Between Benefit and Risk: Constructions of Skill and Competency of Internationally Educated Nurses in Sweden

NJMR NORDIC JOURNAL OF MIGRATION RESEARCH

RESEARCH

HUP HELSINKI UNIVERSITY PRESS

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ABSTRACT

Highly skilled migrants in Sweden are at risk of exclusion from professions commensurate with their qualifications, particularly in regulated fields like nursing. In response, national policies and programmes have been introduced to facilitate the recognition of foreign qualifications and support the integration of skilled migrants. This paper explores how the competencies of internationally educated nurses (IENs) are constructed within bridging programmes, where professional regulators function as gatekeepers to professional re-entry. Drawing on the concept of a 'regime of skill', the study employs a qualitative approach to examine how university educators, administrators and supervisors in clinical training define and evaluate migrant competencies and how such constructions may enable or constrain the professional inclusion of IENs in the Swedish health care system. The analysis identifies two dominant constructions of skill and competency: IENs as an untapped resource and IENs as linguistically and professionally deficient. Both constructions position IENs as 'others', contrasting them with Swedish-trained nurses and reinforcing boundaries around professional belonging, albeit not exclusively through exclusionary practices. This paper argues for the importance of examining sector-specific skill regimes to better understand migrant inclusion or exclusion into the labour market.

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KEYWORDS:
Highly skilled migrants, re-certification process, internationally educated nurses, regime of skill, competency

TO CITE THIS ARTICLE:
Marekovic AS. Between Benefit and Risk: Constructions of Skill and Competency of Internationally Educated Nurses in Sweden. *Nordic Journal of Migration Research*. 2026; 16(3): 2, 1–18. DOI: https://doi.org/10.33134/njmr.1042

INTRODUCTION

The increase in immigration to many European countries during the mid-2010s, including Sweden, has placed labour market integration high on the agenda. Nonetheless, research has reported poor labour market outcomes for many migrants and particular concerns regarding the integration of highly educated immigrants into professions commensurate with their education and skills (Irastorza & Bevelander 2017; van Riemsdijk & Axelsson 2021). This phenomenon has been addressed in international research in terms of 'brain waste' or 'brain abuse' (Bauder 2003), implying skill wastage and institutional barriers to using highly skilled migrants' competencies (Liu-Farrer, Yeoh & Baas 2021). This indicates that migrants' mobility is shaped not only by individual human capital but also by national systems of professional regulation (Ozkan 2018). Research further shows that highly skilled migrants often have strong ambitions to resume their disrupted careers (Eliasson, Teräs & Osman 2022; Mozetič 2021) yet encounter structural, cultural and institutional obstacles to re-entering their professions (Bygnes 2021).

To facilitate labour market integration, many countries have introduced policies to improve recognition of foreign qualifications (Andersson 2021; Ozkan 2018; Shan & Fejes 2015). In Sweden, examples include 'fast-track programmes' for shortage professions (Ennerberg 2022) and bridging programmes in higher education for graduates with foreign qualifications (Andersson 2021; Bengtsson & Viberg 2019). Foreign qualification recognition (FQR) programmes have been acknowledged both as key to integrating highly skilled immigrants into jobs matching their education and competency level (Joyce 2015; 2019) and as potential barriers (Andersson & Guo 2009; Bauder 2003). Exclusion is particularly evident in regulated professions such as medicine, nursing and teaching, where increasingly complex assessment systems filter entry (Walton-Roberts 2021). Although often presented as objective, FQR is neither neutral nor unchanging but shaped by professional and regulatory authorities who determine which skills are valued in the labour market (Nowicka 2014; Shan & Fejes 2015). Accordingly, I approach migrants' skills and competencies as socially and contextually constructed (Liu-Farrer, Yeoh & Baas 2021: 2240) subject to negotiation, (mis)recognition and evaluation by political and professional actors. This implies that professional skills are not 'fixed attributes' (Nowicka 2014: 171) but are valued differently across political, professional and historical contexts (Shan & Fejes 2015; Walton-Roberts 2021). Liu-Farrer, Yeoh and Baas (2021) argue that this framework prompts a deconstruction of the constructive process of skill in cross-border labour migration by focussing on the central actors involved in the interpretation and evaluation of migrants' skills and the outcomes of this process, i.e. who decides what constitutes skill in different social contexts.

