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Complex Professional Learning: Physicians Working for Aid Organizations

Abstract: This article addresses the issue of professional learning of Swedish physicians returning from their work for international aid organisations in the global South. It is a qualitative case study based on 16 in-depth interviews, which uses a thematic narrative analysis, a typology of knowledge, and the concept of symbolic capital. The doctors' assignments in settings radically different from the welfare state context meant professional challenges, including an initial feeling of de-skilling, but also enhanced reflexivity and intensive and complex learning. The doctors acquired new medical and organisational knowledge, improved diagnostic skills, new perspectives on different health care systems, cultural contexts, global power relations, and postcolonial hierarchies. Since their return to Sweden, they have encountered a friendly but rather shallow interest in their experiences. Their new insights and ideas for change have not been easy to validate as symbolic capital, and their intensive individual learning is seldom utilised for organisational learning.

Keywords: Physicians, health care, Sweden, mobility, aid organisations, global South, professional learning, reflexivity

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The global imbalance in the geographical distribution of health care resources and trained personnel—for example, physicians—is visible not only in times of armed conflicts and disasters but even in everyday life of many communities and societies in the global South. International aid organisations like Médecins Sans Frontières (MSF/Doctors Without Borders), the Red Cross, Operation Smile, Rotary International, or UNICEF mobilise physicians from the global North for assignments in the global South. The doctors are supposed to apply and share their medical and organisational knowledge in co-operation with local staff and other "expatriates." What do they experience and *learn* on such an assignment? What skills and perspectives do they acquire, and how do these affect their work and professional status upon their return? The aim of this article, based on a qualitative case study[1], is to discuss these questions with the narratives of 16 Swedish doctors as a point of departure.

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Research overview

This article addresses professional learning in the medical field in relation to international mobility of health professionals and thus spans over several fields. Physicians, just like other professionals in the knowledge society, are supposed to participate in a life-long learning process and to engage in activities "related to exploring, testing, validating, archiving and sharing knowledge" (Jensen, Lahn, & Nerland, 2012, p. 4) and to investigate opportunities for improvement (see also Fenwick & Nerland, 2014; Smeby, 2012). The knowledge required of doctors is not only medical, but also technical, managerial, and cultural (Williams & Baláz, 2008, p. 1924). With physicians' increasing international mobility, mainly from the global South and former Eastern Europe to the West (see, for example, Connell, 2008, 2014; Bradby, 2014), sharing professional knowledge demands translation between different settings and cultural contexts (see, for example, Ackers & Gill, 2008; Czarniawska & Sevòn, 2005; Öhlander, Wolanik Boström & Pettersson, 2016; Williams, 2006; Wolanik Boström & Öhlander, 2015b). The notion of medical universalism also hides the social labour involved in moving between different contexts of practice (Harris, 2014; Wolanik Boström & Öhlander, 2015a).

Because professional mobility from the West to other parts of the globe is at the heart of this article, of relevance are studies about (self-initiated) "expatriates" going on international assignments for firms, companies, the United Nations, or other organizations. An assignment might be a challenging and sometimes stressful experience, but also an opportunity for intensive learning, self-reflection, and identity work. The expatriates are said to gain broader perspectives, cognitive complexity, social competence, and intercultural skills (see Berthoin Antal, 2000; Fee, Gray, & Lu, 2013; Jansson, 2016; Kohonen, 2008; Lazarowa & Tarique, 2005; Lisaité, 2012; Nowicka & Kaweh, 2009; Oddou, Osland, & Blakeney, 2009; Osland, 2000). Research also shows that the new knowledge and identity work is not always recognised and utilised in organisational learning upon their return.

Of importance to my article are also studies of international humanitarian work (see, for example, Fee & Gray, 2011), and in particular of medical professionals engaged in this work, as for example Hunt (2010) on Canadian health professionals; Redfield (2013) on Doctors Without Borders; Bjerneld, Lindmark, Diskett, and Garreth (2004) on returning Swedish professionals' perception of work in humanitarian assistance; and Bjerneld, Lindmark, McSpadden, and Garreth (2006) on motivations, concerns and expectations of Scandinavian health professionals volunteering for humanitarian assignments (see also Bjerneld, 2009). These studies do not, however, have a focus on learning and knowledge sharing, which is the scope of this article. A major inspiration in this respect has been a case study by Williams and Baláz (2008) that combines doctors' international mobility, learning, and knowledge sharing. It discusses how Slovakian doctors, returning from their stays in Western countries, reflected on their learning process and on how their new knowledge is valued and validated upon returning to their workplace (see also Pettersson, Wolanik Boström, & Öhlander, 2015; Wolanik Boström & Öhlander, 2015a, 2015b). My article undertakes an implicit dialogue with Williams and Baláz's work, though with a focus on Western physicians returning from the global South, with postcolonial implications to this direction of mobility.

