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Respected physician in Syria, unemployed refugee in the Netherlands: An analysis of the integration of Syrian refugees with a medical degree in the Dutch medical field

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ABSTRACT

Refugees in the Netherlands are expected to integrate in society and find employment. Despite years of education, Syrian refugees who graduated in medicine (SRGMs') struggle to enter the Dutch medical field. To ensure patient safety, physicians with a medical degree obtained outside Europe are obliged to finish an 'assessment procedure' (AP) and might be forced to redo clinical internships, before being allowed to practice medicine. In this research, SRGMs' experiences were analysed using Bourdieu's capital theory. Semi-structured interviews were conducted with 17 SRGMs. In Syria, they acquired much capital as physicians, in the shape of financial means (*economic capital*), connections (*social capital*), medical degrees and skills (*cultural capital*), and status (*symbolic capital*). Their medical skills often provide the only capital that remains when arriving in the Netherlands, but it loses value as they have to prove their competence first in the AP. This is a long and arduous process. The mean duration, for those who had yet finished the AP, from arrival to employment was 4.5 years (n = 5, range 2.7–5.8 years). SRGMs experience difficulties in these AP years because they are forced to study from home and feel excluded from medical practice. They are unable to regain their economic, social and symbolic capital, whilst struggling to get their cultural capital acknowledged. Mentally this is challenging and when they do finish, this capital gap leaves them at a disadvantage when applying for competitive job applications. Once employed, SRGMs need time to adjust but are finally rebuilding their capital and integrating in Dutch society. Both SRGMs and Dutch society benefit when SRGMs' integration in the Dutch medical field improves. Although certain challenges for SRGMs seem inevitable, by offering a clinical internship *before* the assessment of SRGMs' skills, their capital acquisition might improve which would facilitate their integration.

1. Introduction

In 2011, uprisings against the Syrian government started which were forcefully suppressed by the government, leading to a violent and now protracted armed conflict in Syria. This has forced many Syrians to flee the country and by 2018 about 90,000 Syrians had arrived in the Netherlands (Vluchtelingenwerk Nederland, 2019). As refugees, the government expects them to integrate in Dutch society. *Integration* can be described as the settlement process, interaction with the host society, and the social change after immigration (Penninx and Garcés-Mascareñas, 2016). Although there is not one agreed upon definition of integration, *labour market participation* is often described as an important element to determine the integration success of refugees (Alencar, 2018; Konle-Seidl and Bolits, 2016; Papademetriou and Benton, 2016). Although labour market participation of Syrians refugees in the Netherlands is increasing, it still appears to be relatively low (Dagevos et al., 2020). Only 5,7% of Syrian refugees have an official job two years after their arrival in the Netherlands (CBS, 2018) and 70% of the Syrian refugees who arrived in 2014 were still dependent on social welfare in 2018 (Dagevos et al., 2020) This is notable given their high educational attainment: 92% of Syrian refugees in the Netherlands received education before arriving in the Netherlands, of which 31% attended university (Dagevos et al., 2018). However, research in the Netherlands has shown that higher education of refugees generally does not lead to better economic integration, which might be caused by the necessity of higher Dutch language proficiency and lack of accreditation of skills (Hartog and Zorlu, 2009).

One of the professions in which entering the labour market appears

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to be very difficult for highly educated – and sometimes highly experienced – Syrian refugees is that of healthcare professionals. There are no precise numbers or scientific analyses of the labour market participation of Syrian refugees who graduated in medicine (from now on referred to as *SRGMs*) in the Netherlands, but Dutch media have shown that they struggle with re-entering the medical field (Aerts and Van Beemen, 2019; Online news article; Wittenberg, 2019).

Medical schools around the world differ in terms of education standards, curricula, and assessment methods. Therefore, many countries have developed programs to assess the competence of *international medical graduates*: physicians who graduated from a medical school outside of the country where they intend to practice (Herfs, 2009). The precise program often depends on the country where the medical degree was obtained. In the Netherlands, most international medical graduates with a degree obtained in Europe (i.e. the European Union, the European Economic Area and Switzerland) are directly allowed to practice medicine after their degree is verified and they have passed a language exam (CIBG, 2023). However, all physicians with medical degrees obtained outside Europe are legally obliged to undergo an *Assessment Procedure* (hereinafter referred to as AP) before they receive a physician's registration (Wet BIG, 1993). This AP is organised by the "Committee of International Health Graduates" (Commissie Buitenlands Gediplomeerden Volksgezondheid, CBGV), which belongs to the Dutch Ministry of Health, Welfare and Sport. The AP consists of two main examinations, for which candidates must pay approximately €2200 in total (CBGV, 2021a; CBGV, 2021b). The first is the examination of general knowledge and skills, which consist of practical and written subtests that assess Dutch and English language proficiency and knowledge of the Dutch healthcare system (CBGV, 2021a). The second is the examination of professional knowledge which consists of two written examinations assessing theoretical and applied medical knowledge respectively, and a practical examination in which candidates' clinical skills are assessed during patient consultations (in Dutch). Based on the results of these examinations, the CBGV determines whether a candidate will be obliged to do additional (unpaid) clinical internships before receiving their Dutch physicians' registration (CBGV, 2021b). However, all candidates only receive a registration as basic physician. In order to work as a specialist, physicians with a specialists' title obtained outside Europe must either attempt to get their specialists' title acknowledged by the Royal Dutch Medical Association, or apply for a Dutch residency position and redo their residency (Herfs, 2009). Residency positions in the Netherlands are limited and can be difficult to obtain. Candidates are selected mainly based on their clinical experience, research experience and references from previous employers (De Rover, 2021).

