within the majority of a group for it to be identified as part of a culture. For this paper, I will not be able to identify patterns within a large group, thereby defining the participants' answers as cultural traits based on this characteristic. What I can do is, however, to let the participants give their narrative, and listen to whether they themselves believe something is a part of their culture (Nygaard, 2012, p. 19).

Another characteristic is that culture is unconscious. It is not tangible, and many forms of behaviour or social norms are so ingrained in the individual that we understand it as the normality and expect it from others as well (Nygaard, 2012, p. 21).

Change is also a characteristic, as culture changes within a group over time. For example, what we understand as Danish culture today, is not the same as it would be understood a 100 years ago. We both learn our culture from the previous generation, but at the same time we also

continuously change it. It happens both because of developing societies, social mobility, and an increasing influence from the globalised world (Nygaard, 2012, pp. 22-23).

Finally, is the fact that culture is complex, abstract, and can only be analysed but not fully understood. Furthermore, as we cannot help but to be influenced by our own culture when analysing other cultures, it is important to acknowledge that culture consists of so many intertwining elements, that we can never fully arrive at a perfect understanding of what it is (Nygaard, 2012, p. 29).

The fact that we cannot help but be influenced by our upbringing, supports the fact that though the participants for this project are chosen due to having a different nationality than Danish, it does not entail that an essentialist view is embraced. This study is not steered by the fact that the foreign doctors originate from elsewhere than Denmark, but it cannot be disregarded that the individual's upbringing regarding social norms can differentiate, depending on where you originate from, (Nygaard, 2012). It is not the participants' specific nationality that is of importance, but rather their individual background, and specifically their experiences with hierarchies. Understanding whether there are any conflicting contrasts between their past experiences and what they find themselves in in Denmark, will be a step towards identifying and easing challenges related to this.

Now having presented the larger, theoretical framework and concepts of relevance to my research, I will in the following literature review provide a nuanced presentation of already existing literature on areas related to the research area.

3 Literature review

As mentioned in the introduction, there is not much existing literature on the area of the integration of foreign doctors in a Danish context. Even less if the scope is extended beyond the linguistic aspect and language barriers. So far, one of the most comprehensive studies of foreign doctors in Denmark came from The North Denmark Region, and was introduced with "we must draw the rather limited conclusion that the report presumably . . . has not become as comprehensive and complete as we might have hoped . . . The group of foreign doctors is much too heterogenic to do so" (Regionshospital Nordjylland, 2020, p. 3). With this statement, the authors show that though the report was amongst the largest and most comprehensive studies done on the foreign doctors in Denmark, it is not possible to understand the group fully in just one study.

Though it is difficult to find literature that explores specifically the topic of the challenges that foreign doctors go through in Denmark, it is nevertheless possible to find already existing literature that relates to the topic. What is to follow is an empirical review of previous reports and studies that have created knowledge within areas related to the research scope of this paper, and which enables me to position my research in a broader context.

Furthermore, this will support the introductory argument on how there is a need for further research on the integration of foreign doctors in Denmark specifically, thereby pointing towards a research gap.

The literature review will begin with the presentation of a report, which dealt with foreign doctors' self-image compared to how Danish healthcare staff evaluated them to be. By exploring several topics, the report presented a complex set of results, in which both culture and hierarchies were present. The review will then concern studies of discriminating and gendered hierarchies in healthcare systems outside of Denmark. Finally, a study on the importance of social relations for foreign doctors is included, as the study dealt with some of the challenges that did not have to do with the language. Each of these studies serve to lay an empirical foundation, from which this paper can continue to investigate challenges for the foreign doctors in Denmark.

3.1 The evaluation of foreign doctors versus their self-image

The following is based on a report published by four doctors from Herlev Hospital, Denmark. The report is around 15 years old, however, it is included here, as the authors found many interesting aspects, out of which some of them relate strongly to what the empirical data collected for this paper showed.

The report was written based on a survey, which was sent to foreign doctors, coming from both within and outside the European Union. Furthermore, it was sent to Danish doctors and Danish nurses. The survey covered areas such as language, professional expertise, cultural background, and gender.

Many conclusions came from the results, but an interesting and general theme was that foreign doctors tended to hold a much more positive self-image, than how they were evaluated by their Danish colleagues. This was a recurring result that occurred on a broad spectrum of parameters.

Regarding language, a large part of the Danish personnel had often experienced troubles when it came to understanding the foreign doctors' Danish. Contrary, foreign doctors, especially

those coming from outside of the EU, saw the situation differently, having a bigger confidence in their language capabilities. The same picture showed when it came to the foreign doctors' professional capabilities in the Danish system. More than 70% of the Danish personnel thought that it was more time-consuming when working with foreign doctors, while only 8% of the foreign doctors believed that they spent more time on their tasks than a Danish doctor did. It was especially the non-EU doctors who evaluated themselves much higher than the Danish colleagues did on this parameter (Mitchell, et al., 2008 p. 1835).

Opinions on the significance of one's cultural background were just as conflicting. Around 50% of the Danish personnel believed that the cultural background of foreign doctors from outside of the EU had a significant role. The number was 21% when it came to EU-doctors. On the other hand, 86% of the foreign doctors answered that their cultural background was either without significance or it was a positive contribution. In the study 'cultural background' was elaborated to concern the ability to engage in good teamwork, and expectations for the distribution of roles between doctors and nurses. In that connection, it was also noticeable that the foreign doctors, no matter whether they came from EU-countries or not, estimated that when it came to asking for help and receiving advice, they were either just as good as their Danish colleagues, or they were even better. However, the Danish personnel answered that foreign doctors were equally as good as the Danish doctors, or they were less capable of asking for help and receiving advice (Mitchell, et al., 2008, p. 1836).

The last noticeable finding from the survey was in connection to gender. It turned out that almost 70% of the Danish personnel found that female non-EU doctors seemed more insecure than the Danish doctors. When it came to female EU-doctors, 34% found them to be more insecure than the Danish doctors. However, the numbers for male foreign doctors were lower for both groups. They were thereby evaluated to be more competent (Mitchell, et al., 2008, p. 1836). From this it could be seen how women were in general regarded as being more insecure than males, and how EU-doctors were evaluated as being more secure than non-EU doctors.

By so, it can be concluded from the report that there were significant discrepancies between the foreign doctors' self-image, and how they were viewed and evaluated by others. What the report did not do, however, was to provide the reader with a more nuanced picture of what contributes to this discrepancy. Nor did it say anything about whether these discrepancies had any consequences or caused any issues for the participants.

Although I have not done anything similar to this survey, and though there is a risk that it could be outdated by now, it did nevertheless show a pattern of the foreign doctors emphasising their own status and expertise, which is also an occurring theme showing in the data for this paper. Thereby, a part of my research can investigate this specific part even more in depth, and moreover, as I gained the data from foreign doctors, it will be their self-image that I am interpreting. The reason for this is that their answers in the interviews are a reflection of how they perceive themselves and the world around them.

3.2 Discrimination

As this paper revolves around challenges that can be related to hierarchies, I will now present a study that dealt with a specific type of hierarchy, and one that most likely affects foreign doctors specifically. More precisely, it revolves around a hierarchy that is structured so that some ethnicities are placed above others. I find this relevant to include, as most of the participants had also been exposed to discrimination, and one even believed that her ethnicity had placed her in the bottom of this type of hierarchy that will be presented in the following.

In 2010, the authors Winnifred, Lalonde, and Esses published a study on the bias directed against foreign-born or foreign-trained doctors. The study was performed in Australia, a country that actively recruited doctors from overseas to solve shortages of doctors. Just as in Denmark, the recruitment and retention of foreign doctors were of high importance (Winnifred, Lalonde, and Esses, 2010, p. 1243). What the authors looked into was how a bias against foreign doctors had an impact on both the recruitment and the retention of them. They did this by having prospective patients evaluate fictitious candidates for a job position at a local clinic. The candidates were described the same regarding personality, authorisation, level of degree, and past work experience. However, what the study showed was that the candidates who had obtained their degree from an institution outside of Australia, were evaluated less favourably as compared to those from Australia. However, their data showed that had the candidate obtained their degree in a First World nation, which the authors defined as high-income, industrialised countries such as the USA, Canada, and countries in Western Europe, the bias was eliminated. By so, the fictitious candidate who was described as being born and trained in Pakistan was evaluated much less favourably, than the fictitious candidate who was born in Pakistan but trained in the UK, and the fictitious candidate who was born and trained in Australia (Winnifred, Lalonde, and Esses, 2010).

Overall the purpose of the study was to reveal an obstacle for the recruitment and retention of doctors in Australia. This was done by showing how the bias and mistrust in doctors from elsewhere than First World nations were very much existing, even while Australia was in need of highly skilled workforce coming from outside the country, in order to solve issues with staffing within the healthcare system. However, what the study did not show, was whether this bias and construction of a hierarchy in which doctors from Australia or other First World countries were placed at the top, affected the foreign doctors in any way. Neither has there been any studies on this in a Danish context. However, as will be presented in more detail in section 5.1.1 *Participants* and 6.3.1 *Theme 3: Discrimination*, all participants but one came from countries that would not be defined as First World countries according to Winnifred, Lalonde, and Esses. Furthermore, all but one had experienced discrimination and mistrust in their capabilities. By so, there are similarities between this study, and the one conducted by Winnifred, Lalonde, and Esses, and moreover, this study might be able to fill out a research gap, within the area of hierarchies related to discrimination, and the challenges that can originate from this.

3.3 Gender and hierarchies in a Scandinavian healthcare institution

Another form of hierarchy in the workplace is one based on gender, which will be described as based on the book *Femininity at work: Gender, labour, and changing relations of power in a Swedish hospital* written by Selberg (2012). The book was written based on a thorough and detailed ethnographic study of gender and power relations at a hospital in Sweden. It is included in this literature review, as it treats the gendered aspect of hierarchies, and in the analysis, it will be elaborated how gender, though not explicitly, was also a part of the construction of hierarchies in Danish healthcare institutions, according to the participants' narratives.

Selberg (2012) studied nurses born in Scandinavia, specifically Sweden, where she was able to identify clear indicators of explicit hierarchies in a healthcare institution. Selberg's study was based on a major amount of data, including 32 interviews, with the majority of the participants working as nurses. The aim was to explore the gender dynamics in a Swedish healthcare institution, and how gendered constructions influenced the power relations amongst different groups of employees, within such an institution.

Selberg (2012, p. 38) theoretically refers to Acker (2006), who connects masculinity to characteristics such as strength, rationality, and capability, while femininity is associated with emotions, inferiority, and accommodation. Acker then connects these feminine characteristics with

less well-regarded jobs, and Selberg (2012) found that interactions between the nurses and employees from other groups conformed with what was stated by Acker. The interactions were shaped by heteronormativity, where the nurses would seek to avoid conflicts by remaining in their (feminine) subordinate role in a gendered hierarchy.

It was furthermore found that the nurses were aware of their position in the hierarchy, exemplified by an example from the author herself. Selberg had unintendedly started a heated discussion by using the word 'pyssla' (Swedish word for doing small chores) while discussing the nurses' work tasks (Selberg, 2012, p. 88). A nurse manager made it clear that this specific word was not suitable to be used as it demeaned their job, especially if it was used in front of doctors. Selberg (2012) argues how this statement shows the nurses being aware of the hierarchy, and the position they held in this. Furthermore, they had to be aware of not contributing further to lowering their own status in front of doctors, who would then only regard them as even less.

To conclude, what Selberg's research shows is that gendered power hierarchies were very much present in a Scandinavian healthcare institution. Given that Denmark was only placed as 32nd on the Global Gender Gap report in 2022, in which Sweden took a 5th place, it is very likely that it would be possible to identify similar constructions in the Danish healthcare institutions (World Economic Forum, 2022, p. 10).

What is more, the identified power hierarchies were not only due to gendered groups, but also included the fact that some jobs were regarded as more valuable than others. More specifically, it was regarded as being of higher status to be a doctor, than it was to be a nurse. If one goes back to the report from Herlev Hospital, something similar was found, namely that the Danish staff found culture, specifically regarding expectations of how roles should be divided between doctors and nurses, as something that significantly influenced the foreign doctors. In this paper's analytical section, one will see that some of the findings pointed towards the same conclusion, namely that the foreign doctors, whose narratives are the basis for this investigation, had certain perceptions of hierarchies and distribution of roles. However, it should be kept in mind that this study was not only conducted elsewhere than Denmark, but also with a different focus group than what is done in this paper. Nevertheless, Selberg identified some findings that indicate that it could be interesting to investigate in a Danish context as well.

3.4 The importance of social relations

Another example from Sweden is a study by Frykman and Mozetic (2020), who went through 16 semi-structured interviews with international doctors in the Swedish town Skåne. This study was not focused on hierarchies, but rather on something else that also caused challenges for foreign doctors in their work life and private life.