In this paper, the FQR process for internationally educated nurses (IENs) in Sweden, specifically through bridging programmes, serves as an empirical case to explore how professional regulators construct skill and competency in relation to IENs. Additionally, the analysis explores in relation to 'whom' the competency of IENs is constructed and evaluated. The study uses qualitative interviews with professional regulators involved in bridging programmes for IENs, i.e. university educators, administrative personnel and supervisors in clinical training, to shed light on the re-certification process and the relational construction of skills. These actors serve as 'gatekeepers' for IENs' re-entry into the nursing profession and are, therefore, central to understanding how the regime of skill produces differential opportunities for migrants (Shan & Fejes 2015). Building

on this concept, the study contributes a sector-specific analysis of how professional regulators relationally construct skill and competency in the re-certification of IENs, thereby shaping professional inclusion and exclusion. In the next section, I review central literature on nurse migration and processes of professional re-entry and introduce the Swedish FQR process for IENs. I then outline the theoretical framework and detail the methods and data. In the findings section, I present different relational constructions of skill and competency and how these function as processes of othering for IENs. I conclude by discussing the main findings and how they may be understood as potential barriers or facilitators for the professional inclusion of IENs in Sweden.

NURSE MIGRATION AND PROFESSIONAL RE-ENTRY OF IENs

Nursing has been described as a 'portable profession' (Kingma 2005: 2) where some nations are 'receivers' and others act as 'exporters' of nurses. These migration movements typically occur from the South to the North and from the East to the West, involving both voluntary and involuntary migrants (Newton, Pillay & Higginbottom 2012; Yeates 2009). To address growing health care demands, many OECD countries actively recruit IENs through campaigns or bilateral agreements (Walton Roberts 2021). Sweden, however, has relied on spontaneous migration via family, labour or refugee pathways (Jansson 2017), which may explain its relatively small share of IENs. Although numbers increased between 2011/12 and 2017/18, foreign-trained nurses still constitute only about 3% of the workforce – well below the OECD average of 7% (Socha-Dietrich & Dumont 2021). Comprehensive data on the international migration of nurses to Sweden are limited, but a recent study shows that, between 2012 and 2022, 830 IENs obtained Swedish licensure through re-certification, with most originating from Asia and the Middle East (Hadziabdic et al. 2025).

These movements have been conceptualised as *global nursing care chains*, highlighting both labour demand in high-income countries and the role of state institutions, private actors and professional bodies in regulating migration (Yeates 2009). FQR programmes, which assess migrants' education and competencies against host-country requirements, exemplify such regulation (Andersson 2021; Ozkan 2018). Still, professional re-entry is often difficult. Studies identify barriers including lengthy recognition procedures, financial costs, language requirements and discrimination (Choi, Cook & Brunton 2019; Vaughn, Seeberg & Gotehus 2020). These barriers may result in deskilling, with migrant nurses working in lower-skilled positions such as assistant nurse roles (Korzeniewska & Erdal 2021; Newton, Pillay & Higginbottom 2012). Combined with labour shortages in elderly care, this has contributed to migrant concentration in lower-status care positions (Tingvold & Fagertun 2020). Recent studies also point to the ambivalent positioning of migrant nurses and care workers: although valued as essential labour, these individuals are simultaneously marginalised through exclusionary practices (Christiansen, Kristjánsdóttir & Skaptadóttir 2025; Spiliopoulos & Timmons 2023). Migrant care workers are perceived as solutions to labour shortages and framed as hardworking and naturally caring, while at the same time being juxtaposed with native workers, thereby positioning them as 'others' (Torres & Lindblom 2020). Similarly, Ågotnes and Storm (2022) argue that othering occurs through processes of classification in which migrant care workers are perceived as a homogeneous group, contrasted with an equally homogeneous group of native workers. Although migrant workers are attributed mainly positive traits, such as being empathetic, caring and respectful, these representations nonetheless function to reinforce inequalities within health care, as native workers are characterised as more 'professional'.

Nonetheless, bridging programmes have been shown to facilitate professional re-entry by providing academic support and enhancing familiarity with the professional norms and expectations in the host country (Covell, Primeau & St-Pierre 2018; Hadziabdic et al. 2021). However, research rarely examines the perspectives of educators, who play key roles in supporting and assessing IENs and regulating access to the profession (Connelly et al. 2023; Juntunen et al. 2024). A growing body of literature has examined clinical supervisors' experiences with IENs, often emphasising perceived challenges such as limited language proficiency, differing cultural norms and varying competency levels (Eriksson et al. 2023; Hari et al. 2021; Strøm et al. 2023). Such studies often frame difficulties primarily in terms of deficiencies attributed to IENs. In a similar vein, a recent Swedish study positions university teachers as central actors in the re-certification process, highlighting the organisational constraints of bridging programmes, including scarce resources and time pressure (Marekovic et al. 2025). However, none of these studies problematise the dominant perceptions of IENs as deficient, nor do they examine how such understandings relate to opportunities and obstacles in IENs' professional re-entry. There is thus a need for studies that critically examine the hierarchical relations embedded in evaluations of skills and competencies and that identify exclusionary as well as inclusionary practices within health care.