The experiences of international medical graduates in the Netherlands have been investigated before. According to Herfs (2013), they generally understand the necessity of an assessment of their skills and knowledge. However, they encounter problems related to the procedure's long duration, worsened by long waiting times between the examinations, which generally means they are out of medical practice for years and might create reluctance to start with the procedure entirely (Herfs, 2018). Moreover, issues with lack of information and high costs are also mentioned (Herfs, 2018). Herfs' research does not, though, distinguish between the experiences of refugees and non-refugee physicians or between physicians of different nationalities.

The aim of this research was to gain an in-depth understanding of SRGMs experiences whilst integrating in the Dutch medical field, in order to acquire an understanding on how their integration process might be better facilitated by the CBGV or the Dutch healthcare facilities that later employ these physicians. As opposed to Herfs' work, this research specifically investigates Syrian refugees as their experiences in the armed conflict, their culture and their refugee status might influence their integration. Secondly, this paper looks at the full integration process, from arrival to integration in the workplace, rather than just observing the AP.

In this study, SRGMs' experiences were analysed through the lens of Bourdieu's theory of social mobility and capital (1986). Bourdieu defined *capital* as "accumulated labour" which demands investment and is a scarce resource within any field. Capital provides an advantage in achieving a higher societal status and determines one's power position (Pinxten and Lievens, 2014; Stephens, 2008). Although *capital* is a broad concept, Bourdieu (1986) identifies three main types of capital: *economic capital* (money, assets), *cultural capital* (knowledge, skills, educational qualifications) and *social capital* (connections, group membership). According to Bourdieu, each type of capital has its own logic and is non-replaceable, but one type of capital can facilitate the acquisition of other types of capital. Financial means can be used to obtain a university degree for instance, or one's network can be utilised to find a job. Moreover, when these three types of capital are recognised and legitimised, they provide an individual with a fourth type of capital: *symbolic capital* (status, prestige).

Although Bourdieu developed his theory to understand the limits of social mobility, his ideas have also been used in the field of migration to understand migrants' societal position (Erel, 2010). In these studies, a migrant is generally defined as someone who changes their country of usual residence, irrespective of their reason for migration. It has been established that migrants' capital in the shape of educational credentials and professional training is not always fully transferable to the host country (De Vroome and Van Tubergen, 2010). Foreign education is often questioned in terms of quality and compatibility with the host labour market (Friedberg, 2000) and many migrants experience their skills being devalued or not-recognised in their host country, thus decreasing the value of their cultural capital (Erel, 2010). Additionally, language plays an important role: besides promoting social assimilation, language proficiency can be considered an important skill in itself and also influences the assessment of a migrant's non-lingual cultural capital (Soontiens and Van Tonder, 2014). When applying the capital theory specifically to refugees, De Vroome and Van Tubergen (2010) concluded that their chances of finding employment are also influenced by compatibility of their education, and language proficiency.

Furthermore, for SRGMs specifically, integration entails entering a legally protected professional group with its own power dynamics and valuation of capital, which might further decrease SRGMs' capital and complicate their integration. Gomes and Rego (2013) conclude that the medical field is a socially structured place where physicians and medical students take up positions with more or less prestige according to their medical knowledge, "professional behaviour" and relationships in the field. Moreover, the medical field shapes and reproduces capital through the designing of its own educational programme and the establishment of what "professional competence" entails (Brosnan and Turner, 2009). Such notions of competence can be the source of protectionist policies and creation of high entry barriers for (potential) new physicians (Erel, 2010). As the Dutch medical field has its own requirements of the skills and knowledge one needs to be competent, international medical graduates are excluded from the Dutch medical field until their competence has been verified.

2. Methods

In order to understand SRGMs' perspectives and experiences, a qualitative approach using semi-structured interviews was chosen. In this data collection method, an interview guide helps to direct the interviews towards designated research themes, yet simultaneously allows for spontaneous dialogue and emergence of new concepts throughout the research process (Kallio et al., 2016). Thereby, this method is suitable for studying perceptions and opinions without limiting their responses to a pre-determined theoretical framework (Barriball and While, 1994; Wengraf, 2001).

