

# MOBILE PHYSICIANS MAKING SENSE OF CULTURE(S) On Mobile Everyday Ethnography

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This article, emerging from a study of mobile Polish physicians currently working in Sweden, explores the doctors' ethnography-like descriptions applying the categories of knowledge usually employed by the researchers. The primary material consists of 21 interviews. The term *mobile everyday ethnography* points out the particular epistemological condition induced by occupational mobility: a tendency to explore and describe settings and behaviours in cultural terms, oscillating between an insider's knowledge and an outsider's estrangement. Some recurrent themes in the interviews concerning cultural frictions are presented, followed by a discussion of the specificity of mobile everyday ethnography: its basis in the pragmatics of everyday life, the predominant usage of the popular notion of "culture" and the professional self being the focal point.

*Keywords:* highly skilled mobility, workplace culture, health care, mobile everyday ethnography

## **Introduction**

In our study "Polish doctors in Swedish health care", based on narrative interviews with 21 physicians, we have encountered many fascinating accounts that bear resemblances to "professional" ethnographical descriptions, interpretations and imageries.<sup>1</sup> In the increasingly mobile Europe and within the global health-care market, the mobile doctors<sup>2</sup> (and doubtless other mobile professionals) try to understand the new settings where they work and live – and to understand themselves in the process of adjusting. Spatial mobility among this particular occupation is an interesting case, as there is a common assumption that medicine is culturally unbound and a physician's skills are easily transferable from one organizational setting to another. But although the

human body may be seen as "universal", the ideas of illness, treatment and health-care organization may vary considerably in different settings, as do norms for a doctor's correct performance. As has been shown by for example Harris (2014), although medical training gives knowledge and skills that in theory are applicable to the human body regardless of its geographical location, each national health care has characteristics of its own when it comes to legislation, organization, interpersonal relations etc.

The mobile/migrating<sup>3</sup> physicians in our study, many of whom have not only worked in Poland and Sweden but also in other Western countries, reflect upon situations, activities and environments, drawing broader conclusions about cultural traits of organizations and nations and contrasting them to one

another. The doctors apply and merge the popular, “folky” notion of culture with concepts used by cultural researchers and social scientists. Though they make no claims to being cultural researchers, they present themselves as reflexive and analytical, as they investigate and make sense of the differences and peculiarities they experience. Their interpretations are grounded in a non-systematic, but impressive range of data, including prolonged participation in different settings, something professional ethnographers could hardly do for practical reasons.

### Mobile Everyday Ethnography

In this article, we take the interviews with the mobile Polish physicians as a point of departure for exploring and analysing these ethnography-like descriptions, made by reflexive subjects. The main question we want to raise is: what are the characteristics and epistemological conditions of the ethnography-like descriptions, and what discrepancies are there between the mobile doctors’ ethnographic accounts and the cultural researchers’ techniques, goals and responsibility for the descriptions and interpretations? In academic research, ethnography is considered as both a method and a theoretical orientation. It is usually a systematic, first-hand, in-depth investigation of one or a few social settings, drawing on diverse research techniques, such as participation in people’s everyday life, observation, interviews, small talk and written materials of importance for the focus of inquiry. Ethnographic research is often not only an intellectual, but also a deeply emotional biographical experience (cf. Hammersley & Atkinson 2007). A researcher gives a theoretically informed interpretation of social organization, of the meanings of people’s talk and actions or institutional practices, in both local and wider cultural contexts. But also, in the world outside academy, similar and sometimes very impressive interpretations of workplaces and cultural traits are a part of everyday sense-making. There are several researchers exploring this kind of phenomenon, for example the “lay ethnography” defined by John Weeks (2004, 2006) or “para-ethnography” described by Holmes and Marcus (2005, 2008).

We propose the term *mobile everyday ethnography* in order to point out the particular epistemological condition induced by occupational mobility and everyday sense-making. Mobile everyday ethnography is the mobile doctors’ practice of acquiring knowledge about cultural traits in an unknown setting. This practice includes a specific approach to everyday life, a kind of pragmatic ethnographic sensibility. Everyday ethnographers communicate their descriptions and reasoning based on what they learned from the pragmatic sensibility practised at different workplaces.

The most specific and necessary condition of *mobile everyday ethnography* is of course *mobility*. A rather uncontroversial supposition is that spatial and social mobility amplifies the need – and the power – of observation and analysis of the cultural know-how. Mobility means arriving at potentially unfamiliar circumstances and the need to make sense of everyday life as it emerges in the effort to make it familiar. In her study of international medical graduates, Anna Harris (2014) points out that when a medical practitioner moves to work in a different hospital the setting is “familiar unknown” and requires active work of adjustment. In a similar way, quite a palpable state for many of the doctors in our study is estrangement and de-familiarization (which, interestingly, are also acclaimed techniques in ethnographic research). They have experienced how some of their taken-for-granted classifications, behaviours or hierarchies have become unstable and precarious. Still, having a highly skilled profession, whose services are welcomed all over the world, they belong to a very privileged group among transnational mobile humans. Their occupation has a given status and they have a firm confidence and authority in their efforts to explore the unfamiliar.

While mobility is a prerequisite of *mobile everyday ethnography*, the fact that this ethnography is a part of everyday life gives it its special characteristics and conditions for how the knowledge is made. Thus, to deepen our understanding of the characteristics and epistemological conditions of this kind of ethnography, we will focus on the crucial aspect of the mundane and *everyday*. The articulations of

meaning specificities and differences are parts of an everyday human practice and as such a part of everyday knowledge. The phenomenological approach of *everyday knowledge*, in a Schützian sense, specifies the very centre of the kind of “ethnography” we want to explore here.

