POSITIONING MIGRANT PHYSICIANS
AS DR. HORROR AND DR. NICE:
A study of status and affect in online discussion forums

Abstract
While ethnic hierarchies and labour market enclaves are commonly discussed at the macro level, this study focuses on a less explored area of research, namely, the study of ethnic and professional hierarchies on the level of mediated discourse. Taking various kinds of online discussion forums as the empirical entry point, this article sets out to answer if and how ethnicity, migrant background and/or language skills emerge as new hierarchical logics beside divisions, such as gender and education, when professional status is assigned online. Drawing on affect theory and the notion of status conflict, this article argues that in Finnish online discussion forums, the high-skilled migrant care worker is envisioned as a paradoxical figure who at the same time is seen as a saviour from abroad and an "affect alien" who causes confusion and discomfort. Both positions, the article argues, are the fruits of a narrow discursive construction of the commodified high-skilled migrant as "a servant" for our needs.

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Migrant physicians are working in Finnish healthcare centres and hospitals in increasing numbers (Aalto et al. 2013; Kuusio et al. 2010). From the point of view of patients and the general public, the change towards a more linguistically and ethnoculturally diverse pool of high-skilled healthcare professionals requires abandoning ingrained ideas about migrants mostly having the so-called Three D-jobs (dirty, dangerous and difficult). In turn, from the point of view of migrant physicians, adapting to a new society and healthcare system requires time, patience and devotion to demanding continuing studies.

In most cases, it also requires coping with the feeling of not being highly appreciated by the general public. This, we know from research showing that physicians from countries outside the European Economic Area feel significantly less appreciated by the general public than do "native" doctors (Haukilahti et al. 2012: 1751). Only 20% of migrant physicians in Finland feel that the general public appreciates their professional input much or very much, while 40% of the native Finnish physicians believe the same (ibid.).

One of the parties to blame for this lack of self-experienced appreciation is the media, since, in late modern technologised societies, both mainstream media and social media play an important role in peoples' attitudes about healthcare-related issues (e.g. Maibach & Holtgrave 1995; Torkkola 2008, 2012). Although

the media may not tell people what to think, it is clearly understood that they do tell people what to think about (McCombs 2004). In the context of an increasingly diverse Finnish healthcare sector, this means that despite migrant physicians having a legitimate basis on which to stand, under the influence of diverging expectations and stereotypes, biased media representations may trigger ingrained patterns of thought in patients and potential patients on how, if at all, dark skin, a foreign name and/or an accent relate to qualifications and credentials.

In this setting, the article sets out to answer the following research questions: How is the so-called general public[1] assigning status and negotiating positions for migrant physicians on a broad range of web-based discussion forums? How are the dimensions of affect and rationality influencing this process?[2] And how, if at all, do ethnicity, migrant background and/or language skills emerge as hierarchical logics beside divisions, such as gender and education, when professional status is assigned?

While ethnic hierarchies and labour market enclaves are commonly discussed at the macro level (Forsander 2007; Heikkilä & Pikkarainen 2007), this study focuses on a less explored area of research, namely, the study of ethnic and professional hierarchies on the level of mediated discourse.[3] Taking various kinds of online discussion forums (Health Information, Family Matters, Lifestyle

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& General Discussion, News & Current Affairs, Immigration Policy and Private Blogs) as the empirical entry point, this article aims to produce new knowledge about how the change towards an increasingly diverse pool of high-skilled healthcare professionals is perceived by the general public, represented here by a broad scale of online discussants.

1   Changed demographics and reorganised care

Before arguing why and how status and affect as theoretical concepts can be used when studying the positioning of migrant physicians in online environments, three points follow on the main shifts in migration and healthcare policy. First, it is only during the last 20 years that greater relative numbers of migrants have arrived in Finland, resulting in more than an 800% increase since 1989 (Nordberg 2011). The absolute number is still very small. Only 4.4% (around 230,000 people) of the population of Finland are foreign-born (Statistics Finland 2011).