2.1. Participants and sampling

Seventeen SRGMs in the Netherlands participated in an in-depth

interview exploring their experiences whilst integrating in the Dutch medical field. Participants were recruited through two foundations aimed at supporting (medically) educated refugees. These foundations reached out to their members via email and both posted messages on their social media platforms, explaining the aim and context of this study. In response, seventeen SRGMs reached out to the researcher and all were included. No participants withdrew throughout the process. The sample was mostly male (88%) and aged 30–39 (59%), which is in line with the demographics of Syrian refugee population in the Netherlands (Dagevos et al., 2020). Given the relatively small population of SRGMs in the Netherlands, a sample of seventeen was estimated to be sufficient for gaining a comprehensive overview of their experiences. At the time of the interviews, nine participants were engaged by the AP, three were doing clinical internships, and five were working in Dutch healthcare facilities. Table 1 shows all background characteristics of the participants. To ensure anonymity, the provision of specific characteristics is limited.

2.2. Data collection

An initial semi-structured interview guide was developed by the researcher and tested by peer researchers. An iterative development process of the guide was used as new themes which seemed important emerged in the interviews. This guide roughly structured interviews into four segments: life in Syria and consecutively life in the Netherlands before, during and (when applicable) after the AP. Questions were aimed at retrieving their experiences and their perspectives on the full process.

Interviews took place in March and April 2020 and lasted 115 min on average. According to participants' preferences, four interviews were conducted in English and the rest in Dutch. Given the emerging COVID-19 pandemic, interviews were conducted using video calling or regular phone calls. By taking the time to introduce herself and the research, ensure anonymity and emphasise the right to withdraw or skip questions, the researcher attempted to still create a climate of trust in this digital setting.

Table 1
Overview of participants' characteristics (n = 17).

Demographic variable	*n*	Percentage
Sex		
Male	15	88%
Female	2	12%
Age		
20–29	4	24%
30–39	10	59%
40–49	2	12%
> 50	1	6%
Occupation in Syria		
Basic physician	3	18%
Resident	7	41%
Medical specialist	7	41%
Arrival year in the Netherlands		
2013	3	18%
2014	6	35%
2015	3	18%
2016	0	0%
2017	1	6%
2018	4	24%
Occupation in the Netherlands		
Pre-Assessment: language exams	1	6%
Assessment procedure	8	47%
Clinical internship	3	18%
Basic physician	3	18%
Resident	2	12%
Average time until employment in the Netherlands	5	4.5 years

2.3. Data analysis

Interviews were audio-taped and transcribed using the intelligent verbatim style. Some interview segments were left out of the transcripts at participants' request and all participants were enabled to read their final transcript. No desire for further alterations was expressed. Following the conventional content analysis method, interview transcripts and notes were read repeatedly to achieve immersion and derive codes by extracting key concepts from the data (Hsieh and Shannon, 2005). Based on the data, codes were sorted and categorised, and an initial coding tree was developed. After that, all transcripts were transferred to *Atlas. TI version 8* and individually coded using the developed coding tree, whilst adding codes for missing themes. The final tree consisted of 125 codes. Thematic saturation was reached after fourteen interviews, as the last three interviews revealed no new themes. Through this emersion and inductive approach, the researcher aimed to increase internal validity of the findings. After processing the data, all participants received the drafted results section and were invited to provide comments. Except for some minor remarks, all participants who responded (n = 11) expressed agreeance with the content.

To increase the reliability of this research two strategies were applied. Firstly, questions in the interview guide were formulated non-directionally to avoid misinterpretations and steering of answers (Mortelmans, 2013). Secondly, by inducting codes and themes from the transcripts and including many quotes in the results section, the researcher aimed to limit the subjectivity of the selection and formulation of results (Green and Thorogood, 2018).

2.4. Ethical considerations

All participants received a letter informing them about the aim, procedure, right to withdraw at any moment, privacy policy and contact details of the researcher. They all signed an informed consent form before the interview.

3. Results

Most participants ended up in the Netherlands more or less by coincidence and were unaware of the long road to employment that lay ahead of them. Only five out of seventeen participants – who arrived between 2013 and 2018 – had found employment in Dutch healthcare organisations by April 2020. The mean duration from arrival to employment was 4.5 years (n = 5, range 2.7–5.8 years). These years were occupied by the asylum procedure, civic participation courses and examinations, and – mainly – the AP and the clinical internships. Below, their experiences on the road to employment are outlined. As SRGMs' story starts in Syria, the analysis starts there.

3.1. Life in Syria

When participants described their lives in Syria, they emphasise on one hand the privilege of being a physician, and on the other hand the horrors of the armed conflict. As a medical professional, participants describe that they enjoyed a good position in society before being forced to flee. What they describe, can be considered a capital-rich position. During an intense period of medical school they gained knowledge, experience and skills, enriching their cultural capital. Through their clinical internships and work, they became embedded in society and built a professional network, thus acquiring social capital. Moreover, they earned a generous income, which contributed to their economic capital. Lastly, their work as physician gave them a respectable status in society as they performed an important role helping people, which can be considered symbolic capital.