Theoretical perspectives

For professionals, legitimacy and trust "rest on the capacity to apply professional judgement in ways that are informed, guided by, and validated against a shared knowledge base," even if expert knowledge is generally contested in the knowledge society and professionals are exposed to multiple and contradictory demands (Jensen et al., 2012, p. 2). In clinical practice, a doctor's theoretical (codified) and practical

(tacit, "silent") sets of knowledge are often intertwined, context-dependent, and embodied (see Bolin, 2009; Harris, 2014; Pettersson et al., 2015; Zukas & Kilminster, 2014). There are several thought-provoking typologies of knowledge and learning processes in relation to mobile expatriates (e.g., Berthoin Antal, 2000; Fee et al., 2013). In this article, I apply Williams (2006) and Williams and Baláz's (2008) development of Blackler's (2002) typology of knowledge.

According to Williams (2006) and Williams & Baláz (2008), the most mobile form of knowledge is the *encoded* knowledge of the medical profession (e.g., that found in books, manuals, and so on). They focus, however, on four types of tacit knowledge from Blackler's (2002) typology, which is more related to the particular specialist. *Embrained* knowledge (which is dependent on cognitive and conceptual abilities, for example, to recognize and reflect on patterns) and *embodied* knowledge (practical thinking that results, for example, from participation in clinical work and "learning by doing") are indivisible from the individual and thus are definitely transferable via mobility—although the valorisation of these types of knowledge is dependent on where the individual works. Applied in my study, embrained knowledge might mean that a mobile doctor chooses a number of tests to make a diagnosis, and embodied knowledge might mean that they use their sensory and physical skills for performing surgery (although the surgical procedure obviously relies on encoded and embrained knowledge as well). These types of knowledge and skills may, theoretically, be applied and performed anywhere—but in different medical contexts, they might be valued differently. For a doctor employed by the MFS in a catastrophe area, meticulous documentation of every patient's condition through running many lab tests might be regarded as too time-consuming and as wearing on the inadequate medical resources, and thus a more tacit and quick "professional intuition" will be favoured in diagnosis and treatment.

Encultured knowledge (which involves shared understandings, for example, on health care or life-long learning, transferred via stories, sociality, and so on) and *embedded* knowledge (which is context specific, for example, on management or organisation and is generated in different workplace cultures) represent relational knowledge based on institutionally specific relationships and are only partly transferrable or replicable through mobility between different settings (Williams, 2006). Because these kinds of knowledge are more time and place specific, they easily become "devalorized" by moving, for example, between country-specific practices (Williams, 2006, p. 591). Yet, and here Williams makes an important point—the migrants (in my case, mobile doctors) also have a capacity for *reflexivity* and take with them the *knowledge of* encultured and embedded knowledge. "In part, they carry such knowledge with them, but in part, they carry the means to access such knowledge" (Williams, 2006, p. 592). They might try—more or less successfully—to transfer ideas that "require modification to fit culturally and organizationally different settings" (Williams, 2006, p. 592; see also Blackler, 2002). As Smeby (2012, p. 54) argues, reflexivity "is particularly important in professional work because it is a way of opening up established ways of thinking, not just for improvement, but also for fundamental objections."

In my case study, some of a doctor's knowledge had to be "translated" from a welfare-state clinic to a field hospital in a war zone and back, in other words, recreated in order to adjust to the local context and to be recognized as valid *in situ* (see, for example, Czarniawska & Sevòn, 2005; Harris, 2014; Lazarova & Tarique, 2005; Williams, 2006). Some "recontextualising" (van Oers, 1998; Smeby, 2012, p. 59) of medical, social, and cultural knowledge was needed—both horizontal (such as performing familiar tasks in a different setting and with different equipment) and vertical (such as developing new patterns of activity). As Nowicka (2014) states, skills should be regarded not as fixed personal attributes but as geographically and historically specific. The process of translation, negotiation, and finally validation of skills is affected not only by migration regimes and national policies, but also by

cultural and social factors such as organisational norms, routines, styles of communication, material and embodied practices—even in the seemingly "transnational" profession of physicians (see Harris, 2014; Nowicka 2014; Pettersson et al., 2015; Wolanik Boström & Öhlander, 2015b). In this process, professional status and hierarchies are also negotiated. Some types of knowledge, skills, and insights are easy to translate and share in another context, while others might be difficult, for example, they might be deemed as irrelevant or even problematic if they challenge the status of other professionals or organisational routines.