The Re-certification Process for IENs

In Sweden, the Swedish Board of Health and Welfare (SBHW) regulates access to the nursing profession and issues licenses. The FQR process for foreign-trained nurses varies by region. EU/EEA applicants must have their qualifications validated by the SBHW and demonstrate proficiency in a Scandinavian language to obtain a Swedish nursing licence, what Andersson (2021) terms the recognition of *formal* competence, i.e. validation of foreign higher education credentials. Nurses educated outside the EU/EEA must also undergo initial credential validation by the SBHW and then follow one of two specific pathways to obtain licensure – either independently or through a bridging programme. Both pathways involve assessments of formal and *actual* competence – that is, what individuals know and are able to do (Andersson 2021).

The first pathway is a fully independent process, in which the IEN prepares for and completes theoretical and practical examinations administered by the SBHW. These assess whether the applicant's knowledge and skills meet national requirements. The process also includes a course in Swedish health care laws, and the applicant must independently find a place to undergo a 3-month-long clinical training, where their competence is evaluated by a supervisor. Finally, applicants must demonstrate Swedish language proficiency before applying for licensure (Högstedt 2024). IENs who follow this pathway often migrate primarily for work-related reasons (Hadziabdic et al. 2025).

The second pathway, which is the focus of this study, is additional training through a university-based bridging programme. While supplementary training for IENs has existed since the late 1990s, bridging programmes were first introduced in 2009 at two universities and expanded to three more in 2018 (Högstedt 2024; Marekovic et al. 2025). Admission requires proof of Swedish language proficiency at level C1, indicating advanced competence (Council of Europe 2020). The programme comprises 1 year of full-time studies (60 credits), combining theoretical courses on topics such as the nursing profession, nursing science, pharmacology, pharmaceutical calculation and leadership. It also includes clinical training across diverse health care settings and medical specialties. Although structures vary across

institutions, theoretical and clinical components are generally balanced (Marekovic et al. 2025). At the end of the programme, participants must pass a knowledge test covering both theoretical and clinical skills before applying for licensure from the SBHW (Hadziabdic et al. 2021). Hadziabdic et al. (2025) show that bridging programme participants have primarily migrated for family reunification or asylum, tend to be older at the time of obtaining their licensure and have resided in Sweden longer than those who choose the independent pathway.

THEORETICAL FRAMEWORK

In this study, I focus on how professional regulators involved in bridging programmes construct skill and competency in the re-certification process of IENs in Sweden. More broadly, skill and competency are widely used in migration research, yet there is no consensus on their precise meanings, and the terms are often treated as interchangeable (Nowicka 2014). Skill is commonly associated with measurable attributes linked to human capital, often expressed through policy categories such as 'high-skilled' versus 'low-skilled' migrants. Competency, by contrast, is often understood more broadly as encompassing both theoretical knowledge and the capacity to perform particular tasks (Andersson 2021). Yet, as Shan and Fejes (2015) argue, both concepts are used by policymakers and practitioners to construct the employability and desirability of migrant workers. These constructions are part and parcel of what they conceptualise as 'a regime of skill', defined as a:

> mode of control and modulation that defines the desirability of individuals in the labour market [and,] rather than providing a fixed set of reference points, the regime of skills is rather a shifting ground that affords opportunities to some while closing the doors to others (2015: 227).

Building on this definition, I view the regime of skill as a dynamic system that both constrains and enables the recognition of migrants' competencies, often simultaneously, thereby shaping their opportunities for professional re-entry in multiple ways. Shan and Fejes (2015) argue that what constitutes skill and competency is actively shaped by the interplay of social, cultural and economic relations, producing floating discourses that 'serve as emerging yet shifting social stratifiers, perpetuating hierarchical social order by constantly redefining the desirability and acceptability of workers in the context of globalization and immigration' (2015: 231). In line with this, the regime of skill can be understood as encompassing a range of institutions, such as immigration policies, labour market relations and systems of credential recognition, through which notions of skill and competency are framed and regulated. Drawing on this perspective, I argue that sector-specific research provides an understanding of how professional regulators shape the expression and codification of necessary skills and competencies for specific occupations, thereby contributing to the reproduction and transformation of the regime of skill (Walton-Roberts 2021). These constructions may serve to facilitate or hinder the professional re-entry of highly skilled migrants. The regime of skill should thus be understood as a dynamic field of both constraint and opportunity, rather than a predetermined mechanism of exclusion. Within this terrain, different actors negotiate and construct what comes to be recognised as skill and competency (Liu-Farrer, Yeoh & Baas 2021). Therefore, an analysis of the construction of skill in relation to the re-certification of IENs in Sweden contributes to a deeper understanding of processes of inclusion as well as the exclusion of migrants in a particular professional field.