The armed conflict significantly impacted their lives. Literature describes how physicians in Syria treated large amounts of victims under difficult circumstances whilst their profession created additional danger

for them, as physicians were kidnapped for ransom and became a direct strategic target for air strikes or torture (Abbara et al., 2015; Heisler et al., 2015). Participants confirm these conclusions and experienced their work in this violent time as heavy, both physically and mentally.

> *"During that time our hospital was bombed and a part of the hospital was destroyed. But we still had to keep working, the war was still happening in the outskirts of Aleppo. And there were snipers on the buildings around the hospital, so we couldn't be close to the windows, and we had to switch off the lights at night. It was really heavy for us as well. Sometimes I had to stand a full night in the basement, because we were being shot, as a target for the rebels."*

Strikingly, many participants emphasised how much they still appreciated their profession. The circumstances taught them how to deal with emergencies and scarcity, and they mainly remember the lives they were able to save. The armed conflict made them feel even more essential and esteemed.

Although the precise reasons differ per person, for nearly all participants the armed conflict was the root cause for leaving Syria. They had to leave many belongings, family and friends behind, sometimes overnight and often without preparation or ever having considered working abroad.

3.2. Being a new refugee in the Netherlands

For most participants, the first phase after arrival in the Netherlands is dominated by the asylum procedure and obligatory civic participation courses to acquire a permanent residence permit. As a refugee, their first priority lies at finding safety and settlement:

> "*My problem was that I had lost my documents in Libya, so I just wanted to be acknowledged, also as refugee, acknowledged, as human being. And that you can get money from the bank or receive mail.*"

Generally, Syrians rather quickly receive a refugee status and housing (Dagevos et al., 2018). After these basic needs are secured, participants describe their struggle with becoming an unemployed refugee after a life as healthcare professional in Syria. Besides leaving their social network and many possessions in Syria behind, they have difficulties with losing their income and their role as physician. Many participants emphasise how being a physician has become part of their overall identity and how passionate they are about their profession.

> *"In one of the AZCs [asylum centres] my daughter was sick and I asked for medicines and she received a prescription of a too high dosage. (…) So I said: 'I would like to discuss with the physician that the dosage is too high' and she [the nurse] asked me why I wanted to discuss this and said: 'You received this, so just use it.' So I answered: 'Well, I am a doctor as well so I would like to discuss it" and she replied: 'Look, you are now in an AZC as a refugee, I don't care if you are or were a doctor, that's it.' (…) It was painful."*

In participants' experience, without a recognised degree, even their chances of finding a suitable job outside of medicine are slim. One participant – who obtained a second (Dutch) Master's degree in healthcare management – submitted over a hundred job applications and was never recruited. Therefore, all participants rather quickly decided to start the AP. In terms of capital, they experience a painful loss of social, economic, cultural and symbolic capital and cannot find suitable employment to regain this, without having their medical cultural capital acknowledged.

3.3. The assessment procedure

Despite their gratefulness to live safely in the Netherlands, participants experience the AP's duration as a very difficult time. Nearly all of them mention feelings of stress and sadness and many express their fear of poor career prospects in the Netherlands, because they are getting older and are out of practice for a long time. Moreover, many participants describe this time as a period of isolation, as they feel excluded from the medical field. Multiple participants describe how 'being a physician' has become part of their identity and they struggle with not knowing when and if they will be able to exert their profession again. They feel purposeless without working in a hospital, especially given the stark contrast with their hard work and serious responsibilities in Syria. Some describe how this makes them feel unwelcome.

> *"I feel like a fish that is outside the water. And if I start working it will be like you threw a dying fish back in the water, literally giving me breath again. (…) Being a physician in Syria is not a job. It's an identity. So, you can imagine that the Syrian physician here is not looking for a job, he is looking for the identity."*

Nearly all participants justify the existence of the AP with the aim of assuring the quality of Dutch healthcare, but many of them express frustration about its actual execution and the big impact it has on their lives. Generally, three main issues are identified by the participants: (1) the AP does not acknowledge their prior experience, 2) the AP lacks options to gain clinical experience, and (3) the AP can take multiple years.

Firstly, working experience is not taken into account in the AP, thereby diminishing the value of this cultural capital. The clearest example provided by participants is the lack of a special procedure for medical specialists, which means they have to go through the AP with all basic physicians. The AP examinations require knowledge on a wide range of subjects including elementary subjects, such as cell biology and anatomy, which medical specialists have not used for many years. Most specialised participants found it difficult to retrieve this knowledge and experienced it as unjust, as this knowledge does not necessarily contribute to the quality of care provided within their specialty.

> *"Well, first of all, when you asked me in a test, how would this protein interact with this protein when this certain receptor is there or isn't there? That is information that I have read in 1998. And that was 20 years ago. And it's really unjustified to ask a person who is 40 years old to learn that all over again …"*

Moreover, participants explain that – after passing these examinations and obtaining their basic physicians' registration – Syrian specialists' title generally are not recognised in the Netherlands. Therefore, they have to compete with native Dutch physicians for residency positions and redo their residency (which will be further discussed in section 3.4). All participants with a specialists' title (n = 7) describe this as painful and emphasise what a waste of their expertise and knowledge it is. Hereby they mention that specialists' titles from Syria are being recognised in other countries – Germany for example – and that their fellow SRGMs are working there in their original specialties.

