Castledown

OPEN ACCESS

Migration and Language Education
ISSN 2652-5984
https://www.castledown.com/journals/mle/

Migration and Language Education, 6(1), 102896 (2025)
https://doi.org/10.29140/mle.v6n1.102896

Participating Through Speaking, Or? Linguistic Participation During Placement at the Hospital

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Abstract

This study investigates linguistic challenges and opportunities for doctors with a foreign degree during a "language placement" at a Swedish hospital. Through observations and recordings from two key practices, the team meeting and the ward round, it analyzes what linguistic or communicative practices both the student, and the more senior doctors in the team, participate in, as well as how linguistic participation is affected by institutional roles. The study is theoretically based on the concept of institutional role (Halvorsen & Sarangi, 2015), and the concept of community of practice and participation (Wenger, 1998) which enables an analysis of the student's position in the team compared to full participation as a professional physician. The empirical results show how the linguistic requirements of professional participation are made visible in the two key practices, both containing continuous conversation, in ways organized institutionally. Additionally, results show that even though the placement contains large parts of conversation, the student does not engage in the interaction to any great extent (of the 480 minutes of the recordings, she speaks 9 minutes 55 seconds, distributed over 3 occasions). She participates both in a student role and as a professional colleague, and mainly on the chief physician's initiative. Through the perspective of and participation in a community of practice, the amount of verbal participation can be expected in an institutional point of view. Even though our student Ewa is a trained doctor, not yet with a Swedish license, she does not have access to making decisions or ordinate treatment, and she does not have a leading role communicatively. This might affect her verbal participation. The study contributes to a deeper understanding of how practice structures and linguistic environments can promote or limit language development and provides insights into how professional language training can be adapted to better support these individuals in their pursuit of a professional role in Swedish health care.

Keywords: Vocational Swedish, placement, participation, institutional roles

Introduction

This article presents a study on the linguistic and communicative demands placed on the medical doctor at a Swedish hospital, and the linguistic participation for a student on a course in Medical Swedish for immigrants, doing her placement at the hospital. The student, Ewa, is a trained lung specialist, taking a course in Medical Swedish, which aims to prepare health care personnel with a license from outside EU/EEA to pass the National Board of Health and Welfare's so-called Proficiency test. This test is a compulsory step towards gaining a Swedish license to perform medicine (Hållsten, 2020b). The course consists of three days of SFI (Swedish for Immigrants), one day of Medical Swedish, and one day of placement at a hospital or similar. For Ewa, the placement means one day per week at a cardiac clinic.

The overall aim for the study is to explore to what extent, and in what communicative practices Ewa, our student (at the same time, a trained medical specialist) is offered participation through active language production during the days of placement, understood through the concept of institutional role and professional identity. This is done through analyzing what linguistic or communicative practices a medical doctor participates in during a working day. This is applicable not only for Ewa doing her placement as one step toward applying for a Swedish license to perform medicine, but for all medical doctors in the data: chief physician Diana, assistant doctor Mats, junior physician Maja, and student Ewa. Examples when Ewa is not present or not an active participant are relevant in order to get a fuller picture of what linguistic activities a medical doctor might participate in during a regular working day. Knowing more about the doctor's linguistic participation in general, it is possible to understand Ewa's linguistic participation in a more equitable way, based on what a medical doctor usually does linguistically during a working day. In this sense, the study combines the perspective of the medical doctor's professional communication on one hand, and the student Ewa's linguistic participation on the other. What demands for linguistic and communicative participation are there on a medical doctor, and what opportunities to practice linguistically does the student get during her placement?

In Sweden, there are several efforts and course arrangements for the purpose of learning Swedish for a specific professional field, not only within the health care sector but different vocational areas. For medical doctors with a foreign degree, both regular courses and different study groups or so-called language cafés are organized, with the aim of preparing specifically for the proficiency test (Hållsten, 2020a, 2023), but also for learning the Swedish that one needs to work in the health care sector. Many of the courses contain practical elements, with a general view that placement in a relevant professional setting is important for acquiring a second language.

Even if one explicit purpose of the placement is to give opportunities to practice professional Swedish, the placement does not automatically include active speaking (Sandwall, 2013; Suni, 2017). This can be explained in different ways. Therefore, the data in this study will be analyzed through the concept of institutional settings, institutional roles (Halvorsen & Sarangi, 2015; Linell, 2008) and professional identity (Roberts & Sarangi 2003, Nikolaidou & Karlsson, 2012), as well as through aspects concerning community of practice and participation (Lave & Wenger, 1991; Wenger, 1998), to capture a view of language as one means, among others (for example listening and taking notes), for participation.

The study gives us deeper understanding about what the medical doctor at a Swedish hospital needs to master to participate linguistically to perform their profession, and what kind of language training a placement might offer. Based on this knowledge, we can better discuss what language training a vocational course in Swedish for immigrants can and should accommodate.

Aim and Research Questions

The overall aim for the study is to explore to what extent, and in what communicative practices student Ewa is offered participation through active language production during the days of placement, understood through the concept of institutional role and professional identity. The study aims to answer following questions:

1. During the key practice *the team meeting*, how do the medical doctors occupy and shift between different topics and speech acts within their institutional roles?
2. In what institutional roles, and how, does student Ewa participate linguistically during her days of placement at the hospital?
3. What insights do these topic and speech act shifts and understanding of student Ewa's participation provide about the communicative practices involved in being a medical doctor in a Swedish hospital?

Previous Research

Institutional Roles in Interprofessional Contexts

Research on institutional interaction suggests that participation involves rights and obligations in workplace conversations and is largely shaped by institutional roles, influencing communication patterns in professional settings (Linell, 1990). Studies highlight the complexity of language production in institutional environments, where hierarchical structures impact communicative participation (Rydell, 2015). Hierarchical constraints also affect knowledge representation in professional interactions. Halvorsen and Sarangi (2015) emphasize interprofessional meetings and decision-making, with a focus on institutional and discursive roles. O'Hare (2008) examines interdisciplinary teams during ward rounds, focusing on how senior doctors interact with nurses. While ward rounds are not the focus of the present study, O'Hare's findings are relevant in illustrating how nurses' knowledge–gained through direct observations – may be undervalued in clinical decision-making (see Asmuss & Svennevig, 2009; Halvorsen & Sarangi, 2015; Kurhila & Lehtimaja, 2019; Linell, 2008. For example, nurses may find their expertise underrepresented due to institutional hierarchies (Kurhila & Lehtimaja, 2019). Drawing on Drew and Heritage (1992), Kurhila and Lehtimaja (2019) describe nurses' professional language as "institutional interaction: it is goal-oriented, shaped by certain institutional constraints, and understood in terms of an institution-specific inferential framework" (p. 110). Their study highlights how nurses enact their professional identity through their linguistic and behavioral engagement in essential professional activities. They further argue that the hierarchical structure of hospital work can lead to the underrepresentation of nurses' knowledge and experiences, particularly in doctor-patient interactions and interprofessional settings. As a result, institutional hierarchies may contribute to the undervaluation of nurses' contributions to decision-making processes.