I consider an assignment as a means to acquire and negotiate different forms of *capital* in a specific context, using Bourdieu's (1988) concepts as appropriated by Erel (2010) and Wolanik Boström and Öhlander (2015b) for migration and mobility studies. Also, the notion of "white capital" (Lundström, 2014; Lundström & Twine, 2011) is relevant in this study. Upon their return, the doctors tried to convert some of their experience and knowledge into the symbolic capital in the Swedish medical field. However, the newly acquired competences or social networks must be validated and recognised as valuable in a particular Swedish setting in order to become symbolic capital in accordance with established cultural norms.

Method

This study is mainly based on individual narrative interviews with 16 doctors[2] who had been trained and who worked mainly in Sweden but had participated in at least one medical assignment in the global South. The informants were strategically sampled (see Kvale & Brinkman, 2014; Thörne, Hult, Andersson Gäre, & Abrandt Dahlgren, 2014) in order to achieve variation in a medical specialty, age, and gender, as well as current workplaces in different clinics and towns. All of them received information about the study and gave their consent to the author, who also performed the interviews. The interviews took between 1.5 and 3.5 hours and were guided by open-ended questions, organised in clusters, eliciting responses about biographical and professional background, work experience in Sweden, family circumstances in relation to international mobility, the assignment(s) abroad (motivations to go, experience of work, the workplace, and the country), coming back to the Swedish workplace and society, and the possibility to share the gained knowledge and insights. The open-ended questions were followed by follow-up questions to get more detailed responses. The doctors were also free to elaborate on any themes they found relevant for the topic in question (for example, some reflected on postcolonial power relations and the sustainability of welfare-state healthcare). The interviews were digitally recorded and transcribed verbatim in Swedish, with small edits for better readability. To ensure anonymity, the personal names were changed, and no names of the current workplaces and towns are given.

Thematic narrative analysis of the material (see Czarniawska, 2004; Riessman, 2008) followed on two levels. On the level of the individual interview as a whole, the important themes, topics, and arguments the interviewee was trying to make were identified and interpreted in the context of his or her narrative. On the aggregated level of the 16 cases, important themes, topics, and arguments were identified across the cases and were compared to gain an understanding of both similarities and discrepancies in the empirical material, and these were interpreted in developing a more complex and theory-driven understanding. The study followed ethical recommendations from the Swedish Research Council. All quotations were translated from Swedish to English by the author.

In the following, I present and discuss the empirical findings from the study in themes about challenges of working in the global South; gaining new perspectives

[2] I use the terms "physician" and "doctor" interchangeably.

on medical care, culture, and global power relations; and the ambivalent experiences of returning to Sweden. Finally, I discuss these findings in relation to the concepts of knowledge and symbolic capital.

Challenges of working and learning in the global South

The interviewed doctors told about a dream or a moral obligation to be of real use with their skills and knowledge along with a wish to see the world, to experience an adventure, or to learn about other cultures. The assignments had meant temporarily giving up the security of their Swedish job and working in much harsher, sometimes even dangerous, conditions (see also Bjerneld, 2009; Bjerneld, et al., 2004). Some of the doctors had worked in disaster areas, facing extreme stress and medically and ethically complex issues when personnel, equipment, or medicines had been inadequate. Much of this they had anticipated, but still, some of the encountered injuries and diseases (malaria, HIV, multiresistant tuberculosis, and Ebola) and the very advanced stages of many of the common diseases or malnutrition had not been part of their everyday practice in Sweden. They said that they had been used to sophisticated technology, lab tests, and apparatuses monitoring the patients' condition and well-ventilated operating rooms and meticulous hygiene procedures. For some, the new work situation had felt overwhelming in the beginning. As I interpret it, even though the encoded knowledge could be quickly assembled, it took some time to adjust the embrained and embodied kinds of knowledge to the new cases, routines, and material restrictions.

Jonathan, who had worked as a jeep doctor in an African country, said promptly, "Well, I have learned what really ill people look like." He said that in Sweden, most diseases are controlled at an early stage, but in that locale, they could progress extremely far before any attendance; for example, severe pneumonia, meningitis, badly infected wounds, swollen bellies, and children with seizures. He concluded, "So I have learned that people in the world have inferior conditions; I knew that before, but it became very *palpable.*" The medical experience thus gave him a deeper comprehension of the uneven distribution of health care and living conditions, which he seemed to regard as the most important insight.