Secondly, participants struggle with the lack of options to gain clinical experience before the AP's examinations. As the CBGV only arranges the examinations and – after that – the obliged clinical internships, participants were forced to prepare for the examinations and attain the required knowledge and skills, in their words, "from their own dinner tables". Eight out of seventeen participants attempted to arrange an internship by themselves, but this appears to be very difficult as only one of them succeeded in finding a (part-time) placement. This lack of practical experience in the Netherlands challenges their acquisition of Dutch (medical) language skills, as well as the internalisation of Dutch cultural standards. Although fourteen out of seventeen participants were fluent in Dutch at the time of the interviews, participants emphasise how not being able to practice the Dutch language in a medical setting, makes it difficult to achieve a professional proficiency. In their experience, this negatively influences their performance in the procedure in two ways: not only is Dutch language a skill assessed in itself, all medical knowledge and skills are also assessed in Dutch. Whereas participants generally had no difficulty with retrieving medical knowledge, some believe they underperformed in the written medical examinations because of

this. Moreover, the Dutch notion of medical competence goes beyond formal knowledge and skills. Participants explain that in the practical examination that assesses their communication skills and approach towards patients, they are held to the Dutch cultural standards and unspoken rules. Coming from a different cultural background and with no possibility to gain practical experience, they view this as an unfair assessment. For example, some participants were unaware at the time of the common practice of shaking hands with every patient before starting the consultation, or actively involving the patient in their medical decisions. In Syria, these participants explain, physicians never shake hands with patients and approach their patients in a more paternalistic manner. Participants highlight that they can internalise Dutch cultural standards, but that this requires time and exposure. Since a poorer performance on the examinations can lead to a longer duration of obliged clinical internships (and thus a longer duration of unemployment), many participants express frustration with the lack of options to gain practical experience before being examined.

> *"We can communicate well, but it's really difficult if you have to talk to patients in a different language. (…) Therefore, they might say: 'You are not good in communicating with patients and I have noticed this and this, but that's not right, because I just didn't have any training and that's why I cannot do it well. (…) If you weren't taught, you will make mistakes, for sure, and then you unjustly hear that you cannot do it."*

This contributes to the third main issue: the AP can take multiple years to finish. Most participants study for months or even years in an effort to minimise the eventual duration of the obliged clinical internships. Waiting times between the examinations and before the internships (sometimes many months) further increased the AP's duration. Being excluded from the medical field for a long time not only has a substantial emotional impact on most participants, as mentioned before, but also limits their opportunities to build a professional network. Moreover, they feel as though they are losing clinical knowledge and experience.

> "*It's hard for us, because I have not seen a patient in four years, only as translator*."

> *"Every day that I don't have a clinical internship or need to wait longer, I forget many things, much information. (…) I was finished with my exam and had to wait nine months. Nine months I didn't do anything.*"

Furthermore, many participants describe the financial impact of studying and not being allowed to work as physician for a long period of time. During the AP, sixteen out of seventeen participants were studying full-time and remained dependent on social welfare and/or their spouse's income. This is described as painful by many participants, which is worsened by the pressure many Dutch municipalities put on finding employment. Altogether, the long duration of the AP has a negative impact on their social, cultural and economic capital acquisition.

> *"I'm poor. Part of my income comes from the salary of my wife, and the other part comes from social benefits. (…) So it's … it's making me angry. It's making me nervous. It's making me frustrated because it's not how things are supposed to be. My wife shouldn't be going to work to clean people's houses while I'm sitting at home, studying for exams. That's not how it's supposed to be for medical specialists."*

> *"The first two years were very difficult, because I cannot practice my profession and every now and then I'd receive a message from the municipality: 'When will you work? When will you start?' So that gives pressure, and what jobs will they offer you? They offered me a job as a mailman, and I didn't think it was wrong because every job must be respected, but I've already studied medicine for ten years and worked for fifteen years, so then I have to throw everything away."*

Based on the AP examination results, seven out of eight participants (who had finished the examinations at the time of the interviews) were obliged to do clinical internships before receiving their physicians' registration. Some were disappointed by this verdict as they believe the examination results did not properly reflect their actual competence and struggled with attaining the identity of a student, whilst still feeling like a physician. However, most participants describe how they were glad to work in the medical field again, even as an intern, and acquire practical experience and connections.