As part of their research, the two authors argued how there is a need for more complex research on the area of recruitment and retention of highly skilled migrants. The need for a better understanding of the complexities behind the challenges to a successful integration, is due to the fact that highly skilled migrants, such as specialised doctors, must be seen as more than a supplement to a country's workforce in the globalised world. Indeed, they are also a significant contribution to a country's or institution's expertise and position on a global and competitive market (Frykman and Mozetic, 2020, p. 386).

Frykman and Mozetic used the interviews to expand the research above the general conditions and well-being of the foreign doctors at their workplaces. Rather, emphasis was put on how the doctors perceived their social life, and how this affected the integration. A main finding was that the doctors had found it difficult to establish close bonds with Swedes for the first long time, and that friends from their home country were missed a lot. It was also clear that their Swedish colleagues were mostly described as very nice, friendly and helpful, yet they had barely any personal encounters with them. As one doctor explained it, they had contact with each other basically every day, but in reality, he knew almost nothing about his colleagues' personal lives. Even though they spent much time together, they never got access to each other's backstage areas.

It has not been possible to find any similar studies within the specific area in a Danish context. Though Sweden is a Scandinavian country, sharing many cultural and societal traits with Denmark, the country has generally had more open borders and looser integration policies during time. This can also be seen in the fact that the number of foreign doctors is significantly higher with 27% compared to 9% in Denmark (Lindqvist, 2018). However, though being a smaller group, does not make the foreign doctors in Denmark less relevant to investigate further. Especially as the authors also state, that the recruitment and retention of highly skilled migrants must be understood, as they are a significant contribution to the workforce in a globalised world. This emphasises the need for a further investigation of the foreign doctors in Denmark, and how to ensure their well-being. An aspect of this well-being is social relations, support, and guidance, especially in the

beginning, as this is where they find themselves in an exposed position with a continuous stream of new impressions.

Now having gone through studies on hierarchies and challenges which can be related directly to foreign doctors, and hierarchical structures in healthcare institutions, this paper will continue with a presentation of the methodological framework that has surrounded this research. This will lead to a description of the data collection and the respective participants, leading to an analysis of the data that these participants provided me with.

4 Research paradigm

To build a bridge between knowledge and the reality I am investigating, what will now follow is a description of the research paradigm that surrounds this paper. The paradigm is created in the interplay between the ontological perception of reality, the epistemological perception of what can be defined as knowledge, and the research methodology.

I take a constructivist approach to our reality and see knowledge through the interpretivist lens. These factors combined with an inductive and qualitative course of action, create the frame for the investigation of the foreign doctors in Denmark. Finally, these methodological considerations also include an argumentation for the generalisability, validity, and reliability of the research.

4.1 Ontology: Constructivism

The word ontology originally comes from the Greek word for 'being'. And this is what ontology is in its nature; it concerns how, what, and why something *is*. Engaging with ontology is about understanding how we perceive the whole reality with all its beings around us (Peim, 2017).

A central question with regard to ontology, is whether social entities are objective and exist in a reality external to us as social actors, or whether it should all be considered a social construction (Bryman, 2016, p. 28). Is it beyond our reach and influence, or is it something that we co-create? To exemplify this, one can think of the concept of an organisation, for example a healthcare institution. Heide (2018) presents two metaphors for an organisation, one being the container metaphor. Here, one can see the organisation as a tangible object with defined boundaries, existing independently of the organisational members. Contrary, there is the process metaphor, where the organisation is a never-ending process of development and coming into being. Rather

than being an object, it is the outcome of an ongoing construction between its members (Heide, 2018, pp. 2-3).

For this respective paper, I take the ontological approach of constructivism, and would therefore perceive an institution through the process metaphor. By doing so, I ground my research in the idea that the reality I investigate is not something fixed outside of our influence. Instead, reality is approached as something that is constructed by the social actors existing in it (Bryman, 2016, p. 29). From this view, the hospital in which foreign doctors exist as social actors, is considered to be a process that they all take part in constructing. This ontological approach is also reflected in my view on culture, as not being a pre-given category, in which you can fit a group of individuals, but rather as "an emergent reality in a continuous state of construction and reconstruction" (Bryman, 2016, p. 30). Consequently, this also means that what I present in my study can only be considered one specific version of reality, and not a list of definitive answers. In fact, I do not claim that the findings can be generalised to the point where it could be stated that all foreign doctors in Denmark encounter the challenges identified. Moreover, based on the ontology that our world is socially constructed, it would never be possible to simply uncover one generalisable truth.

4.2 Epistemology: Interpretivism

Epistemological considerations concern what should be accepted as knowledge, and what knowledge even is. First, it is important to draw a distinction between natural sciences and social sciences, as it is argued by many that these two types of science are fundamentally different, and therefore, inevitably, requires different approaches to knowledge (Bryman, 2008, p. 24). This paper belongs to the latter of the two sciences.

The approach to what knowledge is and how it should be understood, comes from an interpretivist stance in this paper. Adopting the interpretivist stance to what should be regarded as knowledge entails a focus on *understanding* what happens in our social world, rather than trying to *explain* it. Humans' actions are a focal point within interpretivism. The social reality holds a meaning to them, thereby making their actions meaningful - both to themselves, but also to study. As the individual and its actions are meaningful, it is the interpretivist's goal to discover what meaning lies behind these actions, rather than to explain what the actions are (Porta and Keating, 2008, p. 24).

Furthermore, the interpretivist researcher does not only extract knowledge by revealing how a social group interprets their social world. The researcher also places this interpretation within yet another social frame, meaning a double interpretation is happening (Bryman, 2016, p. 28). In the case of this study, the interpretation of others' interpretation happens, when I seek to identify patterns in the narratives I gain from interview-participants. What they answer is what they have already interpreted from their situation, and these interpretations are then put into a frame of experienced challenges related to hierarchies.

Moreover, as an interpreter, I seek to answer the problem formulation through an understanding of my participants. The purpose is not to explain why foreign doctors might encounter challenges in the workplace, but by analysing the data I hope to contribute to the research area, with reflective knowledge on what these challenges might be, leading to the possibility of easing them.

4.3 The qualitative, inductive study

This study is designed as an inductive, qualitative one. The inductive logic of inquiry is, contrary to the deductive one, an explorative approach to the research area (Blaikie & Priest, 2019, p. 100). By so, this study is not created on the basis of predetermined theories or hypotheses. Rather the theory will arise from the observations, which is also reflected in the problem formulation, as it is not possible to answer with a simple yes or no. The phrasing of the problem formulation leads to inductive research, which can subsequently lead to findings of a more complex and reflective character.

Moreover, the complexity also arises from the fact that this inductive study relies on subjective data, in the form of transcribed interviews, meaning that it will not be possible to draw specific generalisations. Instead, the end-result will be the exploration and description of patterns and tendencies within this research of a social phenomenon. However, as will be seen in the analysis, there were findings that pointed towards some degree of generalisability, especially if further studies would be conducted. I state this, as the themes and challenges occurred throughout all five interviews.

I use a qualitative research method with the purpose of finding and understanding the meanings that can be extracted from the data, instead of seeking to explain the meaning of it. Semi-structured interviews with relevant participants will provide me with the empirical data that I will

afterwards analyse using a thematic analysis. The aim is to analyse the situation, so that it will be possible to establish and evaluate the lines of action that are present.

For a qualitative study, the final result will typically be open answers and interpretations, thereby ensuring reflexivity throughout the whole study. Therefore, the data will also concern a relatively small, but relevant, group of participants. This allows for me to go into depth with their narratives, thereby ending with a nuanced understanding of the research area.

4.4 Research criteria: Validity and reliability

Regarding the validity of this research, it is important to touch upon the authenticity and credibility of the project. I have not made use of any triangulation of the data but have instead focused on making the analysis as thick and representative as possible. Therefore, I believe that the research has actually resulted in what I set out to do. Furthermore, as I collected the data through interviews, I was also aware of the fact that this method can never result in complete objectivity. Rather, interviews do in fact rely on some sort of subjectivity, as the researcher herself is such an essential part of the method, being an instrument for the research (Brinkmann, 2022, p. 138). Furthermore, a part of preparing for interviews involves a pre-understanding of the topic one wishes to explore further, as you cannot enter the conversation without having a topic to base it on (Brinkmann and Tanggaard, 2020).

However, adding to the validity is the fact that the themes and challenges emerged through not just one participant's narrative. Rather the themes were identified for what they were, exactly because they came from the perspectives of several participants.

Though I did identify challenges, it is also important to mention that the data shows that these participants had found a way to overcome (most) of them over time. As none of them were still in the initial period of working in Denmark, they had learned how to deal with the initial challenges. However, as the research was centred around the initial time in Denmark, this did not affect the analysis. Though they were all at a good place now, this did not mean that it had been like that from the beginning.

To ensure reliability and consistency in the results, I have attempted to be as transparent and detailed regarding the whole process of conducting this research. Furthermore, there has been a focus on presenting all steps of the research, in a way so that it could potentially be replicated by others. This goes for both the description and exemplification of how the six steps as proposed by

Braun and Clarke (2008) were followed in the analysis, but also for the thorough description of participants and data collection.

However, even though it could be possible to conduct the study with another group of participants, it cannot be guaranteed that the results would be the same. As the challenges identified in this paper are based on individual narratives by specific individuals, it is very likely that new participants would also entail new discoveries.

To enhance the reliability of the project, I have furthermore been honest when stating that the interviews did not go exactly as planned, and that specifically the location in which the interviews took place, had a much more significant impact than anticipated. This will be elaborated on in the analysis on p. 45.

It is difficult to determine the reliability of this study by comparing whether the results correlate with previous research in the same area. The reason for this is that there are no other studies on this specific area in Denmark. One thing that can be said to correlate, is the fact that their language capabilities were an important factor for the participants, which previous studies have also concluded. However, since it was actually possible to identify recurring themes through the five interviews, I argue that it is likely that the identified themes and challenges could correlate with future similar studies.

5 Methods

As my research has now been positioned within the scientific and methodological field, I will further specify how the study was conducted. This includes a detailed description of the whole process from initiating data collection to analysing the collected data. In other words, what will be described is everything that has been done, in order to be able to answer the problem formulation. As mentioned in the research criteria, I have strived to be as detailed and transparent as possible, as I describe the preparation leading to the data collection, including the recruitment of participants, and the creation of an interview guide. Furthermore, the actual participants will be presented, as well as my chosen analytical method, namely the thematic analysis. Finally, the ethical considerations, which were of high importance in this study, will be discussed, as well as the effect of the ethical decisions I have taken.

5.1 Data collection

To collect the data for this project, the initial step was to locate participants, who would volunteer to participate in interviews. To do so, I turned to social media, posting on Facebook. More specifically, I found the Facebook group 'Udenlandsk uddannede læger i Danmark' (*Foreign educated doctors in Denmark*). Here, I made a post, in which I explained the situation; that I needed participants in connection to my Masters' thesis. I gave a brief description of the topic, but without being too specific, as I would not risk any influence on potential participants' answers, when it came to the actual interviews. The full post can be seen in appendix 7, but the topic was described as:

> *The thesis revolves around foreign doctors in Denmark and their experiences with communication in the Danish workplace. Focus is not on the Danish language (though I know that this can be tricky), but rather on how culture is reflected in our communication*.

The post got several comments from Facebook users, answering that I should feel free to contact them. As I did so, I asked the users about their current job situation, and where in the country they were located. I asked about their current position, as I would thereby be able to identify whether they fitted the target group. Some were not relevant, as they were not specialist doctors or intending to become so. Those who fitted the target group were invited to an interview, either physically or online, depending on their geographical location. In the process of arranging the practicalities regarding the actual interview, some turned out to not be available after all. However, this was solved as two of the participants effectively reached out to colleagues, and thereby managed to recruit other participants on behalf of me. Finally, I conducted five interviews with five different participants, resulting in 141 minutes of recording in total. The interviews were either held online, at a Danish hospital, or at a private address.

5.1.1 Participants

The group of participants that were eventually interviewed, was made up of three males, which I have named Farhad, Karim, and Emre, and two females, which I have named Ana and Haneen. The participants aged from 37 to 54 years old. All, except Ana who obtained her medical degree in Portugal, had obtained their degree outside of the European Union, respectively in Iraq, Egypt, Türkiye, and Iran. They were all fully specialised within an area already, or well on their way to become so.

I did not include specialisations in the interview, however, some of them mentioned it themselves. Thereby, it can be seen that two of the participants were gastroenterologists, and two worked within orthopaedic surgery. The last participant did not state their speciality.

Reasons for relocation to Denmark differed significantly. Ana had actively and deliberately chosen Denmark as a destination, as she wanted better working conditions and environment. Haneen had chosen Denmark, as she and her husband wanted to experience the world, and chose Denmark both due to the geographical location, existing opportunities, and because they believed that the language would not be too hard to learn. As Farhad had come as a refugee, he had not had any other choices than to follow the available route out of his country of origin. For Emre and Karim, it was because of family relations, respectively, to be closer to a daughter and to a wife. Their time in Denmark ranged between 4,5 to 22 years. As can be seen in the table below, most of them started working within a year after relocating to Denmark. Only Haneen took a few years off, before she started working.