Some doctors remembered their terror of having too little competence for the medical or administrative challenges that they had faced, which can be conceptualized as an initial "deskilling" (which, interestingly enough, is a phenomenon mostly described among highly skilled non-Western migrants moving to the West, see, for example, Connell 2008; McNeil-Walsh, 2008, Nowicka, 2014; Wolanik Boström & Öhlander, 2015b). However, this initial confusion was soon followed by a period of intensive learning and "reskilling." An example here is the narrative of Kajsa, who told me that at the beginning of her first assignment in the Congo, she had felt totally "wrong," "stupid," and "incapable." So much had been unfamiliar—the routines, the available lab tests and treatments, and the range of cases that could or could not be handled according to the organisation's directives. There had also been some initial tensions with the very experienced and very competent local doctors who had not been thrilled with her supervising role as a representative of the aid organisation. They had particularly resented the often-changing guidelines for pharmaceutical products; their own view on knowledge had been more static, and a doctor's status in the local hierarchy relied heavily on never making—or at least never admitting—any mistakes. However, the cooperation had worked well eventually. The team of "expats" from different Western countries cooperated very well, helping each other with information on relevant treatments and on the local context. "It was incredibly valuable, true *learning*," she said. As I understood it, the local and the expatriate doctors formed two "communities of collaboration" (Thörne et al., 2014) that did not seem to engage in much formal learning exchange. Kajsa had found a way to learn by imitation of the local doctors, following them on rounds and engaging in an

intensive and exciting "learning by doing." The learning curve had been extremely steep, she said, and soon she had mastered the local medical procedures, tried to communicate a little in the local language, and even proposed some solutions for the long-term treatment of diabetes patients, which was outside the little hospital's area of responsibility.

Several of the doctors in the study had tried to diminish the hierarchies among the staff in order to learn better. Diego said that he had held some workshops for the local nurses on proper medicine dosage, which they graciously accepted. He said that they had known that he himself "had been there to learn," so implicit and reciprocal learning made things easier and made personal relations less hierarchical.

Edgar had applied for an MSF contract in Zimbabwe—the job description had mentioned malnourished children, violence and rape victims, and HIV patients with all of their associated diseases. In his application, Edgar had written that he had never encountered most of these health problems, but was willing to come and learn. He had received a kind answer from the aid organisation saying that "nobody else from Sweden" had usually been any better equipped, and he got the job. In the beginning, Edgar had been panicking that he knew so little, but he had been assigned to follow a Zimbabwean doctor who had been very understanding about the Western novices and had given him all kinds of useful medical tips, with the addition of the societal and cultural background of the diseases.

> I learned incredibly much, medically speaking, then. And what you can do medically also depends on the *context*, on the kinds of possibilities you have, the space you are allowed, and on the resources, so I learned a lot about *that*. It is really context-dependent, and you have to know your context in order to be most useful. So, I learned a lot about the context.

A huge help in this contextual education had also been an experienced Zimbabwean nurse, who had explained to Edgar why some patients seemed to resist undertaking the recommended treatment for a life-threatening disease, or why a mother of a very sick child would not follow the child to the hospital (she had eight more children at home, and they would starve without her). This help in "translating" the local context had saved both Edgar and the patients a lot of misunderstanding and frustration.

Edgar had also improved his administrative skills, which had been part of the job and at times incredibly demanding because he had received no prior education in this area. In Sweden, many things just worked out smoothly in the background, without the doctor's assistance—the administrative procedures, the technical aspects, the medication supply—while there, on assignment, he had had to assess how much medication they would need 6 months in advance. On the other hand, they also got a new cutting-edge apparatus in the lab for tuberculosis diagnosis because the local ministry was very interested in the progress of treatment.

> It was so great to see how quickly things can develop and get better. All my assignments were actually so positive, even the Ebola, which sounds like the worst thing imaginable of course, but you see how much you can actually *help* people who otherwise would die unnecessarily, and to do so with relatively small means. This is still mighty cool, in spite of all the frustration. (Edgar)

Some interviewed physicians emphasised that working without the usual technical support had improved their diagnostic capabilities. Pia said that her work in a hospital in Africa and then on assignment in Haiti, after the terrible earthquake of 2010, definitely improved her "clinical seeing." In Sweden, she said, medicine was very technical; the doctors learned to rely heavily on devices and apparatuses to understand the patients' health condition, whereas, in the resource-scarce settings, one had to rely more on "seeing" and "feeling" a patient's state. "So, in this way I think that

I have learned a lot, to see a sick person without a pile of machines and devices."