Second, migration movements have recently changed in character. During the 1990s, policy making in Finland mainly concerned refugees and their integration, but between 2006 and 2008, there was an increase in policies that called for a more active recruitment of labour (Saukkonen 2013: 89). Most of these recruitment initiatives were later downplayed partially due to the negative turn in global economics (ibid.). Nevertheless, concerning the care sector, the "pull" factors are still today, in 2013, strong enough to attract physicians and nurses mainly from Russia and other countries, where "push" factors dominate.[4]

Third, the demand for a labour force has to do with another phenomenon, namely, the "crises" of the Finnish healthcare system. The public sector has always held the primary responsibility for social care provision to be part of the "social service state" and public care has been available for everyone in the population, irrespective of labour market attachment (Sipilä, Anttonen & Kröger 2009). However, neo-liberal reforms of the care sector, emphasising market-driven services, flexibility and low-cost solutions, have since the 1990s brought about new strategies for organising care (Wrede 2008; Wrede & Näre 2013). Responsibility for care has been transferred from the state to municipalities and the use of outsourcing services has increased significantly (Kovalainen 2004).

All these changes have contributed to an increase in the number of migrant healthcare professionals in Finland. Although absolute numbers are still small, between 1994 and 2009, physicians from 65 countries have come to the country (Haukilahti et al. 2010: 3318). In 2010, there were around 19,000 physicians in Finland. Of this number, 1125 had a mother tongue other than Finnish or Swedish. Russian and Estonia speakers constitutes half of those 1125 physicians, while the other half consisted of German, Arabic and Polish speakers and other allophones (ibid. 3320). Migrant physicians are over-represented in the public health centres; they are more rarely managers and they are also more often on emergency duty in comparison with their native counterparts (Aalto et al. 2013). In other words, although migrant physicians have the same formal status as their native colleagues in that they are licensed physicians, survey data show that in comparison with their colleagues, their intra-professional positions tend to be less prestigious and duties harder (ibid.).

2   Conflicting statuses and the power of the affect

As suggested above, there are at least two ways of understanding professional status. One is intra-professional in which status is assigned within a profession by the professionals themselves, and the other is extraprofessional in which the general public assigns status to professional groups (Abbott 1981). When putting extraprofessional status under the loop and understanding status assignments as a discursive practice during which various positions are assigned to selves and others according to an existing idea of a hierarchical order, this study can be situated at the crossroads of discourse studies that focus on ethnic diversity (Hall 1997; van Dijk 1987) and classical sociological studies of status (Hughes 1945; Weber 1946).[5]

Within the context of discursive studies on status, Jeanette Laurén and Sirpa Wrede (2008) note that where practical nurses of migrant origin are concerned, ethnicity emerges as a new hierarchical logic alongside other hierarchies, such as education and gender. However, ethnicity does not equal being a migrant. In Finland, as in other countries where the word migrant is frequently used despite its overwhelmingly negative connotation[6] (Huttunen 2002: 21), there is a risk that a routine-like emphasis on this particular characteristic (being an immigrant), in front of others, repeatedly places the professional person in a depreciated category and, while doing so, functions as a reminder of this particular person's outsider-ness from his or her working communities (cf. Nieminen 2010: 154). Consequently, I do not focus solely on if or how ethnicity functions as a condition for social positioning, since it can be assumed that it is in the interplay of migrantness, language skills, credentials and banal markers, such as "niceness", that the power of ethnicity as a status determining signifier plays an important role.

Sometimes this interplay can become conflictual, and when the two assumptions diverge significantly of what an immigrant "is like" and what members of a certain profession "are like", we can talk about *status conflicts*[7] (Hughes 1945; Webster & Driskell 1978). These conflicts are common when new groups, such as ethnocultural minorities, enter certain social or political spheres in a society and the general opinion and/or the professional community within that society is sceptical about the actual suitability of these newcomers for a certain profession. The influence of stereotyped prejudices concerning the newcomers usually contains the assumption that these social and/or ethnic groups are not quite fit for the new positions to which they may aspire (Hughes 1945: 356–357).[8]