All information regarding the participants has been gathered and is presented in the table below for an overview.

PRESENTATION OF PARTICIPANTS						
Name	Gender	Age	Country of origin	Years in Denmark	Years working in Denmark	Reason for relocation
Farhad	Male	54	Iraq	22	21	Refugee
Karim	Male	47	Egypt	15	14	Family relations
Emre	Male	44	Türkiye	15	15	Family relations
Ana	Female	40	Portugal	4,5	4,5	Seeking better work conditions
Haneen	Female	37	Iran	10	7,5	Seeking new opportunities

Table 1: *Presentation of participants*. Developed by author

5.2 Semi-structured interviews

Data was collected through interviews, one of the most used methods for data collection in qualitative research. A reason for this extensive use might be that the method is very suitable for gaining access to the individual's reality, exactly as it appears to them. The participant communicates and constructs a narrative, which gives the researcher access to the individuals' experiences of the specific phenomenon of interest to the researcher. Although an interview will always be a constructed conversation due to the presence of a predetermined topic, the goal is to get as close to the individual's authentic experiences as possible (Brinkmann and Tanggaard, 2020, pp. 33-35).

As interviews exist in various forms, another benefit is that it is a flexible method. It is so, since the forms of interviews exist on a spectrum from being very structured, to interviews with almost no structure. The semi-structured interview, which is the chosen one for this paper, exists somewhere in the middle of the two extremes (Brinkmann and Tanggaard, 2020, p. 41).

A semi-structured interview takes a point of departure in an interview guide based on a specific research area. However, having an interview guide does not mean that the interviewer is bound to follow it. Nor does it mean that they are not free to add or change questions during the interview. The flexibility of a semi-structured interview allows for skipping questions, adding questions, and deviating from the original structure, in order to adjust the conversation to the specific participant (Brinkmann and Tanggaard, 2020, p. 42).

However, this flexibility does not mean that the semi-structured interview equals a casual conversation. Indeed, successful data collection through semi-structured interviews, and interviews in general, requires careful planning and preparation. What is meant by so, is that the researcher must have knowledge on the area in order to ask the questions that can potentially add new knowledge to the research area.

In the case of this paper, I created an interview guide for a semi-structured interview with 28 questions divided into seven themes, all related to the research area (appendix 6). Each question was prepared in order to generate data that would enable me to answer the problem formulation. However, if one compares the interview guide with the actual transcripts, it can be seen that the interviews did certainly not follow the interview guide strictly. As an example, Farhad was very talkative and often strayed from the topic, meaning that I was not able to have him answer every question. Furthermore, I had assumed that the first questions, which concerned forms of addressing,

would be rather quick to go through. However, with Farhad, these questions quickly turned into a long talk about Iraqi hierarchies in general, as can be seen in for example appendix 1, lines 75-90. The last thing to touch upon concerning interviews is how many interviews can be said to be sufficient. The answer depends on the nature and purpose of the research. One way to judge when the data collection can be terminated, is to consider when the data is 'satisfied', meaning that the researcher judges that more interviews will not entail new information. A practical aspect is to consider what is realistic, depending on time and scope of the research (Brinkmann and Tanggaard, 2020, p. 37). For this paper I chose to conduct the interviews with few participants, which made it possible to explore the data in depth, resulting in a very thorough analysis, within the timeframe for the project.

5.2.1 Interview guide

As preparation for the interviews, I created a fixed set of questions and themes prior to conducting them. Predefined themes and questions worked as a tool for me to gain knowledge on the areas that I decided, through the problem formulation, were of interest. However, as it is the case with a semi-structured interview, I was prepared to both omit questions or add new ones during the interview (Thisted, 2018, p. 213). This was dependent on what I deemed to be suitable for the specific interview, but also dependent on what direction the participant steered the conversation.

As can be seen in the interview guide (appendix 6), the questions are separated under seven themes, not to be mistaken with the themes identified in the thematic analysis on p. 36. Each theme in the guide was chosen with the purpose of covering areas that could be of help to answer the problem formulation. At no point did I ask the participants explicitly whether they experienced any challenges related to their experience of hierarchies in Denmark. This was a deliberate choice, as should the participant know exactly what I wished to investigate, it could possibly have an influence on their answers (Silverman, 2010, p. 197).

To start the interview, I began by asking about specific forms of addressing. These questions were meant as a 'warm-up', as I expected them to be relatively easy to answer. Furthermore, having each participant answering all questions under the theme 'forms of addressing each other' would enable me to create an overview of the forms of addressing by country, and compare this to what the participants now saw in Denmark. I then moved on to the participants' initial experience in Denmark. At this point, the intention was to let them talk rather freely, in order to understand what topics mattered the most to them and should potentially be elaborated on.

Following this, the initial plan was that the conversation should revolve around hierarchies, power, and culture, as these are the topics that relate directly to the problem formulation. Finally, in order to relate to Goffman's theories on face and framework, the questions moved to the area of identity and behaviour around others. Below is the full interview guide presented in English. The Danish version, which was the one used during the interviews, can be found in appendix 6.

THEME	QUESTIONS
Presentation	Age Gender/pronouns Country of origin Years in Denmark/years working in Denmark Reason for relocation
Forms of addressing each other	Can you tell me something about how you would usually address others, and how others would address you in your home country? • How would patients address you? How would you address them? • How would you address a supervisor? How would they address you? • How would you address colleagues that were not your supervisor? E.g. a nurse, a secretary, a cleaner, etc. How would they address you? How are the forms of addressing others different now in your Danish workplace?
Initial experience in Denmark	Can you tell me something about your initial experience when you started working in Denmark? What were your first feelings and thoughts? It can be both positive and negative.
Hierarchies	Did you know anything about how politeness and hierarchical status are communicated in Denmark? Can you think of anything that surprised you by the typical way of communicating in your Danish workplace? How is it compared to what it is like in your country of origin? • Has it been easy to adjust to?

	Do you ever feel like the way of communicating affects you in any way (both in relation to work and outside of work)? Are you ever afraid of coming off as impolite or insensitive as you adjust to the usual way of communicating in Danish?
Power	Do you see any explicit forms of hierarchies in your current workplace? • Did you see this in your country of origin? Have you thought of any difference in how power and hierarchies exist in Denmark versus your country of origin?
Culture	Do you think that you have something in your cultural background that influences your relationship with colleagues? Do you think that your cultural background has played any sort of role in regard to your integration in Denmark? Have you in any way experienced that it has caused issues that you grew up and educated yourself elsewhere than in Denmark?
Goffman	Do you feel like you can be yourself when you are at work? Do you behave differently now around patients and colleagues than you did before relocating? • If yes: How do you behave differently? • Do you feel like that around everyone or is it connected to any special group of employees/patients?
End of interview	Do you have any final elaborations or comments?

5.3 Thematic analysis

The data that was collected for my research is analysed through a thematic analysis. Thematic analysis can be used to identify, analyse, and report patterns, also referred to as themes, in written data, making it very useful for the analysis of transcribed interviews (Braun and Clarke, 2008, p. 79).

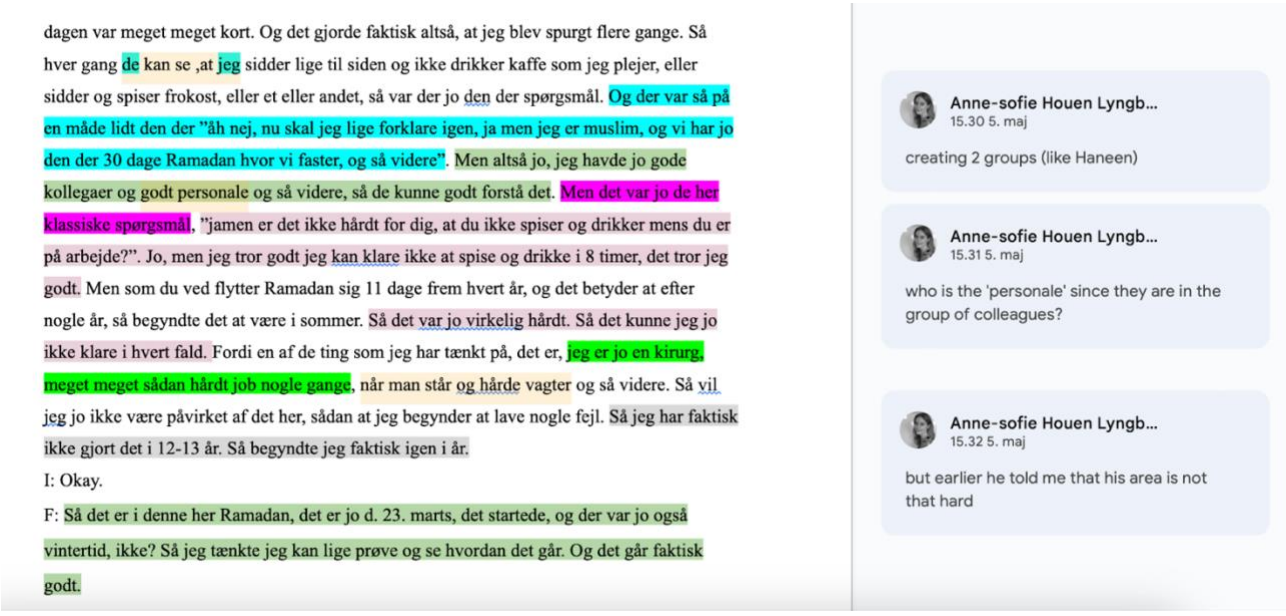
There are not many rules that restrict a thematic analysis, and it has therefore also been criticised for an 'anything goes' approach. Therefore, I have included multiple examples from the

data in the analysis to ensure transparency, and to support my arguments by staying close to the actual data (Braun and Clarke, 2008, p. 78).

Braun and Clarke (2008) propose six steps for conducting a thematic analysis, which I will now unfold, while specifying the academic terms that are introduced in the authors' model. Moreover, I have included tables and screenshots to support my explanation and exemplify how I have followed the steps in the actual analysis.

The very first step towards a thorough thematic analysis is to gain a high degree of familiarisation with the data. As I have conducted interviews, this process of familiarisation already began as the recordings were transcribed. The transcription was also a process in which I noted the first and initial thoughts.

This leads to the second step, in which the first coding takes place. Coding is an analytical process, involving the act of applying words or brief sentences that summarises a specific part of the data (Braun and Clarke, 2008, p. 89). It is a data reduction that allows me to look for repetitions and patterns in the data. The screenshot below illustrates how a section of the data appeared after the initial coding. Here it is seen how multiple colours have been used to categorise the participant's narrative, which showed me the patterns and initial themes that appeared when going through the data. Moreover, several comments were noted during this step, comments I returned to further on in the analysis.


dagen var meget meget kort. Og det gjorde faktisk altså, at jeg blev spurgt flere gange. Så hver gang de kan se ,at jeg sidder lige til siden og ikke drikker kaffe som jeg plejer, eller sidder og spiser frokost, eller et eller andet, så var der jo den der spørgsmål. Og der var så på en måde lidt den der "åh nej, nu skal jeg lige forklare igen, ja men jeg er muslim, og vi har jo den der 30 dage Ramadan hvor vi faster, og så videre". Men altså jo, jeg havde jo gode kollegaer og godt personale og så videre, så de kunne godt forstå det. Men det var jo de her klassiske spørgsmål, "jamen er det ikke hårdt for dig, at du ikke spiser og drikker mens du er på arbejde?". Jo, men jeg tror godt jeg kan klare ikke at spise og drikke i 8 timer, det tror jeg godt. Men som du ved flytter Ramadan sig 11 dage frem hvert år, og det betyder at efter nogle år, så begyndte det at være i sommer. Så det var jo virkelig hårdt. Så det kunne jeg jo ikke klare i hvert fald. Fordi en af de ting som jeg har tænkt på, det er, jeg er jo en kirurg, meget meget sådan hårdt job nogle gange, når man står og hårde vagter og så videre. Så vil jeg jo ikke være påvirket af det her, sådan at jeg begynder at lave nogle fejl. Så jeg har faktisk ikke gjort det i 12-13 år. Så begyndte jeg faktisk igen i år.

I: Okay.

F: Så det er i denne her Ramadan, det er jo d. 23. marts, det startede, og der var jo også vintertid, ikke? Så jeg tænkte jeg kan lige prøve og se hvordan det går. Og det går faktisk godt.

Anne-sofie Houen Lyngb...
15.30 5. maj
creating 2 groups (like Haneen)

Anne-sofie Houen Lyngb...
15.31 5. maj
who is the 'personale' since they are in the group of colleagues?

Anne-sofie Houen Lyngb...
15.32 5. maj
but earlier he told me that his area is not that hard

Screenshot: *First coding of appendix 1, p. 12*. Taken by author.

