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Exploring the experiences of women and migrant medical professionals in Swedish hospitals

Visible and hidden forms of resistance

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Abstract

Purpose – The purpose of this paper is to analyse the different ways in which experiences of marginalisation within organisations are named and acted upon. Of particular interest is examining the ways in which the visibility of gender discrimination and the invisibility of ethnic discrimination indicate what the professionals in the study identify as horizons of possible individual and collective resistance.
Design/methodology/approach – The paper takes as its point of departure Cho *et al.* (2013) notion of "intersectionality as an analytical sensibility" (p. 795). The material consists of qualitative semi-structured interviews with 15 chief medical doctors employed in two Swedish hospitals.
Findings – The findings indicate that while there is an organisational visibility of gender inequality, there is an organisational invisibility of ethnic discrimination. These differences influence the ways in which organisational criticism takes place and inequalities are challenged. Female Swedish identified doctors acted collectively to challenge organisations that they considered male-dominated, while doctors with experience of migration (both female and male) placed more responsibility on themselves and established individual strategies such as working more or des-identification. However, they confronted the organisation by naming ethnic discrimination in a context of organisational silence.
Research limitations/implications – The paper does not explore the different forms of racism (islamophobia, racism against blacks, anti-Semitism). In addition, further research is needed to understand how these various forms of racism shape workplaces in Sweden.
Originality/value – The paper offers new insights into the difference/similarities between how processes of ethnic and gender discrimination are experienced among employees within high-status professions. The value of the paper lies in its special focus on how forms of resistance are affected by the frames of the organisation. The findings stress the importance of intersectional analyses to understand the complex patterns of resistance and consent emerging within organisations.
Keywords Sweden, Gender and ethnic discrimination, Health care organizations, Intersectionality, Resistance
Paper type Research paper

1. Introduction

The purpose of this paper is to analyse the different strategies by which experiences of marginalisation within organisations are named and acted upon. This paper explores how the degree of legitimacy and visibility of gender and ethnic discrimination within the organisation affects what the chiefs of medicine I interviewed identified as horizons of possible organisational change towards more inclusive and democratic workplaces.

The study, inspired by intersectional methodologies, explores the strength of historian James Scott's (1990) concept of hidden and public transcripts and sociologist Joan Acker's (2006) concept of visibility and the legitimacy of inequalities. The empirical material

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consists of interviews with 15 chief medical doctors at two different hospitals in Sweden, both belonging to the same council. All 15 are minority within the organisation. Healy *et al.* (2011, p. 484) analysis of persisting inequality regimes within the public sector shows that the same human and resource management practices that are designed to challenge inequalities are embedded within workplace cultures and the interactions that reproduced them. Nevertheless, the authors argue that the policy documents are important as they "provide legitimacy of actions taken to challenge inequality regimes" (2012, p. 475). The same tension between documents legitimating inequality while simultaneously opening a space of action was analysed by Sara Ahmed in her study of employees engaged in diversity work. The framework of diversity, Sara Ahmed (2007) argued, "opened up a capacity for action" (p. 238); however, working with these documents gave the organisation a legitimacy that risked marginalising the inequalities that diversity employees were contesting (p. 254).

This tension has been a central topic within Swedish gender studies when analysing how gender inequalities persist and are maintained and reproduced within a "women friendly" welfare state and "gender equal" organisations (Eriksson-Zetterquist and Styhre, 2007). While public sector organisations in Sweden often have far-reaching polices and documents that identify gender inequality as a problem, ethnic discrimination and racism are still defined as marginal to workplaces' organisation (de los Reyes, 2014). Swedish post-colonial feminist research has challenged this assumption and explored how processes of racialisation are central to the construction of the public sector, including schools (Kalonaityte, 2010), universities (Mählck, 2013), social work (Mattsson, 2013/2014) and health care (Selberg, 2012). Although this scholarly field is diverse, it illuminates how ideas of professionalism, knowledge and skills are not only gendered and classed but also racialised. This paper contributes to this growing field of research by focusing on the ways (gender and ethnic) inequalities are named and acted upon, what kind of strategies are created to deal with (or to manage) these inequalities and what forms of resistance are legitimate, available and possible – and for whom.