As will be shown in more detail, the everyday ethnographic accounts narrated in our interviews are about how to act and behave, how to understand hierarchies at a specific workplace, the making of gender and class and so on. In other words, the doctors are speaking about what is commonly labelled as culture. In this article then, the ethnography part of *mobile everyday ethnography* is about exploring *culture*. But our study is not about Polish or Swedish cultures as separate and distinct entities. It is about the process in which culture is lived, experienced, narrated and dealt with as an everyday reality. Our analytical standpoint is that instead of presupposing clear-cut cultures bound to specific social categories or defined locations, culture has to be analysed as a process of construction, reconstruction, hybridization, reinvention and safeguarding. To analyse the doctors’ ethnographic narrations of culture we will focus not only on what is said, but also on *how* culture is spoken about. The everyday ethnographic accounts may be analysed in relation to the dominant ideas and ways of speaking about culture. This kind of ethnography seeks an understanding of the particular (workplace, national) culture, but this knowledge is not a source of insiders’ bonding in mutual understanding, as in Weeks’ (2004, 2006) lay ethnography of a bank; neither are the insiders the primarily intended audience. Our impression is that it is usually told to non-Swedish friends, family and other people who may have an interest in the feeling of ambivalent belonging and cultural differences, which includes us as interviewers. The language shifts between emic and etic as the accounts oscillate between an insider’s knowledge and an outsider’s estrangement. In some aspects, a steady common ground with the people of the described “culture” is declared – for example the value of medical knowledge or family life. In other aspects, a sense of difference, distance or confusion prevails.

Both standpoints may create a feeling of mutual understanding and shared assumptions also with us, in the interview situation.

In the following Part 1, we begin with a short presentation of the doctors and the interviews and then continue with a presentation of what the doctors highlight as worth mentioning, or remarkable, in their working life in different settings (with the main focus on Poland and Sweden). In Part 2, we proceed with a discussion about the characteristics of “mobile everyday ethnography”, focusing on it as a practice in everyday life and as a way of exploring the meaning of everyday experiences in terms of culture.

## Part 1. “Ethnographic” Themes in the Interviews

### *Doctors and Interviews*

Health care is often characterized as a global field with transnationally mobile work (Connell 2008). Within Europe, doctors mainly move from southern and southeastern parts to the more northerly countries, for example Germany, the UK and the Nordic countries. Among health workers in Sweden, doctors are the group that shows the largest increase of health-care professionals educated in another country.<sup>4</sup> The doctors we interviewed had experience of moving between at least two, often several, countries and localities.

This article is based on 21 narrative interviews with physicians, 10 women and 11 men, living and working in different parts of Sweden. The interviews were the main basis of the study “Polish doctors in Swedish health care”, conducted between 2010 and 2012. The interviewed doctors, aged 40–55, were born and educated in Poland and had been working as physicians there before the move.<sup>5</sup> They have various specializations, such as anaesthetics, clinical radiology, general practice, gynaecology and obstetrics, surgery etc. They work in different public clinics or health-care centres, in one big city, three medium-sized cities and a small town (those in a small town also worked in the countryside). The interviews could be described as narrative and semi-structured. The interview questions induced

narratives and were focused on professional trajectories and realities of working life and health-care organization in Poland, Sweden and, in many cases, other countries where the physicians used to work. We used a questionnaire organized in themes and grand-tour questions combined with precise questions about specific instances of interest. In the interview situation the questionnaire was supplemented with floating prompts and additional questions (e.g., McCracken 1988). The shortest interview lasted a little more than one hour, the longest ones more than three hours. Most interviews lasted around two hours and took place at the doctor's workplace or in the researcher's office. The interview language was either Polish or Swedish. As we have discussed elsewhere (Wolanik Boström & Öhlander 2011c), the interviews conducted in Polish tended to be longer and richer in details, but all the interviews show similar themes.

### *Talking Differences, Talking Cultures*

What in the professional life do the doctors present as worth paying attention to and tell us about? The reality is complex and ambiguous and just like qualitative researchers, the mobile doctors have to choose the direction of their observations and reflections. But unlike qualitative researchers, it is not their main objective to do cultural analysis; they are doing their job and striving to do it well. Then, in the process of everyday interactions with people and the material environment, many of them get interested in "cultural" differences or sense that transnational medical knowledge is not all it takes to feel at ease in a new setting – they are "thrown into" particular social situations and try to make sense of them.

The ethnographical sensibility seems most palpable when the doctors talk from the perspective of a slightly bewildered alien. The interviewees seem very perceptive of what we choose to call "cultural frictions" in everyday life, that is, experiences of incongruence between one's cultural predispositions and the expected behaviour, especially if this means a challenge to social status. As we have elaborated the theme of status previously (Wolanik Boström & Öhlander 2011b, 2012b, forthcoming), we shall not

dwell on it here, but it is important to point out that the physicians often depict cultural characteristics as a reason why they are mistrusted or treated as inferior at some point. Still, they avoid taking the role of a victim or martyr; the stories rather portray an adventurer learning by his or her mistakes, or a hero facing challenges in a strange land (cf. Osland 2000; Wolanik Boström 2008). The doctors muse reflexively at misunderstandings or organizational peculiarities. Though the narratives do have a serious undertone, they are often humorously self-reflective, delivered with a twist, as clever anecdotes that an otherwise successful subject tells about his/her experience of cultural frictions and insights gained from them.

Some quotations about differences in medical and social practices may sound unnecessarily critical or mocking. It is important to bear in mind that the accounts are not burdened by a professional ethnographer's cautiousness, bordering on anguish, to point out *all* the nuances and complexities of a cultural setting. Our informants spice it up to make a point, often an entertaining one. This difference in how ethnographic findings are narrated is thus another palpable difference between mobile everyday ethnography and professional ethnography. To avoid giving an unfair picture of the usually very successful specialists' work and career in Sweden; we want to emphasize that they do tell about their contentment and work satisfaction, the usually good cooperation with the staff and the often well-functioning work environment, as in the example below:

Jasia: Generally speaking, I think that there is a very good atmosphere at work. And everybody is fairly hardworking and helping one another, I cannot say anything bad about it. It works fine [nods].

Our interviewees also underline their medical competence and experience. They mark that they do not feel any inferior compared to their Swedish, English or American colleagues, in spite of (or, sometimes, just because) having experienced a lot tougher work circumstances in Poland.

Boleslaw: The work itself was really basically the same. We used the same equipment. Well, some things were more easily available then; Poland used to be a relatively poor country, which changed later on. But the principal knowledge was the same [...] So it was attractive just to be able to come here and use it. There are the same common values, even if Poland and Sweden are rather different.