Moving from here to the third step of the analysis, one starts to identify the actual themes. Themes are identified as you gather the many different codes into broader groups, labelled with one word or a short phrase that conveys the meaning of each code under it. It is important to be aware that the identified themes are not necessarily the final ones at this stage of the analysis. A part of the flexibility of thematic analysis is that it involves a continuous going back and forth between data, coding, and themes. Furthermore, it is not the frequency of a theme in the data that is necessarily the most important factor in the selection of these. Instead, what matters the most, is that the themes are meaningful and cover the data in total (Braun and Clarke, 2008, p. 82).

Then comes the fourth step, in which focus is on reviewing the themes identified at this point. Here it should be considered whether the data truly supports a theme, whether a theme should be divided into several themes, and whether all themes adequately reflect the data. At this step in the analysis, I realised that the extracts from the data that I had collected under a theme named *negative experiences in Denmark*, could instead be divided between other themes that said something about the nature of the negative experience, and thereby created a more elaborative description of the data. To further exemplify this step, the table below illustrates how several subthemes were finally categorised into the six final themes.

FROM SUBTHEMES TO THEMES					
Theme 1: *Forms of addressing*	Theme 2: *Hierarchies in the workplace*	Theme 3: *Discrimination*	Theme 4: *Upholding status*	Theme 5: *Insecurity*	Theme 6: *Culture*
Forms of addressing	Politeness Power/status Systems in Iraq Hierarchies Asserting own status	Negative experiences in Denmark Ethnicity Discrimination	Power/status Goffman: Fronstage & Face Asserting own status Negative experiences in Denmark	Negative experiences in Denmark Language Discrimination Positive experiences in Denmark Positive feelings Goffman: Frameworks Goffman: Face	Essentialism Religion Creating two groups

Table 2: *From subthemes to themes*. Developed by author

After this revision, one should be able to tell an overall story about the data by looking at the themes (Braun and Clarke, 2008, pp. 91-92). When this overall story and thematic map is created, the fifth step begins. Here you define the themes, meaning that you identify the essence of them. By doing so, it should be possible to explain the theme in brief sentences, which can then all be collected into a coherent story told by the data in relation to the research question(s). For this purpose, themes should be considered both as they each are, but also in relation to each other. The table below offers a brief description of the chosen themes, as they were in this step.

DESCRIPTION OF THEMES	
Theme 1: *Forms of addressing*	All participants came from medical institutions in which strong hierarchical structures were upheld by the use of official titles, such as Sir, Mr., Mrs, Professor etc.
Theme 2: *Hierarchies in the workplace*	Some participants saw hierarchies in their Danish workplace, and some participants were not fully aware of it. Hierarchies were visible when it came to level of expertise, but also with regard to ethnicity, with non-white doctors being in the bottom.
Theme 3: *Discrimination*	The participants had experienced discrimination at their Danish workplace. However, not all of the participants were aware of it, or they tended to excuse it by referring to their Middle Eastern background.
Theme 4: *Upholding status*	During the interviews, the participants emphasised their competences and status in various ways. Both explicitly and through comparisons. It was primarily the male participants who did so.
Theme 5: *Insecurity*	During job start, the participants had at times felt insecure. This insecurity came from not knowing what was expected at them in a situation. They did not feel that they got any guidance in relation to this.
Theme 6: *Culture*	An essentialist approach to culture was seen from both participants and Danish colleagues.

Table 3: *Description of themes*. Developed by author

The whole process of analysis is individual, depending on both the respective dataset, but also what the researcher sees in the text. To define a theme is about defining what is important in the data related to the research question that sets a basis for the analysis. At this point I had decided on the following themes: *Forms of addressing, hierarchies in the workplace, discrimination, upholding status, insecurity,* and *culture*. The themes were selected, both as they were very present in the data, but also as they covered challenges that the participants had experienced during their initial time at their Danish workplaces. By so, these themes were what led to the identification of challenges, allowing me to answer the first part of the problem formulation:

> ***What cultural challenges related to hierarchies in the workplace do foreign doctors experience during their job-start in Denmark****, and what can be done to either avoid or ease these?*

The sixth and final step is to combine this analytical process into a written product, creating a narrative that can be exemplified with extracts from the data to support the identification of the respective themes. However, the writing does not just start at this point. Throughout the whole process one must continually write and note down, as this is a crucial part of thematic analysis (Braun and Clarke, 2008, p. 89). This step is what is to be read in the analytical section of the paper starting on p. 36.

5.4 Ethics

Before continuing to the analysis, I will present the ethical considerations that I made during the preparation for the interviews. As my research was dependent on gaining access to the participants' thoughts, feelings, and experiences, it was of utmost importance that they were aware of their rights, and how their statements would be handled.

Before starting the interviews, the participants were asked to sign a consent form (appendix 8), thereby giving me the right to use the data for my research. I furthermore asked whether they would like a summary of their respective interview for approval after transcription, which they all declined. The interviews were recorded on my personal phone, and thereafter transferred to an external hard disk that only I had access to. The recordings will be deleted upon the assessment of the thesis, which is also explained in the consent form.

As a part of my ethical considerations, I put much thought into which information should be omitted from the paper. As my intention is not only to do good with this research, but also to avoid any harm inflicted on the participants, it was important for me that it would not be possible to identify the participants. The doctors' specific specialisation is omitted from the paper, as I have made the judgement that it is not relevant in regard to the research. They were informed of this before the interview, however, some of the participants mentioned it during the interview on their own initiative. Their exact workplace is not mentioned, but some of the participants did however mention it themselves. The names used in the paper and transcription have been assigned by me. However, information regarding their age, nationality, how long they have been working in Denmark, and why they chose to relocate is included.

I will end by emphasising that the choice I have made to omit a rather large part of the participants' personal information, did not have a negative impact on my research or made the data and thereby the analysis less thorough. The decisions were all made with the research focus in mind. As reflected in the problem formulation, the focus of the data collection is not dependent on

specific information about specialisation or workplace, as it is not a comparative study, but rather a study of the individual's thoughts and experiences in relation to challenges during jobstart in Denmark.

6 Analysis

The following is the final, written result and presentation of an extensive thematic analysis of the data, including the unfolding of how six themes, and from them five challenges, were identified. The purpose of the analysis is to show the interpretation of the participants' experiences, and through that the identification of the challenges they met, when they started working in Denmark. By identifying, presenting, and understanding these challenges, it is further on possible to discuss and evaluate these, which will be necessary in order to answer the full problem formulation.

The analysis is structured so that each theme is presented separately. Though Goffman's theories played a role in the research and the interviews, these are not presented as a theme in itself. Instead, the theories of face and framework are included throughout the analysis, as a part of the identification of challenges.

The themes that will be presented are *forms of addressing, hierarchies in the workplace, discrimination, upholding status, insecurity,* and *culture*. If one compares with the interview guide, it can be seen that discrimination was not something I originally intended to explore, and neither was upholding status a theme I had expected. However, as it is often the case with semi-structured interviews, the guide was not followed precisely, and it was clear that these were themes that were of importance to the participants.

The transcripts which serve as the foundation for the analysis, can be found as respectively appendix 1 (Farhad), appendix 2 (Karim), appendix 3 (Emre), appendix 4 (Ana), and appendix 5 (Haneen). As all interviews were conducted in Danish, you will find the transcriptions in Danish. However, I have chosen to translate the sentences and paragraphs that are included as examples and descriptions in the analysis. This is done in order to improve the readability. Furthermore, for the translated extracts of the data, I have chosen to correct some of the linguistic mistakes that the participants made in their narratives. As none of them had Danish as their first language, it was expected that linguistic and grammatical mistakes would happen. Again, in order to improve the readability of the analysis, I have decided to correct mistakes in the cases where it made sense. Furthermore, not every sentence would be understandable or make grammatical sense, when taken

out of its context, therefore making it necessary to correct in some instances. Finally, it should be noted that some extracts of the data can be found under more than one theme, as they present several aspects.

6.1 The identification of themes

As mentioned in the description of the thematic analysis on p. 30, after being familiarised with the data, the next step involved data reduction through coding. I coded phrases and paragraphs throughout each transcript, as I saw the repetitions and patterns along the way. At this point I did not consider the frequency of codes, or whether they were present in each of the five transcripts. Thereby, having gone through all the transcripts, I had a long list of codes, which included: *Hierarchies, politeness, ethnicity, power/status, asserting own status, discrimination, positive feelings, negative feelings, positive experiences in Denmark, negative experiences in Denmark, systems in Iraq, insecurity, language, personal facts, Goffman: Face, Goffman: Frameworks, religion, essentialism, creating two groups,* and *forms of addressing*. Furthermore, I continually noted my thoughts and comments along the way. As an example, I had noted "At this point she is still upholding a front", when Haneen told me that she liked Denmark, because there was no use of titles (appendix 5, l. 75). Then later I commented "NOW we are going backstage", as Haneen said "I have to be honest" as an introduction to how she felt around her colleagues (appendix 5, l. 183). By so, I had both started to reflect on her contradictory statements, but also related them to Goffman.

Through step three and four of the thematic analysis I discarded the codes *personal information* and *Iraq systems,* as the data they did in fact not cover anything related to the whole narrative, and furthermore were very specific to the individual, Farhad in particular.

Forms of addressing as a theme was rather simple to identify from the beginning, both as it was easy to identify the statements because they typically appeared in connection to a question directly related to forms of addressing, but also because identifying this theme was with a different purpose than the other five themes. Namely that it should serve as a basis for being able to see whether, and how, they had experienced hierarchies before.

Moreover, I saw how the statements that fell under the codes *positive feelings, negative feelings, positive experiences in Denmark,* and *negative experiences in Denmark* could all be given a new label that would say something specific about the feelings and experiences. More specifically, they were all put under either hierarchies, discrimination and/or insecurity. For

example labelling "I was just thrown into… Chaotic system with almost no help", and "it was of course difficult in the beginning, and I would say that what was stressful . . . well, that language barrier in the beginning ", under insecurity said more about the statements than *negative experiences in Denmark* did (appendix 3, l. 209; appendix 1, ll. 187-190). Another example is how discrimination said much more about a statement such as "you are like number two or a bit more, because you are not Danish" (appendix 5, ll. 183-184) than the code *negative feelings*. I also discovered how *positive feelings* and *positive experiences in Denmark* were often related to either status or more indirectly with hierarchies.

In the table below I have attempted to visually present the process from step two to step four of a thematic analysis applied to my data. It shows examples of statements that were at first coded as negative feelings and experiences. However, after reflecting and considering the whole narratives, it was apparent that they should be relabelled, thereby telling a more comprehensive story about the data.

IDENTIFICATION OF THEMES: AN EXAMPLE
Negative experiences in Denmark Negative feelings ⬇
"So that meant that I did not get a contract, but I did not know that" "[Patient was] not completely satisfied with a foreigner who spoke bad Danish had to do his medical record" "you get this feeling, I have to be honest, that you are number two or even less because you are not Danish" "then they said all these things, and that I should not even be in that speciality. And that was really very hard . . . Like falling from the horse" ⬇

What specific situation caused this feeling? *What kind of negative feeling was it?* ⬇
Themes: *Discrimination* *Insecurity*

Table 4: *Identification of themes: An example*. Developed by author

Whereas the above has shown how the final themes were defined and identified, what will now follow is the analysis of the respective themes, and what challenges emerged from these.

6.1.1 Theme 1: Forms of addressing

After beginning the interview by establishing the personal information as presented in table 1 on p. 26, I followed the interview guide and continued with the forms of addressing. The purpose of these questions was first and foremost to establish whether the participant had previously experienced a working environment in which a hierarchy was explicitly expressed through the use of titles, and also in order to understand how the hierarchy was structured. This understanding would allow me to compare what they came from, to what they were now experiencing in their Danish workplace.

In the table below, I present a schematic overview of how each participant would address others, and how they would be addressed by others. However, as a consequence of the semi-structured interview form, not every participant provided an explicit answer to the questions. Rather some of them tended to stray away from the question, focusing on other topics and stories. In the cases where I did not manage to get a definitive answer to the question, it is marked with a '-'.

FORMS OF ADDRESSING IN HOME COUNTRY						
Participant	Patient to doctor	Doctor to patient	Doctor to supervisor	Supervisor to doctor	Doctor to subordinate	Subordinate to doctor
Farhad	Doctor or Sir	Never with Sir or anything similar	-	-	-	-
Karim	Doctor	Sir	Sir	Doctor or first name depending on age	First name	Doctor or Sir
Emre	-	'With respect'	With respect based on age and level of expertise	-	-	-
Ana	Doctor	First name	Doctor	With or without Doctor. No rules in this case	First name	-
Haneen	Doctor	Mr., Mrs., Miss	Doctor or Professor	Mr., Mrs., Miss unless the doctor was fully educated	Mr., Mrs., Miss	-

Table 5: *Forms of addressing - overview*. Developed by author

As it can be seen in the table, all participants had previously been working in an environment in which titles were used. When I did not get a clear answer regarding the specific form of addressing, it was mainly due to the participant choosing to talk about hierarchies in general. An example of this is when I asked Farhad how he would address a supervisor, and he started to discuss how hospital departments were structured in Iraq based on the levels of expertise. So, although he did

not tell me exactly how he would address a supervisor, he did however provide a long description of the clear hierarchical structure in his former workplace (appendix 1, ll. 75-90).