Joel, who had worked in a hospital in an Asian country with hardly any opportunity to run tests in a lab, said that he had learned to rely on the clinical assessment of asking, "What does the patient *look* like?" One would become more "laid back," adopting a "wait and see" attitude towards smaller problems. "One's threshold for what is considered *really* sick has been raised."

Gaining new perspectives on medical care, culture, and global power relations

Even though the human body's anatomy and physiology is universal, treatment and health care vary in different societies, material conditions notwithstanding, and the cultural characteristics and traditions of society are visible in beliefs, preferences, and professional know-how. Encountering new medical, organisational, and local subcultures was for several of the interviewed doctors demanding, but very educational. It was often an informal, experiential, and pragmatic learning process as they tried to comprehend and adjust to new political, economic, cultural, and occupational contexts. The process had put not only their well-known, taken-for-granted Western medical education and clinical practice into perspective, but had been an eye-opener for how global economic and power relations (especially in post-colonial contexts) also operated in the particular local context. There were examples in the doctors' narratives of gaining encultured, embedded, and reflexive types of knowledge.

The importance of learning about the local economic, cultural, and social patterns features in Diego's narrative. He had worked in Indonesia and Colombia, and he said that understanding the language is far from enough; you must get an insight into the economic and social aspects that unfold in the medical work in very poor settings. In the case of long-term treatments for diseases such as tuberculosis, he had been forced to learn how to give up on cases that would otherwise be far from hopeless in the West. If a little child from a deprived Indian village got tuberculosis, there was no way to accommodate them for 6 months, let alone in a hospital. If you did not have some realistic goals, he said, you would toss and turn and fret all night long. "You learned that you can do *something*, but you cannot do *everything*."

Edgar said that his work in Uzbekistan and Zimbabwe had given him insights into the importance of changing behavioural patterns. In the Ebola assignment, they actually had a medical anthropologist on the team. Edgar said that the assignments widened his perspective on "structures and flows and organisation." He mused as he compared the economic problems of medical care in those countries to his previous discussions with his Swedish colleagues on coffee breaks with the usual complaining about declining welfare politics, the municipality's inefficient structure, or the hospital's "poor" economy.

Several of the interviewed doctors pointed out that Swedish healthcare was admittedly of very high quality, but extremely resource consuming. While none of the doctors directly advocated reduced standards for patient care, they wanted to test new ideas about effective care with much simpler means. They wished for Swedish society to be more prepared if the day came when the economy could no longer bear the huge costs, for example, of keeping very old, senile people clinging to life through costly technical equipment and interventions. They said they wished to simplify the administrative procedures and to consider priorities and alternatives.

In several interviews, it was also implicated that the assignments gave the doctors new insights into how the healthcare organisation in Sweden was showing rather a lot of self-centeredness in relation to global issues and resources, as well as a sense of self-satisfaction bordering on smugness. The assignments seemed for them to be a wake-up call, offering a kind of serum for this kind of Western smugness.

> When you come from Sweden, it is easy to think that that there is only one way to run the medical care, but that is not the case at all. You can run it in many different ways. This is something I really have given a lot of thought to. (Edgar)

Anna emphasised that she had realized the privileged conditions of living in Sweden and the West, and she had learned some humility:

> *Humility* in front of different living conditions and how *well off* we actually are [in Sweden]! It is incredible. This is one of the most important things for one to realise…. It is so easy to go around whining about things at home, but you don't do that when you have come back after an assignment. (Anna)

Another thing Anna learned was to accept different people's ways of working and opinions and to cooperate with them for the greater good of the well-functioning team.

> [I learned] how to be humble, to be able to work on a team and to make a try in spite of our differences. Because in Africa, we are a *team*, we are forced to work together 24 hours a day, and it has to work out. I don't know how to explain this, but maybe I try not to get irritated quite as much. I have become better at team-work, at understanding, at working together. To try to *teach* others to be better, to be able to *accept* each other because we have to make it through the day, so it will be all right. (Anna)

In a similar way, Edgar said that he had started to appreciate his own characteristics as cautious and diplomatic and that he had re-evaluated the neo-liberal "personality development courses" he had been sent to earlier in Sweden. "In the end, everybody is supposed to be *the same*, to be forward and to be leaders and to decide and to take over and to control everything." After working with both local doctors and expatriate teams on his assignments, he started to think that it is not so simple; it might instead be a strength to be careful and diplomatic in order to cooperate successfully.