2. Background

Sweden is often highlighted not only in relation to its social-democratic welfare (i.e. the Scandinavian model) but also as a relatively gender-equal society, inspired by a political project of state feminism (Borchorst and Siim, 2008). However, the Swedish welfare model and the Swedish migration regime have experienced radical changes, as neo-liberal restructuring has rapidly increased inequalities, multicultural policies are being challenged, and neo-assimilationist policies are growing (Schierup and Ålund, 2011). The Swedish public health care sector has been subjected to the introduction of new public management (NPM) strategies that have affected the terms of the health care profession as well as autonomy and working conditions. According to gender researchers Hedegaard and Ahl (2013), the implementation of NPM strategies risk the reproduction and reinforcement of gender hierarchies already existing within the health care organisations (p. 151).

The percentage of female medical doctors has been increasing since 1960 and is today defined as gender equal, with a 40/60 (female/male) split between genders. Since the mid-1980s, gender segregation among medical doctors has become increasingly recognised as an organisational problem. However, despite the increasing proportion of women employed as doctors, gender inequalities continue, particularly regarding wages, specialties and career paths as well as research opportunities (Hedegaard and Ahl, 2013). Moreover, despite the large amount of

medical doctors with migrant backgrounds, the subject of ethnic discrimination remains poorly researched and is identified as a marginal issue among both unions and leadership (Selberg, 2012).

3. Visible and invisible transcripts

Sociologist Joan Acker's (2006) concept of inequality regimes has contributed to a range of studies on how gender, class, ethnicity and sexuality shape the distribution of power and resources as well as identity formations (Healy *et al.*, 2011; Boogard and Roggeband, 2010).

Acker argued that organisational challenges to workplace equality are shaped by two elements: the invisibility of systematic inequalities and the legitimacy of these inequalities (Acker, 2012, pp. 211-212). The author defined the invisibility of inequalities as the degree of awareness of hierarchies and power relationships within the organisation, an awareness that varies between organisations and positions. For instance, Acker (2012) argues that class inequalities are often invisible, hidden and widely accepted (p. 219). The legitimacy of inequalities, the author further argued, varies between types of inequalities and types of organisations.

While Acker provided central analytical tools to explore the reproduction of power relationships within workplaces, her analytical model pays less attention to everyday forms of resistance. To a certain extent, this shortcoming may be explained by Acker's understanding of resistance as the ability to transform inequality regimes; however, as resistance scholars have convincingly argued (Mumby, 2005), it is also vital to explore the everyday forms of resistance that, while not transforming the structural frame of the organisation, create alternative ways of reading the workplace than the one provided by the managers. A similar argument is developed by Patrizia Zanoni *et al.* (2010):

> How unequal power relations can be bent, circumvented, strategically appropriated or countered through language, creating openings not only for alternative meanings but also for micro-emancipatory projects (p. 17).

To bridge Acker's structural focus with an exploration of agency and make the different horizons of possibilities that my informants embodied visible, I will use historian James Scott's (1990) concept of public and hidden transcripts. According to Scott (1990), the "public transcript" is the open performance of power and the "self-portrait of dominant elites as they would have themselves seen" (p. 18). The public transcript is designed to be impressive and affirm and naturalise the power of the dominant elites.

However, Scott also describes "a hidden transcript" – actions, talks and songs that take place "offstage" and beyond the direct observation of the power holders (Scott, 1990, pp. 4-5). The hidden transcript gives opportunities for subordinated groups to develop counter-stories, ask questions and sometimes challenge or confront the public transcript. Scott (1990) argued that one way of exploring the effect of the public transcript is to analyse the "discrepancy between the hidden transcript and the public transcript" (pp. 4-5). Of special interest in this paper is the frontier between the public and the hidden, a zone that, according to Scott (1990), is one of the areas of everyday resistance (p. 14). Scott's notion of everyday resistance has, together with feminist scholarship, influenced the research on resistance and widened the concept by highlighting the more informal, invisible and individual forms of resistance in workplaces (Prasad and Prasad, 2000). The dialogue between Acker and Scott creates an analytical frame that can be used to examine inequalities in organisations as well as the persistence of these inequalities, while also exploring the many ways through which inequalities are identified, named, challenged and acted upon – individually and collectively – in everyday actions in workplaces.