Despite several blank spaces in the table, I argue that it is possible to see a pattern with three general tendencies. First, it shows that patients and subordinates would address the doctor with more respect (as indicated by titles) than it would go the other way. Second, it also shows that a doctor would always address a supervisor with a title, whereas it was not always the case the other way. Third, it is noticeable that Haneen is the only participant who explicitly includes female titles such as Mrs. and Miss. All others either answered Doctor which could cover all genders, or Sir which is reserved for the male gender.

Having attempted to go through the questions regarding forms of addressing, I finished this part of the interview by asking whether they saw anything similar in their current Danish workplaces. Haneen replied "here in Denmark, you do not use that title", Karim said it was "just first name for everyone", and when asked whether anyone addressed him with a title, Farhad replied "No, no, no, there is not" (appendix 5, l. 74; appendix 2, l. 47; appendix 1, l. 111). Thereby, it can be concluded that the participants did not see a hierarchy expressed through the use of official titles in their current workplaces, whereas it had been very present in their former workplaces in respectively Egypt, Iraq, Iran, Türkiye, and Portugal.

However, though the use of titles was not present in Denmark, this does not entail that a hierarchical structure did not exist around them. Haneen and Ana explicitly told me that they felt that hierarchies existed in their current workplaces, and Farhad, Emre, and Muhamed indirectly expressed it as well, even though they were not fully aware of it. This will be unfolded further in the following analysis of theme hierarchies in the workplace.

6.1.2 Theme 2: Hierarchies in the workplace

For Ana the answer was clear, when she was asked whether she saw any type of hierarchy in Denmark. "Yes, I think so" she replied immediately (appendix 4, l. 58). And when asked to elaborate on how the hierarchy was expressed, she said "In the same way [as in Portugal]. You know who you have above you, and who can possibly need you as well" (appendix 4, ll. 62-63). I asked her whether she knew anything about this beforehand, to which she replied no, but it had surprised her to encounter this hierarchy since "yes, they say there is no hierarchy, but I think there is anyway" and "but I think it is very obvious who is the boss" (appendix 4, l. 68 + l. 73). However, she also stated that she did not mind this hierarchy as "it always functions better, when there is

someone who leads the area" (appendix 4, l. 84). So for Ana the case was clear. There was a hierarchical structure in her Danish workplace, even though it was not expressed verbally, however, she did not struggle with this. Rather, she found it to be the optimal way of structuring an organisation.

In the case of Emre, he started out by describing his Danish workplace as "it is very *large, relax*" (appendix 3, l. 77). When asked directly whether he saw any hierarchies in Denmark, he first replied that it was extremely rare, but later continued:

> of course, during surgery . . . You have to say some things before you do it. So there is a little bit of hierarchy, actually . . . Especially the operating room, if you have met an older colleague, it is him who is the boss, even though it is you who is operating . . . Yes, there is a hierarchy, definitely (appendix 3, ll. 91-94).

In Emre's narrative, the hierarchy was limited to the physical space of the operating room, whereas the overall daily life was much less restricted by formal hierarchies than he had experienced in Türkiye.

Neither Karim nor Farhad stated that they experienced an obvious hierarchical structure in their workplace. When asked whether he saw anything similar to what he saw in Egypt, Karim answered "Not much, actually. You cannot sense the management here. Management, they are very invisible… So it is that again, there is not the hierarchy as in Germany or England or our own country" (appendix 2, l. 51-52). When it comes to Farhad, he answered the question by explaining how things were done in Iraq. The explanation served as a description of how the healthcare institutions were structured differently than what he saw in Denmark, meaning that he indirectly answered the question with a no.

Something that was interesting about these four different descriptions of hierarchies in Denmark, is not only that the participants' impressions of it differed, but also that hierarchies took different forms in their mind. What is meant by that, is that Ana described it as roles placed on a vertical system, with someone *above* you, however, she did not use the word *below*. Instead she described this role as someone who *needs you*. For Emre, hierarchies came in quantities and degrees, as he said *a little bit* and then *definitely*. Like Ana, hierarchies existed in the form of roles for Karim as well, when he used the word management. However, there is a difference between describing the top of a hierarchy, as someone who is *above you, a boss, someone who leads* - and then simply using the word *management*. For Ana, the top of the hierarchy was a specific someone, where Karim made it into a more abstract concept. The differences do, however, correlate and

underline the rest of their description of hierarchies. Ana seemed to refer to a specific individual, and she saw hierarchy without a doubt. For Karim, the abstraction of the hierarchy was mentioned in connection to not feeling their presence strongly.

Though some of the participants did not seem to believe that their workplace was hierarchically structured, Farhad and Karim described how they had to gain the confidence of their Danish colleagues, before they were acknowledged as a competent part of the workforce. I include this aspect under hierarchies in the workplace, as it shows that there was an already established hierarchy amongst the employees working there, in which the two participants had to prove themselves, before they could even enter into it.

> For Farhad, he believed it was a natural part of the process:
> because I came from the Middle East, like a third country, right? Then there was this scepticism in the beginning about the things I can and cannot. Does Farhad have the competences to do this or not? And I felt that from day one, and that is of course natural. That is okay (appendix 1, ll. 310-313).

Karim had the same experience of having to prove himself in the beginning, "But of course some people are a bit sceptical when you start working, they think 'okay, is he nice or not nice?'" (appendix 2, ll. 147-148). Both of them did, however, feel that this changed quickly after they had started working, and as can be seen in the quotes, they both found this process of meeting and overcoming scepticism to be a natural part of the jobstart. This acceptance can be due to the fact that they both came from a system where hierarchies were present. Their decoding of the situation was based on their individual frameworks, that had been shaped by their individual backgrounds, as an outcome of the social groups they used to operate in.

Haneen also encountered scepticism, the difference being that she approached it much differently. Her decoding of this scepticism differed from the one of Farhad and Karim, exemplifying how frameworks are an element of a specific group's culture, and thereby not a fixed set of frames of interpretation, that can be applied to all individuals (Goffman, 1986, p. 27). Haneen's approach to this scepticism added a whole new perspective to my original focus on hierarchies. I had only taken my point of departure regarding hierarchies as being based on level of expertise within the medical area. However, when the conversation started to revolve around the notion of hierarchies in Denmark, she pointed out how she did indeed see a very clear hierarchy, but instead of being a professional one, it was a discriminating one based on ethnicity.

She described the hierarchy in Iran as based on educational status, which was reflected in the fact that you would not be addressed as a Doctor until you were done with the whole programme (see table 5). To begin with, she stated how she did not see this type of hierarchy in Denmark, and she said nothing similar to what Ana said concerning who the leader of a department would be. Instead, she saw a hierarchy in which non-white doctors were placed at the bottom. She perfectly addressed this by saying:

> Well, it is a bit different in Iran if it is a hierarchy, it was maybe more professional, so a higher level and therefore there was this hierarchy. But here, sometimes, you get this feeling, I have to be honest, that you are number two or even less because you are not Danish (appendix 5, ll. 181-184).

Haneen was also able to give specific examples of how she saw her own position in the hierarchy being connected to her ethnicity:

> I can also see how they treat my colleagues, who sit in the office with me . . . Well, it is not because that person is necessarily much more competent than me, but it is like, and the only thing that can come [the only thing she can think of], is maybe because I am a foreigner, and it is my skin colour (appendix 5, ll. 218-222).

Moreover, she explained that she did not feel like she was given the same options to develop professionally, because of her ethnicity and how it positioned her in the hierarchy. She talked about seven roles that a doctor must gain competence in, on the way to become a specialised doctor in Denmark. These competences are important for the doctor's career opportunities, but it was Haneen's experience that "if you want to, for example, become a bit better in the other areas than the medical expert, then it is always that you are thinking 'okay, you will not necessarily get the same opportunities'. Because I am a foreigner" (appendix 5, ll. 237-239). It should be noted that these stories were all from a former workplace in Denmark, and she emphasised that she felt more comfortable in the department in which she was currently working. However, these experiences had been a significant part of her initial time in Denmark, thereby fitting the problem formulation, as it concerns challenges in relation to job start in Denmark.

The final observation I wish to present in this section concerning hierarchies in the workplace, is the participants' unconscious participation in and construction of a hierarchical structure. This became apparent through two factors. First, when referring to a supervisor or a colleague who was not a nurse, secretary of cleaning personnel, it was always done with the male pronoun 'he' - however, only by male participants. As it has previously been argued that our reality

is socially constructed between active individuals, it is important to include this aspect of discourse (Bryman, 2016).

Emre and Karim both referred to supervisors and colleagues in general as a 'him', which can be seen in the following examples, in which I have underlined the pronouns in question. Emre's beforementioned description of the hierarchy in the operating room included "if you have met an older colleague, it is him who is the boss " (appendix 3, ll. 93-94). And when Karim was asked how he would address a supervisor in Egypt, it was "then we have to respect our supervisor, so we call him Sir" (appendix 2, ll. 29-30). This is despite the fact that the question was phrased as "Then, what if it was your supervisor? How would you address them?" (appendix 2, l. 28). For a supervisor in Denmark, he did the same by saying "they are not scared of the boss, even though it is him who holds the power" (appendix 2, ll. 83-84). These examples show how, through their use of language, Emre and Karim constructed a reality in which the supervisor is predetermined to be a male. Going back to the literature review on p. 17, Acker's theory on how masculinity was connected to well-regarded jobs, is reflected in the participants' use of discourse.

Another way the participants took part in the construction of hierarchies was in connection to asking for help. Some of them had found it difficult to do so in the beginning, but when they did, it was almost exclusively nurses or secretaries who were mentioned as those the participants would turn to. They did not ask the colleagues with a similar level of medical training, or those who were more experienced.

Farhad and Karim gave examples of specific situations, in which they had felt insecure on whether they had done something wrong. For both of them, it had been the nurses they turned to. When Karim was unsure whether he was working too slowly, the "nurses started saying 'do not worry, it is fine that patients wait for two hours'" (appendix 2, l. 96). And when Farhad was worried after a patient walked out of his consultation, "then I went out and talked to the nurses" (appendix 1, l. 235). He furthermore explained that initially, he did find the lack of hierarchies difficult to get used to and asking for help was a part of this. He said "I did not think of asking the supervisor about it. I only talked with the nurses about it" (appendix 1, l. 243-244).

In the case of Ana and Haneen, the nurses were mainly present in their narratives, when it came to language difficulties. As Ana said "so the nurses were very nice. They would always come with me and help translate something", and Haneen told how "maybe I do not ask directly to my doctor colleague, but then I ask the secretary" (appendix 4, ll. 142-143; appendix 5, ll. 253-254). All of these examples show how the participants, specialist doctors, in general turned to nurses or

secretaries for help. They did not ask those on the same level or even less those above them in the hierarchy.

These descriptions of the participants' various experiences with hierarchies in their Danish workplaces, compared to the section concerning forms of addressing, show that there are in fact existing hierarchies in Denmark, although they are expressed differently. The foreign doctors have to make a significant effort in order to enter this hierarchy and overcome a general scepticism. At times, this was legitimised by referring to their ethnicity. This legitimisation is furthermore due to the fact that they make sense of the situation by applying a framework shaped by their experiences in systems with much more explicit hierarchies. The scepticism, the reference to ethnicity, and especially Haneen's narratives, indicate a hierarchy based on the doctor's national background, rather than education, expertise, or age. This is only an extra factor added to the stressful process it can be to relocate to a new country, but the participants do, however, also add to this themselves, by reproducing a hierarchy through discourse.

This leads me to identifying the challenge: *The foreign doctors have to prove themselves before they are recognised as a colleague that can take a place in the hierarchy in the Danish workplace, adding extra stress to the process of settling in.*

6.1.3 Theme 3: Discrimination

Haneen's narratives were both the revelation of a hierarchy, but also of direct discrimination. However, she was not the only one who experienced being discriminated against, though she was the only one who actually saw it for what it was. How discrimination was expressed was also accounted for by other participants, although it seemed as if they were not fully aware of what they were exposed to. Discrimination was not originally a theme that I sought to investigate. Through the interviews it did, however, become visible that both direct and indirect discrimination were very much apparent in the participants' experiences in Denmark.

Specifically, in regard to this theme, it was very apparent that it had a major impact on the interviews, whether they were held physically in a private home, online, or at the participants' workplace. It can be seen how Haneen, who I interviewed in her private home, was by far the one who gave the most elaborate descriptions of experiences with discrimination. On the other hand, it can be seen how Ana, who was interviewed in her office with colleagues occasionally walking in, would only briefly answer a question regarding negative experiences in relation to being born outside of Denmark with "there are always some negative experiences, and also some positive ones,

right?" (appendix 4, l. 138). This difference illustrates the significance of Goffman's frontstage and backstage. At work, we were in Ana's frontstage area where she would perform, as she was in a situation with observers. In that case, it is likely that she would uphold a front that would fit with the one she would usually present to her colleagues. It was to be expected that the physical setting would affect the narratives, and unfortunately, there were simply no options for creating a more private sphere. Contrary, Haneen found herself in a private setting, in which no observers, except me, were present. Thereby, we got closer to her backstage area, meaning that Haneen provided me with very elaborate, and at times, also very personal answers.