Grounded in scholarship that conceptualises migrants' skills and competencies as socially and contextually constructed (Liu-Farrer, Yeoh & Baas 2021; Nowicka 2014; Walton-Roberts 2021), I specifically draw on Shan and Fejes' (2015) emphasis on the relational character of such constructions. From this perspective, constructions of skill are neither neutral nor static but produced within historically and contextually situated relations of power. Empirical research demonstrates how these constructions vary over time and across institutional settings. For example, Peppler's (2018) historical study of Turkish immigrant physicians in Germany shows how their qualifications were recognised differently over time and how the same professionals could be excluded or included depending on political and professional negotiations and assessments of labour market needs. In this analysis, I suggest that these relational constructions can be analysed as processes of othering. Othering refers to the process whereby a dominant group constructs or defines an inferior group (Fine 1994) in relation to what is considered the 'norm'. The origin of the concept of othering can be traced back to Simone de Beauvoir and the othering of women or to the writings of post-colonial theorists like Edward Saïd who have used it in relation to primarily ethnic minorities (Conti 2018; Jensen 2011). The commonalities lie in the process of categorisation of individuals or groups, based on gender, ethnicity etc., according to perceived differences from the societal norm, making difference a key component of the process (Canales 2000). Othering, thus, includes a comparison of persons perceived as 'ordinary' or 'socially acceptable' with those that appear 'different' in some way. Furthermore, these differences are often framed as deficits and function to justify and reproduce inequalities (Canales 2000; Schwalbe et al. 2000). However, othering may also be framed in positive or benevolent terms (Ågotnes & Storm 2022; Rohde-Abuba 2020) yet emphasising difference rather than commonalities between groups. A key issue to explore is how these categories are defined, by whom and with what consequences (Canales 2000; Liu-Farrer et al. 2021). In the analysis, I explore how professional regulators construct skill and competency of IENs and how this can be understood as processes of othering.

METHODS AND DATA

This study is part of a broader research initiative on IENs' re-entry into the nursing profession in Sweden. An initial study examined IENs' experiences of attending a bridging programme and its role in their professional re-integration (Hadziabdic et al. 2021). The second stage (2021–2023) explored stakeholders' experiences of the bridging programme and their assessment of the students' prerequisites and qualifications. The project has been approved by the Swedish Ethical Review Authority (No. 2021-03844).

The selection of research participants for the study was partly based on convenience, as contacts with two bridging programmes had been established during the initial study. Including educators and clinical supervisors ensured participants had repeated experience interacting with IENs, in both academic and clinical contexts. Access was facilitated through gatekeepers at two universities, who provided contact details for potential interviewees. An information letter outlining the study objective, informed consent, anonymity and the right to withdraw from the study at any time was distributed via email. Those contacted either agreed to or declined participation. Informed consent was obtained at the beginning of each interview, verbally for digital interviews and in writing for the in-person interview. Fifteen individual interviews were

conducted, lasting 45–75 min, either face-to-face (n = 1) or via video-conferencing (n = 14) (Zoom Communications, San Jose, CA, USA). Participants included six teachers, a programme director, two clinical placement liaisons and six clinical supervisors. The interviews were semi-structured and covered themes like participants' role in and experiences with the bridging programme, perceptions of the students' competencies and challenges and opportunities for IENs in Swedish health care. Interview guides were adapted to the participants' roles, and open-ended questions invited reflection on their experiences of teaching and interacting with IENs in the bridging programme. Example questions include: 'What needs do the courses/placement address for IENs?' and 'What knowledge, experiences, or competencies do the students bring with them from their previous education or work?' While the questions were not designed to encourage comparisons, such responses emerged frequently. Follow-up questions were used throughout to prompt elaboration and concrete examples.

All interviews were transcribed verbatim and analysed using thematic analysis inspired by Braun and Clarke (2006). This approach aligns well with a constructionist approach, in which meaning is understood as socially and contextually produced. Viewing skill and competency as relational constructs thus aligns well with the thematic analysis. Analysis began with repeated reading and memo-writing before initial codes were generated. In this phase, the number of codes were high, which prompted a reorganisation. In this process, different ways of making sense of and talking about the students' competencies, deficiencies and struggles in the bridging programme were identified as patterns in the coded data. These patterns were organised into two main themes: 'IENs as an untapped resource' and 'IENs as linguistically and professionally deficient'. Furthermore, each theme included one sub-theme, as follows, that details a particular aspect and is subordinate to the main theme (Braun & Clarke 2006): 'cultural complementarity of IENs' highlights how cultural and linguistic competences were constructed as beneficial to Swedish health care, while 'IENs as potential liabilities in Swedish healthcare', identifies risks associated with perceived deficiencies. The themes were not fixed to specific individuals, as interviewees shifted between different constructions in their accounts. The analysis, therefore, focusses on the content of the different relational constructions of IENs' skill and competency within the regime of skill, rather than on differences across individual accounts.