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4. Methodology, method and data

The findings discussed in this paper are based on a larger study on forms of workplace resistance. The empirical material that is the focus of this paper is based on semi-structured interviews with 15 chiefs of medicine at two different hospitals that belong to the same council (five in one hospital ten in the other). Ten of the doctors, six women and four men, had migrated to Sweden as adults. All of them completed their professional training in their country of origin; while some could easily validate their examinations, others encountered serious difficulties in the process of equalising their qualifications with the Swedish educational system. The remaining five doctors are women who self-identified as Swedish.

The location of the doctors within the workplace was central to the selection process. Each of the participants held high positions in male (and predominantly Swedish) dominated specialities. The interviews took place at the participants' places of work, and contacts were made through e-mail, explaining that the interviews would focus on the experience of being a minority in the workplace.

The analysis of the empirical material was conducted in several steps. First, the transcripts were coded to identify statements regarding unequal treatment, marginalisation and discrimination. The material was then selected to identify statements related to how people describe and talk about their reactions to inequalities. Therefore, the understanding of inequality as well as the conceptualisation of resistance were not defined prior to the interviews.

In arguing for intersectionality as a frame for analytical sensibility, Cho *et al.* (2013) focuses on "categories not as distinct but as always permeated by other categories, fluid and changing, always in the process of creating and being created by dynamics of power" (p. 795). In this context, I am particularly interested in examining the different forms of strategies against marginalisation that different groups of workers employ. Methodologically, this paper is inspired by the growing number of intersectional analyses of work and employment (McBride *et al.*, 2015; Pearson *et al.*, 2012; Durbin and Conley, 2010; Healy *et al.*, 2011; Holvino, 2010), where the focus is on both how different workers experience and resist work practices "at the intersection" (McBride *et al.*, 2015, p. 29) but also on how different forms and constellations of inequalities shape labour relations and understandings of power at work.

In Sweden, there is a growing public debate regarding citizenship and belonging in the context of the parliamentary success of the right-wing, xenophobic parties and the normalisation of their public rhetoric (Mulinari and Neergaard, 2014). Categories such as Swedish or migrant are therefore no longer innocent. I use the phrase "women who self-identified as Swedish" to highlight this tension, and I use the term doctors "with experience of migration" to identify the informant's back ground, even if all the participants with migrant backgrounds were classified as non-white and had experienced racialisation within the workplace. Because the people I interviewed were often one of the very few women or doctors with experience of migration in chief positions within the organisation, I will not state their specialisation, place of birth or age.

5. Informal networks: between individual deficiency and organisational obstacles

The council where the two hospitals were located had both a gender equality plan and an equality implementation plan. The County Administrative Board of the region had established far-reaching goals for gender equality work, including the gender mainstreaming of all activities. Finally, the Swedish Medical Association has a gender equality policy (web page 1) that identifies gender inequality as an organisational problem.

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To use Acker's words, there was a public transcript that made gender inequality visible while rejecting it as illegitimate (in Acker's words) within the health care organisation at large and within the medical profession in particular. However, all the doctors I interviewed experienced forms of marginalisation and exclusion at their workplace that were particularly articulated in relation to the role of informal networks in determining the possibility of career progression within the organisation. Research has shown that informal networks are central in the reproduction and maintenance of inequalities within organisations, including opportunities for career advancement, power and influence and the identification of career possibilities in the labour market (Combs, 2003; Hite, 2004). Similar to the existing research, the employees with whom I spoke also identified informal networks as central to the organisational selection processes. Regarding whether there are aspects other than knowledge that are important for career progress, Mitra[1] stresses the importance of informal networks in one's career:

> Contacts are really important if you want to make a career. If you, like me, are educated abroad, you don't have those types of contacts. And you need the contacts so that others when you apply for a job can say: "ohhh she seems ok". If you're like me, lacking them, your carrier is much more difficult.

Amir, who has worked for many years as a chief resident, adds to Mitra's argument by linking contacts to an emotional regime of trust:

> Nobody trusts you. Nobody knows you or your family. People know each other from their university years. Or their parents have a summerhouse near each other each other nearby.