In the interviews, there is the assumption that common knowledge, values or a shared experiential ground does not need explaining. The well-functioning aspects of (working) life in different countries are taken for granted or less elaborated. Similarities between countries, workplaces, medical competences or social skills are understood as evident unless otherwise stated. The apparent reason is that they are unproblematic and perceived as less interesting than the unexpected and challenging ones (cf. Wolanik Boström & Öhlander 2011b). Eliza tells us that she was happy at a hospital in Poland, both with the work and with the lively social contacts among the staff, but she also remembers when she first heard about the conditions of work in Swedish health care, which put things into perspective. It was in 2000, when Polish medical care was in deep crisis and the physicians felt very strained:

Eliza: [In Sweden] the doctors had four weeks' holidays in a row; it felt cosmic in Poland, impossible at my workplace! And the maternity leave for such a long time... That your employer listens to your wishes and takes them into consideration [laughs], not much attention was paid to in Poland, for example that you should have a comfortable chair, a pad for the computer mouse... It was quite abstract that somebody would care about your needs or treat you like a human who had needs and not just a doctor who worked and treated people and was generally there for someone else, for the patients.

Here, the image of Sweden is outlined against the Polish clinic. Similarities are not interesting; differ-

ences in material details and, above all, in attitudes, are pointed out. And sometimes it is on the basis of the more remarkable and spectacular examples that generalizations about "cultures" are made. Boleslaw says that in his previous Swedish clinic everybody seemed sour and almost mean to each other, while at the current workplace "the culture is different". He is one of our most mobile informants and he also describes medical care in four countries he used to work in:

Boleslaw: In Sweden, there is much aiming towards organizing, written rules, and it suits me. Poland is working on it, but we are individualists, like a micro-USA, you invest in yourself and your own development in order to be a star. It is quite typical for the culture of my homeland. There are some enthusiasts who are really good; if something works well it is thanks to some of them. In Sweden, system-based solutions prevail, so even if someone is less capable and clever, it is a part of the system and it still should work all right. Tel Aviv, now that is a special nation. They have the world's best doctors there, definitely, but it is also combined. Really competent, experienced, proficient people, but at the same time very temperamental. A physicians' meeting here [in Sweden] is very quiet, when you talk I will wait, when I talk, you will wait for your turn. It is not like that in Tel Aviv! They seem to quarrel all the time. But it means nothing negative; it is just a typical southern country. And they can work together pretty well if they meet a challenge. [...] Norway is more like Sweden; maybe they are better at showing their feelings. A typical Swede is a little self-contained, but after a couple of years I think I know how to interpret small things in the facial expressions and body language. But it is not quite easy, I can tell you.

In this lengthy quotation, Boleslaw outlines nation-bound workplace characteristics, inscribing himself in the Polish "we" of individualists. Broad and generalizing descriptions of this kind may be found in most of the interviews. The doctors outline a culture

or mentality predominant in a nation or a setting as an important background, sometimes an explanatory factor, for their work trajectory. In the interviews as a whole, the level of generalization sometimes is a country, sometimes a region (e.g., northern Sweden) or a locality (a town, a hospital, a clinic).

Also comparisons of places and nations are common in the interviews. The doctors describe idiosyncratic characteristics of their present Swedish workplaces, and use their former Polish, English or French ones as a contrast. Dwelling on differences and making comparisons is, of course, to some extent a result of the interview situation, as the doctors know that we are interested in their experiences of work in at least two countries: Poland and Sweden. Still, the stories seem to have been told many times before as means for self-presentation; our observations of informal activities and social talks strengthen this impression. Comparisons are a well-used tool to understand and classify reality. Describing places and cultures as interconnected and contrasting them to other places (and cultures) is a historically well-established genre. New places are expected to be different both from “home” and from other locations. It is also a common human trait to compare as a way to sort things out and make sense of the everyday reality (e.g., Toren 2002; Wolf-Knuts 2014). The tendency to think in differences has even been at the very heart of anthropology (Gingrich & Fox 2002) and ethnology, and though after the post-modern turn and in the era of global flows it is no longer accepted to depict and compare cultures as if they were homogeneous entities, much of our thinking is still impregnated with the search for differences.

For most of the interviewees, moving to another country initially created a feeling of de-skilling, de-familiarization and confusion, not only due to language problems, but also because of implicit social codes about, for example, performing class and gender in the organizational context. In their endeavour to make sense of implicit demands and social know-how, the doctors have observed and reflected on the processes they have been merged into. They show a keen attentiveness to behavioural patterns and implicit norms in different settings and present their

strategies for adjusting or resisting adjustment.

This does not mean that the doctors’ “data gathering” is confined to the workplace; they assert a strong homology between work-life phenomena and other areas of society. As we shall see, insights into the dynamics of children’s football team might be used to formulate a more general opinion on the Swedish collective spirit. Moving on has also had a de-familiarizing effect on the “cultures” they have left behind. And, it is important to say, the evaluations of the perceived patterns vary; one person loves the strictly organized system, another person scorns it.

Judging by the interviews, the doctors focus on social and cultural aspects that might be helpful in functioning as a competent and acknowledged professional. With a shorter stay, a “quick-fix” everyday ethnography might be enough to get a fair idea of what is required in this particular setting. With a prolonged stay, the doctors might need a more complex cultural understanding; there are examples in our interviews of how they encounter increasing demands to understand not only to specific organizational procedures and routines, but also more subtle social rules among colleagues or in bedside manner.

#### *A (too) Successfully Organized System*

An often-described feature of the Swedish medical system is the extensive and detailed administration. Boleslaw says that Sweden has a reputation of being the best-organized country in the world:

Boleslaw: It is much more effective here and it is nice to work in a well-functioning system. But sometimes the system takes over, and then you may lose the human perspective. [...] There is a risk that effectiveness leads to losing the human perspective. You stop working as a physician and work as a businessman with a customer. That is not good.

Jasia complains about all the meetings that are so often held at different levels of the hospital and she appreciates the democratic idea, but is sometimes appalled by the amount of time that is required to actually decide anything.

Jasia: You have many meetings to reach a decision and then, in the end, you reach out to the personnel, and so on. It is a democratic process; you can see that. But there are so incredibly many people disappearing every day from their work assignments to different meetings!

For Eliza, the well-ordered medical care is extremely positive, as she had worked her way through continuous reforms in Polish medical care and is tired of all the changes and experiments:

Eliza: I was struck by the peace and quiet of life here. "Everything is ordered," I thought, "there is time for everything, everything is planned, there is no chaos, everything has an order and you are an important person amidst all that." I liked this order and this peace and quiet, that it is a well-working system.