In their study of literacies involved in the work within elderly care, a sector that has a history of professional knowledge leaning on experience parallel with academic knowledge, Nikolaidou and Karlsson (2012) propose a manifestation of work identity as three folded: institutional, professional, and personal. They show that within an activity of documenting, which tends to be more prominent, taking more and more time from actual caring, the institutional identity tends to be more dominant than the personal identity. This is explained as being a result of an aim to institutionalize documentation, at the expense of regarding personal experiences as a professional, and therefore valuable, knowledge. One's professional identity is constructed together with colleagues in the same workgroup, and the institutional setting with its institutional roles is something that sometimes restrains the professional identity.

This in turn can have the effect that the staff in some cases choose to pass on professional knowledge to colleagues orally rather than through the journal.

The influence of institutional roles on professional practice is further explored by Paul (2017), who examines junior nursing students during their placements. Paul discusses how institutional roles are closely tied to access and hierarchies, formalized through licensing, which determines who is authorized to perform specific tasks or access institutional information, such as digital medical records. This lack of access created challenges for students, who were entrusted with responsibilities but lacked the authority to log into digital systems. As a result, a literacy practice emerged in which students wrote notes for licensed nurses to enter into the system. This dynamic reinforced the students' status as students rather than junior professionals, despite the intended purpose of the placement being to engage in professional nursing practice rather than a "student-in-training" role (Paul, 2017). In another type of educational setting, Wedin and Norlund Shaswar (2019) found that students in a SFI course, remained largely silent, with limited opportunities to engage in conversations, or utilize various speech acts such as arguing, asking questions, or making jokes. Similarly, Rydell (2015) emphasizes that this phenomenon can be understood through the lens of institutional roles. Not all participation occurs through verbal interaction; if expectations for verbal engagement are low, individuals may remain silent, as part of the process of striving for full participation.

Second Language Acquisition in the Healthcare Sector

Research on second language acquisition in the healthcare sector extends beyond physicians to include other professional groups such as nurses and dentists. Studies on foreign-educated nurses, for example, reveal the challenges they face in adapting to a new language and culture (Hull, 2016; Kurhila & Lehtimaja, 2019; Kurhila et al., 2020; Lu, 2018). Research concerning medical doctors' communication has examined core practices such as decision-making, doctor-patient conversations, professional identity, and global mobility (Gulbrandsen et al., 2014; Kahlin & Tykesson, 2018; Wolanik Boström & Öhlander, 2012). Additionally, institutional meetings within the healthcare sector, such as team conferences, have been analyzed with a focus on interprofessional competence and linguistic strategies that facilitate communication. According to Lundgren, there are very few studies with a focus on "conversations 'backstage", with no patients involved" (Lundgren, 2009, p. 54; see also Kahlin & Tykesson, 2018).

At a micro-level, studies have explored repair strategies used by nurses during ward conversations (Kahlin et al., 2019) and the complexities of shared decision-making (Gulbrandsen et al., 2014). Additionally, research indicates that electronic medical records function as an implicit participant in medical conversations, influencing discourse structure and decision-making processes (Berg, 1996; Swinglehurst, 2011).

Opportunities for Linguistic Interaction During Placement

Language acquisition in professional settings is dynamic, with both formal education and workplace experiences providing affordances for learning (Suni, 2017; Van Lier, 2000). While placements can stimulate language acquisition, passive exposure alone is insufficient; active language production is essential (Kahlin & Tykesson, 2018). However, research suggests that placement opportunities do not always result in active linguistic participation (Febring, 2024; Sandwall, 2013). Additionally, Suni (2017) demonstrates that placement programs, even when well-structured and supported by mentors or other forms of assistance, do not inherently serve as opportunities for active language production (Suni, 2017, p. 209–212). Different professional environments offer varying levels of linguistic interaction, with some workplaces being more verbal than others (Söderlundh et al., 2020; Walldén, 2023). Eklund Heinonen (in press) shows, through an analysis of language-related episodes (Swain & Lapkin

1998, p. 326), that during placement as well as instruction in class, the same student as in this study participates explicitly in a limited number of language-related episodes. She can be described as primarily linguistically passive, in the aspect that she primarily listens (Eklund Heinonen, in press). Furthermore, linguistic anxiety and limited social interaction can hinder second language learners' willingness to engage in conversations (Duff et al., 2002; Walldén, 2023). At the same time, as already mentioned, both Rydell (2015) and Wedin and Norlund Sharswar (2019) discuss how silence can be understood through expectations within the space for one's institutional role; not all participation means to be verbal communication.

Professional Identity and Workplace Integration

One way of understanding participation and practices is through the lens of community of practices and legitimate peripheral participation (see "Theoretical Concepts") (Hållsten, 2008; Karlsson & Nikolaidou, 2011; Wenger, 1998). At the same time, the professional identity as a medical doctor might go beyond the community of practice at a specific workplace (Wolyniak Boström & Öhlander, 2012; for a further discussion of professional identity versus institutional, see Nikolaidou & Karlsson 2012). Also, migrating medical doctors often experience a shift in their professional identity as they adapt to new linguistic and cultural norms. Additionally, skills needed in a professional setting are not always to be referred solely to the linguistic register, but rather interactional competence for working together in a new language setting as such (Allwood et al., 2007; Celçe-Murcia, 2008; Kahlin & Tykesson, 2018). In that sense, interactional competence extends beyond linguistic proficiency to encompass the ability to engage effectively in workplace communication (Kahlin & Tykesson, 2018; see also Celçe-Murcia, 2008 for the concept of communicative competence).

The ability to navigate cultural and linguistic barriers is thus integral to successful professional integration. Studies support this, showing that perceived language barriers encompass not only semantic misunderstandings but also other challenges, affecting professional legitimacy and competence. For example, Skjeggestad et al. (2017) discuss how what they call "language barriers" encompassing wide range of topics: not only semantics, but also pragmatics, sometimes regarding culturally sensitive topics, could provoke uncertainty of medical doctor's competence which in turn threatened their professional identity. The foreign medical doctors experienced their knowledge and status as valued less in the new country (Skjeggestad et al., 2017, pp. 1468–1470).

Theoretical Concepts

Institutional Roles and Professional Identity

Theoretically, the study draws upon the concept of institutional roles and institutional settings. From this view, institutional communication is shaped by predefined roles, influencing communication patterns and professional interactions (Drew & Heritage, 1992). Institutional communication, such as in the team meeting, reflect structured hierarchies where access to information and authority to participate varies among professionals (Halvorsen & Sarangi, 2015). Research suggests that professional identity in such contexts is negotiated through language use, interactional competence, and recognition of expertise (Kurhila & Lehtimaja, 2019; Paul, 2017).

The institutional identity is the one we adopt through our position in an institution. It can also be manifested discursively, for example, expressing oneself according to institutional rules and settings can be limiting for a person's professional identity. Nikolaidou and Karlsson (2012) explains that a professional identity is constructed together with colleagues in the same workgroup, based on belonging and participation in a common practice (while a personal identity is based upon more personal experiences) (Nikolaidou & Karlsson, 2012, p. 510).