According to Gail McGuire (2002, p. 318), white and black women received less instrumental help from network members than white men because they were presumed to be "untrustworthy". Both Amir and Mitra stressed the importance of networks as a way of being recognised and acknowledged as a professional. While Mitra and Amir emphasised that they lacked access to informal networks, often due their experience of migration to Sweden (not having gone to the same schools as others or having doctors in the family), the Swedish-identified female doctors with whom I spoke stated that male domination within their workplaces was central in the creation of informal networks. Birgitta describes these networks in the following way:

> I had applied for a job and did not get it because I did not know the right people. I was better, and had more experience. But still I did not get the job. Then I was younger and more insecure; I thought it was my fault. If that would have happened today I would immediately have understood that it was gender discrimination.

The presence of both a public transcript and the increased visibility of gender inequality has affected Birgitta's interpretation of the event. Stina, similar to Birgitta, has worked within the profession for more than 15 years, and she identifies the informal networks as highly relevant in situations of professional transition:

> It becomes especially visible when you leave your residence and apply for other positions, whether you have contacts; perhaps if your father worked together with one of them, then it is easier to get a job in a well-qualified, high status university hospital.

None of the doctors, neither men nor women, believed that they worked in a meritocratic organisation. On the contrary, they asserted that informal networks were often more important than skills, qualifications and work experience. However, while the Swedish-identified women viewed informal networks in terms of gender inequalities and identified men as actors resisting their presence within the

organisations, the migrant doctors, even those that understood exclusion in terms of ethnic discrimination, spoke of their lack of access to informal networks as an effect of deficiencies due to migration, to some extent placing the responsibility on themselves. The different analyses of why they did not have access to informal networks with power resulted in diverse ways of naming the organisational hierarchies.

6. The differences in naming

The Swedish-identified women were openly critical of their organisations, pointing to the gendered aspect of informal networks. Birgitta explains the gendered logic of informal networks:

> Men choose men, women choose men, and boys push each other in a way that they don't push women […] When you are young, you are the sweet girl. At work, you are the little princess; you are totally harmless because you don't know enough to be a threat to anyone, and those men who are at your own level don't yet have any power. To the bosses you are completely harmless and a little sweet thing. Eventually you become the old woman at work who is actually a little threatening because you question things.

Sigrid, who works in a male-dominated specialty, also describes these processes:

> At the clinic now, there will be evening activities and then they want us to go to a sauna. The boss is a man, and all the consultants, apart from me are men, as are most of the junior doctors. There are two female junior doctors, and I have said that this is not a suitable activity as what happens is that the – power and the glory – sit in the male sauna, and we have to sauna with the nurses.

The sauna as a male-coded place of intimacy is a well-known metaphor in Sweden. The female Swedish-identified doctors spoke about a gendered organisation and identified men as actors in the furthering of inequalities. Flavia works in a highly male-dominated profession and questions the idea of the colour-blind organisation:

> It is obvious; you know that, of course, you are often discriminated against. When they say that there is no discrimination, that's just nonsense, because it exists, it really does, as a woman, as an immigrant, you are discriminated against. I have come so far because I work hard, I have worked really hard, much harder than any other Swede, I can tell you that for a fact. But of course, I do not go around shouting there is racism here […].

Flavia stressed that her achievements are due to her hard work, not the assistance of informal networks. She reacted against the organisation's public transcript and its denial of ethnic discrimination and stressed that she is discriminated against as a woman and as an immigrant. By naming ethnic discrimination in an organisation that does not identify it as a problem, Flavia is engaged in developing forms of individual hidden transcripts that challenge the voice of the organisation. Finally, Flavia's last words are worth reflecting on – particularly because other doctors with migrant backgrounds expressed similar thoughts. In her narrative there is a clear boundary between the private self (where she knows she is discriminated against) and her public self (where she knows that articulating this discrimination publicly would threaten her position in the organisation).

The process of transitioning from hidden to public transcripts, from naming the problem to it being recognised as an organisational problem, is discussed by Vladimir:

> I have experienced discrimination, I really have. I left my job because of it; in one place even the younger doctors where given more qualified work than the work I got, and better working hours. I tried to talk to the unions, and they did not even bother to look in to it and said that it was not discrimination, but I am sure it was.