When patients and potential patients negotiate who fits and who does not, the affect, as in emotional involvement, comes into play in at least three ways. First, although we may have rational arguments at hand, for instance, "Ethnicity does not matter" or "All physicians have passed rigid testing", we deal with a topic that relates to bodies that care and are cared for, and health and sickness, possibly even life and death, are all trajectories that urge emotional and personal involvement, at least from the point of view of the patients and their relatives. Second, the setting in which the discussions take place, namely, the online discussion forums, blogs and comment-boxes on news sites, produces and circulates affect as a binding mechanism (cf. Dean 2010; Clough & Halley 2007). These forums are united by the unique characteristics of online communication, namely, the possibility for participants to transcend time and space while maintaining anonymity. This characteristic has therapeutic potential (e.g. Malin 2001; King & Moreggi 1998; Kummervold 2002), but while triggering people to form and express frank opinions without having to be afraid of the consequences, there will always be discussants

who post messages that are overtly heated and/or simply extraneous (e.g. Paasonen 2011).

These kinds of emotional outbursts in online environments shall not be seen as psychological states, but as social and cultural practices (see Ahmed 2004: 9 for emotions in general). According to Brian Massumi (2010), these expressions of emotions become particularly crucial when actors stand in front of an actual or imagined threat. This is point number three for why and how affect matters for extraprofessional status formation, since indeed, increased social mobility and international migration that challenges ingrained ideas of who belongs, and where, can provoke various types of threat-scenarios. These scenarios can be about structural types of threats (e.g. "What if the social, political and cultural sphere is soon to be "taken over" by highly-skilled foreigners?"). Since the patient–doctor relationship is so intimate, in comparison with the relationship between a construction worker and a client, they can also be more subjective (e.g. "What if this foreigner messes with my health and puts my life at risk?"). This threat does not need to correspond to a factual, worsening situation for "native" Finns in the labour market, and neither do people need proof of actual malpractice to experience a situation as threatening (cf. Massumi 2010: 53).

In accordance with Sarah Ahmed (2004: 195), I do not define the affect as contradictory to conscious knowing. Emotional responses can work as a form of conscious judgement and strategic assignment of status, too, just like rational argumentation. Emotional distinctions, such as "I really like him/her, but not him/her, for no reason at all, just because I do", can be the basis of an essentially moral economy in which moral distinctions of worth are also social distinctions of value (cf. Ahmed 2010b: 35). In the context of this study, this reasoning means that someone writing "I hate him/her!!!" online may function as a strategic attempt to position someone else, and possibly to influence other community members or random visitors online to do the same. Subjective expressions of dislike or like may have social and political implications, particularly if the person positioned as "not-liked" is defined as a member of a vulnerable social group.

3   The material and method

The intertwinedness of affect and status forms the theoretical context of my study for which I have gathered an empirical material consisting of 64 threads.[9] These threads have been posted on various online discussion forums between 2006 and 2012. The search words were "maahanmuuttajalääkäri" (immigrant physician) and "venäläislääkäri" (Russian physician). The reason for separating Russian physicians from others is that, in an earlier exploratory study, I noticed that Russian physicians are frequently talked about as a separate category (Haavisto 2011a).

The material encompasses two health information sites, three forums on family matters, seven forums on lifestyle issues and general discussion on all sorts of topics, six news sites, three sites on migration policy (these are commonly known for attracting people with immigrant critical views), and three blogs.[10] The purpose of this broad search technique was to obtain an overview on how the theme concerned is discussed in one segment of the communicative space, namely, the sphere for e-discussions on contemporary matters.

There are both benefits and weakness with this kind of broad research technique. The benefits are that researchers can find and analyse such material online that average internet users are highly likely to face when involving themselves in their daily online activities. Today, for instance, people are not committed to one particular forum but tend to be active in many forums simultaneously. With multiple, convergent and turbulent social media, nobody has to settle on any one direction or theme (Dean 2010, 73). The weakness of the technique is genre-blindness. Participants can seek information from one site, company and/or support from another, and they may go to a third online venue simply because they wish to be entertained or to entertain others (cf. Colineau & Paris 2010). A broad study like this one that aims to grasp how the globalising healthcare sector is discussed online is not fitted to shed light on behavioural differences of web users, and neither to give account on the history or design of specific sites.