In Magdalena's view, the administrative system is totally over-dimensioned and the routines are inflexible and ineffective. Magdalena regards them as a part of the overall Swedish "mentality", characterized by a lack of spontaneity.

Magdalena: When you have a party or a meeting everything is so ordered, everything is planned. And when there is a clause about something, then you can only do it that way, and never go around it and make an exception.

The booking system is too rigid, she says, and results in many patients waiting for months, or being sent home, sometimes hundreds of kilometres, if the required treatment is not acute and does not fit the personnel's schedule.

Magdalena: Everything went so slowly, I felt that I had to be a saviour of the medical care, to earn some money for it, at the same pace as in Poland, [where] everyone wanted something from you all the time, and it was work on high adrenaline, all the time, in a hurry.

Even the personnel's coffee breaks are scheduled and much celebrated, especially among the nurses. It often gets on Magdalena's nerves, if she wants help with a patient and not a single nurse is to be found. In the beginning, she was completely amazed by the custom: "Why drink coffee for fifteen minutes? If I drink it in five minutes, then the patient won't have to wait!" She contrasts the Swedish clinic to her former workplaces in Poland, where the overworked, underpaid personnel used to show more consideration towards the patient.

Magdalena: [In Poland], even when the anaesthetologists tell you that they have had too much to do today, you say: "we *have to* take this one!" And here... a nurse tells me that she has finished for today or has a coffee break now, another has something else... [...] Why is there no goodwill, why are the people working as if they were *clerks*? I thought I would at least try it with my own patients, to squeeze them in, to do three procedures instead of two.

Through the years, the receptionists and the nurses working with Magdalena have learned to speed up and rationalize by means of flexible cooperation. Magdalena has in turn realized that some coffee breaks or lunches are indeed important, even for informal medical communication among the doctors. A lot of problems can get solved. But otherwise, she points out, it does not hurt to take a cup of coffee on the run, in between the patients' visits.

Magdalena's account of particularities of the Swedish clinic leads her to a deeper issue of the ethos of medicine and the clash of a patient-oriented and personnel-oriented work style. It is implied that the emphasis should be on the patient's well-being, with less consideration for staff contentment. The rigid schedule, the safe predictable routines and, above all, the regular, celebrated coffee breaks all seem to connote a "clerk".

### *Collective Spirit and the Value of Similarity*

Many accounts point to the blurred hierarchies in Swedish health care, for example not signalling status by titles, but by more subtle means, which may

take time to learn. Antoni says that he had real trouble handling everybody saying the familiar pronoun *du* (“you”) to each other, including people in leading positions, instead of Mr., Ms., Doctor or Professor. Edyta says that there is also an expectation of a similar level of ambition, which is a problem to her:

Edyta: My doctoral supervisor [in Sweden] told me rather harshly that I was too ambitious and that I wanted to do too much. And for me, it was a contradiction to my own nature and what I learned in Poland and in England.

Antoni gives an example, where the collective spirit leads to a misguided consideration for insiders. A receptionist in his district health-care centre makes a lot of mistakes in classifying patients, and Antoni has asked several times if she could be replaced or retrained, but nothing happens. “No, let us all suffer!,” he sighs, and draws a parallel:

Antoni: It is one of my favourite discussions! When we came to Sweden the kids played football, it was a group of small children, and when a kid happened to miss, everybody applauded and said how good and clever he was. “Good, great!” And my children said “Daddy, something is wrong here, he just screwed up – and they say it was great, so it is a lie!” [laughs]. [...] And I would say, “You have a system here that is levelling down, towards those who are worst. And it is not fair for the best one.”

Jasia reflects upon the Swedish anxiety about “standing out” in any way. It sometimes means avoiding responsibility and especially avoiding confrontations; the preferred strategy is to talk behind someone’s back:

Jasia: There is something I do not quite understand after all these years; when a colleague does something wrongly, I go to him and tell him. But many of my colleagues go to my boss, or come to me, and tell me that he or she does this and that. [...] If there is a new person, there is a lot

of talk behind his back instead of going directly to him and saying: “you know, we don’t do it like that here, we do it this way.” I don’t like it. And I think it is a part of the Swedish culture, to prefer that someone else takes the responsibility and becomes less popular.

In the two latest examples, the doctors make statements about both a particular clinic and the Swedish culture in general, in a notion of cultural homology. It is also a common self-understanding in many organizations, though the chosen “national” characteristics may vary (cf. Weeks 2004, 2006 on the BritArm bank and the notion of Britishness).

### *Unexpected Professional Requirements*

Many interviewees express reflections about discovering implicit social norms and expectations for professional behaviour that were a surprise to them. Edyta, with previous work experience from Poland and England, ponders humorously on what she regards as a Swedish feature: the expectation of being “pleasant” at work. When she first arrived, her future contract in a Swedish clinic depended on her reputation among the personnel; so the expectation of pleasantness was not as innocent as it might seem.

Edyta: In England, everything was about the CV, it determined if you got a job or not. In [the Swedish clinic] it turned out that I have to be liked by the personnel, including the cleaning personnel! It was never an issue in England [laughs]! I used to be quite decisive at work, and here I got shocked that I had to be nice and pleasant towards everybody. And it wasn’t so good for me, because I got so nice that I almost never said no [to working overtime].

The conclusion about compulsory pleasantness derives from her experience from one clinic, but is interpreted here as a Swedish organizational characteristic (a part-to-whole generalization which often appears in our interviews). Nowadays, when Edyta’s anxiety has subsided – she is securely employed, she likes the team very much – she has learned that it is



OK even to say no to overtime, especially for those who have small children; everybody is very understanding.

Eliza says that she does not know any head of the clinic that is not Swedish; she sometimes ponders on why it is harder for non-Swedes to advance. Her conclusion is that it partly depends on the many layers of demands for higher positions, not only medical:

Eliza: Here [in Sweden] you don't feel all the subtleties and nuances. And it does matter in higher positions; the communication with people, the kind of relationships you establish, the authority you get, the charisma you have; and all this has to do with language, with political and social knowledge, with the feeling for subtleties.