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Flavia and Vladimir both emphasised the existence of discrimination and were engaged in challenging their workplaces as "colour-blind" organisations. The naming of discrimination is, in their narratives, more connected to their individual experiences than to collective practices. These different understandings are a product of which public transcripts are present within the organisation (and in society). Both the labour union and the hospital's leadership have identified gender inequality as an organisational problem – an identification that is reinforced by extensive research on gender inequalities within the profession. Gender inequality, to use Acker's concept, is both visible and not legitimate. Racism is a much more sensitive issue within workplaces in Sweden, often defined narrowly as biological racism or Nazism (de los Reyes, 2014). Before the interventions of critical antiracist scholars and the mobilisation of migrant organisations, the subordinated positions most employees with migrant backgrounds had within workplaces were understood as an effect of "the cultural distance" between the majority population and migrant workers (Mattsson, 2001). This difference also affected the ways that doctors with migrant background were able to frame their experience of exclusion or marginalisation.

7. Horizons of possibilities – organising, working harder or exiting

In her comparative study of how black women in the USA and the Netherlands talked about racism, Philiomen Essed stated that there are different ways in which women gain knowledge of racism as well as relevant differences in how they perceive the role of white people in the reproduction of racism. These differences, Essed (1991) asserted, affect the ways in which they struggle against racism. In the present study, all the doctors identified inequality as evolving from informal networks; however, as previously discussed, they named these inequalities in different ways, which affected their identification of possible resistance strategies. The Swedish-identified women had broad experiences of collective organisation aimed at reducing their vulnerability as minorities in the workplace. In the words of Ingrid:

> You have to find a survival strategy. It takes a lot out of your personal life being in charge at work. I actually have a network for unloading. I have my old mentor, X, who is 10 years older than me, and then I have my old supervisor, who has always been my mentor, and we meet and just talk about work.

Ingrid told me that they had formed a women's doctors group when she worked in a section of the hospital where there were only five female doctors. She also had an older female colleague who was her mentor at first – she speaks about it as a way to survive – and also stressed the need to have a collective team that can share the burden. Stina had a similar experience when she began working in the late 1960s:

> Yes, in the beginning we met up every afternoon for coffee, but this gradually disappeared due to the workload […] the five of us would meet up, talk some gossip and drink coffee.

Stina and Ingrid described how, through these meetings, they gained strength and helped one another. The meetings were held between different sections of the hospital, as they often where the only women in their wards. Roberts's (2011) analysis of gay men managing their social identity at work shows how an LGBT network gave people confidence in the workplace and that gay men who worked with other openly gay people felt more comfortable. In their analysis of ethnicity and the

gender identities of black professionals in the UK, Doyin Atewologun and Singh (2010) identified several strategies of identity work developed to challenge the different stereotypes shaping the organisation. For example, they showed that there are central differences between strategies developed by black male and black female professionals. The lack of collective forms of resistance among racialised workers in professions might be linked to the need for professional recognition within the context of "organizational whiteness" (Siebers, 2009, p. 79), where individuality becomes central, making collective forms of visibility more difficult. None of the doctors with migrant backgrounds spoke about collective agendas; instead, they were engaged in individual strategies, such as working harder. Claudia describes the difference as a percentage:

> You have to "show how you are 20 to 30 per cent more capable than the Swedes".

Parvin, who has worked as a doctor for about ten years, explains why she has to work more than her colleagues:

> It feels unfair, but I believe that many migrants have learned that, if you suffer a setback, you cannot give up. But it is very exhausting. It demands a lot of energy. You don't get it for free; you have to work double as hard, be twice as nice, be twice as knowledgeable, to finally be accepted, and it takes a lot of energy.

According to Puwar (2003), there is a taboo attached to naming racism in most professions, "let alone organising against it", and the people who take up the issue will be marked as "risky bodies" (p. 53). Similar to the black British Caribbean graduate in Kenny and Briner's (2010) study, the chief medical doctors in the present study all felt that they had to work harder to gain acceptance, which they may never gain in the end, as one of my interviewees put it. However, there is another strategy that is quite the opposite of working more, involving detaching oneself from the profession's career paths.