FINDINGS

The analysis identified two primary themes and two sub-themes that relate to the skill and competency of IENs constructed by the professional regulators. In these constructions, the professional regulators consistently compared IENs with either students at the undergraduate nursing programme or with practicing registered nurses, thus emphasising differences between the categories. These two groups – undergraduate students and registered nurses – were explicitly and implicitly presented as the 'norm' or 'ideal professional nurse' that IENs were positioned against. These constructions were not just focussed on problems or obstacles; they also emphasised relevant contributions and values added by IENs' skills.

IENs AS AN UNTAPPED RESOURCE

Professional regulators were aware of the shortage of registered nurses in the Swedish health care and viewed bridging programmes as an effective way to make use of knowledge and skills that have been obtained abroad and to facilitate labour market

integration (Bengtsson & Viberg 2019). These programmes were described as enabling IENs' competencies to align with the Swedish requirements within a relatively short period.

> You can't turn down these students who will be registered nurses in one year. I don't understand it. There are ICU [intensive care unit] nurses with work experience from Syria. I mean, they are not newly graduated nurses (Teacher 1).

As the excerpt illustrates, the regulators described the competencies and experience that IENs bring from their nursing education and practice as a potentially underused resource that could be transferred and adapted to the Swedish health care sector at relatively little cost. The competency of IENs represents a contribution to Swedish health care and is recognised in terms of a 'societal good' (Cruz, Felicilda-Reynaldo & Mazzotta 2017). These narratives present the incorporation of IENs into Swedish health care as a 'win–win scenario' (Rohde-Abuba 2020), in which IENs' skills and competencies can be used to address the shortage of nurses, rather than leaving them to become unproductive members of society: 'I mean, it's insane to have educated individuals who cannot work. Especially when there is such a demand for it' (Programme director).

While acknowledging diversity within the group, the regulators emphasised that many IENs are highly educated and experienced: 'Some have many years of experience and hold specialist qualifications' (Teacher 4). Specifically, IENs' medical, physiological and practical competencies were described as comparable to or stronger than those of Swedish nurses. One clinical supervisor noted that one student 'had more experience than most of us who work here' (Supervisor 2), while another emphasised that IENs 'showed more strength in practical matters like wound dressing, changing a catheter, drawing a blood sample and things like that. Those skills are already in place' (Supervisor 3). These competencies were frequently contrasted with those of undergraduate nursing students, who were perceived as less confident:

> In my experience, these students are extremely strong; they really own their [professional] knowledge compared to the students at the undergraduate program. For them [undergraduates], it is a lot [of] 'I don't know…', and they can hardly answer a direct question. But for these students, it is almost like it is ingrained (Teacher 3).

This quote illustrates how IENs are constructed as competent professionals whose embodied expertise contrasts with that of undergraduate students, who still need time to settle into their professional role. The regulators describe the work experience of IENs, both in relation to having developed a habit of interacting with patients and having had time to internalise medical routines and knowledge, as a strength. IENs' competencies, particularly their medical experience and practical knowledge, are thus constructed in relation to students from the undergraduate programme.

This construction of medical skills and embodied work experience as core competencies of IENs is framed as an untapped resource that should make them desirable on the Swedish labour market and on par with practicing 'Swedish' nurses. IENs' practical competence and know-how are viewed as readily transferable to Swedish health care with minimal cost. This is presented as a strength in comparison to undergraduate

students, who require more introduction and guidance in their professional practice. Here, the norm is represented by undergraduate nursing students, against whom IENs are compared and constructed as capable and suitable for nursing work. In this sense, IENs are not constructed as 'tabula rasa', where their backgrounds and experiences are disregarded within the new context (Sayad 2004), but rather as subjects possessing valuable resources. This narrative aligns with a traditional political framing of immigration, in which it becomes 'meaningful and intelligible [...] only if it is a source of "benefits"' (Sayad 2004: 76). IENs' skills are constructed as valuable precisely because they meet a specific labour market demand – while doing so at a relatively lower cost.

Cultural complementarity of IENs

The medical skills of IENs are constructed as beneficial to Swedish health care, alongside additional competencies regulators considered valuable. One specific 'benefit' attributed to IENs in the narratives of the research participants is their complementary role as cultural and linguistic interpreters who can support or enhance nursing practice in various ways. These competencies are understood to complement those of the assumed 'Swedish' nursing staff by contributing distinct forms of knowledge and experience. One example of this complementarity relates to IENs' language skills.

> One example is that they [IEN students] told us that they, during their clinical training often...for good and bad...had to function as interpreters. We had some students who spoke Arabic as their first language, and there are many patients who speak Arabic. So, they sometimes had to help out and interpret. [...] I mean, it's an incredible asset to have those who know several languages, working in health care. It is fantastic (Teacher 6).