An implicit demand may be the expectation of emotional control, no matter how dramatic or irritating situations the doctor is facing. Lech stresses that, because working at a hospital is teamwork, it is essential to have good relationships with the rest of the personnel – “from the professor to the cleaning lady” – and one must appreciate people for what they do. He is usually on the best of terms with all the nurses and the cleaning staff, but sometimes people misunderstand a situation. He felt really hurt once. He and two colleagues tried to save a high-risk patient during a complicated and dramatic operation. Afterwards, one of the nurses wrote a letter to the head of the clinic, complaining that the atmosphere was “bad” and even frightening. Lech explains that he was extremely focused, trying to stop a heavy bleeding, and had no time for explanations. There were three doctors, but Lech had the main responsibility so he received the complaint about the atmosphere.

Lech: I said that was true, there *was* a bad atmosphere during the operation, maybe I missed some course, but I can see a difference between a picnic atmosphere and a funeral atmosphere! If you grade 2 as the lowest point and 10 as the highest, then it was not more than 2. But it ended in a funeral. [...] How do you act when you have a dying person on the table and want to try something

more? What can we, my colleague and I, do more? I was just trying to *think*.

Interviewer: What did the nurse want?

Lech: She wanted us to *talk*, all the time.

In Lech's account, there is a clash of communication styles among the personnel. For him, in a situation on the edge, it may be justified to appear frustrated, rough and uncommunicative.

A similar predicament is depicted by Magdalena, who was given a reprimand for her tendency to raise her voice when she is angry at things that do not function at the ward. Once she burst out during surgery; she was kept waiting many minutes for an instrument which had not been prepared, so she yelled at the nurse. “In such situations, the operating theatre gets half-empty, everybody is trying to leave, as there is a wild and crazy doctor in there.” Magdalena's colleagues have thankfully accepted some of her behaviour as “cultural differences”, but it is obvious to her that a doctor should be calm and not give in to emotions. She says it is exasperating that all the staff are so composed and politically correct all the time, and she feels so inadequate in this respect. In stressful situations among the Swedish staff, she says, shouting results is exactly the opposite reaction from what one wants to obtain – instead of moving faster, people get paralysed, try to move out of the way or just “disappear” somewhere.

### “Swedish” Class and Gender Trouble

Lech and Magdalena ponder on the peculiarities of the expected professional performance: the calm and polite style of communication stipulated on some “course”, the emotional control, the political correctness. They may be interpreted as markers of a social stratum; not performing them rightly may be de-classing (cf. Wolanik Boström & Öhlander 2011a, 2011b, 2012b, forthcoming). Other symbolic markers that many interviewees had been used to in Poland or England, for example the elegant dress style, become superfluous in Sweden.

Bogdan talks about his first encounter with the head of the clinic where he and another male Polish doctor just got employed:

Bogdan: A standard for us, it was a newly ironed shirt and jacket and tie. But when we both came to Sweden, we received our doctors' coats, which were just roughly mangled by the laundry. [...] And when the clinic's boss met me for the first time, he wore a creased working T-shirt with COUNTY COUNCIL printed on it, totally creased, and over it a doctor's coat with rolled-up sleeves. I thought: "What kind of boss is this?"

After some months, Bogdan got used to dressing practically and comfortably and "gave up" his jacket and tie. But his male Polish colleague "kept up the fight" as long as he worked in the clinic; he had a whole collection of conspicuous ties and elegant jackets and stood his ground. In the end, it was actually appreciated by both the staff and the patients, as "he looked like a doctor from mass media". In this story, class and masculinity seem to be negotiable to some degree if one resembles a doctor from a television series (cf. Wolanik Boström 2014).

The performance of gender in the professional role is an aspect that genuinely seems to intrigue the doctors. Several interviewees dwell on the Swedish doctor's role as resolutely gender-neutral, and again, the evaluations of this statement may vary considerably. Antoni says that relations between men and women are flattened. The ideal of equality – which he approves of – tends to be interpreted as striving towards uniformity in male and female physicians' behaviour and conduct. The norm does not admit any difference, which shows in everything from the unisex uniforms to the rules for treating patients. Antoni works in a part of town where there are many migrants; once a female patient insisted on seeing a female doctor, for "religious reasons". Antoni asked a Swedish colleague to take on the patient, but she absolutely refused, as "the team has previously decided that there is no support in religion for such a claim". Antoni still ponders on it, he understands the policy, but on the other hand, if the colleague had some spare time, she could take the trouble to fulfil the patient's wish.

Antoni: Her reaction surprised me, I sensed – maybe it was exaggerated – a kind of equality [thinking], that we are all equal. And we are equal, but we are not identical.

Edyta also mentions the physicians' way of not marking gender, but she is absolutely delighted by it. When she was a young physician in Poland, she was expected to "massage the male doctors' egos", to admire their work and to be "sweet", if she was to be allowed to do the more challenging medical stuff. In England she was told that if a doctor is really good then gender is of no importance. But Sweden is absolutely superior in this respect.

Edyta: I was shocked [in the Swedish clinic] that the colleagues of my age did not treat me as a woman, they just didn't seem to see my gender. In every other place [in Poland, England], when I was talking to a man inside or outside the workplace, gender was important for how we treated each other. And here I noticed that they talked to me in the same way that they talked to each other, they didn't differentiate. And it was so great: so it is really possible, they talk to me as to a human being!

For Eliza, the phenomenon of not marking gender led to "an identity crisis". In Poland, she was expected to dress elegantly at work, wearing well-composed outfits under the open doctor's coat, and a discreet but sophisticated make-up. Receiving compliments from the male colleagues was a usual and very welcome part of the social life at the hospital. Elegance in style was part of a doctor's "image", a mark of professionalism for both male and female doctors. Then she came to work in the north of Sweden and her style suddenly felt "totally different", on the verge of vulgar. The female colleagues were much more laid-back, with a minimum of make-up and a preference for practical, no-nonsense clothes and boots in the colder climate. Nobody expected any compliments at work for their fine looks.

Eliza: You know, what shocked me in the beginning [in Sweden] – that I lost my female identity at work! [...] Nobody here expected me to be a woman but only a doctor, and the less of a woman and the more of a doctor, the better [laughs]! And those unisex uniforms, the same for men and women... if you are a nurse you may have a skirt, if you are a doctor you may not. [...] These are trifle nuances and details, but they do matter for how you see yourself.