Particularly relevant to the team meetings analyzed in this study, Linell (1990) argues that institutional conversations in, for example, institutional settings, are structured around specific agendas, which shape the participation of both those in leading roles and other attendees.

The study will analyze the institutional roles assumed by the other doctors in the setting. It will specifically examine student Ewa's institutional role and the ways in which she is invited to participate linguistically in various practices, and finally how Ewa's professional identity as a trained medical doctor on some occasions is made relevant and in other circumstances, does not align with her assigned institutional role as a student.

Community of Practice, Participation, and Trajectory

Of theoretical interest is Wenger's (1998) concept of *community of practice* and *legitimate peripheral participation* (LPP) as a foundational framework. However, its objective is not to investigate whether or how the hospital team constitutes a community of practice, nor to compare this team to the broader professional community of medical doctors. Rather, the notion of LPP serves as a theoretical lens to discuss how the student Ewa's actions and participation can be understood and enables an exploration of the type of participation Ewa may be striving for and provides insight into how her actions can be interpreted. Wenger (1998) uses the concept of *trajectory* to capture the individual's "pathway" towards participation (Wenger, 1998, p.155; see also Cambell et al., 2009). Additionally, LPP offers a means of analyzing the extent to which Ewa's mentor, chief physician Diana, involves (or not involves) her in daily medical practices through verbal engagement. This, in turn, raises questions of legitimacy: who is recognized as a legitimate new speaker or user of the language, and consequently, who is granted access to the core of the community by crossing implicit boundaries?

Setting: The Daily Team Meeting and the Ward Round

Observations within project "Working in a Second Language: Literacy Practices and Educational Models Designed for Professional Contexts" show that a significant part of the day of placement was spent on doctor-patient conversations, during the ward round and scheduled patient consultations, but also the interprofessional team meeting, preparing for the ward round. These are thus considered key practices for the doctor (and for other parts of the team): as being named, recurring daily and central to the organization of the work. During the ward round, two doctors (chief physician Diana and assistant doctor Mats), junior doctor Maja, and student Ewa participated (in addition to the patients). The ward rounds were primarily oral, but the doctors had writing at hand, checked their handwritten or printed notes and monitors and thus updated themselves during the conversations.

The team meeting is an example of interprofessional interaction, i.e. where several professional groups collaborate. The idea behind team organization is to have the patient and the patient's needs, and from there include the professionals needed: in this case the team consists of medical doctors, nurses, junior nurses, counselors and physio therapists. These meetings were also primarily oral, but here the digital journal was a central artefact. At the current meetings, doctors, assistant doctors, junior doctors, nurses, occupational therapists and counselors are represented. Nurses had pens and paper in their pockets, and the chief physician sat by the computer screen, in control of the digital journal.

Participants

The key participants for the study are, as already mentioned, student Ewa, chief physician and Ewa's mentor, Diana, assistant doctor Mats, and junior doctor Maja. Other participants are the team members at the hospital; among the nurses, Mia (in four of the transcripts from the team meetings), is the one

getting a more active role, but in total, the team consists of several participants such as junior and senior nurses, counselors, and physiotherapists. During the ward round, there were only doctors participating, but at the team meeting, all professional groups sat down and provided updates regarding every patient: points of discussion included their status since the prior day, next steps in treatment, and considerations around the hospital discharge.

Within the data, two participants – student Ewa and junior doctor Maja – can be regarded as peripheral participants. Maja, currently completing her placement after earning her medical degree, is in a mandatory stage required for obtaining her medical license. In this sense, both Ewa and Maja can be classified as trainees or students; however, their backgrounds differ significantly. Ewa is a trained specialist doctor with limited experience in the Swedish healthcare system, whereas Maja, despite having no prior professional experience, has completed her medical education (and possibly previous placements) within the Swedish medical framework. Within the data, two participants, namely student Ewa and junior doctor Maja, can be regarded as peripheral participants.

Data and Method of Analysis

Data

The data was collected at a minor Swedish hospital in December 2022. The focus lays on the two key practices: the daily team meeting and the daily ward round. In total:

- 2 sets of doctor-patient conversations during the ward round at the hospital involving chief physician Diana, assistant doctor Mats, junior doctor Maja, and student Ewa, as well as 14 patients (in total, there were 14 ward round conversations across 2 days, 3 hours per set, 7 conversations on day 1 and 8 on day 2). (Approx. 63 minutes).
- 2 interprofessional team meetings preparing for the ward rounds: chief physician Diana, assistant doctor Mats, junior doctor Maja, nurse Mia, other nurses, junior nurses, physical therapists and counselors, and student Ewa. (1 ½ - 2 hours per meeting).

Table 1 gives an overview of the data, including the different participants' verbal activity.

Eleven sequences are analyzed. To answer RQ1, sequences when chief physician Diana and assistant doctor Mats are engaged verbally are included; not only examples when Ewa has a dominant role or even speaks are chosen, but also examples when a doctor, whoever is present in the setting, participates

Table 1 *Verbal Activity through Speaking across 15 Ward Rounds and 2 Team Meetings*

Participant	Time of verbal activity through speaking, 2 team meetings (240 min.)	Time of verbal activity through speaking, 15 ward rounds (63 min.)	Time of verbal activity through speaking (303 min.)
Ewa (student)	35 sec.	8 min. 40 sec	9 min.15 sec.
Mats (assistant doctor)	15 min 40 sec	5 min. 15 sec	20 min. 55 sec.
Maja (junior doctor)	44 sec.	1 min. 7 sec.	1 min. 51 sec
Diana (chief physician)	191 min.	36 min.	227 min.
Mia (nurse)	1 min. 45 sec.	0 sec.	1 min. 45 sec.
Other participants	28 min. 15 sec.	13 min.	41 min. 15 sec.

in the conversation. As argued in the introduction, this is a way to better understand the linguistic demands on a medical doctor in general, and not only how much and in what situations student Ewa participates linguistically. This is the case in examples from both the ward rounds and the team meetings. To answer RQ2, every sequence when the student Ewa participates through active verbal participation through speaking is included. To understand the context for the medical doctor, though, some examples when Ewa participates passively, but the other doctors are speaking, are also analyzed. RQ3 is answered by discussing findings from RQ1 and RQ2.

Method of Analysis

To understand what linguistic repertoire the medical doctor needs to participate and what arena of (active) linguistic participation the participants take or are given, the linguistic method of interaction analysis has been used (e.g., Broth & Keevalik, 2020; see also Appendix). The method aims to understand human interaction and how participants in social contexts understand each other. Anchored in actual interaction, it can be used for documenting in what institutional roles the participants are given the opportunity to speak. This can deploy who acts on which institutional role, and how the "linguistic floor" is organized institutionally. Through this, both professional (doctor, nurse, junior doctor, student, etc.) and institutional roles (leader, expert, or "doer"/participant who executes instructions) can be observed in individual examples, based on how the participants act and respond to each other.