Interestingly, however, my findings show that irrespective of whether comments were published on a pre-moderated website or on an open forum, on specific health information sites or more general sites, the logics of argumentation do not greatly differ. The tone of the discussions is slightly more straight-forwarded on sites that host a big pool of users such as Suomi24.fi (Lifestyle & General Discussion) and Homma.org (Immigration Policy, representing a view critical of migration) than on sites with a smaller pool of participants. On the other hand, it is important to point out that the so-called immigrant critical forums do not dominate my material. Only three out of 64 threads derive from these forums. Besides, a lot of prejudice can be found in the commentary on family and health oriented sites that enjoy a "good reputation", such as Kaksplus.fi, Vauva.fi, Mammapappa. com (Family Matters) and Iholiitto.fi (Health Information).

All these discussion threads have been analysed with the help of applied Positioning Theory (PT) (Harré & van Langenhove 1999: 1). More precisely put, I have analysed the interplay between status and affect by focusing on how positioning takes place when various actors—discussants and moderators or editors—sometimes consciously, and other times unconsciously, create positions for themselves and for others. This can happen in the first line in an online posting when the object of the discussion is introduced. For example: "Once, when my son was ill, we went to see Dr. Ganchen, a Bulgarian doctor". It can also be more subtle. For example, the discussant may write that he/she has doubts about the quality of medical schools in certain geographic areas.

Although there can be positions available for various grades of professionalism or amateurness or for belongingness and strangeness (Davies & Harré 1990: 43; Harré & Slocum 2003, 127), some sort of categorical distinction always takes place when positions are negotiated (Harré & van Langenhove 1999). In this process, various conditions are applied. These conditions can encompass a foreign-sounding last name or a non-typical way of addressing the patient when he or she enters the room, or something completely different. By using these conditions, web participants allow certain individuals and groups to enter some positions while leaving others outside (Haavisto 2011b).

This is the process that I have focused my attention on. More precisely put, for each speech act within a thread I have asked who positions who, and how emotional expressions are used in this particular act of positioning. All positioning practices do not relate to professional status formation since commentators also position themselves in relation to other commentators or patients. But where they do, I have asked which are the conditions used in the process of assigning professional status.

The software NVivo was used to create "nodes" that mark relevant concepts and topics in the sections that I extracted from the threads. These nodes were then linked to the so-called memos, or electronic notepads, which allowed me to make notes, and then edit and rework my analytical ideas as the project progressed.

4   The findings

4.1   Emotionality vs. rationality in discourse

Previous research done on mainstream media representations show that, in daily newspapers, migrant physicians working in Finland are mostly seen as an economic asset, a helpful troop that is here in order to help "us" deal with a threatening labour shortage in exposed areas (Simola 2008; Haavisto 2011a).

In web discussions, the debate is much more emotionally loaded, politically incorrect and dichotomised. The typical online positioning thread starts with a banal and generalising question, such as "Are migrant physicians trustworthy?" It often evolves in a predictable way, depending on the discussants' own experiences and their ideological or political views on ethnic diversity and migration; discussants either position the physician as Dr. Horror who commits severe errors and plays with life and death or Dr. Nice who is told to be a better doctor than all natives put together and who is equally loved by staff members and patients. Participants with negative experiences of migrant physicians talk about mistrust, suspicion, awkwardness, fright of not being understood or not understanding what the physician says, while participants with good experiences talk about relief, satisfaction and gratefulness. In these emotionally loaded threads that build on personal experience and expressions of like and dislike, discussants do not engage much with each others' comments. Getting your own story out seems to be what counts.

To some extent, discussants deal with questions of a more structural issue. In these cases, arguments tend to be more rational in character. When logical and fact-based reasoning are used in order to contest work-related healthcare migration, the first and foremost discursive logic is the savings–costs binary. In comments claiming support for the recruitment of migrant physicians, highly educated immigrants recruited to Finland can save the state hundreds of thousands of Euros, the argument goes, since state financed medical studies are very expensive. Within this framework, migrant physicians are seen as a diffuse crowd of substitutes who can provide some relief in a tough situation and, besides, there tends to be an underscoring of economic benefits that "we" get from "them". In comments critical of the recruitment of migrant physicians, discussants claim that "tax money" is "wasted" since patients, due to bad service and numerous migrant physicians on the public side, are forced to seek help from the private sector. These discussants thus imply that the State fails to accurately distribute welfare—an argument frequently used by discussants with radical populist/right wing sympathies when opposing immigration policies (Pyrhönen 2013).