At first, she thought that women did not look like women – but that has changed with time, and nowadays she appreciates “the natural beauty that the Swedish women represent”. Eliza ponders whether her experience of one town in northern Sweden applies to the whole of Sweden, and says, “by the way, it is surely different in Stockholm, where you pay very much attention to image, while this is a university town and you may well be a little casual, it is a different culture.” Even so, Eliza herself never comes to work in baggy leisure clothes, even though she has changed her style to much more discreet and less colourful.

Eliza: But I do put on make-up every morning and I select my clothes, maybe it is a need to keep an inner personality, which I don't want to give up. I can modify it so it is not striking and I can better fit into the environment, but I have not given up yet and I don't know if I ever will.

In the examples above, the mobile doctors talk about the pressure of implicit expectations on how to perform as a (male or female) professional, signalling both gender and the right social stratum (e.g., a “natural” femininity, a “relaxed” masculinity). It is done by means of clothes, gestures, the tone of voice, expressed interests etc. (cf. Wolanik Boström & Öhlander 2011b, forthcoming; Wolanik Boström 2014). While Antoni's claim that “we are equal, but not identical” has a more essentialist understanding of gender, Edyta's, Eliza's and Bogdan's messages seem closer to the notion of performativity (cf. Butler 1990): one becomes a subject by “doing” class and

gender in specific, culturally approved ways. In a new setting, one may have to use the pragmatic ethnographic sensibility in order to comprehend what is recognized as the right and appropriate way here; if one chooses to adjust to the new demands it may, in the long run, have palpable identity effects.

## Part 2. The Characteristics of Mobile Everyday Ethnography

So far, we have presented some cultural characteristics that the doctors found worth mentioning. The doctors talk about the over-organized Swedish health care, about being expected to control emotions, about differences in performing gender and class, and about the difficulty in detecting hierarchies. They often focus on those aspects of professional life that they have found different from the taken-for-granted reality, and thus remarkable. An overarching strand is cultural friction: the otherwise highly competent professional subject oversteps subtle, implicit norms and experiences misunderstandings which may derive from the realm of the cultural.

The interviewed doctors explain how, in pursuit of social know-how in a new place, they observe daily routines and details of behaviour in order to deduce broader tendencies, patterns, norms and values. They describe Swedish health care and living in Sweden in *both* emic and etic terms, placing themselves in a kind of “in-between position” (cf. Farahani 2011; Harris 2014). Not quite insiders, as far as the work organization, cultural norms or professional requirements are concerned. Not quite outsiders, as they have a lot of cultural competence and the cultural frictions may be narrated as rather marginal and amusing. In every setting, however, they consistently portray themselves as competent and successful insiders as far as the medical knowledge is concerned.

As mentioned in the introduction, our main analytical interest is to explore the characteristics and epistemological conditions of the doctors' ethnography-like descriptions in relation to the way cultural researchers do ethnography. In the introduction we proposed that two aspects of this knowledge-making might be seen as especially important for un-

derstanding the characteristics of mobile everyday ethnography. The first is the fact that the doctors' mobile ethnography is mostly done in the realm of *everyday life*. They discover the need for a certain kind of cultural knowledge to perform successfully as a physician and a social being, and this kind of pragmatic usefulness influences what they observe. The observations are hardly systematic (in the sense of cultural research) and the doctors do not distinguish between observation and introspection. The second aspect concerns the doctors' ways of understanding and talking about *culture*. Different models of culture inspire different ways of observing and describing a particular setting. In the following we will consider these aspects in more detail to better understand the characteristics of how mobile everyday ethnography is done.

### *Mobile Ethnography as Everyday Knowledge*

In contemporary discussions on ethnographic research, there is the challenging issue of whether, or in what ways, professional ethnographers have any intellectual privilege in describing social reality (cf. Hammersley & Atkinson 2007; Denzin 1997; Hannerz 1998; Atkinson et al. 2007). We have experienced this kind of epistemic dilemma here. The physicians, like most highly skilled informants, are eloquent, reflective and used to expressing their opinions with authority; we feel a great respect and admiration for the epistemological potential of the stories. However, in our work with the interviews we also recognize discrepancies between the everyday ethnographers' and the professional ethnographers' interests, techniques and responsibility towards a wider audience. As the adjectives "mobile", "everyday" or "pragmatic" imply, the doctors' ethnographic sensibility is situated in the demands of movement, change and occupational practice, rather than in theoretical issues and methodological considerations. They may find themselves in an unexpected, socially bewildering situation and then pragmatically use the ethnographic toolkit to make sense of it. Our aim is definitely not to conclude which kind of knowledge might be "better"; we just want to point out that there are different kinds of purposes and

knowledge-making. In order to use the accounts as data, we have to analyse how and why mobile everyday ethnography is created and communicated.

The interviewed doctors' accounts of discrepancies between organizing health care in different countries and about specific work subcultures may be analysed as a way of narrating everyday knowledge (cf. Schütz 1975; Berger & Luckmann 1967). The world of everyday life is both the scene upon which the individual acts and the object for actions. It is on this scene the doctors perform professionalism, as well as class and gender. Everyday life contains a whole range of activities that have to be managed. Attending meetings, discussing a diagnosis with colleagues, explaining a complex issue to a patient, informing the relatives, cooperating with other doctors and nurses, following the routines and procedures of a specific organization – all this everyday experience may be found to run more or less smoothly and taken for granted. Even if the doctors no longer feel quite at home in any location, they certainly want to feel at home in their profession. To get around in the everyday life of a specific workplace, they need to accumulate a useful stock of everyday knowledge about the work routines, the norms for social interaction, accepted ways of expressing authority and interpreting others' behaviour.

Usually, everyday life is a world that is taken for granted. Schütz (1975: 81) states that culture "eliminates troublesome inquiries by offering ready-made directions for use"; he calls this "thinking as usual". Thinking as usual means being oriented, doing as one always has done. In the terminology elaborated by Sara Ahmed (2006), when everyday life is well known and it is possible to act and think as usual, the doctors are oriented, they are "in line", walking the culturally accepted path many persons walked before them. Transnational mobility and being a Polish doctor working in Sweden means new routines and ways of organizing work as well as encountering new cultural traits that cannot be taken for granted, and maybe not easily adapted to thinking as usual. In Ahmed's terminology this is being "out of line". Being out of line means being disoriented, feeling uncomfortable and not at home. The interviewed doc-

tors are, it has to be stressed, never completely out of line (cf. Harris 2014). Their professional skills give them status and they are able to successfully perform medicine, which keeps them in line. They just have to make temporary stops to have a look at the map, find the direction, the path they are supposed to walk. Observing the everyday life of Swedish health care and interpreting what they experience, the doctors make sure they stay in line, learn the cultural ropes of Swedish health care and how to perform in culturally acceptable ways.