As mentioned in the previously, Haneen was aware of how she was seeing discrimination, and how it resulted in her not having the same opportunities as her Danish colleagues. Both Farhad, Emre, and Karim had encountered discrimination due to their ethnicity as well, but they were quick to excuse it. Ana, who was not from a Middle Eastern country, was the only participant who did mention anything about discrimination based on ethnicity.

Farhad recalled two specific events, in which patients had reacted to his ethnicity. The first event, when a patient walked out from a consultation, was mentioned previously in relation to hierarchies, as it was the nurses who comforted him afterwards. But the event was also of a very discriminating nature, as the patient who walked out was "not completely satisfied with a foreigner who spoke bad Danish had to do his medical record, and I could feel that from the beginning" (appendix 1, ll. 232-234). It had affected him afterwards, but only because he was nervous that he was the one who did something wrong, and not because he had just been exposed to direct discrimination. For the other event, an elderly woman had asked him directly "why did you come to Denmark? Why are you not working in your own country?" (appendix 1, l. 251). He did not reply to this, continued his treatment of her, and was afterwards told by the nurses "Farhad we are sorry we did not tell you this, but she is a member of the Danish People's Party" (appendix 1, ll. 253-254). Farhad then laughed, and accepted this as an explanation for the patient's behaviour. In the introduction to these stories he said, "I knew, I expected of course, I do have a little dark hair and skin and so on" (appendix 1, ll. 227-228). He simply decoded the discrimination as a natural and expected consequence of his Middle Eastern background.

Karim had been exposed to direct discrimination coming from colleagues, but just as Farhad did, he excused this behaviour by referring to his ethnicity. For a job interview, he was by the end asked whether he would be able to work with women, and he explained this with "of course it is a bit mixed for them" and "of course some people are a bit sceptical when you start working . . .

Can he work with women or not?" (appendix 2, l. 143 + ll. 147-148). He was very aware of the stereotypes the colleagues had of him in the beginning, but just as it was the case with Farhad, it was a case of 'of course'. It was expected due to his Middle Eastern ethnicity.

In general, the three male participants tended to explain the discrimination with their Middle Eastern background. It was apparent through small parenthetical sentences, such as Emre's comment "It is not a problem until you are Arab" when talking about going through the process of authorisation, and Farhad explaining the initial scepticism with "because I came from the Middle East, like a third country, right", and finally Karim with the comment "Arab, they see me as an Arab" (appendix 3, l. 232; appendix 1, ll. 310-311; appendix 2, l. 143). But Haneen, who was also of a Middle Eastern background, did not accept this as an excuse. However, this might also have to do with the fact that she felt the discrimination had professional consequences, rather than it being 'just' stereotypes. In the case of Karim, the discrimination he accounted for, was limited to culture, specifically that the employers saw him as coming from a culture, which they associated with tensions between genders.

These narratives testify the direct and indirect discrimination that foreign doctors encounter in their Danish workplace. As some of the interviews were conducted at the participant's workplace, it is plausible that the extent of discrimination is more extensive than what can be seen in the data. I argue so, as the data clearly shows that the closer to the participant's backstage area, the more honest and elaborate the answers were.

Although some of the participants did not state that it had any direct consequences for them, Haneen's stories showed that consequences were a possibility, and that such consequences had an effect both mentally and career-wise.

From this, I can identify the second challenge: *The foreign doctors can experience discrimination, but as they tend to decode this as a natural consequence of their ethnicity, the potential consequences of the discrimination can go unnoticed.*

6.1.4 Theme 4: Upholding status

A theme that I had not anticipated, but which did however emerge through the thematic analysis of the data, was the participants' need to express their own status and level of expertise. More specifically, it was the three male participants who, at several occasions, more or less directly pointed out their expertise and educational background. I argue that this can be explained by our need to uphold the face that suits the impression we wish an audience to receive. Though I hoped to

get as close as possible to the participants' backstage area, I was nevertheless an observer leading to a performance.

Especially Farhad emphasised his competences, when he talked about language "So all the tasks that the rest had to do in three months, I had to do in three weeks . . . after six months the headmaster and the teacher said to me 'Farhad, now you are ready to take the exam'", passing exams "All the other colleagues failed maybe once or twice minimum. I could do it in the first try, luckily", employment "After just two months, two months, I got a contract", and his level of expertise "I have had great expertise, I was employed at different departments, had really good expertise with several different specialities" (appendix 1, ll. 128-130 + ll. 487-488 + ll. 138-139 + ll. 221-223).

Farhad was by far the participant who most explicitly established his status and expertise. Besides the above examples, he did it by comparing the education he received in Iraq with the Danish educational system. Because although he admitted that it was very hard as a doctor in Iraq, he also said that the different way of doing it in Denmark consequently meant that:

> but, well, then you also lose a part of the training. If you are interested in becoming a specialist in something … then you lose that part. Because you do not get the opportunity to get a really good and broad knowledge on many different things (appendix 1, ll. 374-377).

Emre and Karim came with similar statements. As they had come here from countries outside of the EU, they had both gone through an extensive process in order to receive their authorisation as medical practitioners in Denmark. This process included language tests, but also professional tests. In connection to what had been challenging in the beginning, Emre said:

> If a Bulgarian doctor comes, then it is the same as the old system, this means that they come to work without language, without knowing anything. So actually, they do not have any exams or brush-up of their expertise . . . If you come from outside of EU, then you also have to take professional exam, medical record-keeping, prescription writing (appendix 3, ll. 224-226 + 229-230).

So, what he indirectly stated here, was that a doctor coming from outside of the EU would be tested much more thoroughly, thereby guaranteeing a better knowledge than someone who came into work "without knowing anything". Also by using comparisons, Karim explained that "Yes, I have a better understanding of the Danish system, because I have had another system", and furthermore explicitly asserted his own status as a specialist doctor, "of course it is difficult as a specialist

doctor, they have a much higher responsibility than education doctors [doctors who are not fully specialised yet]" (appendix 2, l. 111 + l. 200).

A final way through which status was asserted, was by emphasising how professional help was not necessary, even in the beginning. Again, it was the male participants who did so. When Emre was asked whether he found it difficult to ask for help in the beginning, he replied "Professional help? Yes, it is no professional issue . . . Professionally, there is not so much a problem. None at all" (appendix 3, ll. 151-153). The interview with Emre was conducted in his office, and moreover, he was also wearing his white coat. In other words - his appearance signalled that he was a specialist doctor at work. As we usually seek to match our manner, the role we have in a situation, with the appearance, Goffman's theory can be an explanation as to why he would emphasise his own status and expertise in this situation.

Karim also talked about help, but he focused on what would happen if someone other than himself had a bad day, "Here, we help each other as well, if you have a bad colleague, or not a bad… a bad day professionally, we try to help him" (appendix 2, ll. 120-122). What should be noted here, is that he uses the example of someone else needing help - not himself. When it came to himself asking for help, he mentioned how "Yes, I was a little afraid also. We are not used to it in our country" (appendix 2, l. 159). He then continued to talk about how it was difficult to call in sick, meaning that it had not been asking for professional help, which he was hesitant about. On a similar note, Farhad said that it had been difficult to ask for help for the first years, but it had not been an issue because of his high expertise, as "I have not had any problems with it [making medical mistakes]. There were no occasions where I had to do it myself, and then I would get a complaint or something" (appendix 1, ll. 336-338).

For the two female participants, Haneen and Ana, the situation was different. Haneen replied "Professional help, that was not hard to ask for" (appendix 5, l. 244), implying that she had had the need for it. Ana recalled how she had been asked to perform a procedure that she had not been used to doing in Portugal, as it was the nurses' task. She said, "So suddenly I had to do some things that I was not fully prepared for" (appendix 4, ll. 123-124). When asked whether she had told somebody about it, she replied "Yes, I could say it, but . . . Yes, I did, but it did not help much at that time" (appendix 4, ll. 130-132). As she opened up about a situation in which she felt uncomfortable professionally, and had not had an issue with saying it, Ana actually presented a discrepancy between her appearance and her manner, as she was sitting in her office, wearing a white coat.

As mentioned, the participants', and specifically the male participants', need to emphasise a certain status was not a theme I had expected. Nevertheless, it became apparent in various ways, being of obvious importance to some of the participants. It can be explained by the fact that I was actually an observer in the situation, leading to them trying to uphold a suitable face, fitting to what impression they wanted me to gain of them. As they had previously made it clear that a doctor held a certain status in their countries of origin, this status would be what they believed was expected by an observer. Being aware of one's own expertise is not a challenge in itself, but the data did, however, reveal that upholding a status was also done by not asking for help. Nevertheless, the two female participants' answers showed that professional help was in fact sometimes needed.

From these opposite viewpoints, I identify the third challenge: *As the foreign doctors are used to holding a high position in a hierarchy, they use their energy to uphold a face that represents this status, and are as a consequence of this hesitant to ask for help when needed.*

6.1.5 Theme 5: Insecurity

I will now move on to the theme of insecurity, as the data showed that this specific feeling had caused issues in several situations. The insecurity arose from mainly three factors. One of these was that insecurity came from the presence of what might be considered rather mundane, but nevertheless, unwritten rules. Karim, for example, mentioned that he had been in doubt whether he was expected to pay for the coffee at work, and Haneen had more than once been unsure whether she was expected to shake hands, and "sometimes I come with my hand, and then pull it back. These were the kind of situations that got awkward, because I did not know exactly what I should do" (appendix 5, ll. 141-143). In other words, not knowing what was expected of her, made her feel uncomfortable, as it would inevitably make it challenging to uphold a face suitable for the situation.

In general, Haneen was sure that many unwritten rules existed in social settings, but not being able to understand them had been a cause for many feelings of doubt. She explained that even after ten years in Denmark, "there are still also situations where I think 'okay, is it appropriate to say it, or how do I tackle this?'" (appendix 5, ll. 155-156). She saw it as a continuing learning process, and she was not sure whether she would ever be able to say "now I can do it, now I know it" (appendix 5, l. 157). Furthermore, she did not feel that she was supported in this process of familiarising herself with these unwritten rules, and thereby overcoming some of her insecurities.

Both Haneen and Karim had on their own initiative attempted to create a course, where foreign educated doctors could seek guidance on the work culture in Denmark. However, though it had been a great success in both cases, practicalities such as Covid-19, maternity leave, and lack of time had prevented them from continuing the courses. Moreover, for Haneen's course, there had not been Danish doctors present, as she had otherwise wished for. She believed that having specifically Danish doctors present, would be beneficial for the course, as they would be the ones with the most knowledge on the area. Furthermore, having Danish doctors participating in the course would be an opportunity to get useful feedback since, "if we do not get feedback, then we cannot change it" (appendix 5, l. 171).

The second factor that added to the insecurity was language difficulties. Based on others' previous research on foreign doctors in Denmark, I knew that language was one of the main issues for their integration and well-being in the Danish workplace. As I wanted a different focus for this research, I had explained to the participants explicitly that we were to talk about obstacles that did not relate to language. However, it was clear that for all five participants, difficulties with the Danish language had been an obstacle throughout their time in Denmark. Often, the insecurity they experienced would somehow be related back to the area of language. Farhad connected the language barrier to his difficulties in regard to asking for help, when he first started working independently:

> I had to be very careful before I considered calling the attending physician for example. I kind of had to, okay, what is the reason for calling an attending physician right now? Can I not solve this issue on my own? . . . I thought 'how do I phrase this?' (appendix 1, ll. 219-221).

When asked how Emre felt about asking for help when needed, he replied "There were language difficulties from the beginning, so I needed way too much help . . . They helped me way too much actually" (appendix 3, ll. 137-138). For Karim it was also language difficulties that caused most of his issues in the beginning. He explained "I was very stressed . . . I was lacking language suddenly . . . I had to learn something new professionally and in terms of language" (appendix 2, ll. 188-191). Moreover, as he had his first shift in an emergency room and was shocked by the patients' waiting time, he believed it was his fault, as he was too slow due to his lack of language. For Haneen, the language difficulties had even had actual consequences. However, in her case, it had not been because of an insecurity coming from within, but rather the surroundings' reaction to her Danish language. She said:

> The issue is that the language, I did not have troubles in the beginning. There was a time where I got an issue in a specific workplace, where they also said something about language and then they also said something about how I wrote descriptions . . . It was actually thereafter that I started to get… Like falling from the horse or what you say (appendix 5, ll. 272-278).

Finally, a reason for insecurity was when the participants felt they had been asked to work independently sooner than they felt ready for. Moreover, they did not feel like they got the help and support they needed in such a situation. Ana remembered her first 24-hour shift after six months in Denmark, which was "way too soon and fast" (appendix 4, l. 128). Emre had the similar experience, when he was put into independent work after six months, and he described it as "I was just thrown into… chaotic system with almost no help" (appendix 3, l. 209).