POSITIVE DISCURSIVE LOGIC DRAWING ON A NEO-LIBERAL RHETORIC:
Finland saves 350000 Euros per immigrant doctor, so these kinds of racist postings must be stopped. Immigrants are an asset. They wipe our asses when we lie in care homes for old people. ("Vieras", 23.11.2008, www.uusisuomi.fi/comment).

NEGATIVE DISCURSIVE LOGIC DRAWING ON A NEO-LIBERAL RHETORIC:
In Kuusankoski there are no others, so who would you change to? They are arrogant and impolite. Problems aren't solved, so you go to a private clinic instead. This way, you don't get value for your taxes. It gets expensive. ("Vierailija", 10.1.2009, www.kaksplus.fi).

In some cases, discussants with opposing views on whether migrant physicians are an economic asset or a burden engage in rational dialogue. The quotes below feature a dialogue between Pauli Vahtera,[11] a supporter of the True Finns party, and a commentator who uses the signature Hermes Armas Kuuskarre. The comments refer to a provocative blog text written by Vahtera in which he as a self-proclaimed expert harshly criticises current migration and social policies and states that "Finland cannot be the social aids office for the entire world" and claims that migrants bring diseases to Finland and have a tendency to commit sex crimes. Although the text righteously could have triggered accusations of racism, the commentator (Kuuskarre) argues calmly and rationally for his case.

Kuuskarre (commentator): *You are raising a point about physicians, arguing that it would be better if the approximately 1100 foreign born physicians working in Finland would return to their countries of origin. You claim that they would do more good in their own countries than they here do. But what can one physician do in a developing country with ten millions of inhabitants or in a chaotic country stricken by war and misery? A drop in the sea. Instead, here in our healthcare centers, where they have clearly defined job descriptions, they are an asset.*

Vahtera (blogger): *Thank you Hermes Armas Kuuskaarre for your thought provoking and deliberate feedback. /…/ I had wanted to write about the state of our healthcare sector from the perspective of a layperson for a while /…/ By displaying statistics on foreign born doctors and nurses, I just wanted to show that these groups, who have been talked about a lot, in reality don't serve Finns. They are so few in number that they cannot even take care of the immigrant patients. (8.8.2012, http://blogit. iltalehti.fi/pauli-vahtera.)*

What we here see is that commentator (Kuuskarre) impels the blogger (Vahtera) to change positions from all knowing expert to layperson and to withdraw one of his main claims (from "migrant physicians should go home" to "they are so few in number that they don't really serve us"). Although the strategy is problematic, as we will see in further on in the article, rational argumentation based on a neo-liberal logic hence seems to be more effective a tool for urging the so-called immigrant critics to think over their claims than emotional allegations of racism, at least on the bases of this particular empirical material.

4.2   Ethnicity and migrantness as emerging hierarchical logics

The physician's ethnic background tends to come up as an explanatory factor for dissatisfaction, both in emotional expressions of like and dislike, and in comments building on rational argumentation. Ethnicity, however, functions as one status determining factor amongst other factors such as language proficiency and professional capacity. When discussants explicitly mention ethnic background while positioning physicians, the discussant tends to start by complaining about inadequate language skills or a false diagnose, only after which he or she tends to bring up ethnic background. This mostly happens through generalising comments, such as "this is what African/Arab/Russian doctors are like" (more emotional style or argumentation) or "she could not diagnose me, because she is

an African/Arab/Russian physician and in her country this disease is a great taboo/does not exist" (more rational style). Generalisations do, however, also exist in online stories showing appreciation for the professional input of migrant physicians.