Expressions like this one, which were common in the interviews, acknowledge IENs also as interpreters and facilitators of communication with patients and their families. As illustrated in the excerpt above, IENs are described as possessing language competencies, such as Arabic, which are often lacking amongst the predominantly Swedish-speaking nursing staff. These skills are constructed as valuable complements and aids in patient–nurse interactions (Peppler 2018). Similarly, professional regulators emphasise the increasing cultural diversity amongst patients, positioning IENs as important cultural mediators: 'It's the cultural, the multicultural. I think that is the greatest need they [IENs] fulfil. We need more diversity in health care because that is what the patient base looks like today' (Teacher 5). As the quote suggests, regulators rarely refer to specific cultural traits; rather, they invoke a generalised notion of IENs as culturally different from Swedish nursing staff. As non-Swedish professionals, IENs are constructed as reflecting the diversity of the patient population and contributing linguistic and cultural competencies perceived to be lacking amongst Swedish-trained nurses.

Professional regulators construct cultural and linguistic complementarity in terms of distinct skills IENs possess – skills seen to add value to nursing practice, particularly by facilitating communication with patients and relatives from diverse backgrounds and varying levels of language proficiency. Abilities related to 'personality, attitude and behaviour, rather than to formal or technical knowledge' (Moss & Tilly 1996: 253) are conceptualised as soft skills. In this context, the linguistic and cultural complementarity highlighted by professional regulators is presented as an example

of such skills. While not formally required in the nursing profession, these abilities are constructed as part of IENs' competencies. The capacity of IENs to communicate with non-Swedish-speaking patients in their native languages distinguishes them from the presumed norm of Swedish-trained nurses. The construction of complementarity thus frames IENs' skills as valuable contributions to Swedish health care. However, despite this recognition, IENs are simultaneously described as different from the normative standard. These narratives reflect a form of 'positive othering' (Rohde-Abuba 2020), in which IENs are portrayed as providers of a distinct, yet desirable, form of competence that meets specific health care demands.

IENs AS LINGUISTICALLY AND PROFESSIONALLY DEFICIENT

Alongside constructions of IENs' skills as beneficial to nursing work in Sweden, more prevalent narratives emphasise various *deficits* attributed to IENs. They are frequently described as lacking, or needing to develop, specific competencies – an approach well documented in research on migrants and refugees (Keddie 2012; Nilsson & Bunar 2016). In professional regulators' accounts, IENs are often constructed as deficient in Swedish language skills considered essential for effective communication and professional performance. Although programme applicants must demonstrate basic Swedish proficiency (Högstedt et al. 2021), many regulators assess their language competencies as insufficient, particularly in clinical settings where advanced communicative skills are required.

> I think that they [the supervisors] were wondering a bit, if they [the IENs] really had passed the language exams. Some of them had major language difficulties that hindered them from moving forward (Liaison 1).

This reflects a recurring theme: a perceived mismatch between formal language requirements and actual proficiency (Eriksson et al. 2023). Language deficits are primarily associated with challenges in practical nursing tasks requiring effective communication with patients, their relatives and colleagues as well as administrative responsibilities such as maintaining medical records. IENs are frequently described as falling short of expected communicative standards. The following statement illustrates how language proficiency is constructed as a deficit:

> Language was a challenge. I remember one time I wanted the student to register a patient, just as a test in a medical record. And when I read it after, I just felt like: 'My God, is this supposed to be a Swedish lesson?' You know, if you make mistakes with spacing between [compound] words, the whole meaning can get distorted. [...] I could never let her work independently. Not that I was guarding her, but I watched from the side and noticed that she and the patient talked about two completely different things. They didn't really understand each other, but they thought they were talking about the same thing. The language confusion was too great (Supervisor 3).

The construction of language deficits is closely tied to the communicative demands of nursing practice and the question of how limited proficiency can hinder work. The excerpt highlights these deficits in relation to two core aspects of nursing: maintaining accurate documentation of patients' health and treatments and engaging in effective communication with patients during health assessments. Both tasks are fundamental

to nursing practice, yet they are areas in which IENs are perceived to lack essential competencies.

Moreover, IENs are often described as lacking competencies related to the professional role of registered nurses. According to the regulators, the normative expectation of Swedish nurses includes the ability to make independent clinical judgements and lead a team of colleagues. These qualities were frequently portrayed as absent or underdeveloped in the professional practice of IENs.

> It's the ability to bring the whole together, to put the different parts to one whole. To really tackle the role as a registered nurse and all that it includes, to lead the work. But also…not to say that these students back down, but there have been some issues, that they don't take on the role that is needed but are…passive is perhaps too strong a word…but they don't step up in a way that is needed (Teacher 3).