While the satisfaction of saving lives was an often-expressed emotion, there were also narratives about personal failures and disillusionment, for example, realising that they were all caught in global power relations where even the doctors' best efforts could not bring any long-lasting relief if there was no functioning infrastructure for proper housing, latrines, and hygiene. Several doctors said that they learned to appreciate the importance of literacy and education if their work was to have more than just a momentary benefit. For example, Fabian said:

> I think I got a little disillusioned when I was there, or at least reappraised things. I think what truly can lift people's standards of living is not the medical aspect.… I realise that it is important, but it cannot be measured against literacy or basic knowledge. (Fabian)

Edgar said that the situation in the country was politically very unstable and that people lived in uncertain and dangerous circumstances, but as a Western humanitarian worker he had totally different possibilities: "Here I come from my kind of context, with my Swedish passport and citizenship, and as soon as everything goes to hell I can just run away and go back home."

For some doctors working in post-colonial contexts, there were situations that made them more aware of their bodies and their ascribed "whiteness." Peter worked in a region of India where foreigners were scarce, and in the countryside, it was considered much "finer" to be examined and treated by a European doctor than a local one, despite the local doctors being much more experienced with the patients'

specific conditions. Several other doctors told me they had been embarrassed by being put higher in the professional hierarchy than the local doctors, just because they were white or European.

> Sometimes you are treated with what for me is a totally absurd reverence, for example, in Sri Lanka where everyone stood up and curtseyed "Good day, Doctor", and so on, and I just get embarrassed by such things.… But it probably reflects on the culture of a previous colony, where the local people learned how to treat the colonisers, to keep them in a good mood. Ethiopia has never been colonised, which makes it easier. Every other country I have been to was a colony at some point, and then you get to be a part of the colonial powers, actually…. It does not really help whatever you do. (Monika)

Several doctors told me about such sometimes painful insights into the implications of being white Europeans and thus more protected, revered, cherished, and mobile. They were involuntarily attributed "white capital" (Lundström, 2014; Lundström & Twine, 2011), an embodied and institutionalized form of cultural capital, which had given them privileges in professional contexts.

Return to Sweden: A clash of realities

Some doctors said that upon their return they started to regard the previously well-known Swedish reality with a sense of estrangement and bewilderment. Suddenly they found themselves disagreeing with medical priorities or judging the small talk during coffee breaks as pointless and trivial. Feelings of estrangement in the wake of international professional mobility are not uncommon (see Nowicka & Kaweh, 2009; Wolanik Boström & Öhlander, 2015a), but a detachment from coffee-break discussions might actually pose a problem because much of the negotiations around knowledge, status, and "normality" take place during such informal talks.

Kajsa said she had felt like a UFO coming home after her assignment in a rural area of the Congo to the everyday routines at her research centre and the banal discussions during coffee breaks. MSF had held a seminar for medical staff coming home after assignments, and there she had a feeling of community and mutual understanding; all the doctors she had talked to had had their "parallel reality tracks"—one for the assignment experiences, and the "usual" track for Sweden.

Pia had worked for an aid organisation in Haiti just after the disastrous earthquake in 2010. When she had returned, she found the Swedish reality bizarre; her newly decorated house felt unnecessarily spacious, and at the hospital, she had to walk out of the first meeting about wages and working schedules. In the intensive care unit, she felt the need to double-check with her colleagues about whether her decisions on patient care were reasonable and not influenced by the assignment.

> [In Haiti] we could leave young people to die because it was impossible to take care of them, and here we might be taking care of 90–95-year-olds, with dialysis and respirators…. So it was tough, really tough to come back. Not so much being there [in Haiti] as coming *back.* This was much, much worse. (Pia)

In a similar way, Viktor said that after working in war- and poverty-stricken regions, he has trouble taking some of the petty health problems of his Swedish patients seriously.

> The difficulty of coming back is that you come to a Swedish population. It is a good population in many respects, but you also come back to people who have

> problems of lesser medical significance, but they regard those little problems as *very* big. And I have a hard time enduring that sometimes. (Viktor)

On the other hand, in Diego's account, some patients' problems did not seem to get attention in Swedish health care. Diego had become skilled at assessing how astonishingly little that illiterate and poorly educated people understood about their own bodies. Back in Sweden, he sometimes encountered illiterate refugees from poor areas of the globe. They often became very bewildered and overwhelmed by the standard talks that the patients were given, for example, about the function of steroid hormones or the proper dosage and mechanisms of medication. Thanks to his experiences of treating illiterate or uneducated populations in South America, he said he was quite skilled at explaining things to such patients; he did it in a simple but adequate way. However, he said, the Swedish health care system was fashioned after an educated, or at least *literate*, patient. His colleagues seemed to regard language skills as the only problem in communication; they got an interpreter, who translated the medical instructions verbatim and without putting them into a cultural context. People who could not read and understand instructions were left on their own, but Diego found it hard to create awareness about this problem.