A lady came into the reception hall, she smiled and said hello (as you normally do). After this the doctor shouted: don't stare at me with those serpent's eyes of yours (he grabbed the woman from her ears and shouted:) Listen with these instead! /…/ So, it was not a Russian doctor who did this. They do think hierarchies are important, but mostly they are still nice, and they talk. ("Halle" 8.4.2009, mammapappa.com).

The above-cited text fragment insinuates that stories about unpleasant patient–physician encounters are so common online that if a discussant tells a repulsive story about just any physician, he/she feels an urge to point out that, in this particular case, against common expectations, it is not about a migrant physician. In fact, stories about unpleasant encounters with migrant physicians who cannot communicate with their patients and who make inadequate diagnoses are so common that they rarely provoke sympathy votes. Contrarily, in most cases, a dreadful story is countered with another even more dreadful one. Some of these stories may certainly be completely fictional, but also in this case, they contribute to the formation of a discourse of migrant physicians as strange and threatening.

In these stories about unpleasant and/or difficult encounters with migrant physicians, but also in the material in general, humour is frequently used when positioning migrant physicians in online environments. Jokes are made about various accents ("He djidn't ynderstand evrjything, I gjuess"); and there is talk about "guessing-center-doctors", "bad-finnjish doctors" and "miracles from the East". Online discussions also contain unintentional humour. For example, a Russian physician may be insulted and, only then, might the discussant start to ponder whether or not the physician referred to is from Russia or some other place.[12]

One could argue that people engage with humour just for its own sake, rather than to reach a conscious goal (Morreall 2005), that introducing humour and laughter into the healthcare setting may provide relief and a moment of joy (see e.g. Bennett 2003[13]) and that some of the mocking names, such as "guessing-center-doctors", are used on a variety of healthcare-related forums, also when discussing native physicians. Yet, in this material, humour is primarily used in order to ridicule not only the establishment (i.e., an ethnically diverse healthcare sector) but also everyone being part of this establishment and supporting it (i.e., the migrant physicians and the "naive" supporters of multiculturalism and ethnic diversity). It would hence be misleading, even dangerous, to analyse these jokes and pejoratives as positioning practices that "spice up" discussions on difficult topics such as health and sickness.

Contrarily, according to the so-called superiority theory (Morreall 1987), jokes are hardly ever completely "innocent" since humour may be used for positioning oneself above the objects that one is making fun of. In this setting, humour and pejoratives are hence understood as effective positionings tools through which discussants take superior positions and manifest hierarchical orders building on ethnic background and migrantness. Jokes may not be overtly racist per se but they get their racist undertones from their context hence drawing upon a legacy of power relationship reducing people to a set of characteristics or stereotypes as a means of containment (cf. Essed 1991). Being reduced to a set of characteristics can be humiliating as affirmed by Brenda Beagan's (2003: 858) study on

how medical students of minority ethnic background in Canada felt about the ethnic jokes made by their colleagues and patients. The study confirms that even well-meaning jokes can convey disregard, disrespect and marginality and that these mundane experiences of racism are difficult to deal with.

5   Economic assets and affect aliens

In research on mainstream news media and migration, researchers have noted that immigrants tend to be positioned as either "good immigrants" or "bad immigrants" (e.g. Horsti 2005; Raittila 2004). The "good" ones are individuals and/or collectives who are assumed to contribute to the "common good", primarily by working and paying taxes and the "bad" ones are people who are assumed to use "our" welfare (Haavisto 2011b, 183). Much in line with research on employer perceptions of migrant nurses (Näre 2013, 78), in my material the migrant physician is both "good" and "bad" at the same time. On one hand, in rationally motivated comments, he/she is seen as a saviour from abroad and greeted with relief and gratefulness. On the other hand, he/she is also envisioned as a person who causes confusion and discomfort.

In the "saviour stories", migrant physicians are often positioned as being even more professional than physicians in general. Despite a positive tone, these stories are not completely unproblematic since there is a neo-liberal rhetoric that easily comes into play, thereby reifying divisions of "us" and "them". As Camilla Nordberg (2011) points out, in narrow constructions of migrant care workers as a national economic good, it is seldom highlighted that these professionals may fall outside the framework of belongingness in society-at-large. Furthermore, using neo-liberal arguments for why "we should tolerate them" is somewhat dangerous, since it undermines ideological arguments drawing on the principle of equal treatment and anti-discrimination, both from a structural point of view and an individual point of view.