In the first step of analysis, recordings from the two days of placement were searched to identify sequences exemplifying the medical doctor's linguistic repertoire. Here the focus has been on chief physician Diana, assistant doctor Mats, junior doctor Maja, and student Ewa. The analysis has aimed to categorize different speech acts (Searle, 1979; Warga, 2013) such as instructing, explaining, gathering information, making jokes, and complaining, with the purpose to identify the doctor's linguistic repertoire more in detail.

Secondly, all sequences where the student Ewa was linguistically actively participating were identified. The sequences were transcribed in detail according to Broth and Keevallik (2020; see Appendix). All names have been replaced by pseudonyms and the participants have given their informed consent to participate in the study.

In a third step, the doctors' linguistic contributions were categorized according to speech acts and topics of conversation. The sequences when the student is linguistically active were categorized according to institutional or professional role: what role she was in was addressed (e.g., as a colleague, a student, an expert), and how does this role align with her professional identity as a trained doctor? The institutional roles in the team meeting as such (not only Ewa's) were also noted, regarding, for example, the leading role or the expert, but also who was provided an opportunity to speak, by whom, and when.

In a fourth and final step, 11 sequences, in total, from the material were chosen for detailed analyses regarding student Ewa's linguistic or communicative participation, and which of those consists of speech acts and/or topics like those chief physician Diana or assistant doctor Mats practice in their roles as medical doctors. In other words, does Ewa's active linguistic participation function as developing relevant language (or other) proficiency? The linguistic sequences were categorized according to type of topic (core medical topic or side topic), and function, through a categorization of specialized speech acts (Searle, 1979; Warga, 2013): for example, decide, make jokes, complain, educate. This part of the analysis explores if and in what way the different topics are related to the institutional roles in the meeting.

Active participation refers to situations where someone produces language verbally (asking or answering questions, comments, and so forth). Passive participation means situations when the person listens, takes notes, backchannels, or in some other way participates actively but not verbally.

Finally, the transcriptions are discussed with the help of the concept of institutional role (Halvorsen & Sarangi, 2015; Linell, 2008), and community of practice, legitimate peripheral participant and trajectory (Lave & Wenger, 1991; Wenger, 1998).

Ethical Considerations

The study is part of the project "Working in a Second Language: Literacy Practices and Educational Models Designed for Professional Contexts" (ref. 2019-06463). Research permission was granted by the Swedish Ethical Review Authority. Participants' confidentiality and anonymity were ensured through the use of pseudonyms and by anonymizing their personal details. Participants voluntarily signed a consent form indicating their willingness to participate in this study. Participants who did not sign the consent form were able to participate in the recordings and their contributions were removed from the data. This included the patients in the recording of the ward conversations.

Results

The analysis consists of 11 examples, from the team meetings and from the ward round patient conversations. Table 1 gives an overview of the material (see "Data").

In the recordings, the chief physician Diana is the one most verbally active, both during the team meetings and during the 14 medical rounds. Student Ewa's productive participation is 9 minutes and 15 seconds of the material's 303 minutes. In the, in total, 14 round patient conversations, there is only one where Ewa is speaking with a patient (ex. 7), for 8 minutes and 35 seconds (of 63 minutes of ward rounds), before chief physician Diana starts participating in the conversation. This can be compared with assistant doctor Mats (5 min. 15 sec.), but also with previous research showing that students doing placement get a chance to participate verbally in a rather limited extension, especially in professional areas that can be considered as "silent" (Sandwall, 2013; Walldén, 2023). Junior doctor Maja, who also gets to lead one ward round, speaks only 1 minute and 7 seconds before chief physician Diana takes over the conversation.

In nine of the material's 11 examples, chief physician Diana or assistant doctor Mats leads the conversation. Six of the 11 examples are occasions when student Ewa takes or is given an opportunity to participate through speaking, in different roles. At the same time, even though Ewa does not speak, she listens actively (turning her head to the person speaking, nodding, taking notes in her notebook). In one of the ward rounds, she is given the role of leading the conversation (ex. 6, 7), and in two examples from the team meetings, she is addressed as a professional, for sharing her professional opinion (ex. 5, 6). In one example from the team meeting, the assistant doctor takes a pedagogical role, and addresses both student Ewa and junior doctor Maja as students (ex. 8). Two of the examples are categorized as language related episodes, in both cases explicitly through initiating the episode (Eklund Heinonen, in press).

The examples chosen aim to illustrate what kind of conversations a medical doctor participates in during a regular working day. The findings have an intention to shed light on the questions of what linguistic practices a medical doctor is supposed to handle, and what functions the different conversations fulfil. Not least, it shows the breadth of topics and functions covered, and what student Ewa in the future therefore needs to handle participation as a medical doctor.

Typical Medical Doctor's Practices: Chief Physician and Assistant Doctor Reason and Make Decisions During Team Meeting

Starting with three sequences to better understand the linguistic and communicative practices for a Swedish medical doctor, examples 1 through 3 shows how chief physician Diana and assistant doctor

Mats reason and discuss different topics during the team meeting. Ewa, doing her placement with the aim to practice Swedish, does not participate in these sequences, even though she is one of the participants in the settings. Still, the sequence illustrates what kind of linguistic situation and in what functions (reasoning together and as in this case, making jokes) a medical doctor might participate in.

Example 1. Chief Physician Diana and Assistant Doctor Mats Reason Together

Example 1 is from the first team meeting, when chief physician Diana reasons together with assistant doctor Mats.

Diana: chief physician Mats: assistant doctor

1. Diana ja de e bra (.) vill (.) ((vrider huvudet mot Mats))
   yeah that's good (.) do you ((turns her head towards))
2. va sa du?
   what did you say?
3. Mats näe ja sa ingenting (ohör)
   no: I didn't say anything (inaud.)
4. Diana men du tänkte nåt *ja hörde de e bra*
   but you were thinking something *I heard that's fine*
5. Mats va ja mm ja bra
   what yeah mm yeah okay
6. Diana ja
   yeah
7. Mats men ja tänkte på hur länge du väljer å
   yeah but I was thinking for how long you choose to
8. ha pregnyl
   use pregnylja

In example 1, chief physician Diana and assistant doctor Mats discuss a specific medicine. The sequence is initiated by Diana making a joke about "hearing him thinking" (line 4). On line 7, Mats introduces a medical topic, asking Diana about a specific prescription. The conversation is friendly, with laughter and jokes about the fact that Diana presumed that Mats was thinking (line 4–5). The example shows how the two doctors think and reason together, and even though Diana is the one initiating a joke, there is nothing in the conversation saying that Diana, as having the institutional leading role, does not allow Mats to get back to the medical topic of drugs.

Example 2. Chief Physician Diana and Assistant Doctor Mats Reason, while Junior Doctor Maja and Student Ewa Listen

Example 2, from the team meeting, shows how chief physician Diana and assistant doctor Mats reason, and how junior doctor Maja and student Ewa listen more actively.