As the excerpt above illustrates, regulators highlight that IENs face challenges in embodying the social and cultural aspects of the professional role of a Swedish nurse. This perceived deficit is particularly emphasised in relation to leadership competencies, where Swedish nurses are expected to make decisions, delegate tasks and guide colleagues such as assistant nurses (Carlhed Ydhag 2020). IENs are described as lacking these leadership skills: 'They mainly lack in leadership. Here, in Sweden, nurses are the leaders of the nursing work, and many of the IENs are lacking that. It is the doctor who is the leader' (Teacher 5). As the quote suggests, IENs were often described as a homogenous collective positioned as different from the equally homogenous Swedish norm (Ågotnes & Storm 2022). These processes of othering also involve a hierarchical dimension, where 'the other' is viewed not only as different but also as inferior to what is regarded as 'ordinary' (Canales 2000; Schwalbe et al. 2000). These perceived deficits were frequently linked to differences in professional norms and hierarchical relationships across national contexts. For example:

> Well, it is this thing to be able to stand up for one's profession and to dare to question things. To organise and lead the work, relate to the work group and divide tasks…Many have said that this is a challenge, mostly those from Asia, like Thailand or the Philippines. My interpretation is that they have a much more hierarchical order in a way, where nurses just do what they are told (Teacher 4).

The inability to practice in accordance with Swedish professional norms is framed as a deficit, often attributed to cultural background. The Swedish health care system is perceived as less hierarchical, where nurses are expected to take a more active role, both independently and in collaboration with other professional groups. When IENs do not align with these professional expectations, regulators frequently attribute this to cultural differences:

> They [IENs] are more used to hierarchical structures – not that the nurse can guide the doctor, for example. But that is how it is here. And, as a nurse, you must be attentive to what the assistant nurses say. That is something some [IENs] struggle with. It is nothing but cultural differences (Programme director).

In summary, the deficits of IENs are framed as insufficient competencies that hinder or complicate professional practice. A key is the lack of language proficiency, with the importance of Swedish language skills emphasised, particularly in communication – both oral and written. The deficits are also linked to the social and cultural expectations of the Swedish nursing role, which include qualities such as leadership, independence, equality and professionalism. IENs are constructed as lacking these qualities, with cultural backgrounds used to explain the gap. The native Swedish-trained nurse is presented as the norm, against which the deficits of IENs are measured.

IENs as potential liabilities in Swedish health care

The consequences of (particularly) language barriers are emphasised in the regulators' narratives as potential risks. According to the interviews, difficulty in assessing the language competencies of IENs creates uncertainty about their knowledge and ability to provide appropriate medical care. One liaison stated: 'If they [IENs] struggle with the language, then the supervisors will be reluctant to let the student work independently. Because they are uncertain if they have really understood each other' (Liaison 1). The risk of miscommunication raises doubts about the professional competence of IENs. These risks are described as compromising patient safety, with examples such as the misunderstanding of doctors' orders illustrating the dangers involved.

> The language confusion of some students, absolutely not all of them, have been alarming in relation to patient safety. [...] just consider the clinical final examination... Perhaps they will get a doctor's prescription, and you can hear that they don't understand. They confuse milligrams, micrograms and millilitres...and that is really alarming in relation to patient safety (Teacher 3).

As illustrated above, professional regulators fear that when IENs do not fully grasp the context of a doctor's prescription, mistakes may occur that jeopardise patient safety. The construction of risk is framed primarily around IENs' perceived language deficiencies and the potentially serious consequences for patients. Regulators also express concern about miscommunication between IENs and patients, particularly when critical information is misunderstood.

> Well, we [Swedish nurses] also make mistakes, but the risk is even greater if you don't grasp the language. [...] Especially with the slightly confused ladies or the old man with bad hearing...it just doesn't work. [...] There were communication errors, and then the patient proceeded with the information that he or she thought that they had gotten, and the misunderstandings just escalated (Supervisor 3).

Above, the supervisor outlines the risks associated with communication breakdowns between IENs and predominantly Swedish-speaking patients. Misunderstandings in the information provided to patients about their condition or treatment can lead to serious complications. While the possibility of errors is acknowledged for all practicing nurses, the added challenge of language difficulties, as experienced by IENs, is described as significantly increasing the risk of mistakes. As a result, IENs working in Swedish health care are constructed as a greater risk factor compared to Swedish registered nurses.