In the "complaint stories", a different problematic comes into play. In these stories, migrant physicians are positioned as some sort of "affect aliens" (Ahmed 2010a), that is, objects that are seen as the cause for unhappiness and confusion who are presumed to be the origin of bad feelings and discomfort. The dissatisfied discussants argue that migrant physicians create awkwardness and, as Ahmed (2010b: 39) claims, "To create awkwardness, is to be read as being awkward". In the statements that are critical of the recruitment and employment of migrant physicians, a lack of adequate language skills, in combination with "migrantness", functions as the first and foremost objects of the critic. Although it certainly is important for physicians who work outside the lab to be able to communicate with their patients, online talk about insufficient language skills may be a way of expressing xenophobic sentiments in a seemingly ethnicity-neutral way. It is socially more acceptable to dislike someone for not doing his or her job properly than to blame him or her for being of a certain minority ethnic and/or migrant background.

On various web-based discussion forums in which healthcare migration is debated, these two positions taken up by discussants show that intensive tension exists between the particular (our differences, albeit sometimes insignificant and only "cosmetic") and the universal (what unites us all as human beings). On the one hand, this tension revolves around a constant struggle between more rational types of claims drawing on neo-liberal logics combined with positive personal experience supporting high-skilled minority professionals and, on the other hand, more emotionally loaded

statements about increased migration as a threat to the nation and its citizens in combination with negative personal experience.

These two oppositional strands of positioning practice have at least two common features. First, both are the fruits of a narrow discursive construction of the high-skilled migrant as "a servant" for our needs. This criterion of usefulness outplays principles such as equal treatment and anti-discrimination. Second, while constructing affect-laden positions for Dr. Horror and Dr. Nice, the (un)professionalism of the individual is made into a character trait that defines entire groups of people.

Hughes (1945) has said that, in the USA during the 1940s, if the care given by a black physician to a Caucasian patient was experienced as adequate, the physician was positioned as a representative for his/her professional community. If not, the physician was positioned as a representative of his ethnic background. In the web discussions, a similar kind of logic can be seen; sunshine stories about migrant physicians exist, but when the patient–physician encounter has been experienced as unpleasant, the low status of being an immigrant (not being one of "us", being awkward and threatening, etc.) outplays the high-status profession (being respected, helping "us"). Although knowing that this negative feeling is only connected to one person, web discussants claim that they will not return to a physician of the same ethnocultural background. It is as if the non-professionalism of one person suddenly could define the entire community.

This relates closely to the "burden of faultlessness" that Olga Silfver (2010) and Suvi Nieminen (2010) note on a more general level. Migrant high-skilled professionals must be better than good. All the time. If they are not, their background becomes the explanatory factor. If one physician "messes with" the health of a patient, entire communities of migrant doctors may suffer from it. If these kinds of generalising discourses endure, there is a risk that the feelings of not being appreciated by the general public (Haukilahti 2012: 1751) with time grow into collective experiences of humiliation and injured self-respect.

The humiliating potential of online discussions is generally speaking difficult to control. The possibility for anonymity, the lack of consequences for saying and doing things and the absence of journalistic rules and practices trigger emotionally loaded and conflict-laden positioning practices that lie out of control for the once concerned. In the midst of tumultuous discussions, there is not much else than doing a "good job" that migrant physicians themselves can do in order to influence positioning practices and general perceptions. Therefore, I argue, is it primarily the responsibility of mainstream journalists and other public intellectuals to present normalising claims in public. It would be naive to think that these claims questioning the commodification of migrants and demanding equalitarian recruitment and career structures would be directly transmitted to online discussions. Nevertheless, they could function as examples of how convincing, solid and non-generalising arguments for why skills and qualifications that have very little to do with ethnicity, migrantness and accent can be constructed and spread in the communicative space.