Diana: chief physician Mats: assistant doctor Maja: junior physician Ewa: student

1. Diana hur tänker vi nu? (.) hon har förmaksarytmi:
   what are we thinking now? (.) she has atrial arrhythmia:
2. Maja [mm]
   [mm]
3. Ewa [mm]
   [mm]
4. Diana ööh hon går ganska snabbt öhh å sen hon har ((visar med
   eeh sha walks pretty fast eeh and then she has ((shows with
5. pendelrörelse med armen))(ohör) mellan förmaks och
   a pendelling movement with her arm)) between atrium and
6. kammare öh va e vårat mål nu egentligen med den här pacemaker
   ventricles eeh what is our goal now really with this pacemaker
7. Mats jag tänker de kommer va svårt hon har en (ohör) såatt (.)
   I'm thinking it will be hard she has a (ohör.) so that..
8. Diana varför
   Why

The conversation in example 2 concerns a patient with a pacemaker. Chief physician Diana addresses herself to the whole group asking about the purpose of the pacemaker (line 6–7), and assistant doctor Mats fills in and reasons about that. Both student Ewa and junior doctor Maja give feedback signals (line 2–3), but still, Mats and Diana are the ones verbally active. This can be seen as an example of reasoning, and taking the institutional roles into account, also an example where chief physician Diana and assistant doctor Mats (more or less intentionally) demonstrate this practice to the two, in this institutional setting, students.

Example 3. Chief Physician Diana Decides and Instructs Nurse About the Kidney Test

In following sequence, from one of the team meetings, nurse Mia and her colleague talk overlapping about routines for patients who are about to be discharged, how the domiciliary service solves problems with stairs, corners, and mobility at home, and who is responsible. Example 3 starts when a more medical topic is introduced, by chief physician Diana taking the lead of the conversation. From there, the two nurses become silent.

Diana: chief physician Mia: nurse

1. Diana varanbehandlat och kreatinin ppå hundraförtio:
   treated by varan (.) and cretinine over hundredandforty:
2. ööh fem nitton så de e (ohör) eeh trombonymer
   eeh five nineteen so there is (inaud) eeh (.)tromonyms
3. lite stegrat utan dynami:k ((läser innantill))
   a bit escalated without dynamics ((reads aloud))

/…/

5.Diana frå:gan här om vi inte ska ta lite andraeh
   the que:stion here is if perhaps we should take some other
6. njurprover(.)urat har legat här om vi tar prover
   kidney tests (.)uric acid has been here if we take tests
   imorgon vi skre:
   tomorrow we wro:
7. ((Mia börjar skriva på sitt block))
   ((Mia starts writing in her notebooke))
8. Diana jag skulle gärna önska en kalduomin: urat fosfat
   I would like a calduomin: urate phosphate
9. bikarbonat (12) *hhhann du allt*
   bicarbonate (12) *ddid you get all*
10. Mia mm ((läser högt)) kalcium urat kaldumin å
   mm ((reads out loud)) calduomin: urate phosphate and
11. bikarbonat
   bicarbonate
12. Diana mm
   mm

Example 3, from the team meeting, starts with chief physician Diana reading (from the digital journal) and thinking out loud, reasoning, and making decisions about an upcoming kidney test. The other participants are silent. Diana uses the notes from the journal on the screen as support for decision making. On line 5–6, she indirectly instructs nurse Mia to order lab tests. Mia starts writing without Diana explicitly urging or asking her to do anything. The division of labor seems to proceed automatically, as

if the team meeting is a well-established practice with participants in different institutional roles. Diana with a responsibility for patient care, and the one in control of the digital journal, makes decisions, while Mia knows what is expected and performs her tasks without further instructions.

Student Ewa in a Professional role as a Medical Doctor, Making her Professional Identity Relevant

Example 4 through 7, from the team meeting and the ward round, are all sequences when student Ewa participates not only as a student but as a professional, assigned by chief physician Diana.

Example 4. Chief Physician Diana Asks Student Ewa About Her Opinion I

Example 4, from the team meeting, illustrates how chief physician Diana explicitly asks for student Ewa's opinion as a medical doctor.

Diana: chief physician Mats: assistant doctor Ewa: student Maja: junior physician

1.	Diana	jane synkope vad sa vi vi sa vi gör en
		jane sycopia what did we say we we make a
2.		ansiktsskelett va det nåt mer då
		faceskeleton nothing else then
3.	Mats	[ekg]
		[ecg]
4.	Ewa	[ekg]
		[ecg]
5.	Diana	ja men precis ((till Ewa)) hon låte inte på
		yeah exactly ((addressing Ewa)) she doesn't sound like
6.	Ewa	nej (ohör) ingenting ((skakar på huvudet))
		no (inaud) nothing ((shakes her head))
7.	Diana	nä: paul ((refererar till en ny patient))
		no: paul: ((referring to a new patient))
8.		inte nåt nytt speciee[ellt]
		nothing new speci[al]
9.	Maja	[näe]
		[nope]

[[The sequence continues with assistant doctor Mats explaining symptoms concerning kidneys. Maya nods and listens]]

In example 4, line 5, chief physician Diana asks for student Ewa's professional opinion, rather than addressing her as a student, which can be regarded as her assigned institutional role. The sequence starts with Diana talking about a patient's (Jane) symptoms, referring to Ewa's opinion (line 5–9). This is one of four occasions in the whole material, when Ewa is assigned the role as a professional and not only as a student.

Example 5. Chief Physician Diana Asks Student Ewa About Her Opinion II

Another example when student Ewa participates in reasoning about diagnosis is during a discussion about "her" patient (referring to when she leads the medical round conversation, examples 7–8).

Diana: chief physician Ewa: student

1. Diana	(.) reumatisk kanske?
	(.) reumatic perhaps?
2. Ewa	reumatisk kanske (ohör) han e ganska: gammal (.) eftersom
	reumatic perhaps (ohör) he is qui:te old (.)
3.	han har (ohör)vilket är ganska ofta mee njurar å(ohör)
	since he has (inaud) which quite often is with kidneys and(inaud)
4.	vätska anemi
	fluid anemia
5.Diana	(1.0) mm
	(1.0) mm
6.Ewa	((fortsätter turen från rad 4)) och re-(ohör)
	((continues the turn from line 4)) and re-(inaud)
7.Diana	mm (.) men borde ha hög sänka då
	mm (.) but should then have elevated ecr
8.Ewa	jao
	yeah
9. Diana	(2.0) men vi har inte tagit kanske vi borde tar
	(2.0) but we haven't checked perhaps we should
10.Mia	ska vi ta kanske [akut
	shall we perhaps check as an [emergency
11. Diana	[mm
	[mm

Example 5 shows another occasion when student Ewa is addressed as a professional doctor. The fact that chief physician Diana gives recipient support (line 5) instead of taking the turn, is interesting: it is a situation when student Ewa is addressed as a professional not only in line 1 when Diana is asking her about her opinion as a doctor, but, perhaps more in a micro level, also in line 5, when Diana just supports her, not take the turn.

Example 6. Student Ewa is Given the Lead of the Ward Round Conversation

During one of the, in total, 15 ward rounds, chief physician Diana asks student Ewa to lead the conversation. See example 6.