Many different suggestions to improve the AP were mentioned in the interviews, but one specifically was emphasised by nearly all participants: to organise one or more clinical internships *before* the assessment of their medical knowledge and skills (albeit after achieving a basic level of Dutch language skills). This way, participants explain, they could gain practical experience, get acquainted with the Dutch style of practising medicine, practice their (medical) Dutch language skills and start building a professional network. The majority of participants believe that a clinical internship early in the process would thus facilitate a smoother integration into the Dutch medical field. Many of them thereby refer to the situation in Germany where international medical graduates can work in a hospital for two years after passing an examination of German language and basic knowledge on the German healthcare system. This way their fellow SRGMs have a few years to gain experience in the field before they take examinations on medical knowledge and clinical skills.

Lastly, nearly all participants described how two supporting organisations were important for them during the AP. The first is Universitair Asiel Fonds (UAF), a foundation which supports for refugee students in the Netherlands by providing loans and guidance. Sixteen out of seventeen participants received a loan for the costs of the AP examinations. The second is Vereniging Buitenlands Gediplomeerde Artsen (VBGA), an association founded by international medical graduates in the Netherlands with the aim of sharing experiences and information. Participants describe how the VBGA was important to them, as they provide much information on the AP and organise workshops to prepare for certain examinations. All participants attended one or more preparatory courses.

3.4. Applying for residency positions

After the AP and the clinical internships, participants describe how the pursuit of their career continues, as they have to apply for a position in a residency program. As mentioned above, during the AP many participants fear this moment of competition with native Dutch physicians. The five participants who had finished the AP confirm the challenge of finding residency positions in their desired (or previous) specialisation. Only two of them had secured a residency position, both outside their original specialty. They believe their limited professional network for references, non-native language proficiency and limited practical experience in the Netherlands limit their chances of obtaining these positions. Moreover, participants highlight that they are usually much older than the applying Dutch physicians, given their refugee background and years spent on the AP. In their experience, their younger Dutch competitors are preferred by hospitals, because they might have more energy and less family responsibilities; require lower salaries; and have a longer working life ahead of them.

In terms of capital, they indeed seem to have a disadvantage compared to native Dutch physicians. Although their physicians' registration guarantees a basic level of knowledge and skills, SRGMs do not have the same level of cultural capital as Dutch physicians who are fluent in the Dutch language and acquire knowledge on the Dutch healthcare system and Dutch professional behaviour in their education. Additionally, Dutch physicians generally have more social capital as they grew up in the Netherlands and have been educated in the Dutch medical field, whereas SRGMs have only lived here shortly and were excluded from the field most of that time.

Naturally, most participants struggled with not being able to (re-) enter their desired (and/or previous) medical specialty, but all five expressed an understanding of the situation and found ways to cope with

it. One strategy they apply is moving to remote regions where residency candidates are scarcer. Another is to apply for positions in less-popular specialties, which generally have a lower work pace, such as geriatrics or insurance medicine.

> *"It remains a dream, that I can do my specialisation again, but the reality is something else, I can say."*

3.5. Working in Dutch healthcare organisations

Although finding employment is an important milestone, most participants describe that for them true integration is a daily process that continues long beyond that moment. Despite successfully completing the AP, they still encounter challenges in the beginning of their employment. Participants mainly mention challenges concerning language; the Dutch regulatory and administrative system; and Dutch cultural standards. Firstly, practicing a profession in a fast-paced environment as a hospital, requires a high level of Dutch fluency, which participants often had not obtained before being immersed in practice and remains challenging. Secondly, Dutch healthcare is bound by a strict regulation of laws and protocols which create a high administrative burden and required participants to obtain additional knowledge of all rules and skills to manage the IT systems.

> *"Foreign physicians, especially Arabic ones, really struggle with typing. We read from right to left, that's one thing. And in our countries, we barely used computers, we write. So, if I have to use a computer, if I have to write a report here at my work … My colleague will write maybe ten or fifteen reports in half an hour, but if I have to write ten reports it will take five or six hours."*

Thirdly, potentially the biggest challenge highlighted by participants was to internalise Dutch cultural standards and make them compatible with their original professional identity, culture and personality. They describe how the relationship with colleagues is more cooperative than in Syria and, as discussed before, they must adjust their approach towards patients. When allowed time, however, most participants emphasise that are able to adapt.

> *"I notice that in the Netherlands 'He's the best and others just watch him' doesn't exist. No, everybody is equal, we must do everything together, cooperate, that's beautiful. We miss that in Syria. In Syria that doesn't exist, cooperation."*

Generally, the employed participants in this study were satisfied about their integration in their workplace, felt welcome in their teams and were having pleasant interactions with their patients. They are finally building a professional network, earn an income and are *recognised* as physicians again. This means that they obtained the necessary cultural capital and are – at last – able to regain their social, economic and symbolic capital. Many participants also described how essential working is for their integration in Dutch society as it brings them in contact with Dutch natives, makes them part of a system and gives them purpose. Moreover – and at least as important – working is essential for their individual wellbeing: it gives them their identity as physician back.