Babak expressed that it is important to have ambitions but that it is just as important to be satisfied with what you have. When asked if there are disadvantages in being a migrant doctor, he answered:

> Obviously there are disadvantages, but you just have to be aware of them and not be too naive and think that it is too easy. You still have to aim high and have ambitions, but after a while you understand that it is not worth trying too hard, then you'll be happy with what you have.

Babak emphasised that the experience of not being able to progress was very stressful and made him feel unhappy. Therefore, he is now attempting to devote more time to his private life. Vladimir argued in a similar tone, choosing to leave his former workplace and "try his luck" in a private clinic:

> It is beneath my skills, I know that, but I don't want to spend the time I have left fighting, so now I meet old ladies, get home in time, and have a good family life.

Babak and Vladimir did not leave the profession; they worked in the same place for a long time. However, it seems that after working harder and still not being identified as "equal", they developed a strategy that gave them room to stay within the profession without the constant pressures of being the "best" – to detach. Feeling detached from one's work may be considered a form of resistance when you are supposed to identify with the profession, the organisation and the patients. Although detachment

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may not change the organisation, it can function as a way to protect one's mental health and other aspects of life outside the work environment. In other words, it is a survival strategy.

Although my empirical material is limited, it raises the question of how resistance against racism is gender coded. While migrant women stressed that they worked hard and often spoke of staying in the organisation, migrant men also spoke of working hard, but strategies like accepting their location or leaving the organisation to focus on their family life were more common. The migrant women with whom I spoke never identified leaving to focus on their family life as an option, perhaps because the emotional and physical work "at home" is not considered a retreat.

8. Conclusion

Inspired by Joan Acker's concept of visibility and James Scott's concept of public and hidden transcripts, the present paper has explored how the public transcript of an organisation affects the forms of resistance that employees use against gender and racial discrimination. My material shows that there is a public transcript that admits the existence gender inequality but not ethnic discrimination or racism.

These differences influence the ways in which organisational criticism is named and inequalities are challenged. The female Swedish-identified doctors criticised organisations as male-coded and acted collectively to challenge them; doctors with migrant backgrounds, both female and male, placed more responsibility on themselves and established more individual strategies such as working harder or accepting a level of disqualification. However, female doctors with experience of migration never spoke of shifting their focus towards private or family life as a disidentification strategy, although male doctors of migrant backgrounds did. My findings stress the importance of intersectional analyses to understand the complex patterns of resistance and consent emerging within organisations. The visibility of gender inequality gives the female Swedish-identified doctors whom I interviewed the opportunity to create strategies that stress their collective strength, hence increasing the visibility of gender inequality.

For the doctors with migrant backgrounds, both male and female, the situation is more or less the opposite. As neither the workplace nor the labour union is engaged in the topic of racism or ethnic discrimination, placing the responsibility of "integrating" on the doctors themselves, their strategies are more individual, such as working harder and, if all else fails, detaching from work. The fact that the doctors with experience of migration do not identify "Swedishness" as a source of organisational power does not mean that they do not speak about ethnic discrimination and the ways in which it affects their work, workplace position and possibilities, hence individually resisting the idea of the equal organisation. Although there were differences between the three groups, none of them questioned the hieratical organisation *per se*, making (as Acker claims) class inequalities both the most visible and legitimate.

In line with McBride *et al.* (2015), I argue that analyses of work and employment need to more actively engage with and be inspired by an intersectional approach. Analyses of professional workers through the narrow prism of the female working body, without acknowledgement of how racism structures organisations, obscures, in my opinion, the diversified forms through which different categories of workers (and their bodies) are inveigled into oppressive power structures and the strategies they develop to manage and resist them.

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9. Implications and further research

My findings show that there is a need in Sweden for central actors such as unions, councils and workplaces to acknowledge the existence of ethnic discrimination within organisations and work to identify the mechanisms that reproduce racialised inequalities. Further, it shows the need for intersectional approaches to analyses of workplaces to capture the complex webs of how forms of resistance are shaped within the organisational logic. The findings also stress that forms of resistance are not individual or collective, visible or invisible, but often find themselves in a continuum. One potential research question raised through my material is an examination of the forms of resistance that may be possible for different groups of workers. Further research is also needed on how different forms of racism shape an organisation's legacy.

Note

1. Pseudonyms have been used throughout.

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