Diana: chief physician Ewa: student

1. Diana ska du ta nästa patient
   shall you take the next patient
2. Ewa mm (.) jag är [namn] läkare hur mår du idag?
   mm (.) I'm [name] doctor how are you feeling today?

In example 6, in one single utterance, chief physician Diana hands over the initiative to lead the ward round to student Ewa. This is done not through an instruction but a question. Ewa responds with a "mm" (line 2) and turns directly to the patient introducing herself. Assignment to take a leading role in the ward round conversation might be a part of being a student, since the aim for the placement is to practice being a doctor. At the same time, student Ewa is a trained professional, with experience from working as a doctor and not participating as a student.

Example 7. Student Ewa Asks for Advice

Example 7 is from the same ward round as example 6. Student Ewa leads the conversation for 8 minutes and 40 seconds. Apart from one occasion, when she has to ask the patient for clarification, the conversation runs with no interruptions from either part. The transcript starts after approximately 1 minute and 45 seconds, when student Ewa turns to chief physician Diana for advice. By asking for Diana's opinion, she opens a conversation between four participants: Diana, assistant doctor Mats, patient Erik, and herself.

Diana: chief physician Mats: assistant doctor Ewa: student Erik: patient

1. Ewa ((till Diana)) kanske någon inflammation?
   ((to Diana)) perhaps an inflammation?
2. Diana vasadu?
   whatdidyousay?
3. Ewa kanske någon inflammation jag vet inte
   perhaps an inflammation I don't know

4. Diana (ohörb)

(inaud)

5. Erik nej de e slag

no it is a stroke

6. Mats nä som e slage

no it is stroke

7. Erik ja för de va de som jag märkte när jag vakna om ja säger

yeah 'cause that's what I noticed when I woke up if I say

8. Ewa mm ((lutar sig fram mot patienten)

mm ((leans over the patient))

9. Diana (ohör) hematom* också

(inaud) hematoma* too

/…/

10. Ewa vi ska göra en utredning så vi får allt(ohörb)-sett

we shall do an examination so that we get everything (inaud.)-

wise

11. Erik ja

yeah

12. Diana en röntgentid

appointment for an exray

/…/

13. Erik står jag inte ut å [hare

what I can't stand [having

14. Ewa [näe

[nope

15. Diana efter vi får svar från röntgen vi kommer att arbeta

after getting results from exray we will work a bit

16. [mer

[more

17. Erik [jaeja
[yeah
18. Ewa mm å vi kommer att återkomma ti dej me svar
mm and we will come back to you with answers
19. Diana å lite frågor om synkopi
and some questions on syncopation
20. Ewa jaa:
yeah:

Example 7 starts when student Ewa asks chief physician Diana for advice, and rather soon (line 5) Erik, the patient, participates in the conversation adding information, which is backed up by assistant doctor Mats (line 6). Even though the conversation develops into a collective matter with more than just two participants, Ewa keeps a leading role, for example in line 10 where she tells patient Erik that he will get an examination. In line 15, Diana takes over, ordinates, and summarizes. Patient Erik does not orient himself towards Diana, which could be understood as him not noticing that the doctor leading the conversation is shifting. Additionally, even though Diana is participating verbally throughout the conversation, she first comments on possibilities that patient Erik may have experienced syncopation (line 19) and secondly, lets Ewa close the conversation (line 20).

Student Ewa in a Student's Role

Example 8 shows how student Ewa and junior doctor Maja are positioned as students, by assistant doctor Mats who takes a pedagogue's role in the conversation.

Example 8. Assistant Doctor Mats Taking the Role as Pedagogue Towards Junior Doctor Maja and Student Ewa

Assistant doctor Mats does not have the institutional role as a mentor, either for student Ewa or junior doctor Maja; that is chief physician Diana's task. Still, a couple of times during the second team meeting, he addresses himself to Maja and Ewa in a pedagogical role, as in example 8 when he explains the kidneys' functions.

Diana: chief physician Mats: assistant doctor Ewa: student Maja: junior physician

1. Diana vi: avvaktar provsvar (.) han verkar inte nåt
we: wait until we get the results (.) he doesn't seem
2. uppenbarligt sviktig tycker ja
obviously failing I believe
3. Mats näe de e lite intressant faktiskt för att han [(ohör)]
no it's a bit interesting really 'cause he [(inaud)]

4. Diana [(ohör)]
[(inaud)]
5. Mats vad är det mer som kan ge ett så pass förhöjt problem fler
what else can give such an elevated problem more than the
6. än hjärtat de sku va för så de e njurar å hjärta va de finns
heart it could be the kidneys and the heart ehh there are
7. ingen annan [genes kroppen å (.)
no other [genes the body and (.)
8. Maja [näe mm nä]
[no mm no]
9. Mats njurarna är inte så [(ohörb)]
the kidneys aren't that [(inaud)]
10. över hundratie på [femtinie]
over hundred and ten over[fiftynine]
11. Diana [nä nä]
[no no]
12. Mats [så ja]
[so yes]
13. Diana nä ja ja
no yeah yeah
14. Mats så ja tror väl inte
so I really don't think

In example 8, assistant doctor Mats takes a pedagogical role, addressing junior doctor Maja and student Ewa as students, explaining kidney functions and similarities between kidneys and heart (line 5–10). Even though chief physician Diana, with responsibility for the two students, participates in the conversation, Mats is the one closing the sequence (line 14).

Shifting Topic From Medical Core Topics to "Other": Chief Physician Diana Arguing and Asking for Assistance

Categorizing the medical doctor's linguistic practices from a functional point of view, chief physician Diana participates not only in core medical topics. Examples 9–11 show how she is questioning an administrative system, complains about a new form to fill in and asks for technical assistance. She also gives herself time to make jokes.

Example 9. New Form for Ordering an Ambulance

Example 9 concerns a new way of ordering an ambulance. Different organizational units of the hospital are discussed by naming them by the name of the department.

Diana: chief physician Mia: nurse

1.	Diana	dee rätt mycke på de
		it i:s quite much on it
2.	Mia	mm
		mm
3.	Diana	eeh (.)ja vet att eeh: att narkosen tycker ju om att ha mål- eeh: (.) I know that eeh: that anastethia like to have target
4.		värden å så (.) me:n (.) ja vet int: de e ju en sak att
		values and such (.) but: (.) I don't know it's one thing when
5.		man har nån som kan koden å fylla i liksom målvärden
		you have someone who knows the codes and fill in sort of target values
6.		på blodtryck på david
		on blood pressure on david
7.		nån som ändå e stabil eller på: peter
		or someone who is stable anyhow or fo:r peter
8.		som är ännu mer [ja:
		who's even more [yeah:

In example 9, chief physician Diana refers to a different professional group, "the anastesia" (line 3), speaking about a new layout of a form to fill in for ordering an ambulance. "The anastesia" is involved in the conversation in the already interprofessional team meeting. To understand this, you need to know a bit about the organization and the work order at the hospital. This can be seen as a kind of knowledge within a community of practice; expressions and names which you perhaps learn to use through participating and not for example, through a course or a manual. Also, of interest is the way Diana expresses her professional opinion even when it comes to such an "off topic" thing as filling in a form (line 5ff). Perhaps you also need to know, institutionally, which topics are accepted to introduce and by whom.