Mobile everyday ethnography may be a vital skill, helping to gain knowledge and to make oneself at home – or, at least, what we label “culturally passable” (which does not necessarily mean adapting; it may be marking a difference in culturally accepted ways). Unlike a tourist, who might either embrace or reject the unfamiliar, a working physician has to recognize and relate to the upcoming cultural frictions. The daily medical responsibility seems to spur the need to understand the cultural know-how, and thus induces the use of what resembles “ethnographic” methods. The doctors seem to approach the cultural challenges with a pragmatic ethnographic sensibility as a discreet, everyday practice. For instance, using observation as a tool may give an indication of the cultural competence required in a particular situation, thus avoiding cultural frictions and protecting professional pride. Informal conversations are important to gain all kinds of knowledge. The doctors’ data collection is made for private use and hardly systematic, rather conjured up by particular everyday demands. A mobile ethnographer directs his or her attention towards the aspects that affect his or her daily work and social position in the organization and society.

The doctors often attribute features of their experience to the whole Swedish health-care system, or indeed the whole country, rather than to the particular establishment. This is common for how everyday knowledge works, generalizing out of particular examples. But there is also an interesting variation in how these mobile ethnographies depict cultural reality, from rather generalizing and static descriptions to ones unfolding processes, nuances,

paradoxes, inconsistencies etc. This brings us to our next aspect of mobile ethnographies: the notion of culture.

### *Mobile Ethnography and the Notion of Culture*

In order to make sense of a new setting, the doctors extricate “cultures” and “mentalities” and present their own cultural analyses of norms, values, practices and ways of life. They also relate their findings to other “cultures” they have experienced. A discussion about the characteristics of mobile everyday ethnography should thus take into consideration how the idea of “culture” is used in everyday life and in academic research on culture. Without going into detail about the many possible uses of the concept, we want to signal the need to pay attention to *different* ways of “talking culture”. The doctors’ understanding of the term is not always clear-cut and may diverge even within a single interview.

The narratives often use generalizations about cultures. It may begin by stating a seemingly objective fact (“this is typically Swedish”) and evolving towards personal reflections (“and it has affected me this way”), or the other way around (“I experienced this, and it says something important about Swedish culture in general”). Generalizations also lie at the very heart of stories about cultural frictions, for example confusions or conflicts based on not knowing the norms, discovering that embodied dispositions are not those ideally ascribed to the doctor’s role in Sweden etc.

The doctors’ talk about “cultures” is mostly located in the domain of a conventional, popular notion of culture as a kind of container. Narrating culture as a container is a well-established genre, a predominant way to represent settings and people, for example in the mass media (popular books, movies, magazines etc.) or political discourse (e.g., when politicians and health-care workers speak about “immigrant patients”, Öhlander 2004). Also discussing organizations in terms of “cultures” is a common phenomenon, stemming from the huge impact made by the theory of organizational culture and intercultural relations. As John Weeks (2004) reminds us, it is usually expected of the people in an

organization to have an opinion about their culture, and there may also be shared sentiments about what constitutes a valid and appropriate critique of this culture. A side effect of introducing the concept in organizational theory has been that the firm's "culture" becomes yet another issue which the lay ethnographers could have opinions upon and complain about (also Dahlén 1997). Osland and Bird (2000) criticize the fact that much of cross-cultural management training and research still occurs within the framework of bipolar cultural dimensions, neglecting the culture's complexity, paradoxes and the context in which the culture is embedded.

In the history of academic studies of culture, for example in anthropology and European ethnology, a bound and static notion of culture could be found, until the wave of criticism in the 1980s and 1990s shook the very foundation of cultural research and caused a crisis in the concept of culture. Although cultural researchers analytically use the concept in various ways, they all in some respect have to consider and deal with the criticism from the standpoints of methodology or post-modernism (e.g., Clifford & Marcus 1987; Clifford 1988; Hannerz 1992) and from studies on post-colonialism, racism and the politics of diversity (e.g., Bhabha 2001; Gilroy 1993; Stolcke 1995; Ålund & Schierup 1991; also Brumann 1999; Öhlander 2005). It goes without saying that mobile everyday ethnography has a looser relation to the discussions within the field of cultural research. The academic acid test that the concept of culture has gone through is barely noticeable in our material.

As we showed in our examples, the physicians reflect upon situations, actions and environments and draw broader conclusions about cultural traits of nations and organizations. When they use the popular, common ways of "talking culture", the (sub-)culture is depicted as a well-demarcated and homogeneous entity, encompassing certain values, norms and behaviours. The aspects of change, complexity and contradictions – usually included in a contemporary "anthropological" understanding of culture – are seldom elaborated. A nation, an organization, a group or a place may be portrayed as a kind of con-

tainer for a specific set of norms, ideals, values, behaviours and lifestyles (cf. Wolanik Boström & Öhlander 2011b, 2012a, 2012b, forthcoming). The focus is on differences *between* (sub)cultures in Sweden, England, USA etc., not on complexity and inconsistencies *within* a culture.

But the doctors may also challenge stereotypes and generalizations. They portray changes in Poland and Sweden, cultural processes, dislocations, ambivalent belongings and hybridization. In those accounts, the understanding of culture seems closer to the theories of culture in academic research. Several interviewees mention the economic and cultural change in Poland and say that the work conditions and occupational practices that they had experienced have been substantially transformed during the last decade. They point out that they may be making unfair generalizations, as their knowledge of Polish medical care is slightly outdated. Or they may emphasize that differences within a country, for example between the countryside and bigger cities, might be of greater significance than that between countries. And they reflect on how their own cultural predispositions change, sometimes surreptitiously, sometimes more obviously (as in dress code) in the process of mobility.

In ethnographic research, some profound features of a culture may be condensed in "thick description" (Geertz 1973), but the doctors' accounts remind us rather of ethnographic outlines with broad brushstrokes, or impressionistic sketches. Some of the generalizations may seem rather expansive, but the doctors' primary goal is, after all, to acquire the cultural toolkit for moving smoothly in a new setting. In such a case, generalizations and simplifications are often much more practical than the meticulous outlining of cultural complexities and variations, which is usually the professional ethnographers' enterprise.