Encountering a friendly but shallow interest: Weak organisational learning

When the doctors in my study described their return to their Swedish workplaces, they said that their experiences were met with a positive, but rather shallow, interest among their colleagues. Kajsa had given some lectures in different contexts about her assignment in the Congo, and her colleagues were friendly and positive, but mostly their attention span lasted "two minutes." She also felt utterly upset in the Swedish workplace when diagnostics or treatments were performed "in absurdum" just to play it safe, wasting so many resources, and she tried to "merge the two worlds" and suggest possible changes, but nobody seemed to understand her. "Then I realized that this world is *here* and the other world is *there,* and those two shall never meet. I have to keep them separated even in my head because they are *so* different."

Neither for Pia was there any self-evident forum to talk about her experiences in Africa and Haiti, apart from MSF. Pia's colleagues commented that it was "fantastic" that she went, but because they seldom asked any further questions, she did not elaborate; she got the feeling that it might make her be seen as wanting to appear extraordinary and a little self-righteous. The nurses at her hospital were much more interested, however, and used to invite her to talk about the assignments.

In her work for Operation Smile, Anna experienced that everything was "so easy" and everyone so positive—if you had an idea how to make things simpler, you were encouraged to try it out. Back in Sweden, she went around telling everybody how they had developed things on the assignments and had suggested improvements, "I had so many ideas!" However, in the Swedish clinic, there was little enthusiasm for simpler solutions with less administration and a tighter schedule. A colleague from another clinic, who also used to go on assignments, told her that trying new ideas had never worked for him either. "People just get annoyed, you shall not have too many ideas," Anna concluded.

A conclusion from the doctors' stories can be that apart from some lectures, there was no systematic arrangement for knowledge sharing or for utilising their experiences in the Swedish context. This might to some degree depend on the fact that tropical diseases, tuberculosis, and HIV were still of rare occurrence among the doctors' patients, and thus the newly gained knowledge was simply not applicable.

> I have never met anyone with malaria, and I have never found anyone with HIV

> or tuberculosis in Sweden. It exists, but it is unusual. So, I have little use of those skills. But on the other hand, it was a very good experience and a fun thing for my ego, and it was nice to do something good, to help people. (Jonathan)

At the time of the interview, Jonathan was working in a health care centre in a rather well-off part of the city, and there were no such diseases to treat. He never put the assignment on his CV or used it as an argument, for example, when discussing salary—he would perhaps do it if he ever applied for work in a district with lots of immigrants from Africa, he said, but it would still not be the most decisive argument.

Not only the medical communities but also media and society at large showed too little interest in global health problems, according to the doctors. Edgar experienced two very different reactions to his two assignments, even though both were about treating life-threatening, infectious diseases—resistant tuberculosis and Ebola. While the former was met with total disinterest, in spite of outrageous political assaults and human catastrophes, said Edgar, the Ebola assignment was met with almost too much attention by the media because there was the concern that Ebola could be spread to Europe via, for example, air travel. His clinic received a lot of questions, and the media was chasing him for interviews and asking for opinions on mistaken cases. Edgar said that he was very sceptical toward the media coverage based on panic and sensation, but the advantage of it was that the work of MSF/Doctors Without Borders received much attention and they could spread their message, which hopefully would make the world a better place.

> I think it is so exciting how things *work*, like the big structures and why things happen and why.… And what can be done differently? Can one influence it in some way, make it different so it will be better next time? This is the most exciting thing after I have travelled to these countries—a better understanding for things like that. (Edgar)

Monika, who used to go on frequent assignments with different organisations, said that this fact was rather a "negative merit" in her career. She held some lectures through the years, and her colleagues were either not very interested, or they thought that she was "nuts." "Many of them say that they would like to do it themselves, but nothing happens later." She was not expected to learn something that might enhance her career, either. She went to countries that were behind Sweden in terms of medical development, and she could only use rather basic skills because the equipment did not allow for more complicated interventions. Thus, she had gained a very *broad* knowledge, which was "a negative merit," because a narrower in-depth specialty was prioritised in Sweden. "You do not learn the *right* things; you have not considered your *career* hard enough."

Conclusion

These assignments might be regarded as an opportunity for life-long learning, and by encountering different workplaces and national and local cultures knowledge is explored, evaluated, and recontextualized (see Jensen et al., 2012; Smeby, 2012). Also, the return to the previously well-known workplace results in seeing it from a new perspective. Knowledge translation and re-creation are socially situated and relational processes (Czarniawska & Sevòn, 2005; Williams 2006) that also involve negotiation of professional status.