Example 10. Chief Physician Diana Complains About the New Form

In example 10, the conversations from example 9 continues; here, chief physician Diana complains about the new form.

Diana: chief physician Mats: assistant doctor Mia: nurse Anna: junior nurse

1. Diana men ja [fyllde inte i
   but I [didn't fill in
2. Mats [eller precis nänä
   [or exactly no no
3. Diana men för att: det brukade va en ann- eller tidigare ha
   but to: it used to be an- another or earlier have been
4. varit en annan lapp när vi eh skickade dom till
   another piece ((of paper)) when we eh sent them to
5. narkossyrra so-som fyllde i [som man
   nurse wh- filled in [that you
6. Mats [aah
   [o:kay
7. Diana öh men de börja likna dom tycker [ja
   eh but it starts to look like them I [think
8. Mats [aa precis (.) ja
   [ah exactly (.) yeah
9. Diana men för enkla patienter de känns överdrivet tycker ja
   but for simple patients it feels overrated I think
10. Mats ja
    yeah
11. Diana then you perhaps should have two different:
    då kanske man borde ha två olika:
12. Mia ja så man kan välja
    yeah so you could choose
13. Diana ja
    yeah
14. Anna ja
    yeah

15. Mia precis

exactly

16. Diana öh (.) bra bara ja blev lite förvånad ((visar med handen)) ja

eh: (.) ok I was a bit surprised ((shows with her hand)) I

17. va nästan va på väg att inte skriva ((skratt))

was almost about not to fill in ((laughs))

18. Anna *nä precis*

no exactly

19. Mia (ohör) vart de tagit vägen

(inaud) where they went

In example 10, being the chief physician, Diana complains about the new form they have to fill in to order an ambulance. As head of department and as the chief physician, Diana's institutional role might enable her to show resistance against the changes in the administration. As many as three of the other participants (assistant doctor Mats, and two of the nurses, Mia and Anna) back her up (lines 10, 13, 14, 15, 18). But still, it is Diana who introduces this "off topic" of complaining on another unit. Notably, even though many of the participants in the team meeting participate in example 10, student Ewa does not.

Example 11. Chief Physician Diana Asks for Technical Support

The last example, 11, shows how topics of conversation can be affected by technical issues. Here chief physician Diana hands over the initiative to assistant doctor Mats, who seems to be more comfortable with the digital system.

Diana: chief physician Mats: assistant doctor Mia: nurse

1. Diana men nu e frågan e de här (3) e de inte två dagar

but now the question is this (3.0) isn't it two days

2. ihopskrivna eller ((visar med handen))

put together or ((shows with her hand))

3. Mia de där e ju natten som ha [skrivi]

that's something the night has [written]

4. Diana [jaeo men ibland de blir så

[we:ll but sometimes it

att de blir så att de blir två dagar ihop

happens that it will be two days together

6. Mats jah öhha

yeah eeh:

7. Diana hu-hu [s:]

hu-hu [s:]

8. Mats [men dubbelklicka på den här (.) eerah å sen ta avbryt

[but doubleclick on this (.) and then choose cancel on

på den här (.) e:h å sen så får du byta:

on this (.) e:h and then you have to change:

In example 11, the digital journal entails a topic shift into something that does not include any medical themes at all. Chief physician Diana hands over her institutional role as an expert to assistant doctor Mats. This seems to be carried out smoothly, with no face threat. One way to understand this, is Diana being safe in her authoritative expert role medicine-wise, and therefore having no problems stepping aside in this situation. Another explanation can be that since she is in a position of authority medically, she does not think technical expertise is her issue. This can be seen as rather similar to other professional practices, for example, within academia. Research experts might not be technical experts, and the institutional roles might shift in situations similar to example 11.

Discussion

This study has on one hand focused on how medical doctors at a Swedish hospital occupy and shift between different topics and speech acts within their institutional roles, and in what institutional roles they participate. On the other hand, it has analyzed how and in what roles, student Ewa, within a course in medical Swedish, participates linguistically during her days of placement at the hospital. What insights do these topic and speech act shifts and understanding of student Ewa's participation provide about the communicative practices involved in being a medical doctor at a Swedish hospital?

To conclude, the study's chief physician Diana and assistant doctor Mats do a lot of different things verbally during their working day. The 11 transcripts show a variety of speech acts, which can be framed in different functions, both medical and more off-topic. The chief physician Diana is the most dominant participant, verbally, and she is also the one doing most shifts between topics. In contrast, student Ewa's verbal participation during team meetings and ward round conversations is notably limited compared to her colleagues. Across the 303 minutes of recorded observations, she actively engages for only 9 minutes and 15 seconds. The most substantial period of her verbal engagement occurs when she leads a medical round for 8 minutes and 40 seconds. However, even this instance is curtailed when chief physician Diana, assumes the initiative following a question posed by Ewa. Beyond this, during the team meetings, Ewa contributes verbally for approximately 1 minute and 35 seconds. But, to capture a view of language as one means, among others (for example, listening and taking notes), for participation, Ewa engages in more ways than just verbal activity.

Student Ewa's participation occurs partly within the professional identity of a medical doctor. She is assigned the responsibility of leading one medical round (of 14), asked to provide her professional opinion on two occasions, but is positioned as a junior doctor two times, when responding to a question about the effects of a medication and the purpose of a pacemaker. Her verbal contributions emerge in two distinct ways: either she is explicitly allocated the speaking turn by the chief physician (e.g., in examples

4, 5, and 6) or she independently initiates a contribution by addressing herself to the patient, after chief physician Diana allocates her the initiative in the ward round (example 6). Notably, her role and participation pattern are not parallel to those of junior doctor Maja, as being invited to contribute their professional perspectives by the chief physician.

Despite being a trained medical professional, Ewa does not participate in all practices that are integral to the doctor's professional role, for example, thinking aloud while making decisions, gathering information by asking questions, engaging in reasoning with colleagues and other professionals, explaining procedures to patients, and delegating technical issues to appropriate personnel. Her limited engagement in these speech acts aligns in this sense with junior doctor Maja's participation patterns, suggesting that both individuals, though at different career stages, share constraints in their workplace interactions.

Additionally, chief physician Diana is the only individual observed initiating informal topics during the meetings and rounds (examples 1, 9, 10). She makes jokes directed at both team members and patients, expresses complaints about the administrative system, and shares anecdotes. These social and institutional discourse strategies remain exclusive to her role and are not adopted by either assistant doctor Mats, student Ewa, or junior doctor Maja. This differentiation in interactional style underscores the hierarchical structure of communication within the medical team and highlights how certain forms of engagement, such as humor and institutional critique, are linked to professional authority and seniority.