The insecurity generally played a role in situations, in which the participants for some reason were not 100% sure that they did what was expected of them. And since no one told them what was in fact expected, they kept their doubts to themselves, in order to not lose face. The unwritten rules regarding work culture were not something they were guided in, since such rules are so ingrained in a culture that Danish colleagues were most likely not aware of it being a reason for insecurity. Furthermore, even though language disabilities were recognised by Danish colleagues as being valid reasons for insecurity, this does not entail that the participants were supported in this. Finally, when asked to work independently, though the participants felt it was too much too early, they were asked to do so, nevertheless.

All of the above show a general picture of the participants walking with multiple feelings of insecurity, which affected them in various ways, leading to the fourth challenge: *Foreign doctors lack general support in the situations in which they feel insecure, making it difficult to uphold face and hinders their well-being at work.*

6.1.6 Theme 6: Culture

The final theme to be presented is the one of culture. Connected to this, it should be mentioned that the participants did not know much about Denmark beforehand. Farhad and Emre did not even know where the country was located. This also meant that the participants did not have predetermined assumptions or expectations regarding the culture in Denmark. Therefore, when asked whether they had been surprised by what they were met with, most of them replied no. Only Karim had been shocked by the alcohol culture and the extent of it, and Ana had, as mentioned

previously, been surprised to see a hierarchy. From this it can be established that culture shock was generally not a challenge they had encountered.

The participants did however describe significant differences in what they experienced as the Danish work culture, compared to what they came from. In connection to Karim's arranged course, he explained how a specific focus on culture related to work was important, "it is something completely different from where we come from" (appendix 2, l. 219). Regarding the behaviour towards patients, this was also a new experience for Karim, as he explained "Yes, but also in Denmark, you have a completely different culture also about patients" (appendix 2, l. 92). In connection to how they behaved towards patients, Emre concluded that in a Danish hospital, they were in general more polite towards the patients. Not expressed through formality, but because doctors took their time to talk to a patient.

At times, the participants provided descriptions of people in Denmark, and in those cases, the descriptions were shaped by their close contact with personnel and patients. Since the participants worked in different locations, they also had some differing experiences. By Ana, the patients were described as nice, thankful and that "sometimes they would try to speak English themselves where I had to try and speak Danish" (appendix 4, ll. 144-145). Contrary, Karim's experience was that "but here in Denmark, the easiest and simplest [is to say] 'what do you mean?'. They are very stiff here" (appendix 2, ll. 132-133). Furthermore, with regard to their colleagues, the participants had different impressions. Farhad had "Really good relations, good social networks . . . if you experience something, then you will be asked 'well, how is it going?'" (appendix 1, ll. 387-389). On the other hand, Haneen experienced it as being hard to establish close relations, which she believed had to do with the Danish way of being. She said that:

> A work relationship should not necessarily lead to more. It could easily be that you can invite someone home one time, I am very happy if I could do that, for example. But then I should not expect that it will be much more than that (appendix 5, ll. 313-315).

Yet another difference was Farhad, who thought that the environment in Denmark was more competitive than in Iraq, whereas Karim stated that it was definitely more competitive in Egypt. What all of these examples present is that even though all five participants came to Denmark from other countries, had similar backgrounds, and similar job descriptions, they interpreted their surroundings differently.

As I analyse with some inspiration from Goffman's theories, I once again explain these differing viewpoints as being due to the participants' individual application of frames. As they find

themselves in the physical setting of a hospital, something they had already experienced in their home country, it is plausible that they would decode situations with the application of frameworks, which had been formed in their previous workplaces. The natural and social frames would come into play, as they are placed in an institution with similar traits and a similar purpose, meaning they interpret this institution and its individuals, as to what they were used to. Furthermore, since the social frames are shaped by our upbringing and socialisation, these are inevitably intertwined with the concept of culture, making the frameworks relevant for this theme.

Despite differing viewpoints on the work culture, social relations, and patients, the participants had in common that they discursively created two groups. One group, in which they put Danish colleagues, and one group, in which they placed themselves and other foreign doctors. This was apparent through an extensive use of the pronouns 'we' and 'you' or 'them/they'. Moreover, it was seen how some participants connected others' behaviour to geographical borders. This tendency indicates an essentialist perspective on culture, which was also to be expected, as it is the default way of thinking (Holliday, Kullman and Hyde, 2021, p. 72). This perspective was seen in comments such as "of course when you come to a country in Europe, well then you expect, of course, that then they drink alcohol" from Farhad, and from Emre, "I have lived like a Dane in Türkiye. I lived alone since I was 15 years old so… And big cities. Various [inaudible], various relationships and so on" (appendix 1, ll. 208-209; appendix 3, ll. 163-164). With these comments, the two participants assign certain traits to all individuals originating from Denmark, while Emre at the same time distances himself from the traits he assigns to individuals from Türkiye.

However, Karim made it clear that an essentialist perspective on culture also came from Danish colleagues. Moreover, he was able to see that it was not the optimal approach when meeting people, such as himself, from elsewhere. He expressed these reflections, when he said "Arabs, they see me as an Arab, but Arabs are very different also . . . Or those who come from the Middle East, they do not look like each other" (appendix 2, ll. 143-144). However, this does not mean that he did not apply an essentialist perspective himself. That became clear when he said, "Of course there have been problems before with an Indian doctor or an Afghan doctor" (appendix 2, l. 149). In this case, it is not clear whether he is referring to specific cases, but it does show that he connects a troublesome behaviour to nationalities.

Ana was the only participant who did not link behaviour to nationalities. In fact, she did the complete opposite, when describing patients as polite and then adding "I have never worked anywhere else in Denmark. But it can be different from place to place in the same country"

(appendix 4, ll. 102-103). So in this case, she showed that though she experienced the patients as being polite, it did not necessarily have to do with them being Danish. Furthermore, her social relations in Denmark were described as "It is always different, but not because it is two different countries" (appendix 4, l. 160). In this case, she presents her non-essential perspective on culture, and she does not attempt to explain others' behaviour with nationality or cultural traits.

Although Ana stood out in this case, essentialism generally was an important factor in the intercultural interactions that the foreign doctors engaged in. Not only coming from the participants, but also the colleagues. This becomes problematic, since assigning certain traits to someone simply based on their nationality can result in one seeing the culture before the individual, thereby affecting how they meet each other (Holliday, Kullman and Hyde, 2021, p. 72). Therefore, the fifth and final challenge that has been identified is: *The presence of essentialism can affect the interactions between the foreign doctors and Danish colleagues, as well as causing the foreign doctors to exclude themselves.*

6.2 Analytical sum up

What I set out to do in this analysis was to arrive at a point where I had identified the themes that would best describe the narratives, which the participants presented in the interviews. The whole process of coding, labelling, re-labelling, and defining the themes, finally enabled me to not only identify the themes, but also the challenges that emerged from the statements that made up the themes.

What I found was that there were in fact hierarchies in the Danish workplaces, and the foreign doctors had to prove themselves, and work harder in order to enter into this, and be regarded as an equal colleague. Furthermore, the data showed that they were exposed to direct and indirect discrimination, but that they also tended to excuse this behaviour, meaning that the consequences of this discrimination would go unnoticed. Then the foreign doctors often emphasised their own status, potentially because they had been used to holding a high status in a hierarchy, which unfortunately made them hesitant to ask for help. Possibly because they did not reach out, the foreign doctors felt insecure in the beginning, which could put them in uncomfortable situations, where they did not know what behaviour was expected. Finally, as they engaged in intercultural interactions all the time, their approach to the concept of culture had a significance for these interactions. The essentialist perspective was seen as coming both from them, but also from Danish colleagues, which could result in an exclusion of the foreign doctors.

All in all, it can be concluded that these were challenges that hindered the foreign doctors' well-being during their initial time on the Danish labour market. However, as this only answers the first part of the problem formulation, I will now in the following section discuss these findings, in order to put them into a perspective, from which it will be possible to find solutions to how to meet and ease these challenges.

7 Discussion

As I have now analysed the data, and from there identified five challenges, I will now move on to a further discussion of these findings, with the purpose of being able to propose solutions to how the challenges could be handled, thereby answering the last part of the problem formulation:

> *What cultural challenges related to hierarchies in the workplace do foreign doctors experience during their job-start in Denmark, and* ***what can be done to either avoid or ease these?***

That I wish to propose solutions to how these challenges can be handled, is not meant to be the assumption that these challenges can be completely eliminated, but I do argue that it would be possible to ease them, if those relevant to the situation are aware of their presence. The reason for why it would never be possible to eliminate the challenges completely, is that culture as a concept will always be present in the meeting between individuals originating from different groups. I use the word 'groups' intentionally rather than countries, as culture is not just bound to a nationality, but rather to a group of individuals sharing a set of cohesive behavioural traits (Holliday, Kullman and Hyde, 2021, p. 73).

Another reason for why culture should not be disregarded within this research, is due to this theme's intertwinement with some of the other themes. In fact, all five themes were interrelated in multiple directions, adding a layer of complexity to the findings. As an example, it could be seen how the approach to culture at times led to discrimination, and how discrimination was also a part of the hierarchical structure. Underlying all of this, it could be seen how the foreign doctors attempted to uphold a face by emphasising a certain status, however, it was also apparent how insecurity was at the same time present, as they did not always know what would be the most suitable and expected face, and thereby behaviour, which then again leads back to culture.

7.1 Proposed solutions

Despite the fact that the participants entered our conversation with individual backgrounds, upbringings, and experiences, I did nevertheless identify five challenges which had more or less affected them all during job-start in Denmark. It does not mean that every doctor who relocates and starts working in Denmark encounters all of these challenges, but the issue is that there is a risk of meeting these. Furthermore, a general pattern showed that the doctors' surroundings were not aware of these challenges, meaning that, so far, support and guidance on how to manage these challenges had not been given to the participants.

This leads to a discussion of what can possibly be done to ease the challenges identified. As a part of the research design, I stated that a purpose of the analysis was to focus on what could be meaningful to all parties in the situation. I will therefore now propose answers to the second part of the problem formulation, which I deem to be meaningful for the foreign doctors, as it could improve their general well-being in Denmark, but also for those around them. For the colleagues, as the data showed that they took part in the construction of the challenges, and for the society as a whole, as an end-goal is not only to improve the conditions for a rather large part of the DHS, but also because it is necessary that we can continue to recruit and retain for specialist doctors.

However, not all of the five challenges have a nature that makes it possible to meet them with specific initiatives. In fact, to ease these challenges it first and foremost comes down to spreading awareness of them. As most of them are constructed unconsciously by either the Danish colleagues or the foreign doctors themselves, it can only be changed if the individuals become aware of what they are taking part in.

First, as the data suggested, the hierarchies in the Danish workplaces meant that foreign doctors had to work hard in the beginning, in order to enter this hierarchy as acknowledged colleagues. This would be extra pressure adding to an already stressful time, but there would however not be an easy fix to the challenge, as these hierarchies were not tangible, expressed, or even visible to all the foreign doctors. Rather it is something that has been constructed in the mind of those staff members who are already settled into the workplace. Constructed, in the way that they hold an attitude towards the foreign doctors that hinders them from acknowledging their competences from the beginning. It is most likely a mental process that happens unconsciously, but as the participants tended to find this acceptable, and therefore did not say anything about it, it will not change. That it is unconscious entails that it can only be changed if the Danish doctors are made aware of this process, and thereby be able to stop and consider it, before it happens. However, it

should not be the foreign doctors' responsibility to create this awareness, as they will already have enough to put their energy into at this time. Therefore, this is something that points back to the management, meaning those are the ones who should pay attention to the issue.

However, there was also the issue of the male participants constructing hierarchies based on gender, which could be seen when they continuously referred to doctors and supervisors with male pronouns. Going back to Selberg's (2012) study on gender-based hierarchies from the literature review, this finding from the data aligns with the fact that masculine traits were connected to well-regarded jobs. Furthermore, this aspect can also be connected to the findings from the report by Mitchell, et al. (2008), in which it was shown how 50% of the Danish personnel were of the opinion that the non-EU doctors' cultural background affected their expectations for the distribution of roles between doctors and nurses. In this case it is an issue that requires a change of mind from the foreign doctors themselves, which however, might turn out to be difficult given that the report also found that 86% of the foreign doctors believed their cultural background to be either without significance or a positive contribution.

The hierarchical structures were furthermore related to the discrimination foreign doctors were exposed to, directly or indirectly. However, as they tended to decode this behaviour as a natural consequence of their ethnicity, the consequence of this act could potentially go unnoticed, resulting in a challenge. What is more, the study by Winnifred, Lalonde, and Esses (2010) found that there was in fact a general bias against foreign doctors despite their qualifications. As this bias showed even before the prospective patients had met the actual individual, it expressed how foreign doctors would be met with perceptions that could lead to them being evaluated based on a preferred assumption, thereby ignoring the individual characteristics. This approach to foreign doctors can have significant consequences, as it is just the first step into a negative spiral of othering, essentialism, and stereotyping (Holliday, Kullman and Hyde, 2020, p. 25).