The doctors expressed regret about the friendly, but rather superficial, interest from their colleagues. In organisational terms, there seemed to be little encouragement or substantial esteem for these kinds of assignments as a means for professional

development or as a basis for reviewing the weak points of Swedish/Western medical care. The doctors pictured Swedish medical care as self-satisfied and rather conservative in its orientation towards the status quo or, paradoxically, progress—understood as adopting the latest technology, more and more tests and costly procedures, and a growing administration—as if the welfare state economy would be eternally good, and no backlashes or no catastrophes would ever happen (apparently apart from the Ebola threat, which was taken seriously). The perceived organizational smugness left the doctors' insights about the possibility of effective work with fewer resources and tougher priorities as fascinating, but not really relevant—thus generating little symbolic capital (Bourdieu, 1988; Erel, 2010; Nowicka, 2014; Wolanik Boström & Öhlander, 2015b). The doctors' intensive learning in the global South, their critical insights, and the mental "serum" for smugness that they acquired through the experience seldom seemed valued or appreciated.

In spite of some critical reflections about the long-term benefits of aid assignments, the doctors appreciated the experience of saving or improving many lives and making a difference with limited means, as opposed to the overly organized Western medical care. In the interviews, they were generally very reflexive on "recontextualizing" (Smeby, 2012, p. 59) their medical and social knowledge, professional performance, or ways of cooperation to adjust to the demands of the local "community of practice" (Harris, 2014; see also Wolanik Boström & Öhlander, 2015a). Although they did not use the knowledge typology I applied here, the well-educated and reflexive interviewees did use concepts from philosophy, psychology, and social sciences—a frequent phenomenon of a "spill-over" of epistemic cultures from research to other areas (Jensen, Lahn, & Nerland, 2012; Knorr Cetina, 2007; see also Fenwick & Nerland; 2014; Smeby, 2012; Wolanik Boström & Öhlander, 2015a). With narrative and paralinguistic signals, they indicated that they distanced themselves from their personal experience narratives to a meta-level, trying to give a bigger picture of the global medical context and their own professional identity.

If their learning is conceptualized with Blackler's (2002) and Williams and Balaz's (2008) typology, *the encoded* knowledge from books and reports seemed easiest to obtain during an assignment and share back home, if only their colleagues found it relevant (for example, facts and figures about HIV or Ebola). The doctors also reflected on *embrained* knowledge, for example, sharpened diagnostic capabilities, and *embodied* knowledge, as practical thinking resulting from medical procedures in a different context. Some of the physicians could apply only more general skills, while others acquired a lot of specialized medical knowledge, which was of relevance for how it was valued in Sweden. For example, improved surgical skills in cleft palate surgery were more career framing than general surgery, which admittedly did save lives and limbs, but did not require extraordinary competence.

What I find interesting is that every interviewed doctor emphasized that social, political, and cultural insights were the most striking and often overwhelming feature of their learning, but also the most difficult to share upon their return. These insights involved *encultured* knowledge (shared understandings on health care or learning) and *embedded* knowledge (context-specific knowledge on management, organisation, or post-colonial power dimensions in the professional role) (see Fechter & Walsh, 2010; Williams, 2006, p. 591). The experience seemed to enhance *reflexivity* and made clearer the "knowledge of" other types knowledge, as well as the (Western) preconceptions that became more tangible.

Back in Sweden, the doctors carried with them reflexivity and the "knowledge of" other types of knowledge, resulting in changed perspectives and new ideas for change. However, the proposed organisational solutions encountered in the global South or that were preferred by the aid organisations, for example, making things more effective, smoother, and simpler, met resistance in the Swedish context. Some of the interviewed doctors tried to "translate" and modify their ideas, some more successfully than others. Others concluded that they had to settle for keeping the cultural and organisational "realities" apart because they were too different for any

cohesion to occur. This kind of mental split-up suggests fragmentation of their work trajectory (and indeed, even their life trajectory) into parallel tracks. This, in turn, has repercussions for their professional status and career possibilities in Sweden—if they choose to go on assignments that the Swedish employers regard as disrupting administrative schedules and narrowing one's specialisation, and thus not being professionally rewarding, this might create gaps in the physicians' career paths. The intensive, sometimes life-changing *individual learning* of the doctors appears not to be met with structured *organisational learning* that would acknowledge the doctors' experiences in the global South as thought-provoking and valuable in Swedish practice.

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