CONCLUDING DISCUSSION

Building on the concept of a regime of skill (Shan & Fejes 2015), this study contributes a sector-specific analysis of how professional regulators relationally construct skill and competency in the re-certification process for IENs in Sweden. The findings show that IENs' competencies are simultaneously constructed as beneficial and deficient in comparison with Swedish-trained nurses, positioning them as 'others' distinct from their Swedish counterparts (Canales 2000). Two main constructions of skill were identified: IENs as an untapped resource and IENs as linguistically and professionally deficient. The first highlights IENs' medical knowledge and experience as valuable, particularly as they are seen as able to adapt quickly to Swedish professional standards through bridging programmes. These constructions position IENs on par with registered nurses and distinct from undergraduate students. IENs' cultural and linguistic skills are also described as beneficial, supporting communication with non-Swedish-speaking patients and complementing Swedish staff, ultimately enhancing health care delivery. Conversely, constructions of deficiency centre on perceived shortcomings in Swedish language proficiency and alignment with professional norms, particularly regarding leadership, autonomy and role expectations. These deficiencies are also framed as potential risks to patient safety.

These constructions illustrate the multifaceted perceptions of IENs, highlighting both their valued contributions and their perceived shortcomings relative to Swedish health care standards, thereby shaping the regime of skill and the desirability of migrant nurses (Shan & Fejes 2015). IENs are continually positioned in relation to established norms, such as Swedish nursing standards and linguistic or communicative expectations, which function as benchmarks for assessing difference and competence. These norms are represented by undergraduate nursing students and registered nurses reflecting a 'mythical' or stereotypical (Canales 2000) notion of 'Swedishness', against which IENs' competencies are measured. As Canales (2000) notes, othering occurs through the linking of real or imagined attributes to particular groups, thereby reinforcing social separation. By emphasising both actual and perceived differences, the categorisation of 'us' versus 'them' is reproduced. IENs are thus framed as deficient in relation to expectations of communication, leadership and non-hierarchical collaboration, positioning them as the 'other' deviating from the idealised Swedish nurse. However, othering is not exclusively negative (Canales 2010); in this context, it also takes a benevolent form. Rohde-Abuba (2020) describes this as positive othering, where migrants' contributions are recognised and valued, a pattern also observed amongst migrant care workers (Ågotnes & Storm 2022). The findings of this study support these interpretations but also reveal a tension: IENs are simultaneously constructed as beneficial for the labour market and as potential risks within health care. They are perceived as more than merely 'tolerated workers' (Spiliopoulos & Timmons 2023), yet they are not fully trusted (Christiansen et al. 2025), reflecting the ambivalent construction of their competency.

These findings highlight the complex relationship between skill and international mobility, where higher skill does not necessarily facilitate labour market access (Liu-Farrer et al. 2021). Peppler's (2018) study of Turkish physicians in Germany illustrates how the valorisation of migrant professionals can shift over time. Initially recognised for their medical skills, Turkish physicians later became valued only as 'Turkish doctors for Turkish patients' (Peppler 2018: 498) and eventually struggled to have their expertise recognised at all. While this study does not examine temporal

changes in skill evaluation, the findings indicate that such analyses are important. However, this study has pointed to the interconnectedness of evaluations of skill and competence and ideas of nation-specific professional norms. IENs are not only evaluated according to formal expectations for nursing practice but also in relation to expectations of *Swedish* nurses. Recognising this allows us to see how IENs can be valued and misrecognised at the same time. They may be acknowledged for their *formal* qualifications yet misrecognised in relation to their *actual* competence (Andersson 2021). To develop a more comprehensive understanding of the regime of skill in nursing, future research should examine employers in health care settings, policymakers and union officials. Exploring the interplay between these actors and institutions in defining and evaluating skills would deepen our understanding of both the intended and unintended consequences of skill arbitration for highly skilled migrants (Liu-Farrer et al. 2021). Greater insight into how the regime of skill operates could enhance the recognition and valorisation of migrants' competencies, thereby mitigating the risk of brain waste amongst highly skilled migrants (Bauder 2003).

ACKNOWLEDGEMENTS

The author would like to thank the participants for contributing to this study by sharing their work experiences. I also thank my research group, including Emina Hadziabdic, Kristiina Häikkilä and Päivi Juuso, for their support. Finally, I extend my thanks to the anonymous reviewers for their valuable feedback, which helped strengthen the manuscript.

FUNDING INFORMATION

This work was in part supported by a grant from The Research Agreement with Växjö Municipality and Linnaeus University, Sweden.

COMPETING INTERESTS

The author has no competing interests to declare.

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TO CITE THIS ARTICLE:
Marekovic AS. Between Benefit and Risk: Constructions of Skill and Competency of Internationally Educated Nurses in Sweden. *Nordic Journal of Migration Research*. 2026; 16(3): 2, 1–18. DOI: https://doi.org/10.33134/njmr.1042

Submitted: 18 April 2025
Accepted: 27 February 2026
Published: 9 April 2026

Nordic Journal of Migration Research is a peer-reviewed open access journal published by Helsinki University Press.

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