> *"I only see myself as doctor. It's a piece of my identity, but I also want to help people. This is the best way to help people, by being a doctor. (…) It [working as a doctor] has a lot of impact on my personal life, but also financially it's a totally different level. And a piece of identity, as human, that I'm productive and contribute. I received social welfare for five years, that is really unpleasant. And that I can help people, just like in Syria."*

> *"Staying at home, you won't get the feeling that the Netherlands is your home, if you don't serve a purpose in this home. (…) If you work you feel that you have a role in society. Otherwise you're like a rock, you have no purpose."*

4. Discussion

4.1. Experiences of SRGMs in the Netherlands

This study adds a new perspective by analysing a specific group of international medical graduates, namely Syrian refugees, and applying Bourdieu's capital theory (1986) to their experiences.

Interviews revealed how the road to employment is long and arduous, and has a substantial impact on their wellbeing. SRGMs obtain a very low capital position in Dutch society after arrival, whereas they had generally acquired a capital rich position in Syria. They have lost much economic and social capital by leaving their social networks and possessions behind in Syria. Whilst they do bring their medical degree, knowledge, skills and working experience, this cultural capital loses much of its value as the Dutch medical field does not directly acknowledge their medical degree. Along with all other international medical graduates with a degree obtained outside Europe, SRGMs must have their competence validated and go through the assessment procedure, before being allowed to work as a physician in the Netherlands. To pass the AP, SRGMs must not only demonstrate their medical skills and knowledge obtained in Syria, but also acquire new skills and knowledge on the Dutch language, healthcare system and cultural standards. These results illustrate how migration might devalue cultural capital as educational credentials are not always fully transferable (De Vroome and Van Tubergen, 2010); foreign education is often questioned in terms of quality and compatibility with the host labour market (Friedberg, 2000); and the medical field shapes and reproduces capital through the establishment of what "professional competence" entails (Brosnan and Turner, 2009).

The AP appears to be the main hurdle in SRGMs' integration. As being a physician had, for many participants, become part of their identity, not being able to work in the medical field is painful and has substantial emotional impact. Although participants support the aim of the procedure, they described three main problems with its execution. Firstly, SRGMs' previous working experience is neglected and there is no separate procedure for medical specialists, which is perceived as unfair and inefficient. A second issue is the lack options to gain practical experience *before* the examinations. Without being immersed in practice, it is challenging to acquire the required level of Dutch proficiency and adopt the Dutch cultural standards. This relates to the third main issue: the long duration of the procedure, which stems from several years of studying from home, taking examinations, doing clinical internships (for most participants) and long waiting times in-between these steps. In these years, participants experience difficulties with the distance from the medical field, as they lose clinical experience, earn no income and are limited in their options to build a professional network. A vicious cycle is created: SRGMs' lack of confirmed competence keeps them out of medical practice, but being outside practice keeps them from acquiring this competence. In terms of capital, their lack of (acknowledged) cultural capital refrains them from efficiently regaining this cultural capital, thereby limiting their options to rebuild economic and social capital. These findings are in line with Herfs' (2009) conclusions that international medical graduates generally understand the necessity of an assessment of their competence but encounter problems related to the procedure's long duration. Herfs (2018) also highlighted issues with the examinations' high costs. The financial issues participants described, however, mainly concerned them not being able to generate an income for years, and not the costs of the examinations. This might be related to the option – for refugees only – to receive a loan from the UAF for these costs.

After finishing the AP, their struggle is not over yet. Although in theory Syrian physicians can apply for recognition of their specialists' title (CIBG, 2023), in reality Syrian medical specialists' titles are not recognised and they have to redo their residency. When applying for residency positions, participants experience a competitive disadvantage compared to native Dutch physicians. They believe this is related to the

difference in Dutch language proficiency, their limited professional network for references and their older age. Although residency positions are limited and even native Dutch physicians might not obtain a position within their desired specialty, for specialised SRGMs this means they cannot practice their previous profession and their cultural capital in the shape of knowledge, experience and skills in that specific specialty loses much value.

Once employed, they obtain further knowledge and skills, earn an income and build a professional network, and thus are – at last – able to regain their cultural, economic and social capital and regain their position in society. Employment should not only be seen as a marker of successful integration, but also as a means to integrate (Ager and Strang, 2008). This study indeed illustrates how employment is not only a source of cultural, economic and social capital for SRGMs, but they also require capital to achieve employment.

4.2. Suggestions for improvement

The interviews revealed how many SRGMs believe their road to employment in the Netherlands is unnecessarily long and arduous, mainly because of the AP. The question is whether the problems they encounter could be mitigated. As refugees, the loss of social and economic capital seems inescapable, and they must, in any case, acquire additional skills and knowledge, given the differences between Syria and the Netherlands. Yet, the results of this study provide insight in potential improvements that might improve their integration process.