To conclude, there are different ways to articulate culture within mobile everyday ethnography, from rather broad generalizations about places and cultures, clearly from an outsider's perspective, towards what we regard as more nuanced and reflexive descriptions from the perspective of the (semi-)insid-

er. In other words, the material is not univocal, but rather characterized by complexity and paradoxes. Our undertaking as researchers must be to reflect on the different notions of culture that are in use and upon the epistemological conditions of the descriptions.

### Concluding Remarks

The main characteristic of mobile everyday ethnography that we discuss here is that it is primarily told as oral narratives, aimed mostly at friends, family and the like-minded, while professional ethnography is usually written and destined for a wider public. The doctors try to comprehend both the official policies and procedures and what is unspoken; they present many inspiring reflections, but they do not make any claims to be cultural researchers trying to depict complexity. Their interest lies rather in questions like: “What should I know about this place, the norms, values and habits, in order to function as a professional and as a social being?” It might mean learning about the “Swedish way” of being a doctor (e.g., controlling temper, working in non-hierarchical teams, wearing non-gendered working-clothes). That is the main reason why we call it a *pragmatic* ethnographic sensibility, subjecting the deceptive power of the taken-for-granted and experiences of “frictions” to a cultural analysis, in order to achieve a level of cultural proficiency.

There are differences in the purpose of the mobile physicians’ everyday ethnography and that of professional ethnographers. Our audience is different and our understanding of “culture” may diverge. Still, much can be learned from the mobile physicians’ “ethnographic” accounts. Mobility may have been a challenge in many ways, but has given the doctors a first-hand experience of several settings in all their intricacy. They are familiar with the special medical jargon, they know a lot about policies and how these policies are turned into everyday practice. Thanks to the relative estrangement of mobility, they have become attuned to the cultural particularities of different working environments. Their exploration is based on prolonged participant observation, conversations with colleagues and friends, written ma-

terials such as organizational texts, susceptibility to moods and glances and the myriads of details that may be important.

In professional ethnography, the ideal is that the data collection should be systematic and theoretically informed. But in spite of the often ad hoc approach the doctors’ accounts still form an impressive range of data, just as the ethnographical textbooks would recommend. We just have to bear in mind that the focal point of the physicians’ everyday ethnographies is their own (professional) self, their achievements, insights and tribulations. Observations and conversations are not only a researcher’s tools; they are always a part of everyday existence and social life. On the other hand, even if the purpose of the doctors’ “data collection” is definitely more practical than theoretical, the accounts may be an important source of insight into organizations and the realm of the social life. Their – ever so pragmatic – interest may lead to wider issues of prevailing ways of thinking, and may touch upon existential questions of belonging, identity or medical ethos.

Holmes and Marcus (2005, 2008) point out that the practices of ethnography have been assimilated as key intellectual modalities of our time. In a possible site, the researcher often meets a pre-existing ethnographic consciousness or curiosity (“para-ethnography”) and latter-day “key informants” may rather be treated as epistemic partners. The subjects within an epistemic community are “fully capable of doing superb ethnography in their own idioms” (Holmes & Marcus 2008: 84). John Weeks (2004, 2006) who in his study of the culture of complaint in a British bank reflects upon “lay ethnography”, is more cautious and points towards the identity of its intended audience. Lay ethnographies are descriptions of culture created by and for insiders, that is the people of the particular culture. Non-lay (or ordained) ethnographies have an audience that includes people outside the culture being described. Lay ethnography is an attempt by one culture to make sense of itself, using an emic language game, as well as unspoken assumptions – while ordained ethnography deconstructs lay ethnography and other data in an attempt to make one culture intelligible to

another (Weeks 2006: 15ff., cf. Van Maanen 1988). Weeks' conclusion is that "lay ethnography" should be treated as data to be interpreted.

The terms "lay ethnography" and "para-ethnography" are undeniably closely related to our study, especially the kind of lay ethnography presented by marginal members of a cultural context, simultaneously embracing it and opposing it. We chose the term "mobile everyday ethnography" to suggest that mobility seems to enhance a slightly different ethnographic predisposition from the "lay ethnography", told among and aimed at the people of the culture. The doctors are both semi-outsiders and semi-insiders, trying pragmatically to make sense of the occupational and national cultures they encounter, but not quite (or no longer) embracing the dominant cultural traits of any site and bearing in mind that things may be – and indeed are – different in other places. Mobile everyday ethnography becomes a kind of a splendid toolkit in this sense-making. The doctors need it for their own pragmatic reasons but they also may share their insights with colleagues, friends, family and researchers. The accounts are very engaging and enlightening, even if our standpoint is that they must be used with some caution by a researcher who has a scientific, ethical and political responsibility to a broader audience. We hope that by analysing and contextualizing several mobile everyday ethnographies, presenting a range of experiences and evaluations, we may still arrive at the nuances and complexities, as well as cover broader tendencies of occupational cultures.

## Notes

- 1 We would like to express our gratitude to Professor Billy Ehn, Umeå University, Sweden, Dr. Simone Abram, Leeds Met, UK, and the anonymous reviewers of *Ethnologia Europaea* for their comments on earlier versions of this text.
- 2 We use the terms "physician" and "doctor" interchangeably.
- 3 Though the interviewed physicians now live in Sweden with their families, we prefer the term "mobile" to "migrants", as the latter has connotations of moving to one final destiny, or reaching a desired end point. Many of the doctors we interviewed had worked not only in Poland and Sweden but also in the UK, the USA, Israel,

France or Norway. Even those who had been working in Sweden for many years expressed the possibility of further movement (to another town, country, or "back" to Poland).

- 4 An increase from 248 persons in 1996 to 705 in 2011. Of all doctors that worked in Swedish health care during 2011, 24% (including Swedish-born persons) had been educated abroad (Socialstyrelsen 2014).
- 5 The doctors' motives for working abroad as well as for choosing Sweden varied, as did their preparations. Some attended a 5-months' intensive language course (which included information about medical care, the Swedish society's organization and customs as celebrating Midsummer's Eve or Christmas). Other doctors came to Sweden speaking only English and learned Swedish in the course of their work.

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