Linguistic Participation for a Trained Medical Doctor Participating as a Student Doing Placement, and the Complexity of Medical Communication

The assumption that practical training through workplace placements is crucial for acquiring a second language is widely held (Van Lier, 2010). This study provides insights into the linguistic contexts in which a doctor at a Swedish hospital participates, and highlights the extent to which a student at a course in vocational Swedish doing her placement at the same hospital, is given opportunities for active language use.

The linguistic demands placed upon medical doctors are substantial (Hållsten, 2023). Although this study does not focus specifically on doctor-patient interactions, it demonstrates that medical professionals engage in communication for a significant portion of their workday, interacting with multiple professional groups for various purposes.

Student Ewa participates as a student doing placement. At the same time, she is a trained professional. This might create a "hybridity" concerning the institutional role on one hand, and her professional identity on the other. From an institutional perspective, chief physician Diana's role is central in structuring team meetings and other professional interactions. This role may represent a (future) potential position for student Ewa, yet it also highlights the hierarchical structure of medical discourse. Chief physician Diana leads the team meetings, controls access to patient records, and undoubtedly holds ultimate responsibility for patient care. She actively shapes the discussion during the team meeting by switching topics, reasoning aloud, delegating tasks, and engaging in both formal and informal discourse. The digital patient journal reinforces this institutional authority, determining which information is accessible and who controls the meeting agenda. Another aspect, highlighted in the follow up interviews with the chief physician, is the professional demands on the medical doctor: demanding procedures, responsibility for life and death and patient security, often in a high tempo, which can explain the necessity of a specific hierarchy.

Despite being a licensed medical doctor, Ewa lacks a Swedish medical license, which institutionally excludes her from decision-making responsibilities. While her limited proficiency in Swedish may contribute to her minimal verbal participation, other factors must be considered. As shown, team meetings encompass a variety of speech acts and functions, including jokes, complaints about administrative systems, and professional storytelling. These interactions are integral to professional identity and workplace integration but remain largely inaccessible to Ewa in her current role.

Medical team discussions incorporate both core content (e.g., diagnosis, medication, and testing) and non-core content (e.g., administrative procedures, interdepartmental routines, and institutional navigation). Diana's linguistic participation includes humor, complaints, and task delegation, highlighting the multifaceted nature of medical communication. For instance, discussions about ordering an ambulance (examples 10 and 11) extend beyond patient care, touching upon bureaucratic aspects of hospital operations. This suggests that the linguistic demands of medical practice are not confined to "medical Swedish" in the narrow sense but require adaptability and contextual understanding, including making small talk and jokes. The challenge for Ewa, therefore, is not merely acquiring, for example, a medical vocabulary, but also developing the pragmatic competence necessary to navigate professional interactions. This raises critical questions about whether placement aiming at improving one´s professional Swedish sufficiently supports the development of communicative competence (Celçe-Murcia, 2008) in professional practice.

Language Learning and Participation

Student Ewa's participation can be understood through the lens of Legitimate Peripheral Participation (LPP) (Lave & Wenger, 1991; Wenger 1998). As a trained doctor but a novice in the Swedish medical system, she is positioned on the periphery of the community of practice. Unlike junior doctor Maja, who has completed her medical education in Sweden, Ewa faces dual challenges: adapting to the professional culture and acquiring the language skills necessary for full participation.

Despite these differences, Ewa and Maja institutionally share a "junior" status as medical doctors in Sweden. Another potential similarity lies in their professional trajectory: rather than seeking a permanent position at this specific hospital, their primary objective may be obtaining a Swedish medical license. Thus, their goal may not be to become full participants in this particular community of practice but rather to attain full participation within the broader "community of medical doctors."

This might raise questions about Ewa's trajectory within the community of practice (Wenger, 1998). Is her primary goal to practice Swedish, to learn how Swedish doctors work, or to understand linguistic expectations? If her aim was solely to improve her Swedish, one might expect her to take more conversational initiatives or seek opportunities for extended discourse. However, her observed behavior may suggest a different priority; to understand institutional roles and professional practices within Swedish healthcare.

The concept of silent participation warrants attention. Rydell (2015) notes that certain institutional roles necessitate remaining silent. In this context, silence may not indicate linguistic deficiency but rather an institutional expectation: Ewa's role does not grant her authority to initiate medical decisions or lead discussions. This aligns with the hierarchical structure observed in team meetings, where the chief physician's leadership is reinforced through access to medical records and decision-making responsibilities.

Implications for Language Education and Workplace Integration

If language placements do not facilitate active language production, they may still offer other advantages. Student Ewa's engagement through listening, note-taking, and observing professional interactions provides her with insights into workplace organization and team dynamics. However, previous

research suggests a mismatch between classroom instruction in medical Swedish and the linguistic demands encountered in the hospital setting. Other studies within our project indicate that medical Swedish courses often focus on vocabulary and structured dialogues rather than dynamic, multi-party interactions in real-world practice.

This prompts a fundamental question: Are the linguistic or communicative practices emphasized in medical Swedish courses aligned with those required in professional life? If not, adjustments may be necessary. Drawing on Walldén's (2023) observations, research on language learners' integration into workplace settings has largely focused on specialized training programs requiring advanced proficiency. However, there is a relative lack of research on how placement-integrated teaching can support adult migrants entering professional fields such as medicine. Research in this field will provide important knowledge about authentic linguistic demands, and about the institutional setting which is important for designing an educational program in a way that fulfils it's aims.

Future Considerations and Conclusion

The findings underscore the complexity of linguistic integration within professional communities. While workplace placement is valuable, it must address communicative competence (Celçe-Murcia, 2008) alongside institutional, professional, and social dimensions of communication. For student Ewa, the placement serves as a window into the linguistic practices of Swedish doctors but does not necessarily provide an environment conducive to active language use. This raises implications for structuring placements for medical professionals.

In sum, language placement alone is insufficient for linguistic development unless it incorporates opportunities for active participation (Suni, 2017). As a student, Ewa participates institutionally as expected: she adheres to the professional hierarchy, respects decision-making boundaries, and orients herself toward the communicative norms of the setting. However, Ewa's limited verbal engagement draws attention to how vocational language training can better support linguistic and professional integration in high-stakes fields such as medicine. This, in turn, calls for structuring placements för professionals to support both language acquisition and experience of work order (institutional and other), for example, through facilitating for mentors organizational and timewise.

A critical reflection of micro-level analysis of authentic communication in the workplace can raise broader questions of equity and access for migrant professionals as well as for structural boundaries. Future research should explore how placement-integrated language education can facilitate observational learning and active language use, ensuring that trainees are equipped with both medical Swedish and the interactional skills required for professional practice.

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Appendix

Transcript Notation

[ ]	Simultaneous utterances and/or overlaps
( )	Indicates that the transcriber is in doubt about what is being said
(.)	Pauses of less than (0.2) seconds
(1.0)	Measured pause in seconds
?	Question intonation
:	Indicate(s) that the sound followed by the colon(s) is prolonged or extended
(( ))	Embodied action or contextual information
yes	With laughter
<u>Good</u>	Produced with emphasis