As the data indicated, discrimination sometimes happened consciously when Danish colleagues, for example, found it acceptable to ask someone whether they could work with women because of a national background. However, at times it also happened more indirectly, when an individual was just generally treated differently. Therefore, it is again a necessity with awareness on this issue, but it does not only apply to those who practise the discrimination. Rather it is of high importance that foreign doctors know that discrimination is not acceptable, that it is not a case of "of course", as some participants believed.

The third challenge revolved around the upholding of a certain face to assert a status. Again, this challenge comes down to a mental process happening unconsciously for the foreign doctors. It is a challenge they construct themselves, but however, not a challenge they can solve themselves. This mental process is not something that can be interrupted simply by telling the foreign doctors that they should relax. It is not possible due to the fact that we will always attempt to uphold a face when in the frontstage. Of course, this is not only the case for foreign doctors, but they do, however, interpret the situations based on the framework they acquired in a system, in which they held a certain status. The most significant consequence that could potentially come from this challenge, is if a foreign doctor does not ask for help in a situation where they should have done so. Such situations can be avoided if all colleagues surrounding the foreign doctor are aware of this tendency, thereby offering the extra support from the beginning, without being asked.

The extra support would also be crucial if the insecurity, that the participants had felt during the first long time, should ever be eased. As we strive to uphold a suitable face, and conceal the effort we put into this, it is likely that Danish colleagues are not aware of this insecurity and the challenge it poses. Furthermore, as it could be seen in the data, it was at times the little things that a Danish colleague would not give a thought, that caused the insecurity for the foreign doctors. This inevitably means that the foreign doctors are in need of extra support in the beginning - even when they do not make their surroundings aware of it.

Finally, the data showed that the essentialist approach to culture could pose a challenge in itself during intercultural interactions. It is especially important to pay attention to, as this approach is the default mindset whenever the individual encounters someone who is perceived as different. Especially, it is understandable that foreign doctors will succumb to essentialism as they find themselves in a setting with a dominant culture, with Danish doctors making up the majority of the workforce. Therefore, they might be able to see repetitions and patterns within this large group, leading them to identify these as cultural traits. However, the same cannot be said for Danish doctors, as they only encounter a fraction of those from, in the case of this study, originating from Iraq, Egypt, Türkiye, Iran, and Portugal. However, yet, it is the case that the process of letting one's idea about a certain culture come before the actual individual is taking place, and it can only be reversed if one is aware of this process and thereby able to actively change it.

As can be seen in the above description, awareness of these five challenges are the first step towards easing them, as only this can lead to providing the foreign doctors with the extra support and guidance that are needed. Furthermore, awareness of the issues also entails that some of

the responsibility would be taken from the foreign doctors, and rightfully placed with management. Overall, easing these challenges requires a significant effort from the employers, colleagues, and HR-personnel that surround the foreign doctors. Foreign doctors are already in an exposed situation, as they adjust to a new life in a new country, and it can therefore not be expected that they have the surplus of mental resources it takes to initiate processes, programmes, courses or anything else that could ease the challenges.

However, in this connection, I do propose some specific initiatives that could potentially ease some of the challenges, and which could be implemented directly to the departments, in which you find the individuals who experience these challenges. The common thread in these propositions is the distribution of knowledge to enhance cultural competency, and the distribution of tasks and responsibility.

The distribution of knowledge concerns discrimination and culture, for example through brochures, seminars, or an email to all employees. The purpose should be to make all members aware how discrimination can take form, and what one should be aware of when thinking about culture. The distribution of tasks and responsibility entails that management should be in charge of initiatives that would provide foreign doctors with substantive support and guidance. This could be by arranging seminars similar to what was done by Karim and Haneen, or by assisting any employee who would wish to do so. Another initiative could be to implement guidance that is specifically tailored to the individual, as the analysis established that foreign doctors come with individual frameworks, and thereby also individual concerns regarding the situations they find themselves in. In connection to this, I suggest the implementation of mentoring programmes. I do so based on two arguments. First, there is existing evidence showing that mentoring programmes can make a positive difference for foreign doctors. A psychiatric department in Vordingborg, with 25% of the doctors in that specific department coming from outside of Denmark, has by implementing such a programme contributed to a successful and meaningful integration of their employees (Damsgaard, 2019). Second, as it was established in the literature review, social relations do hold an importance in the individual's life, however, both the study by Frykman and Mozetic (2020) and testimonies from the data showed that it can be difficult for foreign doctors to establish close bonds at work. Though it requires time and energy from Danish doctors to act as mentors, they could serve as a close relation at work, or alternatively guide the foreign doctor on where to go in search for a social network. What is more, it would possibly not be necessary to delegate this task to only doctors, as the analysis suggested that the foreign doctors preferred to turn

to the nurses for help. Therefore, it is not unimaginable that pairing a foreign doctor with a nurse in a mentoring programme would be a bad idea.

7.2 Contextual considerations

There are some parts of the context that should be taken into consideration when discussing the findings, as they can have an effect on the results. First and foremost, there is the physical context, which has been touched upon before. Namely, that it most likely had a significance where the interview took place. Naturally, this is not possible to validate, as it would require an interview with the same participants in a different setting, however, it seems likely that being interviewed at their workplace led the participants to uphold a front during the interview. It could be argued to affect the validity of the project, as different settings would potentially lead to new findings. However, I argue that should such findings differ, if interviews were conducted in a more private setting, the potential for more honest and elaborate answers would only support the identification of challenges further.

Another contextual aspect to consider is that of time. As they had all been in Denmark for at least four years, they were no longer going through the initial part of employment, which I was in fact interested in. It is therefore possible that they were no longer able to account for the feelings and emotions they experienced several years ago. Furthermore, culture, thereby also what the individual perceives to be their culture, changes over time. We learn from those around us, and when entering a new society or group, this will affect our own culture, and how we identify ourselves. More specifically, the participants' idea of their own culture might have changed after spending several years in Denmark. Therefore, they potentially see the impact of their cultural background in the beginning, as being less significant than it actually was. Finally, it was clear that they now found themselves in a time and place where they seemed to be satisfied and content. This aspect only adds to the fact that it might be difficult to remember times, where things were not as easy. This contextual aspect is what comes into play, when not all the themes or challenges were apparent by the first look of the data.

Finally, the social context should be considered. What I mean with this, is that these participants find themselves in a position where they for various reasons migrated to another country and got opportunities there. Thereby, it could be plausible that they do not wish to seem anything other than content and satisfied. Especially, if one considers that foreign doctors as a group, have often been criticised in the news.

7.3 Relevance and contribution

However, despite one should take these contextual aspects into consideration when going through the results, it does not change the fact that this is a highly relevant area to investigate further. It cannot be argued that there is a need for an increased number of specialist doctors in the DHS, and that it has so far not been possible to solve this by internal recruitment and education of specialist doctors in Denmark. The current situation and tendencies in society show it necessary to look for other solutions, such as the recruitment and retention of highly skilled workforce from outside of the country. Thereby, the foreign doctors become a group of high relevance to the whole society, and what is more, they do in fact already make up a significant part of the workforce in the DHS. However, as I established in the introduction, this group, doctors who obtained their degree outside of Denmark, has not received much attention so far within academic research. I therefore argue that we need to expand this research area, in order to gain a better and broader understanding of the successful integration of the foreign doctors. We need them in order to overcome a societal issue, and this entails that we have to make an effort, to gain a better understanding of the challenges they encounter.

The ambition with this paper was not only to extend the research within this area, but also to show that there are in fact real issues here, and furthermore, that there are also solutions to these. By doing so, it has brought several forms of contribution to the table, and furthermore it can benefit more than one group. For the foreign doctors, this study is an attempt to make them feel seen and show a genuine interest in their well-being. For relevant professionals, such as recruiters or HR-employees in the DHS, this study can contribute to knowledge on what they should be aware of, and develop further on, in the process of integration. And finally, as the paper centres around how we can improve the general well-being of an important group within the healthcare institutions, it can contribute to solving a societal issue, being of importance to us all.

For other researchers, this paper can be a point of departure for further investigations. Moreover, I believe that this study opens up for several forms of future studies, and not just duplications or versions of a larger scale. Indeed, I see a potential for further explorations of the challenges identified here, but also the potential to uncover other issues. What is more, I believe that studies on how to successfully implement initiatives to ease the challenges would be of benefit to both the foreign doctors, but also those who hold a responsibility for their well-being. Finally, I find that the challenges, as well as the proposed solutions, do not only hold a relevance within the

area of medicine. It could just as well be relevant in any other area, in which we recruit and employ highly skilled workers to Denmark, such as with teaching, research or IT.

8 Conclusion

From the beginning, this project was motivated by the fact that research on foreign doctors specifically in Denmark is rather limited, despite the fact that there is need for them in order to solve a rather serious societal issue. Namely, the fact that the Danish Healthcare System is suffering from too many vacant positions within many groups, including the specialist doctors. Furthermore, this group of highly skilled migrants, should be acknowledged as the valuable contribution they are to the society as a whole. As a part of this acknowledgment, this research set out to investigate what challenges the foreign doctors might encounter when they started working, and in that case, how these challenges could be eased.

The investigation was carried out by conducting interviews with five specialist doctors, who had obtained their degree in respectively, Iraq, Egypt, Türkiye, Iran, and Portugal. Following the six steps, as proposed by Braun and Clarke (2008), a thematic analysis was conducted on the collected data, which led to the findings and answer to the problem formulation.

The analysis also drew inspiration from Goffman's theories on face and frameworks. It was done in order to understand what the participants were foregrounding and backgrounding, but also to understand how and why the participants' perspectives on the respective topics differed.

Regarding culture, it was never the intention to identify patterns in the data to be explained by the participants' nationality. Especially since defining something as being due to the individual's national culture would require a much larger group of participants, since the patterns must be seen within the majority of a group, for it to be labelled as a cultural trait. However, since their experiences would inevitably include intercultural interactions, culture was not something that could be disregarded.

Through the thematic analysis, the following six themes were identified in the data: *forms of addressing, hierarchies in the workplace, discrimination, upholding status, insecurity*, and *culture*. They were not identified due to being the most frequently mentioned topics, but instead because the analysis uncovered the importance of these, and how they told a coherent story representing the data.

As these six themes were further analysed, this led to the definition of five challenges that proved to be of significance to the foreign doctors. The challenges concerned the fact that foreign doctors had to prove themselves to be acknowledged as competent colleagues in the beginning, and that they were discriminated against, but tended to legitimise this, meaning that the consequences of this went unnoticed. Furthermore, as they had come from institutions in which they held a certain status within a strict hierarchy, they put much energy into emphasising this status, which consequently resulted in a hesitance to ask for help. Behind these challenges was an underlying feeling of insecurity, which hindered their well-being, as it made it difficult to uphold a suitable front. Finally, the essentialist perspective on culture played a role, as its presence affected the interaction between foreign doctors and their Danish colleagues, in a manner that risked the exclusion of the foreign doctors.

Answers to the second part of the problem formulation, namely how these challenges could be eased, were discussed, and it was found that it would never be possible to eliminate them completely, and furthermore, not all challenges could be met with specific propositions on how to handle them. However, it was concluded that most importantly, it required an awareness of these challenges, as many of them were unconsciously constructed through mental processes. Only by knowing this, would it be possible to interrupt the processes. Furthermore, some concrete solutions were proposed, such as the distribution of knowledge concerning discrimination and essentialism to enhance cultural competency. Moreover, based on success seen in an actual hospital department in Denmark, mentoring programmes and guidance tailored to the specific doctor were proposed.

These above-mentioned results should be considered in relation to what was included in the literature review. Here, the project was positioned within a research field consisting of literature on the foreign doctors' self-image, different types of hierarchies, and the specific challenge of lacking close social relations. However, the literature review also revealed, again, that research on the specific area was limited. Nevertheless, the findings from this study correlated and supported arguments stated by other researchers. This includes the fact that gendered hierarchies are an issue, that foreign doctors experience discrimination, and finally, that support and guidance that comes from establishing close relations are of utmost importance.

Behind all the findings and proposed solutions, it is important to acknowledge the importance and effect of the methodological framework and research design that shaped and guided the whole project. A constructivist approach to reality meant that, from the beginning, it would not be possible to find one definitive answer to the problem formulation. Instead the results became the

outcome of five individuals' personal narratives, and their diverse perspectives and interpretations are acknowledged as their subjective construction of reality.

Epistemologically, being an interpretivist researcher resulted in an exploration of the challenges that foreign doctors encountered in their Danish workplaces. This also entailed that the challenges were never meant to be explained or eliminated, but rather to be understood in depth, as only by doing so, can we move towards solutions.

Although challenges will continue to exist, the results of this paper provide a step towards creating an understanding and awareness of the well-being of foreign doctors in Denmark. By continuing research on the area, an inclusive and supportive environment can be fostered, so that the foreign specialist doctors can be successfully integrated, and recognised as the beneficial contribution they are to Danish society.

9 List of references

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