One main issue SRGMs experience with the AP, is the lack of options to gain practical experience before the examinations. As participants suggested, a potential improvement would be to organise one or more clinical internships *before* the assessment of their medical knowledge and skills, rather than *after* the examinations. This would allow SRGMs – in an earlier stage – to gain practical experience, get acquainted with the Dutch cultural standards, practice their (medical) Dutch language skills and build a professional network. Thereby, this might accelerate their acquisition of the necessary skills and knowledge and would decrease their distance to the medical field. From a capital perspective, this would provide them with cultural and social capital, and could potentially decrease the time it takes to receive a practising license, thereby also decreasing the negative impact on their economic capital. Additionally, this change might improve SRGMs' wellbeing during the AP as they remain in touch with the medical world and their learning process is facilitated. Participants hereby referred to Germany. There, international medical graduates must also take examinations to apply for a medical practising license ("Approbation") (Marburger Bund, 2022). However, these physicians can apply for a temporary medical license ("Berufserlaubnis") to work for a maximum of two years whilst their eligibility for the Approbation is verified by the authorities. Compared to the proposed early clinical internship, this has the additional benefit of earning an income. Unfortunately, there is sparse literature available on SRGMs' integration in the German medical field. SRGMs in Germany seem to have comparable problems with cultural and linguistic barriers, bureaucracy, a lack of information on the procedures, and long delays (Abbara et al., 2019; Loss et al., 2020), but it is difficult to draw conclusions on whether or not their integration process is or is not better facilitated. However, one study describes how the application for the Approbation takes SRGMs "very long, i.e. several months up to longer than a year" (Loss et al., 2020, p. 6). This indicates that the procedure might be much shorter than in the Netherlands. Further research would be needed to compare both systems more extensively.

Another main issue SRGMs experience with the AP is the lack of acknowledging working experience and specialists' titles. According to participants, a solution would be to create a separate procedure for medical specialists. Their specialised knowledge and skills could be assessed, and in case of any hiatuses they can be dealt with specifically, rather than to force them to go through the AP and then redo a complete residency program. This way, their knowledge, skills and working experience would be better acknowledged and they would not need to compete with native Dutch physicians for residency positions. Hereby, participants also refer to the situation in Germany where specialised international medical graduates can apply for the recognition of their specialists' title after receiving a basic physicians' registration (Marburger Bund, 2022). This system could serve as an example, although no literature is available to evaluate the potential advantages and disadvantages.

Lastly, the findings of this research illustrate that integration does not stop once SRGMs are employed. Healthcare organisations who employ SRGMs should thus allow SRGMs time to adjust and provide them with proper guidance to optimally facilitate their integration process.

4.3. Relevance

A smoother and faster integration trajectory would, in the first place, benefit the SRGMs. Regaining employment can help refugees become independent, gain a sense of self, overcome cultural differences, improve their well-being, and rebuild their lives (Papademetriou and Benton, 2016). Moreover, through their work, SRGMs become embedded in society as they obtain a role and improve their Dutch language skills. Dutch society profits as well when they become self-supporting, and their knowledge and skills are utilised. Especially since it concerns refugees, who have come involuntary and have limited freedom to move abroad, the Dutch government (and thus the CBGV) should prevent unnecessary hindrances in their integration process.

Although some findings will be specific for SRGMs, especially concerning the experiences in the armed conflict or specific cultural differences, many might also apply to other international medical graduates in the Netherlands. As they might also experience cultural differences and difficulties learning the Dutch language, the provided suggestions might also be beneficial for them.

In a broader sense, this research highlights how stringent policies based on the own responsibility of refugees might hinder their capital acquisition, and thereby their integration, with negative consequences for both the individual and the host society.

4.4. Reflections on limitations

The current findings should be understood in light of the limitations. Among the seventeen participants of this study were only two women. Although males are overrepresented in the Syrian refugees population (60%; Dagevos et al., 2020), this difference does not explain the gap in this study. As there was no selection of participants, it would be interesting to explore the gap: are there fewer female physicians in Syria, less female SRGMs in the Netherlands, less females deciding to undergo the AP, or are they less willing or able to talk to researchers?

Additionally, SRGMs were only included when they were either pursuing the AP or had finished it, whereas some participants mentioned that many fellow SRGMs withdrew from the procedure or never started. Thereby certain issues or challenges with the AP might have been missed, which cause SRGMs to quit or never commence with the integration process. An investigation of their experiences could provide additional clues on how to improve the AP and achieve better integration of SRGMs.

Moreover, this research only investigated SRGMs' own perspective. To truly understand the dynamics around SRGMs in the Dutch medical field, the perspectives of their fellow (Dutch) healthcare professionals and patients on SRGMs' integration and functioning in practice should be investigated. These findings could be used to further improve SRGMs integration and to make sure that all stakeholders are involved and all perspectives concerning SRGMs integration are taken into account.

Lastly, only SRGMs were included in our research. It would be relevant to investigate how other groups of international medical graduates experience their integration in the Dutch medical field, and

whether their experiences are similar to, or differ from SRGMs' experiences.

Author contributions

J.J. Postmes: Conceptualization; Methodology; Data curation; Formal analysis; Investigation; Software; Roles/Writing - original draft; Validation, **R.L. Medeiros**: Conceptualization; Supervision; Writing - review & editing; Validation.

Data availability

The data that has been used is confidential.

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