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Notes

1. Web discussions may not reflect the opinion of the general public since like-minded people who hold anti-immigration views may post hundreds of comments daily on various sites, sometimes with different signatures (cf. Horsti & Nikunen 2013). However, since the forums analysed for this study range from medical support forums to motorcycle forums and sites selling baby clothes, the pool of discussants is quite diverse concerning age and gender.
2. More in detail, I am interested in how rational arguments drawing on matters of principle and socio-political circumstances and emotionally loaded references to a person's own experiences and/or hearsay are used in the assignments of status.
3. Discourse can here be understood in its everyday sense, as a synonym to conversation. When the notion is used in relation to my empirical material, it refers to "mediated textual conversation". I have elsewhere reflected on how PT and Discourse Analysis relate to one another (Haavisto 2011b, 33), but this discussion lies outside the scope of this paper.
4. Interestingly, concerning nurses, Finland is simultaneously a sending country and an active recruiter (Wrede & Näre 2013, 59). For more on the "push" and "pull" factors in general, see e.g. Buchan & May (1999: 203, 207).
5. In my understanding, the study of discursive extraprofessional status—which differs significantly from sociological studies in which status is seen and used as a simple index of income, education and occupational prestige—refers to how non-members (the general public, bloggers and other online participants) give social judgments or recognition to a person or group, in this case highly skilled professionals within a globalising care regime. Within this strand of inquiry, status is here defined in a Weberian tradition, as the prestige dimension of stratification. Again, status formation is defined as the activity of assigning social judgments or recognition to a person or group (Weber 1946).
6. In Finland, the word migrant has an overwhelmingly negative connotation (Huttunen 2002: 21) in contrast to the more neutral connotation of "nouveaux arrivants" (recently arrived people) in Quebec or the euphemism "personnes issues de l'immigration" used frequently by the press in France.
7. I am grateful to Sirpa Wrede for introducing this concept to me and to Camilla Nordberg for having read through and commented on the evolving work several times.
8. Conflicts over noneconomic goods such as status and recognition are examined in an extensive number of literature, particularly in the United States (e.g. Blumer 1958; Bobo & Hutchings 1996). In more recent inquiries, status conflicts tend not to be examined as discursive extraprofessional phenomena but rather as intra-organisational phenomena or as emerging in patient–physician encounters (e.g. Helmreich & Schaefer 1994; West 1984).
9. The 64 discussion threads constitute 350 pages when copy-pasted into a Word document.
10. The following online discussion forums were analysed for this study: Health Information: diabetes.fi (2) and iholiitto.fi (3); Family Matters: vauva.fi (5), kaksplus.fi (8) and mammampappa.com (4); Lifestyle & General Discussion (cinema, motorcycling, etc.): Suomi24 (13), Plaza.fi (1), muusikoiden.net (1), motorsport.com (1), tuulenkoirat.net (1), hohtoloota.net (2) and foorumit.

fffin.com (2); News & Current Affairs (discussion forums on YLE, Helsingin Sanomat, etc.): Yle.fi (3), Iltalehti.fi (3), Iltasanomat.fi (2), Uusisuomi.fi (3), MTV3.fi (1), kansanuutiset.fi (1) and lansivayla.fi (2); Migration Policy: Suomaliansanomat.fi (1 thread), hommaforum.fi (1) and kansankokonaisuus.fi (1); Private blogs: pasihelander.blogspot.ca (1), kyllikintarinat.blogspot.fi (1) and boardreader.com (1). I stopped gathering data when I reached saturation (Glaser & Strauss 1967).

11. As a representative for the True Finns party, Vahtera ran for candidacy in the Finnish parliamentary elections in 2011.

12. It may as well have been that the physician talked about as "Russian" comes from Ukraine or Bulgaria, but on online discussion sites, "Russian physician" has become a sort of general term used for physicians from former Eastern Europe. The term "Russian physician" functions on the side of the term "immigrant physician" rather than as a sub-category, a point well worth repeating since it reifies what scholars claim (Huttunen 2002: 21; Kyntäjä 2011: 78); in Finland, the term immigrant ("maahanmuuttaja") still strongly connotes being non-white and/or coming from a Third World country.

13. Referring to a general overview of humour in medicine, not dealing with online humour per se.

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